County of Solano
Community Healthcare Board
Regular Meeting

May 19, 2021
12:00 pm-2:00 pm
Conference Call Microsoft Teams
MS Teams Dial-in number: 1-323-457-3408 and Conference ID: 299 423 65#

Due to COVID-19 social distancing requirements, the Community Health Board meetings will be held via teleconference. To join in for audio only, please use the dial in number and Conference ID above.

The County of Solano Community Health Board does not discriminate against persons with disabilities. If you wish to participate in the meeting and you require assistance to do so, please call Solano County Family Health Services at 707-784-8775 at least 24 hours in advance of the event to make reasonable arrangements to ensure accessibility to the meeting.

Public Comment: To submit public comment, please see the options below.

Mail:

If you wish to address any items listed on the Agenda by written comment, please submit comments in writing to FHS Community Healthcare Board Clerk by U.S. Mail. Written comments must be received no later than 8:30 A.M. on the day of the meeting. The mailing address is: Solano County H&SS, ATTN: FHS CHB Clerk (MS 5-240), P. O. Box 4090, Fairfield, CA 94533. Copies of comments received will be provided to the Board and will become part of the official record but will not be read aloud at the meeting.

Phone:

To submit comments verbally from your phone during the meeting, you may do so by dialing 1-323-457-3408, and Conference ID: 299 423 65#. No attendee ID number is required. Once entered in the meeting, you will be able to hear the meeting and will be called upon to speak during the public speaking period.

Non-confidential materials related to an item on this Agenda, submitted to the Board after posting of the agenda at: https://www.solanocounty.com/depts/ph/bureaus/fhs/community_healthcare_board/ and Family Health Service clinics located at 1119 E. Monte Vista, Vacaville, CA; 2101 Courage Drive, Fairfield, CA; 2201 Courage Drive, Fairfield, CA; and 365 Tuolumne Drive, Vallejo, CA., will be updated at https://www.solanocounty.com/depts/ph/bureaus/fhs/community_healthcare_board/ and emailed upon request. You may request materials by contacting the Clerk at 707-784-8775.

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AGENDA

1) CALL TO ORDER – 12:00 PM

a) Welcome
b) Roll Call

2) APPROVAL OF THE AGENDA

3) APPROVAL OF THE April 21, 2021 MEETING MINUTES

4) PUBLIC COMMENT

This is the opportunity for the Public to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. Due to COVID-19, the public can join as audio only. If you would like to make a comment, please announce your name and the topic you wish to comment and limit comments to three (3) minutes.

5) PROJECT DIRECTOR/CHIEF EXECUTIVE OFFICER REPORT

a) COVID-19 Health Center Impact Update
b) Health Center Operations Update
c) Staffing Update

6) CO-APPLICANT AGREEMENT UPDATE BY DEPUTY COUNTY COUNSEL

7) OPERATIONS COMMITTEE UPDATE REPORTS

a) Fiscal Year 2020/2021 Third Quarter Budget Update – Presented by Fiscal
b) Community Healthcare Board Self-Assessment Results

8) UNFINISHED BUSINESS

None.

9) DISCUSSION

a) Review Community Needs Assessment

10) ACTION ITEMS

a) Review and Approve HRSA H8F Grant Budget

11) BOARD MEMBER COMMENTS

12) PARKING LOT (These items are postponed, until further notice.)

a) Compliance Training and Robert's Rules Review
b) Health Center Marketing Campaign & Website Design
c) The IHI Quadruple Aim Initiative * Health Center Practices*

13) NEXT COMMUNITY HEALTHCARE BOARD MEETING

DATE: June 16, 2021
TIME: 12:00 PM
TO JOIN: Telephone Conference Call
Dial: +1-323-457-3408, Conference ID: 299 423 65#

14) ADJOURN

County of Solano
Community Healthcare Board

DRAFT

REGULAR GOVERNING BOARD MEETING MINUTES

Wednesday, April 21, 2021
Video and Telephone Conference Call

Members Present:

Ruth Forney, Michael Brown, Anthony Lofton, Katrina Morrow, Gerald Hase, Jim Jones, Miriam Johnson, and Brandon Wirth

Members Absent:

Robert Wieda, Sandra Whaley, and Tracee Stacy

Staff Present:

Dr. Bela Matyas, Debbie Vaughn, Dr. Rebekah Kim, Dr. Sneha Innes, Jack Nasser, Tess Lapira, Toya Adams, Anna Mae Gonzales-Smith, Noelle Soto, Cheryl Esters, Clarisa Sudarma, Thomas West, and Nina Delmendo, Janine Harris, Jannett Alberg

1) **Call to Order – 12:05 p.m.**
   a) Welcome
   b) Roll Call

2) **Approval of April 21, 2021, Agenda**

   Motion: To approve the April 21, 2021, Agenda

   Motion by: Jim Jones and seconded by Brandon Wirth

   Discussion: None

   Ayes: Ruth Forney, Michael Brown, Anthony Lofton, Katrina Morrow, Gerald Hase, Jim Jones, Miriam Johnson, and Brandon Wirth

   Nays: None

   Abstain: None

   Motion Carried

3) **Approval of March 17, 2021, Meeting Minutes**

   Motion: To approve the March 17, 2021, Meeting Minutes

   Motion by: Miriam Johnson and seconded by Jim Jones

   Discussion: None

   Ayes: Ruth Forney, Michael Brown, Anthony Lofton, Katrina Morrow, Gerald Hase, Jim Jones, Miriam Johnson, and Brandon Wirth

   Nays: None

   Abstain: None

   Motion Carried

4) Public Comment:

None.

5) Project Director/Chief Executive Officer Report

a) COVID-19 Health Center Impact Update

i. It was mentioned that in Solano County, the number of cases has ranged from 20 to 70 per day with an average of 40 per day, so we remain in the Red Tier. In order to move up to the Orange Tier, we have to cut those numbers in half. The reason we are still in the Red Tier, is because most of the Bay area is in the Orange Tier, but the Sacramento region is in the Red Tier, so our numbers reflect a blend of those numbers, since we are in the middle of those counties.

ii. It was stated that the reason there are so many cases, is because people continue to go to family gatherings and parties, get exposed and become sick. The cases are mostly younger people, and it is suspected that they are tired of COVID-19 or may be convinced that it is behind us but, people are just being careless. This is unfortunate, because it's keeping us in the Red Tier, which hurts our businesses. We will probably remain in the red tier for another couple weeks.

iii. It was mentioned that vaccination rates are improving, but there has been a vaccine shortage, for a while and it was made worse with the Johnson & Johnson hold, so that vaccine was unavailable. The CDC has not decided to release or recall the Johnson & Johnson vaccine. In the meantime our allotment is limited, so we do the best with what we get.

iv. It was noted that as of yesterday, over 50% of the adults in the community have been vaccinated with one dose and over 32% are fully vaccinated, so we are making progress in Solano County. About 76% of people, age 65 and older have been vaccinated with one dose, which is about three quarters of the that population. This is doing a good job of protecting our most vulnerable. About 60% of those ages 50-64 are vaccinated, and about 35% of the people under the age of 50 are vaccinated. The percentage is low for those under the age of 50, because vaccinations were open to these age groups just last week.

v. It was mentioned that there is no real impact on the health centers, and we continue to operate under the OSHA guidelines, for a health facility. We continue to see people ill with COVID-19 and test those people. Jack Nasser has applied to receive additional vaccine from Health Resources & Services Administration (HRSA).

b) Health Center Operations Update

i. It was mentioned that the primary care for adults, pediatrics and dental clinics are fully operational.

c) Staffing Update

i. It was mentioned that FHS is looking at some key, vacant positions to fill. As of yesterday, there were 6 positions that were approved by Fiscal, our Administration and Human Resources Department. We are waiting for certified lists to begin recruitment for those positions. The six positions include a Public Health Nurse, two Nurse Practitioners/Physician Assistants, a Bilingual Office Assistant, two Medical Assistants, one Registered Dental Assistant and a Health Assistant for our Ryan White Program.

ii. It was mentioned that we now have a Sr. Registered Nurse vacancy at our Fairfield Adult Clinic, and we received notice from a mid-level provider in Vacaville, that he will be leaving. There is a plan to backfill those two positions in the future.

iii. It was noted that tomorrow, interviews will be held as a joint recruitment for a Public Health Nurse position, for Public Health, one of our Family Health Services staff will be on the interview panel.

6) Co-Applicant Agreement Update by Deputy County Counsel

There were no updates from Deputy County Counsel, JoAnn Parker.

7) Operations Committee Updates Reports

None.

8) Unfinished Business

None.

9) Discussion

a) Review Patient Grievance/Complaint Process Policy

i. Chair stated this form was discussed, because it sounded like, some patients have some concerns. Maybe they can't be addressed in the policy, but it is on the agenda so questions can be asked about this policy.

ii. It was asked, when a patient files a grievance, how long does the whole process take and how soon do they get back to the person, to let them know they got the grievance? Jack Nasser responded and stated that it is a priority to respond back to the patient, in a quick and reasonable amount of time. They may not have a resolution to the grievance, but will notify them that the grievance was received, that it is being reviewed, and will give them the time frame, in regards, to how long it will take to process the grievance. The staff is asked to update the patient on the progress of the grievance, and once there is a resolution, it will be shared with the patient.

iii. It was noted that there are several consumer members on the board, and that Family Health Services would like to set up a focus group, to discuss their experiences at Family Health Services, and based on their personal experiences, see how the clinic can improve processes and communication. It was mentioned that because the consumer board members are the voice of our other patients, it would be a great idea to create a focus group, with them, aside from this meeting, and present those findings, at this meeting, in the future. This idea was presented to the Board, and it was offered by Jack's team, to have those members partake in that process to help improve patient satisfaction and patient outcomes. Board member, Miriam Johnson, liked the idea and requested to discuss this topic, further with Jack. The Chair agreed that the focus group would be a good idea to meet separate from the Board meeting.

iv. Board member Brandon stated he read the policy and he was looking for a statement in the policy that committed a timeline of and articulated the actions, once the grievance was received, and the participant's understanding of what would happen with that formal grievance. If there is no formal policy on this topic, he encouraged to move towards it. It was noted that there is no timeline in the policy, due to the various types of grievances. Some grievances are resolved sooner than others. As stated earlier, when the patient is informed that their grievance was received, at that time, the patient is notified of a timeline when it could be resolved. It was also mentioned that the policy was updated in

2019 and approved by the Health Resources & Services Administration (HRSA), but it can be revisited in the future. It was clarified that the grievance form is not included in the policy and that the form, is a yellow card, that is available in each of the health centers. It can be handed to the patient to complete or mailed to them. It was stated that maybe when a focus group is in place, input could be considered in updating the policies.

b) Board Self-Assessment

   i. The Chair mentioned that it is time for the Board Members to complete the Board Self-Assessment and that all Board Members should have received the form in the mail, along with a stamped envelope to return the form. The Board Members were advised the forms are due by May 3, 2021. They will be tallied, and a report will be made at the next board meeting.

10) Action Items

None.

11) Board Member Comments

a) Brandon – He expressed interest in starting conversations, to consider in-person board meetings or a hybrid of in-person and/or Zoom meetings. Chair noted that this same discussion was also discussed at the last Executive Committee Meeting.

b) Miriam – She suggested to find a secluded place outdoors, instead of indoors.

c) Ruth – She mentioned that some members may not feel comfortable coming back, in person, so it will be discussed further.

d) Ruth – She thought things were moving forward, even though everything is not safe and out of the woods yet. She stated that a lot of people still don't want to get vaccinated and the Board Members and participants need to do everything they can to protect themselves. She thanked the Board Members, for their patience to meet, using computers and phones, even though it's not easy. Everyone has been getting through it and pretty soon maybe we can do something different. She also thanked the staff for their time, who participated in these meetings, during their lunch hour and it was appreciated.

12) Parking Lot (These Items are postponed, until further notice.)

a) Compliance Training and Robert's Rules Review

b) Health Center Marketing Campaign & Website Design

c) The IHI Quadruple Aim Initiative, "Health Center Practices"

13) Next Community Healthcare Board Meeting

DATE: June 16, 2021

TIME: 12:00 p.m.

TO JOIN: Telephone Conference Call
Dial: 1-323-457-3408, Conference ID: 299 423 65#

15) Adjourn

Meeting was adjourned at 12:45 p.m.

Handouts:

- Family Health Services Patient Grievance/Complaint Process, Policy Number: 500.05 (7/5/2018)
- 2021 Community Healthcare Board Calendar (3/17/2021)

Solano County
Family Health Services

2019 Community Needs Assessment

Published: August 21, 2019

GFA Greg Facktor & Associates

A Consulting Firm Serving
The Healthcare Industry

Forward Thinking Solutions - Proven Results

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I. Organizational Profile

History

Solano County Family Health Services (SCFHS) was originally founded in October 1918, when the Solano County Board of Supervisors opened the Solano County Public Hospital on West Texas Street in Fairfield. The facility began as a fifty-bed hospital that offered surgical, emergency, laboratory, radiology, long-term care, and outpatient primary care services. Staffing included 12 to 15 full-time medical doctors and 30 to 40 nursing and ancillary staff. Over the years, the facility cared for Solano County's indigents, Medi-Cal recipients, and prisoners from the county jail. The County Hospital closed in June 1973. Although the hospital closed, the outpatient primary care clinics continued to operate and see patients five days a week, with some weekend and evening hours offered. The new Fairfield Adult Medical Clinic opened its doors in 2010, as did the Vallejo Medical Clinic. The Vacaville Medical and Dental Clinics opened in 2012.

In 2004, SCFHS became a Section 330-funded Federally Qualified Health Center (FQHC). The mission of the Solano County Health Services Department has always been to provide cost effective services that promote self-reliance and safeguard the physical, emotional and social well-being of the County's low-income residents. SCFHS currently offers medical, dental, behavioral health, vision, pharmacy, education and outreach services through six primary care delivery sites and two mobile medical units located within Solano County. In 2018, SCFHS served over 22,825 unduplicated patients through 75,204 visits and provided care in twenty-six languages.

Services

SCFHS utilizes a patient-centered health home model with a partial open panel for same-day/walk-in care for managing health care services. This approach provides all-inclusive primary care, facilitating partnerships between individual patients and their personal providers, and when appropriate, the patient's family. This allows better access to health care, increases satisfaction, and improves health. SCFHS is dedicated to providing its service area residents with competent comprehensive health care from a primary care team made up of highly dedicated physicians, nurse practitioners, managers, specialists, educators and many other types of providers and support staff.

SCFHS provides comprehensive primary healthcare services by delivering high-quality and accessible services to underserved children, adolescents, and adults. SCFHS's care model is grounded in prevention, wellness, patient stabilization, and related services, including referrals. SCFHS also provides substance use disorder treatment and embraces a harm reduction/low-threshold model of care, and provides case management, as well primary care integration with oral health, mental health, and addiction services.

SCFHS serves Solano County at eight access points: Family Health Services clinic locations (five locations in Vacaville, Fairfield, and Vallejo), a mobile dental clinic, and two satellite medical clinics located within homeless support services. The Family Health Services clinics offer primary care, behavioral health screenings, and comprehensive dental care. Evening and weekend clinics occur on a rotating basis.

- Family Health Services - Vallejo Integrated Care Clinic: 355 Tuolumne St, Vallejo, CA 94590
- Family Health Services - Vallejo: 365 Tuolumne St, Vallejo, CA 94590
- Family Health Services - Fairfield: 2201 Courage Dr, Fairfield, CA 94533
- Family Health Services - Fairfield Pediatric Clinic: 2101 Courage Dr, Fairfield, CA 94533
- Family Health Services - Fairfield Dental: 2101 Courage Dr, Fairfield, CA 94533
- Family Health Services - Vacaville: 1119 E Monte Vista Ave, Vacaville, CA 95688
- FHS Mobile Medical Clinic and Dental Van: 3255 N Texas St, Fairfield, CA 94533

SCFHS provides a wide range of services to address the needs of its community across the lifespan either directly or through referral agreements. These services include:

- General Primary Medical Care
- Diagnostic Laboratory Services
- Diagnostic Radiology
- Screenings
- Emergency Care During and After Hours
- Voluntary Family Planning
- Immunizations
- Well Child Services
- Gynecologic and Obstetrical Care
- Prenatal and Postpartum Care
- Preventive Dental Care
- Pharmaceutical Services
- Case Management
- Eligibility Assistance
- Health Education
- Outreach
- Transportation
- Translation
- Dental Services
- Behavioral Health
- Mental Health Support Services
- Substance Use Disorder Services
- Optometry
- Physical Therapy
- Nutrition
- Complementary and Alternative Medicine
- Podiatry
- Psychiatry
- Dermatology

Overall, SCFHS seeks to serve the safety-net population in its Solano County service area and focuses on offering culturally appropriate medical care to each of its patients. Recognizing that access to care is most critical to maintaining good health, SCFHS has hired bilingual and bicultural providers and support staff to ensure that care is provided with the utmost cultural and linguistic competency. SCFHS is committed to delivering excellent health services in a caring, nurturing, and respectful atmosphere and improving the quality of life for every individual and family in our community. SCFHS's services are available to everyone, without regard to financial position, ethnicity, language, culture, sexual orientation, documentation or immigration status. The private non-profit organization is a fiscally responsible, independent, community health center and a key member of the vital health safety-net across multiple communities.

Governance

SCFHS's governing Community Healthcare Board (Board) consists of local leaders, advocates and health consumers who live and work in the community and is representative of the communities served by the health center. These dedicated individuals approve all major organizational decisions and have fiduciary, quality assurance, and policymaking responsibilities. The Board maintains a clear line of authority through the Chief Executive Officer and executive management team. Current board members are listed herein, with leadership roles appropriately identified:

- Mike Brown
- John Diaz
- Ruth Forney (Chair)
- Carl Holmes
- Sandra Whaley
- Jim Jones
- Anthony Lofton
- Tracee Stacy (Vice Chair)
- Brandon Wirth

II. Purpose & Design of Needs Assessment

Purpose

SCFHS commissioned this needs assessment to discern the specific healthcare needs of its target population in and around its service area. This needs assessment will be shared with Board members, SCFHS staff, funders, local and state government officials as well as federal program officers for the purposes of program planning and fund development. Up-to-date community needs assessments are required by the HRSA Health Center Program to identify and describe target populations and their health needs. This needs assessment is

designed to comply with Health Center Program requirements under Section 330(k)(2) and Section 330(k)(3)(J) of the Public Health Services (PHS) Act.

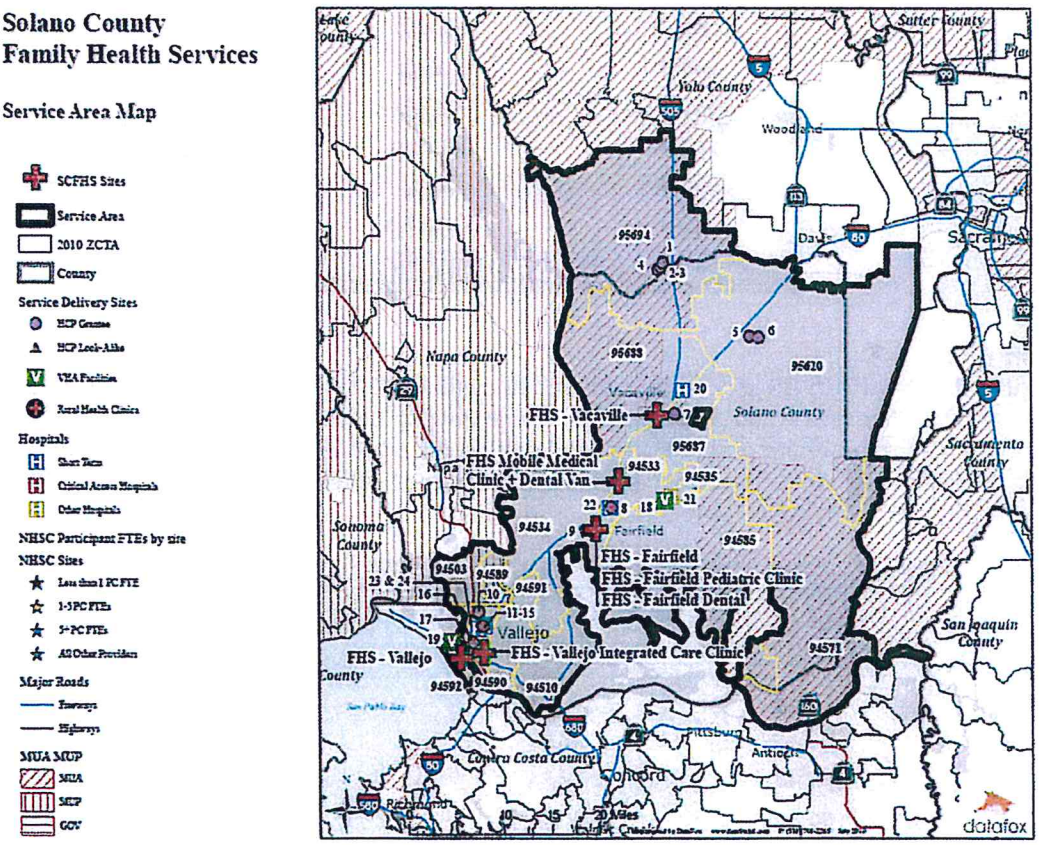
Design

For this needs assessment, secondary data was collected and analyzed from a variety of sources. This quantitative analysis is helpful in highlighting health outcomes that significantly impact a community and can help organizations to better understand which types of services will most positively improve outcomes for their patients. To provide a comprehensive overview, data were located at the zip code, city, state, and national level, where appropriate.

The following data sources were used:

1) Demographic data from U.S. Census Bureau and American Community Survey (ACS)
2) Birth and mortality data from the Birth and Death Profiles published by the California Department of Public Health (CDPH)
3) Health Center Program grantee data from the Uniform Data System (UDS) and UDS Mapper (www.udsmapper.org)
4) UCLA's California Health Interview Survey (www.chis.ucla.edu)
5) Other sources and reports as appropriate and cited

Figure 1: Solano County Family Health Center Service Area Map



III. Demographics

Service Area

Per HRSA, health centers must define and annually review the boundaries of the catchment area to be served, and the identified area must include zip codes in which at least 75 percent of current health center patients reside. SCFHS conducted its patient origin study by reviewing its 2018 data on where their patient populations reside as documented by the zip codes in the health center's electronic health record system. Figure 1 shows the Solano County Family Health Service's service area, which covers 971.4 square miles and includes the zip codes listed in Table 1.

Table 1. SCFHS Service Area Zip Codes

Zip Codes	City
94503	American Canyon
94510	Benicia
94533	Fairfield
94534	Fairfield
94535	Travis AFB
94571	Rio Vista
94585	Suisun City
94589	Vallejo
94590	Vallejo
94591	Vallejo
94592	Vallejo
95694	Winters
95620	Dixon
95687	Vacaville
95688	Vacaville

Population Count

As shown in Table 2, the SCFHS service area population consists of 464,115 individuals, with 122,064 of those individuals residing below 200 percent of the Federal Poverty Level (FPL). Of the 15 zip codes that comprise Solano County's service area, 94533 (Fairfield) has the most residents with 16.12 percent of the service area population; the zip code contributing the least number of individuals is 94592 (Vallejo) with just 0.21 percent of the service area population.

Table 2: Total & Low-Income Populations by Zip Code for SCFHC's Service Area

SCFHS Service Area Zip Codes	Total Population	Low-Income (Below 200% FPL) Population
94503	20,371	4,365
94510	28,043	4,413
94533	74,833	26,100
94534	37,409	4,080
94535	4,130	1,176
94571	9,480	2,427
94585	29,605	7,548

SCFHS Service Area Zip Codes	Total Population	Low-Income (Below 200% FPL) Population
94589	30,833	10,990
94590	37,036	16,232
94591	55,232	14,150
94592	996	240
95694	10,310	2,430
95620	21,588	6,939
95687	67,504	13,270
95688	37,745	7,704
Total	464,115	122,064

Source: UDS Mapper

Gender and Age

In SCFHS's service area, there are slightly more females than males, accounting for 50.34 percent and 49.66 percent of the population, respectively. As shown in Table 3, 25.3 percent of the service area is under the age of 20; 27.5 percent is between 20 and 39; 38.3 percent is between 40 and 69; and, 8.8 percent is 70 or older. Age group numbers across the board are consistent with those of Solano County and California.

Table 3: SCFHS Service Area Population by Age

Age Group	SCFHS Service Area		Solano County		CA	
	Number	Percent	Number	Percent	Number	Percent
Ages 0-9	58,433	12.6 %	54,488	12.5 %	5,019,776	12.9 %
Ages 10-19	59,138	12.7 %	54,733	12.6 %	5,152,529	13.2 %
Ages 20-29	66,469	14.3 %	62,649	14.4 %	5,849,504	15.0 %
Ages 30-39	61,460	13.2 %	57,626	13.2 %	5,442,731	14.0 %
Ages 40-49	58,648	12.6 %	54,524	12.5 %	5,160,830	13.2 %
Ages 50-59	65,225	14.1 %	60,892	14.0 %	5,065,178	13.0 %
Ages 60-69	53,776	11.6 %	50,879	11.7 %	3,866,241	9.9 %
Ages 70-79	26,098	5.6 %	24,864	5.7 %	2,097,028	5.4 %
Ages 80+	14,868	3.2 %	14,326	3.3 %	1,329,030	3.4 %
Total	464,115	100.0 %	434,981	100.0 %	38,982,847	100.0 %

Source: U.S. Census Bureau, 2017 ACS 5-Year Estimates

Race and Ethnicity

SCFHS's service area has a population that is 38.4 percent White Alone, 26.3 percent Hispanic/Latino, 15.5 percent Asian, 13.3 percent Black/African American, and 5.5 percent "Other." (See Table 4.) Since 2000, the service area has seen an increase in the Hispanic/Latino population (64.0 percent), the Asian population (40.6 percent), the self-reported "Other" population (30.2 percent), and Native Hawaiian & Pacific Islanders (27.8 percent). There were decreases in the White Alone (-12.4 percent) and American Indian and Alaska Native (-42.9 percent).

Table 4: SCFHC Service Area Population by Race and Ethnicity

	SCFHS Service Area	Percent of Total			Percent Change Since 2000		
		Service Area	Solano County	CA	Service Area	Solano County	CA
White Alone	178,104	38.4 %	39.0 %	37.9 %	-12.4 %	-12.8 %	-6.6 %
Hispanic or Latino	122,140	26.3 %	25.8 %	38.8 %	64.0 %	61.1 %	37.7 %
Asian	71,787	15.5 %	14.8 %	13.9 %	40.6 %	30.7 %	48.8 %
Black or African American	61,527	13.3 %	13.8 %	5.5 %	5.5 %	3.9 %	-0.9 %
Other	25,422	5.5 %	5.6 %	3.2 %	32.0 %	30.2 %	26.6 %
Native Hawaiian & Pacific Islander	3,827	0.8 %	0.9 %	0.4 %	27.8 %	29.3 %	33.3 %
American Indian and Alaska Native	1,308	0.3 %	0.3 %	0.4 %	-42.9 %	-49.8 %	-23.0 %
Total	464,115	100.0 %	100.0 %	100.0 %	12.7 %	10.2 %	15.1 %

Sources: U.S. Census Bureau, 2017 ACS 5-Year Estimates; U.S. Census Bureau, 2000 Census, Summary File 1

IV. Barriers to Healthcare Access

Poverty

Rising socio-economic status tends to improve health outcomes, while falling socio-economic status tends to decrease levels of health and wellness. Differences in social status, income and wealth, and opportunities for a quality education are often associated with health impacts that disproportionately affect certain populations, such as the poor, young children, and the elderly. Income is one of the strongest predictors of health outcomes worldwide. Health care access, outcomes, and life expectancy improve as income increases.[1] Lower incomes are associated with higher rates of mortality, premature births, and other health issues. Households with higher incomes are likely to have more educated residents, lower unemployment rates, and better access to healthcare. These factors contribute to better health outcomes related to mortality, premature births, and other health indicators.[2] When households earn incomes much lower than the average cost of living, they tend to make sacrifices in important areas. Those lifestyle compromises can include eating less food and/or unhealthier food, living in substandard housing, and/or delaying medical care. Additionally, the lack of resources to meet basic needs causes long-term stress, which makes the body less resistant to other health risks.[3]

As shown in Table 5, 26.9 percent of the population in SCFHS's service area are considered "low income," living below 200 percent FPL, compared with 27.3 percent and 33.9 percent of the populations in Solano County and the US, respectively. In 2019, 200 percent FPL corresponds to $51,500 for a family of four.[4] These residents make up SCFHS's target population, a group that most often lacks health insurance and access to primary care services. Since 2000, the service area has seen a 56.1 percent increase in the number of residents living below 100 percent FPL, a 24.5 percent increase in those living between 100 percent and 199 percent FPL, and an 8.3 percent increase for those at 200 percent FPL and above.

Table 5: Breakdown of Population by Poverty Level

	SCFHS Service Area	Percent of Total (2017)			Percent Change Since 2000		
		Service Area	Solano County	U.S.	Service Area	Solano County	U.S.
Below Poverty	51,134	11.3 %	11.5 %	15.1 %	56.1 %	55.1 %	34.7 %
100% to 199% Poverty	70,930	15.6 %	15.8 %	18.8 %	24.5 %	24.3 %	20.3 %
200% Poverty and Above	331,491	73.1 %	72.7 %	66.1 %	8.3 %	5.3 %	9.3 %

Total Civilian Non-Institutionalized Population	453,555	100.0 %	100.0 %	100.0 %	14.6 %	12.2 %	14.3 %

Sources: U.S. Census Bureau. 2017 ACS 5-Year Estimates; U.S. Census Bureau. 2000 Census Summary 3

In regard to healthcare, various studies have found that those living in poverty face barriers impacting access to care, including: the inability to afford healthcare co-payments, mistrust of providers, inadequate transportation, limited awareness of health resources, long waits, cultural isolation, and fears regarding immigration status. For school-aged children, additional gaps and health disparities exacerbate these barriers.

Residents who live in a poverty-stricken community are often subjected to additional costs and limitations. Research has shown the wide-ranging social and economic effects that result when the poor are concentrated in economically segregated and disadvantaged communities. Concentrated poverty can limit educational opportunities, lead to increased crime rates and poorer health outcomes.[5] Specifically, violent crime rates tend to be higher in economically distressed neighborhoods.[6] For health outcomes, residents living in low-income neighborhoods tend to have worse physical and mental health issues, such as asthma, dental caries, depression, and heart conditions, compared to higher-income areas.[7] Individuals living in poverty are also at higher risk for behaviors that lead to preventable chronic diseases such as limited physical activity, poor dietary habits, high alcohol consumption, and cigarette smoking.[8]

Unemployment

Based on the U.S. Census Bureau American Community Survey (ACS) 5-year estimates from 2017, SCFHS's service area, Solano County, and California had unemployment rates of 8.5 percent, 8.5 percent, and 7.7 percent, respectively (see Table 6). This table illustrates the lingering effects of the "great recession" – with attendant job loss since the year 2000. Over those 17 years, the labor force increased by 20.0 percent in the service area, while the unemployment rate increased 64.2 percent.

Table 6: Employment

		Percent of Total (2017)			Percent Change Since 2000		
	SCFHS Service Area	Service Area	Solano County	CA	Service Area	Solano County	CA
Employed	210,466	91.5 %	91.5 %	92.3 %	17.1 %	13.9 %	22.3 %
Unemployed	19,461	8.5 %	8.5 %	7.7 %	64.2 %	62.5 %	34.3 %
Labor Force	229,927	100.0 %	100.0 %	100.0 %	20.0 %	16.9 %	23.1 %

Sources: U.S. Census Bureau, 2017 ACS 5-Year Estimates; U.S. Census Bureau, 2000 Census Summary File 3

Health Insurance

While health insurance is only one of many determinants of health, access to health insurance and health care services has been shown to improve individual and population health.[9] Coverage has been shown to reduce psychological distress, increase use of medical services, establish usual sources of care, and improve continuity of care – all of which are positively associated with long-term individual health.[10] In contrast, without a regular source of healthcare, the uninsured are less likely to receive important preventive services or treatments for chronic conditions such as asthma, diabetes, or hypertension, making them more likely to develop severe yet preventable health conditions and to be diagnosed at more advanced disease stages. People with Medi-Cal or who are uninsured are significantly more likely to report having difficulty finding a provider or delaying care and once they receive care. They typically also have worse average health outcomes after treatment, even after adjusting for demographic characteristics and prior health status, such as the number and type of co-morbidities.[11,12] Additionally, after diagnosis, the uninsured often receive less or inadequate medical care and are more likely to experience premature death than those who are insured.[13, 14]

Table 7: Health Insurance

	SCFHS Service Area		Solano County		California	
	Number	Percent	Number	Percent	Number	Percent
Medicaid	71,631	15.4 %	65,700	15.6 %	7,292,753	18.9 %
Medicare	51,963	11.2 %	48,180	11.4 %	4,616,218	12.0 %
Other Public Insurance	3,167	0.7 %	2,927	0.7 %	222,921	0.6 %
Private Insurance, Including Capitation	303,509	65.4 %	274,262	64.9 %	22,314,781	58.0 %
None/Uninsured	33,845	7.3 %	31,237	7.4 %	4,041,396	10.5 %
Total	464,115	100.0 %	422,306	100.0 %	38,488,069	100.0 %

Source: U.S. Census Bureau, 2017 ACS 5-Year Estimates

According to the 2017 ACS, 27.3 percent of residents of SCFHS's service area received public insurance benefits (Medicaid, Medicare, or other public insurance), slightly less than the Solano County average (27.7 percent) and below that of the state overall (31.5 percent). (See Table 7.) Over seven percent (7.3 percent) of the service area population remains uninsured, compared with 7.4 percent for Solano County and 10.5 percent for California. Concurrently, the service area's private insurance rate of 65.4 percent is higher than the county percentage (64.9 percent) or that of the state (58.0 percent).Without a regular source of health care, the uninsured are less likely to receive important preventive services or treatments for chronic conditions such as asthma, diabetes, or hypertension, making them more likely to develop severe yet preventable health conditions and to be diagnosed at more advanced disease stages. Also, once diagnosed, the uninsured often receive less, or inadequate medical care and are more likely to experience premature death than those who are insured.[15, 16, 17]

Passage of the Affordable Care Act (ACA) has had significant positive impact on uninsured and underinsured populations in California, increasing coverage in both private and public plans. However, this still leaves a significant number of individuals without insurance. The "residually uninsured" are: 1) undocumented, 2) eligible for Medi-Cal but not enrolled, or 3) eligible for Covered California, with or without subsidy, but not enrolled. Although subsidies are available to people between 138 percent and 400 percent FPL, insurance remains expensive for many. In addition, enrollment in Covered California has a limited open enrollment period each year. The uninsured and those enrolled in Medi-Cal still often struggle to get the services they need. Low Medi-Cal reimbursement rates for providers, as well as geographic, linguistic, cultural, and other barriers limit access to care. The quality of health services provided to low-income Medi-Cal beneficiaries sometimes suffer due to the fragmented nature of care and access issues, particularly access to specialty care.

Educational Attainment

Educational attainment is considered a key driver of health status since low levels of education are often linked to poverty and poor health. As shown in Table 8, there are differences in educational attainment between the SCFHS service area population, the county, and the state. Of service area residents, 12.6 percent are without a high school diploma, while 12.4 percent and 16.8 percent of Solano County and California residents, respectively, have less than a high school education. Similarly, 32.6 percent of the service area adults have some form of college degree, on par with 32.5 percent of county residents. However, both have less than California state residents, 37.0 percent of whom have college degrees.

Table 8: Educational Attainment for Population 18 Years and Over

	SCFHS Service Area	Percent of Total (2017)			Percent Change Since 2000		
		Service Area	Solano County	CA	Service Area	Solano County	CA
Less Than 9th Grade	19,979	5.6 %	5.3 %	8.6 %	10.8 %	6.8 %	-4.3 %
9th-12th Grade, No Diploma	25,083	7.0 %	7.1 %	8.2 %	-26.5 %	-27.0 %	-24.1 %
High School Graduate/GED	87,278	24.4 %	24.7 %	21.8 %	16.3 %	15.3 %	25.2 %
Some College, No Degree	108,442	30.3 %	30.4 %	24.4 %	24.3 %	21.5 %	21.9 %
Associate's Degree	32,967	9.2 %	9.3 %	7.4 %	34.1 %	32.2 %	33.5 %
Bachelor's Degree	59,494	16.6 %	16.4 %	18.9 %	49.6 %	43.8 %	46.8 %
Graduate Degree	24,367	6.8 %	6.8 %	10.7 %	50.6 %	46.5 %	55.7 %
Total	357,610	100.0 %	100.0 %	100.0 %	21.2 %	18.8 %	21.2 %

Source: U.S. Census Bureau, 2017 ACS 5-Year Estimates; 2000 Census Summary File 3

Over the past 16 years, the service area has made real strides in education. High school drop outs (those with 9th to 12th grade education but no diploma) decreased by 26.5 percent; those with a bachelor's degree increased by 49.6 percent; and, those with a graduate degree increased by 50.6 percent. As education and poverty impacts health literacy, it, in turn, affects health access. Defined by *Healthy People 2020*, health literacy is, "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[18] Health literacy is considered a more significant predictor of health status than income level, ethnicity, age, education or employment.[19] Not surprisingly, low-income, minority, and immigrant groups have the poorest health literacy. Nationally, annual costs associated with low health literacy are between $106 to $238 billion.[20] Low health literacy are felt by: a) individuals, families, and communities struggling to access quality care or maintain healthy behaviors, b) health care delivery systems unable to provide safe and effective services and c) governments, employers, insurers and patients facing higher costs.[21]

Language and Immigration

The make-up of the American population is quickly changing, as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Linguistic barriers can have a harmful effect on health outcomes by creating obstacles to healthcare access and utilization. Difficulties with English can hamper a person's ability to seek medical services or understand the healthcare they are given.

SCFHS's service area reflects this shifting ethnic and cultural landscape. As shown in Table 9, according to the 2017 Census Bureau numbers, 20.7 percent of service area residents are foreign-born, with 6.8 percent being born in the Philippines and 6.8 percent being born in Mexico. Nearly one third (30.6 percent) of households in SCFHS's service area speaks a language other than English at home. (See Table 10.) The largest percentage (17.3 percent) of these residents speaks Spanish. When looking only at low-income residents (living below 200 percent of FPL), the percentage of persons who do not speak English at home increases slightly to 33.3 percent. Of this group, 37.9 percent reported speaking English less than "Very Well."[22]

Table 9: Top 10 Nations of Birth

	SCFHS Service Area		Solano County	California	United States
	Number	Percent	Percent	Percent	Percent
U.S. or U.S. Territories	367,993	79.3 %	80.0 %	73.1 %	86.6 %
Philippines	31,727	6.8 %	6.5 %	2.2 %	0.6 %
Mexico	31,619	6.8 %	6.4 %	10.8 %	3.6 %
India	3,380	0.7 %	0.7 %	1.2 %	0.7 %
El Salvador	3,204	0.7 %	0.7 %	1.1 %	0.4 %
China	2,632	0.6 %	0.6 %	2.3 %	0.8 %
Vietnam	2,620	0.6 %	0.6 %	1.3 %	0.4 %
Guatemala	1,577	0.3 %	0.3 %	0.7 %	0.3 %
United Kingdom	1,123	0.2 %	0.2 %	0.3 %	0.2 %
Japan	1,065	0.2 %	0.2 %	0.3 %	0.1 %
All Other Nations	17,175	3.7 %	3.7 %	6.8 %	6.2 %
Total Population	464,115	100.0 %	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2017 ACS 5-Year Estimates

Table 10: Top Ten Languages Spoken at Home for Population 5 Years and Over

	SCFHS Service Area	Percent of Total (2015)			Percent Change Since 2000		
		Service Area	Solano County	CA	Service Area	Solano County	CA
English Only	295,284	69.4 %	70.5 %	56.1 %	2.8 %	1.9 %	5.9 %
Spanish or Spanish Creole	73,628	17.3 %	16.6 %	28.8 %	53.6 %	50.1 %	27.4 %
Tagalog	31,052	7.3 %	6.9 %	2.2 %	23.7 %	13.0 %	25.8 %
Chinese	3,684	0.9 %	0.8 %	3.1 %	55.4 %	41.2 %	36.9 %
Other Indic Languages	2,460	0.6 %	0.6 %	0.6 %	49.2 %	37.5 %	83.1 %
Vietnamese	2,419	0.6 %	0.6 %	1.5 %	87.0 %	82.5 %	32.5 %
Other Pacific Island Languages	2,222	0.5 %	0.5 %	0.3 %	-7.0 %	-12.2 %	7.9 %
Hindi	2,187	0.5 %	0.5 %	0.5 %	144.0 %	153.3 %	118.4 %
Other Asian Languages	1,207	0.3 %	0.3 %	0.5 %	111.4 %	107.0 %	135.1 %
Arabic	1,142	0.3 %	0.3 %	0.5 %	14.4 %	25.2 %	55.5 %
All Other Languages	10,502	2.5 %	2.5 %	6.0 %	-13.2 %	-16.1 %	9.8 %
Total Population	425,787	100.0 %	100.0 %	100.0 %	11.3 %	9.0 %	14.3 %

Source: U.S. Census Bureau, 2015 ACS 5-Year Estimates; Source: U.S. Census Bureau, 2000 Census Summary File 3

**Note that differences in population counts is due to differing sources and estimates.*

However, even beyond addressing language barriers, the delivery of high-quality primary health care requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. According to the National Center for Cultural Competence,[23] nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of those residing in the U.S. Despite some progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders as compared with the U.S. population as a whole.

An Institute of Medicine (IOM) report[24] documented racial/ethnic disparities in the diagnosis and treatment of several conditions, even when analyses were controlled for socioeconomic status, insurance status, co-morbidity, and age, among other potential confounders. These disparities are due, in part, to variations in patients' health beliefs, values, preferences, and behaviors. These include variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms or concerns or beliefs about certain kinds of care (i.e. concerns of a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care; and adherence to preventive measures and medications).

In addition, studies have found that healthcare professionals exhibit the same implicit biases influenced by the patient's characteristics. Despite the medical profession's explicit commitment to providing equal care, some studies suggest that implicit prejudice and stereotyping can influence diagnosis, treatment decisions and level of care in some circumstances for those already vulnerable. Examples include minority ethnic populations, immigrants, low income and low-health literacy individuals, LGBT, children, women, the elderly, the mentally ill, the overweight and the disabled. Compared to Whites, Hispanics and African Americans were nearly twice as likely to report problems communicating with their providers, 14 times more likely to believe that they would receive better health care if they were of a different ethnicity, and nearly twice as likely to feel that they had been treated with disrespect during a recent health care visit. [25] [26]

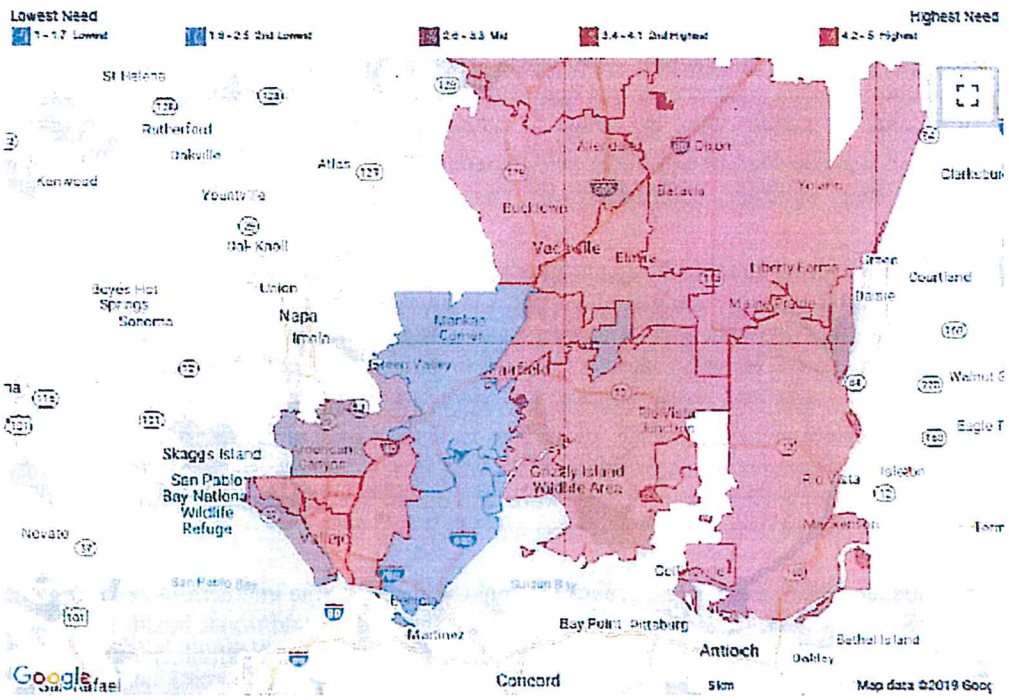
These factors influence patient and physician decision-making as well as the interactions between patients and the healthcare delivery system, thus contributing to health disparities. Additional health studies have also shown that these disparities are frequently evident in chronic health outcomes for ethnic minorities and English language learners. Within California, specific attention has been paid to diabetes care to underserved communities in the state. These studies often demonstrated that ethnic minorities are less likely to receive the standard of care for diabetes than their non-ethnic English-speaking counterparts.[27] Therefore, focus should be given to culturally competent primary health services that help clinical encounters facilitate more favorable outcomes, enhance the potential for a more rewarding interpersonal experience, and increase the satisfaction the patient receiving health care services. Culturally competent health care should include provider's understanding of the:

- Language, beliefs, values, traditions and practices of a culture;
- Culturally-defined, health-related needs of individuals, families and communities;
- Culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and,
- Attitudes toward seeking help from health care providers.

Community Need Index

A Community Need Index (CNI) developed by Catholic Healthcare West (now Dignity Health) in joint-partnership with Solucient, LLC devised the first scoring that includes underlying economic and structural barriers that impact access to healthcare.[28] The CNI aggregates socioeconomic indicators known to contribute to health disparity and applies those data to hospital admissions. The CNI score goes from 1.0 to 5.0 based on barriers related to income, culture/language, education, insurance, and housing in order to quantify healthcare access in communities across the nation. Dignity Health's research has shown that residents of communities with the highest CNI scores (4.2 to 5) are twice as likely as communities with the lowest CNI scores to be hospitalized for manageable conditions such as pneumonia or congestive heart failure.

Figure 2: Community Needs Index (CNI) for SCFHC's Service Area



Zip Code	CNI Score	Population	City	County	State
94503	3	22902	American Canyon	Napa	California
94510	2.4	28108	Benicia	Solano	California
94533	4	75928	Fairfield	Solano	California
94534	2.4	41914	Fairfield	Solano	California
94535	2.8	4729	Travis Afb	Solano	California
94571	3.6	9391	Rio Vista	Solano	California
94585	3.6	30836	Suisun City	Solano	California
94589	4.4	30355	Vallejo	Solano	California
94590	4.6	36531	Vallejo	Solano	California
94591	3.4	56225	Vallejo	Solano	California
94592	2.6	576	Vallejo	Solano	California
95620	4	22444	Dixon	Solano	California
95687	3.4	57952	Vacaville	Solano	California
95688	3.6	37648	Vacaville	Solano	California
95694	3.8	9553	Winters	Yolo	California

Figure 2 shows that the mean CNI score for the service area is 3.4 out of a possible 5.0, which falls within the second highest need range. According to the CNI, two of the 15 zip codes within the service area are designated as ***highest need*** areas; both zip codes are located in Vallejo (94589 and 94590). An additional six zip codes have the second highest possible need (90002, 90003, 90007, 90015, 90017, 90037, 90044, 90057). (See Table 11.)

Table 11: Community Need Index Scores for SCFHC's Service Area Zip Codes

Zip Code	City	CNI Score
94503	American Canyon	3.0
94510	Benicia	2.4
94533	Fairfield	4.0
94534	Fairfield	2.4

Zip Code	City	CNI Score
94535	Travis AFB	2.8
94571	Rio Vista	3.6
94585	Suisun City	3.6
94589	Vallejo	4.4
94590	Vallejo	4.6
94591	Vallejo	3.4
94592	Vallejo	2.6
95694	Winters	4.0
95620	Dixon	4.0
95687	Vacaville	3.4
95688	Vacaville	3.6

Source: Community Need Index (http://cni.chw-interactive.org)

According to the CDC Health Disparities and Inequalities Report 2013, people who live and work in low socioeconomic circumstances are at increased risk for mortality, morbidity, unhealthy behaviors, reduced access to healthcare, and inadequate quality of care.[29] A study by the Johns Hopkins Center for Health Disparities Solutions found that the estimated cost of racial and ethnic disparities in US healthcare from years 2006-2009 was $456.8 billion.[30]

Access to Providers

A central factor regarding access to care is the availability of health care providers to the communities. Insurance coverage is hollow if there are no providers in the area from whom the residents can receive services. Table 12 shows the ratio of the population to various providers.

Table 12: Ratios of Population to Providers

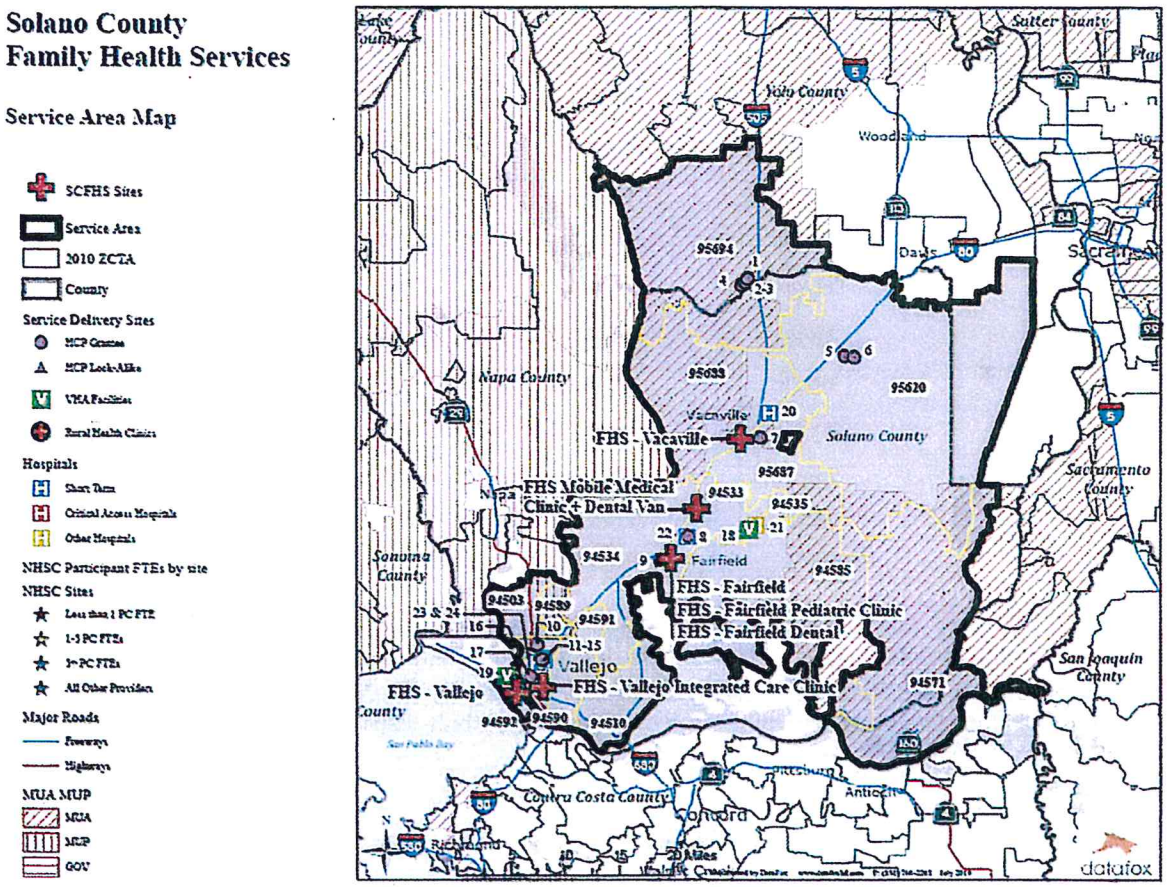
	Solano County	CA	U.S.
Ratio of population to primary care physicians*	1211:1	1281:1	1,320:1
Ratio of population to dentists*	1095:1	1214:1	1,480:1
Ratio of population to mental health providers#	294:1	324:1	470:1

Source: *Area Health Resource File/American Medical Association, 2016; #CMS, National Provider Identification file, 2017

According to UDS Mapper, 47.5 percent of SCFHS's service area are designated as Medically Underserved Areas and Populations (MUA/Ps). Per the 2017 CHIS, an estimated 6.3 percent of adults (18 years and older) living in Solano County report not having a regular source of health care; this percentage increases to 8.8 percent for the low-income community in the County.

Figure 3 shows the locations of the FQHCs, FQHC Look-Alikes, hospitals, and Veterans Health Administration facilities in the SCFHS service area. Figure 3 also shows the areas designated as MUAs and MUPs.

Figure 3: SCFHS's Service Area Map



Label Key

Service Delivery Sites

1) Sutter West Medical Group
2) Winters Healthcare Clinic
3) Winters Healthcare Dental Office
4) Winters Healthcare Foundation
5) Sutter West Medical Group
6) Community Medical Centers, Dixon
7) Community Medical Centers, Vacaville
8) East Fairfield
9) Ole Health - Fairfield
10) La Clinica Dental at Elsa Widenmann Health Center
11) La Clinica Vallejo Great Beginnings Administrative & Support Services
12) La Clinica Vallejo Great Beginnings/North Vallejo Support Services
13) La Clinica North Vallejo Administrative & Support Services
14) La Clinica Vallejo Great Beginnings
15) La Clinica North Vallejo
16) La Clinica Vallejo Dental
17) La Clinica Vallejo

VHA Facilities

18) Fairfield VA Clinic
19) Mare Island VA Clinic

Rural Health Clinics

None

Hospitals

20) Kaiser Foundation Hospital - Vacaville
21) US Air Force Hospital, Travis AFB
22) NorthBay Medical Center
23) Sutter Solano Medical Center
24) Kaiser Foundation Hospital and Rehab Center
25) Adventist Health Vallejo

Penetration Rates for Low-income Population

According to UDS Mapper, 26.30 percent of residents of the service area are low income (living below 200 percent FPL). Table 13 shows the penetration rates among the population for each of the zip codes in SCFHS's service area, with an overall penetration rate of 35.76 percent across current Health Center Program grantees and Look-Alikes. With 122,064 low-income residents in the service area, the current penetration rate translates to 78,420 low-income residents without a medical home. With an average patient utilization rate of 3.7 medical visits per year (based on California UDS data), that calculates to a deficit in capacity of 290,154 medical visits annually for SCFHS's service area.

Table 13: Penetration of Low-Income Population in SCFHS's Service Area

Zip Code	Post Office Name	Low-Income (Below 200% FPL) Population	Penetration of Low-Income Population
94503	American Canyon	4,365	64.51 %
94510	Benicia	4,413	21.26 %
94533	Fairfield	26,100	23.89 %
94534	Fairfield	4,080	32.70 %
94535	Travis AFB	1,176	0.00 %
94571	Rio Vista	2,427	17.63 %
94585	Suisun City	7,548	22.55 %
94589	Vallejo	10,990	46.07 %
94590	Vallejo	16,232	44.30 %
94591	Vallejo	14,150	33.97 %
94592	Vallejo	240	12.92 %
95694	Winters	2,430	116.58 %
95620	Dixon	6,939	54.76 %
95687	Vacaville	13,270	29.64 %
95688	Vacaville	7,704	32.89 %
Total		**122,064**	**35.76 %**

Source: UDS Mapper

Table 14: Utilization of Primary Care Clinics by Federal Poverty Level

	Service Area Utilization	Percent of Utilization	Service Area Population	Percent of Population
Under 100 % FPL	20,629	43.3 %	51,134	11.0 %
100 - 138 % FPL	4,142	8.7 %	25,887	5.6 %
139 - 199 % FPL	2,833	5.9 %	45,043	9.7 %
200 - 399 % FPL	1,238	2.6 %	135,875	29.3 %
400 % FPL and Above	412	0.9 %	195,616	42.1 %
Unknown	18,429	38.6 %	10,560	2.3 %
Total	47,683	100.0 %	464,115	100.0 %

Source: 2017 California Office of Statewide Healthcare Planning and Development, 2017 ACS 5-Year Estimates

Utilization of Primary Care Services

As noted, residents living in low-income neighborhoods tend to have worse physical and mental health issues (e.g., asthma, depression, heart conditions) compared to higher-income areas.[31] Utilization data for SCFHS's service area show that residents under 100 percent FPL are disproportionately accessing primary care clinics by a wide margin (see Table 14). Although 11.0 percent of the population is below 100 percent FPL, this group utilizes 43.3 percent of the total primary care community clinic resources in the service area. These data points underscore the importance of community-based primary care clinics to this population as their primary source of health care.

V. Health Disparities

Leading Causes of Death

The top five leading causes of death in SCFHS's service area from highest to lowest, according to the California Department of Health Services (2017 – most recent available), are: cancers, heart disease, Alzheimer's Disease, chronic lower respiratory disease (CLRD), and stroke. As seen in Table 15, SCFHS's service area has higher five-year average age-adjusted death rates compared to the county in cancers, heart disease, Alzheimer's Disease, CLRD, stroke, unintentional injuries, diabetes, pneumonia, and chronic liver disease and Cirrhosis. Adjusting for age is a statistical way to remove the extraneous effects of age when comparing populations with different age distributions.

Table 15: 5-Year Age-Adjusted Causes of Death (rate per 100,000 persons), 2009-2013

	SCFHS Service Area	Solano County	CA
Malignant Neoplasms (Cancers)	196.2	176.9	152.9
Diseases of the Heart	156.4	139.9	158.4
Alzheimer's Disease	52.0	46.2	29.8
Chronic Lower Respiratory Disease (CLRD)	46.3	42.3	36.2
Cerebrovascular Disease (Stroke)	41.3	37.4	36.6
Unintentional Injuries	29.8	29.6	28.6
Diabetes Mellitus	27.2	24.2	20.3
Pneumonia and Influenza	22.5	20.1	16.6
Chronic Liver Disease and Cirrhosis	11.8	11.0	11.6
Intentional Self Harm (Suicide)	11.3	11.7	10.4
Total Deaths	763.6	704.1	640.5

Source: California Department of Public Health, 2009-2013 Master Death Files; County and State Source: CDC Wonder, Detailed Mortality, 2009-2013

Obesity and Diabetes

Obesity and obesity-related chronic disease are extremely costly; it is estimated that 20.6 percent of all healthcare dollars nationwide are spent treating obesity.[32] Heart disease, cancer, stroke and Chronic Lower Respiratory Disease (CLRD) were among the leading causes of death in SCFHS's service area. One of the reasons that might account for the higher risk is the prevalence of obesity. According to the UCLA Center for Health Policy Research, 2017 California Health Interview Survey (CHIS), 30.7 of adult residents (age 18 and over) of Solano County are obese compared to 26.8 percent for the state. (See Table 16.)

Table 16: Body Mass Index

Category	Teens (Age 12-17)		Adults (Age 18+)	
	Solano County	California	Solano County	California
Underweight (0 - 18.49)	0.0 %	2.7 %	1.0 %	1.8 %
Normal Weight (18.5 - 24.99)	84.9 %	63.4 %	29.4 %	36.4 %
Overweight (25.0 - 29.99)	10.7 %	17.3 %	39.0 %	35.0 %
Obese (30.0 or Higher)	4.4 %	16.7 %	30.7 %	26.8 %
Total	100.0 %	100.0 %	100.0 %	100.0 %

Source: UCLA Center for Health Policy Research, California Health Interview Survey, 2013-2017

Obesity is a major risk factor for Type 2 diabetes, as well as cardiovascular disease, stroke and certain types of cancers. It is approaching tobacco use as the leading preventable cause of death in the United States and is a major contributor of the escalating costs of healthcare. Obesity and obesity-related chronic disease are extremely costly; it is estimated that 20.6 percent of all healthcare dollars nationwide are spent treating obesity.[33] Per the 2017 CHIS, with respect to diabetes, 10.5 percent of adults in Solano County have ever been diagnosed with diabetes; this rate jumps to 11.6 percent for adults in living below 200 percent of the FPL.

Maternal Health and Birth Health Disparities

Women often make the healthcare decisions for the family and are the primary caregivers; therefore, the health of women affects not only the individual but her family and the community. Improving the well-being of mothers, infants, and children is an important public health goal for the US. As stated by *Healthy People 2020*, their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. Pregnancy can also provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. These health risks may include hypertension and heart disease, diabetes, depression, genetic conditions, sexually transmitted diseases (STDs), tobacco use and alcohol abuse, inadequate nutrition, or unhealthy weight.

According to the Centers for Disease Control, the risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care.[34] Early prenatal care provides an effective and cost-efficient way to prevent, detect and treat maternal and fetal medical problems. It provides an excellent opportunity for health care providers to offer counseling on healthy living habits that lead to optimal birth outcomes. Late or no prenatal care substantially increases the likelihood that an infant will require admission to a neonatal intensive care unit or require a longer stay in the hospital at substantial cost to the family and the health care system.

Birth health statistics are often stated as a predictor of a community's overall health. For example, births to teen mothers are a concern since the births can pose medical and social problems for the mother as well as her infant. Adolescent mothers are less likely to get or stay married, less likely to complete high school or college, and more likely to require public assistance and live in poverty than their peers who are not mothers. Compared to children born to older mothers, children born to teens are more likely to have a higher rate of early mortality and hospitalization, drop out of high school, enter foster care, be on welfare, and have children as teens themselves.[35]

Birth health statistics are a predictor of two factors: maternal exposure to health risks and an infant's current and future morbidity. As shown in Table 17, rates per 100,000 residents for low birth weights, infant mortality and births to teen mothers are lower in SCFHS's service area as compared to Solano County. However, rates for late entry into prenatal care are worse in SCFHS's service area as compared to those of the county. Additionally, the service area has lower rates for live birth rates compared to the state.

Table 17: Birth Health Disparities (rates per 1,000 live births, except birth rate is per 1,000 population)

	SCFHS Service Area		Solano County		CA	
	Number	Rate	Number	Rate	Number	Rate
Low Birth Weight (Under 2,500 grams)	1,870	67.8	1,774	68.4	172,292	67.9
Infant Mortality	142	5.2	140	5.4	12,006	4.7
Births to Teen Mothers	1,890	68.6	1,816	70.1	196,898	77.6
Late Entry into Prenatal Care (After 1st Trimester)	6,143	222.8	5,660	218.3	463,386	182.6
Live Births/Birth rate	27,569	11.9	25,924	11.9	2,537,798	13.0

Source: California Department of Public Health 2009-2013 Master Birth Files

Oral Health

The 2000 U.S. Surgeon General's Report "Oral Health in America" conclusively linked chronic oral infections to other overall health problems, including diabetes, heart disease, and adverse pregnancy outcomes. Furthermore, oral health is related to quality of life and poor oral health can have significant consequences on a person's diet, nutrition, speech, social interaction, self-esteem, mental health, education, and career achievement.[36] Dental disease is an epidemic and it is disproportionately affecting the poor, the uninsured, and especially children.

Indeed, a survey of over 21,000 California children found that, by the third grade, over 70 percent had a history of tooth decay. Neglecting the oral health of children creates a cascade of problems that ultimately cost the taxpayers more. These include pain, infection, nutrition problems, tooth loss, sleep deprivation, attention deficit, slower social development, and missed school days.[37] Alarmingly, children on Medi-Cal – particularly Latinos and African Americans – experience higher rates of tooth decay, yet they visit the dentist less often than privately insured children. Even Latino and African American children with private insurance are less likely than white children to visit dentists and have longer intervals between dental visits. These findings indicate racial and ethnic disparities in access to oral health services among minority children covered by Medi-Cal – a substantial portion of CCHC's target population.[38]

Tooth decay is the most common preventable illness affecting U.S. children today. In California, tooth decay among young children has increased over the past two decades.[39] When left untreated, tooth decay can contribute to a wide range of problems, including poor nutrition, sub-normal growth, and unnecessary pain.[40] California students miss an estimated 874,000 days of school each year due to dental problems, costing schools over $29 million annually.[41] Children who reported having recent tooth pain were four times more likely to have a low grade point average compared to children without oral pain.[42]

Although data on dental utilization by service area residents are unavailable, much can be learned from reviewing the data for Solano County and the state. Per the 2017 CHIS, 40.2 percent of all children (3-11 years of age) in Solano County had never been to a dentist. This compares to 14.0 percent for all children in California. For adults, 23.0 percent have not been to a dentist in over a year. (See Table 18.)

Table 18: Time Since Last Dental Visit

	Solano County		California	
	All Residents	Low-income Residents	All Residents	Low-income Residents
Adults				
Never been to a dentist	-	-	2.5 %	4.9 %
6 months ago, or less	57.8 %	46.8 %	57.6 %	41.5 %
More than 6 months up to 1 year ago	18.5 %	39.5 %	15.2 %	18.2 %
More than 1 year up to 2 years ago	12.6 %	3.6 %	10.2 %	12.9 %
More than 2 years up to 5 years ago	4.2 %	4.2 %	7.8 %	11.4 %
More than 5 years ago	6.2 %	5.9 %	6.8 %	11.0 %

Source: 2017 CHIS

The lack of dental insurance is a barrier to accessing oral health care. The 2017 CHIS reports that 28.0 percent of adults in Solano County do not have dental insurance, compared with 34.9 percent for the state. These rates increase for the low-income adults, with 34.7 percent and 49.0 percent in Solano County and California, respectively, not having dental insurance.

The American Academy of Pediatric Dentistry advises that children visit the dentist or have an oral health assessment from his/her primary care professional by six months of age and that a dental home should be established by their first birthday.[43] It is also recommended that they visit the dentist twice yearly thereafter.[44] Meanwhile, the American Dental Association advocates that adults see a dentist at least once a year, and potentially more frequently depending on the patient's individual needs. However, the reality for many is that dental care is out of reach.

Mental Health

Mental health disorders are a significant public health problem, both in their own right and because they are often associated with many other chronic diseases.[45] Untreated disorders may leave individuals at risk for substance abuse, self-destructive behavior, and suicide. Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases.[46] This increased morbidity is often a result of lower use of medical care, lower treatment adherence for concurrent chronic diseases, and higher risk for adverse health outcomes.[47] Also, among all 36.2 million people who received mental health services, the average expenditure per person was $1,591 and among all 4.6 million children who received mental health services, the average expenditure was $1,931.[48]

Mental illness exacerbates morbidity from the multiple chronic diseases with which it is associated, including heart disease, diabetes, obesity, asthma, epilepsy, and cancer.[49,50,51] This increased morbidity is often a result of lower use of medical care, lower treatment adherence for concurrent chronic diseases, and higher risk for adverse health outcomes.[52] Rates for injuries, both intentional (e.g., homicide and suicide) and unintentional (e.g., motor vehicle), are two to six times higher among persons with a mental illness than in the overall population.[53,54] Mental illness is also associated with increased use of tobacco products and alcohol abuse.[55] In a study conducted by the National Survey on Drug Use and Health (NSDUH) in 2014, approximately 1 in 5 adults (43.6 million adults) had any mental illness within 2014 and 4.1 percent (9.8 million adults) had a serious mental illness.[56] NSDUH estimated that there were 43.6 million adults aged 18 or older in the U.S. with any mental illness in the past year, with approximately 16.4 million males and 27.2 million females.[57] Depression is the most common type of mental illness affecting adults in the U.S. The CDC estimates that by the year 2020, depression will be the second leading cause of disability throughout the world, after ischemic heart disease.[58]

As for California, a 2013 report by the California HealthCare Foundation, "Mental Health Care in California: Painting a Picture," detailed that nearly 1 in 6 adults in the state had "a mental health need" and 1 in 20 had a serious mental illness. Other key findings included:[59]

- 1 in 13 suffers from a mental illness that limits participation in daily activities;
- About half of adults and two-thirds of adolescents with mental health needs did not get treatment;
- For children and adults, the prevalence of serious mental illness varied by income, with much higher rates of mental illness at lower income levels;
- There are significant racial and ethnic disparities for incidence of serious mental illness among adults: Native American, multiracial, and African American populations experienced the highest rates; and,
- The distribution of spending on mental health care in the US has changed dramatically over the last 20 years, with inpatient and residential care spending decreasing, and outpatient care and prescription drug spending increasing.

In Solano County, many low-income individuals with mental health concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly-funded treatment services are significant barriers for many. Limited integration of mental health services within the health care system also leads to missed opportunities for early problem identification and prevention.

The effects of mental illness range from minor disruptions in daily functioning to incapacitating personal, social, and occupational abilities, as well as leading to premature death.[60,61,62] In reviewing reported mental health conditions, Solano County shows rates consistent with those of the state and the nation (see Table 19). The economic repercussions of mental illness in the United States are substantial. Approximately 1 in 5 adults in the U.S. — 43.8 million, or 18.5 percent — experiences mental illness in a given year and cost the United States an estimated $300 billion annually, which included approximately $193 billion from lost earnings and wages, $24 billion in disability benefits,[63] and $100 billion in healthcare expenditures.[64]

Table 19: Mental Health Conditions for Adults (18 years of age and older)

	Solano County	CA	U.S.
Serious mental illness in the past year	3.3 %	3.6 %	4.1 %
Any mental illness in the past year	15.8 %	17.4 %	18.1 %
Had serious thoughts of suicide in the past year	4.1 %	4.0 %	4.0 %
Major depressive episode in the past year	5.8 %	6.1 %	6.7 %

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014, 2015, and 2016.

Substance Abuse

The 2016 National Survey on Drug Use and Health estimated that approximately 20.1 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year, including 15.1 million people who had an alcohol use disorder and 7.4 million people who had an illicit drug use disorder.[65] Chronic Liver Disease and Cirrhosis is often associated with SUD, and the age-adjusted death rate for these conditions in the SCFHS service area was 11.8 per 100,000 which is higher than both the county (11.0 per 100,000 persons) and the state (11.6 per 100,00 persons). (See Leading Causes of Death, page 19.) A review of reported substance use shows that the service area rates exceed the rates for the county in most of the listed measures. (See Table 20).

Table 20: Substance Use (Age 12+)

	Solano County	CA	U.S.
Marijuana Use in the Past Year among Individuals	17.9 %	15.9 %	13.6 %
Marijuana Use in the Past Month among Individuals	11.2 %	10.2 %	8.5 %
First Use of Marijuana among Individuals (Expressed as Percentages of the At-Risk Population)	2.4 %	2.1 %	1.9 %
Cocaine Use in the Past Year among Individuals	2.3 %	2.4 %	1.8 %
Heroin Use in the Past Year among Individuals	0.2 %	0.2 %	0.3 %
Alcohol Use in the Past Month among Individuals (Age 12+)	56.7 %	50.3 %	51.7 %
Alcohol Use in the Past Month among Individuals (Age 12-20)	21.4 %	19.8 %	20.8 %
Alcohol Use Disorder in the Past Year among Individuals (Age 12+)	7.0 %	6.4 %	6.0 %

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014, 2015, and 2016.

The National Drug Intelligence Center (NDIC) in 2011 (most recent available) estimated the public cost of treatments for illicit drug use at $3,368,564. These costs were divided into detoxification ($465,213), residential ($1,223,800), outpatient ($1,028,994), and outpatient methadone ($650,557) programs.[66]

SCFHS will continue to target the mental health and substance abuse needs of its service area population. However, most research comparing mental health care across groups throughout the country finds evidence of common disparities in access and use that should be addressed by all mental health care providers. As documented in the U.S. Surgeon General's report on mental health and its supplement, racial and ethnic minorities typically have less access to mental health services than whites have, are less likely to receive needed care, and are more likely to receive poor-quality care when treated.[67,68] Also, minorities are more likely than whites to delay or fail to seek mental health treatment.[69, 70, 71] After entering care, minority patients are also less likely than whites to receive the best available treatments for depression and anxiety.[72, 73]

An Institute of Medicine report studied health service disparities between population groups related to treatment or access not justified by the differences in the health status or preferences of the groups. The report found that overall spending for blacks and Latinos on outpatient mental health care is about 60 percent and 75 percent of spending rates for whites, respectively, after taking into account need for care.[74]

Homelessness and Housing Insecurity

In today's economy, high housing costs, along with gentrification and displacement of communities, are forcing many families into difficult living situations. Living doubled- or tripled-up with another family due to financial constraints can place stress on personal relationships, housing stock, public services, and infrastructure. When shared housing is not an option – or if other factors arise such as job loss, foreclosure, or domestic violence – the result can be homelessness. Housing insecurity among young children is associated with food insecurity and a greater likelihood of poor health. Considering the city's expensive housing market and economic pressures in the area, residents are still vulnerable and at risk for homelessness.

Homelessness within the nine county Bay Area region ranks among the worst in the United States, falling behind only New York City and Los Angeles. The Bay Area shelters a smaller proportion of its homeless in comparison as well. Despite progress on several fronts, a solution to the crisis remains elusive. Between 2011 and 2017, the number of people experiencing homelessness in the Bay Area slowly grew even as the region was growing its inventory of homelessness support assets, including permanent supportive housing units and rapid re-housing programs. While jurisdictions have been successful in moving more homeless individuals and families into stable housing, a larger number of people are experiencing homelessness for the first time. Unsheltered homelessness, in particular, creates severe health and safety risks for both those experiencing homelessness and for those in the surrounding community. For example, in March 2017, an outbreak of Hepatitis A at a San Diego homeless camp infected 592 people and killed 20.[75]

Significant differences also exist between counties within the Bay Area. Solano and Santa Clara counties have the highest unsheltered rates relative to the number of individuals who are experiencing homelessness. The preliminary results from the 2019 Solano County Homeless Point-In-Time Count and Survey, conducted on January 23, 2019, counted 1,151 homeless individuals, of which more than 80 percent were classified as unsheltered. While the count shows an overall drop of more than 6.5 percent in the total number of homeless people in Solano County from 1,232 in 2017 to 1,151 in 2019, the dip in the two-year overall totals is not a trend. The number of homeless people countywide was pegged at 1,082 in 2015, so this year's total shows there are nearly 6.4 percent more homeless people across the county now than there were four years ago. Additionally, the number of homeless children who are of transitional age increased from 192 in 2017 to 204 in 2019.[76] While the county of Solano has pledged significant resources to emergency shelters, rapid and permanent rehousing and youth services, which are expected to decrease the number of chronically homeless unsheltered and youth homeless over the coming years, the homeless population will continue to face many barriers to receiving adequate healthcare.

According to the U.S. Census Bureau, of renter-occupied housing units in SCFHS's service area, 53.8 percent of residents reported housing costs greater than 30 percent of income, compared with 54.3 percent of Solano County, 55.1 percent for California, and 49.1 percent for the U.S. (See Table 21.) Additionally, "overcrowding" – defined as more than one person per room – is at 8.6 percent for renter-occupied housing units in the service area, compared with 8.5 percent for the county, 13.3 percent for the state, and 6.2 percent for the nation. (See Table 22.)

Table 21: Housing Affordability – Housing Costs Greater than 30 Percent of Income

	SCFHS Service Area	Solano County	California	United States
Owner-Occupied Housing Units w/ Mortgage	34.8 %	34.8 %	40.0 %	29.8 %
Owner-Occupied Housing Units w/o Mortgage	13.3 %	13.3 %	16.3 %	15.2 %
Renter-Occupied Housing Units	53.8 %	54.3 %	55.1 %	49.1 %

Source: U.S. Census Bureau, 2017 ACS 5-Year Estimates

Table 22: Overcrowding – More than One Person per Room

	SCFHS Service Area	Solano County	California	United States
All Occupied Housing Units	5.0 %	5.0 %	8.2 %	3.3 %
Owner-Occupied Housing Units	2.7 %	2.6 %	4.0 %	1.7 %
Renter-Occupied Housing Units	8.6 %	8.5 %	13.3 %	6.2 %

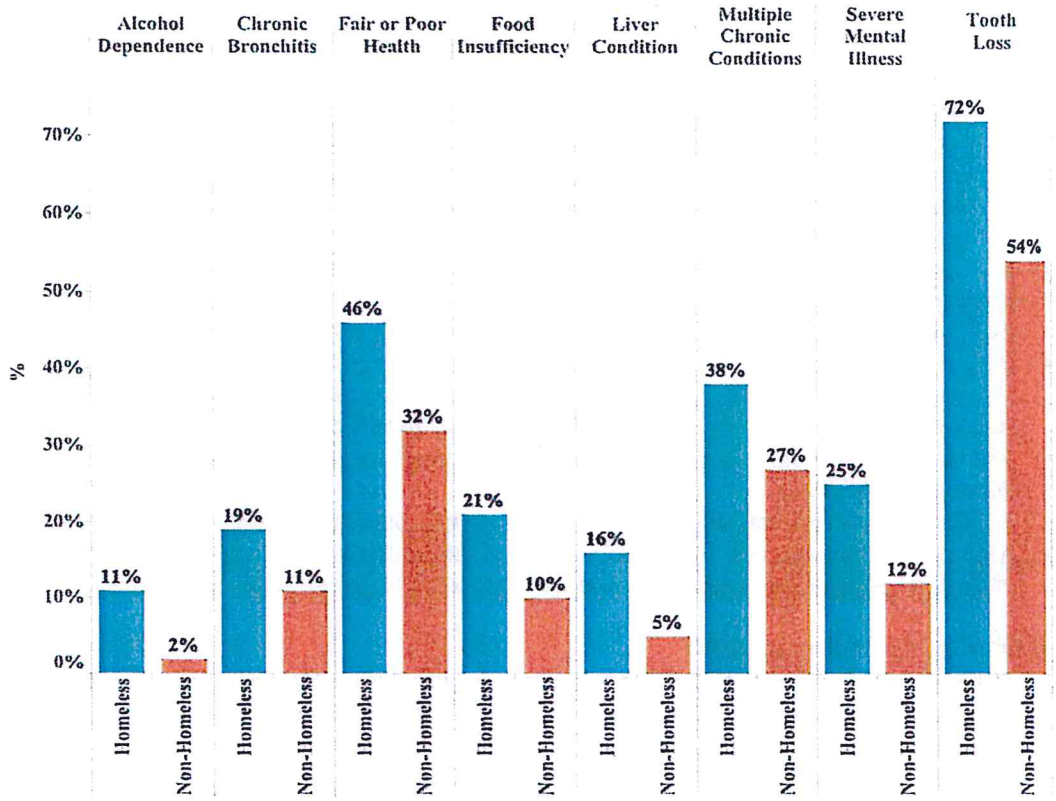
Source: U.S. Census Bureau, 2017ACS 5-Year Estimates

Poor health and homelessness are closely related. In fact, individuals experiencing homelessness are three to six times more likely to become ill than housed people.[77] Multiple morbidities are common, with high proportions of homeless individuals suffering some type of infectious disease or chronic health problem, such as pneumonia, tuberculosis, hepatitis C, cardiovascular disease, cancer, diabetes, HIV/AIDS, asthma, and overweight/obesity.[78,79] Those conditions that require regular, uninterrupted treatment, such as tuberculosis and HIV/AIDS, are particularly difficult to treat or control among those without adequate housing. Research by Dr. Margot Kushel at the University of California, San Francisco has found that homelessness has devastating consequences to health. Individuals experiencing homelessness have poor access to medical care, which leads to under diagnosis and greater difficulty managing chronic health problems like arthritis or diabetes. That can trigger underlying mental health issues, which can then lead to substance abuse.[80]

Unfortunately, many homeless people who are ill and need treatment do not ever receive medical care. Barriers to healthcare include lack of knowledge about where to get treated, lack of access to transportation, and lack of identification. Psychological barriers also exist, such as embarrassment, nervousness about filling out forms and answering questions properly, and self-consciousness about appearance and hygiene when living on the streets.[81] As a result, homeless people are three to four times more likely to die than the general population.[82] An analysis of HRSA's 2009 Health Center Patient Survey showed that, even among a largely low-income population, there are significant disparities when comparing homeless and non-homeless individuals.[83] As shown in Figure 4, a significantly higher percentage of the homeless population suffers from chronic conditions compared to the non-homeless population. Multiple chronic conditions include 2 or more of hypertension, diabetes, asthma, emphysema, heart problems, stroke, cancer, and HIV/AIDS.

Considering the difficult nature of treating homeless persons and the increase in health risks, the cost of providing services for this subpopulation is significant. However, a 2009 study on the cost of housing and homelessness showed consistent findings that public costs can be reduced by nearly 80 percent when homeless individuals are housed and provided with supportive care. [84]

Figure 4: Health Status of Health Center Users (Homeless vs. Non-Homeless)



VI. Conclusions

This community needs assessment was compiled for SCFHS as an informational resource to guide strategic planning activities, fund development, and program development. The collected data identifies common needs, issues, and priorities across various segments of the service area population, as well as those unique to particular age, race/ethnic, and socio-economic groups within the community.

Key socioeconomic and access to care findings include:

- The SCFHS service area population consists of 464,115 individuals, with 122,064 living under 200 percent of FPL.
- 25.3 percent of the service area is under the age of 20; 27.5 percent is between 20 and 39; 38.3 percent is between 40 and 69; and, 8.8 percent is 70 or older.
- SCFHS's service area has a population that is 38.4 percent White Alone, 26.3 percent Hispanic/Latino, 15.5 percent Asian, 13.3 percent Black/African American, and 5.5 percent "Other."

- 26.9 percent of the population in SCFHS's service area are considered "low income," living below 200 percent FPL, compared with 27.3 percent and 33.9 percent of the populations in Solano County and the US, respectively.
- SCFHS's service area, Solano County, and U.S. had unemployment rates of 8.5 percent, 8.5 percent, and 7.7 percent, respectively.
- 27.3 percent of residents of SCFHS's service area received public insurance benefits (Medicaid, Medicare, or other public insurance), slightly less than the Solano County average (27.7 percent) and below that of the state overall (31.5 percent).
- 7.3 percent of the service area population remains uninsured, compared with 7.4 percent for Solano County and 10.5 percent for California.
- 12.6 percent are without a high school diploma, while 12.4 percent and 16.8 percent of Solano County and California residents, respectively, have less than a high school education.
- 32.6 percent of the service area adults have some form of college degree, on par with 32.5 percent of county residents. However, both have less than California state residents, 37.0 percent of whom have college degrees.
- 20.7 percent of service area residents are foreign-born, with 6.8 percent being born in the Philippines and 6.8 percent being born in Mexico. Nearly one third (30.6 percent) of households in SCFHS's service area speaks a language other than English at home.
- Per the Community Need Index, the mean CNI score for the service area is 3.4 out of a possible 5.0, which falls within the second highest need range. According to the CNI, two of the 15 zip codes within the service area are designated as *highest need* areas.
- 47.5 percent of SCFHS's service area are designated as Medically Underserved Areas and Populations (MUA/Ps).
- 26.30 percent of residents of the service area are low income (living below 200 percent FPL).
- Although 11.0 percent of the population is below 100 percent FPL, this group utilizes 43.3 percent of the total primary care community clinic resources in the service area.

Key health disparity findings include:

- SCFHS's service area has higher five-year average age-adjusted death rates compared to the county in cancers, heart disease, Alzheimer's Disease, CLRD, stroke, unintentional injuries, diabetes, pneumonia, and chronic liver disease and Cirrhosis.
- 30.7 of adult residents (age 18 and over) of Solano County are obese compared to 26.8 percent for the state.
- SCFHS's rates for late entry into prenatal care are worse in SCFHS's service area as compared to those of the county.
- 40.2 percent of all children (3-11 years of age) in Solano County had never been to a dentist. This compares to 14.0 percent for all children in California.
- A review of reported substance use shows that the service area rates exceed the rates for the county in most of the listed variables for drug and alcohol usage.
- A review of reported substance use shows that the service area rates exceed the rates for the state and the nation in all of the listed variables except for alcohol usage.
- "Overcrowding" – defined as more than one person per room – is at 8.6 percent for renter-occupied housing units in the service area, compared with 8.5 percent for the county, 13.3 percent for the state, and 6.2 percent for the nation.
- 2019 Solano County Homeless Point-In-Time Count and Survey, conducted on January 23rd, 2019, counted 1,151 homeless individuals, of which more than 80 percent were classified as unsheltered.

The data presented in this assessment confirm the need for capacity in high quality, culturally competent, coordinated, and comprehensive primary medical, dental, and behavioral health services in the community.

The overall penetration rate by existing FQHC and Look-Alikes for the low-income community in SCFHS's service area is only 35.76 percent. With 122,064 low-income residents in the service area, that translates to residents receiving services, leaving 78,420 low-income residents without a HRSA Health Center Program medical home. With an average patient utilization rate of 3.7 medical visits per year (based on California 2017 UDS data), that calculates to a deficit of 290,154 medical visits annually for SCFHS's service area. With the support of its partners on the federal, state and community levels, SCFHS will continue to invest in, and expand its service offerings to close the gap on health disparities and access to affordable healthcare services in the area.

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