VENTURA COUNTY
COMMUNITY HEALTH
IMPROVEMENT COLLABORATIVE

Community Health

NEEDS ASSESSMENT 2025

Adventist Health Simi Valley
Camarillo Health Care District
Gold Coast Health Plan, A Public Entity
Dignity Health. St. John's Regional Medical Center | St. John's Hospital Camarillo
Community Memorial Healthcare
Clinicas del Camino Real, Incorporated
Kaiser Permanente
Communities Lifting Communities
Ventura County Behavioral Health, A Department of Ventura County Health Care Agency
Ventura County Health Care Agency
Ventura County Public Health, A Department of Ventura County Health Care Agency

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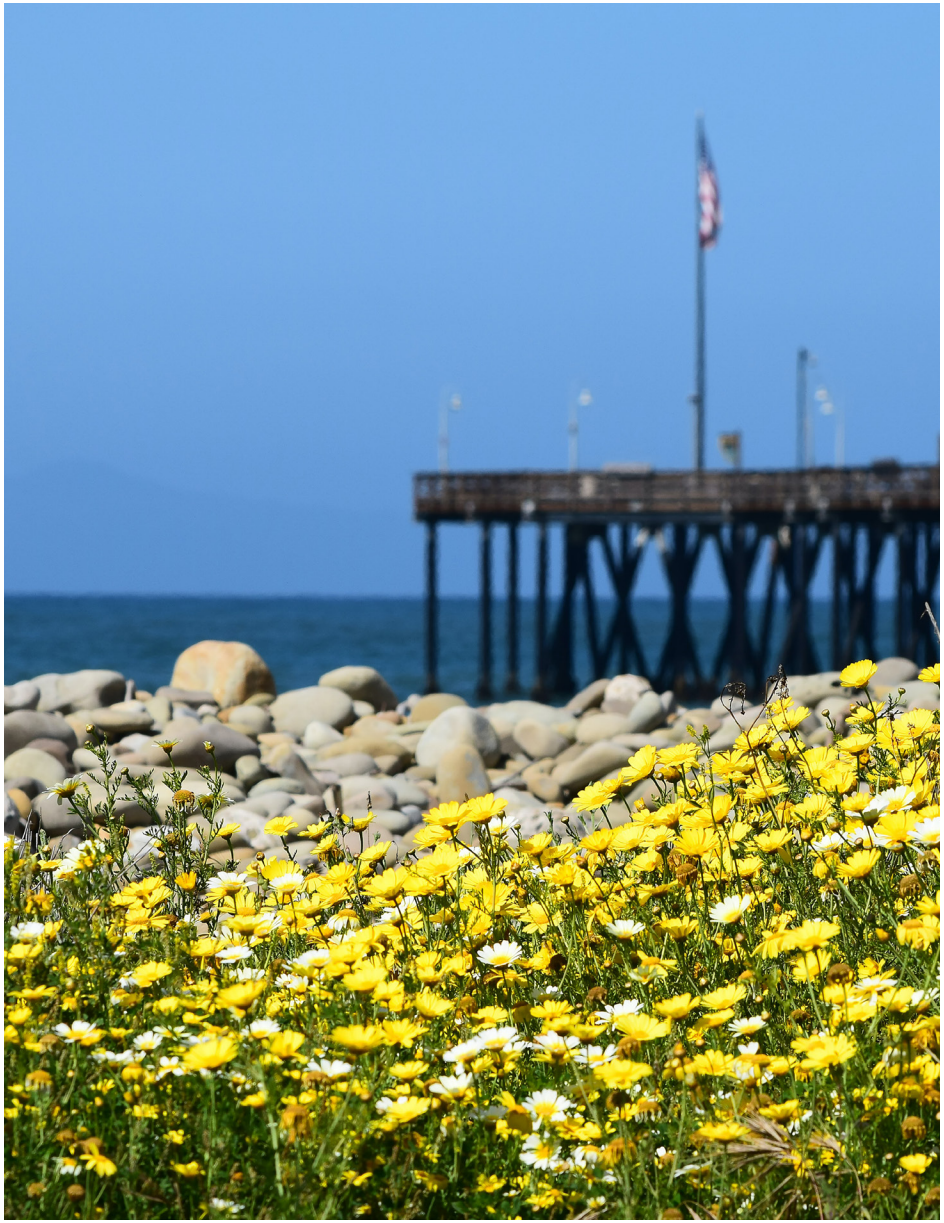


June 1, 2025

To our Ventura County Community:

On behalf of the Ventura County Community Health Improvement Collaborative (VCCHIC), we extend our sincere thanks to our community partners for their support in compiling the 2025 Community Health Needs Assessment (CHNA).

The 2025 CHNA is the third county-wide CHNA conducted by VCCHIC, a formal, charter-bound partnership of ten local health care organizations. This CHNA is a collective effort of hospitals, health district, behavioral and public health departments, community clinics and the Medi-Cal Managed Care plans committed to better understanding Ventura County's health and social needs.

VCCHIC's members, dozens of local partners, and thousands of residents generously provided a tremendous amount of information about the challenges, circumstances, and opportunities that Ventura County residents face every day. Since January 2025, more than 6,000 community health survey responses, 10 community focus groups, and 6 partner listening sessions that supplied a broad range of viewpoints and expertise from across the county. This report blends that personal input with rigorous community health data to uplift a broad range of needs in Ventura County.

What emerges from this wealth of information is that while Ventura County's current health care landscape looks different from the peak-COVID era illustrated in our 2022 CHNA, for our residents many significant health needs persist — along with emergent ones that must be confronted.

As demonstrated in the Data Scoring Tables available in Appendix B — which synthesize dozens of unique community health data indicators — the significant health challenges facing Ventura County residents remain mostly constant from three years ago. Yet, the poor and worsening overall health scores pertaining to Women's Health and Older Adults' Health, along with Substance Use and Mental Health — two linked issues that are commonly referred to collectively as "Behavioral Health" in this report and elsewhere — are of special note. These data findings were echoed in our community survey and focus group findings as matters of great concern to many Ventura County residents.

Introduction

Women's Health and Older Adults' Health qualitative and quantitative data, meanwhile, give a better understanding of the component health outcome measures contained within the overarching Health Topics. These separate indicators point to the complexities – and potential areas for future focus – within these broad topics.

This CHNA, however, is much more than a compilation of mortality and health data points. It captures the richness of community needs at a particular – and particularly fraught – moment. The personal, lived experience uplifted at our focus groups and partner listening sessions brought to life the needs, challenges, and strengths that abstract data cannot fully articulate.

As you will find in this report, that vital feedback does more than inform what we choose as priorities. What we heard in those sessions humanizes the stakes we all face – and the cost born by individuals, families and communities across our county when key health needs and life challenges go unheeded. It reinforces VCCHIC's commitment to continually bring more community partners into the process of seeking lasting solutions to these challenges.

The wealth of information accumulated in the 2025 CHNA is a unique resource that all community partners can use to benchmark local conditions, assess community needs, identify disparities, and evaluate progress. This information also guides VCCHIC's strategic priorities and plans for the next 3 years.

After a great deal of data analysis, partner input, and strategic consideration, the VCCHIC Steering Committee has chosen its 2025 CHNA priorities – **Behavioral Health**, **Women's Health**, and **Older Adults' Health**. Because access to care, care navigation and health equity are permanent VCCHIC principles that are essential to improving community health, they will be embedded as goals and strategies within each of the three priority areas above.

VCCHIC will now move toward developing its Community Health Implementation Strategy (CHIS) – a planning process that requires inclusive, active participation from across the county. VCCHIC is committed to bringing the full range of community expertise and insights into this process to develop a high-quality CHIS and to meaningfully improve community health over the next three years.

As VCCHIC works to design these strategic interventions – interventions that unite our priorities and principles to meet the real, pressing challenges faced by our community members today – we invite you to join, inform, and work with us.

Thank you again for your collective efforts to better understand the needs of Ventura County. We look forward to working together to meet the needs of our community through collaborative partnerships, innovation, and advocacy.

Signed by

VCCHIC Steering Committee Members/Organizations

Communities Lifting Communities

Community Health Needs Assessment (CHNA) at a Glance

Data Analysis Overview

Secondary Data

Review of 328 indicators in the HCI Data Library across health and quality of life topic areas.

Community Member Focus Groups

Conversations with community members to understand their own, family, and community health needs.

Community Partner Listening Sessions

Discussions with community partners to understand the health needs experienced by the clients and communities they serve.

Community Survey

Quantitative data regarding community-serving organizations and their views on the health needs.

Life Expectancy Data

Key indicator of the population's longevity and overall health.

Community Health Assessment and Planning Cycle

1. Plan & Engage
2. Collect & Analyze Data
3. Synthesize Data & Prioritize
4. Mobilize Shared Action
5. Implement & Track

Prioritized Health Needs

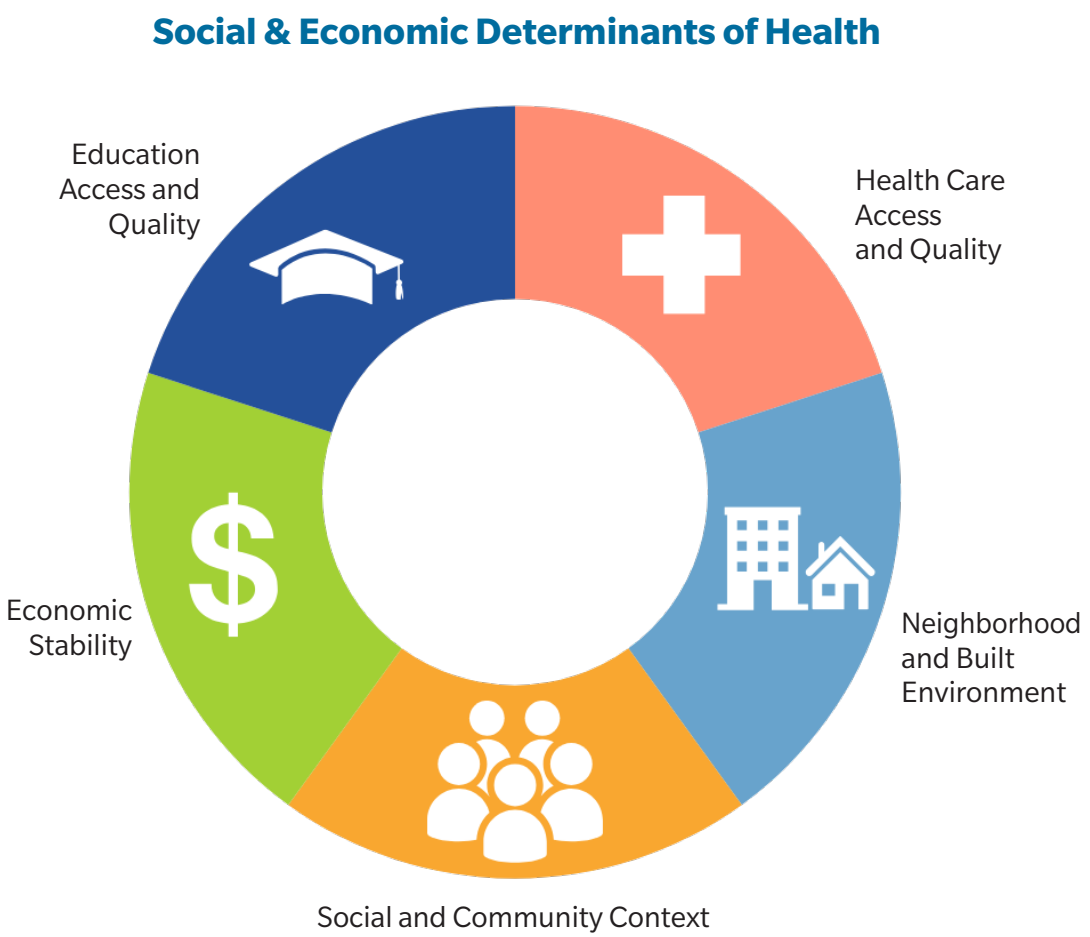
- Behavioral Health
- Older Adults' Health
- Women's Health

Healthy People 2030

The Healthy People 2030 foundational principles include:

- The health and well-being of all people and communities is essential to a thriving, equitable society.
- Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental and social health dimensions.
- Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.
- Achieving health and well-being requires eliminating health disparities, achieving health equity and attaining health literacy.
- Healthy physical, social and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving health and well-being nationwide is a shared responsibility that is distributed across the national, state, tribal and community levels, including the public, private and non-profit sectors.
- Working to attain full potential for the health and well-being of the population is a component of decision-making and policy formulation across all sectors (Office of Disease Prevention and Health Promotion, n.d.).

FIGURE 1: HEALTHY PEOPLE 2030 FRAMEWORK



3.1 CHNA Purpose

The Ventura County Community Health Needs Assessment (CHNA) is conducted and published every three years or as per Internal Revenue Service (IRS), the Health Resources and Services Administration's (HRSA) Health Center Compliance Manual, Section 330 of the Public Health Service Act and Public Health Accreditation Board (PHAB) requirements.

This report includes a description of:

- The community demographics and population served;
- The process and methods used to obtained, analyze and synthesize primary and secondary data;
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;
- The process and criteria used in identifying certain health needs as significant community needs.

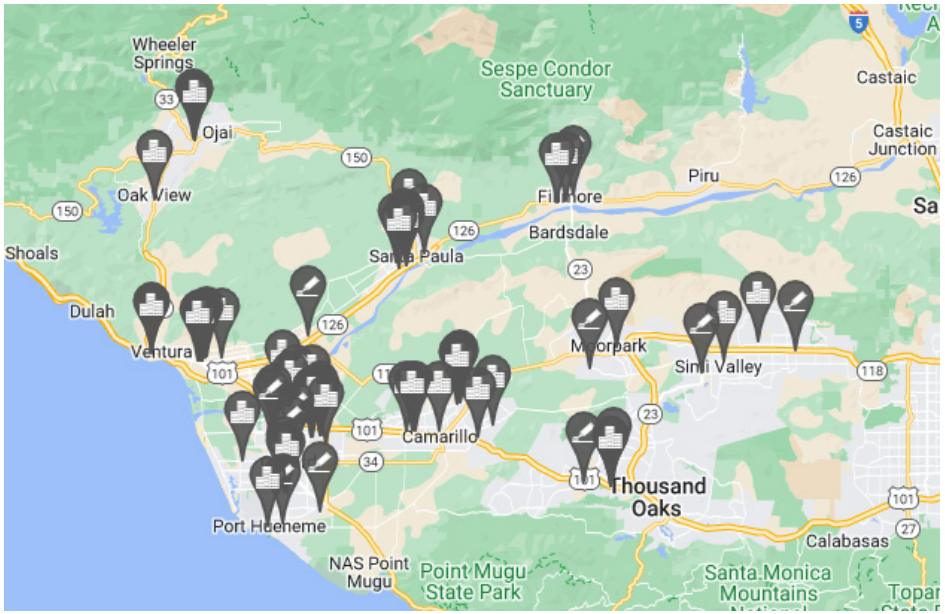
The Ventura County Community Health Improvement Collaborative (VCCHIC) will work to develop implementation strategies, to be included in each member organization's individual Community Health Improvement Plan (CHIP) or Community Health Implementation Strategy (CHIS), that align with CHNA-identified health priorities and focus on achieving health equity. Together, these organizations will support health advocacy, education, prevention and partnerships that extend the care continuum for historically medically underserved populations and populations that may be at higher risk for poor health outcomes.

3.2 Ventura County Community Health Improvement Collaborative (VCCHIC)

VCCHIC is a formal, charter-bound partnership of ten health agencies that came together to participate in the development of a joint CHNA exercise and report. At present, the ten institutions that constitute the VCCHIC Steering Committee are:

- Adventist Health Simi Valley
- Camarillo Health Care District
- Clinicas Del Camino Real, Inc.
- Community Memorial Healthcare
- Gold Coast Health Plan
- Kaiser Foundation Health Plan
- St. John's Regional Medical Center and St. John's Hospital Camarillo Dignity Health
- Ventura County Behavioral Health
- Ventura County Health Care Agency Community Health Center
- Ventura County Public Health

FIGURE 2: LOCATION OF VCCHIC PARTNERS WITHIN VENTURA COUNTY



Source: Google Map on Health Matters in Ventura County

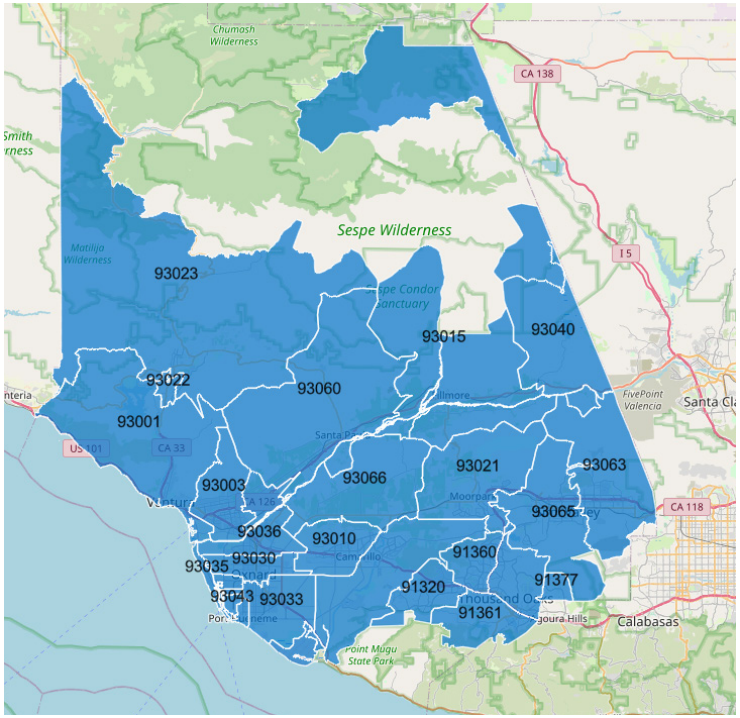
3.3 Mission

The mission of VCCHIC is to build partnerships to improve population health outcomes in Ventura County. These partnerships are necessary to accomplish the shared vision of working collaboratively to develop strategies based upon the identified health priorities from the community health needs assessment. This will result in a collective approach to addressing population health and benefiting the communities in which we serve.

3.4 Service Area

With the purpose of jointly addressing health challenges of residents and serving communities with impactful solutions that leverage shared resources and coordinate care, the ten health care institutions that make up the VCCHIC Steering Committee have come together in defining their service area as the County of Ventura.

FIGURE3: ZIP CODE TABULATED AREAS WITHIN VENTURA COUNTY



Source: Esri

3.5 Collaborative Structure

VCCHIC is the decision-making entity for the 2025 Community Health Needs Assessment and is chaired by the Director of Public Health Nursing at Ventura County Public Health. Primary representatives for the VCCHIC Steering Committee include:

- Mohnisha Jit, MPH, Ventura County Public Health – *Epidemiologist, Maternal, Child, and Adolescent Health Programs*
- George West, JD, St. John's Regional Medical Center and St. John's Hospital Camarillo, Dignity Health – *Market Vice President, Mission Integration*
- Lisa Hemenway, Adventist Health Simi Valley – *Director, Community Well Being*
- Dr. Joni Bhutra, MD, MBA, Ventura County Health Care Agency Community Health Center – *Chief of Pediatrics, Clinical Medical Director*
- Blair Barker, MPH, Camarillo Health Care District – *Program Officer*
- Erin Slack, MPH, Gold Coast Health Plan – *Senior Manager of Population Health*
- Sarah Conlon, MHA, Clinicas Del Camino Real, Inc. – *Operations Director*
- Kristine Supple, MPH, Community Memorial Healthcare – *Associate Vice President of Care Coordination*
- Courtney Lubell, MA, Ventura County Behavioral Health – *Special Projects MHSA/BHSA Manager*
- Erica Mahgerefteh, MPH, Kaiser Permanente – *Senior Consultant, Medi-Cal and State Programs*

3.6 Distribution of 2022 CHNA report

To meet the requirements of the IRS regulations 501(r) for charitable hospitals, hospitals are required to make the CHNA and Implementation Strategy (IS) available publicly through print copies and on the internet. Public comment is also solicited and documented. In keeping with these regulations, VCCHIC partners made the 2022 CHNA report available to community members to read online and in paper format. No written comments had been received at the time this report was written.

Adventist Health Simi Valley

- 2022 CHNA: 2022-chna-simi-valley-web.pdf
- 2022 Implementation Strategy: simi-valley-2022-chis.pdf

Community Memorial Healthcare

- 2022 CHNA and Implementation Strategy: Community Health Needs Assessment | Health care Services in Ventura County, CA

St. John's Regional Medical Center and St. John's Hospital Camarillo, Dignity Health

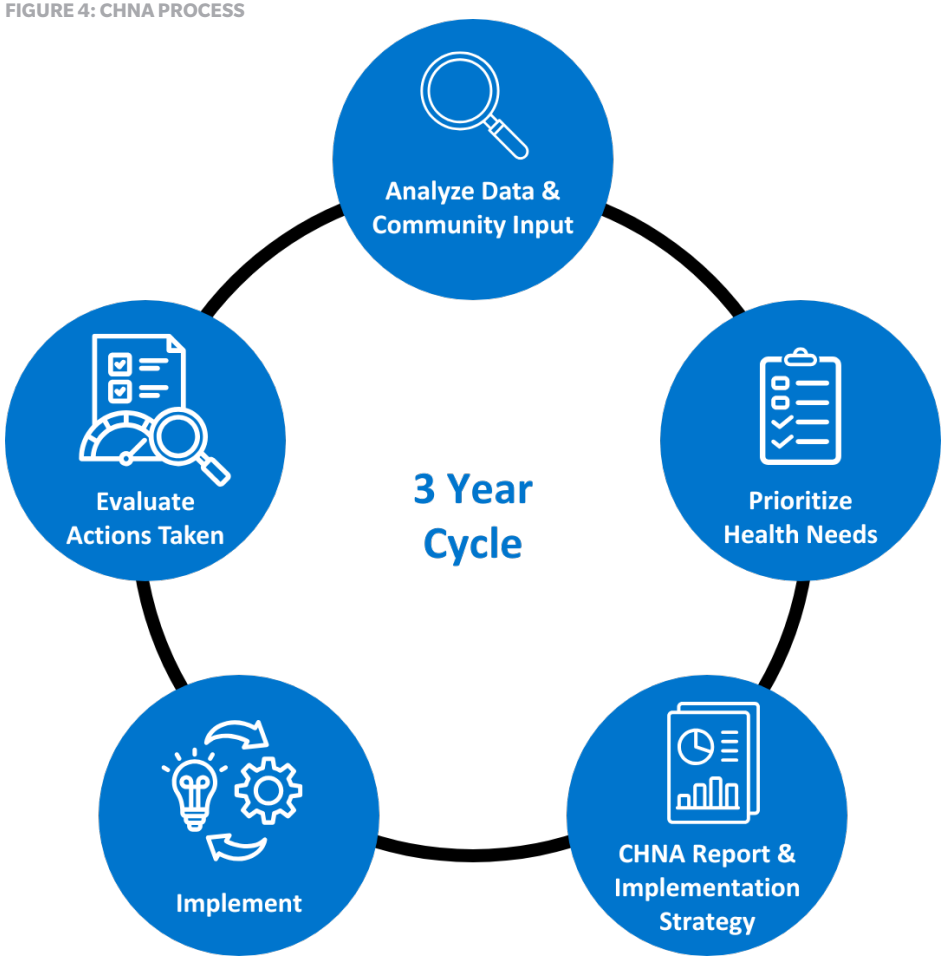
- 2022 CHNA and Implementation Strategy: Community Benefit | St. John's Regional Medical Center and St. John's Hospital Camarillo | Dignity Health

3.7 Evaluation of Progress since 2022 CHNA

3.7.1 The CHNA Cycle

The CHNA process is conducted as part of a three-year cycle (Figure 4). An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.

FIGURE 4: CHNA PROCESS



3.7.2 Introduction to the 2022 Impact Evaluation

Devised by VCCHIC and partners amid the COVID-19 pandemic, the 2022 Ventura County Community Health Implementation Strategy (CHIS) crafted specific goals, strategies and related objectives for each of the three top priorities selected from the 2022 CHNA:

- Addressing Mental Health and Substance Use Across the Lifespan
- Prevention of Chronic Conditions by Promoting Healthy Lifestyles
- Advancing Equitable Access to Health care

As a comprehensive action plan, the 2022 CHIS sought to address social drivers of health (SDoH) to improve access to care and services for those facing disparate challenges. To meet its ambitious goals, it sought to leverage current community resources, while also working collaboratively across multiple sectors to engage new community partners.

For each of three overarching goals, VCCHIC members and community partners developed unique objectives and strategies with an eye on strengthening alignment and consistency across collaborative organizations. These plans were then used by VCCHIC member organizations to guide their health improvement efforts from 2023 to 2025.

At the time of this report, the 2022 Ventura County CHIS is nearing the final six months of its life cycle. As such, the impact across its 3-year span cannot yet be fully assessed. A fuller, comprehensive impact assessment will be made available in 2026 on our Health Matters in Ventura County website – www.healthmattersinvc.org.

The 3-year implementation period of the 2022 CHIS was an especially challenging one to deliver on its ambitious goals. Against the backdrop of a once-in-a-lifetime health crisis, Ventura County's countless care and service providers labored tirelessly to meet the basic needs of residents and their loved ones. When residents needed their health care system to rise to the challenge, VCCHIC and partners across the county stood together to support their community. That context makes the above-and-beyond achievements of VCCHIC members and partners related to the 2022 CHIS even more impressive.

Addressing Mental Health and Substance Use Across the Lifespan

Goal: Increase access to mental health and substance use related services in Ventura County

Strategy: Expand reach of mental health and substance use prevention programs and measures
Objective: Improve mental health access through education, leveraging existing behavioral health resources, building organization-based networks and sharing lessons learned.
Intended Population: Children and Older Adults (0-75) in Ventura County
Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) founding member organizations
Collaboration Partners: Ventura County Behavioral Health
Anticipated Outcomes
Short-Term: Number of providers and community members educated to address mental health related stigma
Medium-Term: Percentage of patients identified receiving mental health care through hospital or community-based services for depression, anxiety, suicide or substance use
Long-Term: Reduced ER visits due to mental illness and/or substance use, by diverting those with mental health/substance use needs to mental health/substance use care specific centers

3.7.3 Progress and Impact: Goal One

Considerable progress was made across the entirety of VCCHIC member organizations toward this goal's objectives. Some of the most impressive gains came in the collaborative workforce development efforts to create a large, culturally attuned cadre of Substance Use Navigators across the County.

Astute leveraging of VCCHIC resources – as well as complementary avenues such as Medi-Cal and CalAIM – to coordinate care and referrals across sectors (such as hospitals, managed care plans, and community-based providers) helped residents gain access to needed behavioral health services.

The collaborative spirit of this goal not only led to expanded partnerships with local organizations such as Conejo Health, but also helped lay the path for the Ventura County Behavioral Health Department to formally join VCCHIC's Steering Committee and help tie these objectives with its own initiatives.

What our 2025 CHNA reveals, though, is despite these impressive efforts to expand, coordinate, and improve behavioral health care across Ventura County – these efforts could not keep up with the increased local demand in the pandemic era.

Preventing Chronic Conditions by Promoting Healthy Lifestyles

Goal: Address some of the social determinants of health (SDOH) that contribute to chronic conditions and inhibit healthy lifestyles in Ventura County

Strategy: Promote an environment conducive to both physical exercise and increased access to healthy foods
Objective: Identify policies and programs, evaluated through a health equity lens, that promote healthy behaviors and increase access to physical activities and healthy foods in Ventura County.
Intended Population: All age, race and ethnic groups in Ventura County
Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, state and county health departments, local businesses and non-profit organizations
Collaboration Partners: VCCHIC partner organizations
Anticipated Outcomes
Short-Term: Number of community-based programs (CalFRESH, recreational clubs and screening events) that invest in a community activity to promote physical activity, healthy eating and/or cancer screening
Medium-Term: • Number of community members utilizing CalFRESH benefits at Farmer's Markets. • Number of community members enrolled in physical activity programs • Planned cancer prevention coordination activities
Long-Term: • Reduction in emergency room and hospital utilization from uncontrolled diabetes • Reduction in morbidity from all cancers • Reduction in mortality from all cancers

3.7.4 Progress and Impact: Goal Two

This CHIS goal catalyzed perhaps the greatest breadth of VCCHIC programmatic responses to meet its expansive objectives. Befitting VCCHIC's emphasis on preventive health, all Steering Committee organizations – and many local partners – made concerted efforts to improve food security, physical fitness, as well as diabetes and cancer screenings over the course of the past 3 years.

Innovative programs to braid resources (such as CalFresh, grants, and in-kind member support) and encourage use of local farmers markets for families facing food insecurity were a direct outgrowth of this goal and the VCCHIC efforts to expand cross-sectoral partnerships to achieve gains.

Broad-based wellness and preventive programs that sought to improve the overall health of at-risk groups such as older adults and those living in areas with inequitable access to recreation – are good examples of how VCCHIC members worked to improve long-term health inequities in the community through upstream interventions.

Likewise, the establishment and growth of the Ventura County Community Information Exchange – itself a product of the 2019 Ventura County CHIS – has set the stage for improved referral practices between community-based providers and VCCHIC members to ensure person-centered prevention efforts are aligned across service delivery systems.

Our 2025 CHNA reveals that many of these local concerns – lack of access to recreation, increasing cancer rates, food insecurity, etc. – remain pressing for residents and will require continuing innovations to ensure the gains from the 2022 CHIS are improved upon.

Advancing Equitable Access to Healthcare

Goal: Expand access to preventative care services to reduce the need for emergency visits in Ventura County

Strategy: Develop and implement health equity conscious policies and programs to expand preventative care service availability and accessibility in Ventura County	
Objective: Implement policies and programs aimed at expanding and promoting access to culturally appropriate preventative care services among underserved populations in Ventura County	
Intended Population: Underserved populations including low-income, immigrant, migrant, refugee, LGBTQIA+, Latinx and Black/African American	
Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, American Hospital Association Institute for Diversity and Health Equity (AHA IFDHE)	
Collaboration Partners: VCCHIC partner organizations	
Anticipated Outcomes	**Data Source**
Short-Term: • Number of organizations that participate in SOGI and/or DEI assessments • Number of organizations participating in the PHM strategy	American Hospital Association, Dignity Health, Gold Coast Health Plans and any state-level accreditation organization
Medium-Term: Number of collaborative wellness and prevention programs that were developed because of the PHM strategy	VCCHIC Founders
Long-Term: • Increase primary care visits including screenings • Increase in infant, child, and adolescent well-child visits • Increase in childhood and adolescent vaccinations • Reduce emergency room visits	Gold Coast Health Plan, VCCHIC health care partners, Department of Health Care Access and Information (HCAI)

3.7.5 Progress and Impact: Goal Three

As one of VCCHIC's foundational principles, advancing equitable access to care in Ventura County has been a longstanding goal. The organizations that comprise the VCCHIC Steering Committee made great strides since 2022 in terms of their efforts to zero in on populations facing inequitable barriers to care. This was seen in everything from placement of food banks to outreach for preventive health screenings and vaccinations, from multilingual communications to carrying out vital training for their staff and leadership. VCCHIC itself has set out to improve its internal equity training, assessments, and practices to better meet the needs of the communities it serves.

Collectively, we also recognize that much work still needs to be done to ensure that this goal is met. We understand that if Ventura County is to see significant health improvements of any kind, on any priority issue – it needs to grapple with disparate health impacts as well as the complex conditions and drivers fueling these inequities.

Most importantly, VCCHIC has pledged to work more collaboratively with local partners to devise the most effective, community-driven solutions. This CHNA Report stands as a testament to that effort – and the trust and openness of community partners willing to work with VCCHIC to improve its impact.

3.8 Priority Health Needs from Preceding 2022 CHNA

VCCHIC's priority health areas for the 2022 CHNA cycle were:

- Addressing Mental Health and Substance Abuse Across the Lifespan
- Prevention of Chronic Conditions by Promoting Healthy Lifestyles
- Advancing Equitable Access to Health care

A detailed impact evaluation outlining the goals, objectives and status of each strategy is provided in Appendix A.

3.9 Collaborations

VCCHIC commissioned Conduent Healthy Communities Institute (HCI) to conduct its 2025 Community Health Needs Assessment. Conduent HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. To learn more about Conduent HCI, please visit www.conduent.com/communityhealth.

3.10 Report Authors

Report author from VCCHIC:

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Sarah Jameson, MPH, Epidemiologist

Profile of Ventura County

Located in Southern California, Ventura County has an area of land of 1,843.1 square miles which encompasses 10 cities, 23 census-designated places, and 15 other unincorporated communities. In 2024, Ventura County's population had a median age of 40.3 and a median household income of $103,111. Additionally, 50.9% of the population is female, 5.1% are below five years of age, 20.8% are below 18 years and 18.6% are 65 years and above and 37.9% of the people in Ventura County speak a non-English language at home (Claritas Pop-Facts, 2024).

The homeownership rate is 60.4%, households with an internet subscription is 95.9%, and among county residents, 4.9% have veteran status and 22.9% are foreign born (American Community Survey, 2023). In 2024, the percentage of households with a computer is 88.7% (Claritas Consumer Profiles, 2024).

4.1 Demographic Profile

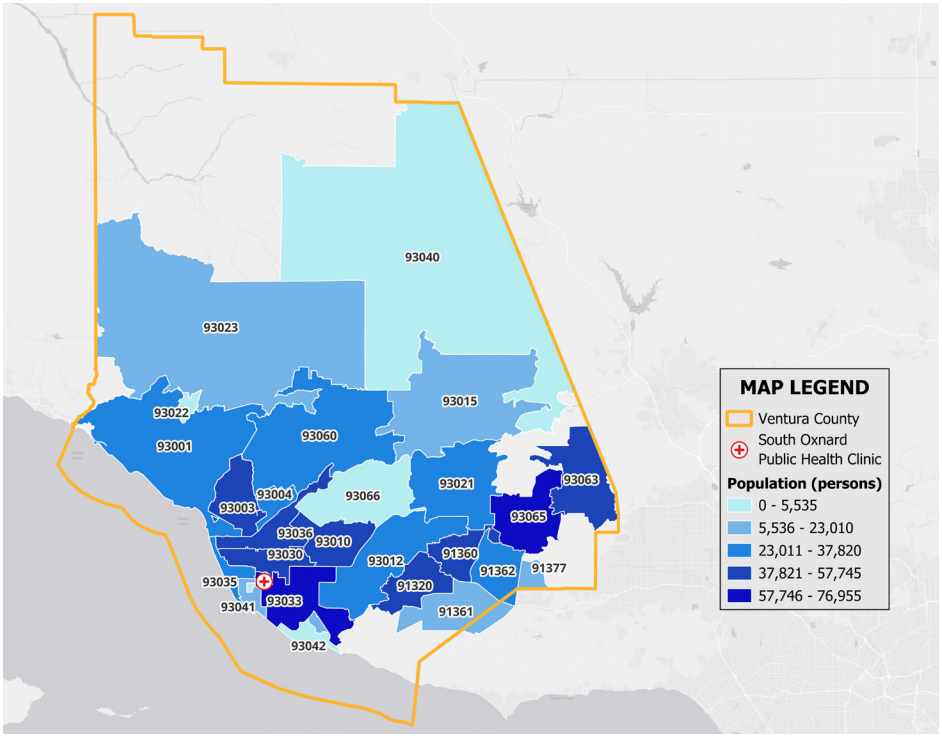
The following section explores the demographic profile of Ventura County. Demographics are an integral part of describing the community and its population and are critical to forming further insights into the health needs of the community to best plan for improvement. All Ventura County residents should have the opportunity to make choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background. Unfortunately, some population groups don't have the same opportunities to be as healthy as others; these groups may experience more inequities and thus require different approaches and support to health improvement (Centers for Disease Control and Prevention, 2024).

All demographic estimates are sourced from the U.S. Census Bureau's (a) 2024 population estimates or (b) 2019-2023 American Community Survey (ACS), or (c) 2024 Claritas Pop-Facts®, unless otherwise indicated. The Pop-Facts data set provides current estimates using the 2010 Census and incorporation of newly available ACS data. Periods of measurement and sources for the data discussed are given in these sections if they are not mentioned elsewhere in the tables and figures enclosed within the report. For more information on the demographics in Ventura County, please visit www.healthmattersinvc.org/demographicdata

4.1.1 Population

According to 2024 Claritas Pop-Facts, Ventura County has a population of 831,228 and is the 12th largest county in terms of population. Figure 5 illustrates the population size in Ventura County by zip code. The most populated zip codes are 93033 (Oxnard) and 93065 (Simi Valley) with population totals of 76,955 and 73,034.

FIGURE 5: POPULATION BY ZIP CODE, 2024



Source: Claritas Pop-Facts

Table 1 presents the U.S. Census Bureau population estimates in Ventura County by year for 2021, 2022, 2023, and 2024. During this time span, the overall population change in both Ventura County and California was less than one percent. In that same time period, the U.S. population grew by 2.43%.

TABLE 1: TOTAL POPULATION: PAST FOUR YEARS, 2021-2024

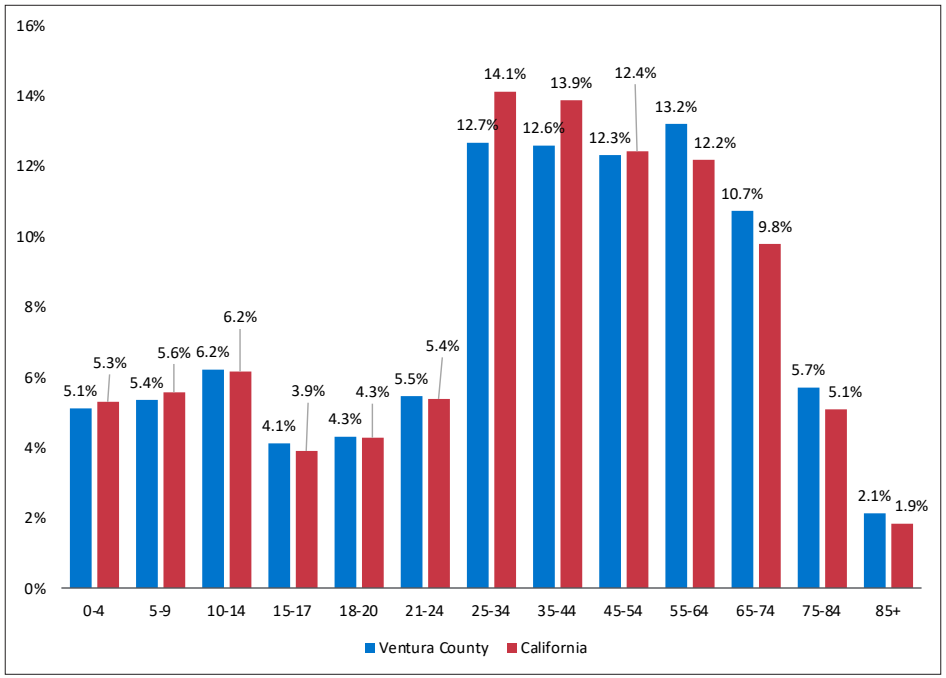
Total Population					
	2021	2022	2023	2024	Percent Change 2020-2023
Ventura County	839,471	832,871	829,590	835,427	-0.48
California	39,145,060	39,040,616	38,965,193	39,431,263	+0.73
United States	332,048,977	333,271,411	334,914,895	340,110,988	+2.43

Source: U.S. Census Bureau

4.1.2 Age

Distribution of age impacts the health care needs of a population. Economic means, work status and entitlement program eligibility are based on age which can affect an individual's ability to access preventive health care services (Office of Disease Prevention and Health Promotion, n.d.) . Figure 6 shows the Ventura County population by age as compared to the age distribution for the state of California. Overall, Ventura County's age distribution is similar to California. Notably, Ventura has a lower percentage of its population between 25-34 and 35-44 years of age compared to California. However, the percentage of the population aged 55 and above is slightly greater in Ventura than in California.

FIGURE 6: POPULATION BY AGE, 2024



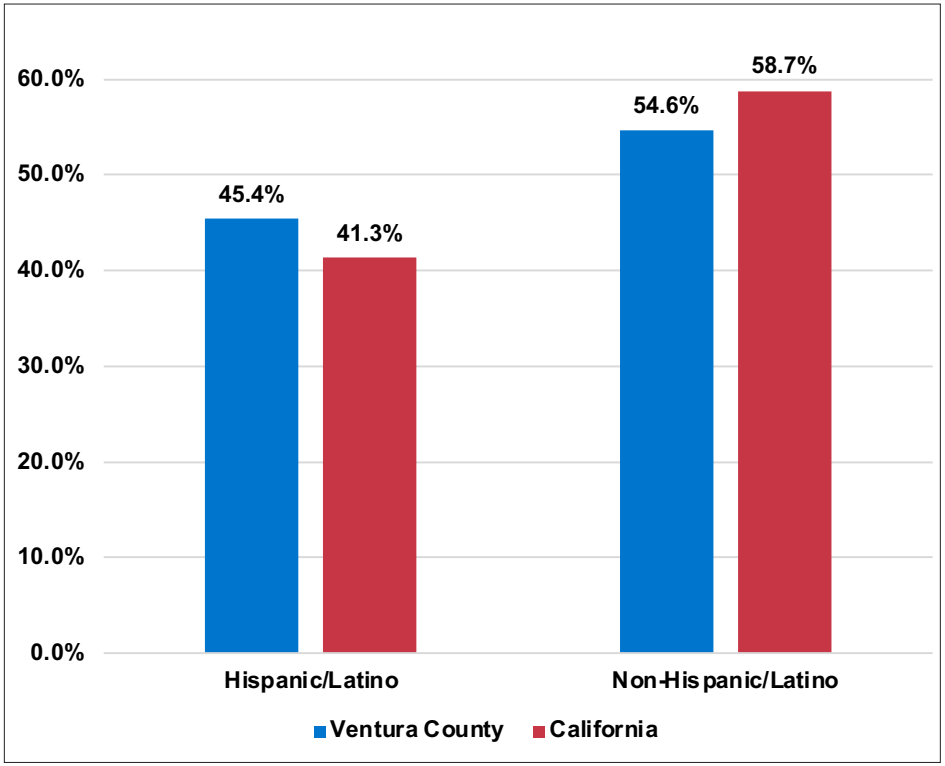
Source: Claritas Pop-Facts

4.1.3 Race/Ethnicity

The race and ethnicity composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care and childcare. Race and ethnicity data are also useful for identifying and understanding disparities in housing, employment, income and poverty.

Figure 7 shows the ethnicity of residents in Ventura County compared to California. In Ventura County, 45.4% of residents identify as Hispanic/Latino (of any race), which is somewhat higher than the California population (41.3%).

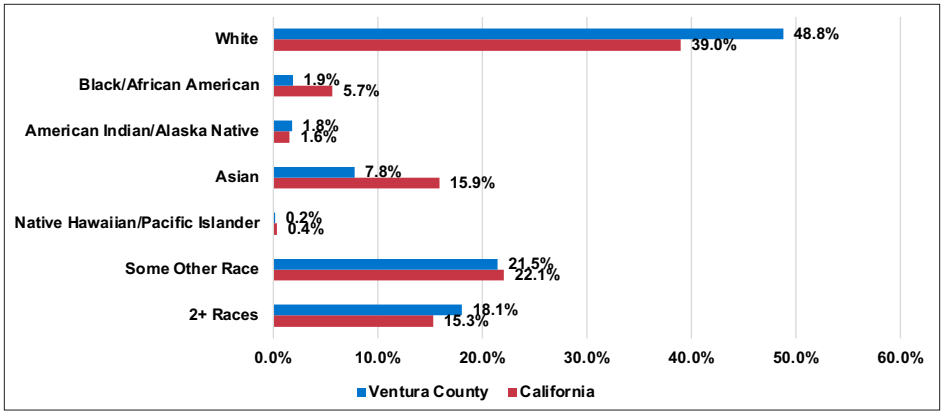
FIGURE 7: VENTURA COUNTY POPULATION BY ETHNICITY, 2024



Source: Claritas Pop-Facts

Figure 8 shows the racial composition of Ventura County and California. Compared to California, Ventura County has a larger White population (48.8%) and smaller Black or African American and Asian populations (1.9% and 7.8%, respectively).

FIGURE 8: VENTURA COUNTY POPULATION BY RACE, 2024



Source: Claritas Pop-Facts

Table 2 presents a closer examination of population trends over a span of four years. Overall, Ventura County has experienced a slight increase in share of residents identifying as Asian, Hispanic/Latino and Two or More Races from 2020 to 2023. Meanwhile, there has been a slight decrease in residents identifying as White in the past four years.

TABLE 2: POPULATION BY RACE OR ETHNICITY: PAST FOUR YEARS

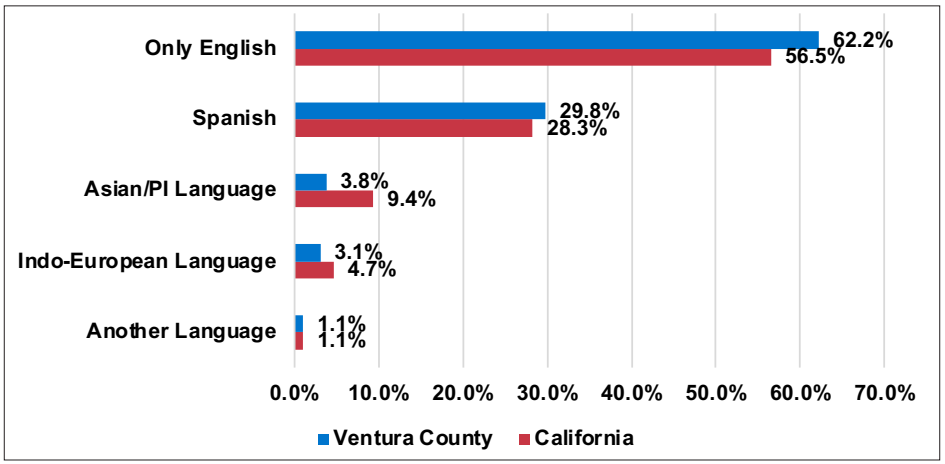
Ventura County				
	2020	2021	2022	2023
American Indian and Alaska Native	1.9%	1.9%	1.9%	1.9%
Asian	8.0%	8.1%	8.2%	8.3%
Black or African American	2.4%	2.4%	2.4%	2.4%
Native Hawaiian and Other Pacific Islander	0.3%	0.3%	0.3%	0.3%
Two or More Races	3.7%	3.8%	3.8%	3.9%
White	83.7%	83.5%	83.3%	83.2%
Hispanic	43.4%	43.8%	44.3%	44.8%

Source: U.S. Census Bureau. 2024 race or ethnicity estimates not available at time of publishing.

4.1.4 Language Spoken at Home

Figure 9 shows the percentage of the population that speaks a language other than English at home, comparing the values for Ventura County with the California state value. In Ventura County, 62.2% of the population aged five and older speak only English while 37.8% of the population speak a language other than English at home, with the most common non-English language being Spanish (29.8%). This measurement indicates where there may be language or cultural barriers to accessing health care.

FIGURE 9: POPULATION AGE 5+ LANGUAGE SPOKEN AT HOME, 2024



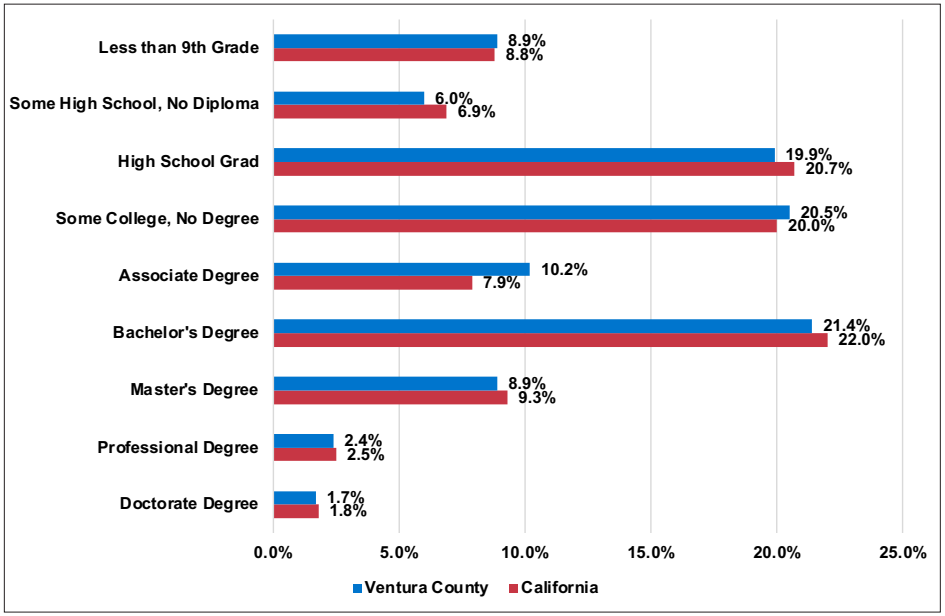
Source: Claritas Pop-Facts

4.1.5 Education

Education is an important indicator for health and well-being across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors (Office of Disease Prevention and Health Promotion, n.d.).

Figure 10 displays the educational attainment for the population age 25+ in Ventura County. All levels of educational attainment are similar between Ventura County and California state values. Notably, Ventura County has a higher percentage of the population with an associate degree (10.2%) than California (7.9%).

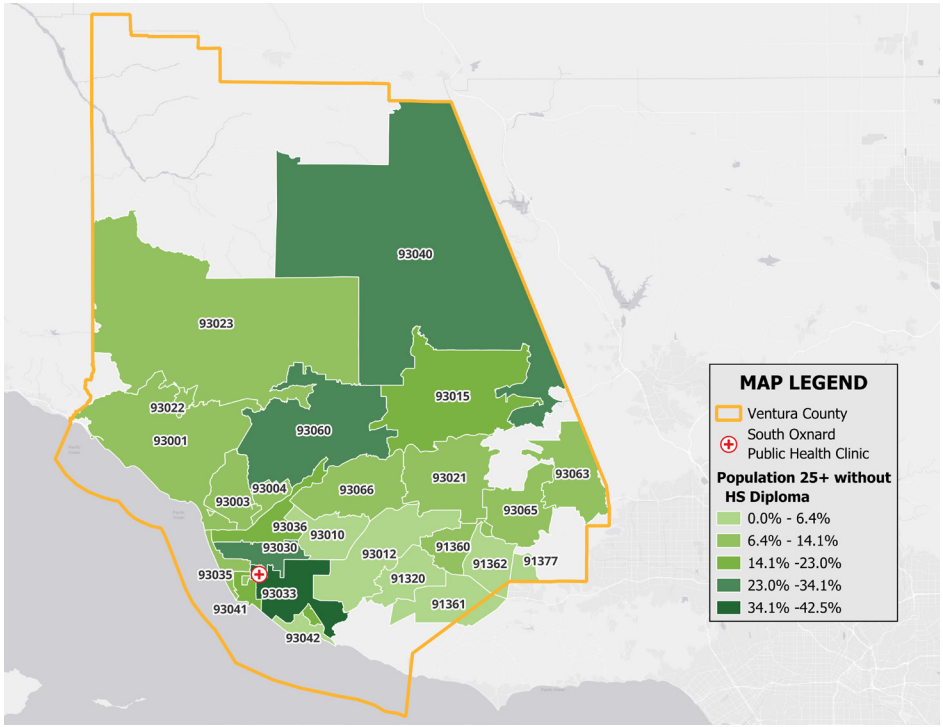
FIGURE 10: EDUCATIONAL ATTAINMENT BY PEOPLE 25+, 2024



Source: Claritas Pop-Facts

Figure 11 depicts the *Population Age 25+ With Less Than High School Graduation* at the granular zip code level, with darker green regions indicating a greater percentage of individuals with less than a high school graduation. In this map, the areas with the highest percentage of individuals without a high school degree are 93033 (42.7%), 93040 (33.7%), 93060 (33.0%), and 93030 (30.2%).

FIGURE 11: POPULATION AGE 25+ WITH LESS THAN HIGH SCHOOL GRADUATION, 2024



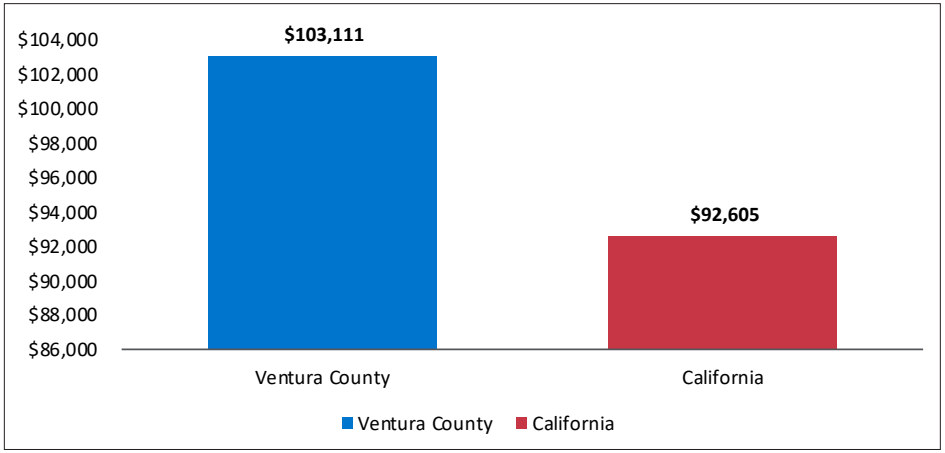
Source: Claritas Pop-Facts

4.1.6. Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work (Office of Disease Prevention and Health Promotion, n.d.).

Figure 12 shows the Median Household Income for Ventura County and California. Ventura has a median household income above the state value and the national values. Ventura County has an estimated median household income of approximately $103,111, which was $10,506 higher than the median household income of California ($92,605) and $25,392 higher than the national value of $77,719 (American Community Survey 2019-2023).

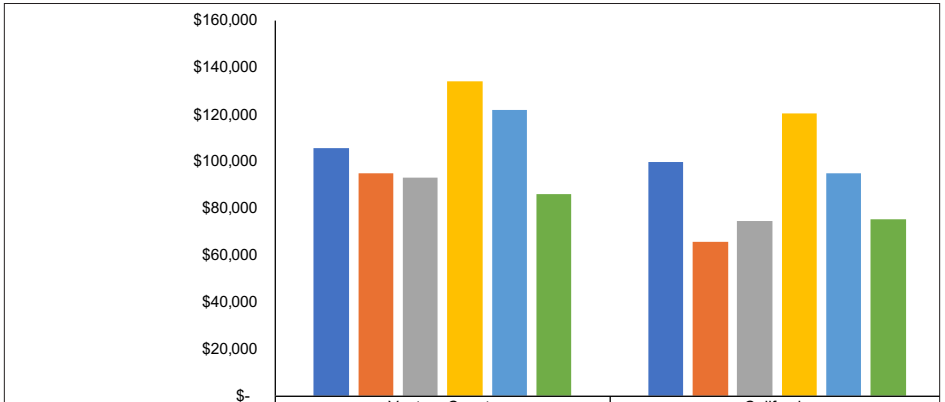
FIGURE 12: MEDIAN HOUSEHOLD INCOME, 2024



Source: Claritas Pop-Facts

Figure 13 shows Median Household Income by race and ethnicity for Ventura County. All of the racial and ethnic groups in Ventura County have higher median household incomes in comparison to the overall California state value. The Asian population has the highest median household income at $134,322. Not only is this the highest, but it also represents the greatest difference from the overall Ventura County value. The Hispanic/Latino population ($86,240) has a median income below the median household incomes of Ventura County and California.

FIGURE 13: MEDIAN HOUSEHOLD INCOME BY RACE OR ETHNICITY, 2024

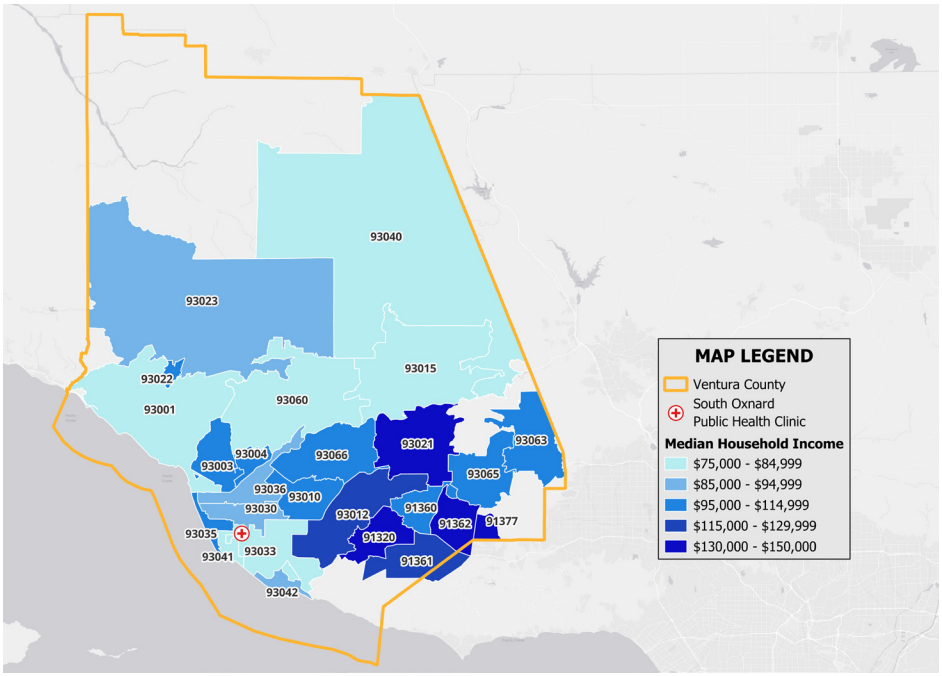


	Ventura County	California
White	$105,946	$99,794
Black/African American	$94,941	$65,932
American Indian/Alaskan Native	$93,102	$74,709
Asian	$134,322	$120,716
Native Hawaiian/Pacific Islander	$122,131	$95,072
Hispanic/Latino	$86,240	$75,515

Source: Claritas Pop-Facts

Per the American Community Survey 2023 one-year estimates, the median household income was $106,721 for 2-person households, $136,054 for 4-person households, $123,911 for 6-person households, and $150,674 for 7+ person households. Looking at Figure 14, the regions with the darker shades of blue indicate zip codes with higher median household incomes, while the lighter shades indicate lower median household incomes. The zip code with the highest median household income in Ventura County is 91377 ($203,613), while the zip code with the lowest median household income is 93042 ($61,667).

FIGURE 14: MEDIAN HOUSEHOLD INCOME BY ZIP CODE, 2024



Source: Claritas Pop-Facts

4.1.7 Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes (Office of Disease Prevention and Health Promotion, n.d.).

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health (Office of Disease Prevention and Health Promotion, n.d.). Table 3 lists the industries that employ the civilian population 16 years of age and over in Ventura County. Most of the employed population work in health care and social assistance (12.1%) followed by retail trade (10.4%) and total manufacturing (10.2%). The smallest percent of the civilian employed population are in the management of companies (0.1%).

TABLE 3: INDUSTRY OF WORK FOR THE CIVILIAN EMPLOYED POPULATION 16 YEARS AND OVER

Occupation Industry	Number	Percent
Accommodation/Food Services	29,599	7.1%
Admin/Support/Waste Management	17,015	4.1%
Agriculture/Forest/Fishing/Hunting	23,684	5.7%
Entertainment/Rec Services	8,469	2.1%
Construction	25,584	6.2%
Educational Services	33,371	8.1%
Finance/Insurance/Real Estate/Rent/Lease	26,325	6.4%
Health Care/Social Assistant	50,146	12.1%
Information	9,355	2.3%
Management of Companies	362	0.1%
Total Manufacturing	42,183	10.2%
Oth Services, Not Pub Admin	18,400	4.4%
Prof/Science/Technology/Admin	35,783	8.6%
Public Administration	21,316	5.2%
Retail Trade	42,975	10.4%
Transport/Warehouse/Utils	16,881	4.1%
Wholesale Trade	12,836	3.1%
TOTAL	**401,448**	

Source: American Community Survey 2019-2023

4.2 Social Determinants of Health

Healthy People 2030 defines social determinants of health as conditions in which people are born, grow, live, work, and age that affect a wide range of health outcomes and risks. The social determinants of health partly explain why some people are healthier than others, and generally why some people are not as healthy as they could be. Resources that address the social determinants of health and improve quality of life can have a significant impact on population health outcomes (Office of Disease Prevention and Health Promotion, n.d.). Examples of these resources include access to education, good paying jobs, public safety, affordable housing, availability of healthy foods, and local emergency and health services.

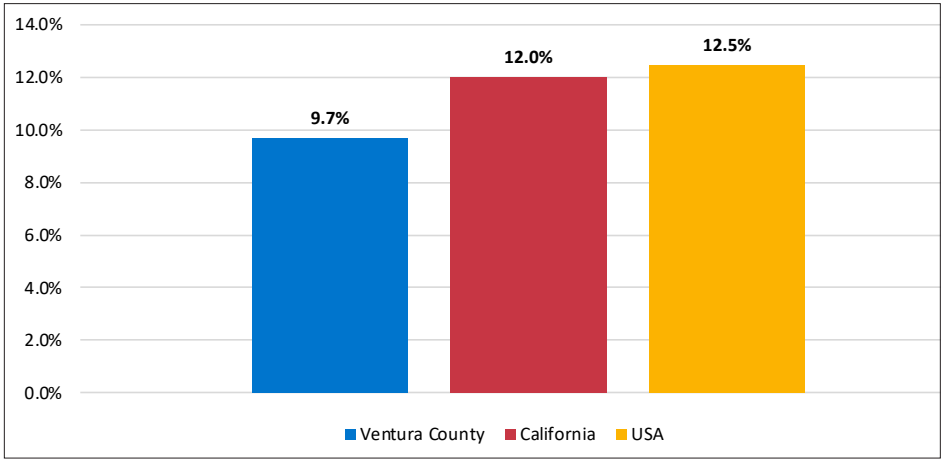
Understanding the different social determinants in a service area can lead to potential programs and services that work to improve disparities within that community. Programs that address the social determinants such as targeted outreach to people living alone, translation services for people with limited English proficiency, and universal job training for entry level positions can help to improve the overall health of the community. This section explores the social and economic determinants of health in Ventura County. These social determinants and other factors help build the context of the service area to allow for better understanding of the results of both primary and secondary data.

4.2.1 Poverty

In 2024, the federal poverty level was $31,200 for a family of four (U.S. Department of Health and Human Services, 2024). Federal assistance programs, such as Head Start, the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program and the Children's Health Insurance Program, use the guidelines (or percentage multiples of the guidelines — for instance, 125% or 185% of the guidelines) in determining eligibility.

As shown in Figure 15, Ventura County has lower rates of poverty compared to the state and national poverty rates. Ventura County has a poverty rate of 9.7%, while state and national rates of poverty are 12.0% and 12.5%, respectively.

FIGURE 15: PEOPLE LIVING BELOW POVERTY LEVEL, 2023



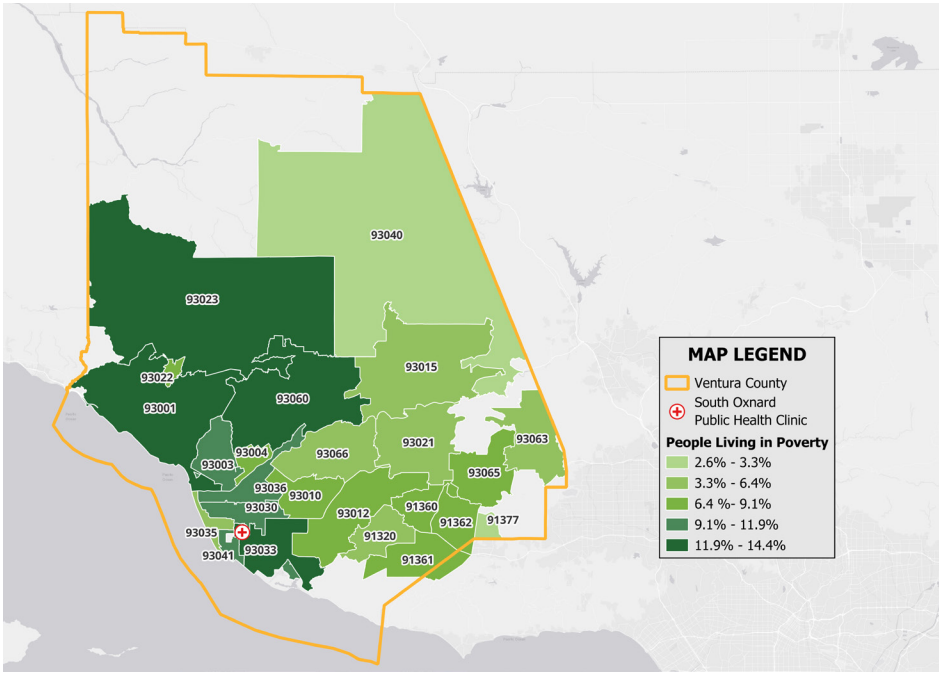
Source: American Community Survey

Profile of Ventura County

The United Way of California has created an estimate of the minimum income required to meet basic needs for a given household type in a specific community. This threshold of affordability is referred to as the Real Cost Measure (RCM). The RCM builds a bare-bones budget that reflects constrained yet reasonable choices for essential expenses: housing, food, transportation, health care, taxes and childcare. According to United Way's report "Breaking Barriers, Building Opportunity", one in three households in California, over 3.3 million families—including those with income well above the federal poverty level—struggle every month to meet basic needs. The United Way of California estimates that an income of at least $114,456 is required to meet the basic needs for a family of four (two adults, one infant, one school age child), in Ventura County; this figure is $105,736 for California (United Way of California, 2025). This is more than three times the federal poverty level for a family of four. In Ventura County, 53% of Hispanic households and 31% of Black/ African American households are living below the RCM. Additionally, 74% of those without a high school diploma are living below the RCM.

Figure 16 depicts the Percentage of People Living Below Poverty Level disaggregated by sub-county geographies. The dark green regions indicate zip codes with the highest levels of poverty in the county while lighter shades represent lower rates of poverty. The Ventura County zip codes with the largest proportion percentage of the population living below poverty level are 93060 (12.2%) and 93033 (12.1%).

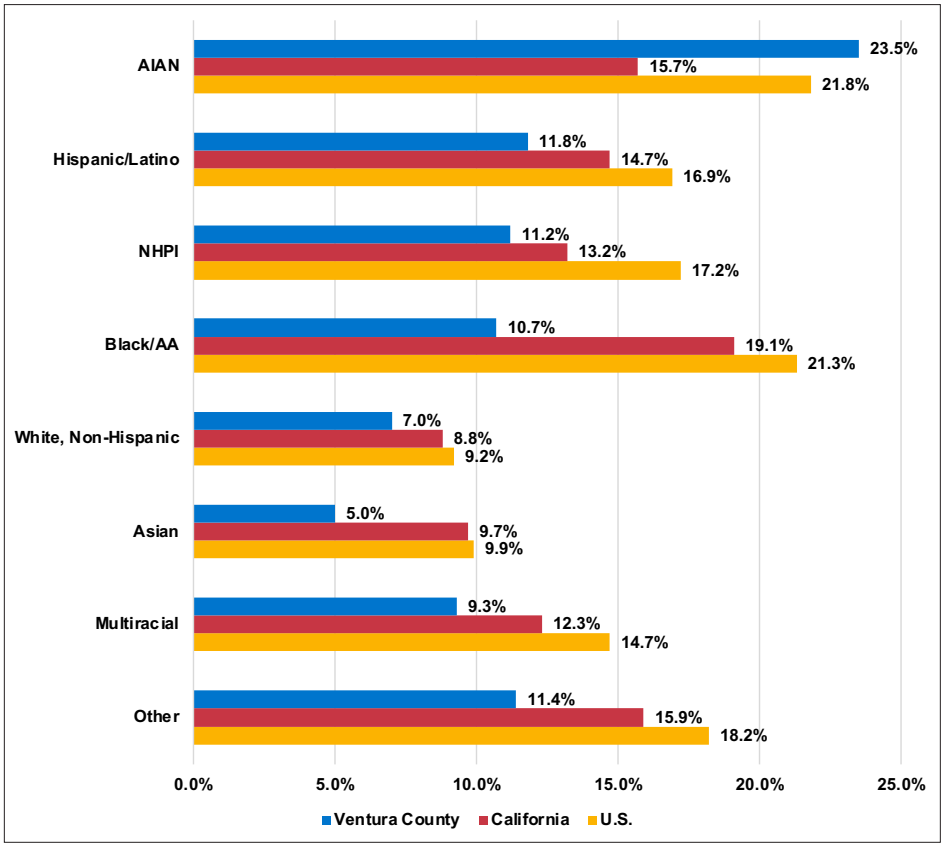
FIGURE 16: PEOPLE LIVING BELOW POVERTY LEVEL, 2019-2023



Source: American Community Survey

Examining the context of poverty more deeply, Figure 17 shows the Percentage of People Living Below Poverty Level by Race or Ethnicity in comparison to state and national values. All race and ethnic groups in Ventura County, except American Indian/Alaska Native, have lower percentages of people living in poverty compared to state and national levels. The race or ethnic group in Ventura County with the greatest percentage of its population living in poverty is the American Indian/Alaska Native population with 23.5% while the Asian American population has the lowest percentage with 5.0%.

FIGURE 17: PEOPLE LIVING BELOW POVERTY LEVEL BY RACE OR ETHNICITY, 2019-2023



Source: American Community Survey

According to the American Community Survey, for the 2019-2023 period, 12.3% of children in Ventura County were living below the federal poverty level. This is lower than the percentage of children living below the poverty level in California (15.1%) and the United States (16.3%). Further analysis indicates that American Indian/Alaska Native children were especially likely to live in poverty in Ventura (40.2%), followed by Hispanic/Latino children (17.4%). In terms of geographic area, 93060 had the greatest levels of poverty, with one in four people under the age of 18 living below the federal poverty level (25.8%). There were also high levels of poverty in zip codes 93023 and 93033, where one in five people under the age of 18 live below the federal poverty level (20.7% and 20.4%, respectively).

For the 2019-2023 period, 8.4% of individuals aged 65 and over were living below the federal poverty level in Ventura County. This is lower than the California (11.3%) and the United States values (10.4%). Similar to our findings with the population under 18, we found that both American Indian/Alaska Native (12.2%) and Hispanic/Latino (11.2%) older adults were more likely to experience poverty than the overall older adult population in Ventura. Finally, examining these rates by zip code, we found that poverty among older adults is most common in 93030 (12.9%), 93041 (12.6%), and 93060 (12.2%).

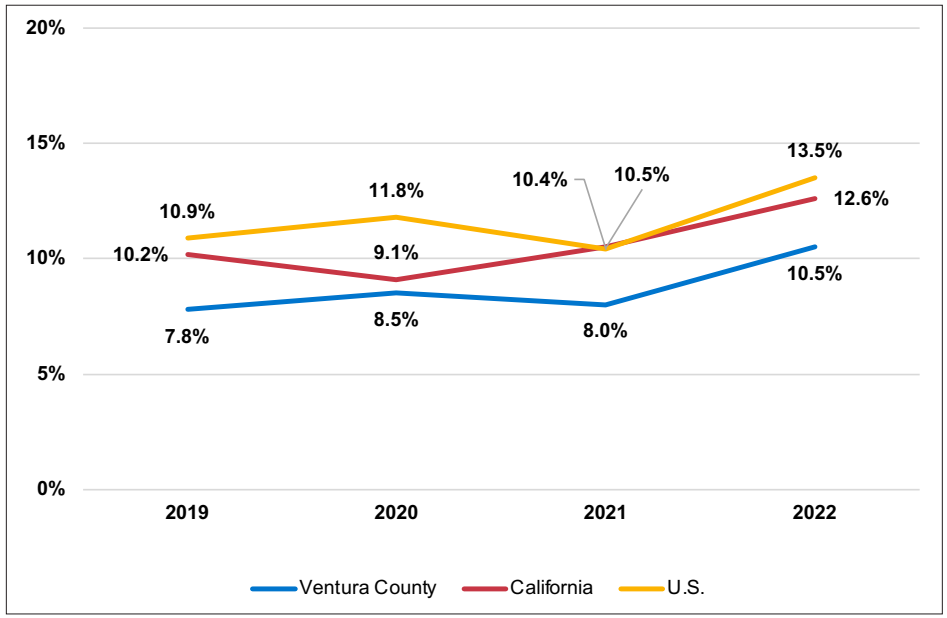
The Gini index measures income distribution among the residents of a specified geography. A value of zero indicates perfect equality of income (all households having equal income) and a value of one indicates perfect inequality (one household having all the income). A value of 0.5 indicates an uneven distribution of income. The Gini index for Ventura County is 0.446 (American Community Survey, 2023), indicating there may be some uneven distribution of outcomes. Having lower income affects housing stability, food access, health care spending, health care access and the health status of residents. These disparities correspond with race or ethnicity, languages spoken at home, foreign-born status and female-headed households among other factors. It is likely that these income related disparities are contributing to the poor health outcomes in the county (Office of Disease Prevention and Health Promotion, n.d.).

4.2.2 Food Insecurity

Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources. Food insecurity, and the resulting hunger, is associated with disability, lack of adequate employment and racial and ethnic disparities (Office of Disease Prevention and Health Promotion, n.d.). It leads to the intake of nutritionally deficient, high calorie foods that can cause obesity, diabetes, heart disease, high blood pressure, and hyperlipidemia. Food assistance programs such as the National School Lunch Program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Supplemental Nutrition Assistance Program (SNAP) help address food insecurity in populations at higher risk of food insecurity by delivering food benefits.

Figure 18 describes the percentage of the population in Ventura County that has experienced food insecurity, compared to state and national rates. Ventura, along with the overall California and U.S. populations, experienced an increase in food insecurity during this period, from 7.8% in 2019 to 10.5% in 2022. For all four time periods, Ventura has had a lower rate of food insecurity than both the state and nation.

FIGURE 18: FOOD INSECURITY RATE, 2019-2022



Source: Feeding America

4.2.3 Transportation

Public transportation offers mobility, particularly to people without cars. Transit can help bridge the spatial divide between people and jobs, services and training opportunities. Public transportation also reduces fuel consumption, minimizes air pollution and relieves traffic congestion. Active travel, such as walking to public transportation or walking and cycling to work can be a good way to increase physical activity (Office of Disease Prevention and Health Promotion, n.d.).

The majority of workers in Ventura County (70.4%) drive alone to work, which is higher than both the state-wide and nation-wide rates (67.1% and 69.2%, respectively). Driving alone to work can have long lasting impacts on health, affecting aspects such as active living, pollution, and accidents due to vehicle collisions. In contrast, not having a vehicle at all may act as a barrier to accessing services, including health services. In Ventura, 4.12% of households have no vehicle, which is lower than the state-wide rate of 7.0% of households.

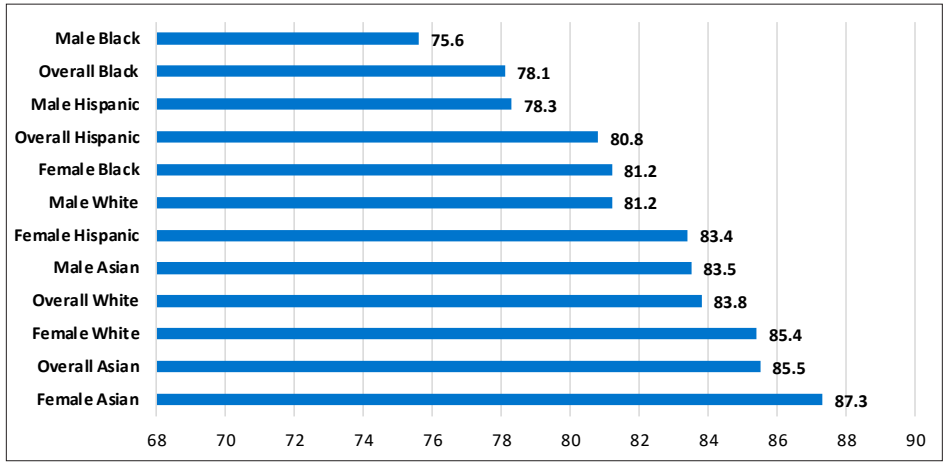
4.2.4 Housing

High costs of homeownership and rentals can strain homeowners, renters, and the local housing market. With a limited income, paying a high mortgage or rent may not leave enough money for other expenses such as food, transportation, and medical services. Moreover, high housing costs reduce the proportion of income a household can allocate to savings each month. In Ventura County, just over 1 in 3 mortgaged homeowners (36.5%) spend at least 30% of their household income on housing. This is lower than the California value (38.4%), but higher than the overall U.S. value (28.5%). In contrast, more than half of Ventura renters (58.2%) spend at least 30% of their household income on rent, which is a higher rate than both California and the U.S. (56.1% and 51.8%, respectively).

4.3 Life Expectancy in Ventura County, 2021-2023

Life expectancy is a measure of a population's longevity and overall health. Americans born today can expect to live 78.4 years while Ventura County residents born today can expect to live 81.1 years, 2.7 years longer than the United States average (Murphy, Kochanek, Xu, & Arias, 2024). Figure 19 shows that Ventura's Asian (Non-Hispanic) population has the longest life expectancy of all racial/ethnic groups (85.5 years), followed by the White (Non-Hispanic) population (83.8 years). Ventura's Black population has the lowest life expectancy, at 78.1 years.

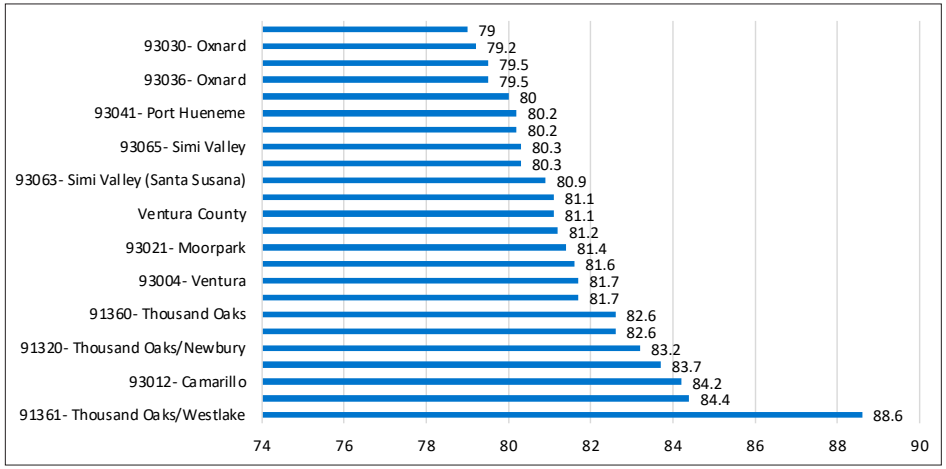
FIGURE 19: LIFE EXPECTANCY BY RACE OR ETHNICITY FOR VENTURA COUNTY, 2021-2023



Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025

There were also differences in life expectancy across different geographic areas within Ventura County. As seen in Figure 20, the population of zip code 91361, in Thousand Oaks/Westlake, had the highest life expectancy in the county at 88.6 years. Life expectancy in Ventura is lowest in Oxnard. Three of the four zip codes with the lowest life expectancy are in Oxnard, including 93033 (79.0 years), 93030 (79.2 years), and 93036 (79.5 years). In fact, between zip codes 93033 and 91361, there is a 9.6-year difference in life expectancy. In total, there were twelve zip codes in Ventura County that had a lower life expectancy than the overall county average

FIGURE 20: LIFE EXPECTANCY BY ZIP CODE, 2021-2023



Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025

4.4 Mortality and Years of Life Lost (Premature Death)

Mortality trends help drive public policy and health priorities; this has been especially true during the past few years in response to the COVID-19 pandemic. The 10 leading causes of death in Ventura County for the 2021-2023 three-year period were diseases of the Heart, Cancer, Alzheimer's Disease, Chronic Respiratory Disease, COVID-19, Cerebrovascular Disease (Stroke), Diabetes, Accidental (Unintentional Injuries), Drug-Induced Deaths, and Chronic Liver Disease. Diseases of the Heart and Cancer were the Leading Causes of Death in Ventura County, California, and the United States. To analyze statistically valid rates for comparison purposes by race or ethnicity, it is necessary to include three years of data.

TABLE 4: LEADING CAUSES OF DEATH, 2021-2023 (VC) AND 2023 (CA AND US)

Rank	Ventura County (2021-2023)	California (2023)	United States (2023)
1	Diseases of the Heart	Ischemic Heart Disease	Diseases of the Heart
2	All Cancers	Alzheimer's Disease	All Cancers
3	Alzheimer's Disease	Cerebrovascular Disease (Stroke)	Accidental (Unintentional Injuries)
4	Chronic Respiratory Disease	COVID -19	COVID -19
5	COVID-19	Hypertensive Heart Disease	Cerebrovascular Disease (Stroke)
6	Cerebrovascular Disease (Stroke)	Drug-Induced Deaths	Chronic Respiratory Disease
7	Diabetes	Chronic Respiratory Disease	Alzheimer's Disease
8	Accidental (Unintentional Injuries)	Lung Cancer	Diabetes
9	Drug-Induced Deaths	Chronic Kidney Diseases	Kidney Disease
10	Chronic Liver Disease	Prostate Cancer	Chronic Liver Disease

Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025

In the United States, the All-Cause Mortality Rate for the total population increased by 17.5% from 2021 to 2023 (from 625.4 per 100,000 standard population to 735) (Murphy, Kochanek, Xu, & Arias, 2024). Ventura County also experienced a statistically significant increase in the All-Cause Mortality Rate since the previous assessment period. Table 5 shows the Age-Adjusted Death Rate for the top 10 Leading Causes of Death from 2021-2023 as compared to the rate for the previous assessment period in 2019-21. There was a statistically significant increase in the Age-Adjusted Death Rate for Heart Disease, Alzheimer's Disease, Respiratory Disease, Diabetes, and Chronic Liver Disease. There was a statistically significant decrease in the rate of Death Due Accident.

TABLE 5: COMPARISON OF AGE-ADJUSTED DEATH RATES FOR VENTURA COUNTY

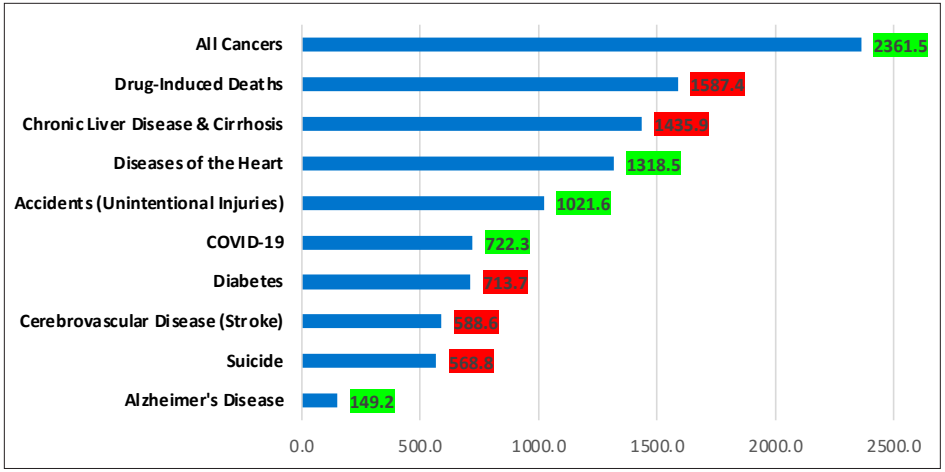
Causes of Death	2019-2021	2021-2023
All-Cause Mortality	625.4	735.0
Diseases of the Heart	137.6	175.1
All Cancers	125.2	130.9
Alzheimer's Disease	43.7	51.6
Accidents (Unintentional Injuries)	43.0	28.8
COVID-19	37.3	41.8
Cerebrovascular Disease (Stroke)	35.7	40.1
Chronic Lower Respiratory Disease	26.7	42.1
Drug-Induced Deaths	23.7	26.7
Diabetes	21.8	30.2
Chronic Liver Disease and Cirrhosis	14.9	22.7

Statistically Significant Increase
Statistically Significant Decrease
No Statistically Significant Difference

Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025.

Another way of analyzing mortality data is by looking at years of life lost (YLL). A premature death occurs when someone does not reach their achievable life expectancy; and this can be measured as YLL. Figure 21 shows the Leading Causes of Premature Death in Ventura County based upon the Age-Adjusted YLL rate per 100,000 population per year. Cancer remains the leading cause of premature death in Ventura, accounting for 2,361.5 years of life lost across the Ventura population. Drug-Induced Deaths and Chronic Liver Disease and Cirrhosis are the second and third leading causes of premature death, up from fourth and sixth, respectively from the previous assessment cycle. Heart disease is now the fourth leading cause of premature death, down from second.

FIGURE 21: AGE-ADJUSTED YEARS OF LIFE LOST RATE PER 100,000 POPULATION PER YEAR, 2021-2023



Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025.

**Rates highlighted in green improved and highlighted in red worsened from the previous assessment period using data from 2019-21.*

Table 6 shows the Leading Causes of Premature Death for males and females based upon the Age-Adjusted YLL rate Per 100,000 population Per year from 2021-2023. The top two leading causes of premature death are the same for both males and females.

TABLE 6: LEADING CAUSES OF PREMATURE DEATH BY GENDER, 2021-2023

Rank	Ventura County	Male	Female
1	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart
2	All Cancers	All Cancers	All Cancers
3	Alzheimer's Disease	COVID-19	Alzheimer's Disease
4	Chronic Respiratory Disease	Chronic Respiratory Disease	Cerebrovascular Disease (Stroke)
5	COVID-19	Drug-Induced Deaths	Chronic Liver Disease
6	Cerebrovascular Disease (Stroke)	Accidental (Unintentional Injuries)	COVID-19
7	Diabetes	Cerebrovascular Disease (Stroke)	Breast Cancer
8	Accidental (Unintentional Injuries)	Alzheimer's Disease	Accidental (Unintentional Injuries)
9	Drug-Induced Deaths	Diabetes	Dementia
10	Chronic Liver Disease	Prostate Cancer	Diabetes

Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025.

Table 7 shows the leading causes of premature death by race or ethnicity based upon the Age-Adjusted YLL rate Per 100,000 Population Per year from 2021-2023. The top two leading causes of premature death are the same for all racial/ethnic groups, which include cancers and diseases of the heart.

TABLE 7: LEADING CAUSES OF PREMATURE DEATH BY RACE OR ETHNICITY, 2021-2023

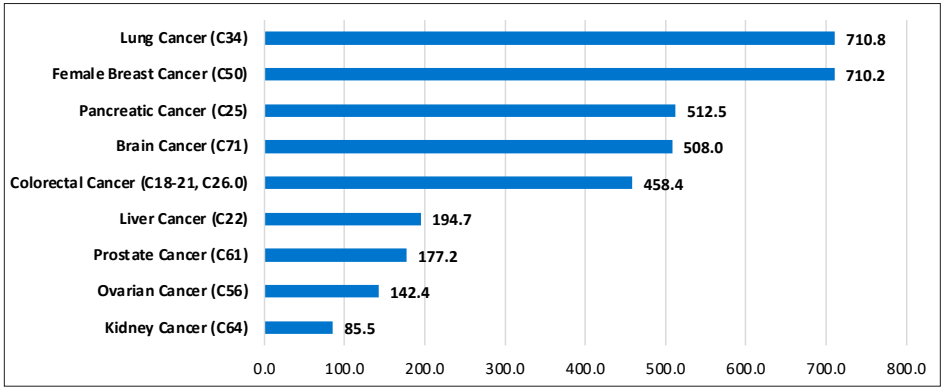
Rank	Hispanic/Latino	White Non-Hispanic	Asian Non-Hispanic	Black Non-Hispanic
1	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart
2	All Cancers	All Cancers	All Cancers	All Cancers
3	COVID-19	Alzheimer's Disease	Alzheimer's Disease	Cerebrovascular Disease (Stroke)
4	Alzheimer's Disease	Chronic Respiratory Disease	COVID-19	Alzheimer's Disease
5	Cerebrovascular Disease (Stroke)	Cerebrovascular Disease (Stroke)	Cerebrovascular Disease (Stroke)	Diabetes
6	Diabetes	COVID-19	Diabetes	Chronic Respiratory Disease
7	Chronic Liver Disease	Drug-Induced Death	Chronic Respiratory Disease	Drug-Induced Death
8	Chronic Respiratory Disease	Accidents (Unintentional Injuries)	Accidents (Unintentional Injuries)	Accidents (Unintentional Injuries)
9	Accidents (Unintentional Injuries)	Diabetes	Dementia	COVID-19
10	Drug-Induced Deaths	Chronic Liver Disease	Suicide	Breast Cancer

Source: Vital Records Business Intelligence System (deaths 2019-2021) and Claritas Pop-Facts (2020), analysis by Ventura County Public Health, March 2022.

4.4.1 Premature Deaths from Cancer

Cancer was the Leading Cause of both Death and Premature Death in Ventura County from 2021-2023. Figure 22 shows the Age-Adjusted YLL rate Per 100,000 population Per year by type of cancer. Female Breast Cancer had the highest Premature Death rate and resulted in an average of 22.4 years of life lost Per death. Lung Cancer had the second highest Premature Death rate and resulted in an average of 19.2 YLL Per Death.

FIGURE 22: ALL CANCERS - AGE-ADJUSTED YEARS OF LIFE LOST RATE PER 100,000 POPULATION PER YEAR, 2021-2023



Source: Vital Records Business Intelligence System (deaths 2021-2023) and Claritas Pop-Facts (2023), California Community Burden of Disease Engine (2023 for California). CDC Wonder, 2023, analysis by Ventura County Public Health, March 2025.

**Codes next to the type of cancer refer to the ICD-10 code.*

Disparities

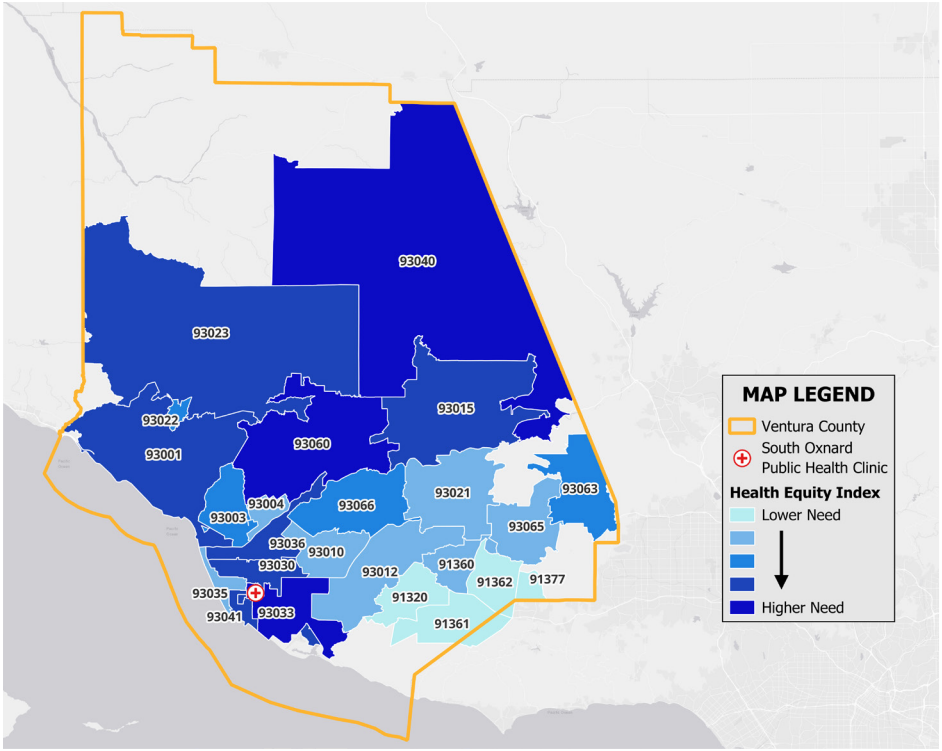
According to the Centers for Disease Control and Prevention, health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Those disparities that are systematic and avoidable and therefore considered unjust or unfair, are considered health inequities (Centers for Disease Control and Prevention, 2024). VCCHIC wants to lessen the disparities by focusing on achieving health equity. "Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

5.1 Health Equity Index

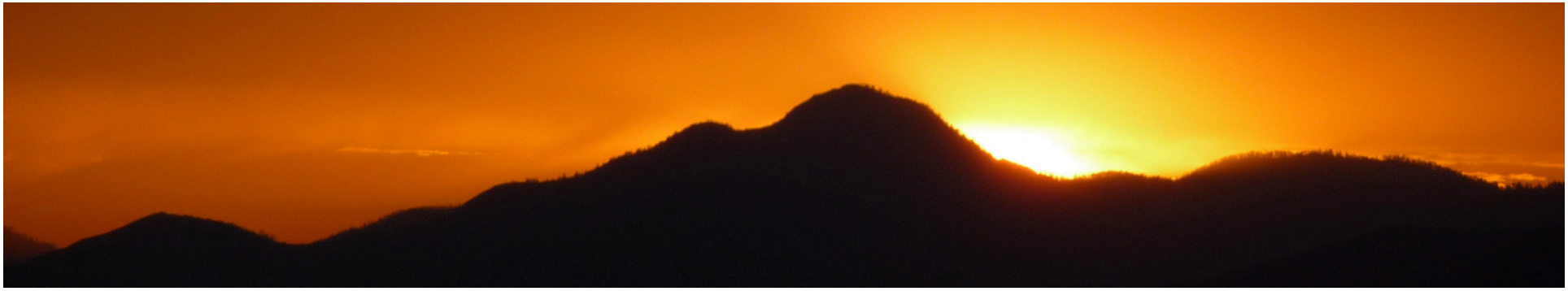
All communities can be described by various social and economic factors that are well known to be strong determinants of health outcomes, as discussed in Section 4 of this report. Conduent Healthy Communities Institute developed the Health Equity Index to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for seven different social and economic determinants of health — income, poverty, employment, educational attainment, linguistic barriers, Medicaid enrollment, and race — that are associated with poor health outcomes including preventable hospitalizations and premature death. Within Ventura County, zip codes are ranked based on their index value to identify the relative levels of need. Those geographic areas with the highest values (from 0-100) are estimated to have the highest socioeconomic need which can be correlated with preventable hospitalizations and premature death.

Relative areas of need, as defined by the 2024 Health Equity Index, are illustrated below in Figure 23. The zip codes in Ventura County with the greatest predicted health needs (as indicated by the darkest shades of blue) are 93040, 93033, and 93060, with scores of 96.2, 92.5, and 91.6, respectively.

FIGURE 23: HEALTH EQUITY INDEX, VENTURA COUNTY, 2024



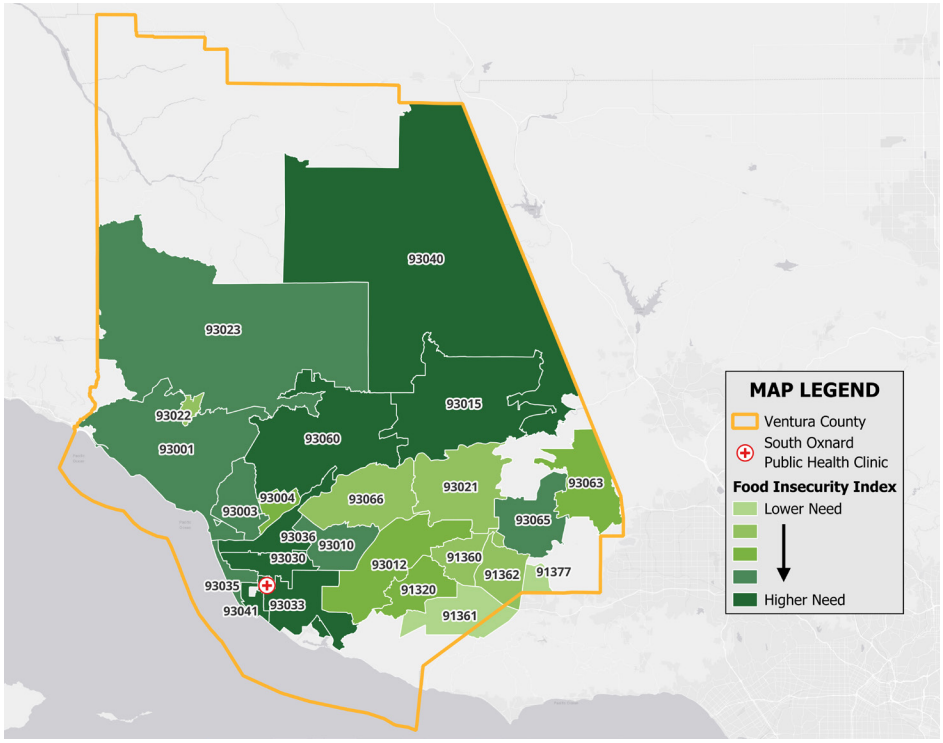
Source: Health Matters in Ventura County



5.2 Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. This index incorporates estimates for four different social and economic determinants of health — poverty, educational attainment, household environment, and personal transportation expenditure — that are associated with higher levels of food insecurity among adults. Zip codes are ranked based on their value to identify the relative levels of need, as illustrated by the map in Figure 24. According to the 2024 FII for Ventura County, the following zip codes have the highest level of food insecurity (as indicated by the darkest shades of green): 93033, 93060, 93041, 93030, 93040, 93036, and 93015. See Appendix A for a detailed FII methodology.

FIGURE 24: FOOD INSECURITY INDEX, VENTURA COUNTY, 2024

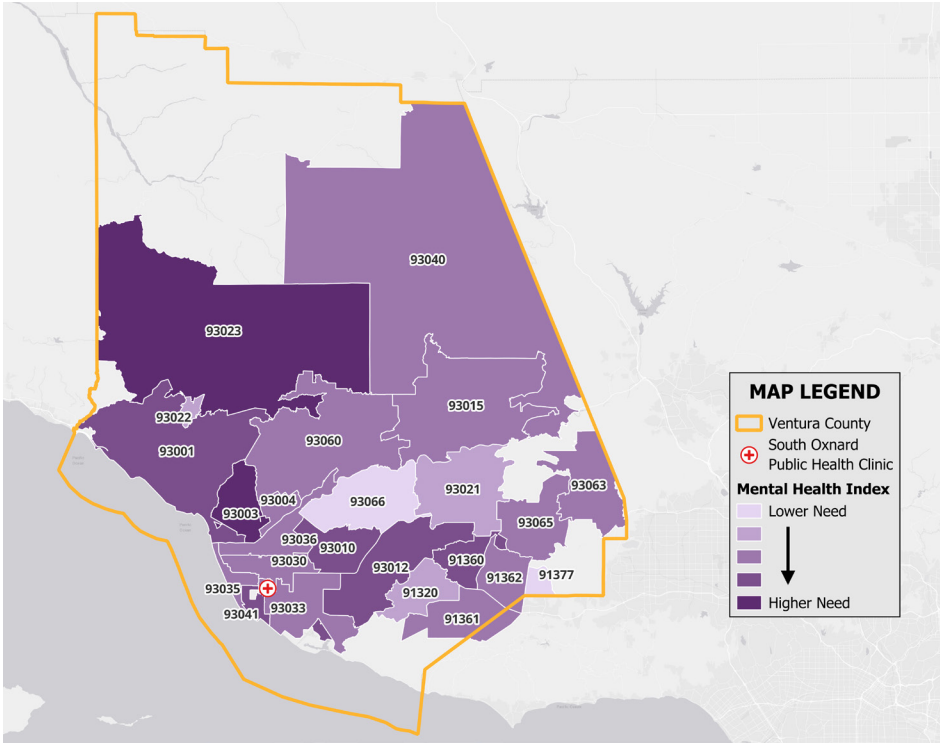


Source: Health Matters in Ventura County

5.3 Mental Health Index

Conduent's Mental Health Index (MHI) estimates areas of greater mental health needs correlated with social and economic hardship. This index incorporates estimates for six different social and economic determinants of health — disability, employment, health care access, health insurance, household environment, and transportation — that are associated with self-reported poor mental health. Zip codes are ranked based on their value to identify the relative levels of need, as illustrated by the map in Figure 25. According to the 2024 MHI for Ventura County, the following zip codes have the highest level of food insecurity (as indicated by the darkest shades of purple): 93023 and 93003 with scores of 60.3 and 54.0, respectively. See Appendix A for a detailed MHI methodology.

FIGURE 25: MENTAL HEALTH INDEX, VENTURA COUNTY, 2024



Source: Health Matters in Ventura County

5.4 Index of Disparity

Critical components in assessing the needs of a community include identifying barriers and disparities in health care. Additionally, the identification of barriers and disparities will help inform and focus strategies for Ventura County to address prioritized health needs. Conduent HCI uses the Index of Disparity, a tool used to summarize disparities across groups within a population, across all indicators.

Table 8 lists the indicators with the greatest, significant race or ethnic disparities and highlights the groups that were impacted.

TABLE 8: INDICATORS WITH SIGNIFICANT RACE OR ETHNIC DISPARITIES, 2020-2022

Disparities by Race or Ethnicity	
Health Indicator	***Population Experiencing Disparities***
Adult Arrest Rate	Black (99.0) White (22.2) Hispanic (51.1)
Adults who Smoke	White (3.1) Hispanic (0.3)
Age-Adjusted Death Rate due to All Opioid Overdose	Black (40.4) White (44.2) API (6.1) Hispanic (22.5)
Age-Adjusted ED Visit Rate due to Heroin Overdose	Black (7.6) White (5.6) Hispanic (3.2)
Age-Adjusted ER Rate due to Adult Alcohol Use	Black (30.1) White (51.2) AIAN (10.1) API (3.7) Hispanic (39.7)
Age-Adjusted ER Rate due to Adult Asthma	Black (28.1) White (11.4) API (3.4) Hispanic (11.5)
Age-Adjusted ER Rate due to Adult Mental Health	Black (111.1) White (78.8) AIAN (17.3) API (20.2) Hispanic (64.7)
Age-Adjusted ER Rate due to Adult Suicide and Intentional Self-inflicted Injury	Black (58.6) White (36.8) API (9.6) Hispanic (23.4)
Age-Adjusted ER Rate due to Asthma	Black (28.0) White (13.2) API (4.3) Hispanic (13.6)
Age-Adjusted ER Rate due to COPD	Black (22.2) White (8.1) API (2.5) Hispanic (4.7)
Age-Adjusted ER Rate due to Dental Problems	Black (41.6) White (23.2) AIAN (8.2) API (4.5) Hispanic (22.2)
Age-Adjusted ER Rate due to Diabetes	Black (32.4) White (19.5) AIAN (14.6) API (6.2) Hispanic (31.7)
Age-Adjusted ER Rate due to Hypertension	Black (52.1) White (22.5) AIAN (7.5) API (20.7) Hispanic (29.6)
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	Black (4.8) White (3.6) API (1.3) Hispanic (6.5)
Age-Adjusted ER Rate due to Opioid Use	Black (12.3) White (11.7) API (0.9) Hispanic (6.6)
Age-Adjusted ER Rate due to Substance Use	Black (32) White (26.3) API (3.8) Hispanic (18.4)
Age-Adjusted ER Rate due to Type 2 Diabetes	Black (29.4) White (16.8) AIAN (14) API (6.2) Hispanic (30.0)
Age-Adjusted ER Rate due to Uncontrolled Diabetes	Black (26) White (13.7) AIAN (10.4) API (4.2) Hispanic (22.6)
Age-Adjusted Hospitalization Rate due to Adult Mental Health	Black (54.9) White (35.9) AIAN (11.0) API (10.5) Hispanic (20.3)
Age-Adjusted Hospitalization Rate due to Hypertension	Black (9.3) White (2.9) API (2) Hispanic (4.2)
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	Black (8.7) White (7.0) API (2.7) Hispanic (14.0)
Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes	Black (8.9) White (6) API (0.7) Hispanic (6.3)

Disparities

Age-Adjusted Hospitalization Rate due to Type 2 Diabetes	Black (17.6) White (11.3) API (4.7) Hispanic (21.0)
Child Abuse Allegation Rate	Black (74.9) White (27.2) AIAN (36.3) API (10.2) Hispanic (50.1)
Child Abuse Investigation Rate	Black (42.1) White (14.9) Hispanic (29.2)
Deaths in Custody	White (0.2) Hispanic (0.1)
Diabetes: Medicare Population	Black (33%) White (20%) AIAN (35%) API (37%) Hispanic (29%)
Families Living Below Poverty Level	White (5.4%) Asian (1.9%) AIAN (34.5%) Mult (7.8%) Other (11.7%) Hispanic (11.4%)
Food Insecurity Rate	White (7%) Hispanic (17%)
Households Below the Real Cost Measure	White (19%) Hispanic (46%)
Juvenile Arrest Rate	Black (19.6) White (3.3) Hispanic (9.3)
Preterm Births	Black (11.6%) White (7.3%) Asian (8.3%) AIAN (0%) PI (0%) Mult (5.9%) Other (0%) Hispanic (8.2%)
Preventable Hospital Stays: Medicare Population	Black (3336) White (1901) AIAN (0) API (1854) Hispanic (2738)

AIAN = American Indian or Alaska Native; API = Asian or Pacific Islander

Community Input

6.1 Community Survey Key Findings

Between January and March 2025, VCCHIC conducted a community survey to assess the needs and priorities of residents in Ventura County. The survey was widely distributed by VCCHIC partners and community-based organizations. The survey included 42 questions about attitudes and experiences related to health care, mental health, substance use, housing services, discrimination, and demographics. A total of 6,681 surveys were collected. The survey was made available both online and on paper with 11.5% of surveys completed on paper.

6.1.1 Demographics of Survey Respondents

VCCHIC members went to great lengths to collect surveys from populations who may be underrepresented through other data collection methods including older adults, Spanish-speaking populations, and those receiving housing, mental health, and substance use services:

- **Language:** 78.6 of surveys were completed in English and 21.4% were completed in Spanish.
- **Age:** While all age groups were represented in the survey, survey respondents were more likely to be older compared to Ventura County residents with 4.1% at 17 years or under, 4.5% at 18-24 years, 26.7% at 25-44 years, 31.5% at 45-54 year, and 33.3% 65 years or older.
- **Race and/or ethnicity:** Survey respondents generally reflected the racial and ethnic diversity of Ventura County: 49.6% White, 43.7% Hispanic/Latino, 5.0% Asian American, 3.3% Indigenous (Latin America), 2.3% Black, 1.7% Indigenous (North America), 0.7% Middle Eastern or North African, less than 1% identifying as Native Hawaiian or Pacific Islander or other Indigenous, and 3% identifying as another category.
- **Gender:** Survey respondents were much more likely to identify as female or woman compared to Ventura County residents with 73.0% identifying as female or woman (compared to 50.9% of Ventura County's population), 25.6% identifying as male/man (compared to 49.1% of Ventura County's population), 1.4% identifying as transgender or nonbinary, and 0.7% self-describing their gender.
- **Zip code:** Survey respondents were geographically distributed across Ventura County, with the highest percentage of respondents from Ventura, Santa Paula, Oxnard, Camarillo, and Ojai.

6.1.2 Top Community Health Priorities

Survey respondents were asked the following questions to better understand their priorities for health: "What do you think makes a healthy community?" and "Which issues deserve the most attention?" Respondents were allowed to select their top three from a list of options. Responses to these questions are shown in Figures 26 and 27. As shown, access to health care, affordable housing, safe communities, a clean environment, good jobs and a healthy economy, and access to community services are key priorities for community members for a healthy community. These themes are generally consistent with those from the 2022 Community Health Assessment Survey. Notably, 82.5% of respondents indicated access to health care as what makes a healthy community and 72.8% of respondents indicated affordable health care as an issue that needed to receive the most attention. This represents a significant portion of respondents compared to other topics, which is consistent with 2016 and 2022 survey findings.

FIGURE 26: RESPONSES TO "WHAT DO YOU THINK MAKES A HEALTHY COMMUNITY?"

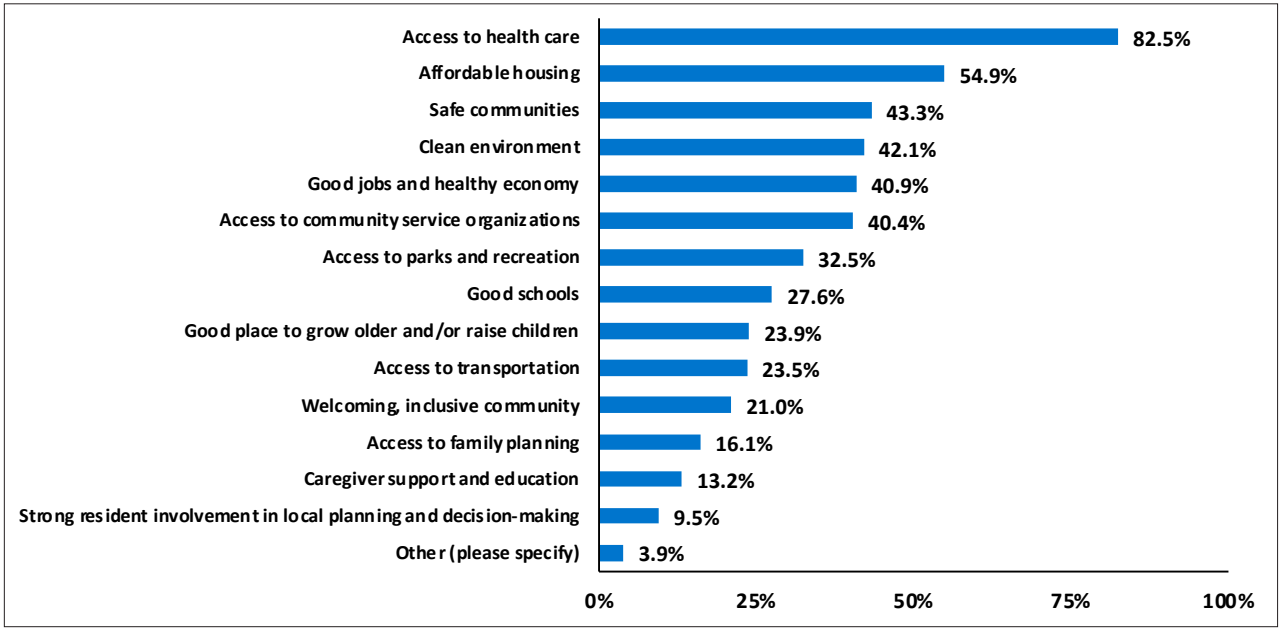
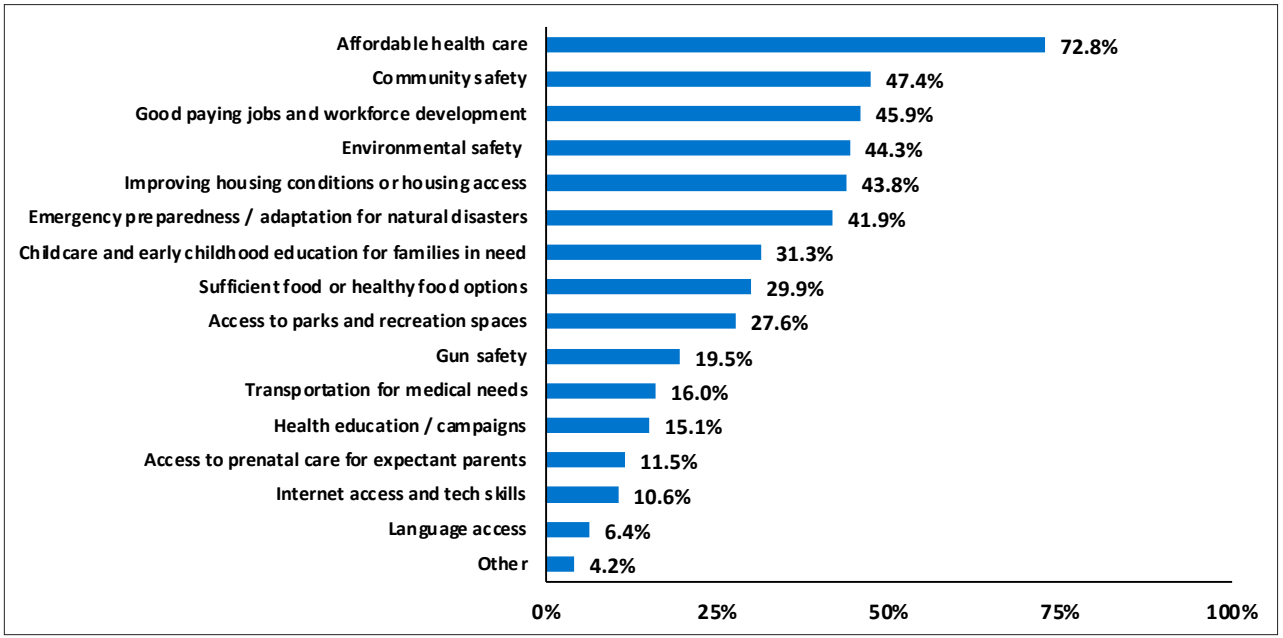
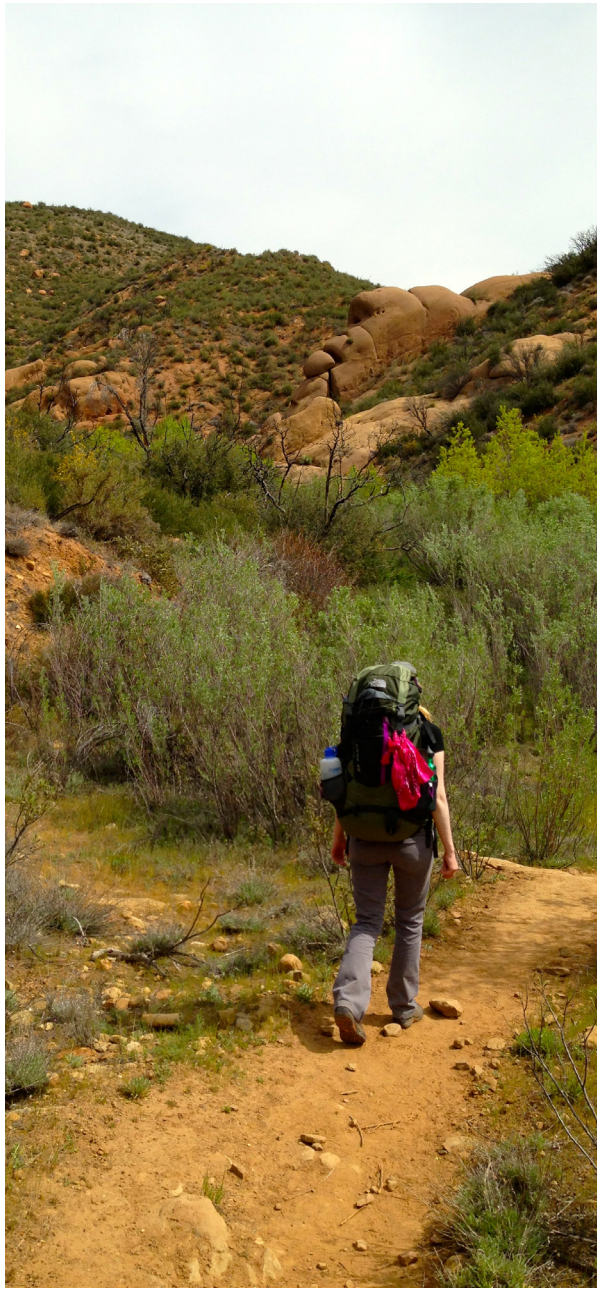


FIGURE 27: RESPONSES TO "WHICH ISSUES DESERVE THE MOST ATTENTION?"





Community Input

To better understand the top health problems community members face, survey respondents were asked "What are the most important health problems in your community?" As shown in Figure 28, the top five responses included 1) Mental Health Problems; 2) Chronic Conditions; 3) Aging Complications; 4) Cancers; and 5) Caregiver Stress. These responses are similar to those in the 2022 Community Health Assessment Survey, in which respondents ranked Mental Health Problems; Cancers; Aging Complications; Diabetes; and Heart Disease and Stroke as the most important health problems in their community.

FIGURE 28: MOST IMPORTANT HEALTH PROBLEMS FOR SURVEY PARTICIPANTS

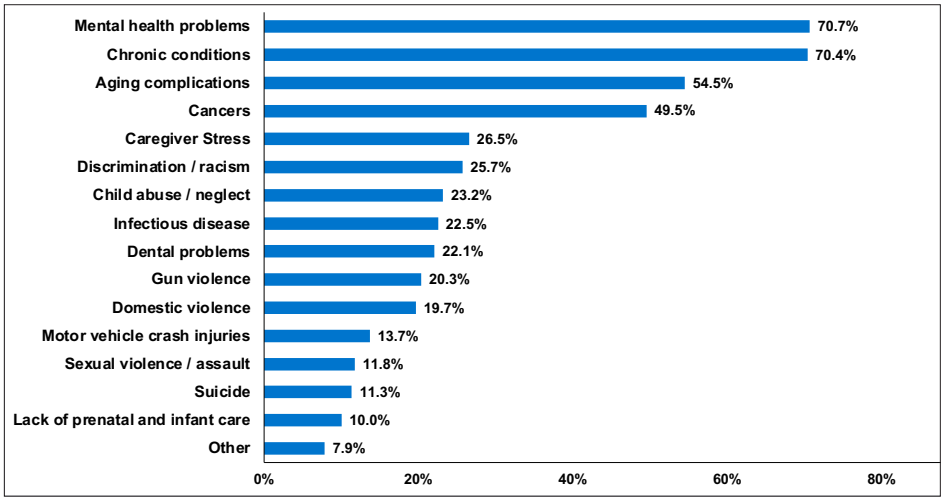
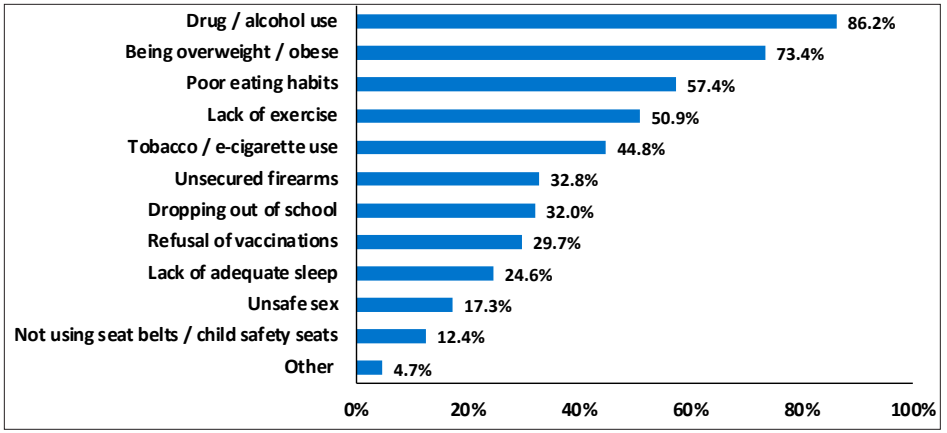


Figure 29 shows responses to the question about top risky behaviors. Drug and Alcohol Abuse, being Overweight or Obese, Poor Eating Habits, Lack of Exercise, and Tobacco or E-Cigarette Use topped the list of topics. This is generally consistent with the top risky behaviors identified in 2022, which included Drug Abuse, Alcohol Abuse, being Overweight or Obese, and Poor Eating Habits. In 2025, Unsecured Firearms was added as a new category for this question and ranked sixth highest as a "risky behavior" by respondents.

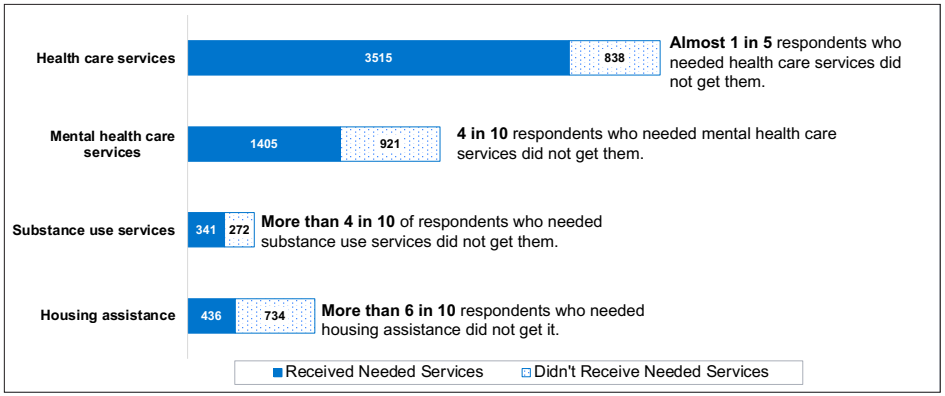
FIGURE 29: RESPONSES TO "WHAT ARE THE MOST 'RISKY BEHAVIORS' IN YOUR COMMUNITY?"



6.1.3 Gaps and Barriers to Care

Figure 30 shows responses to questions about whether respondents received needed health and social services. While most respondents received needed health care services, there were noted gaps, especially by specific populations. Overall, 19.3% of respondents who needed health care services did not receive them. Four in 10 (39.6%) of respondents who needed mental health care services did not get them and 44% of respondents who needed substance use services did not receive them. Finally, most respondents (62.7%) who needed housing assistance did not get it. Lack of access to health care services may have been related to housing instability and income as 28.0% of those who were unstably housed did not get needed services and a greater proportion of those with incomes below $59,999, reported receiving needed health care services.

FIGURE 30: SURVEY RESPONDENTS RECEIVING NEEDED SERVICES



As shown in Figure 31, LGBTQ+ populations were more likely to indicate not receiving health care services they needed. Almost 1 in 3 (31.7%) of those who identified as transgender, or nonbinary reported not receiving needed health care services. More than one in four (25.6%) of those who identify as gay or lesbian, 29.6% of those who identify as bisexual, and 37.9% of those identifying as queer indicated not being receiving needed health care services compared to 17.6% of respondents identifying as heterosexual.

FIGURE 31: SURVEY RESPONDENTS NOT RECEIVING NEEDED HEALTH CARE SERVICES BY GENDER AND SEXUAL ORIENTATION

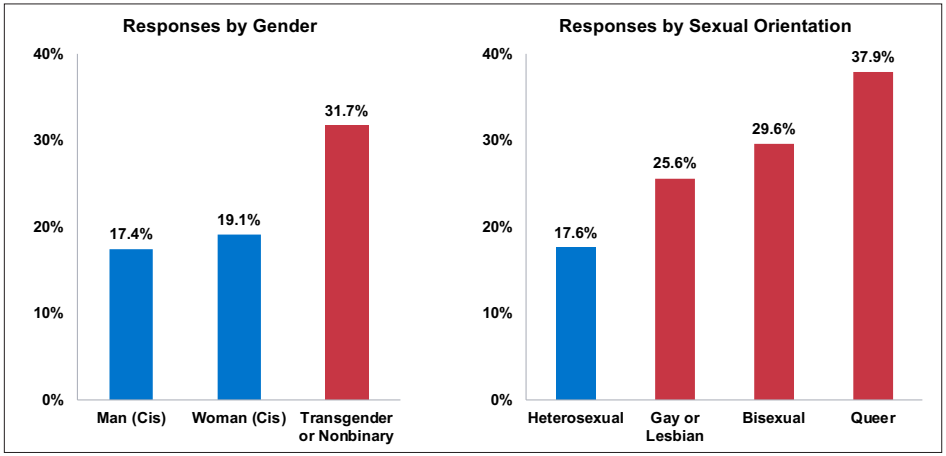
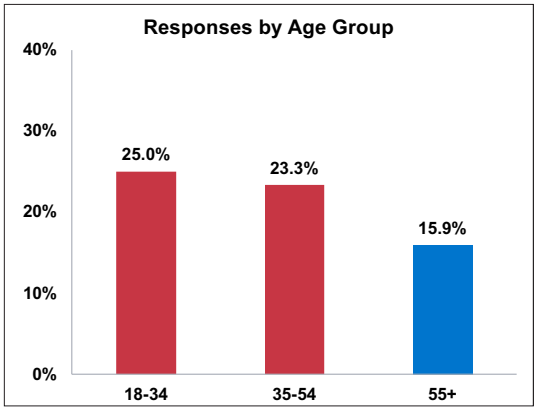


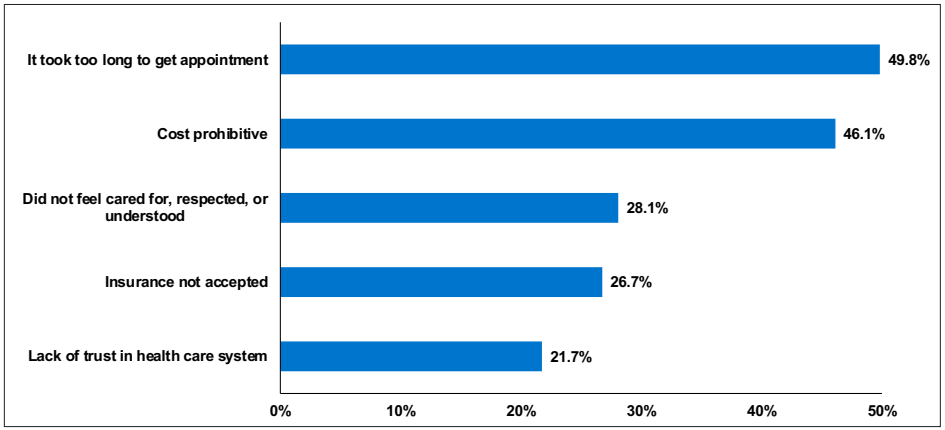
Figure 32 shows that younger populations were also more likely to indicate not receiving needed health care services. While 15.9% of those 55 years and older received needed health care services compared to 25.0% of those ages 18-34 and 23.3% of those between ages 35-54.

FIGURE 32: SURVEY RESPONDENTS RECEIVING NEEDED HEALTH CARE SERVICES BY AGE GROUP



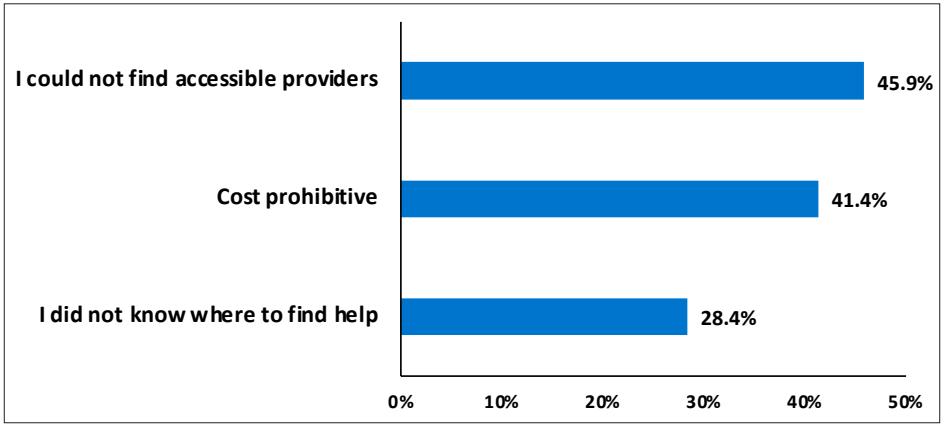
As shown in Figure 33, the most common reasons respondents indicated for not receiving health care services included taking too long to get an appointment, cost, not feeling cared for or respected, insurance not being accepted, and lack of trust in the health care systems.

FIGURE 33: RESPONSES FOR "WHY DID YOU NOT GET NEEDED HEALTH CARE?"



As shown in Figure 34, the most common reasons respondents indicated for not receiving mental health care services included not being able to find providers, cost, and not knowing where to find help.

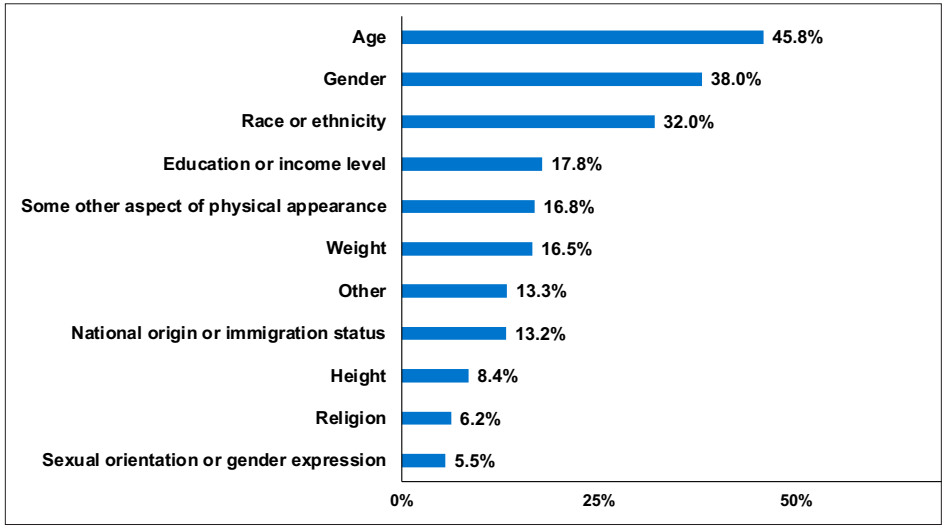
FIGURE 34: RESPONSES FOR "WHY DID YOU NOT GET NEEDED MENTAL HEALTH CARE?"



6.1.4. Experiences of Discrimination

The 2025 Community Health Assessment Survey included several questions about experiences of discrimination. Respondents were asked about experiences such as whether they had experienced being treated with less courtesy, receiving poor service, or people thinking they are not smart. Respondents were then asked the main reason for their experiences. Figure 35 shows responses indicating that age, gender, race and/or ethnicity and education or income level were reasons respondents felt they were experiencing discrimination. These experiences may be correlated with the demographics of survey respondents, who were more likely to be older and identify as a woman compared to the general demographics of Ventura County.

FIGURE 35: RESPONSES FOR "WHAT WAS THE MAIN REASON FOR DISCRIMINATION?"



6.2 Community Focus Groups and Partner Listening Sessions Summary

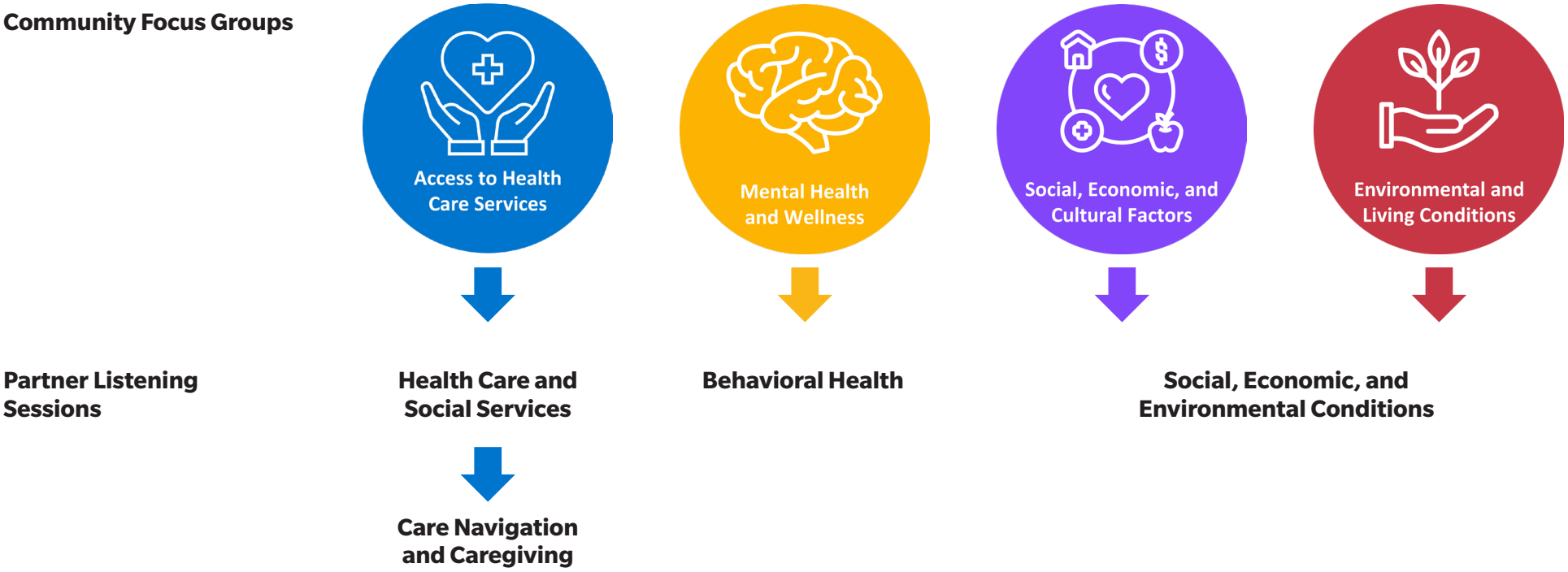
One of the key objectives of this assessment was to engage the community members and partners to understand the assets, needs, challenges, and potential solutions for improving health in Ventura County. Starting in December 2024, VCCHIC worked with community-based organizations to recruit and host focus groups with community members and partner listening sessions.

Between January and March 2025, Conduent HCI and VCCHIC partners facilitated focus groups with community members representing communities who may be at higher risk for poor health outcomes or may otherwise be underrepresented in other data collection processes. Focus groups were conducted with the following populations: 1) Adolescents and young adults; 2) Black and African American populations; 3) Farmworkers (Spanish and Mixteco); 4) Gold Coast Health Plan Community Advisory Committee; 5) Hispanic and Latino populations (Spanish); 6) LGBTQIA+ populations; 7) Older adults and their caregivers; 8) Persons with disabilities and their caregivers; 9) Unhoused and housing insecure individuals; and 10) Veterans.

In February and March 2025, Conduent HCI conducted listening sessions with community partners to understand the current and future capacity of community partners, and potential actions to improve health and address disparities. Discussions were held with community partners serving the following community groups or providing the following services: 1) Adolescent Health; 2) Health Care Services; 3) Behavioral Health; 4) Older Adults' Health; 5) Prenatal, Early Childhood, Childhood Health; and 6) Social Services.

Figure 36 shows the key themes that emerged across the community focus groups and corresponding themes among partner listening sessions:

FIGURE 36: KEY THEMES ACROSS COMMUNITY FOCUS GROUPS AND PARTNER LISTENING SESSIONS



6.2.1 Key Themes Across Community Focus Groups

Access to Health Care Services

Access to health care services was a key theme across focus groups. Barriers to timely and affordable health care, including long wait times, insurance approval processes, and high costs, prevent many from seeking necessary health care. Focus group participants highlighted the following barriers related to access to health care services.

- **Long Wait Times:** Scheduling appointments and communicating with providers can be difficult.
- **Barriers to Access:** Work schedules, transportation issues, and insurance approvals can block access to health care.
- **High Costs:** Many avoid necessary medical care because of cost.
- **Language and Cultural Barriers:** Language differences and a shortage of culturally competent providers make it harder for Spanish-speaking individuals, Indigenous people, LGBTQIA+ individuals, and persons with disabilities to access care.

> Accessing timely and appropriate medical care, tests, and treatments is a significant struggle. They refer me to a specialist, but that specialist can't see me until 23 months away. **– Persons with Disabilities and Caregiver Focus Group**

> I feel like LGBTQ-informed clinicians of health, mental health are few and far between … and they're even less trans-informed clinicians, physicians. **– LGBTQIA+ Focus Group**

Mental Health and Wellness

Mental health was highlighted as a critical component of overall well-being, with the lack of access to mental health resources being a significant concern. Community members groups participants highlighted the following barriers related to mental health and well-being.

- **Need for Accessible and Affordable Services:** More accessible and affordable mental health services, including counseling, therapy, and support groups, are needed.
- **Stigma:** Stigma surrounding mental health issues, especially in certain communities and professions like the military, can prevent people from seeking help.
- **Complex System:** Navigating the mental health services system is often described as complex and frustrating.

> People in general don't wanna get tagged having mental health issues 'cause no matter how society's trying to make it, there is a stigma…And then being in the military, Lord knows you never want anyone to say you got a mental health problem. **– Veterans Focus Group**

> La salud mental en los jóvenes no sé qué es lo que está pasando, que hay una desconexión tan grande. **– Hispanic and Latino Focus Group**

Social, Economic, and Cultural Factors

Focus group participants highlighted social, economic, and cultural factors as a key impact on health. The high cost of living, lack of time, and the food environment make it difficult for people to prioritize their own health. Community members expressed the following barriers related to this topic.

- **Cultural Traditions:** Cultural traditions and lack of nutrition education often lead to unhealthy eating habits, which are passed down through generations.
- **Cost of Healthy Food:** Healthy food is less affordable than less healthy food.
- **Time Constraints:** People struggle to prioritize health education due to lack of time and competing priorities.
- **Cultural Norms and Stigmas:** Stigmas around topics like mental and sexual health create barriers to care.

> The behaviors and the cultural influence in dietary preferences leads to high risk for health issues and developing diabetes. **– Gold Coast Community Advisory Committee**

Environmental and Living Conditions

Environmental conditions, such as air and water quality, and neighborhood safety can impact access to health care and overall health. Focus group participants highlighted the following barriers related to this topic.

- **Poor Air Quality:** Poor air quality, especially during wildfires, cause significant health concerns.
- **Safety and Crime:** Crime in some neighborhoods deters physical activity and access to resources.
- **Chemical Exposure:** Exposure to agricultural chemicals and pesticides pose health risks to the broader community, not just those working in the fields.

> A lot of respiratory issues because of the pollution. Like my niece and nephew, they have really bad asthma. **– Adolescent and Young Adult Focus Group**

> Pues aquí obviamente es una comunidad agrícola. Y es sabido que todas las personas, aunque no estemos directamente en el campo, estamos expuestos a todos esos químicos que se usan para los campos, entonces de una u otra forma, todos estamos expuestos a esa contaminación. **– Farmworkers Focus Group**

6.2.2 Key Themes Across Partner Listening Sessions

Health Care and Social Services

People struggle to navigate complex health care and social services systems, especially the most vulnerable, including unhoused and older adult populations. The following key themes were highlighted:

- **Navigation:** People with multiple diagnoses struggle to navigate complex health care and social services systems including finding appropriate providers and coordinating care.
- **Delays in Accessing Health care:** A shortage of providers, particularly for specialized services, causes delays in health care appointments.
- **Coordination:** Poor collaboration and coordination between agencies creates more barriers to accessing support.
- **Funding:** Funding for social services is at risk, threatening the health of the vulnerable.
- **Social Security:** Threats to Social Security affect older adults' survival and highlight issues in health literacy, wellness and prevention.

> Most of our [clients] are full-service partnership and most are on Social Security which is critical to their existence to housing and associated food services. [Loss of Social Security benefits] could literally be life or death impact for our population and that scares me for them.
> **– Behavioral Health Listening Session**

Behavioral Health Services

Community partners emphasized the need for accessible and culturally competent mental health services. The following key themes were highlighted:

- **Accessibility:** More accessible and culturally competent mental health services are needed, especially for populations that are underserved such as LGBTQIA+ youth, postpartum women, and trauma-affected adolescents.
- **Barriers:** Provider shortages, language, culture, distrust of the medical system and a need for more education and de-stigmatization around mental health prevent residents from accessing services.

> I think right now in our political climate there is a lot of suicidal ideation with young folks…there is increased hostility and rejection…from family relationships in addition to friendships, but just this feeling of hopelessness. **– Behavioral Health Listening Session**

Care Navigation and Caregiving

Lack of affordable and reliable caregiving support strains families. The following key themes were highlighted:

- **Caregiver Shortage:** There is a growing need for qualified, consistent, affordable and culturally competent caregivers, especially for home-based health care that is causing stress and financial strain on individuals and families.
- **Transportation Challenges:** Older adults and people with disabilities struggle with transportation to essential services, leading caregivers to lose work time managing travel.
- **Impact of Unpaid Caregiving:** Unpaid caregiving drains financial and emotional reserves worsening mental health needs in the community.

> We have three rural clinics. If they're aging it's just too hard [to travel to the clinic]…and they don't know how to use the technology to try to get online…there are all kinds of combined issues for the unhoused and aging populations. **– Health Care Services Listening Session**

Social, Economic, and Environmental Conditions

Housing insecurity and high living costs worsen health issues and force tough choices between food, rent and health care. The following key themes were highlighted:

- **Cost:** High cost of living forces difficult choices between meeting basic needs and health care.
- **Housing:** Insecurity and lack of affordable housing worsen health challenges.
- **Safety:** Fear of deportation and threats to personal safety creates stress for undocumented families.
- **Transportation:** from rural areas to services is insufficient to address the needs.

> Social Security is being reviewed for potential cuts... housing takes most of your income... in a high-cost area like Ventura County. – **Behavioral Health Listening Session**

6.2.3 Communities Of Concern

Participants of community focus groups and partner listening sessions expressed special concern for the following populations during discussions:

Undocumented immigrants and other immigrant groups:

Participants discussed the undocumented community as facing significant challenges in affording housing, meeting rising costs of living and accessing support resources. Participants discussed the fear of deportation that lately affects these groups and the impacts on stress, personal and family security and overall mental health. Discussed the undocumented community as facing significant challenges, including fear of being targeted and a reluctance to access health care services.

> Individuals were calling [payer providers] and cancelling their health coverage because they thought that the information would be shared with the federal government and lead to deportation. – **Behavioral Health Listening Session**

> With the current climate, these people are afraid to go places. I mean not going to go to the doctor. Maybe not even go to the emergency room because, they're afraid someone's gonna pick them up. – **Veterans Focus Group**

Older Adults and Disabled Populations and Their Caregivers

Participants expressed concern for older adults, especially those with limited income, who may be isolated or have difficulty accessing needed services. Older adult and disabled populations, especially those that are homebound, are noted as particularly vulnerable. Family caregivers to both these populations struggle in low-income and/or rural settings to source or provide continuity of adequate care.

> I think about seniors and elderly who don't have the resources or even transportation to get this kind of information.
> **– Black and African American Focus Group**

> Transportation [to access health care] needs to be door to door…we [also] need people that would be willing to go into the home…it's so expensive to provide caregivers… [and] people want to age in place.
> **– Older Adults' Health Listening Session**

Children and Transitional Age Youth

There was concern for the health of children who have less autonomy and who are subject to conditions that could be harmful to their well-being. In addition, partners expressed that transitional age youth and incarcerated youth need targeted support during key life transitions.

> I know a lot of youngsters that their family they have to move from all the projects and now their families are struggling, now the little kids pretty much just gather up and now they're into gangs. **– Unhoused and Housing Insecure Individuals Focus Group**

> The need for trauma informed care is the biggest [concern related to behavioral health]…there seems to be huge gaps in services throughout [Ventura] County geographically, culturally and linguistically.
> **– Adolescent Health Listening Session**

Unhoused and Housing Insecure Individuals

The unhoused population is a concern with particular focus on those with unstable housing. Rising costs of living often exacerbate the growing housing crisis and require that individuals and families choose between meeting basic needs and seeking health care.

> [Residents think] I'll have one meal today because I've got to save up money for my rent…there are 3 to 5 families living in a household because they can't afford to pay rent.
> **– Behavioral Health Listening Session**

6.2.4 Community Focus Group Summaries

Adolescents and Young Adults Focus Groups Summary

The following is a summary of findings from focus groups conducted with adolescents and young adults in February 2025. Participants recognized key assets available in the community to support health including wellness centers, physical education, and school resources. Key themes included barriers to accessing health care and health resources, the importance of healthy lifestyle choices and nutrition, the significance of mental health support and wellness resources, the impact of environmental factors on health, and the challenges faced by marginalized groups in accessing equitable health care. Participants expressed concerns about socioeconomic disparities, the availability and affordability of health care services, the prevalence of unhealthy food options, and the need for more comprehensive and inclusive health initiatives within their communities.

Black and African American Focus Group Summary

The following is a summary of findings from a focus group conducted with Ventura residents identifying as Black or African American in March 2025. Participants recognized key assets available in the community to support health including community clinics, hospitals, gyms, healthy spaces, and available exercise programs for older adults. Participants emphasized the need for more education and access to resources, such as free clinics and informational materials, to help people,

especially older adults and the Black community, learn about nutrition, disease prevention, and healthy living. The high cost and lack of accessibility of healthy food options, especially for those experiencing homelessness or limited resources, is a significant barrier to maintaining a healthy diet. Generational and cultural factors, such as traditional cooking methods and family influences, also play a role in shaping eating habits and health behaviors. Additionally, people struggle with a lack of personal motivation and accountability for their health and desire more empathy and understanding from health care providers and social service programs to address their individual needs and circumstances.

Gold Coast Community Advisory Committee Focus Group Summary

The following is a summary of findings from a focus group conducted with the Gold Coast Community Advisory Committee in January 2025. The feedback comments highlight the significant challenges and concerns faced by the community due to recent events and executive orders. People were deeply worried about the increased targeting and profiling of immigrant families, which has led to a profound sense of fear and instability. This fear has created major barriers to accessing essential health care services, as families are hesitant to leave their homes or engage with providers they do not know and trust. At the same time, participants expressed frustration with the slow and inflexible regulatory processes that hinder the implementation of new, more responsive service delivery models. There was a strong emphasis on the need to strengthen community partnerships and leverage trusted relationships to effectively reach and support families. Additionally, participants suggested exploring innovative approaches, such as telehealth, remote monitoring, and home-based care, to address the community's evolving needs and concerns. Overall, the feedback highlights the urgent need for a comprehensive and collaborative approach to addressing the multifaceted challenges faced by the community, with a focus on building trust, increasing flexibility, and implementing innovative solutions to ensure equitable access to health care and other essential services.

LGBTQIA+ Focus Groups Summary

The following is a summary of findings from a focus group with individuals who identify as LGBTQIA+ in February 2025. The conversation revealed a range of challenges people face in accessing inclusive and knowledgeable health care services in Ventura County. Participants recognized key assets available in the community to support health including outreach and testing services, partnerships with public health services, community clinics, and limited LGBTQIA+-focused service providers that offer culturally competent care. Key issues include a lack of LGBTQIA+-informed providers, inadequate sexual health education, barriers to mental health care, and cultural insensitivities that alienate diverse communities. Underlying these problems is a lack of funding and resources dedicated to supporting the health care needs of LGBTQIA+ individuals and other marginalized groups. Participants expressed frustration at having to navigate complex systems and advocate for themselves just to receive basic care, with those facing intersecting marginalities often bearing the heaviest burden.

Older Adults and Caregivers Focus Group Summary

The following is a summary of findings from a focus group conducted with older adults and their caregivers in February 2025. Participants recognized key assets available in the community to support health including walkable spaces, local hospitals and community clinics, supportive services, support groups, and various programs for older adults. The feedback comments highlight the significant challenges and struggles faced by caregivers, including overwhelming stress and burnout, difficulties navigating the health care system, lack of comprehensive caregiver training and support services, and the need for emotional and psychological support. Caregivers expressed a desire for more visibility and awareness of the available resources and services in their communities to help them cope with the demands of caregiving. The comments suggest a need for a more holistic and supportive approach to address the multifaceted needs of caregivers, from improving access to care coordination and caregiver training to providing mental health resources and increasing overall awareness of the caregiver experience.

Persons with Disabilities and Caregivers Focus Group Summary

The following is a summary of findings from a focus group conducted with persons with disabilities and their caregivers in March 2025. Participants recognized key assets available in the community to support health including opportunities for home and community exercise, Special Olympics, and community and school programs. The feedback comments reveal a range of challenges that people with disabilities and their families face in accessing appropriate health care, resources, and support. Key issues include navigating the complex health care system, finding suitable programs and services, especially for teenagers and adults, and the lack of disability-specific training and knowledge among health care providers. Families

also struggle with supporting their adult children with disabilities as they age, and ensuring their loved ones receive necessary preventive care like breast cancer screening. Overall, the comments highlight the need for more comprehensive, tailored, and accessible resources and services to better meet the diverse needs of individuals with disabilities and their caregivers.

Spanish-Speaking Focus Groups Summary

The following is a summary of findings from focus groups with Spanish-speaking residents and farmworkers in March 2025. Key themes include the health impacts of environmental exposures like chemicals, pollution, and wildfire; struggles with mental health issues, stress, and lack of support; barriers to accessing affordable health care and health insurance; concerns about affordability and access to healthy foods; and a desire for more information and resources from community organizations. Overall, the comments suggest a need for increased education, outreach, and support to address the diverse health needs of this community.

Unhoused and Housing Insecure Individuals Focus Group Summary

The following is a summary of findings from a focus group conducted with unhoused and housing insecure individuals in February 2025. Participants recognized key assets available in the community to support health including local churches, county health and behavioral health department, substance use treatment services, and community-based organizations providing services for unhoused and housing insecure individuals. The feedback comments highlight the significant challenges people face in finding stable housing and accessing appropriate resources to address their needs. People describe barriers such as discrimination from landlords, lack of rental history or credit, and the criminalization of homelessness through new shelter policies. They also express frustration with the complex systems and processes required to navigate and receive assistance, often feeling that resources are not reaching those who need them most. Stigma and negative perceptions towards individuals with low income and families create additional obstacles, with people reporting experiences of class discrimination and lack of understanding from service providers and the community. The feedback also emphasizes the severe physical and mental health impacts of homelessness, and the need for specialized, trauma-informed support to address these issues. Despite these challenges, participants shared examples of organizations and programs that have provided valuable assistance, such as the National Health Foundation, Community Memorial Healthcare, and Saint Vincent de Paul. They also highlight the importance of peer support and one-stop- shops that can help connect individuals to a range of resources and services.

Veterans Focus Group Summary

The following is a summary of findings from a focus group conducted with veterans in February 2025. Participants recognized key assets available in the community to support health including veterans' organizations such as Gold Coast Veterans Foundation, Salvation Army, and US Vets, local hospitals, and Veterans Affairs (VA). The feedback comments provided by people cover a range of topics related to health care access and community wellness. Key themes include the importance of outreach and mobile health care services to reach underserved populations, the need to address mental health stigma and support, and the value of promoting healthier lifestyles through education, incentives, and community engagement. Participants also emphasized the role of veteran-focused organizations in providing tailored services and fostering a sense of community. Additionally, they identified barriers such as high health care costs, transportation challenges, and cultural stigmas that can prevent people from accessing the care they need. Overall, the feedback highlights the multifaceted nature of improving community health and wellness, with a focus on increasing access, reducing barriers, and leveraging community resources and connections.

6.2.5 Partner Listening Session Summaries

Adolescent Health Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with partners that serve the adolescent and young adults in the community. Participants, representing various organizations, shared insights on challenges such as mental health, access to health care based on immigration status, and the need for culturally responsive and trauma-informed care. The conversation highlighted the importance of support systems, stigma reduction, and the role of funding in facilitating services. The effectiveness of teen centers, school-based wellness centers, and collaborative efforts was also discussed, alongside the need for advocacy and parent education to bridge service gaps. Participants identified mental health as

the most pressing challenge for adolescents, emphasizing the need for therapy and support groups, especially for LGBTQ+ youth and those affected by the current political climate. Access to health care based on immigration status was discussed as a significant barrier, with bullying at schools and financial situations exacerbating mental health issues. The need for culturally responsive and trauma-informed care was highlighted, particularly for youth in custody and those with adverse childhood experiences. The lack of support from family, schools, and peers was identified as a root cause of mental health challenges, with stigma being a significant barrier to seeking help. Funding was repeatedly mentioned as a barrier to providing adequate mental health services, with strict parameters and bureaucracy complicating the process.

Health Care Services Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with health care partners that serve the community. Participants discussed various challenges and opportunities related to health care access, mental health services, and the social determinants of health. The conversation included identifying barriers such as transportation, awareness of resources, and coordination of services. Participants also highlighted the importance of culturally competent care and the impact of policy changes on vulnerable populations. The session aimed at gathering insights to inform collaborative efforts for improving health outcomes in the community. Participants identified mental health as a top health need, citing a lack of providers and difficulties in accessing care, especially for specific populations like the elderly and LGBTQ individuals. Access to health care was discussed as a critical issue, with long waiting times for appointments and a shift towards out-of-pocket payment models that are unaffordable for many. Participants highlighted the impact of social determinants such as housing, food insecurity, and transportation on health, emphasizing the need for comprehensive support systems. The discussion identified barriers to service, including mistrust and fear among populations, particularly due to immigration status and potential program cuts. Participants shared examples of effective programs such as Enhanced Care Management (ECM) and caregiver navigation and discussed opportunities for leveraging collaborative efforts to improve health outcomes.

Behavioral Health Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with partners that provide Behavioral Health services in the community. The conversation was rich with insights from professionals working with diverse populations, discussing the challenges and solutions related to social security, housing insecurity, substance use, and the impact of these issues on mental health. Participants expressed concern over the potential impact of Social Security threats on vulnerable populations, particularly those with severe mental illness who rely on these benefits for their basic needs. Housing insecurity was highlighted as a significant health need, with high costs and scarcity of affordable housing forcing individuals to make difficult choices, such as skipping meals to pay rent. Substance use was identified as a barrier to addressing mental health issues, with a lack of dual diagnosis programs and the need to address substance use before mental health in some services. Fear of deportation was discussed as a key factor affecting mental health, leading to individuals avoiding participation in programs and services due to concerns about information sharing with government entities. Participants noted that individuals with limited English proficiency face significant barriers in accessing services, compounded by stigma and a lack of representation among service providers.

Older Adults' Health Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with partners that serve the older adults in the community. The conversation touched on issues such as mental health services, caregiver support, transportation, and the challenges faced by the "forgotten middle class." The participants also considered the role of technology, the importance of education and outreach, and the need for better coordination among service providers. Participants identified a shortage of mental health practitioners and services for the older adult population, emphasizing the need for more providers with expertise in geriatric care. The conversation highlighted the challenges of caregiver affordability and the stress on families to provide or finance caregiving, especially for those not qualifying for public assistance. Transportation was repeatedly mentioned as a significant barrier, with issues such as long wait times, limited-service areas, and the need for door-to-door service being discussed. Participants noted a lack of education and outreach as a key driver of health issues, suggesting that better information dissemination could help prevent crises and improve service navigation. The need for better coordination and collaboration among agencies and service providers was a recurring theme, with participants suggesting that this could reduce duplication of efforts and improve the system of care.

Prenatal, Early Childhood and Childhood Health Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with partners that serve mothers and young children in the community. Participants discussed various challenges such as access to care, housing, mental health, childcare, and the difficulties faced by certain populations like the Mixteco community, single-parent households, and teens. The conversation also touched on barriers to service provision, effective programs, and opportunities for improvement. The dialogue was solution-oriented, with an emphasis on collaboration, resource availability, and direct community involvement to better understand and meet health needs. Participants identified a shortage of providers and difficulty scheduling timely appointments as significant barriers to accessing care. There was a consensus on the need for better coordination and availability of both primary and specialty care. Housing insecurity and mental health were highlighted as top health needs, with a focus on the impact of housing costs, availability, and the specific mental health challenges faced by pregnant women and children. The Mixteco community, single-parent households, and teens were identified as populations that are particularly difficult to reach and serve, with language barriers, health care literacy, and cultural differences being significant obstacles. Participants discussed various barriers to providing services, including staffing issues, lack of knowledge about available resources, and the complexity of navigating health care systems. Effective programs such as community health workers, health navigators, and school-based initiatives were praised for their impact. Opportunities for improvement included leveraging collaborations, enhancing social media presence, and involving the community directly in conversations.

Social Services Listening Session Summary

The following is a summary of findings from listening sessions conducted in March 2025 with partners that provide social services to the community. Participants discussed topics such as mental health, housing, and the challenges faced by specific communities like the undocumented and indigenous populations. The conversation also touched on the effectiveness of existing programs, barriers to service delivery, and opportunities for improvement. The participants, representing a diverse array of service providers and stakeholders, shared insights into the complexities of health needs, the impact of trauma, and the importance of funding and collaboration to enhance health outcomes in their community. Mental health was identified as a top health need, with participants discussing the impact of trauma, the importance of follow-through in care, and the challenges faced by previously homeless individuals. Funding was repeatedly mentioned as a critical barrier to addressing health needs, with concerns about the sustainability of programs and the need for financial resources to support housing, mental health services, and other health-related initiatives. Housing challenges, including homelessness, were highlighted as significant health needs, with a focus on the lack of affordable housing and the need for supportive services for those experiencing homelessness. Participants discussed the difficulties in navigating health services, particularly for vulnerable populations, and the need for better coordination and support to connect individuals with the appropriate care. The conversation highlighted the unique challenges faced by undocumented and indigenous populations, including fear of deportation, language barriers, and cultural misunderstandings, which contribute to these communities being difficult to reach and serve.

Secondary data used in this assessment consisted of community health indicators, while primary data consisted of focus group discussions, and a community survey. Findings from these data sources as well as from Life Expectancy and Years of Life Lost analysis were combined to identify the significant health needs for Ventura County.

Data Synthesis and Identification of Significant Health Needs

To gain a comprehensive understanding of the significant health needs, the findings from all five data sources were analyzed for areas of overlap. Secondary data used in this assessment consisted of community health indicators, while primary data consisted of community member focus group discussions, partner listening sessions and a community survey. Findings from these data sources as well as from Life Expectancy and Years of Life Lost analysis were combined to identify the significant health needs for Ventura County.

7.1 Criteria for Significant Health Needs

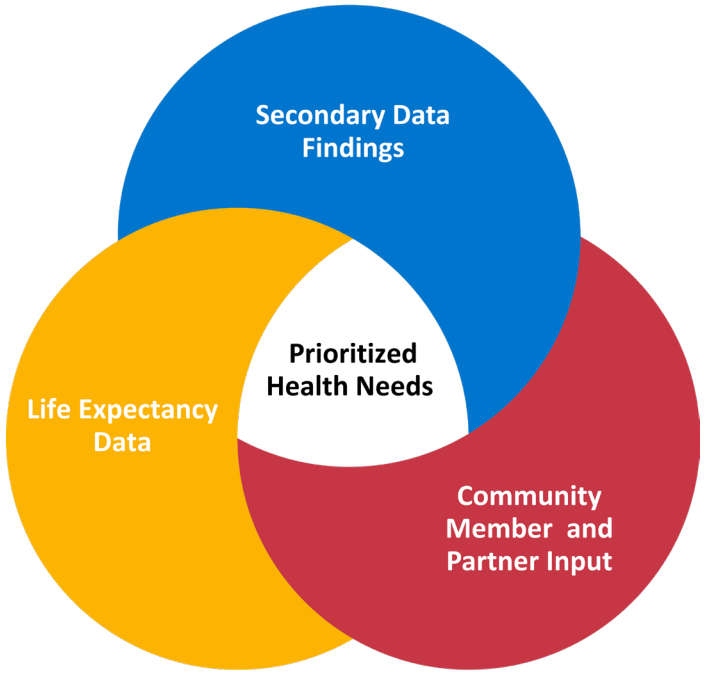
Health needs were determined to be significant if they met the following criteria in at least one of the three data sources: scoring 1.45 or higher in the secondary data analysis, frequency by which the topic was discussed across focus groups and listening sessions, identification as a priority issue by 20% or more of survey respondents and inclusion as a leading cause of death. Figure 37 visualizes these criteria

FIGURE 37: VISUAL OF DATA SYNTHESIS APPROACH

7.2 Data Synthesis

The data synthesis process combines sources of secondary data with community input and life expectancy findings to identify significant health needs in the community. This process involves a systematic examination of health indicators from secondary data sources alongside insights obtained from community member focus groups and partner listening sessions as well as findings of life expectancy data analysis.

FIGURE 38: DATA SYNTHESIS VENN DIAGRAM



7.2 Significant Health Needs

Based on the criteria shown in Figure 48, fifteen needs emerged as significant. Figure 39 shows those significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all CHNA data types.

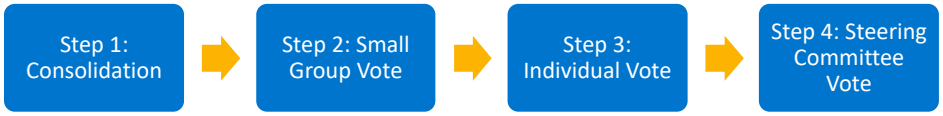
FIGURE 39: SIGNIFICANT HEALTH NEEDS

- Access to Health Care & Social Services
- Adolescent Health
- Cancer
- Care Navigation & Caregiving
- Children's Health
- Chronic Diseases
- Community
- Economy
- Education
- Environmental Health
- Infectious Diseases
- Mental Health & Mental Disorders
- Nutrition, Healthy Eating & Physical Activity
- Older Adults
- Prevention & Safety
- Respiratory Diseases
- Socio-Political Environment
- Substance Use
- Women's Health

8.1 Prioritization Process

In April 2025, VCCHIC convened a meeting of Steering Committee member organizations and community input events (focus groups and listening sessions) host organization representatives to participate in an HCI-facilitated presentation of primary and secondary data. During the 2.5-hour virtual meeting, 47 participants met to discuss findings, consolidate the list of significant health needs and vote, both in small groups and individually, for the top three health topics that they considered VCCHIC to be uniquely suited to address over the next three years of the Community Health Needs Assessment (CHNA) cycle.

FIGURE 40: PRIORITIZATION PROCESS

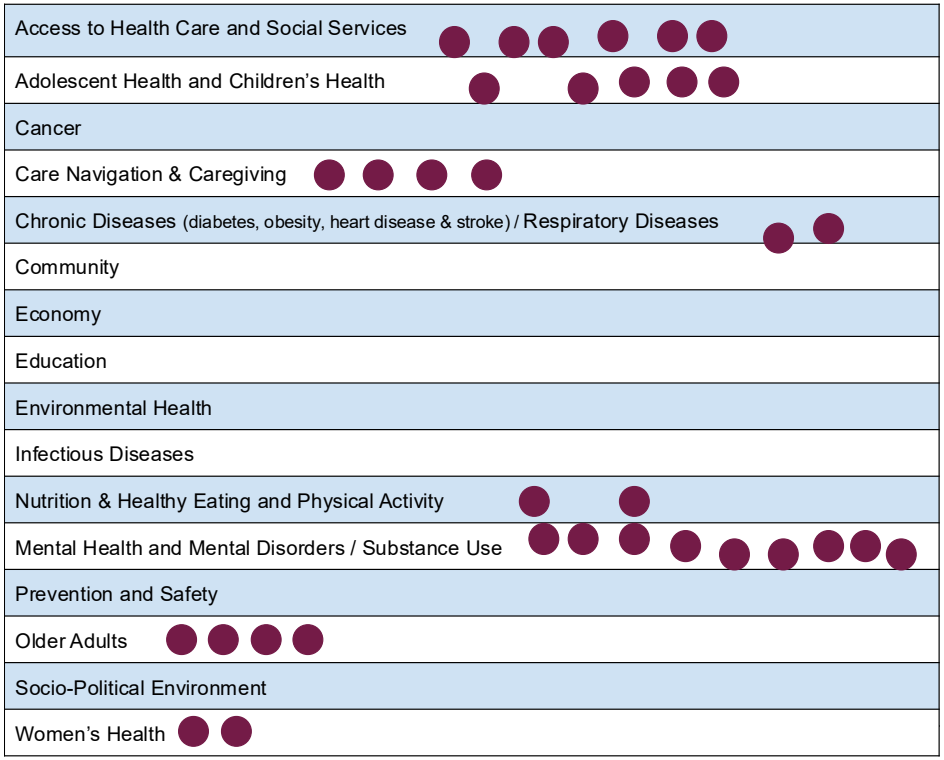


The week following the prioritization presentation, the VCCHIC Steering Committee -- representing local non-profit hospitals, the behavioral and public health departments, community clinics, Medi-Cal Managed Care plans, and health district – met to discuss the outcomes of the prioritization session votes, remove any health topics that fall outside of VCCHIC's ability to impact and conducted a final vote to identify the top health needs. On the recommendation of senior leadership, Steering Committee members voted to remove Access to Health Care and Social Services and Care Navigation from the list of health topics prior to the vote with the rationale that these topics are already integral to the operations, mission, vision and values of each VCCHIC organization and, therefore, should not be considered as separate health topics in the Community Health Implementation Strategy (CHIS).

Prioritization Session Vote

During the prioritization session, virtual attendees participated in small group break-out discussions to express thoughts about secondary, primary, and mortality data findings presented. At the end of the session, facilitators asked the group to consolidate related health topics and vote as a group on the top three health topics they considered VCCHIC to be uniquely positioned to address in the next three years. Figure 41 shows the results of that group vote.

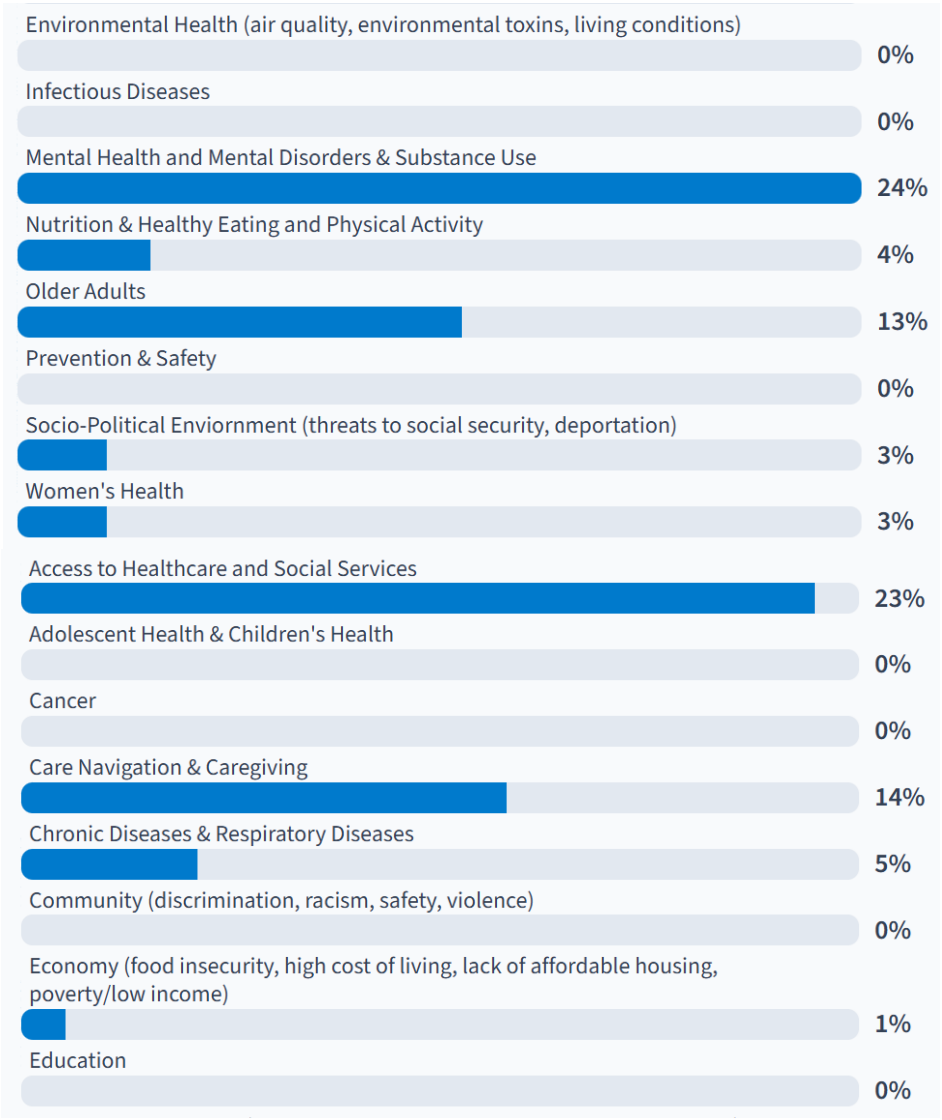
FIGURE 41: SMALL GROUP VOTE RESULTS



Immediately following the group vote, participants accessed a live polling tool to rank-vote the top three health needs. Figure 42 shows the results of that individual voting.

Prioritization of Significant Health Needs

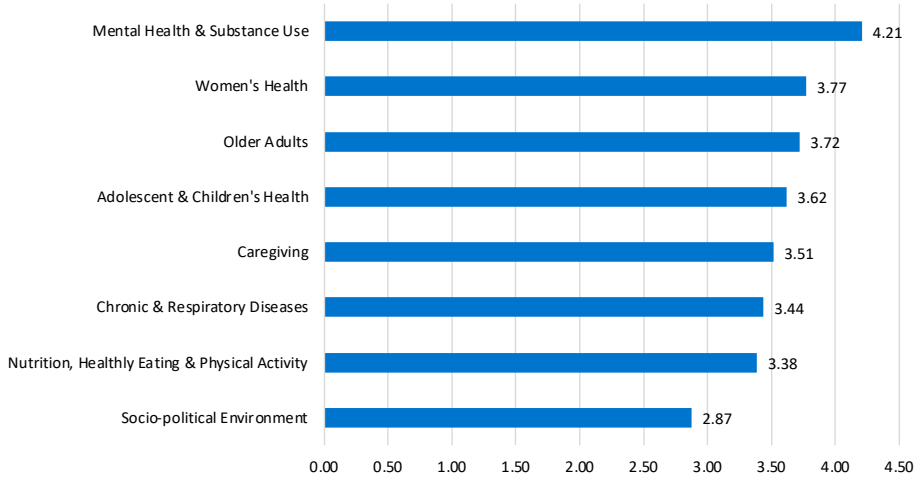
FIGURE 42: INDIVIDUAL VOTE RESULTS



Steering Committee Prioritization Meeting

In April 2025, VCCHIC Steering Committee members convened a final session to discuss the outcomes of the prioritization session and conduct a final vote. After some discussion, they further combined significant health needs and, using a digital survey tool, assigned a score of 1-5 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. In addition to considering the data presented by HCI in the presentation, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria. Figure 43 shows the outcome of the Steering Committee vote.

FIGURE 43: STEERING COMMITTEE VOTE RESULTS



Completion of the online exercise resulted in a numerical score for each health topic and criterion. Numerical scores for the three criteria were aggregated and averaged to produce score and overall ranking for each health topic.

8.2 Prioritization Criteria

Criteria used for the small group and individual votes (Figure 44) provided a framework for participants to contextualize their expertise and lived experiences.

FIGURE 44: SMALL GROUP AND INDIVIDUAL VOTING CRITERIA

Scope	Severity	Ability to Impact
How many people or communities in Ventura County are or will be impacted by the issue?	How concerning is this issue? How does this issue impact health and quality of life?	Can actionable and measurable goals be defined to address the health need? Are the goals achievable in a reasonable timeframe with the resources available to us?

Criteria used for the Steering Committee vote used a scoring scale of 1-5 for each criterion – scope, severity and ability to impact—by health topic. The scores were associated with the following definitions:

FIGURE 45: STEERING COMMITTEE VOTING CRITERIA

	Scope	Severity	Ability to Impact
1	very small impact	slightly severe	negligible ability to impact
2	small impact	low severity	low ability to impact
3	moderate impact	moderately severe	moderate ability to impact
4	large impact	very severe	significant ability to impact
5	very large impact	extremely severe	consequential ability to impact

8.3 VCCHIC 2025 Prioritized Health Needs

VCCHIC plans to build upon efforts that emerged from its previous CHNA process, collaborating with other facilities and community partners, to address the three priority health needs visualized in Figure 46. A deeper dive into the primary and secondary data for each of these priority health topics is provided in the next section of the report. This information highlights how each topic became a high priority health need for the Ventura County Community Improvement Health Collaborative.

FIGURE 46: 2025 PRIORITIZED HEALTH NEEDS

Prioritized Health Needs

This section provides a detailed description of each prioritized health need. An overview is provided for each health topic, followed by a table highlighting the poorest performing indicators and a description of key themes that emerged from primary data. The three prioritized health needs are presented in alphabetical order.

9.1 Behavioral Health

Overview

Behavioral health is a key component to overall health and is closely linked with physical health. Behavioral health includes the topics of mental distress, mental conditions, suicidal thoughts and behaviors, and substance use. Promoting positive behavioral health includes addressing factors at multiple levels, including social determinants of health – supporting the environments where we live, work, learn, and play (Centers for Disease Control and Prevention, 2024).

Health and Quality of Life Indicators

Based on a review of 42 health and quality of life indicators, *Alcohol and Drug Use* ranked 3rd as a health topic area of concern with a score of 1.70. Scores are calculated based on the county's values compared to other communities, Healthy People 2030 targets, and trends. Scores range from 0-3, with a score of 3 being the worst outcome. Indicators with scores of 2.12 or above are shown in Table 9 below. See Appendix B for the full list of indicators categorized within this topic, including the source for each indicator.

TABLE 9. DATA SCORING RESULTS FOR ALCOHOL AND DRUG USE

SCORE	ALCOHOL & DRUG USE	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	CA Counties	U.S. Counties	Trend
2.71	Alcohol-Impaired Driving Deaths	*percentage of driving deaths with alcohol involvement*	38.7	-	26.7	26.3			
2.53	Liquor Store Density	*stores/ 100,000 population*	15.8	-	11.2	10.9			
2.29	Age-Adjusted Death Rate due to Fentanyl Overdose	*deaths/ 100,000 population*	21.7	-	16.6	-		-	
2.29	Age-Adjusted ED Visit Rate due to All Drug Overdose	*Rate per 100,000 residents*	163.3	-	143.7	-		-	
2.29	Age-Adjusted Hospitalization Rate due to Adult Alcohol Use	*hospitalizations/ 10,000 population 18+ years*	16.9	-	14.9	-		-	
2.18	Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin)	*Rate per 100,000 residents*	73.3	-	54.9	-		-	
2.18	Age-Adjusted Hospitalization Rate due to Adolescent Alcohol Use	*hospitalizations/ 10,000 population aged 10-17*	4.6	-	2.9	-		-	=
2.18	Age-Adjusted Hospitalization Rate due to Heroin Overdose	*Rate per 100,000 residents*	1.2	-	0.7	-		-	
2.12	Adults who Binge Drink: Last 30 Days	*percent*	19.1	-	-	16.6			-

In the *Alcohol and Drug Use* topic area, the indicator with the worst score (2.71) was *Alcohol-Impaired Driving Deaths*. Over a third (38.7%) of motor vehicle crash deaths in Ventura County involved alcohol, which is much higher than California (26.7%) and the U.S. (26.3%). Ventura County also has a higher *Liquor Store Density*, with 15.8 stores per 100,000 population compared to 11.2 stores per 100,0000 population in California and 10.9 per 100,000 in the U.S. Deaths due to overdoses were also worse than the California score and have been increasing. For example, the *Age Adjusted Death Rate due to Fentanyl Overdose* in Ventura County was 21.7 per 100,000 population compared to 16.6 per 100,000 population in California. Similarly, the *Age-Adjusted Death Rate due to All Opioid Overdose* was 27.0 per 100,000 population compared to 20.8 per 100,000 population in California. Hospitalization and ER rates due to alcohol use and overdoses for various substances (opioids, heroin, prescription opioid) were also higher than rates in California.

Based on a review of 21 health and quality of life indicators, *Mental Health & Mental Disorders* ranked 7th as a health topic area of concern with a score of 1.48. Scores are calculated based on comparisons of the county's values compared to other communities, Healthy People 2030 targets, and trends. Scores range from 0-3, with

a score of 3 being the worst outcome. Indicators with scores of 1.70 or above are shown in Table 10 below. See Appendix B for the full list of indicators categorized within this topic, including the source for each indicator

TABLE 10. DATA SCORING RESULTS FOR MENTAL HEALTH AND MENTAL DISORDERS

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	CA Counties	U.S. Counties	Trend
2.12	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	*ER visits/ 10,000 population aged 10-17*	82.1	-	69.6	-		-	
2.00	Depression: Medicare Population	*percent*	16.0	-	14.0	16.0			-
1.82	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	*hospitalizations/ 10,000 population under 18 years*	25.0	-	24.1	-		-	
1.76	Adults with Likely Serious Psychological Distress	*percent*	16.4	-	16.7	-		-	
1.76	Youth Depression	*percent*	36.0	-	32.0	-	-	-	-
1.71	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6.0	-	5.0	6.0			-

In the *Mental Health & Mental Disorders* topic area, the indicator with the worst score (2.12) was *Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury*, which was higher in Ventura County, with a rate of 82.1 per 10,000 population ages 10-17 years, compared to 69.6 per 10,0000 population ages 10-17 years in California. Similarly, the *Age-Adjusted Hospitalization Rate due to Pediatric Mental Health* was also higher in Ventura than California overall, and both of these indicators related to pediatric mental health have been increasing over time. Other indicators of concern include *Depression: Medicare Population* and *Adults with Likely Serious Psychological Distress*. Both indicators showed adults in Ventura County with higher needs compared to California, and the percentage of adults with likely serious psychological distress has been increasing.

Community Input

Four in 10 community survey respondents who needed mental health care services did not get them. The most common reported reasons for not getting needed mental health care were that community members were not able to find accessible providers (45.9%), costs were prohibitive (41.4%), and respondents didn't know where to find help (28.4%). Relatedly, more than 4 in 10 respondents who needed services to address substance use, did not get them.

In community member focus groups, mental health was highlighted as a critical component of overall well-being, with the lack of access to mental health resources being a significant concern. Additionally, participants highlighted the need for more accessible and affordable mental health services, including counseling, therapy, and support groups; stigma surrounding mental health issues that prevent people from seeking help, especially in certain communities and professions like the military; and the complexities of navigating the mental health services system.

Community partners emphasized the need for accessible and culturally competent mental health services. Partner input focused on providing more accessible and culturally competent mental health services, especially for populations that have been underserved such as LGBTQIA+ youth, postpartum women, and trauma-affected adolescents. They also noted that provider shortages, language, culture, distrust of the medical system and a need for more education and de-stigmatization around mental health prevent residents from accessing services.

> "The Hispanic culture is usually not OK to go see a doctor, psychiatrist or psychologist or anything at all. And there's a lot of ethnicities that are like that, where it's just…we don't do that and it's bad. **– Veterans Focus Group**"

> "I think right now in our political climate there is a lot of suicidal ideations with young folks…there is increased hostility and rejection…from family relationships in addition to friendships, but just this feeling of hopelessness. **– Behavioral Health Listening Session**"

Life Expectancy

Drug-Induced Deaths ranked ninth for Leading Causes of Death and is the fifth Leading Cause of Premature Death for males in the county. Drug-Induced Deaths ranked seventh in Leading Causes of Premature Death for both White and Black (Non-Hispanic) populations in Ventura County and tenth for Hispanic/Latino populations. Suicide ranked tenth in Leading Causes of Premature Death for the Asian (Non-Hispanic) population. Supporting tables and figures are available in Appendix B.

9.2 Older Adults' Health

Overview

With 18.6% of the population aged 65 and older, Ventura County's population is slightly older compared to California. Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease. In addition, 1 in 4 older adults fall each year, and falls are a leading cause of injury for this age group. Older adults are also more likely to go to the hospital for some infectious diseases — including pneumonia, which is a leading cause of death for this age group. Making sure older adults get preventive care, including vaccines to protect against the flu and pneumonia, can help them stay healthy (Office of Disease Prevention and Health Promotion, n.d.).

Health and Quality of Life Indicators

Based on a review of 25 health and quality of life indicators, *Older Adults' Health* ranked 2nd as a health topic area of concern with a score of 1.71. Scores are calculated based on the county's values compared to other communities, Healthy People 2030 targets, and trends. Scores range from 0-3, with a score of 3 being the worst outcome. Indicators with scores of 2.1 or above are shown in Table 11 below. See Appendix B for the full list of indicators categorized within this topic, including the source for each indicator.

Many key indicators of concern in the *Older Adults' Health* topic area are associated with chronic diseases and cancer. Older adults in the county have a higher rate of rheumatoid arthritis or osteoarthritis (37.0%) in the Medicare population as compared with the state rate (32.0%). In the same population, rates of asthma (8.0%), osteoporosis (15.0%), cancer (13.0%), atrial fibrillation (15.0%), hyperlipidemia (67.0%), and stroke (6.0%) are all higher in Ventura County than in the state of California. In addition, the *Prostate Cancer Incidence Rate* in Ventura County is quite high at 115.4 cases per 100,000 males compared to 95.4 per 100,000 males in California.

TABLE 11. DATA SCORING RESULTS FOR OLDER ADULTS

SCORE	OLDER ADULTS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	CA Counties	U.S. Counties	Trend
2.71	Asthma: Medicare Population	*percent*	8.0	-	7.0	7.0			-
2.71	Osteoporosis: Medicare Population	*percent*	15.0	-	13.0	11.0			-
2.53	Cancer: Medicare Population	*percent*	13.0	-	11.0	12.0			-
2.35	Atrial Fibrillation: Medicare Population	*percent*	15.0	-	13.0	14.0			-
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	115.4	-	95.4	110.5			
2.35	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.0	-	32.0	35.0			-
2.18	Hyperlipidemia: Medicare Population	*percent*	67.0	-	61.0	65.0			-
2.18	Stroke: Medicare Population	*percent*	6.0	-	5.0	6.0			-

Community Input

Older adult community members were eager to share their responses in the community survey with 33.3% of respondents being 65 years and older. Respondents (26.5%) named caregiver stress as the top health problem in the community and age (45.8%) as the primary reason for discrimination.

Focus group participants expressed concern for older adults, especially those with limited income, who may be isolated or have difficulty accessing the services they need. Community partners expressed concerns for older adult and disabled populations, especially those that are homebound, who were noted as particularly vulnerable. Family caregivers to both these populations struggle in low-income and/or rural settings to source or provide continuity of adequate care. A more detailed summary of the partner conversation on Older Adults' Health can be found in the Community Input section of this report.

> I think about seniors and elderly who don't have the resources or even transportation to get this kind of information.
> **– Black and African American Focus Group**

> Transportation [to access health care] needs to be door to door… we [also] need people that would be willing to go into the home… it's so expensive to provide caregivers…[and] people want to age in place. **– Older Adults' Health Listening Session**

Life Expectancy

Alzheimer's Disease is the third Leading Cause of Death in Ventura as compared with California (second) and the U.S. (seventh). Alzheimer's Disease is the third Leading Cause of Premature Death for females and the eighth for males. Similarly, dementia is the ninth Leading Cause of Premature Death for females but falls below the top ten for males. Alzheimer's Disease is the third Leading Cause of Premature Death for both White (Non-Hispanic) and Asian (Non-Hispanic) and fourth for both Hispanic/Latino and Black (Non-Hispanic) populations. Dementia is also the ninth Leading Causes of Premature Death for Asian (Non-Hispanic) community members.

9.3 Women's Health

Overview

In Ventura County, Women's Health is the top area of concern with a score of 1.74, up from 1.41 in 2022. Heart diseases, cancers, Alzheimer's Disease and strokes are the leading causes of premature death for women in the county. Maternal mortality and associated racial and ethnic disparities are of key concern to community partners focused on providing prenatal care and aiming to ensure birth equity in the county.

Health and Quality of Life Indicators

Based on a review of six health and quality of life indicators, Women's Health ranked 1st as a health topic area of concern with a score of 1.74. Scores are calculated based on the county's values compared to other communities, Healthy People 2030 targets, and trends. Scores range from 0-3, with a score of 3 being the worst outcome. Table 12 shows all six indicators in the Women's Health topic area.

TABLE 12. DATA SCORING RESULTS FOR WOMEN'S HEALTH

SCORE	WOMEN'S HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	CA Counties	U.S. Counties	Trend
2.47	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.2	15.3	17.6	-		-	
2.18	Breast Cancer Incidence Rate	*cases/ 100,000 females*	130.7	-	121.0	127.0			
1.47	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	7.5	-	7.3	7.5			
1.41	Cervical Cancer Screening: 21-65	*percent*	82.2	-	-	82.8			-
1.41	Mammogram in Past 2 Years: 50-74	*percent*	75.2	80.3	-	76.5			-
1.35	Mammography Screening: Medicare Population	*percent*	43.0	-	41.0	47.0			-

Indicators in this topic area were largely associated with breast and cervical cancer. Both *Breast Cancer Incidence* and *Age-Adjusted Death Rate due to Breast Cancer* in Ventura County were higher compared to California. There were 130.7 breast cancer cases per 100,000 females in Ventura County compared to 121.0 per 100,000 females in California. The *Age-Adjusted Death Rate due to Breast Cancer* in Ventura County was 20.2 per 100,000 females compared to 17.6 in California. The *Cervical Cancer Incidence Rate* was slightly higher than the state with 7.5 cervical cancer cases per 100,000 females in Ventura County compared to 7.3 per 100,000 females in California.

In addition to indicators in the *Women's Health* topic area, several indicators related to mental health showed disparities impacting females. One in five (21.0%) older adult females in Ventura County was treated for depression compared to 12.0% of males. Females were more likely to be hospitalized or go to the ER due to a mental health condition in Ventura County. The *Age-Adjusted ER Rate due to Adolescent Suicide* and *Intentional Self-inflicted Injury* was 123.9 per 10,000 females aged 10-17 compared to 41.3 per 10,000 males aged 10-17. The *Age-Adjusted ER Rate due to Pediatric Mental Health* was 31.7 per 10,000 females under 18 years compared to 18.2 per 10,000 males under 18 years.

Prioritized Health Needs

Community Input

Survey respondents indicated that the top reasons for discrimination were age (45.8%), gender (38%) and race or ethnicity (32%). While 19.3% of respondents who needed health care services did not get them, women (19.1%) were more likely to indicate that they did not get all the health care services they needed compared to men (17.4%). Those identifying as transgender or non-binary (31.7%) were most likely to report not receiving needed health care services.

Community members participating in the focus group cited a lack of sexual health education as a community health concern. They further indicated that inadequate sexual health education leads to gaps in knowledge and stigma, especially for LGBTQ individuals, youth, and seniors. This lack of education leads to gaps in knowledge about basic sexual and reproductive health, as well as stigma around these topics. Focus group participants noted that young people, including those who identify as female, often feel uncomfortable, ashamed, and scared about the changes they are experiencing during puberty due to the lack of education. Community partners highlighted housing insecurity and mental health as top health needs, with a focus on the impact of housing costs, availability, and the specific mental health challenges faced by pregnant women and children.

> “Lack of sexual health education leads to people ignoring a lot of things. It leads to poor health outcomes in the long run. It contributes to teen pregnancy. I mean, there’s just so many health disparities that it ends up contributing to overall. And if we just had some basic education. It would really take us further in being healthy and taking care of ourselves.” **– LGBTQIA+ Focus Group**

Life Expectancy

Leading Causes of Premature Death for females in Ventura County include (in order from highest to lowest) Diseases of the Heart, All Cancers, Alzheimer’s Disease, Cerebrovascular Disease (Stroke), Chronic Liver Disease, COVID-19, Breast Cancer, Accidental (Unintentional Injuries), Dementia and Diabetes. Breast Cancer is the tenth Leading Cause of Premature Death in Black (Non-Hispanic) community members but falls below the top ten Leading Causes of Premature Death for Hispanic/Latino, White (Non-Hispanic) and Asian (Non-Hispanic) populations.

Community Resources to Address Priority Health Issues

Ventura County Public Health (VCPH) has made significant investments to help connect residents to community resources across Ventura County. Through its support of 211 Ventura County, it has helped create an invaluable service directory for Ventura County residents seeking services.

211 Ventura County offers a comprehensive online resource directory that connects residents to health information, social services, and referrals. This resource directory is available publicly to all constituents of VCCHIC and their partners. The community resources are searchable by topic areas such as housing, food, income and expenses, transportation, education or by target populations such as children and family, youth, and seniors. Recognizing the value, VCCHIC has linked all the resources available through 211 Ventura County to the Health Matters in Ventura County website, which can be found at: www.healthmattersinvc.org/211resources.

The 211 Ventura County resource directory is also available through the Ventura County Community Information Exchange (VCCIE), which seeks to provide a county-wide referral management system supporting providers and their clients for improved access and coordination of services. The VCCIE was developed in response to the need for improved care coordination as a strategic priority in the 2022 Ventura County CHNA. Since its inception, VCCIE has onboarded organizations providing services in caregiver support, housing support, substance use counseling services, veteran services, as well as mental health and wellness. More information can be found on the VCCIE website at: www.venturacountycie.org.

Link to the 211 directory is also available in Appendix D of this report.

Conclusion

This Community Health Needs Assessment (CHNA) describes barriers to health faced by the community, putting into focus its priority health issues—Behavioral Health, Older Adults' Health and Women's Health—and providing information necessary to community partners and planners to build upon each other's work in a coordinated, collaborative manner. VCCHIC has established clear priorities based on the results of this community health assessment to improve health outcomes for the residents of Ventura County and will ensure continued community involvement in the strategy development process. Over the next year, VCCHIC organizations will work together on the development of strategies to address the priorities outlined in the report. In collaboration with community stakeholders and members and with a focus on shared accountability, community-led decision-making and equity-based implementation of the 2025 Community Health Implementation Strategy, VCCHIC hopes to realize its vision of advancing the health of the communities we serve.

APPENDIX A.

SECONDARY DATA METHODOLOGY

The 2025 Community Health Needs Assessment conducted by Ventura County Community Health Improvement Collaborative (VCCHIC) included analysis of both primary and secondary data. Primary data are data that have been collected for the purposes of this community assessment. Primary data were obtained through a community survey, community member focus groups, and community partner listening sessions.

Secondary data are health and quality of life indicator data that have already been collected by public sources such as government agencies. Each type of data was analyzed using a unique methodology. Findings were organized by health topics and then synthesized for a comprehensive overview of the health needs in the VCCHIC Service Area.

Secondary Data Sources

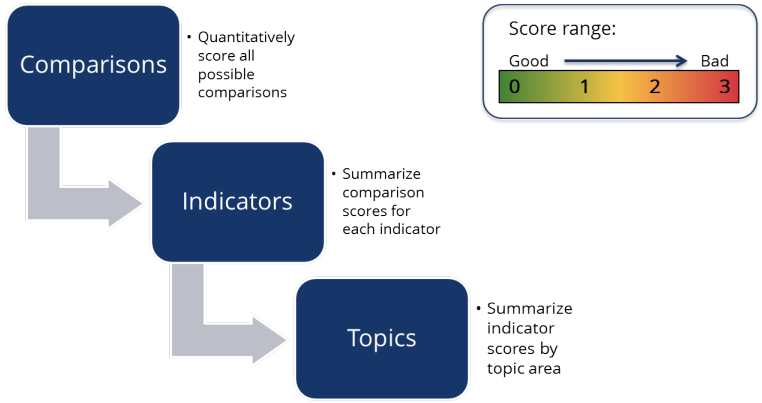
The following list of data sources that were used for this Ventura County CHNA report may be used as a key for the table of indicators included later in this appendix.

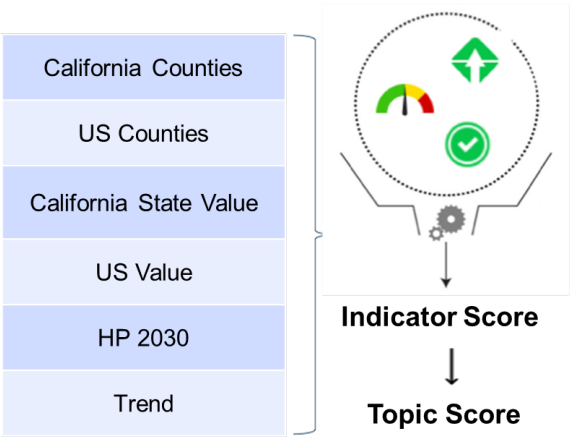
Ventura County Secondary Data Sources

1. American Community Survey 1-Year
2. American Community Survey 5-Year
3. American Lung Association
4. California Department of Education
5. California Department of Health Care Access and Information
6. California Department of Justice
7. California Department of Public Health
8. California Department of Public Health, Immunization Branch
9. California Department of Public Health, STD Control Branch
10. California Health Interview Survey
11. California Health Interview Survey, Neighborhood Edition
12. California Healthy Kids Survey
13. California Opioid Overdose Surveillance Dashboard
14. California Secretary of State
15. California State Highway Patrol
16. CDC - PLACES
17. Centers for Disease Control and Prevention
18. Centers for Medicare & Medicaid Services
19. Child Welfare Dynamic Report System
20. Claritas Consumer Profiles
21. Claritas Pop-Facts
22. Controlled Substance Utilization Review and Evaluation System
23. County Health Rankings
24. Feeding America
25. National Cancer Institute
26. National Center for Education Statistics
27. National Environmental Public Health Tracking Network
28. U.S. Bureau of Labor Statistics
29. U.S. Census - County Business Patterns
30. U.S. Census Bureau - Small Area Health Insurance Estimates
31. U.S. Environmental Protection Agency
32. United For ALICE
33. United Ways of California

Secondary Data Scoring

Data scoring is done in three stages:





Each indicator with data available in Ventura County is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability,

all missing comparisons are substituted with a neutral score for the purpose of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

The health and quality of life topic areas are described as follows:

Quality of Life	Health	
Community	Adolescent Health	Maternal, Fetal & Infant Health
Economy	Alcohol & Drug Use	Men's Health
Education	Cancer	Mental Health & Mental Disorders
Environment	Children's Health	Older Adults
Transportation	Diabetes	Oral Health
	Disabilities	Prevention & Safety
	Environmental Health	Physical Activity
	Family Planning	Respiratory Diseases
	Health Care Access and Quality	Tobacco Use
	Heart Disease & Stroke	Women's Health
	Immunization & Infectious Diseases	Wellness & Lifestyle
		Weight Status

Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined in the Ventura County Service Area. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value.

The Index of Disparity was run for the county, and the indicators with the highest race or ethnicity index value were found, with their associated subgroup with the negative disparity listed below in SECTION 5: Disparities.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds ®

Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators.

Data scores represent the relative community health needs according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or Ethnic and Special Population Groupings

The secondary data presented in this report derives from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment covers ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Data Scoring Results

TABLE A. VENTURA COUNTY TOPIC SCORING RESULTS

Health Topic	Score
Older Adults	1.72
Women's Health	1.72
Alcohol & Drug Use	1.70
Adolescent Health	1.56
Other Conditions	1.52
Cancer	1.48
Mental Health & Mental Disorders	1.46
Nutrition & Healthy Eating	1.42
Weight Status	1.42
Heart Disease & Stroke	1.41
Physical Activity	1.39
Health Care Access & Quality	1.38
Prevention & Safety	1.35
Sexually Transmitted Infections	1.32
Diabetes	1.32
Children's Health	1.30
Wellness & Lifestyle	1.29
Maternal, Fetal & Infant Health	1.21
Mortality Data	1.20
Immunizations & Infectious Diseases	1.18
Tobacco Use	1.05
Respiratory Diseases	1.02
Oral Health	0.93

Quality of Life Topic	Score
Education	1.65
Economy	1.36
Environmental Health	1.36
Community	1.33

SECONDARY DATA METHODOLOGY

The following tables list each indicator by topic area for VCCHIC's service area.
Secondary data for this report are up to date as of November 18, 2024.

TABLE B. VENTURA COUNTY INDICATOR SCORING RESULTS

SCORE	ADOLESCENT HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.12	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population aged 10-17	82.1		69.6		2020-2022		5
1.76	Teens who have Ever Used Inhalants: 7th Graders	percent	4.0		3.6		2017-2019		12
1.76	Teens who have Ever Used Recreational Prescription Drugs: 9th Graders	percent	10.0		8.8		2017-2019		12
1.76	Teens who Use Alcohol or Drugs: 7th Graders	percent	7.8		7.0		2017-2019		12
1.76	Teens who Use Alcohol: 7th Graders	percent	4.7		4.2		2017-2019		12
1.76	Youth Depression	percent	36.0		32.0		2017-2019		12
1.74	Children and Teens with Asthma	percent	12.3		11.6		2021-2022		11
1.59	Students who Binge Drink: 11th Graders	percent	8.2		8.0		2017-2019		12
1.59	Students who Use Alcohol: 11th Graders	percent	16.8		16.0		2017-2019		12
1.59	Teens who have Ever Used Inhalants: 9th Graders	percent	4.0		3.9		2017-2019		12
1.59	Teens who have Ever Used Recreational Prescription Drugs: 11th Graders	percent	12.0		11.4		2017-2019		12
1.59	Teens who Smoke: 11th Graders	percent	2.1		2.0		2017-2019		12
1.59	Teens who Smoke: 7th Graders	percent	1.1		1.0		2017-2019		12
1.59	Teens who Use Alcohol or Drugs: 9th Graders	percent	15.2		15.0		2017-2019		12
1.59	Teens who Use Alcohol: 9th Graders	percent	10.0		9.3		2017-2019		12
1.59	Teens who Use Marijuana: 9th Graders	percent	10.3		10.0		2017-2019		12
1.59	Youth Gang Membership	percent	4.3		4.2		2017-2019		12
1.56	Teens who are Overweight or Obese	percent	36.6		37.4		2021-2022		11

1.56	Youth Connectedness to School: 11th Graders	percent	43.3		40.2		2017-2019	12
1.41	Students who Use Marijuana: 11th Graders	percent	14.6		16.0		2017-2019	12
1.41	Teens who have Ever Used Inhalants: 11th Graders	percent	3.0		3.2		2017-2019	12
1.41	Teens who Use Alcohol or Drugs: 11th Graders	percent	23.0		23.0		2017-2019	12
1.41	Teens who Use Marijuana: 7th Graders	percent	4.0		4.0		2017-2019	12
1.29	Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population aged 10-17	16.1		20.0		2020-2022	5
1.24	Teens who Smoke: 9th Graders	percent	1.5		2.0		2017-2019	12
0.62	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	9.5		9.5	14.2	2020-2022	7

SCORE	ALCOHOL & DRUG USE	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.71	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	38.7		26.7	26.3	2017-2021		23
2.53	Liquor Store Density	stores/ 100,000 population	15.8		11.2	10.9	2022		29
2.29	Age-Adjusted Death Rate due to Fentanyl Overdose		21.7		16.6		2022		13
2.29	Age-Adjusted ED Visit Rate due to All Drug Overdose	Rate per 100,000 residents	163.3		143.7		2022		13
2.29	Age-Adjusted Hospitalization Rate due to Adult Alcohol Use	hospitalizations/ 10,000 population 18+ years	16.9		14.9		2020-2022		5
2.18	Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin)	Rate per 100,000 residents	73.3		54.9		2022		13
2.18	Age-Adjusted Hospitalization Rate due to Adolescent Alcohol Use	hospitalizations/ 10,000 population aged 10-17	4.6		2.9		2020-2022		5
2.18	Age-Adjusted Hospitalization Rate due to Heroin Overdose	Rate per 100,000 residents	1.2		0.7		2022		13
2.12	Adults who Binge Drink: Last 30 Days	percent	19.1			16.6	2022		16

2.00	Age-Adjusted Death Rate due to All Opioid Overdose	Rate per 100,000 residents	24.4		18.7	2022	Black (40.422) White (44.203) API (6.08) Hisp (22.512)	13
2.00	Age-Adjusted Death Rate due to Prescription Opioid Overdose	Rate per 100,000 residents	24.3		18.1	2022		13
2.00	Age-Adjusted Death Rate due to Synthetic Opioid Overdose (excluding Methadone)	Rate per 100,000 residents	21.8	8.9	16.7	2022		13
1.85	Age-Adjusted ER Rate due to Adult Alcohol Use	ER visits/ 10,000 population 18+ years	41.1		34.8	2020-2022	Black (30.1) White (51.2) AIAN (10.1) API (3.7) Hisp (39.7)	5
1.82	Age-Adjusted ER Rate due to Opioid Use	ER visits/ 10,000 population 18+ years	8.8		7.7	2020-2022	Black (12.3) White (11.7) API (0.9) Hisp (6.6)	5
1.76	Teens who have Ever Used Inhalants: 7th Graders	percent	4.0		3.6	2017-2019		12
1.76	Teens who have Ever Used Recreational Prescription Drugs: 9th Graders	percent	10.0		8.8	2017-2019		12
1.76	Teens who Use Alcohol or Drugs: 7th Graders	percent	7.8		7.0	2017-2019		12
1.76	Teens who Use Alcohol: 7th Graders	percent	4.7		4.2	2017-2019		12
1.65	Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	20.7		20.5	2020-2022	Black (32) White (26.3) API (3.8) Hisp (18.4)	5
1.65	Age-Adjusted Hospitalization Rate due to Opioid Overdose (excluding Heroin)	Rate per 100,000 residents	11.8		12.1	2022		13
1.59	Students who Binge Drink: 11th Graders	percent	8.2		8.0	2017-2019		12
1.59	Students who Use Alcohol: 11th Graders	percent	16.8		16.0	2017-2019		12
1.59	Teens who have Ever Used Inhalants: 9th Graders	percent	4.0		3.9	2017-2019		12
1.59	Teens who have Ever Used Recreational Prescription Drugs: 11th Graders	percent	12.0		11.4	2017-2019		12
1.59	Teens who Use Alcohol or Drugs: 9th Graders	percent	15.2		15.0	2017-2019		12
1.59	Teens who Use Alcohol: 9th Graders	percent	10.0		9.3	2017-2019		12
1.59	Teens who Use Marijuana: 9th Graders	percent	10.3		10.0	2017-2019		12

1.53	Adults who Drink Excessively	percent	17.7		17.2	18.1	2021		23
1.53	Age-Adjusted ED Visit Rate due to Heroin Overdose	Rate per 100,000 residents	3.8		3.6		2022	Black (7.6) White (5.617) Hisp (3.15)	13
1.41	Age-Adjusted ER Rate due to Adolescent Alcohol Use	ER visits/ 10,000 population aged 10-17	12.9		8.0		2020-2022		5
1.41	Quarterly Opioid Prescription Rate	prescriptions per 10,000 population	297.8				Q3 2022		22
1.41	Students who Use Marijuana: 11th Graders	percent	14.6		16.0		2017-2019		12
1.41	Teens who have Ever Used Inhalants: 11th Graders	percent	3.0		3.2		2017-2019		12
1.41	Teens who Use Alcohol or Drugs: 11th Graders	percent	23.0		23.0		2017-2019		12
1.41	Teens who Use Marijuana: 7th Graders	percent	4.0		4.0		2017-2019		12
1.32	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	Deaths per 100,000 population	17.9		16.5	23.5	2018-2020		17
1.26	Opioid Prescription Patients	percent	2.4				Q3 2022		22
1.24	Age-Adjusted Hospitalization Rate due to Opioid Use	hospitalizations/ 10,000 population 18+ years	2.3		2.4		2020-2022		5
1.18	Age-Adjusted Hospitalization Rate due to All Drug Overdose	Rate per 100,000 residents	42.4		48.3		2022		13
1.06	Age-Adjusted Death Rate due to Heroin Overdose	deaths/ 100,000 population	1.1	4.2	1.2		2022		13
1.00	Age-Adjusted Long Acting or Extended Release Opioid Prescription Rate to Opioid Naive Residents	per 100,000 population	1.1		1.2		2022		13
0.88	Age-Adjusted Hospitalization Rate due to Substance Use	hospitalizations/ 10,000 population 18+ years	3.6		4.0		2020-2022		5

SCORE	CANCER	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.53	Cancer: Medicare Population	percent	13.0		11.0	12.0	2022		18
2.47	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.2	15.3	17.6		2020-2022		7
2.35	Prostate Cancer Incidence Rate	cases/ 100,000 males	115.4		95.4	110.5	2016-2020		25
2.18	Breast Cancer Incidence Rate	cases/ 100,000 females	130.7		121.0	127.0	2016-2020		25

1.59	Colon Cancer Screening: USPSTF Recommendation	percent	62.0			66.3	2022		16
1.53	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	11.8	8.9	11.5		2020-2022		7
1.53	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.8		10.1	11.9	2016-2020		25
1.47	Cervical Cancer Incidence Rate	cases/ 100,000 females	7.5		7.3	7.5	2017-2021		25
1.41	Cervical Cancer Screening: 21-65	Percent	82.2			82.8	2020		16
1.41	Mammogram in Past 2 Years: 50-74	percent	75.2	80.3		76.5	2022		16
1.35	Mammography Screening: Medicare Population	percent	43.0		41.0	47.0	2022		18
1.18	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	17.9	16.9	18.2		2020-2022		7
1.06	Adults with Cancer (Non-Skin) or Melanoma	percent	7.9			8.2	2022		16
1.06	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	123.8	122.7	122.0		2020-2022		7
1.00	Colorectal Cancer Incidence Rate	cases/ 100,000 population	34.0		33.5	36.4	2017-2021		25
0.53	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	18.4	25.1	20.6		2020-2022		7
0.47	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	35.6		37.6	54.0	2016-2020		25

SCORE	CHILDREN'S HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.09	Food Insecure Children Likely Ineligible for Assistance	percent	38.0		35.0		2022		24
1.94	Child Care Centers	per 1,000 population under age 5	6.3		8.1	7.0	2022		23
1.82	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	hospitalizations/ 10,000 population under 18 years	25.0		24.1		2020-2022		5
1.76	Teens who have Ever Used Inhalants: 7th Graders	percent	4.0		3.6		2017-2019		12
1.76	Teens who have Ever Used Recreational Prescription Drugs: 9th Graders	percent	10.0		8.8		2017-2019		12

1.74	Children and Teens with Asthma	percent	12.3		11.6		2021-2022		11
1.59	Teens who have Ever Used Inhalants: 9th Graders	percent	4.0		3.9		2017-2019		12
1.59	Teens who have Ever Used Recreational Prescription Drugs: 11th Graders	percent	12.0		11.4		2017-2019		12
1.47	Kindergartners with Required Immunizations	percent	95.1		92.8		2021-2022		8
1.41	Children who Visited a Dentist	percent	92.7		91.9		2017-2018		11
1.41	Teens who have Ever Used Inhalants: 11th Graders	percent	3.0		3.2		2017-2019		12
1.29	Children with Health Insurance	percent	97.1		96.8	94.9	2022		1
1.24	Children who are Overweight for Age	percent	13.9		16.6		2021-2022		11
1.09	Child Abuse Allegation Rate	cases/ 1,000 children	42.2		49.0		2023	Black (74.9) White (27.2) AIAN (36.3) API (10.2) Hisp (50.1)	19
1.09	Child Abuse Investigation Rate	cases/ 1,000 children	22.4		32.7		2023	Black (42.1) White (14.9) Hisp (29.2)	19
1.00	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	hospitalizations/ 10,000 population under 18 years	3.3		5.0		2020-2022		5
0.71	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	17.2		23.7		2020-2022		5
0.71	Age-Adjusted ER Rate due to Pediatric Mental Health	ER visits/ 10,000 population under 18 years	24.9		27.9		2020-2022		5
0.59	Child Food Insecurity Rate	percent	13.6		16.9	18.5	2022		24
0.53	Substantiated Child Abuse Rate	cases/ 1,000 children	3.2	8.7	6.1	7.7	2022	White (1.9) AIAN (0) Hisp (4.2)	19
0.44	Child Mortality Rate: Under 20	deaths/ 100,000 population under 20	31.5		37.7	50.6	2018-2021		23

SCORE	COMMUNITY	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
3.00	Median Household Gross Rent	dollars	2264		1992	1406	2023		1
2.71	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	38.7		26.7	26.3	2017-2021		23
2.56	Mortgaged Owners Median Monthly Household Costs	dollars	2940		2759	1828	2018-2022		2

2.18	Median Monthly Owner Costs for Households without a Mortgage	dollars	823		834	629	2023		1
2.18	Workers Commuting by Public Transportation	percent	0.6	5.3	3.1	3.5	2023		1
2.18	Youth not in School or Working	percent	1.9		1.7	1.7	2023		1
1.94	Hate Crime Offenses	offenses	24				2022		6
1.94	People 65+ Living Alone (Count)	people	29418				2018-2022		2
1.91	Workers Commuting by Public Transit	percent	1.1		5.0		2022		21
1.88	Juvenile Arrest Rate	arrests/ 1,000 population aged 0-17	5.5		2.8		2022	Black (19.5771339) White (3.302951) Hisp (9.3407021)	6
1.88	Workers who Walk to Work	percent	1.8		2.5	2.4	2023		1
1.74	Drivers who Drive Alone to Work	percent	79.0		73.8		2022		21
1.71	Social Associations	membership associations/ 10,000 population	6.4		6.0	9.1	2021		23
1.62	Persons with Health Insurance	percent	91.5	92.4	92.5		2022		30
1.88	Workers who Walk to Work	percent	1.8		2.5	2.4	2023		1
1.59	Youth Gang Membership	percent	4.3		4.2		2017-2019		12
1.56	Youth Connectedness to School: 11th Graders	percent	43.3		40.2		2017-2019		12
1.53	Female Population 16+ in Civilian Labor Force	percent	58.4		58.8	59.2	2023		1
1.53	People 25+ with a High School Diploma or Higher	percent	85.4		84.4	89.1	2018-2022		2
1.50	Total Employment Change	percent	6.5		8.1	5.8	2021-2022		29
1.50	Workers who Drive Alone to Work	percent	70.4		67.1	69.2	2023		1
1.47	Population 16+ in Civilian Labor Force	percent	60.4		60.2	60.6	2023		1
1.41	Adult Arrest Rate	arrests/ 1,000 population 18+	36.2		25.1		2022	Black (99.0312164) White (22.2452147) Hisp (51.1197995)	6
1.38	Average Commute Time	minutes	29.0		33.0		2022		21
1.35	Voter Engagement	Percent of adults	68.9		66.2		2022		10
1.32	Mean Travel Time to Work	minutes	26.6		29.2	26.8	2023		1
1.24	Children Living Below Poverty Level	percent	13.3		14.9	16.0	2023		1
1.24	People Living Below Poverty Level	percent	9.7	8.0	12.0	12.5	2023		1

1.18	Bicycle-Involved Collision Rate	collisions/ 100,000 population	0.2		0.3		2023	15
1.18	Voter Turnout: Presidential Election	percent	85.9	58.4	80.7		2020	14
1.12	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	9.2	10.1	11.5		2020-2022	7
1.09	Child Abuse Allegation Rate	cases/ 1,000 children	42.2		49.0		2023	Black (74.9) White (27.2) AIAN (36.3) API (10.2) Hisp (50.1) 19
1.09	Child Abuse Investigation Rate	cases/ 1,000 children	22.4		32.7		2023	Black (42.1) White (14.9) Hisp (29.2) 19
1.09	Families Below Poverty	percent	6.2		9.4		2022	21
1.00	Deaths in Custody	per 10,000 population	0.1		0.3		2020	White (0.20179598) Hisp (0.07158093) 6
1.00	Households with One or More Types of Computing Devices	percent	97.3		97.2	96.1	2023	1
1.00	People 25+ with a Bachelor's Degree or Higher	percent	37.9		37.5	36.2	2023	1
0.97	Households with a Smartphone	percent	87.7		86.7	84.7	2023	20
0.94	Residential Segregation - Black/White	Score	49.1		58.0	62.7	2024	23
0.88	Age-Adjusted Death Rate due to Homicide	deaths/ 100,000 population	3.7	5.5	5.1	6.6	2018-2020	17
0.79	People 65+ Living Alone	percent	21.2		21.6	25.7	2023	1
0.65	Persons with an Internet Subscription	percent	95.9		95.4	93.8	2023	1
0.56	Violent Crime Rate	crimes/ 100,000 population	198.1		493.1	380.7	2022	6
0.53	Substantiated Child Abuse Rate	cases/ 1,000 children	3.2	8.7	6.1	7.7	2022	White (1.9) AIAN (0) Hisp (4.2) 19
0.35	Households with an Internet Subscription	percent	95.5		94.3	92.2	2023	1
0.35	Per Capita Income	dollars	48481		48013	43313	2023	1
0.35	Solo Drivers with a Long Commute	percent	32.0		41.6	36.4	2018-2022	23
0.29	Age-Adjusted Death Rate due to Firearms	deaths/ 100,000 population	6.3	10.7	7.4	12.0	2018-2020	17
0.29	Children in Single-Parent Households	percent	17.0		23.1	24.9	2023	1
0.00	Median Household Income	dollars	107667		95521	77719	2023	1

SECONDARY DATA METHODOLOGY

SCORE	DIABETES	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.94	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	22.7		23.6		2020-2022		7
1.65	Adults with Diabetes	percent	10.7		10.7		2021-2022		10
1.59	Age-Adjusted Hospitalization Rate due to Diabetes	hospitalizations/ 10,000 population 18+ years	15.8		17.6		2020-2022		5
1.59	Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	5.5		6.6		2020-2022	Black (8.9) White (6) API (0.7) Hisp (6.3)	5
1.59	Age-Adjusted Hospitalization Rate due to Type 2 Diabetes	hospitalizations/ 10,000 population 18+ years	12.5		14.1		2020-2022	Black (17.6) White (11.3) API (4.7) Hisp (21)	5
1.47	Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	8.0		8.6		2020-2022	Black (8.7) White (7) API (2.7) Hisp (14)	5
1.35	Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes	hospitalizations/ 10,000 population 18+ years	2.3		2.5		2020-2022		5
1.18	Diabetes: Medicare Population	percent	22.0		21.0	24.0	2022	Black (33) White (20) AIAN (35) API (37) Hisp (29)	18
1.12	Age-Adjusted ER Rate due to Short-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	0.7		0.9		2020-2022		5
1.00	Age-Adjusted ER Rate due to Type 2 Diabetes	ER visits/ 10,000 population 18+ years	17.4		21.6		2020-2022	Black (29.4) White (16.8) AIAN (14) API (6.2) Hisp (30)	5
1.00	Age-Adjusted ER Rate due to Uncontrolled Diabetes	ER visits/ 10,000 population 18+ years	13.7		16.3		2020-2022	Black (26) White (13.7) AIAN (10.4) API (4.2) Hisp (22.6)	5
0.82	Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population 18+ years	19.5		24.1		2020-2022	Black (32.4) White (19.5) AIAN (14.6) API (6.2) Hisp (31.7)	5
0.82	Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	3.7		5.3		2020-2022	Black (4.8) White (3.6) API (1.3) Hisp (6.5)	5

SCORE	ECONOMY	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
3.00	Median Household Gross Rent	dollars	2264		1992	1406	2023		1
2.56	Mortgaged Owners Median Monthly Household Costs	dollars	2940		2759	1828	2018-2022		2
2.47	Overcrowded Households	percent	7.7		8.2	3.5	2023		1
2.35	Renters Spending 30% or More of Household Income on Rent	percent	58.2	25.5	56.1	51.8	2023		1

2.18	Median Monthly Owner Costs for Households without a Mortgage	dollars	823		834	629	2023	1
2.18	Youth not in School or Working	percent	1.9		1.7	1.7	2023	1
2.12	Unemployed Workers in Civilian Labor Force	percent	5.2		5.9	4.4	August 2024	28
2.09	Food Insecure Children Likely Ineligible for Assistance	percent	38.0		35.0		2022	24
1.94	People 65+ Living Below Poverty Level (Count)	people	11377				2018-2022	2
1.71	Mortgaged Owners Spending 30% or More of Household Income on Housing	percent	36.5	25.5	38.4	28.5	2023	1
1.71	Severe Housing Problems	percent	22.9		25.7	16.7	2016-2020	23
1.65	Students Eligible for the Free Lunch Program	percent	47.4		52.6	42.8	2022-2023	26
1.65	Veterans Living Below Poverty Level	percent	7.2		7.4	7.6	2023	1
1.59	Households with Student Loan Debt	percent	10.7		11.3	10.3	2023	20
1.53	Adults Receiving Food Stamp Benefits	percent	30.8		31.7		2022	10
1.53	Female Population 16+ in Civilian Labor Force	percent	58.4		58.8	59.2	2023	1
1.50	Total Employment Change	percent	6.5		8.1	5.8	2021-2022	29
1.47	Population 16+ in Civilian Labor Force	percent	60.4		60.2	60.6	2023	1
1.35	Size of Labor Force	persons	414000				August 2024	28
1.29	Income Inequality		0.4		0.5	0.5	2023	1
1.24	Children Living Below Poverty Level	percent	13.3		14.9	16.0	2023	1
1.24	Families Living Below Poverty Level	percent	7.4		8.5	8.8	2023	White (5.4) Asian (1.9) AIAN (34.5) Mult (7.8) Other (11.7) Hisp (11.4) 1
1.24	People 65+ Living Below Poverty Level	percent	8.4		11.0	10.0	2018-2022	2
1.24	People Living Below Poverty Level	percent	9.7	8.0	12.0	12.5	2023	1
1.15	Adults who Feel Overwhelmed by Financial Burdens	percent	35.6		36.8	37.6	2023	20
1.15	Households Above the Federal Poverty Level and Below the Real Cost Measure	percent	20.0		24.0		2021	33
1.09	Families Below Poverty with Children	percent	4.3		6.9		2022	21

1.06	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	percent	2.0	2.3	2.2	2023		20
1.06	Households with a 401k Plan	percent	46.4	44.0	40.1	2023		20
0.97	Households Below the Real Cost Measure	percent	27.0	34.0		2021	White (19) Hisp (46)	33
0.97	Households Living Below Poverty Level	percent	8.1	12.0		2021		32
0.97	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	64.7	57.0		2021		32
0.97	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	27.2	31.0		2021		32
0.97	Households with a Savings Account	percent	75.7	73.3	71.1	2023		20
0.94	Residential Segregation - Black/White	Score	49.1	58.0	62.7	2024		23
0.65	Unemployed Veterans	percent	1.8	3.1	2.6	2023		1
0.59	Adults with Disability Living in Poverty	percent	18.3	22.7	24.9	2018-2022		2
0.59	Child Food Insecurity Rate	percent	13.6	16.9	18.5	2022		24
0.59	Food Insecurity Rate	percent	10.5	12.6	13.5	2022	White (7) Hisp (17)	24
0.35	Per Capita Income	dollars	48481	48013	43313	2023		1
0.26	Homeowner Vacancy Rate	percent	0.2	0.7	0.8	2023		1
0.00	Median Household Income	dollars	107667	95521	77719	2023		1

SCORE	EDUCATION	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.29	Veterans with a High School Diploma or Higher	percent	95.2		95.5	95.7	2023		1
2.24	Student-to-Teacher Ratio	students/ teacher	22.5		21.9	15.4	2022-2023		26
2.12	6th Grade Students Proficient in Math	percent	28.8		32.5		2022		4
1.94	8th Grade Students Proficient in Math	percent	26.5		29.2		2022		4
1.94	Child Care Centers	per 1,000 population under age 5	6.3		8.1	7.0	2022		23
1.82	7th Grade Students Proficient in Math	percent	28.8		32.0		2022		4
1.65	11th Grade Students Proficient in Math	percent	25.0		27.0		2022		4
1.65	3rd Grade Students Proficient in Math	percent	43.4		43.5		2022		4

1.65	4th Grade Students Proficient in Math	percent	36.5		38.3		2022	4
1.65	5th Grade Students Proficient in Math	percent	30.3		31.6		2022	4
1.65	7th Grade Students Proficient in English/Language Arts	percent	46.2		49.2		2022	4
1.56	Youth Connectedness to School: 11th Graders	percent	43.3		40.2		2017-2019	12
1.53	People 25+ with a High School Diploma or Higher	percent	85.4		84.4	89.1	2018-2022	2
1.50	11th Grade Students Proficient in English/Language Arts	percent	51.2		54.8		2022	4
1.50	3rd Grade Students Proficient in English/Language Arts	percent	42.1		42.2		2022	4
1.50	4th Grade Students Proficient in English/Language Arts	percent	43.4		44.2		2022	4
1.50	5th Grade Students Proficient in English/Language Arts	percent	46.6		47.1		2022	4
1.50	6th Grade Students Proficient in English/Language Arts	percent	42.0		45.1		2022	4
1.50	8th Grade Students Proficient in English/Language Arts	percent	43.7		46.6		2022	4
1.44	Population Age 25+: Bachelor's Degree	percent	20.6		21.1		2021	21
1.18	High School Graduation	percent	87.8	90.7	86.2		2022-2023	4
1.00	People 25+ with a Bachelor's Degree or Higher	percent	37.9		37.5	36.2	2023	1

SCORE	ENVIRONMENTAL HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.71	Asthma: Medicare Population	percent	8.0		7.0	7.0	2022		18
2.53	Liquor Store Density	stores/ 100,000 population	15.8		11.2	10.9	2022		29
2.47	Overcrowded Households	percent	7.7		8.2	3.5	2023		1
2.00	Daily Dose of UV Irradiance	Joule per square meter	4812.0		4541.0		2020		27
1.88	Air Pollution due to Particulate Matter	micrograms per cubic meter	7.9		7.1	7.4	2019		23
1.74	Adults with Asthma	percent	17.1		17.0	15.7	2022		10
1.71	Severe Housing Problems	percent	22.9		25.7	16.7	2016-2020		23

1.68	Annual Ozone Air Quality	grade	F			2020-2022		3
1.65	PBT Released	pounds	2270.3			2022		31
1.41	Adult Arrest Rate	arrests/ 1,000 population 18+	36.2		25.1	2022	Black (99.0312164) White (22.2452147) Hisp (51.1197995)	6
1.41	Proximity to Highways	percent	5.0		5.8	2020		27
1.35	Annual Particle Pollution	grade	D			2020-2022		3
1.35	Number of Extreme Heat Days	days	10			2023		27
1.35	Number of Extreme Precipitation Days	days	7			2023		27
1.35	Recognized Carcinogens Released into Air	pounds	11.3			2022		31
1.35	Weeks of Moderate Drought or Worse	weeks per year	43			2021		27
1.06	Access to Parks	percent	82.1		79.5	2020		27
1.00	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	hospitalizations/ 10,000 population under 18 years	3.3		5.0	2020-2022		5
0.88	Adults with Current Asthma	percent	9.8			9.9	2022	16
0.76	Food Environment Index		8.9		8.6	7.7	2024	23
0.71	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	17.2		23.7	2020-2022		5
0.71	Age-Adjusted Hospitalization Rate due to Adult Asthma	hospitalizations/ 10,000 population 18+ years	1.2		1.7	2020-2022		5
0.62	Access to Exercise Opportunities	percent	97.8		94.2	84.1	2024	23
0.53	Age-Adjusted ER Rate due to Adult Asthma	ER visits/ 10,000 population 18+ years	10.9		15.3	2020-2022	Black (28.1) White (11.4) API (3.4) Hisp (11.5)	5
0.53	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	12.5		17.5	2020-2022	Black (28) White (13.2) API (4.3) Hisp (13.6)	5
0.53	Age-Adjusted Hospitalization Rate due to Asthma	hospitalizations/ 10,000 population	1.7		2.5	2020-2022		5

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.12	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	62.0		86.5	131.4	2023		23

1.94	Adults who have had a Routine Checkup	percent	70.0			76.1	2022		16
1.94	People with a Usual Source of Health Care	percent	83.5		82.5		2022		10
1.85	Adults with Health Insurance: 18-64	percent	87.7		91.2		2020-2022		10
1.74	Adults Delayed or had Difficulty Obtaining Care	percent	26.0		24.9		2021-2022		11
1.65	Adults Needing and Receiving Behavioral Health Care Services	percent	57.1		55.9		2021-2022		10
1.65	People Delayed or had Difficulty Obtaining Care	percent	17.1	5.9	16.5		2021-2022		10
1.62	Persons with Health Insurance	percent	91.5	92.4	92.5		2022		30
1.41	Adults without Health Insurance	percent	7.8			10.8	2022		16
1.41	Children and Teens Delayed or had Difficulty Obtaining Care	percent	8.1		8.5		2021-2022		11
1.41	Children who Visited a Dentist	percent	92.7		91.9		2017-2018		11
1.32	Adults with Health Insurance (5-year): 19+	percent	87.8		90.0	87.8	2018-2022		2
1.29	Children with Health Insurance	percent	97.1		96.8	94.9	2022		1
1.06	Adults who Visited a Dentist	percent	65.0			63.9	2022		16
1.00	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	2119.0		2275.0	2677.0	2022	Black (3336) White (1901) AIAN (0) API (1854) Hisp (2738)	18
0.82	Primary Care Provider Rate	providers/ 100,000 population	81.3		81.1	74.9	2021		23
0.35	Mental Health Provider Rate	providers/ 100,000 population	480.4		449.8	313.9	2023		23
0.18	Dentist Rate	dentists/ 100,000 population	97.9		92.9	73.5	2022		23

SCORE	HEART DISEASE & STROKE	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.35	Atrial Fibrillation: Medicare Population	percent	15.0		13.0	14.0	2022		18
2.18	Hyperlipidemia: Medicare Population	percent	67.0		61.0	65.0	2022		18
2.18	Stroke: Medicare Population	percent	6.0		5.0	6.0	2022		18
1.94	Adults who Have Taken Medications for High Blood Pressure	percent	73.6			78.2	2021		16

1.91	Adults with Heart Disease	percent	8.2		7.3		2021-2022		11
1.82	Hypertension: Medicare Population	percent	63.0		58.0	65.0	2022		18
1.71	Ischemic Heart Disease: Medicare Population	percent	21.0		18.0	21.0	2022		18
1.47	Age-Adjusted Hospitalization Rate due to Hypertension	hospitalizations/ 10,000 population 18+ years	3.3		3.7		2020-2022	Black (9.3) White (2.9) API (2) Hisp (4.2)	5
1.47	High Blood Pressure Prevalence	percent	32.8	41.9	34.8		2022		10
1.32	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	24.7		27.0		2020-2022	Black (52.1) White (22.5) AIAN (7.5) API (20.7) Hisp (29.6)	5
1.24	Age-Adjusted Death Rate due to Coronary Heart Disease	deaths/ 100,000 population	78.6	71.1	77.2		2020-2022		7
1.24	High Cholesterol Prevalence	percent	34.8			35.5	2021		16
1.06	Adults who Experienced Coronary Heart Disease	percent	6.2			6.8	2022		16
1.06	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	43.7		44.3		2021		27
1.06	Age-Adjusted Hospitalization Rate due to Heart Attack	hospitalizations/ 10,000 population 35+ years	21.8		21.1		2020		27
1.06	Cholesterol Test History	percent	86.8			86.4	2021		16
1.00	Age-Adjusted Hospitalization Rate due to Heart Failure	hospitalizations/ 10,000 population 18+ years	23.5		28.3		2020-2022		5
1.00	Heart Failure: Medicare Population	percent	10.0		10.0	11.0	2022		18
0.97	Age-Adjusted ER Rate due to Heart Failure	ER visits/ 10,000 population 18+ years	6.5		9.7		2020-2022		5
0.88	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	34.1	33.4	37.0		2020-2022		7
0.71	Adults who Experienced a Stroke	percent	3.2			3.6	2022		16

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.47	Overcrowded Households	percent	7.7		8.2	3.5	2023		1
1.82	Persons Living and Diagnosed with HIV who are in Care	percent	72.0		73.7		2022		7
1.59	Tuberculosis Incidence Rate	cases/ 100,000 population	3.9	1.4	5.4		2023		7
1.47	Cervical Cancer Incidence Rate	cases/ 100,000 females	7.5		7.3	7.5	2017-2021		25

1.47	Kindergartners with Required Immunizations	percent	95.1		92.8		2021-2022	8
1.38	Congenital Syphilis Incidence Rate	cases/ 100,000 live births	83.5	33.9	120.9		2021	9
1.35	Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza	ER visits/ 10,000 population 18+ years	15.0		14.9		2020-2022	5
1.32	Gonorrhea Incidence Rate	cases/ 100,000 population	110.0		230.9	214.0	2021	9
1.29	Death Rate Among Persons with Diagnosed HIV Infection	deaths/ 100,000 population	2.0		5.4		2022	7
1.29	HIV Diagnosis Rate	cases/ 100,000 population	6.5		12.2		2022	7
1.18	Age-Adjusted Hospitalization Rate due to Hepatitis	hospitalizations/ 10,000 population 18+ years	1.0		1.0		2020-2022	5
1.06	Chlamydia Incidence Rate	cases/ 100,000 population	371.1		484.7	495.5	2021	9
1.06	Syphilis Incidence Rate	cases/ 100,000 population	15.6		22.3	16.2	2021	9
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	6.6		10.9		2020-2022	7
1.00	Age-Adjusted ER Rate due to Hepatitis	ER visits/ 10,000 population 18+ years	0.5		0.5		2020-2022	5
0.88	Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia	hospitalizations/ 10,000 population 18+ years	6.4		6.5		2020-2022	5
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	Percent	77.0		73.0	70.1	2023	20
0.62	Flu Vaccinations: Medicare Population	percent	53.0		48.0	50.0	2022	18
0.59	Pneumonia Vaccinations: Medicare Population	percent	9.0		8.0	8.0	2022	18
0.53	Age-Adjusted ER Rate due to Community Acquired Pneumonia	ER visits/ 10,000 population 18+ years	12.1		14.1		2020-2022	5
0.53	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	0.9		1.0		2020-2022	5

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.76	In-Hospital Exclusive Breastfeeding	percent	73.1		68.5		2022		7

1.47	Any In-Hospital Breastfeeding	percent	95.8		93.8		2022		7
1.47	Babies with Low Birthweight	percent	6.6		7.2		2020-2022		7
1.38	Congenital Syphilis Incidence Rate	cases/ 100,000 live births	83.5	33.9	120.9		2021		9
1.18	Infant Mortality Rate	deaths/ 1,000 live births	3.5	5.0	3.7		2019-2021		7
1.00	Mothers who Received Early Prenatal Care	percent	89.2		87.6		2020-2022		7
0.82	Preterm Births	percent	7.9	9.4	9.0		2020-2022	Black (11.63) White (7.26) Asian (8.25) AIAN (0) PI (0) Mult (5.87) Other (0) Hisp (8.22)	7
0.62	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	9.5		9.5	14.2	2020-2022		7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.12	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population aged 10-17	82.1		69.6		2020-2022		5
2.00	Depression: Medicare Population	percent	16.0		14.0	16.0	2022		18
1.82	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	hospitalizations/ 10,000 population under 18 years	25.0		24.1		2020-2022		5
1.76	Adults with Likely Serious Psychological Distress	percent	16.4		16.7		2021-2022		10
1.76	Youth Depression	percent	36.0		32.0		2017-2019		12
1.71	Alzheimer's Disease or Dementia: Medicare Population	percent	6.0		5.0	6.0	2022		18
1.68	Age-Adjusted ER Rate due to Adult Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population 18+ years	29.9		24.6		2020-2022	Black (58.6) White (36.8) API (9.6) Hisp (23.4)	5
1.65	Adults Needing and Receiving Behavioral Health Care Services	percent	57.1		55.9		2021-2022		10
1.65	Age-Adjusted Hospitalization Rate due to Adult Mental Health	hospitalizations/ 10,000 population 18+ years	32.7		33.3		2020-2022	Black (54.9) White (35.9) AIAN (11) API (10.5) Hisp (20.3)	5
1.47	Adults Needing Help With Mental, Emotional or Substance Abuse Problems	percent	23.0		25.4		2022		10
1.47	Poor Mental Health: Average Number of Days	days	4.9		4.7	4.8	2021		23

1.41	Adults Ever Diagnosed with Depression	percent	21.1			20.7	2022		16
1.35	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	10.2	12.8	10.1		2020-2022		7
1.35	Age-Adjusted Hospitalization Rate due to Adult Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population 18+ years	13.7		13.7		2020-2022		5
1.29	Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population aged 10-17	16.1		20.0		2020-2022		5
1.06	Age-Adjusted ER Rate due to Adult Mental Health	ER visits/ 10,000 population 18+ years	67.5		66.2		2020-2022	Black (111.1) White (78.8) AIAN (17.3) API (20.2) Hisp (64.7)	5
1.06	Poor Mental Health: 14+ Days	percent	15.7			15.8	2022		16
0.71	Age-Adjusted ER Rate due to Pediatric Mental Health	ER visits/ 10,000 population under 18 years	24.9		27.9		2020-2022		5
0.35	Mental Health Provider Rate	providers/ 100,000 population	480.4		449.8	313.9	2023		23

SCORE	NUTRITION & HEALTHY EATING	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.91	Adults who Drink Sugar-Sweetened Beverages	percent	19.5		14.6		2021-2022		11
1.85	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	Percent	40.7		40.9	40.4	2023		20
1.53	Adults Receiving Food Stamp Benefits	percent	30.8		31.7		2022		10
1.06	Adults who Frequently Cook Meals at Home	Percent	81.1		78.2	78.0	2023		20
0.76	Food Environment Index		8.9		8.6	7.7	2024		23

SCORE	OLDER ADULTS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.71	Asthma: Medicare Population	percent	8.0		7.0	7.0	2022		18
2.71	Osteoporosis: Medicare Population	percent	15.0		13.0	11.0	2022		18
2.53	Cancer: Medicare Population	percent	13.0		11.0	12.0	2022		18
2.35	Atrial Fibrillation: Medicare Population	percent	15.0		13.0	14.0	2022		18
2.35	Prostate Cancer Incidence Rate	cases/ 100,000 males	115.4		95.4	110.5	2016-2020		25

2.35	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37.0	32.0	35.0	2022		18
2.18	Hyperlipidemia: Medicare Population	percent	67.0	61.0	65.0	2022		18
2.18	Stroke: Medicare Population	percent	6.0	5.0	6.0	2022		18
2.00	Depression: Medicare Population	percent	16.0	14.0	16.0	2022		18
1.94	People 65+ Living Alone (Count)	people	29418			2018-2022		2
1.94	People 65+ Living Below Poverty Level (Count)	people	11377			2018-2022		2
1.82	Hypertension: Medicare Population	percent	63.0	58.0	65.0	2022		18
1.71	Alzheimer's Disease or Dementia: Medicare Population	percent	6.0	5.0	6.0	2022		18
1.71	Ischemic Heart Disease: Medicare Population	percent	21.0	18.0	21.0	2022		18
1.35	Chronic Kidney Disease: Medicare Population	percent	17.0	16.0	18.0	2022		18
1.35	Mammography Screening: Medicare Population	percent	43.0	41.0	47.0	2022		18
1.29	COPD: Medicare Population	percent	9.0	8.0	11.0	2022		18
1.29	Hospitalization Rate due to Hip Fractures Among Males 65+	hospitalizations/ 100,000 males 65+ years	111.6	276.5		2020-2022		5
1.24	People 65+ Living Below Poverty Level	percent	8.4	11.0	10.0	2018-2022		2
1.18	Diabetes: Medicare Population	percent	22.0	21.0	24.0	2022	Black (33) White (20) AIAN (35) API (37) Hisp (29)	18
1.18	Hospitalization Rate due to Hip Fractures Among Females 65+	hospitalizations/ 100,000 females 65+ years	240.3	486.7		2020-2022		5
1.00	Elder Index (Elderly Household Below Income Threshold)	percent	24.1	27.7		2019-2020		10
1.00	Heart Failure: Medicare Population	percent	10.0	10.0	11.0	2022		18
0.88	Adults 65+ with Total Tooth Loss	percent	10.9		12.2	2022		16
0.79	People 65+ Living Alone	percent	21.2	21.6	25.7	2023		1

SCORE	ORAL HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.53	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.8		10.1	11.9	2016-2020		25

1.41	Children who Visited a Dentist	percent	92.7		91.9		2017-2018		11
1.06	Adults who Visited a Dentist	percent	65.0			63.9	2022		16
0.88	Adults 65+ with Total Tooth Loss	percent	10.9			12.2	2022		16
0.53	Age-Adjusted ER Rate due to Dental Problems	ER visits/ 10,000 population	20.8		25.7		2020-2022	Black (41.6) White (23.2) AIAN (8.2) API (4.5) Hisp (22.2)	5
0.18	Dentist Rate	dentists/ 100,000 population	97.9		92.9	73.5	2022		23

SCORE	OTHER CONDITIONS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.71	Osteoporosis: Medicare Population	percent	15.0		13.0	11.0	2022		18
2.35	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37.0		32.0	35.0	2022		18
1.53	Age-Adjusted ER Rate due to Dehydration	ER visits/ 10,000 population 18+ years	10.7		9.0		2020-2022		5
1.41	Age-Adjusted Hospitalization Rate due to Urinary Tract Infections	hospitalizations/ 10,000 population 18+ years	7.7		6.7		2020-2022		5
1.35	Chronic Kidney Disease: Medicare Population	percent	17.0		16.0	18.0	2022		18
1.24	Age-Adjusted Hospitalization Rate due to Dehydration	hospitalizations/ 10,000 population 18+ years	7.7		7.1		2020-2022		5
1.06	Adults with Arthritis	percent	24.3			26.6	2022		16
0.53	Age-Adjusted ER Rate due to Urinary Tract Infections	ER visits/ 10,000 population 18+ years	66.0		77.0		2020-2022		5

SCORE	PHYSICAL ACTIVITY	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.88	Workers who Walk to Work	percent	1.8		2.5	2.4	2023		1
1.68	Adults Who Are Obese	percent	29.1		28.8	33.6	2022		10
1.88	Workers who Walk to Work	percent	1.8		2.5	2.4	2023		1
1.56	Adults who are Overweight or Obese	percent	62.4		62.3	67.7	2022		10
1.06	Access to Parks	percent	82.1		79.5		2020		27
1.06	Adults who Follow a Regular Exercise Routine	Percent	73.1		69.3	67.2	2023		20
0.62	Access to Exercise Opportunities	percent	97.8		94.2	84.1	2024		23

SCORE	PREVENTION & SAFETY	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.94	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	48.9	43.2	47.9		2020-2022		7
1.85	Age-Adjusted Hospitalization Rate due to Unintentional Falls	hospitalizations/ 10,000 population 18+ years	43.2		37.9		2020-2022		5
1.71	Severe Housing Problems	percent	22.9		25.7	16.7	2016-2020		23
1.29	Hospitalization Rate due to Hip Fractures Among Males 65+	hospitalizations/ 100,000 males 65+ years	111.6		276.5		2020-2022		5
1.18	Age-Adjusted ER Rate due to Unintentional Falls	ER visits/ 10,000 population 18+ years	163.1		161.5		2020-2022		5
1.18	Hospitalization Rate due to Hip Fractures Among Females 65+	hospitalizations/ 100,000 females 65+ years	240.3		486.7		2020-2022		5
0.29	Age-Adjusted Death Rate due to Firearms	deaths/ 100,000 population	6.3	10.7	7.4	12.0	2018-2020		17

SCORE	RESPIRATORY DISEASES	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.71	Asthma: Medicare Population	percent	8.0		7.0	7.0	2022		18
1.74	Adults with Asthma	percent	17.1		17.0	15.7	2022		10
1.74	Children and Teens with Asthma	percent	12.3		11.6		2021-2022		11
1.59	Teens who Smoke: 11th Graders	percent	2.1		2.0		2017-2019		12
1.59	Teens who Smoke: 7th Graders	percent	1.1		1.0		2017-2019		12
1.59	Tuberculosis Incidence Rate	cases/ 100,000 population	3.9	1.4	5.4		2023		7
1.41	Proximity to Highways	percent	5.0		5.8		2020		27
1.35	Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza	ER visits/ 10,000 population 18+ years	15.0		14.9		2020-2022		5
1.29	COPD: Medicare Population	percent	9.0		8.0	11.0	2022		18
1.24	Teens who Smoke: 9th Graders	percent	1.5		2.0		2017-2019		12
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	6.6		10.9		2020-2022		7
1.00	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	hospitalizations/ 10,000 population under 18 years	3.3		5.0		2020-2022		5

0.97	Adults Who Used Electronic Cigarettes: Past 30 Days	percent	5.1		5.5	5.9	2023		20
0.88	Adults with COPD	Percent of adults	5.8			6.8	2022		16
0.88	Adults with Current Asthma	percent	9.8			9.9	2022		16
0.88	Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia	hospitalizations/ 10,000 population 18+ years	6.4		6.5		2020-2022		5
0.82	Adults who Smoke	percent	2.7	6.1	6.1		2021-2022	White (3.1) Hisp (0.3)	10
0.71	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	17.2		23.7		2020-2022		5
0.71	Age-Adjusted Hospitalization Rate due to Adult Asthma	hospitalizations/ 10,000 population 18+ years	1.2		1.7		2020-2022		5
0.71	Age-Adjusted Hospitalization Rate due to COPD	hospitalizations/ 10,000 population 18+ years	4.8		5.5		2020-2022		5
0.65	Adults Who Used Smokeless Tobacco: Past 30 Days	percent	1.1		1.0	1.7	2023		20
0.53	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	18.4	25.1	20.6		2020-2022		7
0.53	Age-Adjusted ER Rate due to Adult Asthma	ER visits/ 10,000 population 18+ years	10.9		15.3		2020-2022	Black (28.1) White (11.4) API (3.4) Hisp (11.5)	5
0.53	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	12.5		17.5		2020-2022	Black (28) White (13.2) API (4.3) Hisp (13.6)	5
0.53	Age-Adjusted ER Rate due to Community Acquired Pneumonia	ER visits/ 10,000 population 18+ years	12.1		14.1		2020-2022		5
0.53	Age-Adjusted ER Rate due to COPD	ER visits/ 10,000 population 18+ years	7.4		10.4		2020-2022	Black (22.2) White (8.1) API (2.5) Hisp (4.7)	5
0.53	Age-Adjusted Hospitalization Rate due to Asthma	hospitalizations/ 10,000 population	1.7		2.5		2020-2022		5
0.53	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	0.9		1.0		2020-2022		5
0.47	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	35.6		37.6	54.0	2016-2020		25

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.82	Persons Living and Diagnosed with HIV who are in Care	percent	72.0		73.7		2022		7

1.38	Congenital Syphilis Incidence Rate	cases/ 100,000 live births	83.5	33.9	120.9		2021	9
1.32	Gonorrhea Incidence Rate	cases/ 100,000 population	110.0		230.9	214.0	2021	9
1.29	Death Rate Among Persons with Diagnosed HIV Infection	deaths/ 100,000 population	2.0		5.4		2022	7
1.29	HIV Diagnosis Rate	cases/ 100,000 population	6.5		12.2		2022	7
1.06	Chlamydia Incidence Rate	cases/ 100,000 population	371.1		484.7	495.5	2021	9
1.06	Syphilis Incidence Rate	cases/ 100,000 population	15.6		22.3	16.2	2021	9

SCORE	TOBACCO USE	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.59	Teens who Smoke: 11th Graders	percent	2.1		2.0		2017-2019		12
1.59	Teens who Smoke: 7th Graders	percent	1.1		1.0		2017-2019		12
1.24	Teens who Smoke: 9th Graders	percent	1.5		2.0		2017-2019		12
0.97	Adults Who Used Electronic Cigarettes: Past 30 Days	percent	5.1		5.5	5.9	2023		20
0.82	Adults who Smoke	percent	2.7	6.1	6.1		2021-2022	White (3.1) Hisp (0.3)	10
0.65	Adults Who Used Smokeless Tobacco: Past 30 Days	percent	1.1		1.0	1.7	2023		20
0.47	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	35.6		37.6	54.0	2016-2020		25

SCORE	WEIGHT STATUS	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.68	Adults Who Are Obese	percent	29.1		28.8	33.6	2022		10
1.56	Adults who are Overweight or Obese	percent	62.4		62.3	67.7	2022		10
1.56	Teens who are Overweight or Obese	percent	36.6		37.4		2021-2022		11
1.24	Children who are Overweight for Age	percent	13.9		16.6		2021-2022		11
1.06	Adults Happy with Weight	Percent	52.2		50.4	48.7	2023		20

SCORE	WELLNESS & LIFESTYLE	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
1.91	Adults who Drink Sugar-Sweetened Beverages	percent	19.5		14.6		2021-2022		11
1.85	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	Percent	40.7		40.9	40.4	2023		20
1.53	Poor Physical Health: Average Number of Days	days	3.6		3.1	3.3	2021		23
1.47	High Blood Pressure Prevalence	percent	32.8	41.9	34.8		2022		10
1.41	Poor Physical Health: 14+ Days	percent	13.1			12.7	2022		16
1.41	Self-Reported General Health Assessment: Poor or Fair	percent	18.3			17.9	2022		16
1.29	Self-Reported General Health Assessment: Good or Better	percent	90.8		86.0		2022		10
1.24	Insufficient Sleep	percent	33.5	26.7		36.0	2022		16
1.15	Adult Self-Reported General Health Assessment: Good or Better	percent	89.8		85.0		2021-2022		10
1.06	Adults Happy with Weight	Percent	52.2		50.4	48.7	2023		20
1.06	Adults who Follow a Regular Exercise Routine	Percent	73.1		69.3	67.2	2023		20
1.06	Adults who Frequently Cook Meals at Home	Percent	81.1		78.2	78.0	2023		20
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	Percent	77.0		73.0	70.1	2023		20
0.79	Life Expectancy	years	81.3		79.9	77.6	2019-2021		23

SCORE	WOMEN'S HEALTH	UNITS	VENTURA COUNTY	HP2030	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY	Source
2.47	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.2	15.3	17.6		2020-2022		7
2.18	Breast Cancer Incidence Rate	cases/ 100,000 females	130.7		121.0	127.0	2016-2020		25
1.47	Cervical Cancer Incidence Rate	cases/ 100,000 females	7.5		7.3	7.5	2017-2021		25
1.41	Cervical Cancer Screening: 21-65	Percent	82.2			82.8	2020		16
1.41	Mammogram in Past 2 Years: 50-74	percent	75.2	80.3		76.5	2022		16
1.35	Mammography Screening: Medicare Population	percent	43.0		41.0	47.0	2022		18

AIAN = American Indian or Alaska Native; API = Asian or Pacific Islander; Hisp = Hispanic or Latino

PRIMARY DATA METHODOLOGY

Community input for VCCHIC was collected to expand upon the information gathered from the secondary data and consisted of a community survey in English and Spanish, community member focus groups and community partner listening sessions.

Community Survey Methodology

Since one of the most valuable ways to learn about the health of a community is by reaching out to the different constituents in the community, including residents, VCCHIC prioritized local participation for this community health needs assessment and improvement planning cycle. The community survey was distributed online through Qualtrics from February through March of 2025. The survey was made available in both English and Spanish. Paper surveys were also made available and answers to the paper survey were entered into Qualtrics.

Survey Limitations

When conducting a community health needs assessment, it's crucial to acknowledge the limitations of using a convenience sample for survey data collection. Convenience sampling involves selecting participants based on their availability and willingness to participate, rather than through random selection. This approach can introduce significant bias, as the sample may not accurately represent the broader community. In our survey, most respondents were female, white, and many were over 65 years of age, which further limits the generalizability of the findings. The lack of diversity in the sample means that the results may not fully capture the health needs and perspectives of other demographic groups within the community. Additionally, self-selection bias can occur, where individuals who choose to participate may differ in important ways from those who do not, further skewing the results. Non-response bias is another concern, as those who opt out of the survey might have different health needs or opinions compared to respondents. These limitations can affect the reliability and validity of the data, making it essential to interpret the results with caution and consider supplementary methods to ensure a comprehensive understanding of community health needs.

2025 Community Health Survey Questionnaire

Please take 5-10 minutes to complete this survey. The purpose of this survey is to get your opinions about how to improve the health of Ventura County residents. Your feedback is very important to us!

Taking part in the survey is voluntary and all of your responses will be kept private. We will not be asking for your name, email, or other identifying information. You have the choice to not answer any questions that you choose.

This survey is being conducted by Ventura County Community Health Improvement Collaborative (VCCHIC). VCCHIC is a collective impact partnership uniting dozens of local health- and service-minded stakeholders across Ventura County – including hospitals, governmental health agencies, community clinics, health plans, community-based organizations, advocates, philanthropies, and residents – the Ventura County Community Health Improvement Collaborative works to improve health for all.

1. Please enter the zip code where you live: _____

2. Please select your current age group.

- o 0-17 years
- o 18-24 years
- o 25-34 years
- o 35-44 years
- o 45-54 years
- o 55-64 years
- o 65 years and older

Plase note: In this survey, "community" refers to the major areas where you live, shop, play, work and get services.

3. What do you think makes a "Healthy Community"? These are the things which most improve life in a community. (Choose the five options that are most important to you.)
   - o Access to health care (e.g., having a regular doctor, insurance coverage)
   - o Access to organizations which provide community services (e.g. food banks, shelters, screenings, free vaccinations etc.)
   - o Access to family planning (birth control, etc.)
   - o Access to parks and recreation (includes arts and cultural events)
   - o Access to transportation
   - o Affordable housing
   - o Caregiver support and education
   - o Clean environment (e.g. clean air, water, soil)
   - o Good jobs and healthy economy
   - o Good place to grow older and/or raise children
   - o Good schools
   - o Strong resident involvement in local planning and decision-making
   - o Safe communities
   - o Welcoming, inclusive community (regardless of one's ethnicity, race, religion, sexual orientation, etc.)
   - o Other (please specify): _____

4. What do you think are the five most important "health problems" in our community? These are problems which have the greatest impact on overall community health.

   (Choose the five options that are most important to you.)
   - o Aging complications (e.g. dementia, falls, social isolation etc.)
   - o Cancers
   - o Caregiver stress
   - o Child abuse / neglect
   - o Chronic conditions (diabetes, high blood pressure, heart disease, respiratory/lung disease, etc.)
   - o Dental problems
   - o Discrimination / racism
   - o Domestic violence
   - o Gun violence
   - o Infectious diseases (e.g. COVID-19, sexually transmitted infections, hepatitis, HIV/AIDS, TB, etc.)
   - o Mental health problems (e.g. trauma, depression, bipolar, etc.)
   - o Motor vehicle crash injuries (includes pedestrians and cyclists)
   - o Lack of health care access for those who are pregnant & infants
   - o Sexual violence / assault
   - o Suicide
   - o Other - please specify: _____

5. What do you think are the five most important "risky behaviors" in our community? (Choose the five behaviors which you think have the greatest impact on overall community health.)
   - o Being overweight / obese
   - o Dropping out of school
   - o Drug / alcohol use
   - o Lack of adequate sleep
   - o Lack of exercise
   - o Not using seat belts / child safety seats
   - o Poor eating habits
   - o Refusal of vaccinations
   - o Tobacco / e-cigarette use
   - o Unsafe sex
   - o Unsecured firearms
   - o Other - please specify: _____

6. Which of the following issues deserves the most attention and investment in order to make your community a healthier place? (Choose the five options that are most important to you.)
   - o Access to parks and recreation spaces
   - o Access to prenatal care for expectant parents
   - o Affordable health care
   - o Childcare and early childhood education for families in need
   - o Community safety
   - o Emergency preparedness / adaptation for natural disasters (e.g. wildfires, heat waves, tsunamis, earthquakes, etc.)
   - o Environmental safety (clean air, clean water, clean soil, pesticide concerns)
   - o Good paying jobs and workforce development
   - o Gun safety
   - o Health education / campaigns
   - o Improving housing conditions or housing access
   - o Internet access and relevant technology skills to communicate, access virtual school, or work remotely from home
   - o Language access / lack of interpreters
   - o Sufficient food or healthy food options
   - o Transportation for medical needs
   - o Other - please specify: _____

7. Do you provide regular care or assistance to a friend or family member?
   - o No
   - o Yes, Paid
   - o Yes, Unpaid
   - o Prefer not to answer

8. If yes, who do you provide regular care or assistance for (select all that apply)?
   - o Adult 65 or older with dementia
   - o Adult 65 or older without dementia
   - o Adult under 65 years old with a disability
   - o Child (under 18 years old) with a disability
   - o Child (under 18 years old) without a disability
   - o Other - please specify: _____

9. Please indicate how much stress you currently experience in the following areas of your life...

	None at All	Some	A Lot	Not Applicable
Caregiving responsibilities for a family member	o	o	o	o
Child's/children's mental health	o	o	o	o
Child's/children's overall physical health	o	o	o	o
Citizenship / immigration status	o	o	o	o
College / school	o	o	o	o
Debt / expenses	o	o	o	o
Employment / work	o	o	o	o
Food / grocery access	o	o	o	o
Housing situation	o	o	o	o
Overall mental health	o	o	o	o
Overall physical health	o	o	o	o
Racism and/or other forms of discrimination	o	o	o	o
Relationships with your partner, family, and/or friends	o	o	o	o

10. If you or someone you care for needed mental health services / care in the last 12 months, did you receive all the services you needed? (e.g. counseling, therapy, medication, psychiatric services, etc.)
    - o No, I did not get all the care I needed
    - o Yes, I got all the care I needed
    - o I did not need services in the last 12 months

11. If no, what are the main reasons for not getting the mental health care you needed? (Check all that apply.)
- o I did not know where to find help
- o I could not find providers that I could access, or were accepting new patients
- o The hours of services were not convenient for me
- o Location was not convenient
- o Cost - too expensive, can't pay (e.g. no health insurance or limited coverage)
- o I was worried or nervous about seeking this type of care
- o I was afraid of being judged for my situation
- o There were no services available in my preferred language
- o I had previous negative experiences with mental health services
- o I did not think services would help
- o Other: _____

12. If you or someone you care for needed other health services (non-mental health care) in the last 12 months, did you get all the services you needed? (e.g. regular check-ups, lab work, screenings, surgeries, immunizations, etc.)
- o No, I did not get all the care I needed
- o Yes, I got all the care I needed
- o I did not need services in the last 12 months

13. If no, what are the main reasons for not getting the other health services (non-mental health care) you needed? (Select all that apply)
- o Cost - too expensive/can't pay (no health insurance or limited health insurance)
- o Cultural/religious reasons
- o Did not feel cared for, respected, or understood
- o Fear of being mistreated by a service provider
- o I was afraid of being judged for my situation
- o Lack of transportation
- o Inconvenient location
- o Insurance not accepted
- o It took too long to get an appointment
- o Lack of services available in my language
- o Lack of trust in health care/dental services and/or providers
- o Other: _____

14. Please tell us how often you currently use the following substances. (Be assured that all responses will remain confidential to maintain your privacy):

	Never	Rarely (less than once a month)	Sometimes (1-3 times a month	Often (1-3 times a week)	Very Often (4 or more times a week)	I prefer not to say
Alcohol (e.g., beer, wine, liquor)	o	o	o	o	o	o
Cannabis/ marijuana products	o	o	o	o	o	o
Prescription medication used in a way not as prescribed by a doctor	o	o	o	o	o	o
Tobacco product (e.g., chewing tobacco, cigarettes, cigars, vaping, e-cigarettes)	o	o	o	o	o	o
Other drugs (e.g., cocaine, methamphetamine, heroin, ketamine, etc.)	o	o	o	o	o	o

15. If you or someone you care for needed substance use services / treatment in the last 12 months, did you get all the services you needed? (e.g. alcohol or drug treatment services, detox, support groups, medication, etc.)
- o No, I did not get all the treatment I needed
- o Yes, I got all the treatment I needed
- o I did not need treatment in the last 12 months

16. If no, what are the main reasons for not getting the substance use services / treatment you needed? (Check all that apply.)
    - o I did not know where to find help
    - o The hours of services were not convenient for me
    - o I had no health insurance or had limited coverage
    - o I was afraid of being mistreated by a service provider
    - o I was afraid of being judged for my situation
    - o There were no services available in my preferred language
    - o Getting services required too much travel
    - o I had previous negative experiences with mental health services
    - o I did not think services would help
    - o Other: _____

17. If you or someone you care for needed housing in the last 12 months, were you able to find housing resources? (e.g., local housing authorities, nonprofit organizations, emergency rental assistance programs, shelters, etc.)
    - o No, I did not find housing resources
    - o Yes, I got the housing resources I needed
    - o I did not need housing resources in the last 12 months

18. If no, what are the main reasons for not getting the housing services you needed? (Check all that apply.)
    - o I couldn't afford rent or housing costs
    - o I couldn't find available housing in my preferred area
    - o I did not know where to find housing resources or services
    - o I did not meet eligibility criteria for housing assistance
    - o I was afraid of being mistreated by a landlord/service provider
    - o I was afraid of being judged for my situation
    - o I had previous negative past experiences with housing resources
    - o There was a long waiting list for affordable housing options
    - o I encountered discrimination in the housing search process
    - o I was unsure if my citizenship status would affect my eligibility for housing services
    - o Other: _____

19. In your day-to-day life, how often have any of the following things happened to you?

	Almost Every day	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy or respect than other people	o	o	o	o	o
You receive poorer service than other people at businesses or health care facilities	o	o	o	o	o
People act as if they think you are not smart	o	o	o	o	o
People act as if they are afraid of you	o	o	o	o	o
You are threatened or harassed	o	o	o	o	o

20. What do you think is the main reason for these experiences? You may select more than one option.
    - o Your National Origins or Immigration Status
    - o Your Gender
    - o Your Race or Ethnicity
    - o Your Age
    - o Your Religion
    - o Your Height
    - o Your Weight
    - o Some other Aspect of Your Physical Appearance
    - o Your Sexual Orientation or Gender Expression
    - o Your Education or Income Level
    - o Not Applicable
    - o Other: _____

21. Have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations?

	No	Occasionally	Often or Always
At school?	o	o	o
Getting hired or getting a job?	o	o	o
At work?	o	o	o
Getting housing?	o	o	o
Getting medical care?	o	o	o
Getting service at a store or restaurant?	o	o	o
Getting credit, bank loans, or a mortgage?	o	o	o
On the street or in a public setting?	o	o	o
From the police or in court?	o	o	o

Suicide Prevention

22. Over the past 12 months, have you thought seriously about killing yourself?
    - o No
    - o Yes
    - o Prefer not to answer

23. Over the past 12 months, have you made a suicide attempt?
    - o No
    - o Yes
    - o Prefer not to answer

24. If yes, did you receive medical attention?
    - o No
    - o Yes
    - o Prefer not to answer

25. Do you know of support resources in your community to help those having suicidal thoughts?
    - o No
    - o Yes
    - o Prefer not to answer

Please reach out if you need help: https://www.wellnesseveryday.org/preventing-suicide

Call or Text 988

Web Chat: www.988lifeline.org

Free • Confidential • 24/7

Now we are going to ask some demographic questions. These are very important and help us guide interventions in the community.

26. What is your current gender identity?
    - o Woman
    - o Man
    - o Nonbinary or Genderqueer (Neither exclusively male nor female)
    - o Transgender Man
    - o Transgender Woman
    - o I prefer to self-describe as _____
    - o Prefer not to answer

27. What was your sex assigned at birth (what the doctor put on your birth certificate)?
    - o Female
    - o Male
    - o Intersex
    - o Unknown or information is unavailable
    - o Prefer not to answer

28. Which best describes your sexual orientation?

- o Asexual
- o Bisexual
- o Lesbian or gay or homosexual
- o Queer
- o Straight or heterosexual
- o I prefer to self-describe as: _____
- o Don't know
- o Prefer not to answer

29. Which of the following best describes your marital/relationship status?

- o Domestic Partner
- o Married
- o Not Married/Single
- o Other
- o Prefer not to answer

30. Which of the following best describes your current living situation?

- o Homeowner
- o Homeless / Unhoused
- o Hotel / motel
- o Live with a friend/family member
- o Living in vehicle or RV
- o Renter
- o Shelter
- o Other - please specify:_____

31. What is the highest level of school you have completed or the highest degree you have received?

- o Less than high school degree
- o High school graduate (high school diploma or equivalent including GED)
- o Some college but no degree
- o Associate degree in college (2-year)
- o Bachelor's degree in college (4-year)
- o Master's degree
- o Doctoral degree
- o Professional degree (JD, MD)

32. Information about income is very important to understand. Would you please give your best guess? Please indicate the answer that includes your entire household income in 2024 before taxes.

- o Less than $15,000
- o $15,000 to $29,999
- o $30,000 to $59,999
- o $60,000 to $99,999
- o $100,000 or more

33. What kind of business or industry do you work in?

- o Agriculture
- o Construction
- o Education
- o Food Service or Retail
- o Government
- o Health care and/or Social Services
- o Military
- o Technology
- o Transportation
- o Other - please specify: _____

34. What is your current employment status? (select all that apply)

- o Employed
- o Full or part-time family caregiver
- o Homemaker / stay-at-home parent
- o Not working but looking for a job
- o Not working but not looking for a job
- o Retired
- o Self-employed
- o Student
- o Unable to work
- o Other: _____

35. Please choose one or more race/ethnicities that you consider yourself to be (Please select all that apply):

- o Asian or Asian American (e.g., Chinese, Filipino, Indian, Japanese, Korean, Pakistani, Sri Lankan, Vietnamese, etc.)
- o Black or African American (e.g., Ethiopian, Ghanaian, Jamaican, Nigerian, Somali, etc.)
- o Indigenous, Central and South America (e.g., K'iche, Maya, Mixtec, Purepecha, Quechua, Triqui, Zapotec, etc.)
- o Latino/a/e, Hispanic, or Caribbean (e.g., Colombian, Cuban, Guatemalan, Mexican, Puerto Rican, Salvadoran, South American, etc.)
- o Middle Eastern or Arab American (e.g., Algerian, Egyptian, Iraqi, Jordanian, Lebanese, Moroccan, etc.)
- o Native Hawaiian or Other Pacific Islander (e.g., Chamorro, Fijian, Samoan, Tahitian, Tongan, etc.)
- o Native North American or Alaska Native (e.g., Chumash, Inuit, Kumeyaay, Miwok, Pomo, Tongva, Yurok, etc.)
- o Other Indigenous or Aboriginal Peoples Outside the Americas
- o White / Caucasian
- o Other: _____

36. What language do you speak at home the most?

- o Arabic
- o Cantonese
- o English
- o Gujarati
- o Mandarin
- o Mixtec
- o Persian
- o Spanish
- o Tagalog
- o Other - please specify:_____

37. Have you ever served in the US Armed Forces, Reserves, or National Guard?

- o No
- o Yes, currently serve
- o Yes, served in the past
- o Prefer not to answer

38. Do you have a disability? (Disability is defined as a physical or mental impairment or medical condition lasting at least 6 months that substantially limits a major life activity.)

- o No
- o Yes
- o Prefer not to answer

39. If yes, please select the type(s) of disabilities that you have.

- o Post-traumatic stress disorder
- o Major depressive disorder
- o Anxiety disorder
- o Bipolar disorder

- o Schizophrenia
- o Difficulty seeing
- o Difficulty hearing or having speech understood
- o Physical/Mobility Disability
- o Chronic Health Condition/Chronic Pain
- o Learning disability
- o Developmental disability
- o Dementia
- o Other - please specify:_____

40. How do you pay for your health care (select all that apply)?

- o Health insurance (e.g., private insurance, Blue Shield, HMO)
- o Indian Health Services
- o Medi-Cal
- o Medicare
- o Pay cash (no insurance)
- o Veterans' Administration
- o Other - please specify: _____

41. Where do you get most of your trusted health information? Select all that apply.

- o Community organization/agency
- o Doctor or health care provider
- o Facebook, Instagram, X (formerly Twitter), Tik Tok
- o Other social media
- o Family or friends
- o Health Department
- o Hospital
- o Internet
- o Library
- o Newspaper/Magazine
- o Radio
- o Church or church group
- o School or college
- o TV
- o Workplace
- o Other (please specify): _____

42. Who do you trust the most to meet your health and/or wellness needs?

- o My primary care doctor or health care provider
- o Nurse or nurse practitioner
- o Online health website or app
- o Pharmacist
- o Health coach or wellness adviser
- o Specialty doctor relevant to my current health issues
- o Spiritual or religious leader
- o Trusted family member or friend
- o Someone at my local Health Department
- o Someone at my local community clinic
- o Someone at my local service organization (such as a senior center, neighborhood service center, YMCA, etc.)
- o Someone at my local hospital or emergency room
- o Other (please specify): _____

Focus Groups and Listening Session Methodology

Ten focus groups and listening sessions were conducted in February and March 2025. The groups were organized and hosted by VCCHIC members and other community partners. A complete list of host organizations can be found in the Acknowledgements section of this report. Participants were recruited by partner community-based organizations through email invitations and flyers.

People who are more likely to be socially marginalized were recruited for participation in the focus groups. Each focus group included both a facilitator and a note taker as

well as recording tools to capture the conversation for later transcription and analysis.

Listening sessions were convened around populations or health topics of concern in Ventura County. This list and the associated host organizations can be found in the Acknowledgements section of this report. HCI facilitated and recorded and transcribed each listening session. Participant responses were also collected using Poll Everywhere live polling exercises. A list of the questions asked during the focus group and listening session discussions can be found in this Appendix. The audio recordings and transcripts were analyzed using Qualtrics qualitative data analytics tools. Specific input collected from each discussion is detailed in the Community Input section of this report.

Ventura County Focus Group Discussion Questions

1. What resources in or aspects of your community help people become or stay healthy?
2. What makes it harder for people in your community to be healthy?
3. Are there specific groups in your community facing unique health challenges? If so, who are they, and what challenges are they facing?
4. What are the most important health-related challenges facing people in your community?
5. What can be done to improve health in your community?

Ventura County Listening Session Discussion Questions

1. What are the top three (3) health needs that community members in the population(s) you serve are facing?
2. What are the key factors or drivers contributing to the health needs of community members that we have discussed?
3. What communities have been most difficult to reach or serve?
4. What are the greatest barriers or challenges to addressing these health needs in Ventura County?
5. What efforts or programs have been most effective in improving health in Ventura County?
6. What key opportunities (trends, policies, activities) can VCCHIC leverage to improve health in Ventura County?

PRIORITIZATION ACTIVITY

The prioritization process is described in detail in the Prioritization section of this report. This Appendix contains a copy of the prioritization matrix activity the VCCHIC Steering Committee completed.

Instructions: Assign a score to each priority health topic for each criterion. Consider the needs identified through the Community Health Needs Assessment (CHNA) process and your own knowledge, experience, and expertise.

Criteria 1: **Scope**

- How many people or communities in Ventura County are or will be impacted by the issue?

Criteria 2: **Severity**

- How concerning is this issue?
- Hoes does this issue impact health and quality of life?

Criteria 3: Ability to Impact

- Can actionable and measurable goals be defined to address the health need?
- Are the goals achievable in a reasonable timeframe with the resources available to us?

	Scope	Severity	Ability to Impact
Adolescent & Children's Health			
Caregiving			
Chronic & Respiratory Diseases			
Mental Health & Substance Use			
Nutrition, Healthy Eating & Physical Activity			
Older Adults			
Socio-political Environment			
Women's Health			

COMMUNITY RESOURCES

Based on the secondary data analysis presented in this report, Ventura County has shown that some health and quality of life indicators (e.g., oral health, respiratory diseases, tobacco use, immunizations, STIs, maternal and infant health, nutrition and healthy eating) are better compared to California and the U.S. Additionally, many social and economic indicators (e.g., income, poverty, employment) are better compared to California and the U.S.

During the data collection process for this CHNA, community members identified many service organizations and community leaders that were helpful to them. Community members also expressed appreciation for the people and organizations they interacted with. Community partners focused on opportunities to build community-based approaches and leverage funding to achieve common objectives and serve populations of interest.

A current list of community resources, can be found on the Health Matters in Ventura County website at www.healthmattersinvc.org/211resources

This list of resources was developed through documentation of mentions by community input participants in conjunction to those accessed through the 2-1-1 website for Ventura County.

COMMUNITY MEMORIAL HEALTHCARE DEMOGRAPHICS

Data Source	Period of Measure	Indicator	93001	93003	93004	93010	93012	93015	93022	93023	93030	93033	93035	93036	93041	93042	93043	93060	93066	% CMH Service Area
Claritas Demographics	*2024*	Total Population	33,375	49,760	31,522	45,638	37,251	18,984	5,535	20,473	57,745	76,955	27,285	49,198	23,010	41	492	34,180	3291	
		Population by Age																		
		0-4	4.8%	4.7%	5.0%	5.1%	4.1%	6.3%	4.9%	4.2%	6.1%	6.4%	4.3%	6.2%	5.6%	4.9%	7.7%	6.1%	5.1%	5.4%
		5-9	5.1%	4.8%	5.0%	5.4%	4.2%	6.7%	5.0%	4.3%	6.6%	7.3%	4.3%	6.3%	6.1%	4.9%	8.7%	6.3%	4.9%	5.7%
		10-14	5.3%	5.4%	6.0%	5.5%	5.1%	7.6%	5.5%	4.9%	7.6%	8.7%	4.9%	6.9%	6.4%	7.3%	4.7%	7.7%	5.4%	6.5%
		15-17	3.3%	3.6%	4.0%	3.6%	3.7%	4.9%	3.5%	3.1%	5.0%	5.1%	3.2%	4.6%	3.9%	2.4%	2.6%	4.7%	5.7%	4.2%
		18-20	3.4%	3.5%	4.0%	3.7%	5.0%	4.8%	3.5%	3.2%	5.0%	5.0%	3.3%	4.5%	4.9%	14.6%	11.4%	4.6%	5.9%	4.3%
		21-24	4.7%	4.6%	5.2%	5.0%	5.5%	5.9%	4.4%	4.2%	6.6%	6.2%	4.5%	5.8%	6.5%	17.1%	16.5%	5.9%	6.9%	5.6%
		25-34	14.0%	12.7%	11.9%	12.5%	11.0%	13.0%	10.3%	9.2%	14.7%	14.8%	13.0%	16.1%	16.0%	29.3%	30.9%	13.4%	11.0%	13.5%
		35-44	14.1%	13.4%	12.6%	12.5%	11.0%	13.6%	12.7%	11.2%	13.7%	14.0%	12.7%	14.3%	13.8%	12.2%	13.6%	13.1%	10.7%	13.2%
		45-54	12.6%	11.9%	12.0%	11.4%	11.5%	12.3%	12.1%	11.3%	11.9%	11.3%	11.5%	12.2%	10.2%	4.9%	2.6%	12.0%	9.9%	11.7%
		55-64	14.0%	13.6%	13.8%	13.0%	13.7%	11.4%	14.7%	14.9%	10.6%	9.8%	15.6%	10.7%	10.6%	2.4%	0.6%	11.1%	13.8%	12.2%
		65-74	11.9%	12.2%	11.6%	11.7%	13.1%	8.1%	15.3%	17.1%	7.7%	7.0%	13.9%	7.7%	9.5%	0.0%	0.4%	8.8%	11.5%	10.2%
		75-84	5.3%	6.5%	6.4%	7.6%	8.2%	4.1%	6.5%	9.3%	3.3%	3.2%	6.8%	3.5%	4.8%	0.0%	0.2%	4.7%	7.3%	5.3%
		85+	1.7%	3.1%	2.6%	3.0%	3.8%	1.4%	1.7%	3.1%	1.3%	1.1%	2.1%	1.3%	1.7%	0.0%	0.0%	1.7%	2.0%	2.0%
		Population by Sex																		
		Male	49.5%	48.2%	48.3%	48.8%	46.9%	49.5%	49.3%	47.0%	50.0%	50.5%	49.3%	49.5%	49.7%	61.0%	60.0%	49.9%	51.9%	49.2%
		Female	50.5%	51.8%	51.7%	51.2%	53.1%	50.5%	50.7%	53.0%	50.0%	49.5%	50.7%	50.5%	50.3%	39.0%	40.0%	50.1%	48.1%	50.8%
		Population by Race/Ethnicity																		
		White	56.6%	61.4%	58.1%	56.2%	61.0%	32.5%	69.2%	72.6%	21.9%	16.2%	47.2%	27.5%	36.0%	63.4%	57.9%	31.4%	49.3%	41.5%
		Black/African American	1.9%	2.0%	1.8%	2.9%	2.0%	0.7%	0.5%	0.6%	2.6%	1.3%	2.5%	3.0%	3.8%	12.2%	9.4%	0.5%	2.8%	2.0%
		American Indian/Alaska Native	1.6%	1.5%	1.6%	1.0%	0.7%	2.4%	2.5%	1.3%	3.8%	4.1%	2.1%	2.4%	3.1%	0.0%	1.6%	2.5%	1.9%	2.3%
		Asian	2.5%	4.4%	4.9%	9.6%	12.5%	1.5%	1.8%	2.5%	7.5%	6.8%	6.6%	7.3%	5.5%	7.3%	4.5%	0.8%	3.5%	6.0%
		Native Hawaiian/Pacific Islander	0.1%	0.3%	0.2%	0.3%	0.3%	0.1%	0.2%	0.1%	0.3%	0.2%	0.3%	0.4%	0.6%	0.0%	1.8%	0.1%	0.2%	0.2%
		Some Other Race	21.3%	12.5%	13.0%	12.6%	8.8%	40.6%	9.9%	8.8%	41.8%	48.9%	22.0%	32.8%	29.8%	4.9%	12.6%	43.0%	23.5%	27.7%
		2+ Races	16.0%	18.0%	20.4%	17.5%	14.7%	22.1%	15.9%	14.2%	22.2%	22.5%	19.3%	26.8%	21.2%	12.2%	12.2%	21.7%	18.9%	20.1%
		Hispanic/Latino	42.7%	34.1%	39.2%	33.0%	23.6%	77.5%	29.8%	23.7%	79.6%	86.3%	47.5%	71.7%	60.6%	22.0%	32.1%	81.1%	47.4%	56.9%
		Median Household Income	$ 81,748	$ 95,395	$ 111,424	$ 110,555	$ 119,668	$ 84,665	$ 103,750	$ 90,331	$ 88,242	$ 81,926	$ 100,942	$ 93,566	$ 75,291	$ 87,500	$ 77,500	$ 79,283	$ 110,952	$ 87,827
		Population Age 5+ with Language Other than English Spoken at Home	32.3%	23.6%	24.2%	24.5%	24.8%	51.2%	21.6%	22.7%	67.6%	78.4%	37.4%	55.8%	45.7%	7.7%	15.9%	62.1%	34.4%	45.7%
		People 25+ with a High School Degree or Higher	85.9%	91.5%	89.6%	93.6%	94.9%	78.0%	90.5%	91.1%	70.1%	57.5%	88.3%	77.6%	77.0%	95.0%	90.8%	65.9%	88.3%	80.4%
		People 25+ with a Bachelor's Degree or Higher	34.4%	40.4%	36.8%	40.4%	48.4%	15.2%	35.2%	40.6%	18.1%	10.6%	34.8%	24.0%	19.5%	25.0%	23.1%	14.9%	30.9%	28.7%
		Population 16+: Unemployed	6.5%	7.0%	6.0%	6.6%	6.5%	4.8%	4.4%	6.8%	5.4%	8.6%	5.8%	8.8%	8.5%	0.0%	7.1%	7.5%	6.6%	6.9%
		Families Living Below Poverty Level	9.5%	5.3%	2.8%	4.0%	4.3%	5.9%	3.9%	5.5%	8.0%	12.1%	4.1%	7.7%	9.3%	0.0%	12.4%	11.7%	6.9%	7.1%
American Community Survey	*2019-2023*	People Living Below Poverty Level	12.7%	10.5%	7.7%	7.3%	7.1%	5.4%	9.1%	12.7%	11.9%	12.9%	5.1%	11.6%	10.4%	--	--	14.4%	6.4%	10.4%
		Homeownership	39.3%	55.6%	64.5%	61.0%	65.1%	59.6%	76.6%	67.0%	43.2%	55.4%	48.7%	49.7%	37.9%	--	--	51.3%	70.0%	54.0%
		Renters Spending 30% or More of Household Income on Rent	54.2%	59.7%	54.3%	67.6%	62.0%	57.7%	51.1%	63.8%	51.8%	59.8%	63.9%	61.4%	62.2%	--	--	56.9%	62.7%	59.1%
		Households with an Internet Subscription	91.9%	94.3%	91.2%	95.2%	95.6%	88.9%	95.1%	92.6%	89.0%	88.2%	96.1%	93.1%	93.4%	--	--	89.4%	93.8%	92.4%
		Persons in Households with an Internet Subscription	93.6%	96.1%	93.5%	96.6%	96.2%	91.4%	94.9%	94.2%	92.0%	90.6%	97.1%	92.9%	95.2%	--	--	91.6%	90.5%	93.6%

ACKNOWLEDGEMENTS

The Ventura County Community Health Improvement Collaborative (VCCHIC) is grateful to the host organizations that supported the community input collection process. The populations associated with each focus group and topics associated with each listening session are listed next to the name of the host organization in the tables below.

Focus Group Partners

Focus Group	Host Organization
Adolescents and young adults	California State University Channel Islands Pacifica High School
Black and African American populations	Interface Children & Family Services National Health Foundation
Farmworkers	Mixteco/Indigena Community Organizing Project (MICOP)
Gold Coast Health Plan Community Advisory Committee	Gold Coast Health Plan
Hispanic and Latino populations	Clinicas del Camino Real, Inc.
LGBTQIA+ populations	Diversity Collective Ventura County
Older adults and their caregivers	Camarillo Health Care District
Persons with disabilities and their caregivers	Tri Counties Regional Center
Unhoused and housing insecure individuals	The Partnership for Safe Families and Communities of Ventura County
Veterans	Gold Coast Veterans Foundation

Listening Session Partners

Listening Session	Host Organization
Adolescent Health	Ventura County Public Health
Health care Services	Community Memorial Healthcare
Behavioral Health	Ventura County Behavioral Health
Older Adults' Health	Camarillo Health Care District
Prenatal, Early Childhood, Childhood Health	Gold Coast Health Plan
Social Services	Ventura County Community Information Exchange

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