TEHAMA COUNTY

Community Health Improvement Plan

2025-2028

TCHSA

Data Strategy Consulting

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The Tehama County Community Health Improvement Plan (CHIP) is a collaborative, stakeholder-driven effort aimed at enhancing the health and well-being of all residents. Developed using the **Mobilizing for Action through Planning and Partnerships (MAPP)** framework, the CHIP reflects a shared vision for addressing the county's most pressing health challenges. This plan is rooted in data-driven strategies and shaped by input from community members, stakeholders, and local leaders. It prioritizes equity and transparency and encourages interventions that are both practical and sustainable. The CHIP is designed to guide *collective action*, promote both short and long-term improvements, and create opportunities for all individuals to achieve better health outcomes.

Health disparities are driven by a multitude of structural, environmental, and behavioral factors. Community involvement throughout the creation of improvement plans results in creative solutions to the public health problems that drive these disparities. Though this plan cannot address all the drivers, it focuses on those disproportionately impacting the most vulnerable residents of Tehama County. This plan was informed by a comprehensive assessment process that incorporated surveys, focus groups, and analysis of local health data. These assessments identified critical areas for intervention. With these priorities in focus, the CHIP outlines actionable strategies to address systemic barriers and strengthen community resilience. It also serves as a dynamic tool to nurture ongoing collaboration, strengthen internal capacity, and support lasting progress toward a healthier, more equitable Tehama County.

County Profile

Demographic profile and analysis of leading health challenges from the Community Health Assessment

There are an estimated 65,500 individuals living in Tehama County, an increase of 4% since 2015. One in four residents in the county is under 18 years of age and over 21% are 65 years and older. Tehama County has a higher proportion of adults over 65 years than California (15%). This was the fastest growing age group between 2015 and 2021 with its population increasing 13%.

The largest racial or ethnic group in Tehama County is the white, non-Hispanic group, with a population of 42,200 (64% of the total population). More than one in four residents (27%) is Hispanic or Latino. This population had the most growth from 2015 to 2021, increasing by about 2,700 from 15,200 in 2015 to 17,900 in 2021. More than a third of children 5-17 years (36%) and about one in six adults (17%) in Tehama County speaks a language other than English at home. About 90% of non-English speaking residents speak Spanish.

Tehama County faces significant health challenges driven by economic hardship, limited access to care, and adverse health behaviors. The county ranks in the ninth percentile statewide for income, with only 55% of residents earning 200% or more of the federal poverty level (approximately $25,000). Per capita income is $24,300, well below the California average of $37,200. Educational attainment is also low, with less than 16% of adults holding a bachelor's degree or higher, compared to 34% statewide. Disparities are evident across racial and ethnic groups, with only 10% of Latino and 7% of Native American residents attaining a bachelor's degree or higher. Employment rates are also lower, at 66% compared to 73% statewide, particularly affecting Native American, multiracial, and Asian populations. High poverty and low educational attainment contribute to chronic stress, poor health behaviors, and barriers to healthcare access.

Healthcare access remains a critical issue. One in ten residents lacks health insurance, with lower coverage among American Indian/Alaska Native (81%), Latino (82%), and multiracial (85%) residents, compared to White residents (92%). The county faces a shortage of providers, with a population-to-primary care physician ratio of 2,030:1, significantly higher than the state average of 1,240:1. Mental health care is even more strained, with a ratio of 570 residents per provider, compared to 240:1 in California. These gaps exacerbate health disparities and contribute to delayed or unmet care needs. Preventive care utilization is below state averages, including lower rates of mammograms (66% vs. 76%) and colorectal screenings (57% vs. 63%). Preventable hospitalizations are also higher, at 1,054 per 100,000 compared to 694 statewide, reflecting inadequate access to primary and preventive care services.

The built environment presents challenges for accessing critical resources and maintaining an active lifestyle. Food insecurity is a major concern, affecting 16% of residents—one of the highest rates in California. Geographic disparities compound these challenges, with higher rates of food insecurity and poor access to supermarkets in rural areas. Only 25% of residents live within walking distance of a park, beach, or open space, compared to 77% statewide, further limiting opportunities for physical activity. Broadband internet access, crucial for telehealth and education, is also limited, with only 74% of households having access compared to 89% statewide.

Behavioral risks further strain community health. Almost 20% of adults smoke, double the state average, and 25% are physically inactive. Alcohol-related motor vehicle crashes account for over half of all traffic incidents, with a death rate of 22 per 100,000, more than twice the state average of 10 per 100,000. Mental health challenges are prevalent, with 17% of residents reporting poor mental health compared to 12% statewide, and suicide rates ranking among the highest in the state.

Chronic disease rates are high, with 33% of adults experiencing hypertension (vs. 28% statewide) and 12% diagnosed with diabetes (vs. 10% statewide). Obesity affects 34% of adults, ranking in the 93rd percentile statewide. Life expectancy is lower at 76.5 years compared to 81 years statewide, and premature death rates are nearly double the state average (9,917 per 100,000 vs. 5,998). Mortality rates for cancer, heart disease, stroke, and diabetes, along with alcohol-related deaths, are among the highest in the state.

Tehama County's Community Health Assessment emphasizes the urgent need for strategies that address economic and social inequities, expand healthcare infrastructure, improve access to healthy foods and physical activity, and promote behavioral health interventions. Coordinated efforts targeting these disparities are essential to improving overall health and well-being in the county.

MAPP Framework

The **MAPP** framework is the guiding structure for development of the CHIP. Developed by the National Association of County and City Health Officials (NACCHO) in partnership with the Centers for Disease Control and Prevention (CDC), MAPP is a community-driven, strategic planning process designed to improve public health and strengthen local systems. It provides a systematic approach for engaging stakeholders, assessing community needs and resources, and identifying priorities to address the most pressing health challenges.

The MAPP framework includes six core phases: **1) Organize for Success**—establishing partnerships and planning processes; **2) Visioning**—creating a shared vision for a healthier future; **3) Conducting Assessments**—gathering data through key assessments that examine community health status, strengths, forces of change, and local public health systems; **4) Identifying Strategic Issues**—prioritizing key challenges based on assessment findings; **5) Formulating Goals and Strategies**—developing clear objectives and action steps; and **6) Taking Action**—implementing and evaluating strategies to ensure progress.

By using the MAPP framework, the CHIP process champions broad collaboration, data-informed decision-making, and a focus on equity and sustainability. It builds a foundation

for sustainable improvements by empowering community partners to work together toward shared goals, ultimately promoting health, well-being, and quality of life for all residents in Tehama County.

Stakeholder and Community Engagement

The CHIP relies on the active involvement of community stakeholders and partners, whose expertise, perspectives, and resources are essential to its success. Using the MAPP framework, this collaborative approach ensures that the CHIP reflects the needs and priorities of the entire community. Tehama County Public Health convened a diverse stakeholder steering committee to oversee the CHIP including representatives from local organizations, healthcare, education, and the businesses community. Stakeholders contributed valuable insights and knowledge that helped identify critical health challenges and opportunities for improvement. Their participation fostered shared ownership and accountability, ensuring that the strategies outlined in the CHIP are both practical and impactful. By working together, community partners helped create an inclusive plan that promotes health equity, addresses some of the root drivers of health disparities, and builds a stronger, healthier future for the entire county. The complete list of CHIP Steering Committee representatives and agencies can be reviewed in *Exhibit D*.

The case for health equity

*Health equity is the concept that everyone should have the same opportunity to be healthy, regardless of their social or economic background. The **7 Vital Conditions for Health and Wellbeing framework** provides a powerful foundation for advancing health equity. These conditions are the characteristics of a thriving community and provide an aspirational roadmap for CHIP efforts.*

By recognizing that health outcomes are shaped by the broader social, economic, and environmental conditions in which people live, this framework highlights the systemic factors that influence well-being across generations. It emphasizes equitable access to essential needs such as safe housing, reliable transportation, lifelong learning, and economic stability, while also addressing social connections, civic engagement, and environmental health. These interconnected conditions underscore the importance of reducing disparities and creating opportunities for all individuals to thrive, particularly those in historically underserved and vulnerable populations.

Vision Mission Values

The Steering Committee developed the following vision, mission, and values to orient and guide CHIP activities. These principles reflect a commitment to advancing health equity, championing systemic improvements, and facilitating transparent communication.

Vision: *Our vision for a healthy Tehama County is a safe, inclusive, equitable, respectful community with strong healthy individuals at its core.*

Mission Statement: *We exist to monitor, review, and improve community health outcomes. While advocating for processes and systems, within our individual organizations, that align with the community health outcome goals.*

Values:

- *Consistency*
- *Collaboration*
- *Advocacy*
- *Community Focus*
- *Open Communication*

The CHIP is a dynamic roadmap and is designed to complement and align with existing community efforts. By building upon the strengths of existing efforts, partnerships, and initiatives, this CHIP seeks to promote a collective impact response to health needs in the community. This plan is not intended to yield results purely on its own, but rather work in tandem with similar programming, policies, and community efforts that promote health equity. Furthermore, we recognize that the public health landscape is continuously evolving. As circumstances, priorities, and resources may shift we intend to be responsive, evaluating CHIP activities in the light of those shifts in an effort to make the appropriate adjustments to maintain plan efficacy.

Methods

Assessments, a core component of the MAPP framework, provided the foundation for identifying priority areas and shaping strategies outlined in the CHIP. By capturing data on health disparities, barriers, and community strengths, the assessments ensured that the CHIP is both evidence-based and responsive to the unique needs of Tehama County residents.

Key methods for conducting these assessments included analyzing local health and socio-economic indicators, conducting surveys, and facilitating focus groups and interviews with diverse stakeholders, community members, and key informants. Emphasis was placed on identifying disparities and barriers affecting vulnerable populations.

MAPP Assessments

Community Context Assessment

The **Community Context Assessment** aimed to assess health equity challenges and opportunities through the lived experience of actual Tehama County residents. Focus groups representing key industries—such as healthcare, education, and transportation—and diverse demographic groups, including Latino, Native American, unhoused individuals, and persons with disabilities, explored community strengths, barriers, and priorities. Findings revealed significant barriers to health equity, including a shortage of healthcare providers, particularly specialists and mental health professionals, along with limited access to affordable long-term care services. Transportation challenges, especially for seniors and persons with disabilities, and limited broadband infrastructure further restricted access to telehealth and other vital services. Economic pressures, such as rising costs of living and food insecurity, compounded these issues, leaving many residents unable to prioritize healthcare. Participants emphasized the need for culturally responsive care, expanded outreach, and greater investment in addressing systemic inequities affecting vulnerable populations.

Despite these challenges, the assessment highlighted several community strengths and promising initiatives. Strong social networks and close-knit partnerships among agencies

and organizations were noted as key assets for resilience and collective problem-solving. Specific initiatives, such as the development of school-based wellness centers and a family resource hub in Corning, aim to improve access to healthcare and health education for students and families. Programs like **Healthy Families Tehama** further demonstrate the county's commitment to linking early education systems with healthcare resources to meet family needs. Infrastructure improvements, including expanded public transit through the **TRAX and paratransit systems**, have enhanced mobility for vulnerable residents, although gaps remain in remote areas. Recommendations from the assessment focused on expanding mobile medical units, increasing training opportunities to build a local healthcare workforce, and improving communication strategies—such as developing a comprehensive resource guide—to ensure residents are aware of available services. These findings underscore the need for collaborative, data-driven strategies to address disparities and promote sustainable health improvements in the county. *The full assessment is provided in Exhibit A.*

Community Partner Assessment

The **Stakeholder Analysis** examined the roles, strengths, and capacities of key organizations represented in the CHIP Steering Committee. The analysis involved surveys and key informant interviews with stakeholders from diverse sectors, including healthcare, education, transportation, and social services. Findings highlighted that stakeholders bring extensive knowledge, long-standing ties to the community, and broad networks of partnerships that enhance their ability to mobilize resources and support CHIP initiatives. Many stakeholders demonstrated expertise in areas such as healthcare delivery, disaster response, and community engagement, positioning them as valuable contributors to community planning. The analysis also revealed a shared enthusiasm for CHIP activities and alignment between organizational goals and the CHIP mission, reinforcing stakeholder commitment to improving health outcomes.

Key strengths identified in the assessment included stakeholder efforts to address accessibility and cultural inclusivity, such as offering bilingual resources, hosting cultural health fairs, and conducting surveys to collect direct feedback from residents. Successful interventions included collaborations that increased healthcare access, workforce development programs, and innovative community events like farmers' markets and mobile health screenings. Despite these successes, stakeholders noted challenges in areas such as securing sustainable funding, building strategic plans, and engaging in advocacy. Differences in decision-making authority were also noted, with some agencies

having significant influence over resource allocation while others expressed limited capacity to shape policies.

The findings highlighted the steering committee's potential to drive transformative change through enhanced collaboration, communication, and resource-sharing. Recommendations included addressing funding gaps, strengthening strategic planning processes, and investing in advocacy skills to amplify collective influence. Stakeholders also expressed interest in bold initiatives, such as expanding mobile services, improving housing and transportation infrastructure, and launching mental health programs to address pressing community challenges. *The full assessment is provided in Exhibit B*.

Priority Areas of Focus

Triangulation

Triangulation is a research practice which involves examining multiple data sources to better understand a research topic or question. Triangulation was used as part of the MAPP framework to identify cross-cutting themes from the assessments and community plans. Cross-cutting themes are defined as those that were mentioned across nearly all data sources. A scoring system was used to classify themes as predominant or secondary. Themes were grouped into the following categories: *Community Strengths and Organizational Capacity; Systems of Power, Privilege, and Oppression; Social Determinants of Health; Health Behaviors and Health Outcomes; Infrastructure and Technology*. The complete list of primary and secondary themes can be reviewed in the appendix.

Cross-cutting Health Equity Themes	
Social Determinants of Health	○ Healthcare Access and Quality ○ Educational Attainment ○ Economic Opportunity (Employment, Poverty Cost of Living) ○ Housing Insecurity ○ Park Access (Accessible Recreation) ○ Access to Healthy Food
Health Behaviors	○ Mental Health and Substance Use Services
Technology and Infrastructure	○ Transportation Gaps ○ Broadband Internet Access

Topic Selection

The process for selecting the three priority areas of focus was community-driven and data-informed. The assessments provided a detailed and nuanced understanding of Tehama County's health equity challenges and Triangulation distilled those findings into the most relevant themes. After a careful review of those findings, the steering committee elected to develop detailed Issue Statements on five of the themes. Issue Statements, another component of MAPP summarized the themes by describing the populations most impacted and potential root causes and contributing factors. Based on this tailored evaluation, the steering committee chose to prioritize ***healthcare access, mental health and substance abuse prevention programs, and access to healthy food*** as key areas for plan focus. *Full Issue Statements are provided in Exhibit C.*

Objectives and Strategies

Priority Area 1: Healthcare Access		
Subcategory 1: Workforce Development		
Objective 1: *Expand healthcare career and technical education (CTE) programs in Tehama County by 2028 to build a local pipeline of future healthcare professionals.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Support one school district with developing CTE goals	Spring 2025-2026	Tehama County CTE Coalition, Healthy Rural California
2) Expand CTE programs in one high school and one community college that focus upon either a medical, dental, behavioral health, or substance use recovery professions within Tehama County	Spring 2026-2027	Tehama County CTE Coalition, Healthy Rural California
3) Partner with Butte and Shasta college to fill gaps in medical and dental related CTE needs. Host up to four student interns in medical and dental offices in Tehama County	Fall 2025 to 2027	Tehama County CTE Coalition, Healthy Rural California, Chico State, Northern CA Dental Society
Objective 2: *Increase provider retention rates by 5% in Tehama County by 2027*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Work with community partners to integrate providers and their spouses into the community through economic opportunities, housing support, recreation, and cultural activities. Conduct a survey to determine what providers look for in a community	2025-2027	Partnership, Health Alliance of Northern California, North Valley Medical Association, CA Association of Rural Health clinics

2) Offer one provider cultural training per year	2025-2028	Partnership, Health Alliance of Northern California, North Valley Medical Association
Secondary Strategies	**Timeframe**	**Collaborating Partners**
3) Develop a structured retention bonus program to reward providers who commit to long-term service in the county	2025-2028	
Objective 3: *Increase provider recruitment rates by 5% in Tehama County by 2027*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Develop one targeted advertising campaign promoting healthcare employment opportunities in Tehama County	Spring 2025 to 2026	Partnership, HANC Health Alliance of Northern California, City of Red Bluff, City of Corning
2) Develop one regional recruitment magazine for healthcare providers	2025-2028	Partnership, Health Alliance of Northern California, North Valley Medical Association
Secondary Strategies	**Timeframe**	**Collaborating Partners**
3) "Grow Our Own" provider program – Establish training pipelines and partnerships with local educational institutions to support students from the community in pursuing healthcare careers	2025-2027	Partnership, HANC Health Alliance of Northern California, City of Red Bluff and City of Corning, St. Elizabeth Hospital
4) Research opportunities available for J1 visa holders	2025-2027	Partnership, Health Alliance of Northern California, North Valley Medical Association, CA Association of Rural Health clinics
5) Advocate for and facilitate participation in state and federal loan repayment programs	2025-2028	Partnership, Health Alliance of Northern California, North Valley Medical Association

Objective 4: *Expand a residency rotation program in collaboration with 4 regional medical centers (SRMC, MMCR, SCHC, Enloe and UC Davis Family Practice Program in Chico) to recruit and retain at least 60% of family practice, internal medicine, and psychiatric residents in Tehama County for hands-on experience and community integration.*

Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Develop one formal agreement with nearby teaching health center and universities to create a sustainable pipeline for residency rotations	2025-2028	Healthy Rural California, UC Davis and Touro University College of Osteopathic Medicine, Partnership
2) Engage at least three healthcare providers in Tehama County to act as mentors and faculty for residency rotations	2025-2028	Healthy Rural California, UC Davis and Touro University College of Osteopathic Medicine, Partnership, North Valley Medical Association
3) Partner with five community organizations to promote policies that provide resources such as housing, childcare, and spousal employment opportunities for residents during their rotations	Fall 2025 - 2028	Healthy Rural California, UC Davis and Touro University College of Osteopathic Medicine, Partnership, North Valley Medical Association, City Planning Depts, Economic Development Chamber
4) Explore housing opportunities within Tehama County for residency students to support their stay during their rotations. This can include reduced housing costs, room rentals, hosting and other opportunities. Identify two specific and viable opportunities	2025-2026	Rolling Hills, Healthy Rural California, Partnership, North Valley Medical Association, City Planning Depts, Economic Development Chamber, Northern CA Dental Society
Secondary Strategies	**Timeframe**	**Collaborating Partners**
5) Seek grants and other financial support to offset program costs, particularly through initiatives aimed at improving rural healthcare access and provider recruitment	2025-2028	Healthy Rural California, UC Davis and Touro University College of Osteopathic Medicine, Partnership

Subcategory 2: Mobile and Telehealth Expansion		
Objective 1: (POLICY) *Develop and implement policies to expand existing public health mobile units, ensuring the inclusion of dental and other essential health services, with the goal of reaching at least 60% of underserved and rural areas.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Hire two service providers to staff mobile units including community health workers	2025-2026	Tehama Health Services Agency, Partnership
2) Acquire Medi-Cal and Denti-Cal authorization through HRSA for mobile unit expansion	2025	Tehama Health Services Agency, Partnership
3) Establish two active mobile dental units and integrate them with other healthcare services in Tehama County	2026-2027	Tehama Public Health/MCAH, Tehama Dept of Education, Dental Health Coalition, School Health Nurses group, First 5, Partnership
Secondary Strategies	**Timeframe**	**Collaborating Partners**
4) **POLICY** Design policies to ensure regular, rotating service delivery in high-priority areas (e.g., Paskenta, Rancho Tehama) to increase access to healthcare and dental services	Summer 2025-2027	Tehama Public Health/MCAH, Tehama Dept of Education, Dental Health Coalition, School Health Nurses group, First 5, Partnership
Objective 2: *Ensure access and increase utilization of telehealth services for mental health services (mild, moderate, and SMHS) by 10%.*		
Primary Strategies	**Timeframe**	**Responsible Agency**
1) Offer one annual training to clinicians on effective telehealth communication, platform usage, and addressing barriers specific to virtual care	2025-2028	Tehama County Behavioral Health, Red Bluff Restpadd, Victor, Remi Vista, Children' First, Board of Behavioral Science, Linda Garret JD, Partnership
2) Provide technical assistance for a minimum of fifty patients accessing telehealth services	2025-2027	Tehama County Behavioral Health-TCHSA Medical Clinic, Red Bluff Restpadd-Victor, Remi Vista, Children' First
Secondary Strategies	**Timeframe**	**Collaborating Partners**

3) Ensure telehealth options are offered as part of routine mental health services, including intake and follow-up care, to normalize its use	2025-2026	Tehama County Behavioral Health & Partnership, Help me Grow, Far Northern California, First 5
4) Develop a standard survey and conduct annually to identify and address ongoing barriers to telehealth utilization. Add telehealth Utilization question to the MHSA focus groups	2025-2028	Tehama County Behavioral Health, Red Bluff Restpadd, Victor, Remi Vista, Children' First
Objective 3: *Improve broadband access in low-income and rural areas of Tehama County by 10% to support equitable telehealth access.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Promote collaboration between public and private sectors to share broadband-related resources	2025	Partnership, Rolling Hills, TCHSA all centers and Greenville Rancheria
2) Provide workshops and training programs to teach at least one hundred individuals and organizations how to effectively *use* broadband services for telehealth and other digital health tools	2025-2026	Partnership, TCHSA all centers
Secondary Strategies	**Timeframe**	**Collaborating Partners**
3) Support organizations that do not currently offer telehealth services by providing technical assistance, training, and tools needed to establish and expand telehealth programs	2025-2028	Partnership, County libraries, Chico State Library

Priority Area 2: Mental Health and Substance Use Prevention		
Subcategory 1: Youth and School-based Mental Health Programs		
Objective 1: *Expand access to youth wellness support through growth of community school-based services by 2027.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Provide school-based trauma-informed training for teachers and students	2025-2028	First 5, Expect More Tehama, Dept of Ed, Healthy Rural CA

2) **(POLICY)** Establish policy requiring all Tehama County teachers to complete annual ACEs (Adverse Childhood Experiences) training to increase awareness and trauma-informed practices in schools	2025-2028	First 5, Expect More Tehama, Dept of Ed., TCHSA BH
Secondary Strategies	**Timeframe**	**Collaborating Partners**
3) Train 20 mental health professionals to expand their mental health services to the 0-5 population	2025-2026	First 5, Expect More Tehama, Dept of Ed, Zero to Three non-profit
4) Establish school wellness centers	2025-2028	First 5, Expect More Tehama, Dept of Ed, Healthy Rural CA
Objective 2: *Develop and implement parent-focused educational sessions to front-load critical information on youth mental health and safety issues including social media use, suicide prevention, dating violence, and vaping, while assessing existing mental health curricula and programmatic responses across schools.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Utilize a survey to obtain data from administrators to identify gaps and tailor strategies to meet each school's specific needs	2025	Dept. of Ed., Expect More Tehama, school districts
Objective 3: *Increase public awareness and visibility of Tehama County's mobile crisis unit to improve access to services.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Develop one marketing campaign for mobile health related services within the community	2025	Tehama County Behavioral Health and Public Health
2) Develop one tracking utilization tool	2025-2026	Tehama County Behavioral Health
3) Partner with two primary care clinics, one emergency department, and one urgent care facility to refer patients to the mobile crisis unit	2025-2028	Tehama County Behavioral Health, Far Northern Regional Center, First 5, Sac Valley Med Share
Secondary Strategies	**Timeframe**	**Collaborating Partners**
4) Collaborate with school districts and other community partners to integrate awareness campaigns or provide on-site visits	2025-2028	Tehama County Behavioral Health, Far Northern Regional Center,

5) Organize health fairs, open houses, or informational sessions to showcase the mobile crisis unit and educate residents about services	2025	Tehama County Behavioral Health
Subcategory 2: Substance Use Disorder Prevention		
Objective 1: *Increase provider and community education on SUD interventions, including Narcan, SBIRT (Screening, Brief Intervention, and Referral to Treatment), and recognizing signs of SUD and mental illness.*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Offer a minimum of six evidence-based substance abuse awareness classes to high school students, teens in the juvenile justice system, and parents	2025-2027	Healthy Rural CA, Tehama High Schools, Tehama County Health Services, Health Alliance of Northern California
2) Expand opioid safety coalition by three new members	2025-2026	Healthy Rural CA, Tehama County Health Services, Rolling Hills, Rancheria, Tehama County High Schools
3) Explore restarting the CA Bridge Program or an alternative program that focuses on Opioid Substance Use Treatment at St. Elizabeth	2025-2027	St. Elizabeth, Tehama County Health Services
Secondary Strategies	**Timeframe**	**Responsible Agency**
4) Expand prevention-oriented education such as SBIRT at continuation schools (Corning and Centennial) Salisbury High and Rancho Tehama	2025-2027	Healthy Rural CA, Tehama High Schools, Tehama County Health Services
5) Partner with county MH, Butte Glen Medical Society, PHP, and non-profit organizations to provide one annual training on SUD prevention and treatment resources available to providers	2025-2028	Healthy Rural CA, Tehama County Health Services, Rolling Hills

Priority Area 3: Food Access		
Objective 1: Increase enrollment of eligible Tehama County households at or below 138% of the federal poverty level into nutrition assistance programs by 20% by 2028.		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Convene a workgroup representing 75% of charitable food service organizations in Tehama County to reduce silos and reduce waste	Fall 2025-2026	Tehama Public Health, Salvation Army, PATH, New Life Church, WIC, Lord's Table-Area on Ageing-UCCE (Janessa), Farm to Fork, Gleaners-UCSF Champion Provider Fellowship (Food as Medicine), Local Chef's
2) Engage schools to collect data for how many eligible youths access free and reduced-price lunch	2025-2026	TCHSA, school districts, Dept. of Education
3) Determine baseline of community members who are currently receiving nutrition benefits	2025	TCHSA, St. Elizabeth Community Hospital
4) Determine baseline percentage of seniors receiving SNAP benefits	2026	Tehama Public Health, TCDSS-Community Action Agency
Secondary Strategies	**Timeframe**	**Responsible Agency**
5) **(POLICY)** Recommend policies through coalition efforts that support access to healthy foods	2026-2027	Tehama Public Health, Salvation Army, PATH, New Life Church, WIC, Lord's Table
6) Partner with the public assistance department on targeted outreach and enrollment in nutrition assistance programs	2026-2028	Tehama County Public Health, TCDSS
Objective 2: *Increase enrollment of eligible Tehama County households at or below 138% of the federal poverty level in nutrition assistance programs by 20% from baseline by 2028*		
Primary Strategies	**Timeframe**	**Collaborating Partners**
1) Participate in a grant writing training	2025-2026	TCHSA Public Health, Tehama Together, all other workgroup members
2) Identify and obtain funding to support Objective 2 Food Access strategies	2025-2026	TCHSA Public Health and partner willing to serve as fiscal agent

3) Develop 6 culturally tailored materials and resources to increase nutrition literacy	2026-2027	Tehama Public Health, Salvation Army, PATH, New Life Church, WIC, Lord's Table
4) Cooking classes and food safety/nutrition education opportunities	2025-2028	TCHSA Public Health, Tehama Together, TCDSS, WIC

Evaluation

The evaluation plan for the CHIP will focus on measuring progress toward plan objectives. Evaluation activities will include collecting and analyzing data to monitor performance related to priority areas of focus. The plan will incorporate both quantitative data and qualitative feedback from stakeholders to track outcomes, identify barriers, and refine strategies over time. Using a performance management system that aligns with the Results Based Accountability framework, quantity, quality, and impact measures will be collected. Some potential measures may include:

- Provider retention and recruitment rates
- Mobile service utilization
- School-based mental health trainings
- Provider participation in loan repayment programs
- Consumer-reported experiences accessing and utilizing telehealth services

Quarterly progress reports will be prepared and shared with steering committee members and other relevant stakeholders to ensure transparency and collective accountability. Additionally, regular updates will be presented to the County Board of Supervisors to inform local policymakers about the plan's impact and progress. Midyear evaluations will assess the effectiveness of interventions and activities, allowing for adjustments to strategies as needed. At the conclusion of the CHIP cycle, a comprehensive evaluation will be performed, summarizing achievements, identifying lessons learned, and presenting recommendations for sustaining and expanding plan gains. Conducting the evaluation utilizing this approach ensures continuous monitoring, community engagement, and accountability throughout the implementation process.

Sample Year 1 Timeline	Evaluation Activity
Q1-Q2	• Baseline data collection and stakeholder input • First quarterly progress report to Steering Committee

	• Use "Turn the Curve" RBA process to identify and align measures with strategies
Q2-Q3	• Midyear evaluation preparation • Ongoing data collection for performance monitoring; acquisition of additional reports/tools from partners and collaborators • Conduct stakeholder focus groups/SME interviews to refine strategies within implementation workgroups
Q3	• Midyear evaluation and strategy refinement/adjustments based on identified barriers • (Potential) presentation of progress report to Board of Supervisors • Continued quarterly reporting to stakeholder committees
Q4	• Year-end evaluation • Final progress report to Steering Committee • Development of Year 2 sustainability recommendations

Appendix

Exhibit A: Community Context Assessment

Tehama County Community Context Assessment

Background/Rationale

The community context assessment serves as a research tool designed to understand the lived experiences of communities affected by social systems, with the aim of enhancing the overall effectiveness of these systems. This assessment focuses on capturing the views, insights, values, and priorities of individuals experiencing or affected by structural inequities. By emphasizing three key domains—community strengths, built environment, and forces of change—this analysis examines the attitudes, beliefs, and perceptions of Tehama County residents regarding health equity. It identifies the most significant drivers of health disparities, health-related community challenges, and potential areas for intervention.

Methods

Nine focus groups were conducted involving stakeholders representing industry and demographic sectors within Tehama County. The industry groups included: 1) Economy, 2) Transportation, 3) Health Behaviors, 4) Healthcare Access, and 5) Education. The Demographic groups included: 1) Latino, 2) Native American, and 3) Unhoused Persons and 4) Persons with Disabilities. Participants were asked 10-12 questions from 4 specific domains pertaining to community strengths and assets, built environment, forces of change, and health systems. Focus groups were conducted remotely and ranged in size from 3 to 9 participants. The following lists the primary questions that were asked:

- *What does health equity mean to you?*
- *What are the predominant forms of inequity you see in your practice or day-to-day work?*
- *What acts as a barrier to achieving better health outcomes within the community (policy, structure, systems)*
- *What do you view are some of the greatest strengths and assets within your community?*
- *Are there specific policies, practices, or events that have weakened or threatened these strengths?*
- *What physical assets and resources exist in the built environment of your community?*
- *How can the built environment be improved to support better health outcomes?*

- *What improvements/interventions do you think would have the greatest impact on health equity?*
- *How has your industry partnered in the past with the health department and/or other healthcare agencies?*
- *How will you know that the actions taken to improve community health are working? What does success look like in your practice/industry and community?*
- *What important first steps would you take to ensure that we can act on the key strategies and interventions proposed?*

Findings

Understanding Health Equity

Participants were first asked to describe their understanding of health equity beyond the formal definition, in terms of real-world impressions, beliefs and experiences. In responding to this question groups described access to care, removal of structural and system barriers and tailored care particularly for vulnerable communities as being the most notable representations of health equity.

Equal Access to Care: Many responses emphasize the importance of having equal access to healthcare services regardless of an individual's financial means, their background, or their location. This also includes equitable logistical solutions involved in securing equal access such as additional supports for those with disabilities.

Structural and Systematic Barriers: There's a recognition of the barriers that prevent achieving health equity, such as inadequate transportation and systemic challenges within healthcare, system that hinder equal access to care, underlining the need for collective reforms to achieve true health equity. Additionally, others discuss the role played by social determinants of health

Tailored Care for Vulnerable Groups: Several responses highlight the need for healthcare services that are specifically tailored to address the unique needs of constituents - particularly vulnerable populations, such as the elderly, people with disabilities, and the unhoused. Meeting clients within their unique life circumstances however complex those circumstances may be is described as a critical facet of promoting health equity.

Community Involvement and Advocacy: A few responses also mention the role of community involvement and advocacy in promoting health equity. For instance, the importance of elders taking care of their health and ensuring everyone is knowledgeable about the healthcare issues impacting their communities and the resources available to them, suggests a community-driven approach to health equity.

These responses collectively highlight concerns about how health equity is promoted and sustained within the community. Participants express a strong interest in ensuring that healthcare is accessible and inclusive, addressing systemic barriers and the specific needs of vulnerable groups. Each theme illustrates stakeholders' awareness of the multifaceted ways in which health equity manifests and the forces that may impede it.

Predominant Forms of Inequity and Barriers

Participants were asked to describe the most significant forms of inequity they see in their day-to-day environments and the forces that act as barriers. Almost every group to some extent described access to healthcare, technology, and transportation as the most predominant barriers.

Access to Healthcare Services:

Respondents from both industry and demographic groups emphasize a critical shortage of healthcare providers, particularly within the specialties. This shortage is attributed to doctors retiring or leaving the profession, or the inability to attract talented new providers to the region which exacerbates inequities in healthcare accessibility. Furthermore, there is a lack of affordable hospice caregivers for the aging population and long-term care services for those struggling with mental illness. Residents requiring specialty services must incur significant wait lists or frequently travel outside the county to access the care they need.

"Not enough providers—doctors leaving and retiring."

Technological and Infrastructure Barriers:

Several participants discuss technological and infrastructural limitations that hinder equitable access to services. These challenges include limited broadband internet infrastructure, resulting in unreliable or slow internet connections that hinder video consultations and data transmission. Additionally, there is often a lack of access to the necessary devices and technology literacy, making it difficult for residents to effectively utilize telehealth platforms. This is particularly highlighted by respondents dealing with rural or underserved populations.

"Bandwidth issues, areas of limited access, not enough outreach."

Transportation Challenges:

Transportation emerges as a critical barrier, particularly affecting persons with disabilities and the elderly. The lack of reliable transportation directly impacts these individuals' ability to access healthcare facilities, which is a significant equity issue. Transportation is cited as a challenge not necessarily because of the lack of transportation networks but rather because

existing networks have reduced service times and/or limited routes. For residents not utilizing public transit, high fuel costs can disproportionately impact those who need to drive longer distances for daily activities, increasing their overall cost of living. Challenges faced by unhoused individuals are also frequently noted, with a focus on the difficulties in accessing stable housing and subsequent healthcare services, which significantly affect their health outcomes.

"Transportation issues—very major issue for all my clients."

"Homeless individuals that cannot get into housing have poor health outcomes."

Economic and Business-related Inequities:

Almost half of the groups describe economic conditions such as inflation and high cost of living as a driver of inequity. Families are struggling to make ends meet forcing them to reprioritize spending. *"They have to prioritize their paycheck in a different way. All the costs are going up."* Families are concerned about whether healthcare costs will be covered and how to balance out of pocket costs with the additional demands of running a household. Participants describe how "the basics" including food and shelter feel out of reach to some. In particular, access to healthy food options is discussed as a persistent challenge both due to cost and limited physical proximity.

Though not as frequently discussed, conditions affecting small businesses such as strict business licensing requirements and inconsistent procedures make it a difficult for new businesses. These conditions not only impact economic vitality but also the overall well-being and health equity of the community.

"Tehama County is the 5th poorest county in the state—impacts small businesses heavily."

Systemic Barriers:

Six groups describe systemic challenges within the healthcare system as a barrier. A recurrent theme is the lack of continuity and turnover among healthcare providers as detailed previously. Young and inexperienced providers on temporary stays, are also seen as part of the challenge, as they contribute to a lack of stable and trusted healthcare relationships. One participant describes scenarios where families have waited up to 6 months to see a provider only to have the provider leave, resulting in a lapse of care. These families are then sometimes resistant to engage with a new provider. Due to waitlists, appointments often feel rushed which compromises the formation of a trusted relationship between patient and provider. If families are not equipped beforehand with the appropriate questions to ask, they risk missing a critical opportunity to engage with their providers.

There is also perceived distrust in the healthcare system, which participants believe may be rooted in historical and intergenerational trauma. Older populations, in particular, hold a

significant distrust towards western medicine. This sentiment extends to the general perception of healthcare, with many seeing it as low-priority due to negative past experiences.

"Our systems are built based upon the 'success' of the program not the individual," notes one response, highlighting a mismatch between healthcare programs and individual needs.

"Systemic things- so much thing are broken, you have to start at the very bottom and fix upwards."

"Mental health issues are the primary issues we see and face, and they are not being addressed sufficiently."

Cultural and Educational Barriers:

Though less frequently discussed, educational attainment, or the lack thereof, is a barrier, with many adults lacking even a high school diploma. Access to post-secondary education is a challenge as residents must leave the county to get a degree.

This lack of education extends to health education, leaving significant portions of the population uninformed about their health needs and the services available to them. As one respondent puts it, *"No-one knows this information; media makes a big difference. The people who need these services are not on social media."* The lack of information combined with overall challenges in securing quality care drives feelings of helplessness and hopelessness as some respondents describe the sentiments of frustrated parents.

“A lot of parents feel their voice does not matter, or they don’t feel heard, don’t know where to go.”

The responses reveal a consensus that systemic inefficiencies, access challenge, unaddressed healthcare needs, and economic constraints are significant barriers to better health outcomes. These factors create a complex environment where improving health equity is challenging without addressing these foundational issues. The sentiments expressed are generally of concern and *urgency,* suggesting that respondents feel significant improvements are needed to overcome these barriers.

Greatest Strengths and Assets within the Community

Participants were asked to describe the greatest strengths and assets within Tehama County including cultural, social, operational, economic, etc. strengths. The responses describe various characteristics related to cohesion, support systems and partnerships, infrastructure, and resilience.

Community Cohesion and Connectedness:

This theme resonates across several groups, emphasizing long-standing familial ties and a strong sense of belonging. The community prides itself on small-town appeal where "people genuinely care," as evidenced by the deep relationships and networks that facilitate cooperation and mutual support. The importance of community connectedness is mentioned notably among families in the demographic groups illustrating its cross-cultural significance. Furthermore, connectedness serves to promote resilience and preparedness amongst service networks. Close knit, trusted relationships among agency partners helps the community better plan and respond to challenges. *"It's not the plan you have on the shelf; it's who's number you have in your phone."* This theme is mentioned by 4 groups.

Health and Wellbeing:

In response to the ongoing recognition of healthcare access challenges, participants highlight a significant strength: consistent efforts to address access barriers and promote initiatives aimed at improving health outcomes. Though challenged with an overall dearth of providers, the community benefits from an existing network of compassionate healthcare providers and proactive interventions like mobile clinics, aiming to *"help improve ease of access [and] help resolve barriers."* Notably, the community has and continues to strive to integrate health behavior initiatives and community partnerships in order to enhance overall quality of life. This theme is referenced 3 times.

Support Systems for Vulnerable Groups:

Specific attention is given to supporting vulnerable populations, including persons with disabilities, the unhoused, and youth. The community is actively working to improve conditions for these groups through ADA-compliant housing, expanded transportation, micro-shelters, and educational programs. For the unhoused, a touching sentiment reflects the community's ethos: "The success is the smaller stories." This theme is repeatedly addressed, being mentioned 5 times.

Infrastructure and Accessibility:

Infrastructure, particularly in transportation and housing, is noted as both a strength and needing improvement. The community has made significant strides in expanding public transportation and low-income housing options, with an expanded COC and the development of new homeless navigation center in addition to more transitional housing. The development and accessibility of infrastructure are discussed by 4 groups.

Workforce Engagement:

Economic strengths are highlighted through strong local small business networks, and nonprofit collaborations. Participants describe a business community that is actively growing and developing robust networks. Businesses are invested in cultivating the future workforce, often supporting with paid internships and training opportunities for emerging professionals. Civic engagement is seen as vital, with various groups working together to address community issues, reflected in the broad participation across economic and educational programs. The theme of economic and civic vitality is discussed by 3 groups.

Outlier Themes

Emergency Preparedness: The community takes pride in its ability to respond to emergencies, with a focus on having key contacts and resources readily available rather than just plans on paper.

Economic Development through Arts and Culture: Although not as frequently mentioned, the role of the arts in economic development represents a unique aspect of the community's strength. This includes the presence of art districts, public art, and art events, which not only enhance the local economy but also enrich the community's cultural landscape.

Overall, the responses paint a picture of a community deeply invested in fostering a supportive, interconnected environment that values health, education, and the well-being of all its members. Though several of the areas discussed also have deficits, the recognition of progress within these domains illustrates the community's investment to exploring and implementing strategies to address these barriers.

Physical Assets and Resources in the Environment

Respondents describe a physical environment that is both advantageous and limiting. In terms of assets within the built environment, respondents most frequently discuss natural resources and recreational areas such as rivers (Sacramento River), nature trails, and community parks. While most describe the parks favorably some lament that several parks are in varying states of disrepair and present concerns regarding safely due to homeless encampments. Others express concerns that viable trail systems may go underutilized. Enhanced marketing is posited as a recommendation to potentially increase community awareness as most hear of nature activities through "word of mouth". *Transportation* is another significant aspect of the built environment that is discussed as an asset with opportunity for improvement. Public Transit services including the TRAX system and paratransit system have succeeded in enhancing the mobility of residents, including the elderly and those with disabilities. They offer expanded reach to various locations within the county however some participants report that despite this, remote regions in the western portion of the county remain underserved. Furthermore, roads leading to remote areas become impassable following severe storm systems, posing additional challenges for access and

transportation networks. Participants highlight efforts to ensure accessibility, including trained bus drivers to assist wheelchair users and the provision of backup generators by utility companies. There's a note that perceived accessibility may not align with reality, which warrants further exploration to determine the proportion of residents

Forces of Change - Improvements that would Yield the Greatest Impact on Health Equity

Health System Improvements: This theme appeared frequently, emphasizing the need for mobile medical units, more frequent services, and improved specialty and mental health services accessibility. Specific suggestions include:

"Mobile medical unit, having them more frequently"

"More walk-in clinics. People don't want to sit for 4 hours in a walk-in clinic so they will just go to the ER."

Responses also highlight the importance of cultural sensitivity and inclusivity within care networks, especially for minority groups. Recommendations include:

"Sensitive; Understanding the history, be aware of the local tribes"

"More translators, more bilingual translators, having translation in appointment, provide population opportunity to learn another language to support"

Likewise, there are mentions of the need for more healthcare workers and training programs to ensure reliable service delivery:

"Ask about model for training CNAs to Registered nurses supporting students as they are completing their education and knowing that they will have the support when they get through it"

Infrastructure and Accessibility: There is a strong call for better infrastructure to accommodate people with disabilities and improve general accessibility.

"When the county allows someone to build, start expecting more from them than just ADA requirements"

Workforce Development: Respondents describe critical workforce investments including the need for a regional training center for short-term vocational training along with simplifying the administrative burden for businesses to operate in county. Current permitting processes create undo complexity that can be streamlined to attract more businesses.

Cultivating Trust: Building trust is another notable theme. Trust is described as a product of relationship, time, and authentic engagement. Participants share that allied health professional can assist in cultivating these relationships by helping to bridge cultural and knowledge barriers.

"Need more community health workers. Don't have enough providers that have the time and space to build trust with their constituent"

Improved Communication and Information Distribution: Improving how information about healthcare resources is communicated to the public is also emphasized:

"Do a better job of letting people know what resources are not available to them other resources are that are available to clients, creating a resource guide"

These themes suggest a comprehensive approach to enhancing health equity, focusing on improving access, enhancing cultural competency, ensuring infrastructure accessibility, fostering community trust, expanding the workforce, and improving living conditions.

Emerging Efforts and Successful Interventions

Within the K12 education section there is an effort to integrate education and healthcare through the development of a family resource center and a planned student wellness center. These centers aim to educate parents and students on accessing healthcare and advocating for themselves, with the student wellness center potentially staffed by medical professionals for needs beyond what a school nurse can provide. This project is still in the planning stages, focusing on resource access and education.

Corning Elementary and High School are creating physical spaces that serve as hubs for linking to various services, with a strong emphasis on health, including telemedicine. They are currently applying for funding to support these initiatives.

Healthy Families Tehama is another initiative that collaborates with hospitals and early education systems to meet families' needs directly. This initiative emphasizes ongoing engagement and information sharing with the TK-12 system, recognizing the importance of continuous involvement rather than one-off interactions.

Evidence of Success

Respondents shared the following indicators for measuring the success of interventions aimed at improving health outcomes.

Health Indicators	
	Decreased appointment no-show rates
	Increased utilization of prevention services
	"People being able to make decisions based on choice rather than need"
Social Indicators	
	Moving from the 7th poorest county to the 8th
	Increased community knowledge and "word of mouth"
	Decreased truancy rates

Additional Observations

While most groups displayed enthusiasm, there were noticeable differences in cadence and demeanor between them. Industry sector individuals spoke with more candor and assertiveness, likely due to their roles that require consistently discussing their programs in front of multiple audiences. In contrast, demographic representatives appeared more muted in their presentations, which could reflect historical and political dynamics of inclusion and representation. Groups that have not historically experienced representation may display less visible eagerness in discussing community challenges, necessitating alternative or more sensitive practices.

Specific groups had visible vocal champions whose energy influenced the group's mood, and the consequences of such passionate representation are noteworthy. Additionally, certain topics, like the role of discrimination or historical injustices on current health outcomes, rarely arose. This could be due to various reasons, including issues around power and influence. While close-knit relationships facilitate rapid planning and decision-making, they also risk concentrating decision-making power and excluding others who may also be impacted.

Attachments

Tehama County Community Context Assessment Survey Report

METHODS

Data collection. The survey was designed in Survey Monkey in both English and Spanish languages and was open to Tehama County adult residents between April 29 and July 1, 2024.

The survey was distributed in the following ways:

- At 7 community events in May and June, a flyer was distributed with the QR code to the survey.
- Mailers were sent to all households in Tehama County during the second week of June.
- Distributed via email, posted in offices, public spaces or businesses, and shared on social media by community partners.

Data analysis. 240 responses were received. All but 5 were received in the English language survey. Fourteen responses were excluded from data analysis due to the following reasons: respondent did not live in Tehama County, respondent was under the age of 18, or because there were no survey responses other than age and county of residence. The final sample size for analysis was 226.

Descriptive statistics were produced for each survey question and are reported in the following sections:

- Demographics
- Community health perspectives
- Health equity perspectives
- Public transportation utilization
- Healthcare utilization and telehealth perspectives

RESULTS

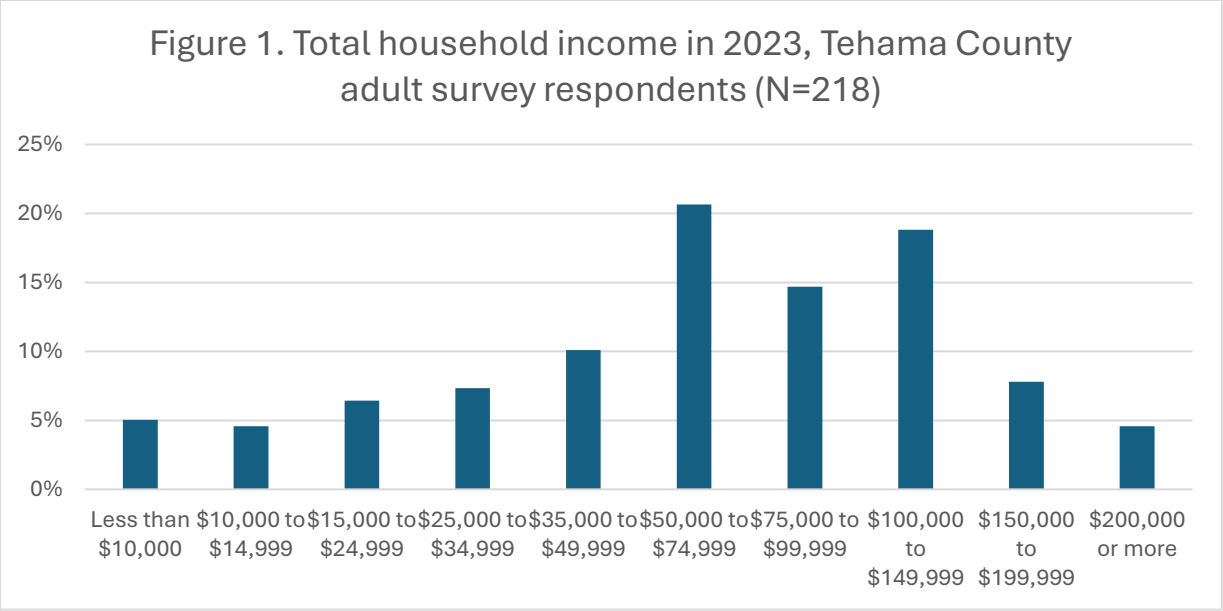
Demographics

Age, gender and racial and ethnic identity, zip code, and tenure in Tehama County:

- **The majority (61%) of respondents were 50 years of age or older.** About 1 in 4 (25%) were 30-49 years of age and 14% were 18 to 29 years of age.
- **The majority (76%) of respondents identified as female;** 22% identified as male and 2% identified as non-binary or other.
- **The majority (71%) of respondents identified as white, non-Hispanic. Nearly 1 in 5 (17%) identified as Hispanic or Latino, and 7% identified as Black or African American, non-Hispanic**. About 6% of respondents identified as either Asian or Asian American, American Indian or Alaska Native, another race, or Native Hawaiian.
- **The majority (67%) of residents lived in zip code 96080.** Nearly 1 in 5 (17%) lived in zip code 96021, 6% lived in 96055, and 5% lived in 96035. About 3% of respondents lived in the following zip codes: 96061, 96074, 96063, 96059, 96075, 96078.
- **The majority (75%) of respondents have lived in Tehama County 10 or more years.** Ten percent (10%) have lived in the county for 5-9 years and 11% for 1-4 years. About 3% of respondents have lived in the county for less than 1 year.

Medi-Cal status and household income:

- **About 1 in 4 (26%) of respondents reported currently receiving Medi-Cal benefits.**
- **The majority (54%) of respondents reported a total household income in 2023 of $50,000 to $149,999** (Figure 1).



Comparison between survey respondents and Tehama County adult population[1]:

- **Females were overrepresented in the survey** compared to the adult Tehama County population (76% vs. 50% female); males were underrepresented.
- **Residents living in zip code 96080 were overrepresented in the survey** compared to the adult Tehama County population (67% vs. 41%). About 17% of survey respondents lived in zip code 96021 compared to 22% of the Tehama County adult population. The remaining 14% of survey respondents lived in 8 other zip codes; about 11% of the adult Tehama County population lived in these zip codes.
- **Middle and higher-income households were slightly overrepresented in the survey;** lower-income households were slightly underrepresented. For example, 54% of survey respondents reported that their total household income in 2023 was between $50,000-$149,000, compared to 46% of the Tehama County households in 2022.

[1] The U.S. Census Bureau American Community Survey 2022 1-year and 5-year estimates were used for this comparison to survey respondents. In some cases, exact comparisons were not possible due to how data were reported by the U.S. Census Bureau.

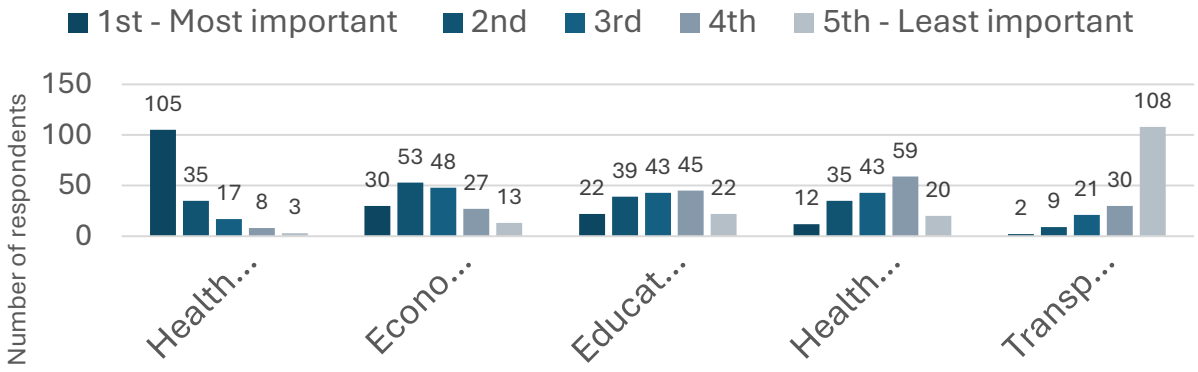
- **Older adults (50 years and older) were slightly overrepresented in the survey;** younger adults were slightly underrepresented.
- **White, non-Hispanic residents were slightly overrepresented in the survey and Hispanic or Latino residents were slightly** underrepresented in the survey compared to the adult Tehama County population. About 13% of the survey population identified as non-Hispanic and non-white, slightly overrepresented in the survey compared to the adult Tehama County population.
- **The survey respondents represent a large proportion (75%) of residents who have lived in the county for more than 10 years**; no county population comparison was known or available at the time of this analysis.

Community health perspectives

Survey respondents were asked to rank five health issues and needs from most important to least important. These five health issues were identified by the Tehama County health department in partnership with community-based organizations in 2023. Survey respondents overwhelmingly ranked "healthcare access" as most important, followed by "economic factors" and "education factors." "Transportation factors" was overwhelming ranked as least important by survey respondents. "Healthcare access" was statistically significant from all other choices and clearly ranked as the most important. "Economic factors" and "education factors" were statistically similar in terms of rating of importance (Figure 2).

Overall, healthcare access was ranked 1.62 (1 being the most important), economic factors were ranked 2.67, education factors were ranked 3.04, health behaviors and outcomes were ranked 3.25, and transportation factors were ranked 4.41 (data not shown).

Figure 2. Ranked health issues and needs, Tehama County adult survey respondents (N=171)



Respondents were also asked to look at a larger and more specific list of community issues and asked to select the three issues that most affect the quality of life in Tehama County. At least 20% of respondents selected the following:

- Lack of access to high-quality healthcare, including mental healthcare (51%)
- Homelessness (40%)
- Economic opportunity (37%)
- Drug and alcohol abuse (32%)
- Housing challenges (22%)
- Public safety (21%)

Less than 20% of respondents thought the following were top issues that affect quality of life in Tehama County:

- Education opportunities (13%)
- Lack of access to recreation (parks, trails, community centers, etc.) (11%)
- Transportation challenges (5%)
- Domestic violence (4%)
- Hopelessness (4%)
- Other (3%)
- Pollution (2%)

Respondents were asked to select from a list what three things would significantly improve their or their family's quality of life. At least 20% of respondents selected the following:

- Improved access to high-quality healthcare, including mental healthcare (52%)
- Reduced homelessness (52%)
- Improved public safety (38%)
- Higher paying employment (35%)
- More affordable housing (33%)
- Better or more recreational facilities (parks, trials, community centers, etc.) (26%)

Less than 20% of respondents thought the following would significantly improve their or their family's quality of life:

- Improved access to social and cultural opportunities (19%)
- Availability of diverse employment (13%)
- Improved access to educational opportunities (12%)
- Improved transportation options (9%)
- Reduced pollution (6%)
- Other (5%)

Health equity perspectives

About half (51%, n=122) of all survey respondents responded to the question about what groups they felt experience the most health inequities in Tehama County. Of these, about half (53%, n=65) felt that unhoused or homeless population and 48% (n=58) felt that older adults (65 and older) experienced the most health inequities in Tehama County. About 25-30% of respondents thought that the following groups experience the most the health inequities: adolescents and young adults (13-24 years), adults 25-64 years, persons with disabilities, and infants and children (0-12 years) (Table 1).

Table 1. What groups do you feel experience the most health inequities in Tehama County? (N=122 who selected at least one group)	**n**	**Percent**
Unhoused or homeless population	65	53%
Older adults 65 years and older	58	48%
Adolescents and Young Adults (13-24 years)	36	30%
Adults ages 25-64 years	33	27%
Persons with disabilities	31	25%

Infants and Children (0-12 years)	30	25%
Racial and ethnic minorities	23	19%
LGBTQ+ population	16	13%
Native/Indigenous Communities	15	12%
Other	12	10%

Respondents were asked what strategies they thought would have the most impact on health equity. About half (51%, n=87) of respondents reported "more healthcare providers and specialists," 33% (n=56) reported "improving the availability of community resources to low- and middle-income residents, and 33% (n=56) reported "increase availability of substance use and mental health services" (Table 2).

Table 2. What strategies do you think will have the most impact on health equity? (N=172 who selected at least one strategy)	**n**	**Percent**
More healthcare providers and specialists	87	51%
Improve availability of community resources to low- and middle-income residents	56	33%
Increase availability of substance use and mental health services	56	33%
Improve patient-provider relationship and medical decision-making	35	20%
Expand safety net services, such as Medi-Cal, WIC, or CalFresh/food stamps	29	17%
Expand early intervention programs or services	26	15%

Develop social support networks (groups or networks of people where people can go for emotional or practical support)	26	15%
Improve technology access and infrastructure, such as broadband internet access	24	14%
Improved promotion of existing County and community-based services available to residents	23	13%
Increase digital literacy (for example, increasing people's ability to find, use or evaluate information on computers)	18	10%
Expand youth health promotion programs	17	10%
Other	5	3%

Public transportation utilization

Respondents were asked if they used public transportation in the past 12 months. Only 4% (n=7) of respondents reported that they had used public transportation in the past 12 months. Of the 96% of respondents who did not use public transportation, 63% said they did not use it because they didn't need to use public transportation. The next most cited reasons for not using it were not living close enough to it (13%), the schedule didn't work for their needs (11%), and it doesn't go where they need to go (10%).

Healthcare utilization and telehealth perspectives

Respondents were asked if they were offered a telehealth or telemedicine appointment in the past 12 months. Forty percent (40%, n=66) reported that they were offered this type of appointment; nearly all (88%, n=58) reported that they did receive care from a doctor or health professional through a telehealth or telemedicine visit in the past 12 months. Of the 8 respondents who did not, 5 (or 63%) said they didn't because they prefer to go in-person.

Respondents were also asked about missing doctor or healthcare appointments. About 20% (n=33) of respondents reported missing a doctor or healthcare appointment in the past 12 months. These respondents were asked why they missed their appointment(s). The top reasons were work obligations (30%, n=10), other (24%, n=8), financial reasons (21%, n=7), it was too far to drive (15%, n=5), and they forgot about it (15%, n=5).

ADDITIONAL TABLES

In 2023, a process led by the Tehama County health department in partnership with community-based organizations identified the following as the most important health issues and needs in Tehama County. Please rank the following from most important to least important, from your perspective.	**1st - Most important**	**2nd**	**3rd**	**4th**	**5th - Least important**
Healthcare access	105	35	17	8	3
Economic factors	30	53	48	27	13
Education factors	22	39	43	45	22
Health behaviors and outcomes	12	35	43	59	20
Transportation factors	2	9	21	30	108

Please look at this list of community issues. In your opinion, which three issues most affect the quality of life in Tehama County? Select 3 answer choices. (N=211 who selected at least one issue).	**n**	**Percent**

Lack of access to high-quality healthcare, including mental healthcare	107	51%
Homelessness	84	40%
Economic opportunity	78	37%
Drug and alcohol abuse	67	32%
Housing challenges	46	22%
Public safety	45	21%
Education opportunities	27	13%
Lack of access to recreation (parks, trails, community centers, etc.)	24	11%
Transportation challenges	10	5%
Domestic violence	9	4%
Hopelessness	8	4%
Other	6	3%
Pollution	4	2%

In your opinion, which of the following three would significantly improve your or your family's quality of life? Select 3 answer choices. (N=171 who selected at least one)	**n**	**Percent**
Improved access to high-quality healthcare, including mental healthcare	94	55%
Reduced homelessness	89	52%
Improved public safety	65	38%
Higher paying employment	59	35%
More affordable housing	56	33%
Better or more recreational facilities (parks, trials, community centers, etc.)	44	26%

Improved access to social and cultural opportunities	32	19%
Availability of diverse employment	22	13%
Improved access to educational opportunities	21	12%
Improved transportation options	15	9%
Reduced pollution	11	6%
Other	9	5%

During the past 12 months, have you used public transportation (such as a bus, paratransit, METs) in Tehama County? (N=168)	**n**	**Percent**
Yes	7	4%
No	161	96%

If you have not used public transportation in Tehama County in the past 12 months, what are the reasons? Select all that apply. (Total N = 161 from previous question)	**n**	**Percent**
I don't need to use public transportation	102	63%
It is too expensive or costs too much	2	1%
I don't live close enough to it	21	13%
It doesn't come close enough to my place of employment	9	6%
It doesn't go where I need to go	16	10%
The schedule doesn't work for my needs	17	11%
Often it is not on time	0	0%
The trips are not long enough	5	3%
No benches/shelters while waiting	6	4%

Bad customer service	0	0%
I don't like sharing rides with others	4	2%
I don't know how	2	1%
Language barrier	0	0%
Other	3	2%

Exhibit B: Community Partner Assessment

Tehama County: Stakeholder Analysis

Purpose

This report summarizes the findings derived from key informant interviews with stakeholder groups within the Community Health Improvement Plan (CHIP) Steering Committee. Tasked with serving as an advisory body for the CHIP, the steering committee includes a

mosaic of diverse organizations, each possessing distinct roles, characteristics, and spheres of influence. The primary aim of this analysis is to explore the multifaceted dynamics within the steering committee, shedding light on key interests and activities of member agencies and discerning the levels of influence they may exert on the CHIP planning process. Through a collective examination of organizational roles, engagement in health initiatives, and potential impacts on strategic planning, this report seeks to provide valuable insights into the inherent strengths of this stakeholder body and potential areas of vulnerability.

Methods

Eight representatives from stakeholder agencies completed a survey and six participated in key informant interviews where they were asked the following questions:

1. *Please tell us about your organization, its goals, and at a high-level, what it does in Tehama County.*
2. *How does your organization prioritize and select activities to address the diverse health needs within Tehama County? Are there specific criteria or considerations that guide these decisions?*
3. *Could you share specific examples of successful activities undertaken by your organization that have had a positive impact on community health outcomes?*
4. *How would you describe the current level of influence that you or your organization have or has in shaping resource allocation towards achieving community health goals in Tehama County?*
5. *In your experience, what barriers or challenges do you or your organization face when attempting to secure resources or influence funding decisions to advance community health goals?*
6. *What would it mean if the Steering Committee was truly designed for success? How would that transform the way the group functions and engages with its members and the community? What is standing in the way of this occurring now?*
7. *If resources were unlimited, what innovative and ambitious activities or projects would you like to see the CHIP Steering Committee and its organizations undertake to address the most pressing health challenges in the community?*
8. *Does your organization or agency have a strategic, operational, or some other plan guiding your organization's work?*
9. *Do you think there are related issues that we did not cover that should be further explored? Is there anything else you'd like to tell me?*
10. *Knowing what you have just shared and uncovered with the work on the CHA and CHIP together, can we count on your support throughout this process?*

Relevant Findings

Stakeholder Characteristics

Stakeholders display a **rich historical and contextual frame of reference**. Most of the stakeholder's express roots within the county, indicating an elevated level of personal investment valuable for gaining buy-in and fostering trust with the constituents they serve. Their long and diverse histories position them to relate to the community in unique and nuanced manners, adding depth and meaning to the relationships and ties formed. Stakeholders possess broad and diverse community alliances including within different regions, sectors, industries, and cultural ethnic populations.

Stakeholders possess a **diverse range of strengths and assets**. Many individuals exhibit expertise in various domains, including technical and clinical proficiencies, financial acumen, and access to state and federal funding streams. Some stakeholders possess political clout and established connections within their respective communities, enabling them to mobilize resources effectively, especially during health crises like the pandemic. Stakeholders display a broad understanding of systems and institutions including healthcare, land use and planning, transportation and infrastructure, and disaster services. Others highlight their involvement in educational collaborations, indicating a collective commitment to advancing shared objectives through multifaceted approaches.

Stakeholders display a **marked interest in CHIP related activities**. Participants appear genuinely enthusiastic regarding their participation in the CHIP without overt signs of resignation. Multiple respondents express a high level of interest, often citing direct alignment with the vision and mission of their organizations. This alignment underscores the perceived relevance and importance of CHIP activities in contributing to the broader goals of the involved entities. Several individuals are actively involved in community outreach events, interdepartmental programming, and regional partnerships, showcasing proactive engagement beyond the committee itself. While there is measurable interest, a few participants also indicate a need to further understand how members can most effectively contribute to CHIP activities. This suggests an openness to involvement but also highlights the importance of clarifying roles and expectations for active participation.

Stakeholders express differing levels of **decision-making authority**. Several indicate significant decision-making power within their organizations. These individuals have the autonomy to decide how resources are utilized, indicating a high level of influence over the implementation of MAPP. The majority of stakeholder seem to indicate shared decision-making authority. These individuals express a role in decision-making as part of the larger organization and collaborative efforts. How this authority translates into activities and initiatives is explored in greater detail within the report.

Strengths and Capacities

Supporting Unique Needs

Collectively, the responses reveal a diverse array of strategies employed by stakeholder agencies to address the distinctive needs of their communities. A recurring theme is the importance of ***accessibility and community engagement***. For instance, several agencies highlight their commitment to accessibility through means such as hotlines staffed with bilingual personnel, resource networks, and linkage supports. Additionally, the sponsorship of cultural health fairs targeting specific ethnic communities demonstrates a proactive effort to enhance service quality by providing information in a culturally sensitive manner.

Direct community involvement emerges as another common thread, exemplified by agencies actively seeking feedback through methods such as consumer-facing questionnaires and surveys. This approach illustrates a commitment to ***responsiveness,*** allowing agencies to truly "meet residents where they are at" and adapt their services based on direct input from those most impacted. Notably, a few agencies also emphasize **quality of life** as a priority implying a holistic focus on improving overall community well-being without necessarily specifying explicit actions.

Furthermore, agencies emphasize ***collaboration and resource-sharing as a means to support unique community needs***, even amidst budget limitations, aiming to forge partnerships with external agencies or organizations interested in collaborating on

programs. Some agencies attest to a more comprehensive approach interweaving diverse strategies that support workforce development, economic development, and education. Effective collaboration can enhance an agency's abilities to employ multi-pronged engagement strategies.

The collective sentiment across the responses revolves around a shared commitment to accessibility, community engagement, and to varying degrees, collaboration. The agencies showcase a nuanced understanding of their communities, employing a mix of targeted initiatives, formal and informal feedback mechanisms, and more comprehensive strategies to address the unique needs within their purview.

Successful Interventions

The responses shed light on various successful activities undertaken by organizations to positively impact community health outcomes. A common theme is **collaboration and partnerships** formed to amplify the reach and effectiveness of initiatives. The sponsorship of cultural events, such as the Cinco de Mayo celebration with resource provision and scholarships (Latino Outreach of Tehama County), addresses both cultural and educational aspects of community engagement. Similarly, collaboration between agencies, as seen in the partnership with the Corning Health Care District and Tehama County Department of Social Services (Empower Tehama), highlights the effectiveness of **joint efforts** in establishing satellite healthcare facilities. Agencies express that such partnerships and collaboration allow for a holistic and coordinated approach to community health. They facilitate the pooling of resources, enhance the reach and accessibility of services and interventions, and integrate specialized talent and expertise from each partnering agency.

Furthermore, a shared commitment to **education and workforce** development is evident, as exemplified by the establishment of a medical assisting class by Shasta College and efforts by agencies to attract and retain industry professionals (Expect More Tehama). The emphasis on continuous support, from cradle -to-career, is another commonality, showcasing a comprehensive lifelong approach to addressing health outcomes and building healthier communities.

However, differences arise in the specific activities and programming agencies institute. For instance, some organizations focus on community events and resource distribution such as during the COVID-19 Pandemic while others concentrate on providing physical services such as health screenings (Paskenta Nomlaki Tribe) and development of the built environment through accessible parks and affordable transportation. Additionally, initiatives like the 'Stay and Play' program by the Tehama County Library and the organization of various community events, including Farmers Markets by the Chamber of Commerce, highlight the diverse service provisions led by these agencies. These differences are largely driven by the scope and directives of the individual agencies. The multi-disciplinary nature of these interventions suggests that this stakeholder body is equipped to imagine and engineer a diverse collection of initiatives and strategies that support unique and evolving community needs.

Levels of Influence

The responses offer varied perspectives on the level of influence organizations have in shaping resource allocation for community health goals. Some agencies express a very influential role while others attest to having a more restricted stance. A recurring theme is the acknowledgment of the larger organization's position and presence within the community as a correlate for impact, where agencies with greater visibility and engagement experience more perceived impact.

Several responses showcase active community engagement efforts, such as hosting annual health events, leading projects serving marginalized populations and operating as a safe space for collaboration. Collaboration emerges as a common strategy to bolster influence, with some organizations actively utilizing **partnerships and contracts** with county organizations (Empower Tehama and TRAXX) to enhance their reach and fill service gaps. Additionally, the influence leveraged through ***cultural representation*** underscores the importance of diverse perspectives in shaping resource allocation.

Differences in perceived extent of influence also stem from **representation and inclusion,** with some agencies attesting to the power experienced by “having a seat at the table” and an audience with constituents. The dichotomy between running solitary programs and the

broader approach of connecting, convening, and leveraging resources is particularly evident in the response from Expect More Tehama, reflecting a strategic leaning towards **collective impact** initiatives to amplify reach.

The stakeholder tasked with overseeing the Community Health and Needs Assessment (CHNA) at Dignity Health emphasizes the importance of "honoring the existing work" while also pushing for change as a means to enhance influence. They recognize that "progress can be disruptive". Innovation and new ideas can generate resistance. But to move the dial, it's essential to have a team of stakeholders willing to take risks and challenge existing norms. Though not all agencies in the steering committee demonstrated this same appetite for risk, those that do should be supported and their experiences leveraged to assist the overall committee in being more dynamic and impactful.

Areas of Opportunity and Predominant Interests

Designing the Steering Committee for Success

Collectively, the responses underscore the significance of effective leadership and communication within a steering committee to drive transformative change in community health outcomes. A common theme is the role of the committee in defining strategic goals, ensuring clear communication, and offering mentorship to subcommittees, emphasizing the importance of **coordination and focus**. The notion of creating a centralized resource hub for community members emerges as a shared goal highlighting the need for improved accessibility and communication among different participating entities.

There is a recognition of the importance of regular communication, collaborative problem-solving, and the excitement that emerges from **generating ideas collectively**. Collaboration is seen as a key factor in success, with suggestions to connect various services, organize available resources, and support one another in joint endeavors. However, differences exist in perceived challenges and barriers to success. Some agencies highlight the need for staffing and funding gaps to be addressed, acknowledging the limitations in running programs with critical staffing shortages, while others express more optimism believing that a willingness to have difficult conversations and increased accountability can overcome potential obstacles.

The overarching sentiment is that a successful steering committee must facilitate transformative change by **advancing policies, mobilizing resources, and gaining widespread buy-in from partners and organizations**. The committee's success is intricately linked to its ability to foster collaboration, transparency, and effective communication, ultimately translating into improved community health outcomes.

Activities Most Meaningful to the Steering Committee to Pursue

The stakeholders convey a shared interest in enhancing community health outcomes through a variety of strategies. There is a notable emphasis on **improving accessibility to resources**, with suggestions ranging from implementing touch-screen kiosks in public spaces to expanding mobile services. Additionally, there is agreement on the significance of tackling key community issues, including homelessness, affordable housing, mental health, and substance abuse, with a shared goal for the county to exemplify best practices in these domains.

Several agencies also highlight an interest in **targeted healthcare interventions**, particularly mental health first aid training for law enforcement, initiatives to meet the healthcare needs of marginalized populations like older and aging adults, and efforts to expand and retain the healthcare labor force. Furthermore, some agencies express the desire to lean into promising non-traditional service models from neighboring counties with better health outcomes, underscoring the desire to learn from the effective strategies implemented in similar communities. Lastly, there is an overarching sentiment emphasizing the significance of nurturing relationships with institutions such as churches, schools, and community centers to strengthen community bonds and encourage meaningful engagement with residents in settings familiar to them.

Weaknesses and Gaps

Agencies reveal various levels of **strategic and operational planning**. With some agencies having developed robust plans detailing anticipated activities over extended periods of time while others report having little or no strategic documentation. Developing such plans

may be critical for agencies as it provides a roadmap for achieving goals and aligning organizational efforts. A well-crafted strategic plan helps stakeholders prioritize initiatives, allocate resources effectively, and respond proactively to community needs. Agencies may encounter obstacles to planning due to a lack of resources, both in terms of time and financial constraints. Limited capacity and competing priorities can also hinder the planning process. Additionally, insufficient community engagement and input may result in plans that fail to adequately reflect the diverse needs and perspectives of the residents served. Some agencies have successfully encompassed community input and constituent feedback into their annual planning allowing for more timely and relevant interventions. Other agencies have aligned their strategic goals with that of larger governing or regional bodies, creating opportunities for broader impact and shared language. The joint impact of the stakeholder committee may be enhanced by supporting those agencies with less developed strategic plans, to draft meaningful and relevant planning documentation. Not as a mere exercise but as one that details tangible directives towards the achievement of organizational priorities. Supporting these agencies with assessing the level of community engagement required in the planning process, conducting surveys or needs assessments, or establishing clear communications may be aspects of shared learned that can be supplied by steering committee.

Furthermore, agencies report challenges related to **securing ongoing funding** to support health related initiatives. One significant challenge lies in the inherent competition for limited resources. With multiple agencies vying for funding from government bodies and other sources, securing adequate financial support becomes highly competitive. Additionally, economic uncertainties, budget constraints, and shifting political priorities further complicate the funding landscape. Agencies report often facing the challenge of demonstrating the immediate and long-term impacts of their initiatives to justify the allocation of resources. Funding is often tied to specific interventions with funders preferring “shovel ready projects”. Agencies must navigate intricate bureaucratic procedures, comply with stringent reporting criteria, and provide extensive documentation, often without dedicated staff to support these efforts. To overcome these challenges, agencies can enhance their existing grant-writing capabilities- clearly articulating the goals, outcomes, and community impact of their initiatives. Building strategic partnerships with like organizations may help them pool resources, engage in more effective advocacy, and demonstrate a track record of successful project implementation which may make them more attractive to potential funders. Additionally, diversifying funding sources, exploring public-private partnerships, employing shared or part time grant-writers, can

contribute to a more sustainable and resilient funding strategy which can intern equip the steering committee with more resources for effective collaboration.

Lastly **political positioning and advocacy** are also areas where agencies express more limited reach. Bureaucratic constraints and a focus on operations may divert attention and resources away from policy-oriented activities. Additionally, agencies may face limitations in terms of expertise and capacity to engage effectively in advocacy efforts. Some agencies also express a hesitancy to engage in advocacy due to concerns about political neutrality, particularly in environments where agencies are expected to remain impartial. To increase their political influence, stakeholder agencies can take proactive steps. Investing in staff training to enhance policy analysis and advocacy skills, fostering a culture that values policy engagement, and establishing collaborative relationships with local and regional policymakers, community leaders, and advocacy groups can amplify agencies' voices, enhancing their collective influence. Agencies should also leverage data to support their advocacy efforts, demonstrating the real-world impact of policies on communities. A steering committee with a politically active arm has the potential to elevate pressing health issues, expanding awareness, and attracting resources to vital initiatives.

Exhibit C: Issue Statements

Tehama County Issue Statement
Homelessness and Housing Insecurity

Who and What: Residents in Tehama County are experiencing homelessness, at a rate of 53.2 per 10,000 population, significantly higher than the comparable California rate of 38.2 per 10,000 population (CHA). Twenty-nine percent of all Tehama County households (or an estimated 6,883 households) earn less than $25,000 annually. These households are generally classified as "Very Low Income" by HUD and typically face challenges affording market housing costs. According to HUD, a "Very Low Income" Household earns 50% of Area Median Income, which was $26,900 for a three-person household in 2018. There is a need for a wider range of housing choices and opportunities, including transitional housing, low-income housing, and moderate-income housing that can provide opportunities for upward mobility.

Where: County-wide

Potential Root Causes/Contributing Factors:

- Economic factors including limited job opportunities, lower wages and lack of economic diversification
- Housing shortages
- Aging housing infrastructure
- High costs and regulations attached to building new units (zoning restrictions)
- Untreated mental health and substance use challenges which impact individual ability to obtain and retain employment
- Few safety net services including local shelters and transitional housing
- Multigenerational poverty

Subcategories:

- Housing for Persons with Disabilities
- Temporary and Transitional Housing
- Homeless Street Outreach
- Permanent Supportive Housing
- Permanent Affordable Housing
- Financial Assistance for Rent and Utilities

Tehama County Issue Statement

Transportation

Who and What: Transportation issues including **lack of vehicle access**, inadequate infrastructure, long distances, and lengthy times to reach needed services affect the health of a community in several ways. Lack of or limited access to transportation presents barriers to accessing health care contributing to missed appointments, delayed care, and missed or delayed medication use and resulting in poor disease management and health outcomes. According to the American Community Survey, 7% of Tehama County households lack access to a vehicle. An extensive analysis by the Tehama County Transportation Commission found that by census block group, as many as 38% of households (range 0-38%) were zero-vehicle households. **Active commuting**, or travel by bus, walking, or cycling can serve as a transportation alternative, especially among households with limited or no access to a vehicle. About 3% of Tehama County residents 16 years and older use active commuting to travel to work compared to 9% of California residents, despite having shorter **commute times to work**. A safer, more connected active transportation network will increase access to goods and services, including access to regional transit connections particularly for disadvantaged, remote populations.

Where: Transportation gaps are most likely occurring within rural regions in the county

Root Causes and Contributing Factors:

- Lack of connecting infrastructure (trails, bike paths)
- Lack of available routes
- Lack of knowledge of existing services
- Safety concerns
- Legal status and lack of driver's license
- Lack of vehicle access
- Disability access challenges

Subcategories:

- Enhanced mobility for underserved populations
- Safe and convenient bicycle access
- Integrate bicycle and pedestrian networks with existing and

potential recreational opportunities

Tehama County Issue Statement
Food Access

Who and What: Access to healthy food was identified within the CCA, Plans and CHA. Only one in three Tehama County residents have adequate access to a supermarket, living within a half a mile (for urban areas) or a mile (for rural areas) of a grocery store (CHA). Those most impacted include homeless individuals, minors, migrant workers, and low-income residents not eligible for SNAP benefits.

Where: Access varies by geography a higher proportion of residents living near a supermarket in Red Bluff, Corning, and Tehama (60%, 60%, and 54%, respectively) than in more rural areas.

Root Causes and Contributing Factors:

- Low wages – Quote: "I've had people who are juggling between do I fix this, or do I eat?"
- Unemployment and underemployment (seasonal work -i.e. migrant workers)
- Limited transportation
- Limited operating hours make access difficult particularly for shift workers
- Social conditioning and familiarity
  - People usually don't consume foods which they are not familiar, so they are rejected. Sometimes the cooks also don't prefer to cook some vegetables like broccoli, cauliflower as it's a labor-intensive process.
  - There is a high concentration of familiarity with processed foods and it's accepted by majority of people, and they are accustomed to the taste
- Cultural reservations
  - Lack of ethnic or culturally appropriate food options
  - Cultural stigmas or taboo
- Social Isolation
- Environmental conditions impacting price and availability of food
- Historical focus on homeless families, alienating other groups of people including Hispanic families
- Silos between food serving charitable organizations lead to challenges in utilizing excess food donations

Subcategories

- Transportation assistance
- Food assistance programs
- Nutrition literacy
- Emergency food access
- Income and employment support
- Food deserts

Tehama County Issue Statement
Mental Health Services

Who and What: There are insufficient mental health and substance use disorder prevention and treatment services within Tehama County. There are 570 residents for every mental health provider in the county compared to 240:1 in California overall (CHA). Those most impacted include residents experiencing severe and/or acute mental health and substance-use related conditions.

Where: County-wide

Root Causes and Contributing Factors:

- Lack of diverse treatment facilities including rehabilitation centers, inpatient, and crisis facilities
- Eligibility and insurance coverage
- Genetics
- Environmental triggers and trauma including physical, verbal, sexual abuse, growing up in the foster care system, abandonment, etc.
- Failure of treatment which leads to rehospitalization.
    - Quote- “We’ve gotten negative feedback, if we get somebody that's getting hospitalized, say three times in a year, we'll decline them on the next one to let somebody else try not because we're trying to be petty, but it's like, OK, if we're not successful with our treatment, let another provider try this.”
- Extensive waiting lists
- Self-medication by the patients with drugs and alcohol
- Challenges with service population/lack of cooperation

    - Some homeless patients don't want homes, they want to be homeless Quote- "They prefer to live homeless, to do whatever they want to do, you know, use drugs however they want to not be told what to do, to not follow a structured environment."
    - Burning out a placement due to becoming complacent by not addressing underlying health or substance use issue.
- Justice-involvement leading to delays or inadequate treatment
    - A proportion end up in jails, legal system where there are insufficient resources for individuals who are severely mentally ill. Quote "They're just sitting there, not being treated, no place to go, you know, a year plus of being sick and no place to go. It's not OK, but that's how it is right now."

Mental Health Subcategories

- Mental Health Workforce Development
- Crisis Intervention and Mobile Services
- Community-Based Peer Support and Recovery Programs
- Youth and School-Based Mental Health Programs
- Substance Use Disorder Prevention and Treatment
- Stigma Reduction and Public Awareness Campaigns

Tehama County Issue Statement
Access to Healthcare

Who and What: Tehama County residents experience several challenges accessing healthcare services. Preventable hospitalizations are inpatient stays for treating conditions that may be avoidable, in part, through timely and quality primary care and preventive

screenings. The observed rate of preventable hospitalizations in Tehama County is higher than the state rate (1,054 per 100,000 compared to 694 per 100,000) (CHA).

Challenges as described in the CCA, CHA, CPA include:

- Out-of-pocket costs
- Geographic accessibility
- Long waitlists
- Hours of operation conflicting with work schedules
- Culturally and linguistically sensitive providers
- Health literacy required to navigate healthcare system
- Concerns pertaining to legal status
- Inaccessibility of specialists
- Facilities willing to accept client's insurance
- Services for chronic disease management

Those most impacted include uninsured and underinsured, low-income residents.

Where: Remote areas are disproportionately impacted by access challenges

Root Causes and Contributing Factors:

<u>Workforce</u>

- Lack of practitioners in the area
    - Quote "Psychiatry residents were placed all around the Sacramento to complete their rotations. We want to establish something solid."
- Burn out among primary care providers
- Aging and retirement among existing providers
- Non-competitive wages for physicians
- Newer practitioners seeking work/life balance
- Primary care providers transitioning to specialties with higher compensation

<u>Cultural</u>

- Communication and cultural sensitivity - how medical professionals speaks to members can dictate whether the member continues care
  Quote "It doesn't need to be on the 6th grade level, it's insulting.
  And but it does need to be in layman's terms."
    - Quote "However, getting them to go back and do their follow up care, it has everything to do with how that provider or medical staff person treats them and I see that across the board in different in different kind of old country."

- Lack of trust
  - "Health providers need to put in some effort to make real connections with the patients. So, it helps the native or any kind of population to build trust and makes them feel comfortable to talk about their health problems openly."
  - "Providers (Nurses, medical assistants etc.) need to make the patient feel that they are listening, or it might make the patient defensive, angry, not valued and heard."
- Language barriers

Environment/Infrastructure

- Geographic barriers and distance to care
- Poverty and unemployment
- Lack of infrastructure in county for employment in other fields
- Lack of patient advocates/navigators
- Low health literacy or health education access
- Social isolation
- Broadband connectivity for telehealth

Institutional

- Limited reimbursements and funding for public health investments
- Telehealth not suitable for all specialties or for clients that have comorbidities

Subcategories

- Mobile services
- Telehealth expansion
- Health education and literacy
- Workforce development including recruitment and retention

Exhibit D: CHIP Steering Committee Representatives and Agencies

Name	Organization
Minnie Sagar	TCHSA

Carissa Crawford	TCHSA
Natalie Shepard	TCHSA
Michelle Schmidt	TCHSA
Aleksandar Topalovic	TCHSA
Sruthi Vobbilisetti	TCHSA
Vicky Reilly	TCHSA
Carol James	TCHSA
Suzanne Ciciliot	Rolling Hills Clinic
Debra Weaver	Rolling Hills Clinic
Alicia Meyer	Tehama County Library
Kathy Garcia	Expect More Tehama
George West	Dignity Health
Kristy Bird MaKieve	Butte-Glenn Medical Society and Healthy Rural California
Rosalia Renteria	3CORE
Dave Gowan	Red Bluff Chamber of Commerce
Jessica Riske-Gomez	TRAX
Ashley Fox	TRAX
Cole Houghtby	TRAX
Michaele Brown	Empower Tehama
Barbara Weaver	Tehama Schools.org
Andrea Curry	Tehama County Continuum of Care (Tehama CoC)
Megan Palermo	Student Attendance Review Board (SARB) Director for the Tehama County Department of Education
Carrie Samson	Greenville Rancheria / Tribal Community

Monika Brunkal	Partnership HealthPlan of California
Hannah O'Leary	Partnership HealthPlan of California
Tim Sharp	Partnership HealthPlan of California
Miraya Pahua	Northern Valley Catholic Social Services
Beth Lindauer	City of Red Bluff Planning
Christina Meeds	City of Corning Planning
Cathy Gifford	Far Northern Regional Services
Chere Sullivan	Far Northern Regional Services
Amanda Gettig	Ganey Science
Jessica Martinez	Tehama County Planning Dept
Amanda Smith	Partnership HealthPlan of California
Yvonne Ezenwa	Data Strategy Consulting
Jenny Mercado	Data Strategy Consulting
Sarah Marikos	Data Strategy Consulting
Kimberlee Monroe	Empower Tehama
Christine Smith	Partnership HealthPlan of California
Alexis Ross	Common Spirit
Laura Fierce	TCHSA
Eric Rushing	Partnership HealthPlan of California
Dr. Timothy Peters	TCHSA