RIDGECREST REGIONAL HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT
SEPTEMBER 2025

PREPARED BY HPSA ACUMEN.

Acknowledgements

HPSA Acumen extends its sincere gratitude to the local public health experts whose insights and support were instrumental in the development of this report. In particular, we are deeply appreciative of the guidance provided by Ziad Jureidini, Strategy and Experience Director at Ridgecrest Regional Hospital, whose expertise greatly enriched our work.

We also thank all individuals who generously shared their time and perspectives during interviews, as well as to the broader Ridgecrest community for their openness and engagement throughout this process.

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Introduction

Ridgecrest Regional Hospital (RRH) is a non-profit hospital located in the northeastern corner of Kern County, CA. The hospital serves residents throughout much of the Southern Sierra Region of California, including communities from as far north as Big Pine, CA, which is over 100 miles north of Ridgecrest and as far south as California City, located 49 miles away. Additional information about RRH can be found at https://www.rrh.org/about-us/.

Kern County spans a strikingly diverse landscape, defined not only by its vastness but also by a pronounced geographic divide often referred to as the "cactus curtain." This informal boundary separates the arid Mojave Desert of the eastern third of the county from the more fertile valleys and foothills that dominate the western two-thirds. The eastern region, characterized by Joshua trees, rugged terrain, and wide-open skies, is markedly distinct in both climate and ecology, leading to different environmental and public health challenges compared to its western counterpart.

RRH stands as the primary healthcare provider for this eastern region, serving as a crucial medical anchor for residents living beyond the cactus curtain. With substantial distances between communities, as well as unique environmental and public health challenges associated with desert living, RRH's role becomes even more pronounced. The hospital's commitment to addressing the needs of those on the eastern side of Kern County is central to bridging the gap in access and ensuring that all populations, regardless of geography, are included in the broader health improvement initiatives.

RRH staff partnered with HPSA Acumen, a healthcare shortage analysis firm headquartered in Jamestown, New York, to complete this assessment. HPSA Acumen outlined a strategic approach that incorporated a variety of data sources, alongside community-informed data collection efforts. This method was designed to ensure a comprehensive understanding of the community's most pressing health needs and guide efforts in addressing prioritized health needs of community members in Ridgecrest.

The following report outlines the methodology used, provides findings from a series of surveys and interviews, and includes an analysis of compiled, publicly available health indicator data. The primary goal of this assessment is to document, synthesize, prioritize, and better understand the needs of the community. This was achieved by engaging residents, public health experts, and community leaders, and by utilizing the best available data to inform future planning and resource allocation.

Methodology

The 2025 CHNA for RRH was conducted using a comprehensive and multi-faceted approach to gather and analyze data on the health needs of the community. The goal was to build a complete picture of healthcare needs by incorporating both publicly available data to see documented health factors, illness, and causes of death, along with a community survey that captured perceptions to be considered in future healthcare initiatives.

Data Collection

Surveys

Two surveys were created using Microsoft Forms: one for community members, and one for healthcare providers. A hard-copy version of the community member survey was also made available. Responses for both surveys were solicited between mid-July 2025 and mid-August 2025. Flyers, posters, and survey forms were distributed in hospital waiting rooms and outpatient facilities. The surveys were also promoted at community events and through email lists maintained by the hospital. The surveys were designed to reach a wide range of socio-economic groups to ensure that the unique perspectives and needs of smaller subpopulations within the community were represented.

Methodological Considerations

A large number of surveys were collected from a broad geographic area served by RRH. Respondents represented a wide range of ages and income levels. However, it is important to note that the marketing and distribution channels used for the survey tended to reach community members who are already using healthcare services. As a result, there was a tendency for higher representation from the elderly. This outcome is common in essentially all voluntary surveys. While it can be argued that this was not a purely random sample, the responses nonetheless provided valuable insights from all necessary market segments, even if certain subpopulations were somewhat oversampled.

To strengthen the reliability of the findings, the survey methodology deliberately aimed to obtain at least 30 responses from every major income group and every significant minority group within the community, in accordance with the Central Limit Theorem, ensuring that sample means would approximate a normal distribution. Recognizing that Hispanic residents comprise approximately 20% of the local population, special efforts were made to secure adequate participation from this group. Surveys were provided in both English and Spanish, ensuring accessibility and encouraging broader participation. To further support the representativeness of the results, a minimum goal of 50 responses overall was set for each major group, and the overall target was to achieve a minimum of 100 completed surveys.

To ensure that the unique views and needs of smaller subgroups within the community were recognized, the results were analyzed across various socio-economic strata. This allowed for the identification of specific needs or vulnerabilities that may have been more prominent in certain community groups.

Extant Data

Extant data on a variety of health topics were compiled and summarized as part of this assessment. This includes demographic data from the U.S. Census Bureau, mortality rates from the California Department of Public Health, and emergency room and intake statistics from the California Department of Health Care Access and Information, among others. A full list of the secondary data sources is provided in the Works Sited.

Primary Sources:

- U.S. Census American Community Survey (ACS) data
- CA Department of Health Care Access and Information (HCAI)
- National Center for Education Statistics
- Education Data Partnership (CA)
- U.S. Center for Disease Control and Prevention
- FBI Crime Data Explorer
- California Office of the Attorney General
- CMS Medicare
- UCLA Center for Health Policy Research data.

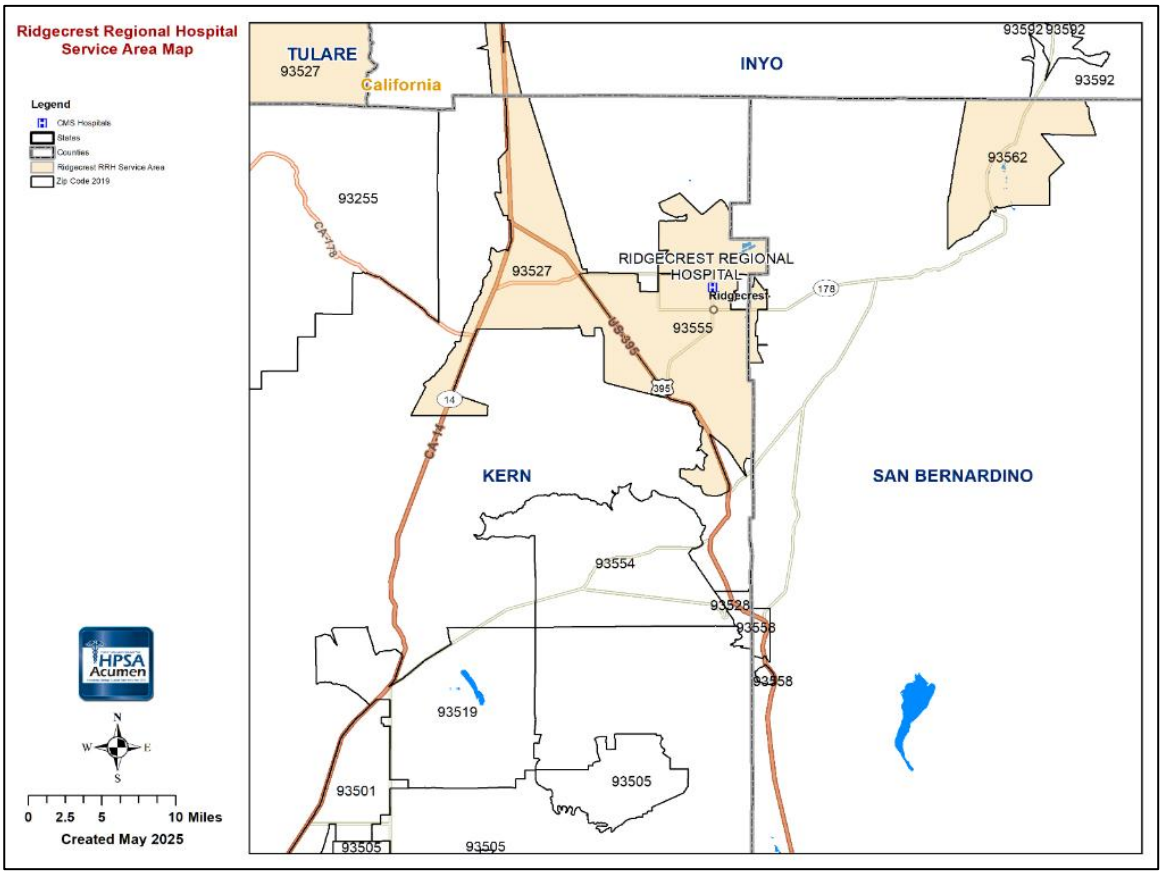
ACS topics included:
Gender, race/ethnicity, citizenship status, veteran status, languages spoken, educational attainment, income, poverty and unemployment, internet access, and transportation access.

Crime topics included:
Violent and property crime, ER causes of injury, and reported crimes.

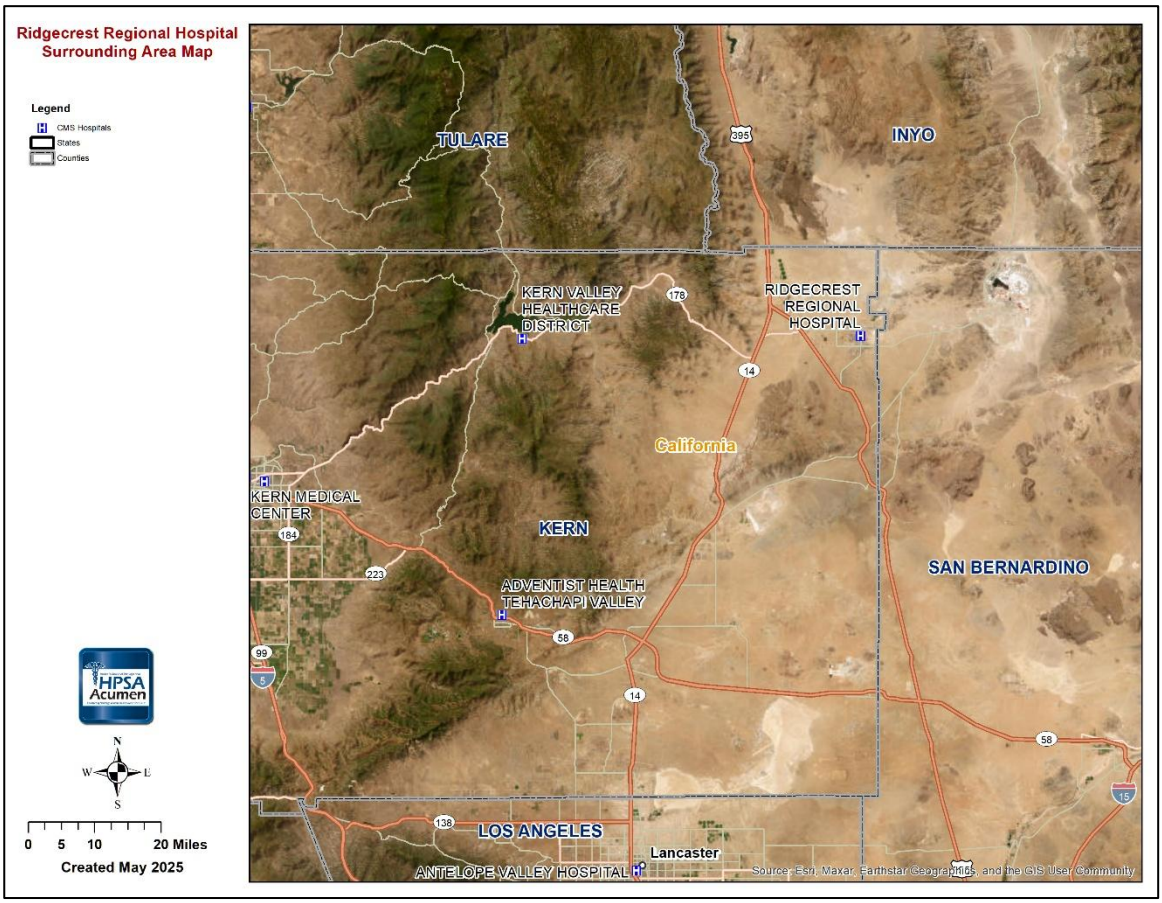
Health topics included:
Patient origin, health insurance status, payor source, ER visitation, sexually transmitted infection data, and death/morbidity statistics.

Description of Service Area

Geography and Population
The community served by RRH is centered around the city of Ridgecrest, located in the northeastern corner of Kern County. The map below depicts the Ridgecrest (93555 ZIP code) boundaries, along with the county boundaries. The hospital service area extends beyond this ZIP code, encompassing remote and rural regions, including Inyokern to the west, Johannesburg and Randsburg to the south, and Trona and Searles Valley to the northeast. Each of these areas roughly corresponds to its respective ZIP code.



Source: HPSA Acumen, ArcGIS.



Source: HPSA Acumen, ArcGIS.

The table shown below provides an estimation of the total population for each of the three ZIP codes mentioned above, which roughly correspond to the areas served by the hospital.

ZIP Code	Approximate Location	Total Population
93555	Ridgecrest	33,629
93562	Trona	1,822
93527	Inyokern	1,801
Total		**37,252**

Source: U.S. Census Bureau, ACS, 2019-2023.

Many of the health-related statistics in this report focus primarily on the 93555-ZIP code, which represents the core of the hospital's service area. This focus is due to the disproportionate concentration of the population residing in that region. Furthermore, data for the additional ZIP codes is often unavailable from many sources. However, much of the qualitative feedback received provides clear context and relevance for the more remote regions as well. When applicable, such as with ACS data, this report will combine ZIP codes 93555, 93562, and 93527. In these cases, the data will be labeled simply as "Ridgecrest," while data exclusive to 93555 will be clearly identified as such.

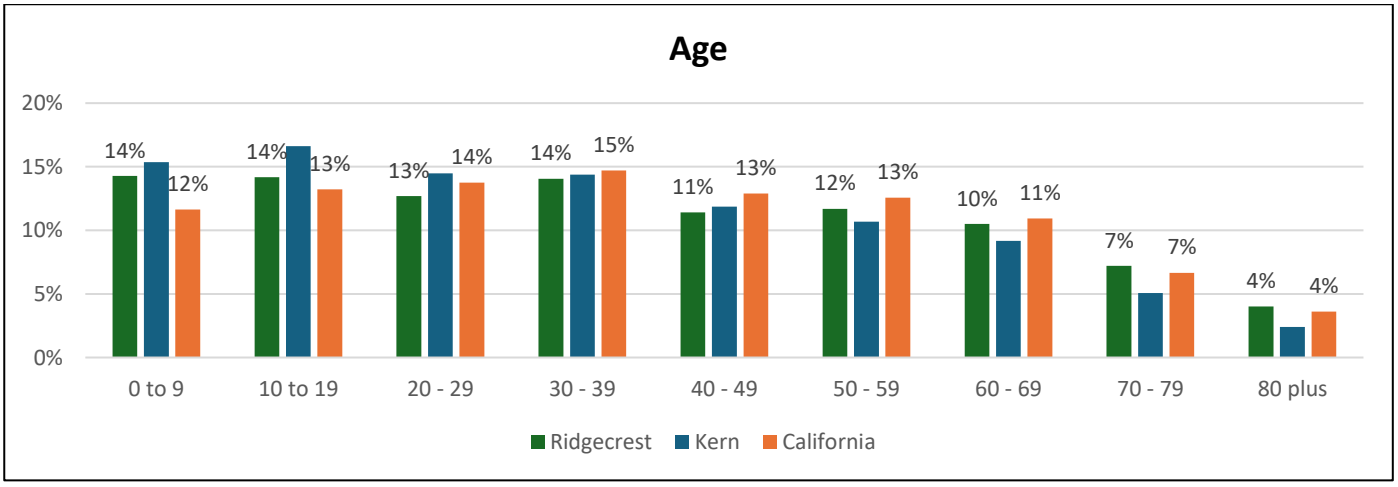
Demographics

Within Ridgecrest, there are slightly more women than men, approximately 51% to 49%, right in line with national levels. In contrast, Kern County has a slightly higher proportion of men, with 51% male and 49% female. Additionally, across the state of California, an estimated 1.5% of individuals identify as transgender, 4.5% as gay or lesbian, and 3.4% as bisexual. This estimation remains static from the previous study, as the Pulse Survey has discontinued tracking these metrics in 2025.

	Ridgecrest	Kern County	CA
Male	49%	51%	50%
Female	51%	49%	50%

Source: U.S. Census Bureau, ACS, 2019-2023. Kern County and CA are ACS 2021 1-year estimates.

The age distribution of Ridgecrest is similar to Kern County overall but tends to skew slightly younger.



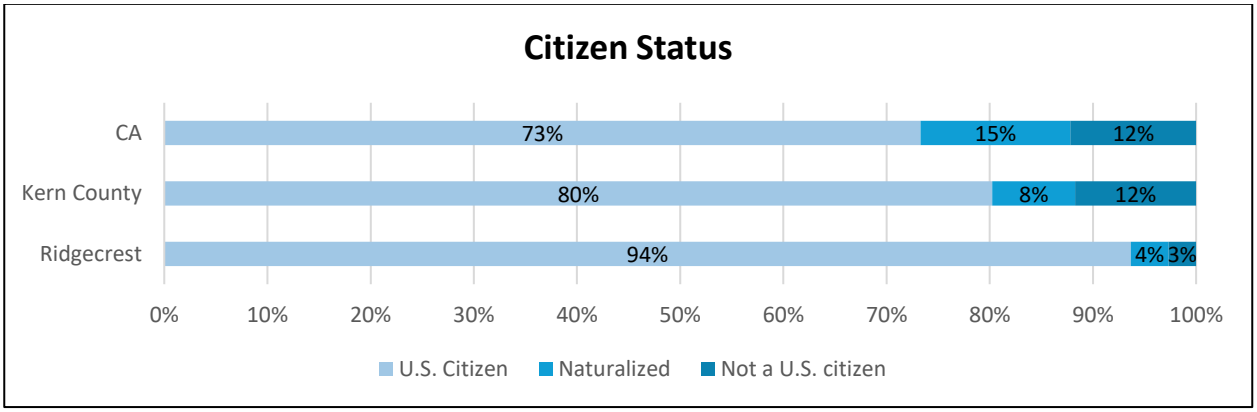
Source: U.S. Census Bureau, ACS, 2019-2023.

Approximately two-thirds of the population of Ridgecrest is White, compared to only about one-third in both Kern County and the state of California. Kern County is nearly 60% Hispanic or Latino, while in Ridgecrest, individuals identifying as Hispanic or Latino make up roughly 20% of the population.

Race	Ridgecrest	Kern County	CA
White Alone	66%	31%	35%
Black or African American alone	4%	5%	5%
Hispanic or Latino	19%	56%	40%
Asian	3%	5%	15%
Native Hawaiian and Other Pacific Islander alone	0%	0%	0%
American Indian and Alaska Native alone	0%	0%	0%
Some other race alone	1%	0%	1%
Two or more races:	6%	3%	4%

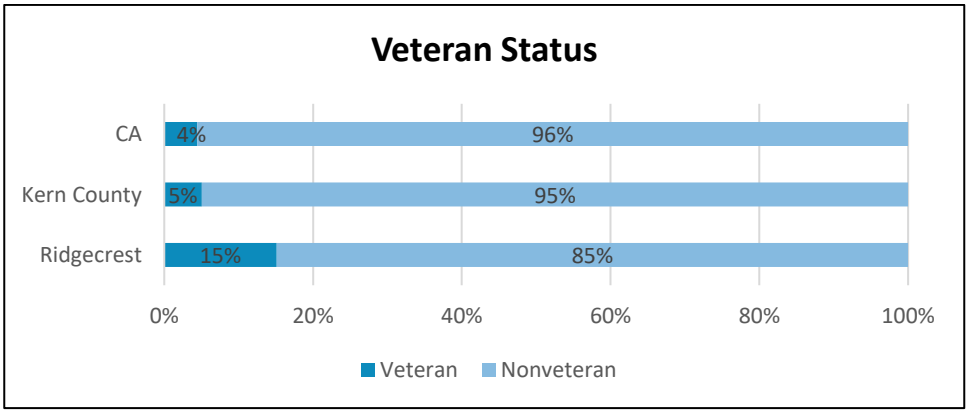
Source: U.S. Census Bureau, ACS, 2019-2023.

Approximately 98% of Ridgecrest residents are US citizens (including naturalized citizens), compared to about 88% of residents in both Kern County and California.



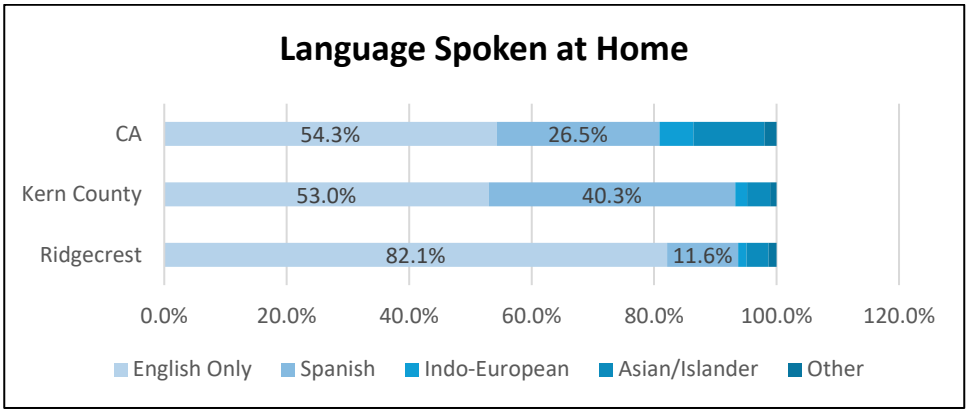
Source: U.S. Census Bureau, ACS, 2019-2023.

The veteran population in Ridgecrest is significantly higher than in both Kern County and California. Veterans make up 15% of Ridgecrest's population, compared to 5% in Kern County, and just 4% statewide. This rate is triple the county average and almost quadruple the state average, highlighting Ridgecrest's distinctive demographics and its relevance for planning veteran services.



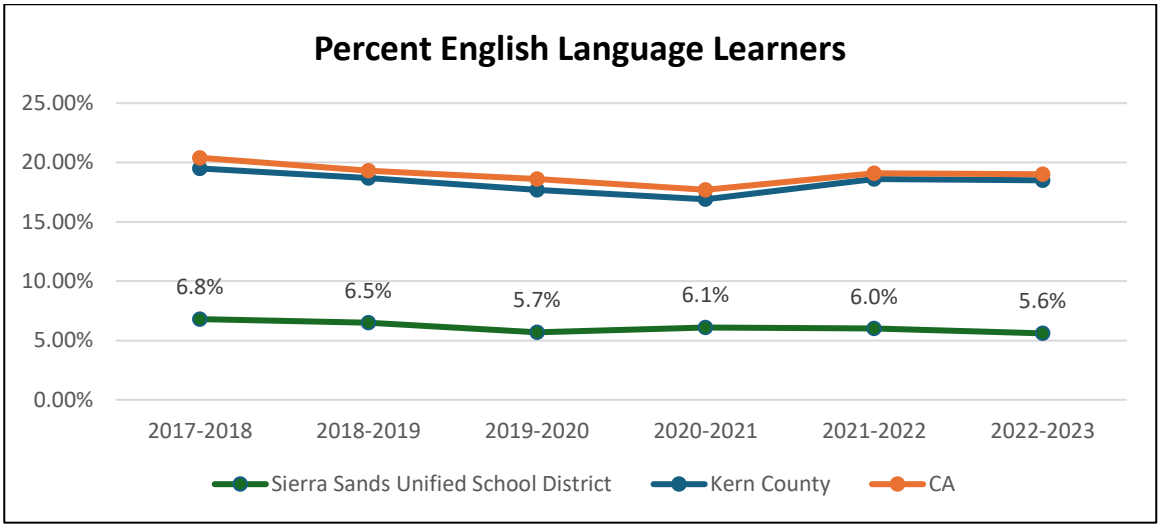
Source: U.S. Census Bureau, ACS, 2019-2023.

Nearly 12% of Ridgecrest residents speak Spanish as their primary language at home, a figure significantly lower than Kern County's overall rate of 40%.



Source: U.S. Census Bureau, ACS, 2019-2023.

Approximately 5.6% of students in the Sierra Sands Unified School District (SSUSD) are classified as English Language Learners (ELLs), a rate significantly lower than the nearly 20% seen across both Kern County and the state of California. SSUSD serves a range of students from elementary through high school, including those in specialized and magnet programs. As the primary educational provider in this geographically isolated area, the district plays a central role in both academic development and community engagement. The relatively low percentage of ELL students suggests that most families in the area are proficient in English, and that language barriers are less prominent in this part of Kern County.



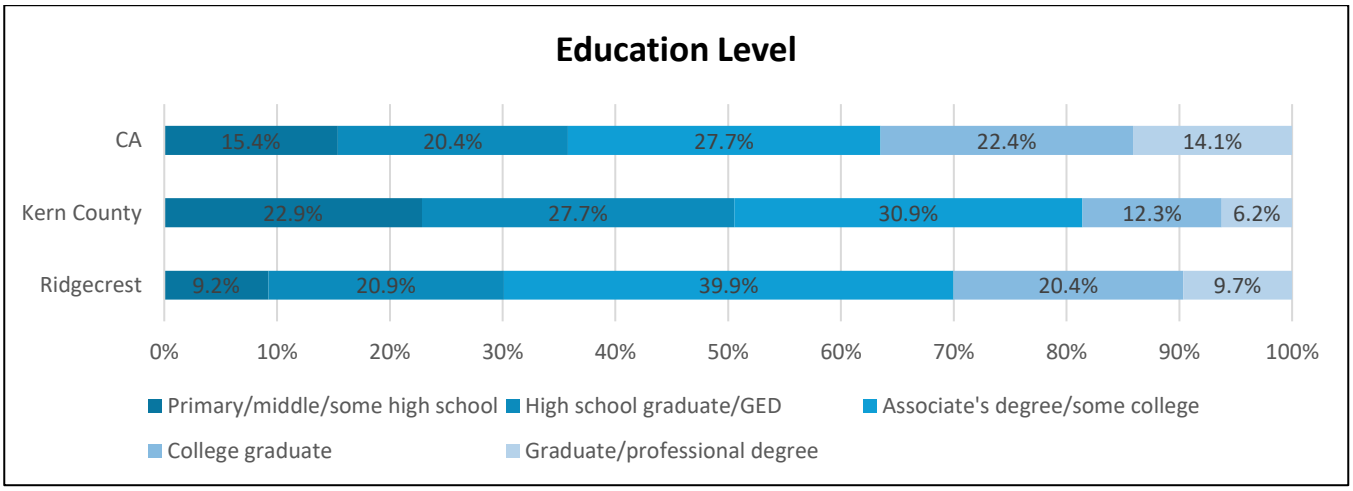
Source: Education Data Partnership, 2017-2023. https://www.ed-data.org/.

While specific data on migrant farm workers in the Ridgecrest area is unavailable, it's important to consider the broader context of Kern County. Kern County is one of California's top agricultural producers and relies heavily on a large, mobile migrant workforce. However, Ridgecrest's economy is distinct, centered around the Naval Air Weapons Station China Lake and located in the arid eastern third of the county. Due to its desert geography, agricultural activity, and by extension, the presence of migrant farm workers, is minimal in Ridgecrest. Therefore, while county-level data highlights the significance of migrant labor in Kern County, it is not a major factor in healthcare planning for Ridgecrest specifically.

Education, Income, and Employment

In Kern half of the residents have a High School education or less. In Ridgecrest, only 30% have high school education or less. Across California, just over 1/3 of the population has a high school level education or lower. In this context, Ridgecrest is performing better than both the county and state. About 40% of Ridgecrest residents have completed some college, and another 30% have earned a 4-year college or graduate degree.

While California shows a higher percentage of residents with college and professional degrees, Ridgecrest, as a very rural area, demonstrates strong access to higher education. With 70% of the population reporting they went to college, the data reflects a community where education is clearly a priority, and the outcomes suggest that local efforts are having a positive impact.

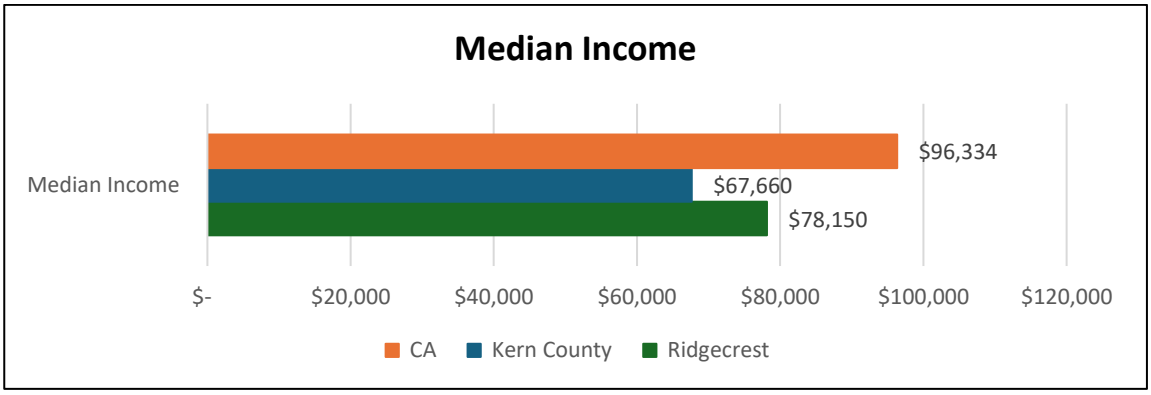


Source: U.S. Census Bureau, ACS, 2019-2023.

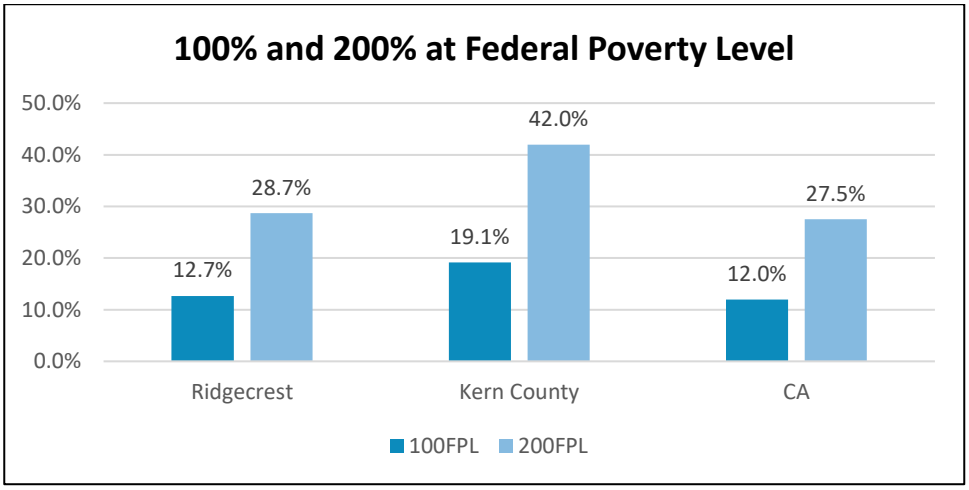
Residents of Ridgecrest have a higher median income, and lower poverty rates compared to Kern County overall. According to the data, the median income in Kern County is approximately 70% of the state average, while Ridgecrest's median income is 81% of the California Average. Specifically, the median income in Ridgecrest is $78,150, compared to $67,660 in Kern County and $96,334 statewide.

Ridgecrest's poverty and low-income rates are in line with the state averages, which compare favorably to those in Kern County. As shown in the table below, 12.7% of Ridgecrest residents fall below the Federal Poverty Level (100% FPL), compared to 19.1% in Kern County and 12% in California. When including individuals living below 200% FPL, which captures both low-income residents and those officially in poverty, Ridgecrest again shows a clear contrast: 27% compared to 42% in Kern County.

The cost of living in Ridgecrest is notably lower than in many other parts of California. Although these cost-of-living comparisons below come from non-traditional data sources, estimates suggest that Ridgecrest is close to the national average of cost of living, ranging between 30-34% less than California overall.



Source: U.S. Census Bureau, ACS, 2019-2023.

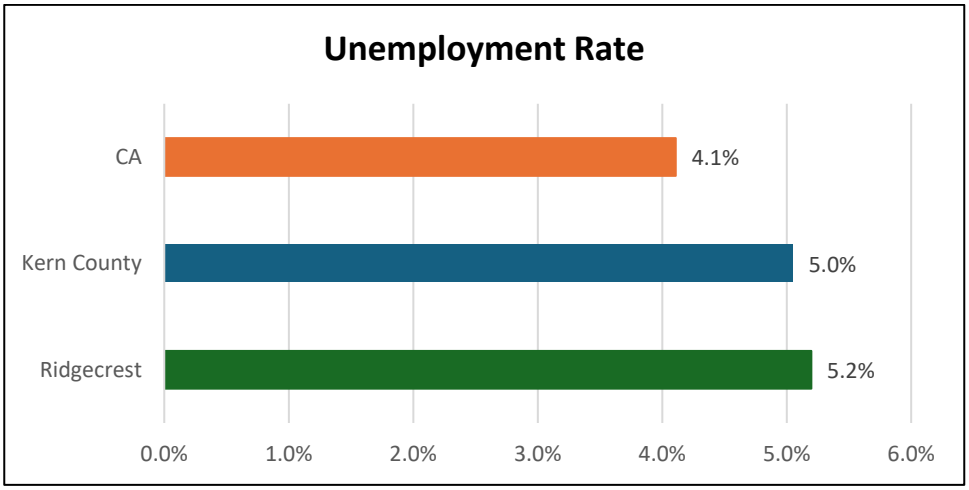


Source: U.S. Census Bureau, ACS, 2019-2023.

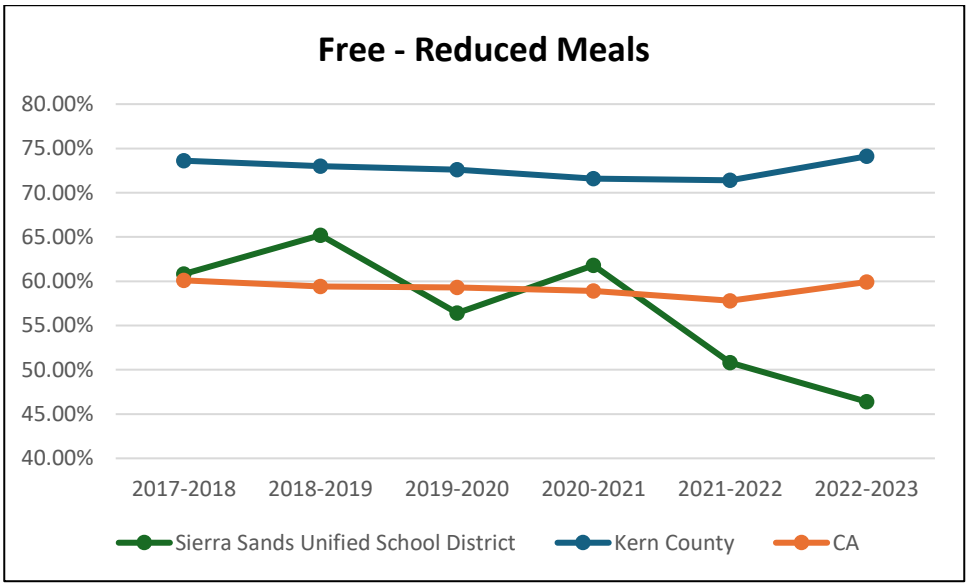
Cost of Living Comparison			
Geographic Area	**AreaVibes**	**Best Places**	**PayScale**
Ridgecrest	110	99.8	103
California	140	133.2	N/A
National	100	100	100

Sources: 100 represents a baseline national average. https://www.areavibes.com/ridgecrest-ca/cost-of-living/.
https://www.bestplaces.net/cost_of_living/zip-code/california/ridgecrest/93555/.
https://www.payscale.com/cost-of-living-calculator/California-Ridgecrest/.

Ridgecrest's unemployment rate is comparable to that of Kern County, indicating similar economic conditions across the region. Meanwhile, the eligibility rate for free and reduced-price meals within the SSUSD closely mirrors the statewide average for California. Notably, this rate has declined significantly over the past two years, suggesting potential improvements in household income or changes in program participation.



Source: U.S. Census Bureau, ACS, 2019-2023.



Source: Education Data Partnership, 2017-2023. https://www.ed-data.org/.

Understanding the types of industries and occupations that dominate the local workforce is key to identifying potential health risks, resource needs, and social determinants of health that impact the community. While most recent estimates for occupation and industry data are not available on a ZIP code level, insights can be gained by examining the data based on local communities. For Ridgecrest, the greatest proportion of workers are employed in public administration, followed by educational services, professional and management services, and healthcare.

Industry	Estimate	Percent
Civilian employed population 16 years and over	**11,869**	
Agriculture, forestry, fishing and hunting, and mining	283	2%
Construction	497	4%
Manufacturing	418	4%
Wholesale trade	111	1%
Retail trade	1,121	9%
Transportation and warehousing, and utilities	502	4%
Information	174	2%
Finance and insurance, and real estate and rental and leasing	480	4%

Industry	Estimate	Percent
Professional, scientific, and management, administrative, waste management	1,377	12%
Educational services, health care and social assistance	2,362	20%
Arts, entertainment, recreation, accommodation and food services	528	4%
Other services, except public administration	404	3%
Public administration	3,612	30%

Source: U.S. Census Bureau, ACS, 2019-2023.

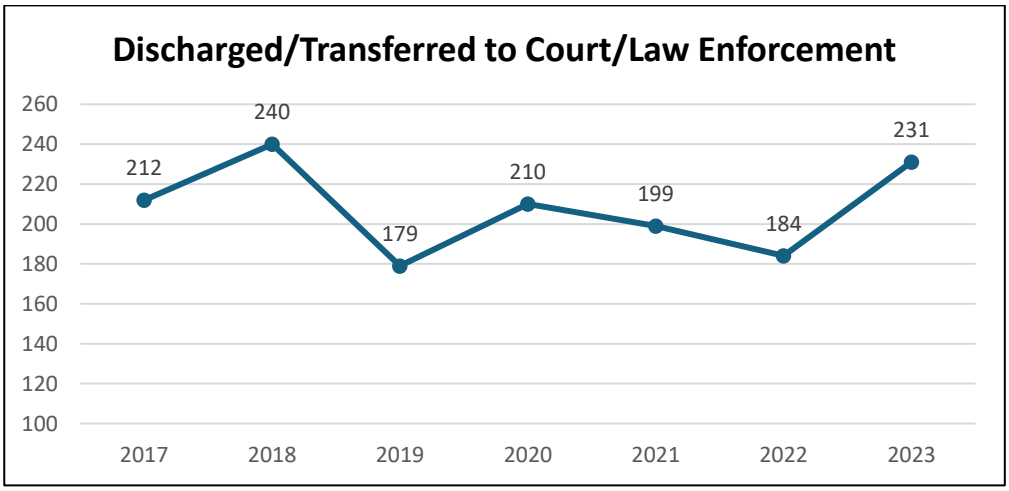
In Ridgecrest, there is a strong representation in fields such as management, business, computer sciences, and education. These industries are often associated with higher wages, job security, and improved health outcomes. Access to higher-paying jobs and educational opportunities can directly influence health by providing the means to afford better healthcare, nutrition, and living conditions.

Occupation	Estimate	Percent
Civilian employed population 16 years and over	**11,869**	
Management, business, science, and arts occupations	6,179	52%
Service occupations	1,533	13%
Sales and office occupations	2,068	17%
Natural resources, construction, and maintenance occupations	1,094	9%
Production, transportation, and material moving occupations	995	8%

Source: U.S. Census Bureau, ACS, 2019-2023.

Crime Metrics

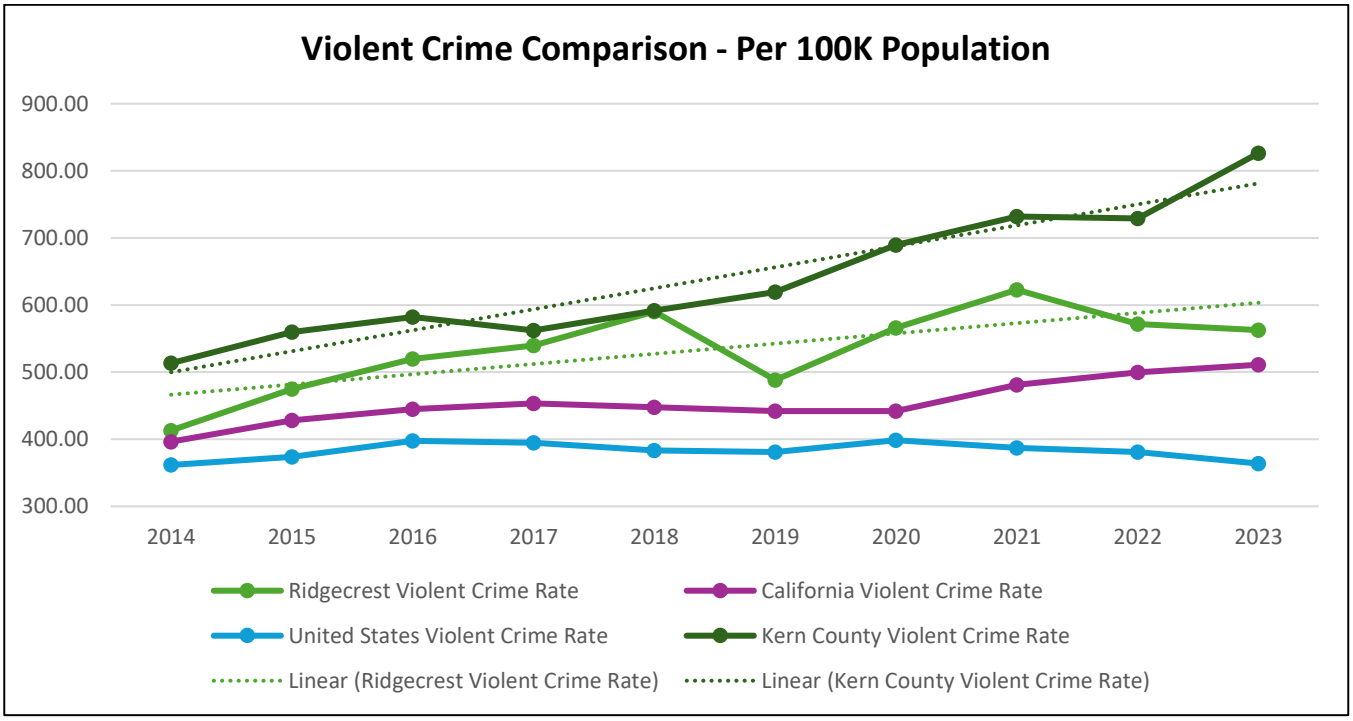
Among individuals visiting the Emergency Department at RRH, the number of cases resulting in discharge or transfer to law enforcement has remained generally consistent, although the data shows notable year-to-year fluctuations. While there is no clear long-term upward or downward trend, the increase from 184 in 2022 to 231 in 2023 may warrant further attention. These variations may reflect changes in law enforcement involvement, hospital protocols, or community-level factors that influence such transfers.



Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/.

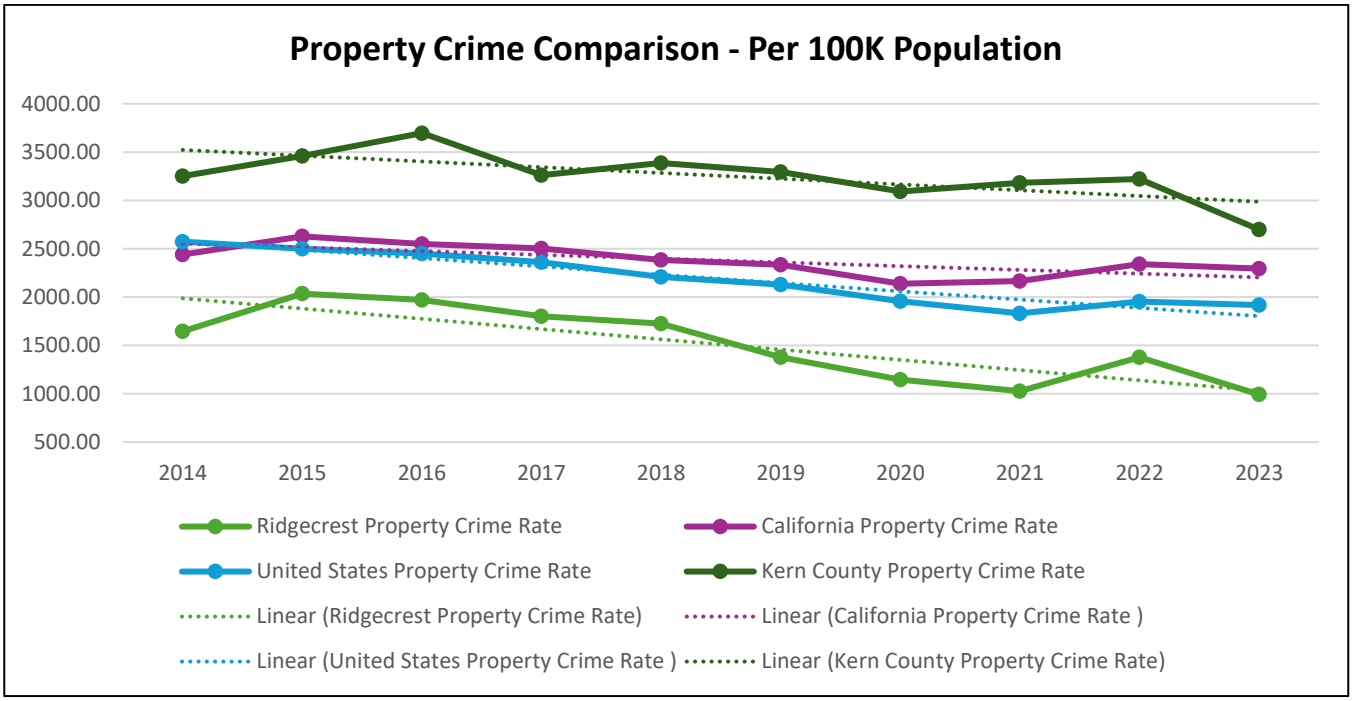
Data on assault cases from the Department of Health Care Access and Information (HCAI), covering the years 2017 to 2023, was sourced from hcai.ca.gov. However, this specific metric is no longer being collected. A more detailed analysis of assault-related trends is provided later in the report.

Using population data and total number of crimes reported to Police Departments, crime rates were calculated to compare Ridgecrest with both Kern County and the state of California. In 2023, the violent crime rate in Ridgecrest was 46% lower than that of Kern County overall. Although Ridgecrest's rate was still 10% higher than the statewide average, it still compared favorably within the region. Over the entire ten-year period, Ridgecrest's violent crime rate was, on average, 17% higher than California's, but 20% lower than Kern County overall.



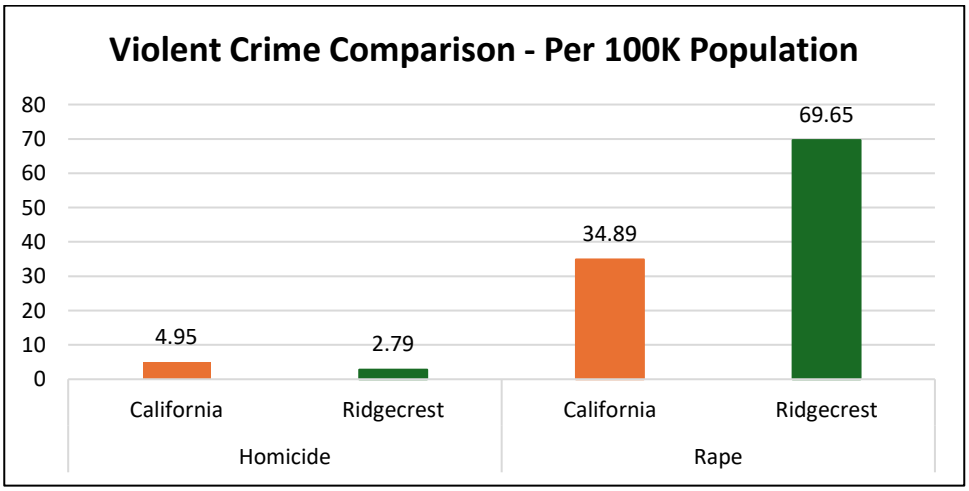
Source: California Department of Justice. https://openjustice.doj.ca.gov/. FBI Crime Explorer. https://cde.ucr.cjis.gov/.

Ridgecrest's property crime rate shows a clear downward trend over the past 10-year period and remains significantly below both state and county averages, especially in recent years. In 2023, the rate was 43% of California's (993/2,294 per 100K). There was a brief uptick in 2022, possibly linked to the post-Covid economic climate, but the trend resumed downward in 2023, reaching its all-time lowest rate in the past decade.

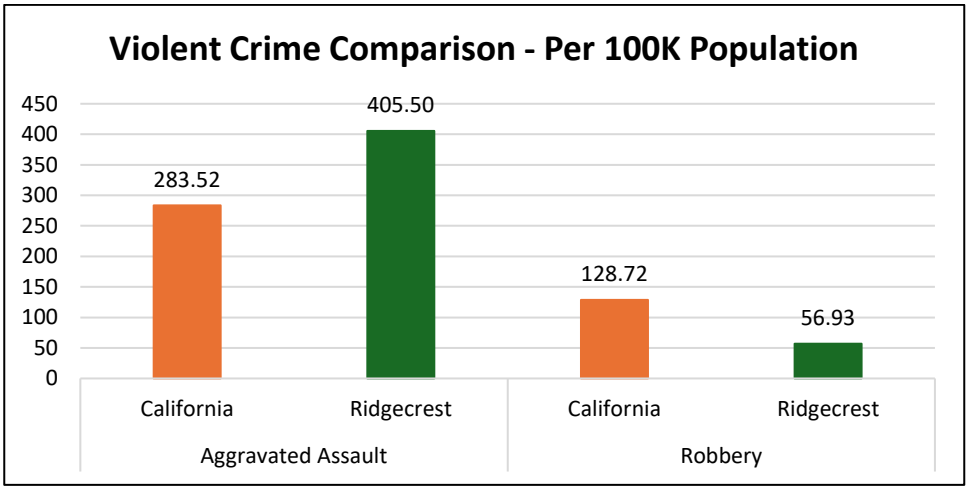


Source: California Department of Justice. https://openjustice.doj.ca.gov/. FBI Crime Explorer. https://cde.ucr.cjis.gov/.

When examining violent crime, Ridgecrest was compared to California overall, as it provided the most appropriate geographic benchmark. Homicide rates in Ridgecrest and California were statistically similar, with Ridgecrest slightly lower than the state average. Ridgecrest also reported a significantly lower robbery rate, at less than half the statewide figure. However, the city's reported rape rate was twice as high as California, and the rate of aggravated assault was approximately 43% higher. Given the small population size of the community, even a few incidents can significantly impact per capita crime rates. To estimate the approximate number of instances, the rate per 100,000 can be multiplied by 37%, reflecting Ridgecrest's estimated population size. For example, a homicide rate of 2.79 per 100,000 equates to roughly one incident per year. Aggravated assault in Ridgecrest equates to approximately 150 incidents annually.



Source: https://openjustice.doj.ca.gov/.



Source: https://openjustice.doj.ca.gov/.

Assessment Results by Health Topic and Prioritization

The following section of the report summarizes the results of the assessment by health topic. The topics are ordered by severity, with the most severe need being listed first. A summary of the determination of the needs rank is provided at the end of each section. Health topics grouped by level of priority are outlined in the table below.

Priority Level	Rank	Topic
High	1	Access to Care
Moderate - High	2	Chronic Diseases
Moderate	3	Maternal Health
Moderate - Low	4	Mental Health and Substance Abuse
Moderate - Low	5	Elder/Senior Care
Moderate - Low	6	Sexual Health
Low	7	Health Education, Wellness, and Disease Prevention
Low	8	Environmental

Disease and Chronic Health Conditions

Priority: Moderate - High

Extant Data on Disease and Chronic Health Conditions - three categories:

1. 2020 – 2023 California Mortality Statistics
2. 2020 – 2023 California Death Statistics – Grouped Data
3. Health Outcomes

2020 – 2023 California Mortality Statistics

Using California Vital Statistics data, mortality ratios were calculated for California, Kern County, Ridgecrest, and California City, based on total deaths from 2020 to 2023 and average population sizes for each area. RRH is not only planning for its primary market but is also studying the healthcare shortages and needs in the eastern third of the county.

Currently, Ridgecrest is not part of a Health Care District, which in other areas are tasked with addressing local health needs and funding community-based health initiatives. To the south, California City falls within the East Kern Health Care District (EKHCD), faces similar service gaps and has expressed interest in regional collaboration, including the annexation of Ridgecrest.

To account for mutual needs and potential alignment in service provision, this analysis includes a column for California City, as a representative jurisdiction within the EKHCD. In the tables below, Ridgecrest includes ZIP codes from the northern part of the eastern third of the county, while the southern part is referred to as either California or EKHCD. These ratios in the following charts provide a standardized way to compare health outcomes between large regions and smaller rural communities.

In line with state privacy practices, any masked or missing data was excluded from the analysis. To establish a statewide benchmark, the chart below represents the top eleven causes of death per population for the state of California, based on mortality ratios from 2020-2023.

Kern County was then compared to the state and to other counties using the same standardized method applied earlier. Rankings were based on mortality-per-population ratios across 53 counties with unmasked data. This analysis identified the top eleven causes of death statewide ranked in order.

This comparative analysis identified several areas of concern for Kern County:

- Diabetes mellitus ranked 2nd highest among all counties.
- Accidental poisoning ranked 5th.
- Several causes, including cerebrovascular disease and heart disease, placed Kern in the bottom quartile statewide.

The table below provides a summary of Kern County's ranking by cause of death:

Cause of Death	Rank of Cause of Death in California	Kern Rank Across all CA Counties	Kern Quartile in State
All other diseases (Residual)	1	49	4th Quartile
Other and unspecified infectious and parasitic diseases and their sequelae	2	16	2nd Quartile
All other forms of chronic ischemic heart disease	3	18	2nd Quartile
Cerebrovascular diseases (Stroke)	4	46	4th Quartile
Alzheimer's disease	5	27	2nd Quartile
Diabetes mellitus	6	2	1st Quartile
Other chronic lower respiratory diseases	7	17	2nd Quartile
All other forms of heart disease	8	44	4th Quartile
Accidental poisoning and exposure to noxious substances	9	5	1st Quartile
Malignant neoplasms of trachea, bronchus, and lung	10	42	4th Quartile
Acute myocardial infarction	11	36	3rd Quartile

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

Some causes of death that existed in Kern County were not viewable at the sub-county level for Ridgecrest. As previously mentioned, data suppression for low-frequency causes limited visibility into certain Ridgecrest-specific mortality trends. On a county level, however, Kern County had a significantly higher mortality ratio for Assault (homicide): more than double the state rate. The suicide rate was 17% higher than the state average. These rates correspond to around 114 deaths per year for homicide in the county and 114 deaths per year for suicide during the 2020-2023 period.

Cause of Death	California	Kern	Kern VS. CA	Ridgecrest	Ridgecrest vs. CA	California City	CA City vs. CA
Assault (homicide)	0.06	0.12	213.6%	0	0.0%	0	0.0%
Intentional self-harm (suicide)	0.11	0.12	117.3%	0	0.0%	0	0.0%
Essential hypertension and hypertensive renal disease	0.17	0.18	105.5%	0	0.0%	0	0.0%
Influenza and pneumonia	0.14	0.13	97.2%	0	0.0%	0	0.0%
Nephritis, Nephrotic Syndrome, and nephrosis	0.12	0.11	94.1%	0	0.0%	0	0.0%
Parkinson's disease	0.11	0.09	81.8%	0	0.0%	0	0.0%

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

To put the size of the problem in perspective, diabetes deaths averaged 404 per year, chronic lower respiratory disease averaged 435 per year, and accidents averaged 764 per year. The notes below detail our initial findings. Based on the data, we identified four causes of death for Ridgecrest that warrant further study and targeted public health intervention:

- Diabetes
- Lung Disease
- Heart Diseases
- Cancer

Both Ridgecrest and California City face overlapping concerns in chronic lower respiratory disease, diabetes, and a relatively lesser concern of heart disease. Specifically, heart disease rates are 20% higher in Ridgecrest compared to the state, and 40% higher in California City. It is worth noting that liver disease data for Ridgecrest was deidentified due to low case counts, though it may correspond with unusually high rates in California City. Normally this would be identified as a focus issue because it is a county issue and an issue to the south in CA City, however the number was small enough in Ridgecrest, it may be a secondary focus to accompany any joint initiatives rolled out regionally.

Note on shading: Yellow highlights indicate rates 15% to 33% above the state average; red indicates rates more than 33% above.

Cause of Death	California	Kern	Kern VS. State	Ridgecrest	Ridgecrest VS. State	California City	CA City VS. State	Notes
Chronic liver disease and cirrhosis	0.17	0.21	124%	0.00	0%	0.30	176%	No data for Ridgecrest, instances were de-identified.
Chronic lower respiratory diseases	0.31	0.47	153%	0.45	147%	0.53	170%	Ridgecrest 1.5X the state rate. CA City similarly high.
Diabetes mellitus	0.29	0.44	150%	0.54	182%	0.45	154%	Ridgecrest 1.8X the state rate. CA City similarly high.
Accidents (unintentional injuries)	0.52	0.83	160%	0.55	106%	0.78	149%	Ridgecrest was essentially the same as the state. CA City 1.5X state rate.
Diseases of heart	1.68	1.76	105%	2.00	119%	2.35	140%	Ridgecrest was 20% higher than the state. CA City was 40% higher than state.
Other	1.96	2.02	103%	1.79	91%	2.49	128%	Ridgecrest was below state avg.
Malignant neoplasms (Cancer)	1.53	1.32	86%	1.42	93%	1.58	103%	Ridgecrest was below state avg.
Alzheimer's disease	0.44	0.41	93%	0.00	0%	0.39	87%	No data for Ridgecrest, instances were deidentified.
Cerebrovascular diseases (Stroke)	0.46	0.34	73%	0.50	107%	0.40	86%	Simmer to the state rate.

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.
The ratios in the data above represent occurrence rates over a four-year period, which considered the individual average population of each area examined. We used this method to create a population-based weighted average. The scoring number represents a figure used to stabilize comparisons between areas of high incidence like the entire state, or smaller areas like the service area.

Understanding the influence of lifestyle choices on chronic diseases is crucial for improving public health outcomes. Nationally, heart disease and cancer remain the top causes of death, but preventable conditions like diabetes, chronic liver disease, and chronic lower respiratory disease, are also significant contributors. While healthcare providers are likely aware of these issues, a broader public and policymaker awareness of the impact of diet, physical activity, and smoking on these conditions is essential.

Diabetes-related deaths are largely preventable. According to the Center for Disease Control and Prevention's (CDC) National Diabetes Statistics Report, Type 1 diabetes was once referred to as "childhood" diabetes" and accounts for approximately 5% (possibly up to 10%) of all cases. It is now increasingly seen alongside lifestyle-related Type 2 cases. Gestational Diabetes occurs in 2% of pregnancies (could be as high as 10%). That leaves 90-95% of diabetics falling into the category of Type 2, linked to lifestyle and poor diet. Regarding preventable deaths, it is estimated that a significant portion of diabetes-related deaths can be prevented through effective management, healthy eating, physical activity, and regular check-ups.[1]

[1] Centers for Disease Control and Prevention. (2024, May 15). National Diabetes Statistics Report. Centers for Disease Control and Prevention. https://www.cdc.gov/diabetes/php/data-research/index.html

Approximately 50% of Chronic Liver Disease and Cirrhosis (CLDC) cases are alcohol-related, with an additional 15% caused by non-alcoholic fatty liver disease (NAFLD), which is linked to obesity, high blood sugar, insulin resistance (such as in Type 2 Diabetes), and metabolic syndrome. This suggests that roughly two-thirds of CLDC cases are potentially preventable.

Chronic Lower Respiratory Disease (CLRD) accounts for a significant portion of respiratory illness. Roughly 92% of CLRD cases are chronic obstructive pulmonary disease (COPD), with about 75% attributed to smoking and 24% to workplace exposures, indicating that lifestyle interventions could significantly reduce the burden of these diseases.

2020 – 2023 California Death Statistics – Grouped Data

As mentioned above, the California Death Data, at times, is structured in a way that is difficult to interpret. There were instances where deaths related to heart conditions or other causes were allocated across multiple categories, making the data less straightforward. To address this, we have consolidated the underlying data into broader categories of death rather than maintaining overly specific classifications. Our methodology involved grouping related causes of death together, allowing for a more cohesive and comprehensive view of mortality trends. We believe this approach provides a clearer, more holistic picture of deaths within California and Kern County.

This section expands on available data by detailing Kern County metrics related to education, diversity, and gender. In cases where ZIP code–level data was unavailable, county-level statistics were used as a proxy. Because city-specific data for Ridgecrest was not available, it is assumed that Kern County figures reasonably reflect trends within Ridgecrest.

Cause of Death - California	2020	2021	2022	2023	Grand Total	Percent of Total
Heart Related	66,426	65,450	66,038	63,151	261,065	21.3%
Cancer	59,078	58,744	59,424	59,018	236,264	19.3%
Other	31,822	33,291	35,333	34,320	134,766	11.0%
Infections	33,504	46,024	19,468	6,831	105,827	8.6%
Lung Related - Not Cancer	22,163	20,190	21,081	21,673	85,107	6.9%
Brain Disorder - Parkinson, Alzheimer's, etc.	22,783	20,818	21,490	19,968	85,059	6.9%
Accidents	17,795	20,290	20,426	19,487	77,998	6.4%
Cerebrovascular and related (Stroke)	17,877	18,334	18,327	17,736	72,274	5.9%
Diabetes	11,609	11,410	11,538	11,188	45,745	3.7%
Kidney Related - Not Cancer	10,255	11,005	11,534	11,313	44,107	3.6%
Liver Related - Not Cancer	6,514	7,332	6,810	6,533	27,189	2.2%
Suicide	3,902	3,946	4,053	3,783	15,684	1.3%
Medical Complications	1,443	1,740	3,014	2,518	8,715	0.7%
Violence	2,142	2,294	2,089	1,692	8,217	0.7%
Blood Poisoning (Bacterial, Fungal, or Viral)	1,656	1,739	1,760	1,679	6,834	0.6%
Malnutrition	997	1,032	1,322	1,272	4,623	0.4%
Circulatory system - Not Stroke or Heart	1,165	1,038	1,165	1,113	4,481	0.4%
Stomach Related - Not Cancer	421	420	460	424	1,725	0.1%
Pregnancy	18	16	-	-	34	0.0%
Grand Total	**311,570**	**325,113**	**305,332**	**283,699**	**1,225,714**	

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

A review of mortality data from 2020 to 2023 reveals a sharp increase in infection-related deaths in 2021, followed by a significant decline in 2022 and 2023. This temporary spike was likely driven by the COVID-19 pandemic, which mirrors trends seen across California.

Cause of Death – Kern County	2020	2021	2022	2023	Grand Total	Percent of Total
Heart Related	1,635	1,622	1,562	1,618	6,437	20.8%
Cancer	1,225	1,185	1,221	1,279	4,910	15.9%
Other	668	782	834	780	3,064	9.9%
Accidents	642	795	803	762	3,002	9.7%
Infections	740	1,400	454	161	2,755	8.9%
Lung Related - Not Cancer	633	618	643	639	2,533	8.2%
Brain Disorder - Parkinson, Alzheimer's, etc.	482	486	447	404	1,819	5.9%
Diabetes	422	418	402	377	1,619	5.2%
Cerebrovascular and related (Stroke)	259	329	358	301	1,247	4.0%
Kidney Related - Not Cancer	242	269	261	280	1,052	3.4%
Liver Related - Not Cancer	201	233	202	191	827	2.7%
Suicide	121	107	113	117	458	1.5%
Violence (Homicide)	130	133	111	81	455	1.5%
Blood Poisoning (Bacterial, Fungal, or Viral)	75	77	67	90	309	1.0%
Medical Complications	44	43	84	67	238	0.8%
Malnutrition	16	22	38	28	104	0.3%
Circulatory system - Not Stroke or Heart	15	36	31	-	82	0.3%
Stomach Related - Not Cancer	11	15	14	12	52	0.2%
Grand Total	**7,561**	**8,570**	**7,645**	**7,187**	**30,963**	

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

Over the full four-year period, heart-related conditions and cancer were the two leading causes of death, together accounting for nearly 37% of all deaths, and therefore should both receive consideration along with the main concerns that were flagged. The identified issues for Ridgecrest involving lungs (8.2%), diabetes (5.2%) account for 13.4% of deaths in Kern County – half of the deaths if you combine these four issues. These consistent patterns point to critical areas where RRH may focus resources, particularly around chronic disease prevention, injury reduction, and infectious disease preparedness.

Further analysis comparing cause-of-death categories with educational attainment revealed a clear disparity. Individuals with only a high school diploma or GED experienced significantly higher mortality rates across nearly every major cause. For example, cancer deaths were 27% more common among this group compared to those with graduate degrees. Cerebrovascular-related mortality was 71% higher, while deaths from lung conditions not linked to cancer were 93% higher. Heart disease deaths were 128% higher, and diabetes-related deaths were 134% higher. These differences underline the critical link between educational attainment and health outcomes, suggesting that targeted community education and outreach could help reduce preventable deaths in the Ridgecrest area.

Cause of Death – Kern County	Bachelor's Degree	Graduate Degree	High School Graduate or GED Completed	Less than High School	Some College Credit, No 4-Year Degree
Blood Poisoning (Bacterial, Fungal, or Viral)			1.78	2.04	0.71
Brain Disorder - Parkinson, Alzheimer's, etc.	5.08	5.14	5.73	4.22	2.90
Cancer	15.14	18.16	23.03	20.45	17.45
Cerebrovascular and related (Stroke)	3.73	4.18	7.13	5.90	4.25
Diabetes	4.06	4.11	9.60	8.74	4.80
Infections	4.91	7.92	8.22	9.46	4.46
Kidney Related - Not Cancer	2.63		3.53	2.43	1.61
Liver Related - Not Cancer	1.76		4.01	3.88	2.38
Lung Related - Not Cancer	4.06	4.48	8.66	5.88	5.23
Other			0.77	1.84	
Suicide	2.05		3.29	1.69	1.39
Violence (Homicide)			3.14	3.47	0.94
Heart Related	20.15	17.86	40.69	28.32	19.74
Grand Total	**6.70**	**8.80**	**9.50**	**7.15**	**5.35**

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

The data by gender reveals notable disparities across Kern County, particularly in the categories highlighted in red. Males were 5.5 times more likely to die from violence than females, 3.5 times more likely to die by suicide, and over 2.7 times more likely to die from an accident. In contrast, females experienced nearly double the mortality rate from brain disorders compared to males. While these trends are consistent with broader national patterns, they may underscore the need for targeted interventions.

Cause of Death – Kern County	Sum of Death Female	Sum of Death Male	Weighted Avg. Female	Weighted Avg. Male	Gender Disparities in Male over Female
Accidents	812	2,249	4.51	12.12	2.69
Blood Poisoning (Bacterial, Fungal, or Viral)	155	155	0.86	0.84	0.97
Brain Disorder - Parkinson, Alzheimer's, etc.	1,153	666	3.20	1.80	0.56
Cancer	2,375	2,569	6.60	7.91	1.20
Cerebrovascular and related (Stroke)	642	605	3.57	3.26	0.91
Diabetes	722	898	4.01	4.84	1.21
Infections	1,243	1,782	3.45	4.80	1.39
Kidney Related - Not Cancer	524	537	1.46	1.45	0.99
Liver Related - Not Cancer	268	541	1.49	1.67	1.12
Lung Related - Not Cancer	985	849	3.13	2.62	0.84
Other	189	189	0.38	0.34	0.89
Suicide	100	360	0.56	1.94	3.49
Violence (Homicide)	68	387	0.38	2.09	5.52
Heart Related	2,713	3,751	15.07	13.48	0.89
Grand Total	**11,949**	**15,538**			

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.

The data presented in the following table provides a breakdown of causes of death in Kern County by race and ethnicity, revealing significant disparities across different populations. These disparities in mortality rates are crucial to understanding the unique health challenges faced by various racial and ethnic groups, and they highlight the need for tailored public health strategies. A notable finding across Kern County, is the contrast between the relatively low mortality rates among Hispanic residents and the higher rates observed among white and black populations. This can be seen on the table below. It should be noted that data for other racial and ethnic groups, particularly Native American/Alaskan Native and Multi-Race populations, are insufficient to support accurate comparisons.

Cause of Death – Kern County	Hispanic	White	Black/ African American	Asian	Native American / Alaskan Native	Multi-Race	Black Rates vs. White Rates	White Rates vs. Hispanic Rates
Accidents	5.46	14.31	15.25	3.70	46.00	4.84	**107%**	**262%**
Blood Poisoning (Bacterial, Fungal, or Viral)	0.58	1.32					**0%**	**228%**
Brain Disorder - Parkinson, Alzheimer's, etc.	0.83	6.44	3.75	2.47			**58%**	**776%**
Cancer	6.24	14.50	17.26	10.27		4.26	**119%**	**232%**
Cerebrovascular and related (Stroke)	1.71	6.72	5.39	3.70			**80%**	**393%**
Diabetes	2.97	7.17	7.86	4.27			**110%**	**241%**
Infections	3.44	5.79	8.54	7.71	72.00	4.10	**147%**	**168%**
Kidney Related - Not Cancer	0.69	2.83	3.27	3.03			**116%**	**410%**
Liver Related - Not Cancer	1.56	3.05					**0%**	**196%**
Lung Related - Not Cancer	0.67	6.89	5.62	4.71			**82%**	**1028%**
Other	0.35	0.64					**0%**	**183%**
Suicide	0.71	2.57					**0%**	**362%**
Violence	1.36	0.81	4.42				**546%**	**60%**
Heart Related	7.42	26.19	26.21	13.64	68.00	4.81	**100%**	**353%**
Grand Total	**2.10**	**7.57**	**9.91**	**6.62**	**58.00**	**4.58**		

Source: California Department of Health – California Vital Data (Cal-ViDa): 2020 – 2023.
Note: the discrepancies between the races were too significant, which casts doubt on the reliability of this table.

Heart disease mortality rates for both White and Black residents were approximately 3.5 times higher than the rate for Hispanic residents. For diabetes, mortality among White and Black populations was roughly 2.5 times higher. Liver-related mortality was roughly double, and lung-related deaths were nearly ten times higher among White residents compared to Hispanic residents.

For all key issues, the data suggests public health strategies should be focused on Black and White communities. Among Hispanic residents, the only category with a higher mortality rate than White residents, was violence (homicide). However, the Black homicide rate was 3.25 times higher than the rate for Hispanic residents. When considering these concerning rate disparities, consider how many deaths it would amount to in Ridgecrest, i.e. homicide amounts to 1 in 2023. The stark contrasts raise questions about the accuracy and completeness of the data.

Poverty levels by race were analyzed to understand lower Hispanic mortality rates, but no clear explanation emerged. Cultural and behavioral factors, such as strong family networks, home-cooked diets, community support systems, and lower substance use, may contribute. Data limitations, including underreporting due to migratory healthcare use, non-permanent residency, or untracked alternative medicine practices, may also play a role.

In contrast, Black residents consistently experience disproportionately high mortality rates in violence, cancer, and infections. These patterns underscore the urgent need for targeted interventions addressing social determinants of health and improving access care. Compared to White residents, cancer mortality was approximately 20% higher among Black residents, infection-related deaths nearly 50% higher rate, and homicide rates were 5.5 times greater.

Hispanic residents generally have lower mortality rates across most causes of death, suggesting a potential connection to lifestyle and behavioral patterns. While several cultural, socioeconomic, and healthcare-related factors (including poverty) were explored, none fully accounted for the observed disparities. These inconsistencies warrant further investigation to better understand the underlying causes and to inform effective public health strategies.

2021 – 2022 Morbidity Data Statistics

In addition to the statistics on causes of deaths, the analysis included illnesses and diseases affecting the population, as well as high-risk behaviors, social needs, disabilities, and prevention measures. CDC morbidity data was examined to identify additional community health issues. Available data levels for this include County and ZIP Code, which were aggregated to Ridgecrest. Statewide statistics were not available from CDC. For this metric, a weighted average across all counties was applied and summarized by each data measure.

Health Status

Health Status metrics included residents' perceptions of their general health, mental health, and physical distress. Totals across all measures in the Health Status category were averaged to provide an overall picture for this category.

Health Status	Ridgecrest	EKHCD + Expansion	Kern County	California
Fair or poor self-rated health status among adults	20.0	25.9	25.3	18.8
Frequent mental distress among adults	17.3	19.8	18.8	16.0
Frequent physical distress among adults	15.3	17.9	16.2	13.1
Health Status Avg.	**17.5**	**21.2**	**20.1**	**16.0**

Source: CDC Places: Local Data for Better Health – 2021/2022.

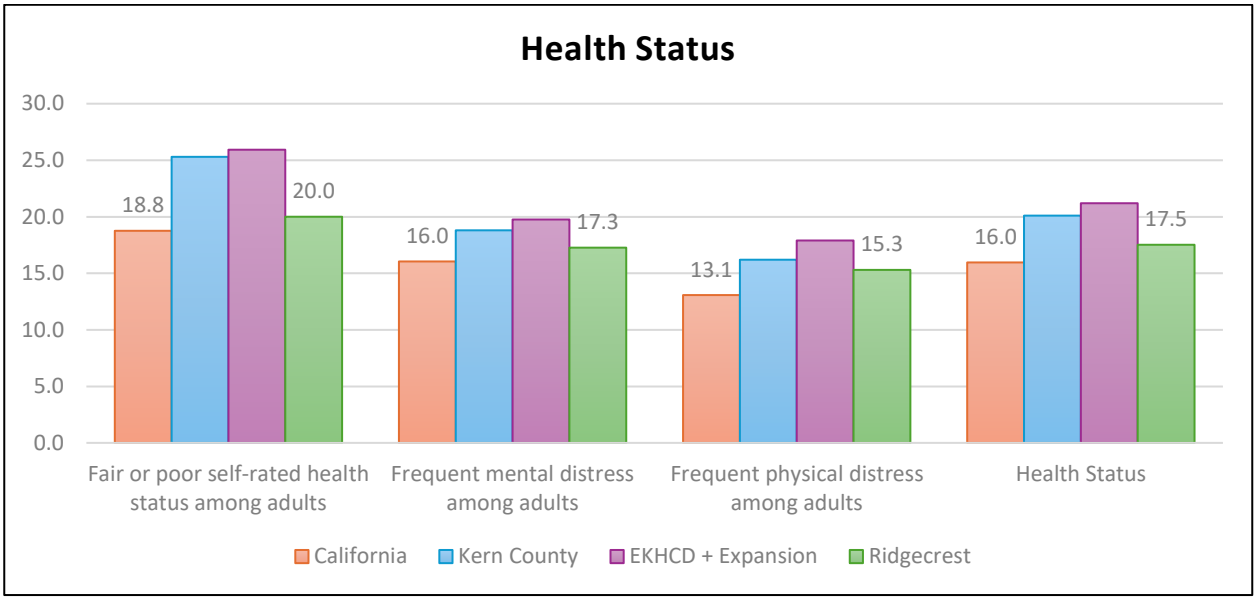
Ridgecrest scored between Kern County and state/national averages on the health status measures in the table above. None of the indicators flagged as being elevated when compared to other county rates in the state of California.

Health Status	Ridgecrest	EKHCD + Expansion	Lower Quartile	Upper Quartile	Upper Decile
Fair or poor self-rated health status among adults	20.0	25.9	17.1	21.9	25.4
Frequent mental distress among adults	17.3	19.8	15.7	18.3	19.2
Frequent physical distress among adults	15.3	17.9	12.9	15.9	16.9
Health Status Avg.	**17.5**	**21.2**	**14.7**	**18.7**	**21.7**

Source: CDC Places: Local Data for Better Health – 2021/2022.

Physical distress, within the context of health status metrics, refers to the frequency and severity of physical health problems experienced by individuals in a given population. This may include chronic pain, physical disability, fatigue, and other conditions that limit the ability to perform daily activities. The data presented offers insight into

geographic distribution of such challenges and identifies areas that may benefit from more targeted healthcare interventions and resource allocation, thereby improving overall quality of life and well-being.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Health Outcomes

Health Outcomes in the study encompassed a range of resident-reported conditions, from tooth loss to arthritis and diabetes. The totals for all Health Status measures were averaged to provide an aggregate view of health across the areas studied. Ridgecrest rates were in line with state metrics and better than those for Kern County. EKHCD+ reported higher rates than both Ridgecrest and the state, indicating greater health challenges in that region.

Health Outcomes	Ridgecrest	EKHCD + Expansion	Kern County	California
All teeth lost among adults aged >=65 years	12.3	19.3	21.5	10.7
Arthritis among adults	28.8	26.7	21.1	21.8
Cancer (non-skin) or melanoma among adults	9.6	7.5	5.8	6.7
Chronic obstructive pulmonary disease among adults	8.3	10.6	7.1	5.4
Coronary heart disease among adults	7.9	8.8	6.3	5.8
Current asthma among adults	11.0	11.4	10.4	9.6
Depression among adults	23.7	23.5	21.8	20.6
Diagnosed diabetes among adults	12.6	14.1	12.8	11.5
High blood pressure among adults	35.8	34.4	30.1	28.4
High cholesterol among adults who have ever been screened	37.8	34.9	33.4	34.1
Obesity among adults	33.8	35.2	35.6	28.3
Stroke among adults	4.2	5.1	3.7	3.1
Health Outcomes Avg.	**18.8**	**19.3**	**17.5**	**15.5**

Source: CDC Places: Local Data for Better Health – 2021/2022.

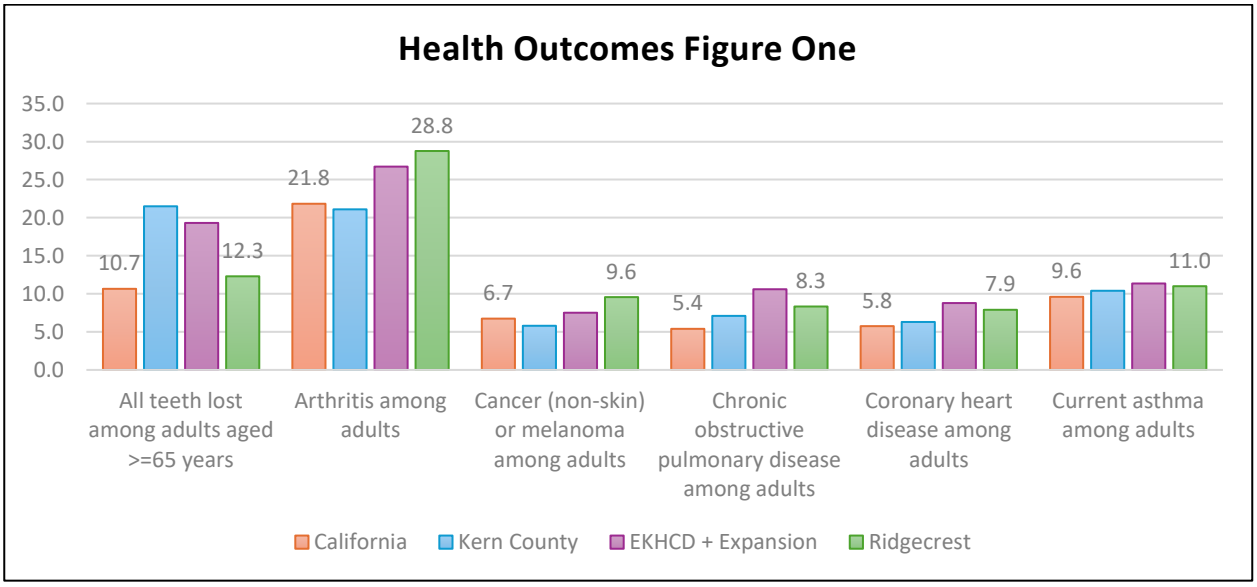
According to the table below, none of the 12 health indicators in Ridgecrest ranked within the top 10% of California counties, but eight categories fell within the top quartile of the state rates, signaling an elevated chronic disease burden. These include COPD, coronary heart disease, current asthma, depression, high blood pressure, high

cholesterol, obesity, and stroke. While Ridgecrest does not fall within the highest decile for any single indicator (red shading), the number of outcomes in the upper quartile (yellow shading) suggests a pattern of elevated chronic disease burden.

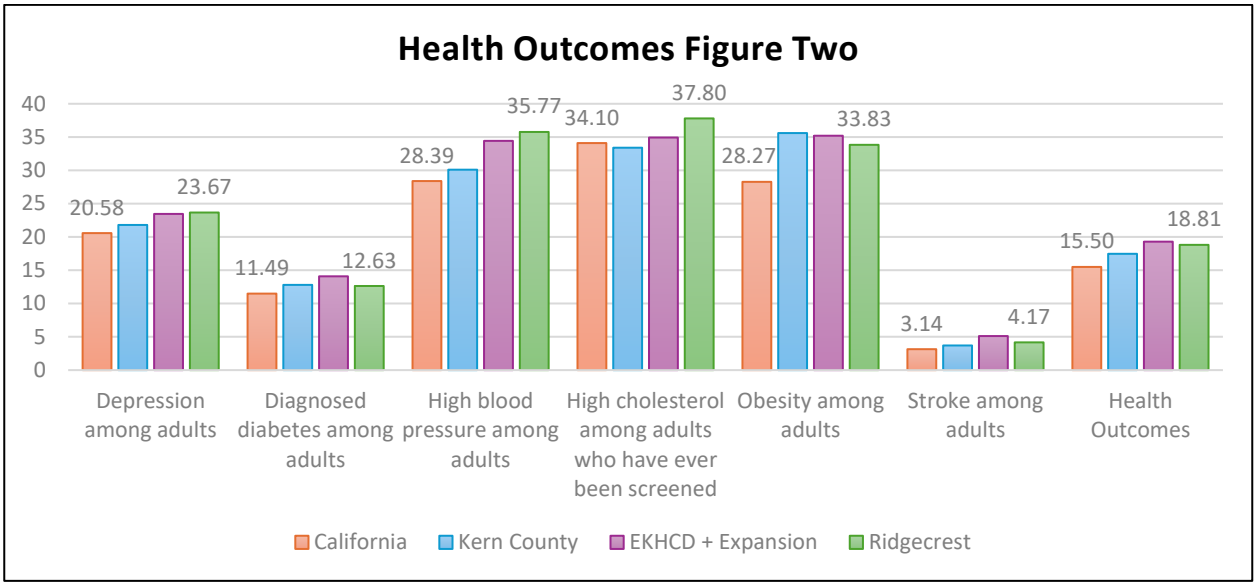
Health Outcomes	Ridgecrest	EKHCD + Expansion	Lower Quartile	Upper Quartile	Upper Decile
All teeth lost among adults aged >=65 years	12.3	19.3	8.5	14.5	15.8
Arthritis among adults	28.8	26.7	22.2	29.2	32.6
Cancer (non-skin) or melanoma among adults	9.6	7.5	6.7	10.4	11.5
Chronic obstructive pulmonary disease among adults	8.3	10.6	5.7	8.0	9.2
Coronary heart disease among adults	7.9	8.8	6.0	7.8	9.2
Current asthma among adults	11.0	11.4	10.0	10.8	11.1
Depression among adults	23.7	23.5	21.0	23.3	24.1
Diagnosed diabetes among adults	12.6	14.1	10.7	12.8	13.5
High blood pressure among adults	35.8	34.4	29.0	33.2	36.9
High cholesterol among adults who have ever been screened	37.8	34.9	33.4	36.8	39.3
Obesity among adults	33.8	35.2	28.3	32.7	34.6
Stroke among adults	4.2	5.1	3.2	4.0	4.7
Total Health Outcomes Avg.	**18.8**	**19.3**	**7.6**	**27.1**	**33.6**

Source: CDC Places: Local Data for Better Health – 2021/2022.

While the table above lists numerical data, Figures One and Two visually clarify how Ridgecrest compares to regional and state health outcomes, making patterns and disparities more immediately apparent. Specifically, COPD rates in Ridgecrest are 54% higher than the state average, heart disease is 36% higher, asthma and depression are both 15% higher, high blood pressure is 26% higher, and obesity is about 20% higher. Cancer prevalence is also 43% higher than the state average; however, despite this, Ridgecrest's cancer mortality rate remains lower than California overall, suggesting better cancer outcomes or treatment effectiveness locally. These findings are further illustrated in the accompanying tables and charts, which offer a clearer comparison of Ridgecrest's health status relative to state benchmarks. These areas should be considered for regional healthcare initiatives.



Source: CDC Places: Local Data for Better Health – 2021/2022.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Health Risk Behaviors

Health Risk Behaviors include activities that contribute to poor health outcomes, such as binge drinking and cigarette use. Additional metrics tracked by the CDC include lack of leisure-time physical activity and short sleep duration. Overall, Ridgecrest rates were similar to California averages, and generally lower than those reported for Kern County.

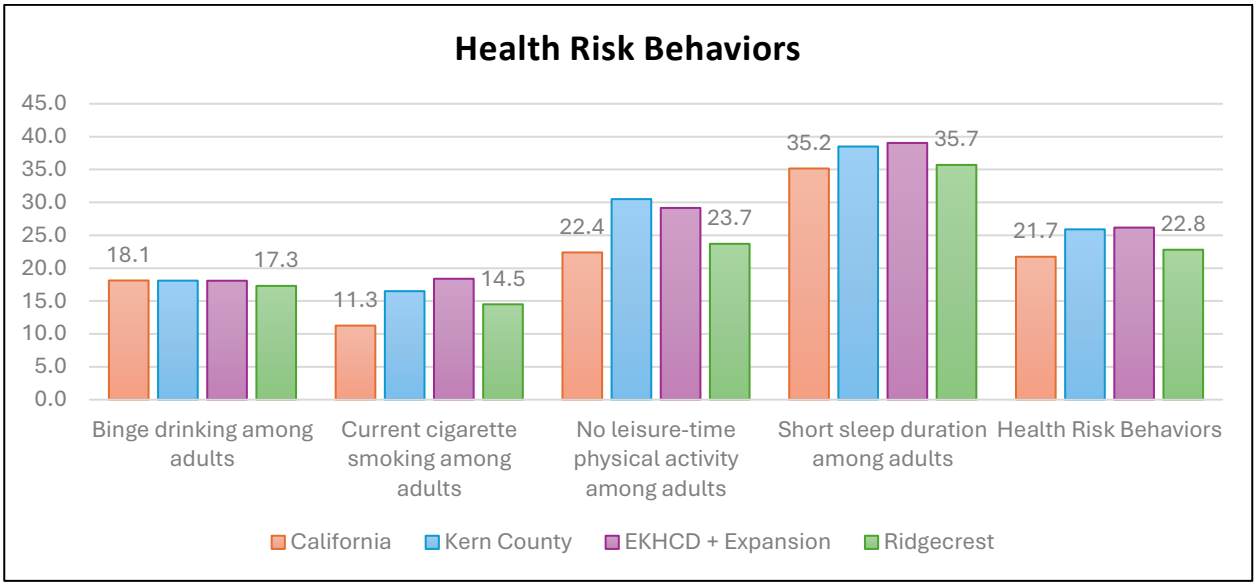
Health Risk Behaviors	Ridgecrest	EKHCD + Expansion	Kern County	California
Binge drinking among adults	17.3	18.1	18.1	18.1
Current cigarette smoking among adults	14.5	18.4	16.5	11.3
No leisure-time physical activity among adults	23.7	29.2	30.5	22.4
Short sleep duration among adults	35.7	39.0	38.5	35.2
Health Risk Behaviors Avg.	**22.8**	**26.2**	**25.9**	**21.7**

Source: CDC Places: Local Data for Better Health – 2021/2022.

When comparing Ridgecrest to statewide quartile benchmarks, binge drinking fell within the lower range, with a rate just above the lower quartile and well below the upper decile. However, all other indicators including cigarette use, physical inactivity, and short sleep duration were close to or within the upper quartile range. These elevated behaviors may contribute to long-term health concerns, namely, current cigarette smoking among adults is 128% of the state rate. However, if you look at the tables later on in the study regarding tobacco usage in adults, you will see a massive decrease over the half-decade from 19% down to 7% of adults still smoking. Logically, it will take time for this cultural shift to reduce numbers of lung disease and mortality.

Health Risk Behaviors	Ridgecrest	EKHCD + Expansion	Low Quartile	Upper Quartile	Upper Decile
Binge drinking among adults	17.3	18.1	17.0	19.1	19.8
Current cigarette smoking among adults	14.5	18.4	10.8	14.9	15.9
No leisure-time physical activity among adults	23.7	29.2	20.7	25.3	28.3
Short sleep duration among adults	35.7	39.0	32.4	35.9	38.0
Health Risk Behaviors Avg.	**22.8**	**26.2**	**16.0**	**30.5**	**34.9**

Source: CDC Places: Local Data for Better Health – 2021/2022.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Health-Related Social Needs

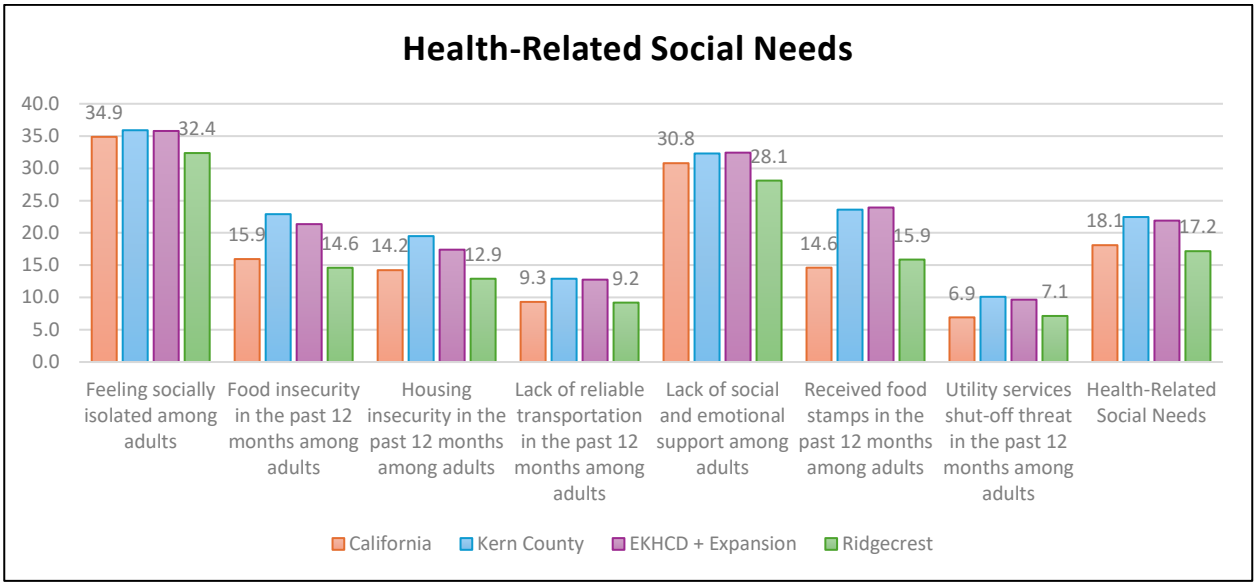
Health-Related Social Needs (HRSNs) reflect the critical influence of societal factors such as economic instability, access to food, housing, transportation, and social support on health outcomes. These factors can often exacerbate health disparities and contribute to poorer well-being. The following data highlights how these challenges manifest in Ridgecrest and surrounding areas, comparing them to both local and statewide averages.

Health-Related Social Needs	Ridgecrest	EKHCD + Expansion	Kern County	California
Feeling socially isolated among adults	32.4	35.8	35.9	34.9
Food insecurity in the past 12 months among adults	14.6	21.4	22.9	15.9
Housing insecurity in the past 12 months among adults	12.9	17.4	19.5	14.2
Lack of reliable transportation in the past 12 months among adults	9.2	12.8	12.9	9.3
Lack of social and emotional support among adults	28.1	32.4	32.3	30.8
Received food stamps in the past 12 months among adults	15.9	23.9	23.6	14.6
Utility services shut-off threat in the past 12 months among adults	7.1	9.7	10.1	6.9
Health-Related Social Needs Avg.	**17.2**	**21.9**	**22.5**	**18.1**

Source: CDC Places: Local Data for Better Health – 2021/2022.

The data in the table above shows that Ridgecrest does not rank among the highest counties for any health-related social needs measured. While some indicators such as social isolation (32.4%) and food insecurity (14.6%) are present, these rates remain below the upper quartile thresholds, suggesting moderate levels of social need. Overall, Ridgecrest's average for health-related social needs (17.2%) is lower than both California and Kern County. This indicates that, compared to other regions, Ridgecrest experiences fewer extreme social barriers, which may contribute positively to the community's overall health status.

The chart below provides another representation of the table above. Ridgecrest was not flagged for any of the health-related social needs in the table above and in the chart below.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Disability Topics

Overall, Ridgecrest rates were between the county and state rates.

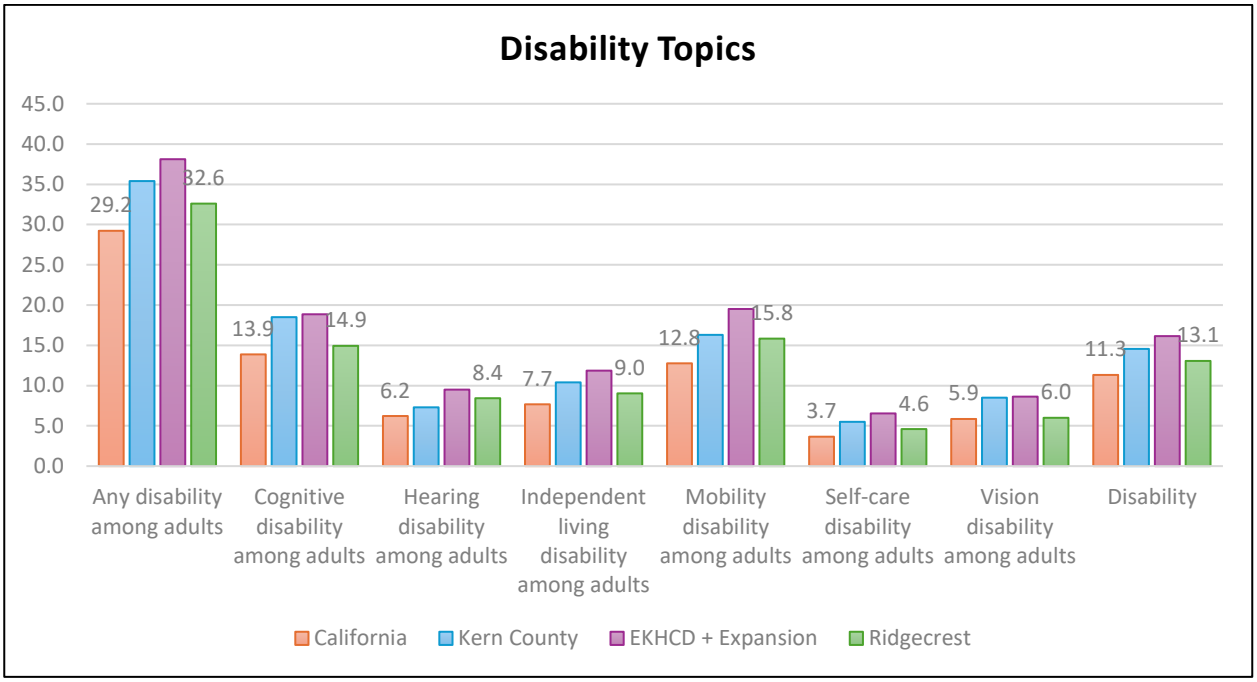
Disability Topics	Ridgecrest	EKHCD + Expansion	Kern County	California
Any disability among adults	32.6	38.1	35.4	29.2
Cognitive disability among adults	14.9	18.9	18.5	13.9
Hearing disability among adults	8.4	9.5	7.3	6.2
Independent living disability among adults	9.0	11.9	10.4	7.7
Mobility disability among adults	15.8	19.5	16.3	12.8
Self-care disability among adults	4.6	6.5	5.5	3.7
Vision disability among adults	6.0	8.6	8.5	5.9
Disability Avg.	**13.1**	**16.1**	**14.6**	**11.3**

Source: CDC Places: Local Data for Better Health – 2021/2022.

When flagging rates that would fall in the top 10% of California counties, none of the categories flagged Ridgecrest, and only hearing disability registered in the upper quartile.

Disability Topics	Ridgecrest	EKHCD + Expansion	Lower Quartile	Upper Quartile	Upper Decile
Any disability among adults	32.6	38.1	28.5	35.1	37.1
Cognitive disability among adults	14.9	18.9	13.1	16.7	18.3
Hearing disability among adults	8.4	9.5	6.5	8.3	9.7
Independent living disability among adults	9.0	11.9	7.4	9.7	10.4
Mobility disability among adults	15.8	19.5	12.2	16.6	17.5
Self-care disability among adults	4.6	6.5	3.4	4.7	5.3
Vision disability among adults	6.0	8.6	5.1	6.6	8.2
Disability Avg.	**13.1**	**16.1**	**6.0**	**15.2**	**29.5**

Source: CDC Places: Local Data for Better Health – 2021/2022.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Prevention

Prevention metrics cover access and health prevention behaviors among residents in each area. Unlike most other topics, a lower score here indicates a negative outcome. Ridgecrest performs well, with higher rates of cholesterol screening, colorectal cancer screening, taking medication to control high blood pressure, and routine medical checkups compared to other areas. For mammography use and dental visits, Ridgecrest falls between state and county averages.

Prevention	Ridgecrest	EKHCD + Expansion	Kern County	California
Cholesterol screening among adults	85.9	81.9	80.7	85.5
Colorectal cancer screening among adults aged 45–75 years	63.1	51.1	52.7	57.4
Mammography use among women aged 50-74 years	74.7	71.6	73.4	75.7
Taking medicine to control high blood pressure among adults with high blood pressure	75.4	67.4	69.8	72.6
Visited dentist or dental clinic in the past year among adults	61.6	52.7	52.1	62.7
Visits to doctor for routine checkup within the past year among adults	74.1	71.6	69.5	70.9
Prevention Avg.	**72.5**	**65.9**	**66.4**	**70.8**

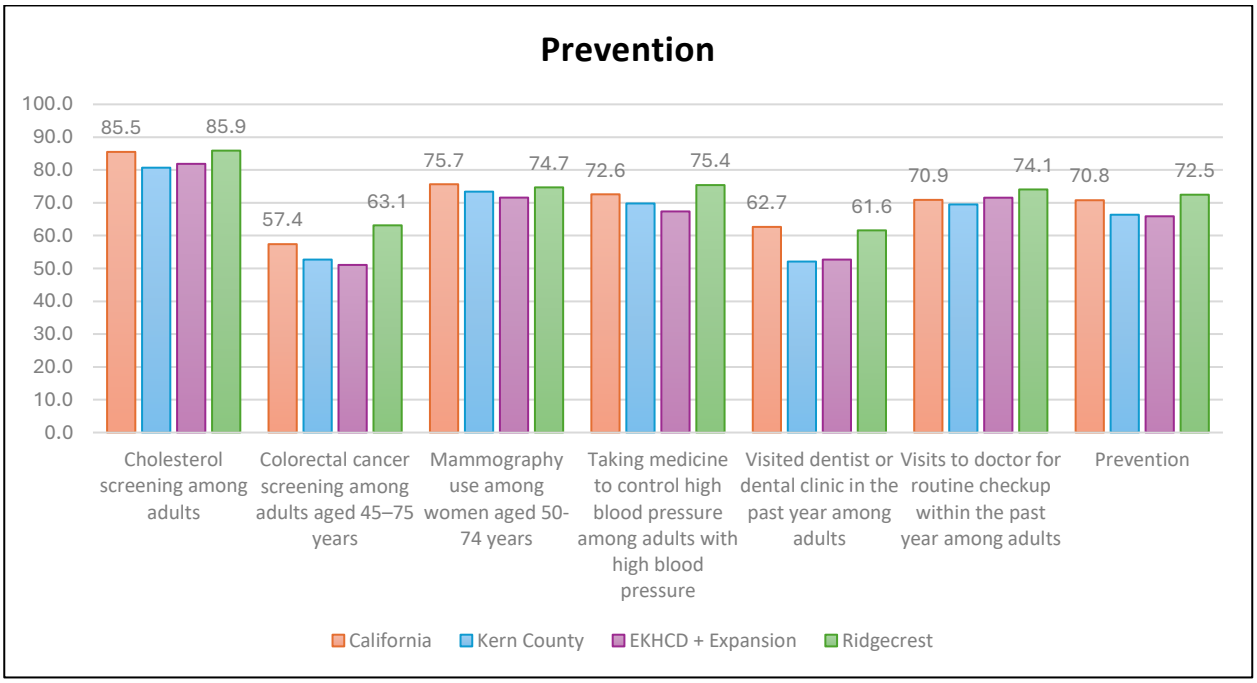
Source: CDC Places: Local Data for Better Health – 2021/2022.

Prevention is critically important in healthcare because it supports proactive management of health, helping to avoid serious complications. Ridgecrest did not flag in any concerns in these prevention categories.

Prevention	Ridgecrest	EKHCD + Expansion	Low Quartile	Upper Quartile	Upper Decile
Cholesterol screening among adults	85.9	81.9	88.3	87.3	88.3
Colorectal cancer screening among adults aged 45–75 years	63.1	51.1	57.7	64.0	66.1
Mammography use among women aged 50-74 years	74.7	71.6	73.0	77.0	78.6
Taking medicine to control high blood pressure among adults with high blood pressure	75.4	67.4	72.5	76.7	78.5
Visited dentist or dental clinic in the past year among adults	61.6	52.7	58.0	65.8	68.4
Visits to doctor for routine checkup within the past year among adults	74.1	71.6	69.2	72.9	74.3
Prevention Avg.	**72.5**	**65.9**	**60.5**	**75.8**	**83.0**

Source: CDC Places: Local Data for Better Health – 2021/2022.

Consistent preventive care leads to a healthier community by reducing incidences of chronic disease and improving overall quality of life for individuals. Emphasizing prevention allows for minimizing costly health crises and better allocation of healthcare resources. Continued support of these preventive strategies is essential to fostering a healthier society and ensuring sustainable healthcare practices.



Source: CDC Places: Local Data for Better Health – 2021/2022.

Environmental Conditions

Priority: Low

Extant data on environmental conditions - two categories:

1. Found Chemicals and Legal Limits
2. Arsenic Levels

Our survey results expressed concern about environmental conditions, both from providers and the public. These concerns seemed very reasonable and needed to be thoroughly addressed in this study.

The proximity to China Lake Naval Air Weapons Station has created concern for the environmental conditions surrounding Ridgecrest. Dozens of waste deposit sites from this base are located around Ridgecrest and northeast Kern County, including both neighboring Inyo and San Bernardino Counties. These sites typically consist of buried materials and waste deposits, with chemicals ranging from asbestos to vast amounts of motor oil, old munitions, and various other chemicals associated with the naval base. Another known soil contamination from the base, includes PFSA, or Per- and Polyfluoroalkyl Substances. These are “forever chemicals” which do not break down in the environment or do so only after incredibly long periods of time. These chemicals have been linked to such issues as an increased risk of certain cancers, fertility problems, increased cholesterol, liver damage, thyroid disease, and immune system changes.

The Environmental Working Group (EWG) is a U.S.-based nonprofit organization based out of Washington DC., focused on research and advocacy. The group is known for publishing consumer guides and databases, such as the Tap Water Database. EWG's drinking water quality report shows results of tests conducted by the water utility and provided by the California State Water Resources Control Board, as well as information from the U.S. EPA Enforcement and Compliance History database (ECHO). For the latest quarter assessed by the U.S. EPA (April 2024 - June 2024), tap water provided by this water utility followed federal health-based drinking water standards.

Chemicals tested for but not detected:
1,1,1-Trichloroethane, 1,1,2,2-Tetrachloroethane, 1,1,2-Trichloroethane, 1,1-Dichloroethane, 1,1-Dichloroethylene, 1,2,3-Trichloropropane, 1,2,4-Trichlorobenzene, 1,2-Dibromo-3-chloropropane (DBCP), 1,2-Dichloroethane, 1,2-Dichloropropane, 1,3-Butadiene, 1,3-Dichloropropene, 1,4-Dioxane, 1-butanol, 11-chloroeicosafluoro-3-oxaundecane-1-sulfonic aci, 2,3,7,8-TCDD (Dioxin), 2,4,5-TP (Silvex), 2,4-D, 2-methoxyethanol, 2-propen-1-ol, 4,8-dioxa-3H-perfluorononanoic acid (ADONA), 9-chlorohexadecafluoro-3-oxanone-1-sulfonic acid (, Alachlor (Lasso), Alpha-hexachlorocyclohexane, Aluminum, Antimony, Asbestos, Atrazine, Barium, Bentazon (Basagran), Benzene, Benzo[a]pyrene, Beryllium, Bromochloromethane, Bromomethane, Butylated hydroxyanisole, Cadmium, Carbofuran, Carbon tetrachloride, Chlordane, Chlorodifluoromethane, Chloromethane, Chlorpyriphos, Chromium (total), cis-1,2-Dichloroethylene, cis-1,3-Dichloropropene, Cobalt, Cyanide, Dalapon, Di(2-ethylhexyl) adipate, Di(2-ethylhexyl) phthalate, Dichloromethane (methylene chloride), Dimethipin, Dinoseb, Diquat, Endothall, Endrin, Ethoprop, Ethylbenzene, Ethylene dibromide, Glyphosate, Heptachlor, Heptachlor epoxide, Hexachlorobenzene (HCB), Hexachlorocyclopentadiene, Hexafluoropropylene oxide dimer acid (HFPO-DA), Lindane, Mercury (inorganic), Methoxychlor, Molinate, Monobromoacetic acid, Monochloroacetic acid, Monochlorobenzene (chlorobenzene), MTBE, N-ethyl perfluorooctane sulfonamido acetic acid (N, N-methyl perfluorooctanesulfonamidoacetic acid, Nitrite, o-Dichlorobenzene, o-toluidine, Oxamyl (Vydate), Oxyflurofen, p-Dichlorobenzene, Pentachlorophenol, Perchlorate, Perfluorobutane sulfonate (PFBS), Perfluorodecanoic acid (PFDA), Perfluorododecanoic acid (PFDoA), Perfluoroheptanoic acid (PFHPA), Perfluorohexane sulfonate (PFHXS), Perfluorohexanoic Acid (PFHxA), Perfluorononanoic acid (PFNA), Perfluorooctane sulfonate (PFOS), Perfluorooctanoic acid (PFOA), Perfluorotetradecanoic acid (PFTA), Perfluorotridecanoic acid (PFTrDA), Perfluoroundecanoic acid (PFUnA),

Permethrin, Picloram, Polychlorinated biphenyls (PCBs), Profenofos, Quinoline, Selenium, Silver, Simazine, Styrene, Tebuconazole, Tetrachloroethylene (perchloroethylene), Thallium, Thiobencarb, Toluene, Toxaphene, trans-1,2-Dichloroethylene, trans-1,3-Dichloropropene, Tribufos, Trichloroacetic acid, Trichloroethylene, Trichlorofluoromethane, Trichlorotrifluoroethane, Vinyl chloride, Xylenes (total)

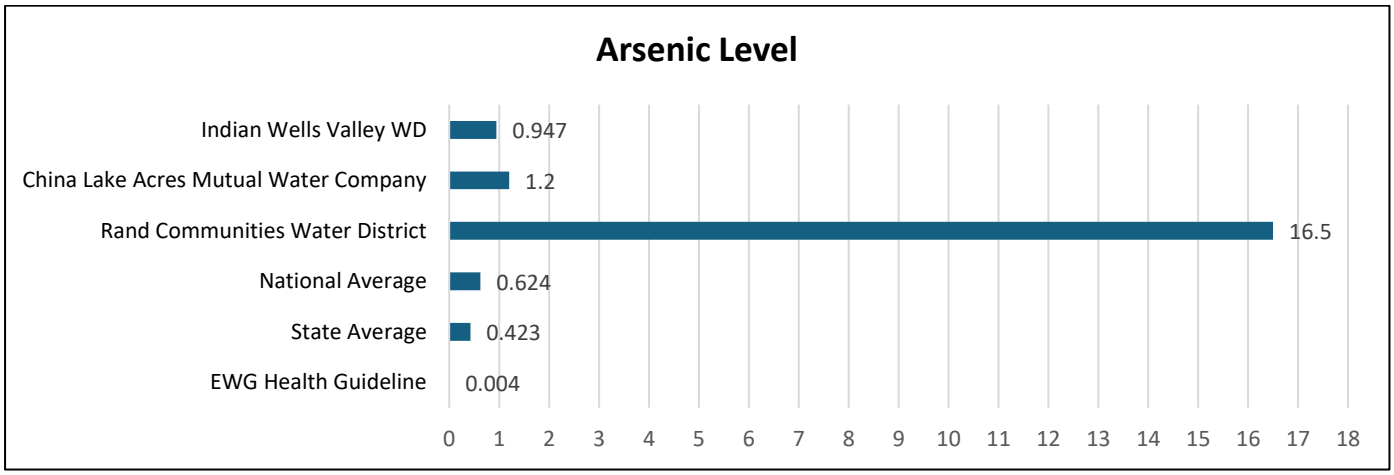
Chemicals tested for and detected, but not flagged:
Arsenic, Bromodichloromethane, Bromoform, Chromium (Hexavalent), Dibromochloromethane, Dichloroacetic Acid, Haloacetic Acids (HAA5), Haloacetic acids (HAA9), Nitrate, Nitrate and nitrite, Radium, combined (-226 and -228), Total trihalomethanes (TTHMs), Uranium, Chlorate, Fluoride, Germanium, Manganese, Molybdenum, Strontium, Vanadium.

Other chemicals of varying but lesser concern can be found on their website, including haloacetic acids, nitrates and nitrite, radium, total trihalomethanes, and uranium, all within federally acceptable tolerances.

Area of Measurement	Arsenic (PPB)	Haloacetic acids (PPB)	Nitrate (PPM)	Nitrate and nitrite (PPM)	Radium (pCi/L)	Total trihalomethanes (PPB)	Uranium (pCi/L)
EWG Health Guideline	0.004	0.1	0.14	0.14	0.05	0.15	0.43
Legal Limit	10	60	10	10	5	80	20
National Average	0.624	19.8	0.824	0.78	0.33	29.1	1.03
Indian Wells Valley WD	0.947	21	1.75	1.55	0.9	5.34	2.3

Source: EWG. https://www.ewg.org/tapwater/.
PPB, parts per billion. PPM, parts per million. And pCi/L, picocuries per liter.

According to EWG, their report raised some concerns over a variety of chemicals. Some of these concerns were over legal limits, however many of these chemicals have no established legal limit. For example, Indian Wells Valley Water District, which supplies most of Ridgecrest proper, has an arsenic score of 0.947ppb, which is under the legal limit of 10ppb. However, there is a legitimate concern of neighboring ground water sources, such as Rand Communities Water District (Johannesburg, CA serving 303 residents 30 minutes south of Ridgecrest), are above the legal limit with 16.5ppb. For those living south of Ridgecrest, this potential for arsenic exposure is a concern.



Source: EWG. https://www.ewg.org/tapwater/. All data is PPB, or parts per billion.

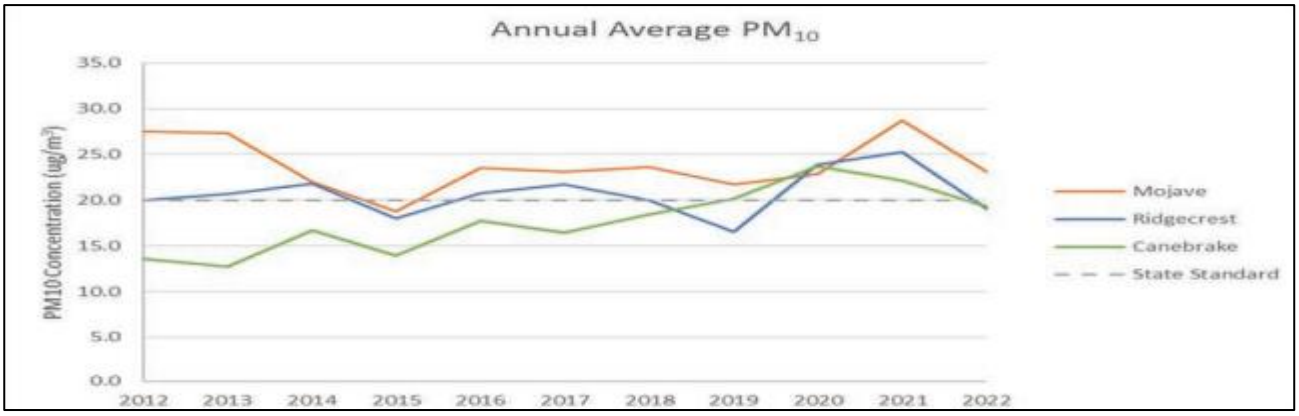
Arsenic is a chemical that can negatively impact a wide range of organs and systems, such as cardiovascular, endocrine, nervous, respiratory, and immune health. Arsenic is a well-known carcinogen, can contribute to

diabetes, and can cause other health problems, particularly from long-term exposure, even at lower levels. Acute toxicity levels are much higher; however, it is strongly recommended to treat any drinking water that contains 10ppb or more.

Water utilities for Ridgecrest's Indian Wells Valley Water District, along with China Lake's and California City's utilities had zero contaminants above legal limits. However, the EWG could not locate any test results for lead levels in drinking water for these utilities from either state or federal sources. Additionally, there is no available information on the utilities' compliance with lead testing and reporting requirements. For more details, individuals are encouraged to contact the utilities directly to inquire about their lead testing results.

In summary, all water measures are within legal limits in Ridgecrest. There are contaminants in the water, as there would be almost anywhere, and advocacy groups push for higher quality control. Though it may be completely warranted to demand stricter tolerances for the sake of health, scientific understanding is still evolving, and decisions can only be made based on legal limits. Regardless of what contaminants are present in the water before the utilities' filtration efforts, all measures of what is coming out of the faucets are within legal limits, with the exception of Johannesburg 30 minutes south of Ridgecrest, which was flagged for arsenic. For any community members not satisfied with these findings, it is worth noting that all contaminants found in the water tests for at the regional water utilities, including arsenic, can be filtered out of the water using reverse osmosis. For any contaminants not removed by this common type of filtration, all levels found were below the aspirational tolerances set by the EWG advocacy group.

According to the Eastern Kern Air Pollution Control District (EKAPCD), there are a variety of sources of air pollution for the immediate region. These include mining and cement industries, commercial and military aerospace activity, emissions from agriculture (including the cannabis industry), and pollution emitted from the naval base. In recent years, wildfires have contributed significantly to air quality monitoring abnormalities. However, according to the EKAPCD's 2022-2023 district report, the levels of particulate matter were relatively aligned with the state standard of 20 PM10. Generally, while there are identified contributors to both air pollution and air quality, the Ridgecrest area is typically considered to be consistently measured as having good or moderate air quality.

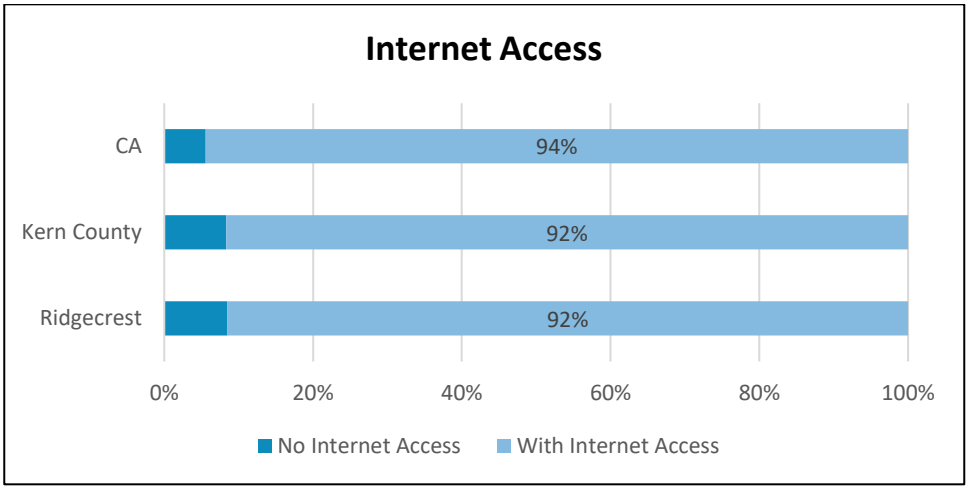


Source: EKAPCD 2022-2023 District Report.

Access to Care
Priority: High

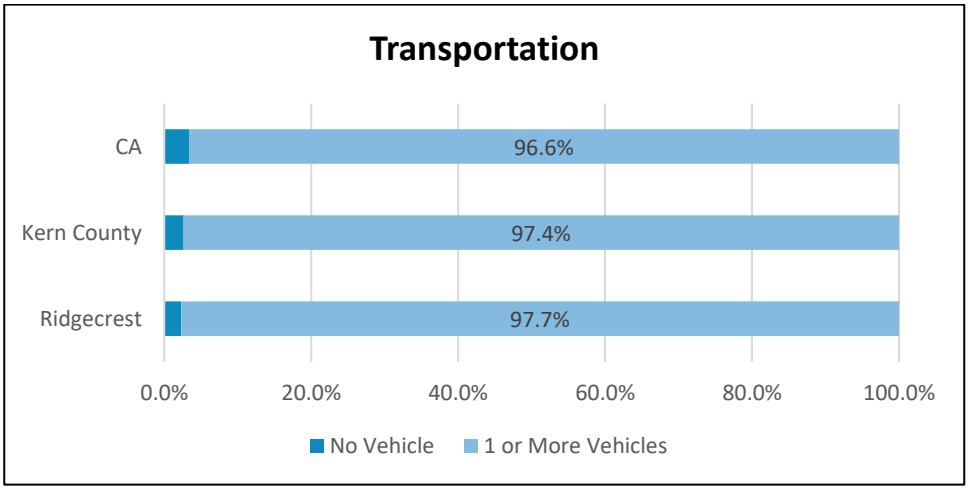
Extant Data on Access to Care - four categories:
1. Internet Access
2. Vehicles Available for Personal Use
3. Health Insurance Coverage
4. Payer Source Among RRH Inpatients

With approximately 92% of Ridgecrest households reporting internet access, matching the county average and falling slightly below California's 94%, digital connectivity is generally not a barrier. This baseline access supports the feasibility of offering telehealth services and other online tools, though attention may still be needed for the roughly 3,000 residents who remain without internet access.



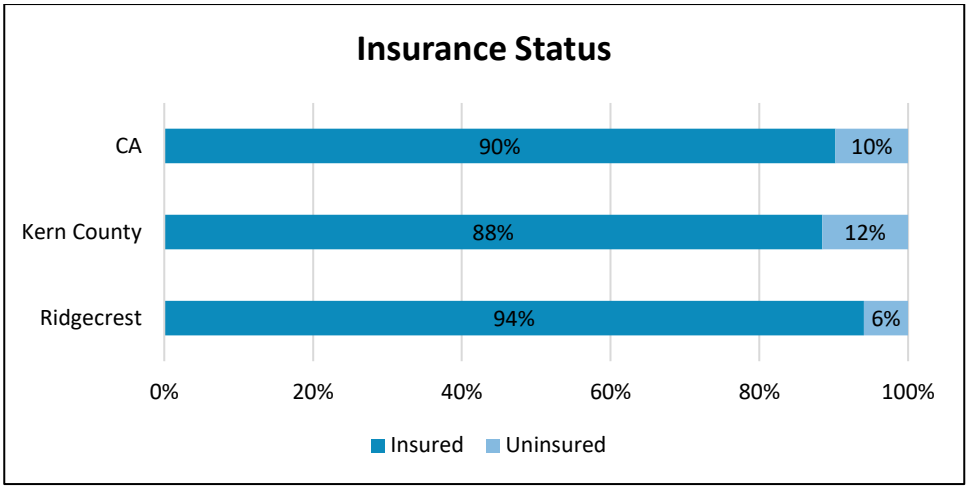
Source: U.S. Census Bureau, ACS, 2019-2023.

Approximately 98% of Ridgecrest households have one or more vehicles available for personal use, a rate consistent with both Kern County and California overall. In the previous CHNA, transportation was identified as a high priority issue. However, based on the data presented below, and the limited representation of transportation concerns in the current survey results, this priority should be reevaluated. Specifically, future consideration should focus on transportation needs for vulnerable populations, including elderly, low-income residents, and minorities. This issue will be explored further in the section analyzing the survey results.



Source: U.S. Census Bureau, ACS, 2019-2023.

An estimated 94% of Ridgecrest residents have some form of health insurance, a rate that exceeds both the Kern County average (88%) and the California statewide average (90%). It also stands at about two percentage points higher than the national average. This relatively high level of coverage suggests that most residents have access to at least basic health services in the area.



Source: U.S. Census Bureau, ACS, 2019-2023.

The inpatient discharge data from RRH further contextualizes this coverage. In 2023, just over 1/3 of inpatient discharges were billed to Medicare, and another 1/3 to MediCal. This reflects a patient population that is largely made up of older adults and lower-income individuals, indicating that public insurance plays a dominant role in covering healthcare costs locally.

Private insurance accounted for just over 1/4 of all inpatient discharges, which is a relatively modest proportion that aligns with Ridgecrest's broader reliance on public programs. Only 1% of patients were self-pay, consistent with the community's high overall insurance coverage and suggests that cost barriers to inpatient care may still exist, they are likely less widespread when compared to other regions with higher uninsured rates.

What stands out is the minimal reliance on self-pay and other less common payer types, which may help reduce financial strain on the healthcare system due to uncompensated care. At the same time, the heavy dependence on Medicare and Medi-Cal underscores the importance of maintaining and supporting these programs in Ridgecrest.

Expected Payer Source	Discharges	Percent of Total
Medicare	744	34%
Medi-Cal	643	33%
Private Coverage	495	26%
Other Government	90	6%
Self-Pay	19	1%
Workers' Compensation	-	0%
Other Payer Types	-	0%
Total	**1,991**	**100%**

Source: Department of Health Care Access and Information (HCAI), 2023. https://hcai.ca.gov/.
Note: Payer source data is from the inpatient department.

Maternal Health

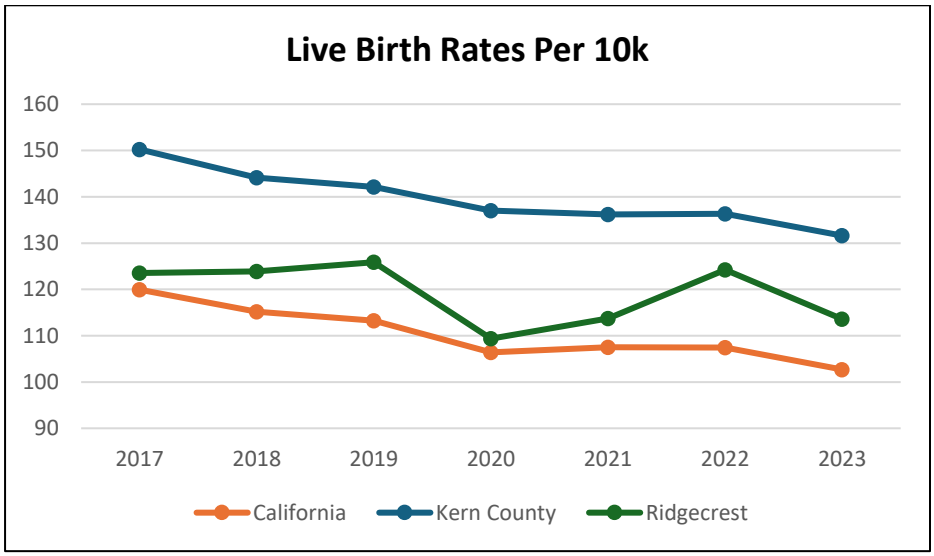
Priority: Moderate

Extant Data on Maternal Health - three categories:

1. Live Birth Rates
2. Maternal Health Related Discharges from RRH
3. Number of Obstetrical Procedures at RRH

Overall, live birth rates have declined by approximately 15% across California, Kern, and Ridgecrest since 2017. In 2023, Ridgecrest reported a live birth rate of 103 per 100,000 residents. When multiplied by the city's estimated population factor of 3.7, this equates to an approximate rate of 381 births per year. According to the American College of Obstetricians and Gynecologists, their workforce survey estimates that a typical OB/GYN handles between 100-200 deliveries annually. [2]

Drawing inspiration from the military adage familiar at the bases around Ridgecrest, "two is one, and one is none," this principle underscores the importance of redundancy in sustaining critical operations. In the context of maternal health services in this rural area, this wisdom translates to the strong suggestion of maintaining a minimum of two OB/GYN providers, to ensure continuous and reliable coverage - even in the face of expected attrition or unexpected absences. With current birth volumes supporting this staffing model, the recently bolstered OB/GYN program appears both stable and resilient at this scale. Moreover, increases in demand or need for specialized support can be judiciously met by integrating advanced practitioners, ensuring that the community's maternal health needs remain well-covered and adaptable to future changes.



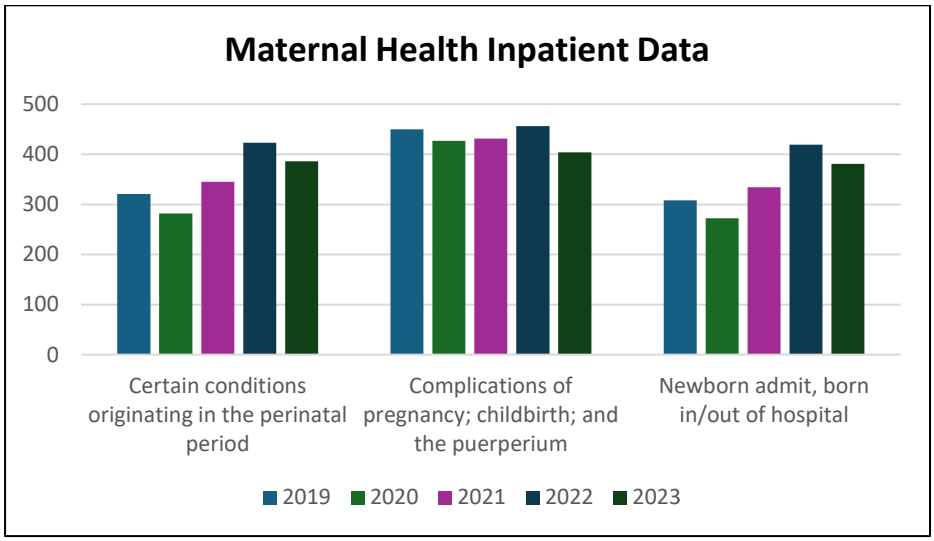
Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/.

The most recent HCAI data through 2023 show that newborn admissions increased from approximately 308 in 2019 to 381 in 2023, an overall rise of about a quarter. This increase could reflect several factors, including improved access to hospital care, greater detection and treatment of early complications, or a rebound from increased pregnancy during the COVID-19 Pandemic lockdown. While the increase may signal enhanced care accessibility, it may also warrant closer monitoring to ensure it is not driven by rising health complications in newborns.

[2] ACOG. (2017). The Obstetrician–Gynecologist Workforce in the United States: Facts, Figures, and Implications, 2017. *The American Congress of Obstetricians and Gynecologists (ACOG)*.

At the same time, inpatient admissions for certain conditions originating in the perinatal period declined by about 9%, and those related to complications of pregnancy, childbirth, and the puerperium decreased by approximately 11%. These reductions suggest that maternal health outcomes may be improving, potentially due to more effective prenatal care, early interventions, and consistent access to hospital services.

Taken together, these trends indicate that maternal and newborn care services are being actively utilized, with positive signs of stabilization or improvement in several key areas. Continued investment in hospital-based maternity care appears to be supporting better outcomes for both mothers and infants in the Ridgecrest community.



Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/.

The last set of bars in the table directly above show more babies were born in the hospital in recent years. The raw data here suggests that complications of childbirth align with the number of newborns admitted; however, it should be noted that this metric includes both childbirth and pregnancy – it is not a one-to-one comparison.

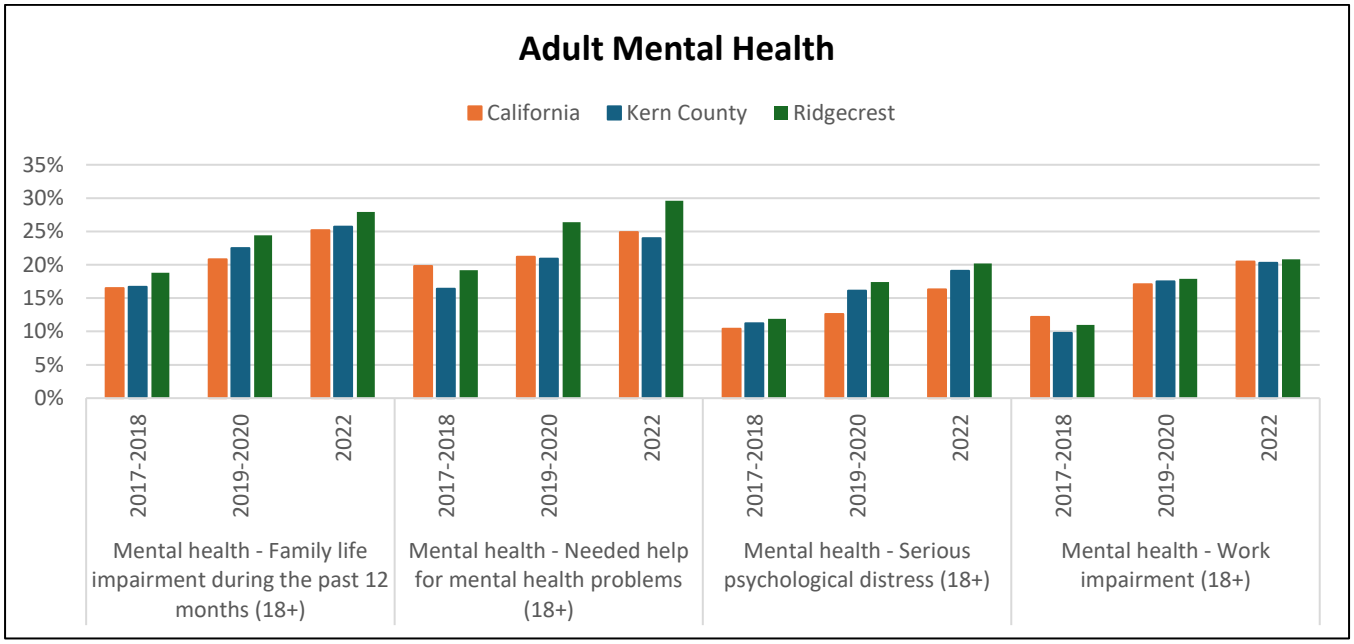
Mental Health

Priority: Moderate - Low

Extant Data on Mental Health - three categories:

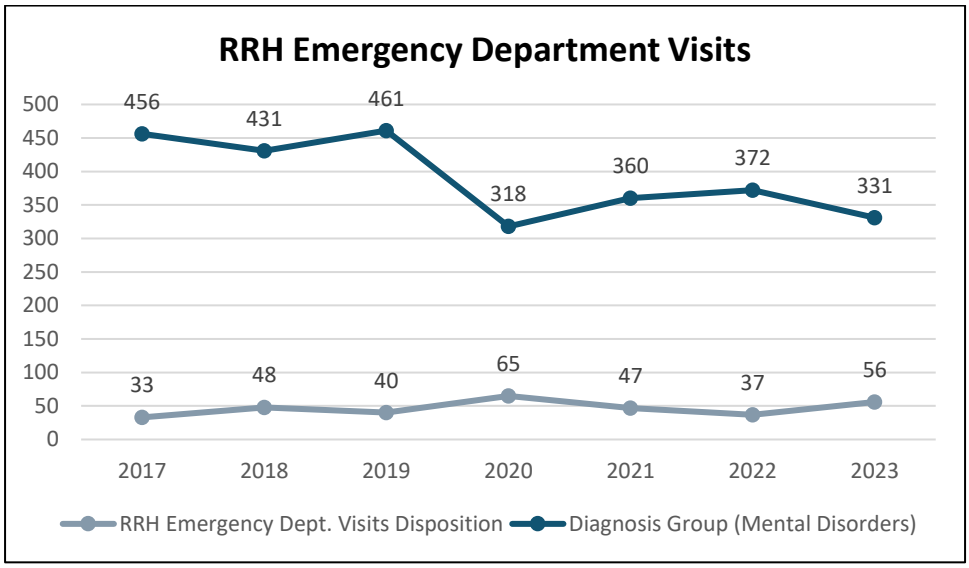
1. Adult Mental Health
2. RRH Inpatient and Emergency Department Visits
3. Middle & High School Social and Emotional Health

Residents in Ridgecrest consistently experience higher rates of mental health challenges compared to both Kern County and California. In nearly every metric and year, Ridgecrest was one to several percentage points higher than the state average. Notably, in 2022, 30% of Ridgecrest adults reported needing help with mental health problems, compared to 24% in California and 25% in Kern County. Similarly elevated rates were observed in family life impairments as well as serious psychological distress. The main takeaway is that a significant proportion of Ridgecrest residents reported struggling with mental health needs, underscoring a persistent and pressing community concern.

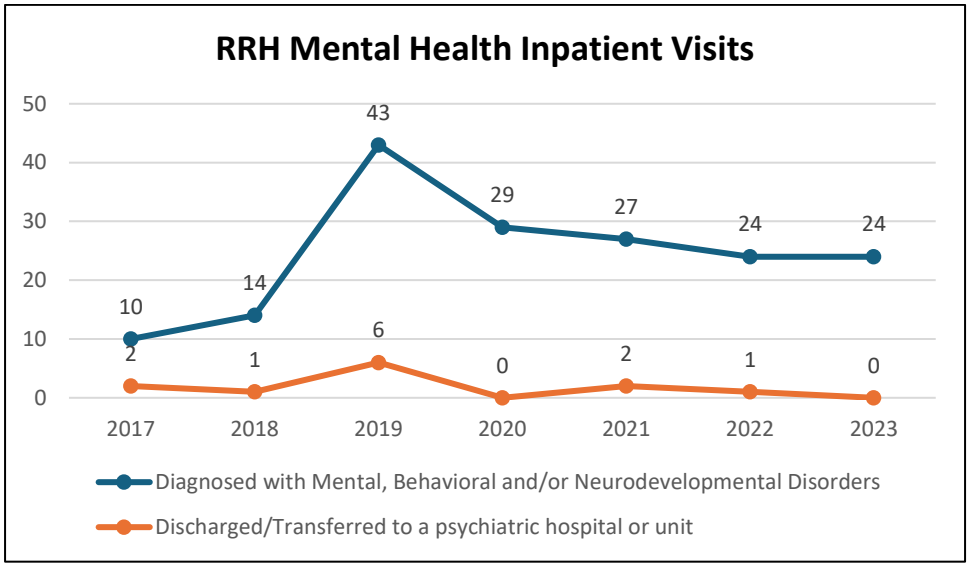


Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2017-2022. http://healthpolicy.ucla.edu/ (*no data reported for 2021*)

In 2023, 331 visits to the emergency department had their principal diagnosis group related to mental health. These visits represent approximately 2% of all visits to the emergency department that year. Out of those mental health visits, 56 received a final disposition to psychiatric care. As shown in the second chart below, 24 of the 331 visits, or only 7% of all mental health visits resulted in inpatient admissions from the emergency department. When framed more broadly, these 24 admissions make up 2% of the hospital's total 1,088 inpatient admissions for the year.



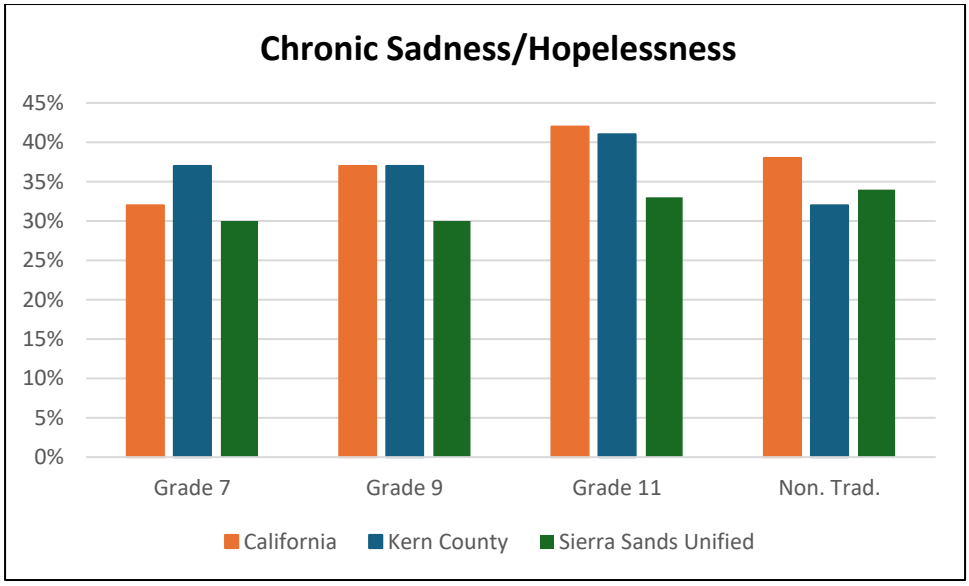
Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/



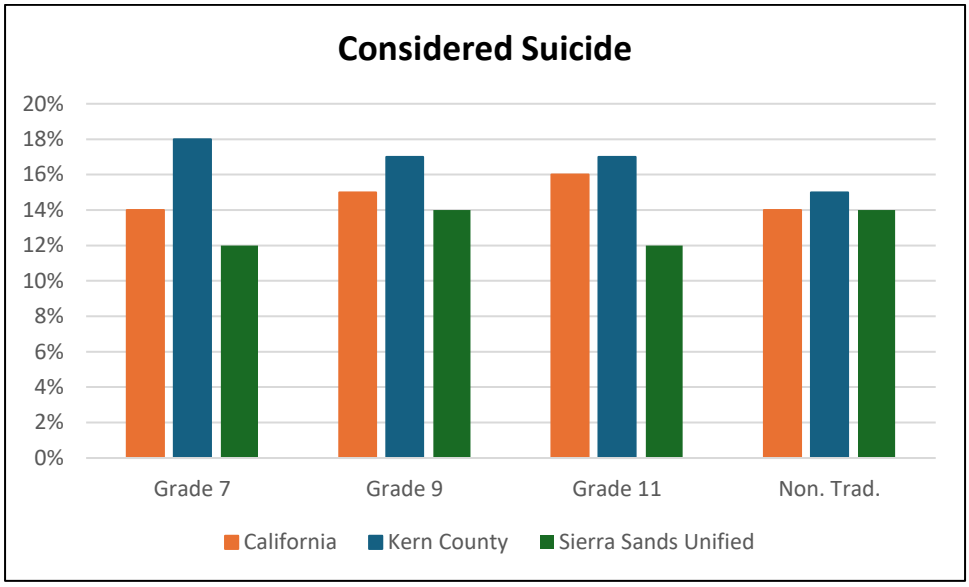
Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/

To summarize adult mental health findings, 30% need help with mental health, 20% serious psychological distress and 20% struggle with work impairment, but this appears to be a significant outpatient need. Inpatient shows 2% of emergency room services are used for MH and 2% of admissions. An average of one mental health visit was transferred to a psychiatric unit or hospital per year. Therefore, the hospital services are aligned, and the ER is not overburdened by mental health. There is, however, expressed need for additional outpatient mental health services voiced here, and in the community survey (and in the substance abuse statistics).

A California Department of Education survey indicated lower levels of chronic sadness, hopelessness, and suicidal ideation among most middle and high school students in Ridgecrest (SSUSD) compared to Kern County and the state overall. Students in grades 7, 9, and 11 consistently reported lower rates of both "Considered Suicide" and "Chronic Sadness/Hopelessness" than their peers in Kern County and across California. Among non-traditional students, Ridgecrest reported rates similar to state averages for suicidal ideation and slightly higher levels of chronic sadness compared to Kern County, though still lower than California overall.



Source: California Department of Education, CalSCHLS, 2017-2023. https://calschls.org/.



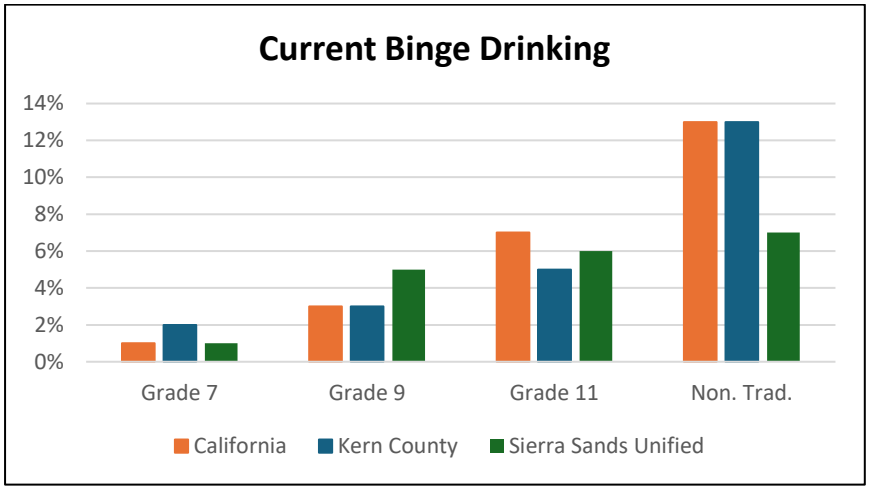
Source: California Department of Education, CalSCHLS, 2017-2023. https://calschls.org/.

Substance Use or Addiction
Priority: Moderate - Low

Extant Data on Substance Use or Addiction - six categories:

1. Middle and High School Binge Drinking
2. Middle and High School Marijuana Use
3. Middle and High School Cigarette Use
4. Middle and High School Vaping Use
5. Adult Nicotine Use
6. Opioid Related Overdose Deaths

For the purposes of this data from CalSCHLS, non-traditional (also known as Cont. School) students are defined as students enrolled in community day schools or continuation education programs.

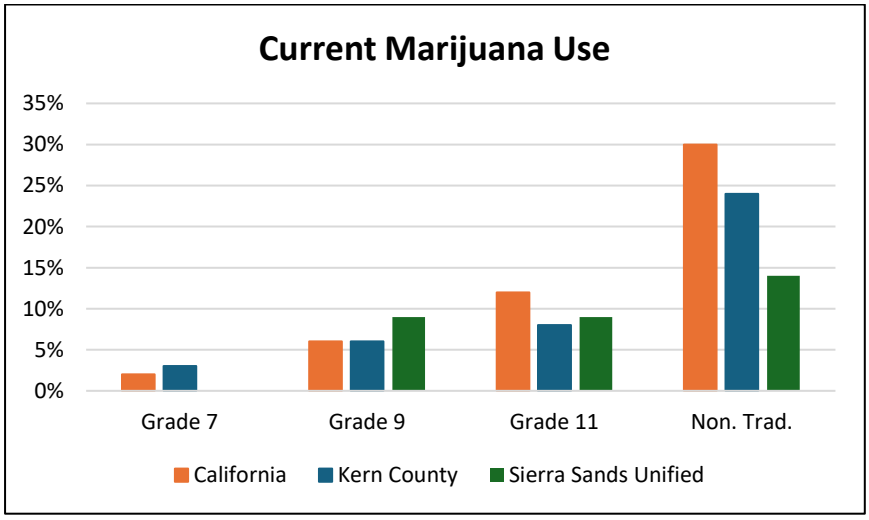


Source: California Department of Education, CalSCHLS, 2021-2023. https://calschls.org/.

Current binge drinking rates generally increase with grade level across all regions. In Grade 7, rates are low overall, with SSUSD (Ridgecrest) at just over 1%, compared to about 2% in Kern County. By Grade 9, Ridgecrest shows slightly higher binge drinking (around 5%) than the state and county averages (approximately 3%). For Grade 11, Ridgecrest is below the state average (6% vs. 7%) and slightly above Kern County (5%). Among non-traditional students, binge drinking peaks across all regions, with California and Kern County nearing 14%, while Ridgecrest remains lower at around 9%. Overall, these rates are average and should be monitored.

Marijuana use is consistently higher than binge drinking. In Grade 7, reported use remains low statewide. SSUSD, representing Ridgecrest, reports no use, while Kern County is slightly higher at just under 3%. California reports just over 2% for this age group.

By Grade 9, marijuana use increases notably. SSUSD reports approximately 9%, which is slightly higher than the 6% reported for both Kern County and the state overall. In Grade 11, California reports the highest rate at 12%. Ridgecrest and Kern County are somewhat lower, at around 9% and 8%, respectively. Among non-traditional students, usage increases significantly. California reports a rate of 30%, Kern County follows with 25%, and SSUSD reports approximately 16%.



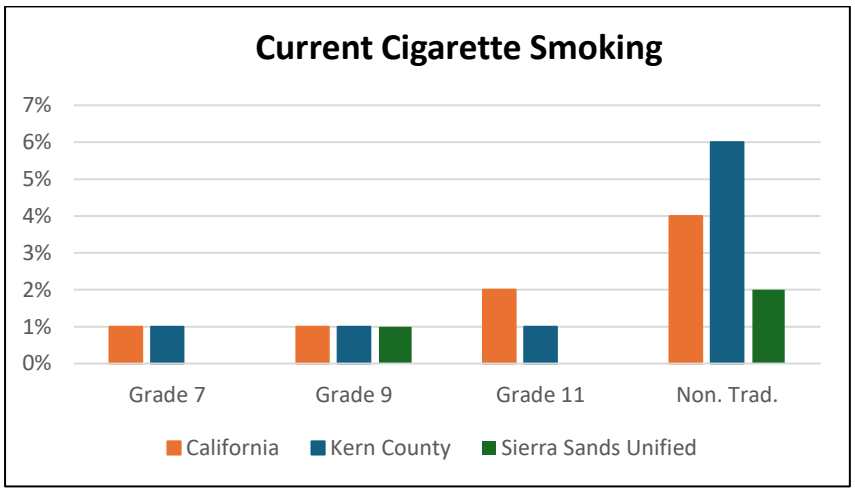
Source: California Department of Education, CalSCHLS, 2021-2023. https://calschls.org/.

Marijuana use rises with grade level and is considerably more common among non-traditional students. In Ridgecrest, nearly one in ten traditional high school students report current marijuana use. Among non-traditional students, the rate nearly doubles, highlighting a clear need for targeted prevention and intervention strategies for this subgroup.

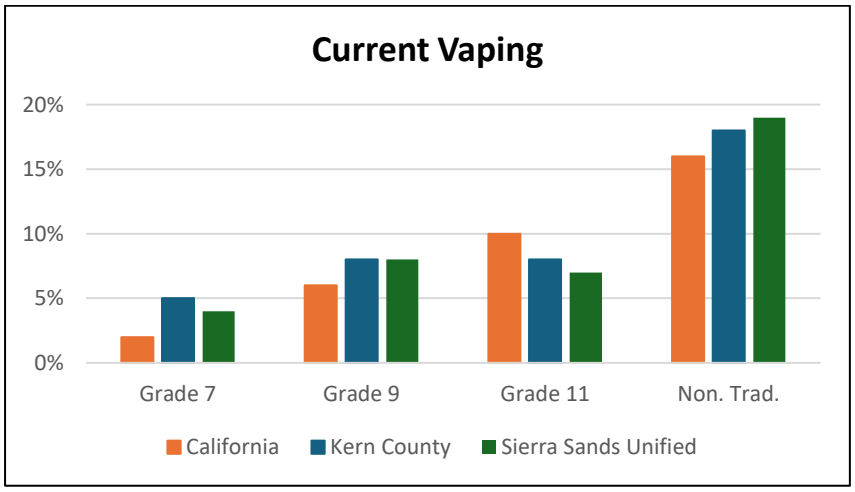
Cigarette smoking rates among youth in Ridgecrest remain exceptionally low across all grade levels. According to the data, fewer than 1% of high school students in SSUSD currently smoke cigarettes. Notably, there was no reported cigarette use in Grade 7 or Grade 11 for this district, which suggests that traditional tobacco use is not a prevalent issue among local youth.

Vaping, however, presents as more prominent, particularly among non-traditional students. In Grade 7 and Grade 9, current vaping rates in SSUSD are on par with or slightly below those of Kern County. For example, Grade 9 students reported vaping rates of approximately 8%, which mirrors the county average. Grade 11 students in Ridgecrest report lower vaping rates than their peers across the county and the state, further reinforcing the trend of moderate use in the traditional high school population. Even though vaping initially looked slightly high: 19% compared to 16% in the state, it was only among students continuing education programs (GED). The rate for Ridgecrest (SSUSD) is 19%, slightly above Kern County's 18%. While the 1% difference is not statistically significant

and may be within the margin of error for this type of survey sample, the broader trend is unmistakable: vaping prevalence more than doubles among non-traditional students compared to traditional high school peers, so any anti-vaping messaging would be better directed to that student demographic.



Source: California Department of Education, CalSCHLS, 2021-2023. https://calschls.org/.



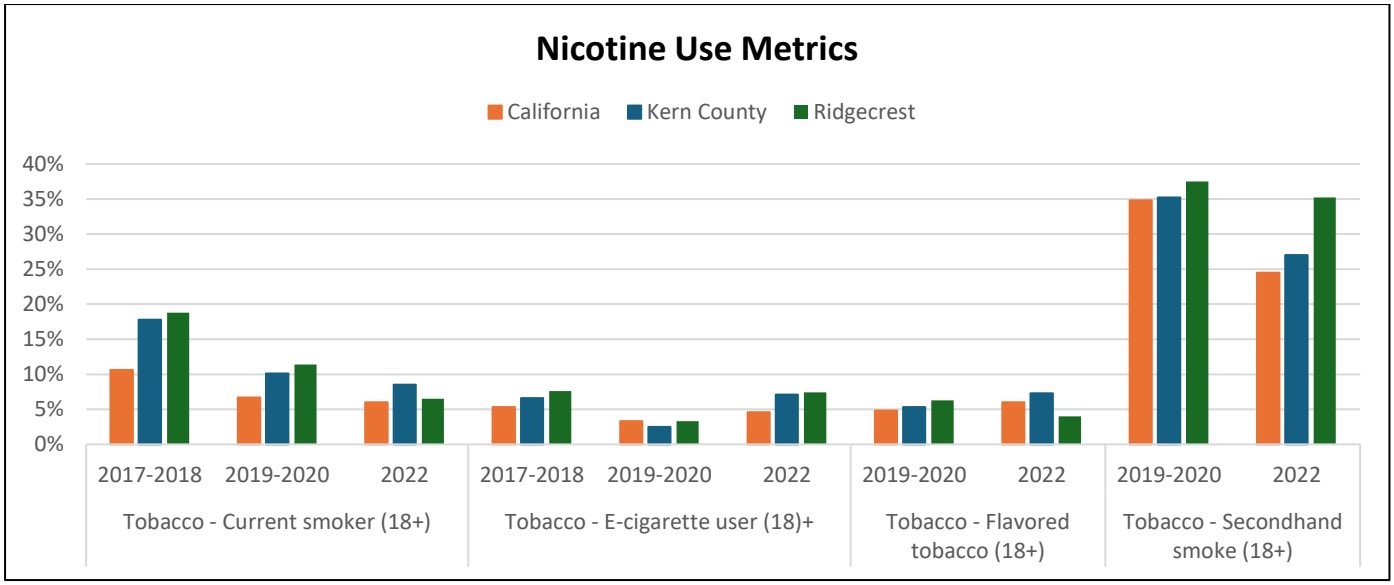
Source: California Department of Education, CalSCHLS, 2021-2023. https://calschls.org/.

Adult smoking in Ridgecrest dropped from 19% in 2017–2018 to 7% in 2022, reflecting a broader decline seen across Kern County and California. Vaping rates have remained steady at around 6–7%, and flavored tobacco use is in line with or below county averages, suggesting overall progress in smoking cessation initiatives.

Despite low usage rates, 35% of adults reported secondhand smoke or vapor exposure in 2022, significantly higher than the state (22%) and county (26%) averages. This gap may stem from how the CHIS survey defines exposure, including occasional contact in public or social settings. The discrepancy may be due to the broad framing of the CHIS 2025 Adult Questionnaire, which asks (QA25_C84): "During the past year, when has someone else smoked tobacco or vaped around you in California"[3] This wording could inflate the rate of reported secondhand exposure by including brief or incidental exposures, such as those occurring in public spaces.

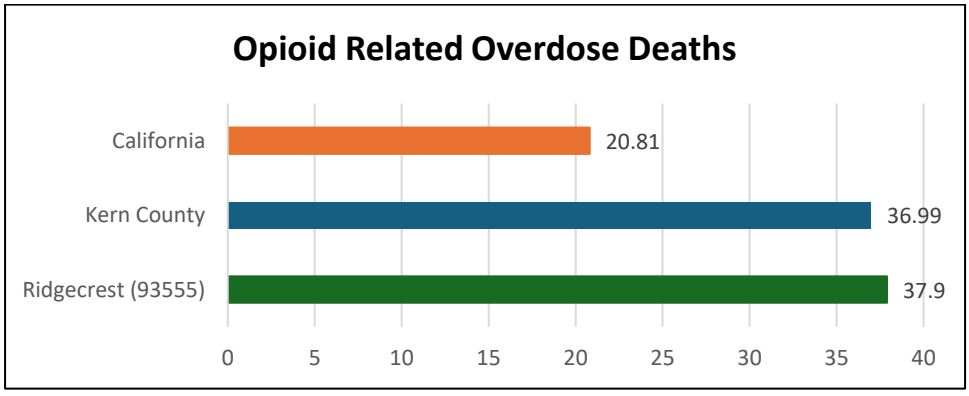
[3] California Health Interview Survey. Adolescant CAWI Questionnaire. Version 1.26. March 13, 2025. UCLA Center for Health Policy Research.

Ultimately, while traditional smoking and vaping rates are declining or relatively low, it shows a clear impact of local and statewide prevention efforts. This is a marker of success for past healthcare initiatives, but of course, should be monitored and maintained going forward. Continued public health focus may want to direct efforts to non-traditional students.



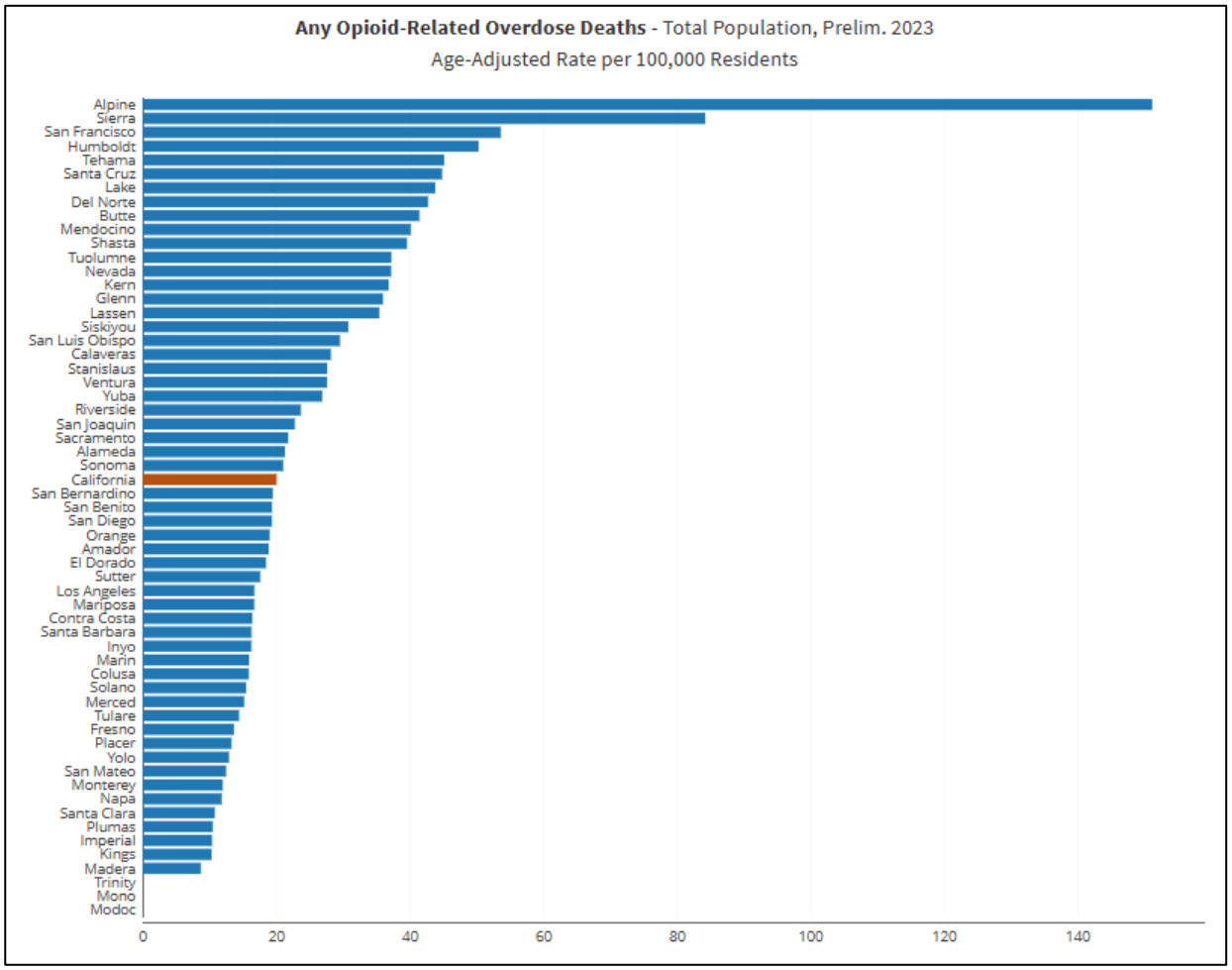
Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2017-2022. http://healthpolicy.ucla.edu/
Note: Data is missing from source for 2021.

The rate of opioid-related OD deaths for 93555 (Ridgecrest) and Kern County over all are significantly higher than California. Given the size of the population in that ZIP code, of 33,629 residents, that accounts for around 13 deaths per year. While not shown in the chart, data for nearby areas reveal that Trona (93562 a 31 min drive) has a rate similar to Kern County, while Inyokern (93527 15 minutes) faces a notably higher rate of opioid-related deaths. This variation within a small geographic region suggests the need for localized prevention and treatment strategies that reflect differing levels of risk and community impact.



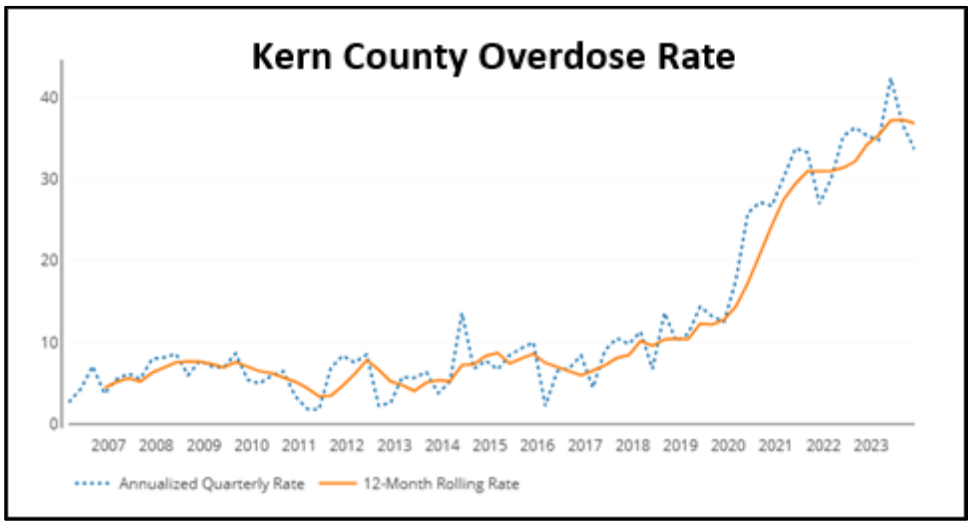
Source: California Department of Public Health, 2023. https://skylab.cdph.ca.gov/ODdash/
Note: Rates are an age-adjusted rate per 100k residents.

California on average was in the middle, San Francisco was at the top of the chart. Right near the upper quarter mark is where Kern County fits into the spectrum.



Source: California Department of Health. 2023.

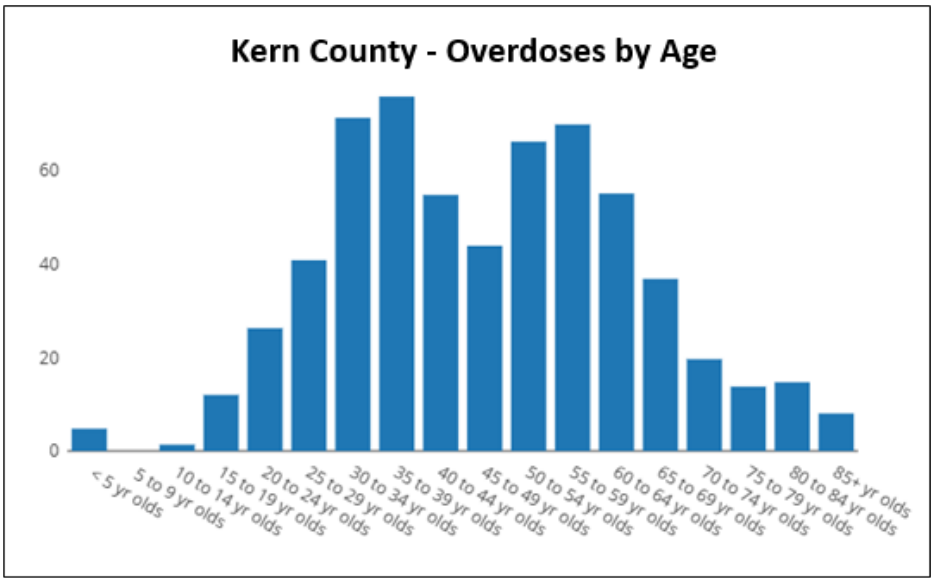
Having noted that Kern County's rates were in the top quarter of the state, trends over time were examined. Over the past fifteen years, the rolling rate of opioid overdose death rate in Kern County has quadrupled, a significant concern that warrants further consideration.



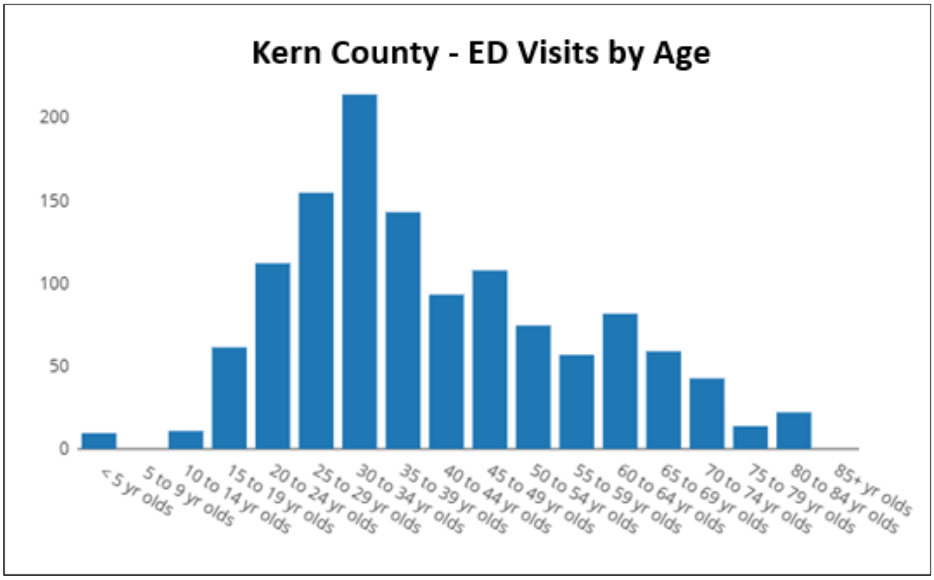
Source: California Department of Health. 2023.

A deeper dive into this data revealed that overdose rates were particularly elevated among individuals aged 30 to 40, and surprisingly also among those aged 50 to 60. The following charts show that the majority of emergency department visits related to opioids were from the 30-35 age range.

Overdose Deaths – All Opioids – Kern County

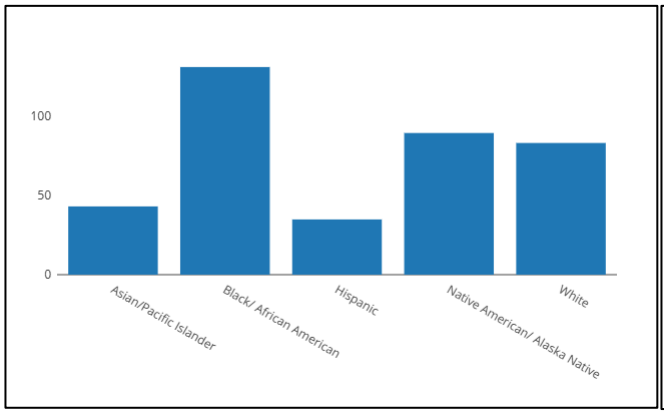


Source: California Department of Health. 2023.

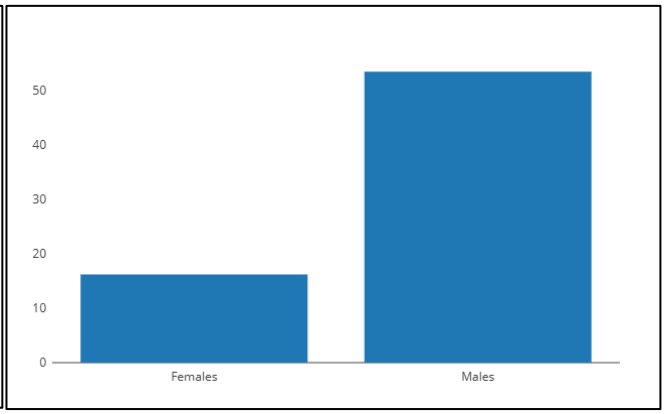


Source: California Department of Health. 2023.

The breakdown of overdose rates by race, ethnicity, and sex provided additional valuable insights. African American men showed the highest rates at 86.31 per 100,000 residents. Hispanic rates were much lower in comparison, less than half of those experienced by White and Native residents. These findings suggest that a targeted approach could be beneficial, focusing on African American men to promote cultural change and provide additional support, with the goal of reducing the overdose rate back to pre-covid levels.



Source: California Department of Health. 2023.



Source: California Department of Health. 2023.

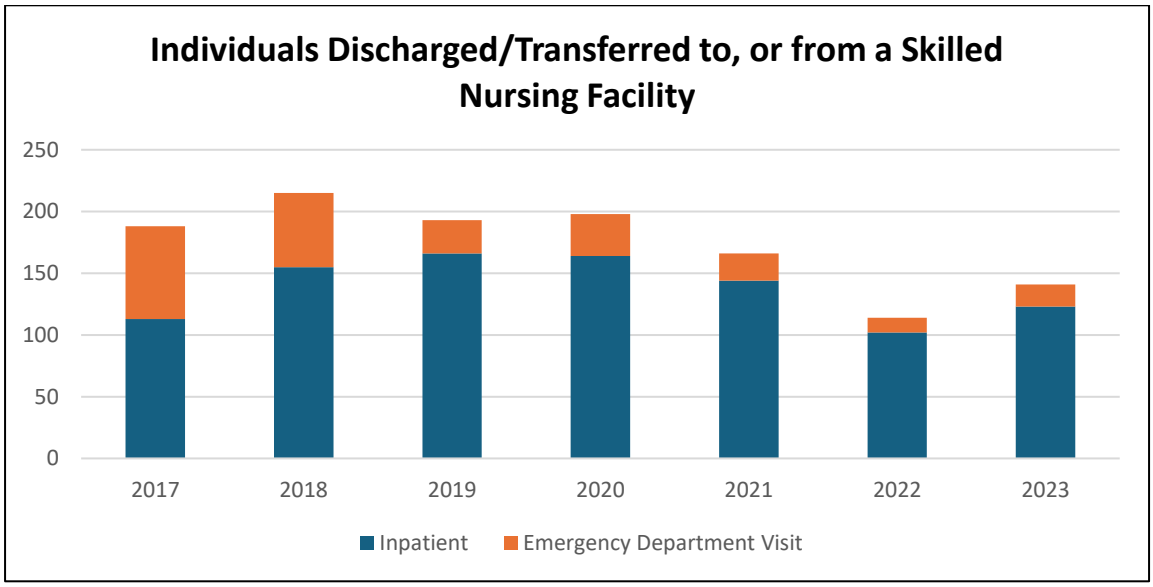
Elder/Senior Care

Priority: Moderate - Low

Extant Data on Elder/Senior Care- two categories:

1. Individuals Discharged/Transferred to a Skilled Nursing Facility (from RRH)
2. Age Demographics of Inpatient visits

The number of inpatient and emergency department visits that have resulted in a discharge or transfer to a skilled nursing facility has remained relatively static. Notable reductions occurred in 2022, though the overall trend suggests this is a metric worth continued monitoring.



Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/

In the most recent data from 2023, 42.7% of inpatient visits involved individuals over the age of 60. By contrast, only 21.7% of Ridgecrest fit into this age demographic. This disparity highlights the increasing demand for advanced elderly care.

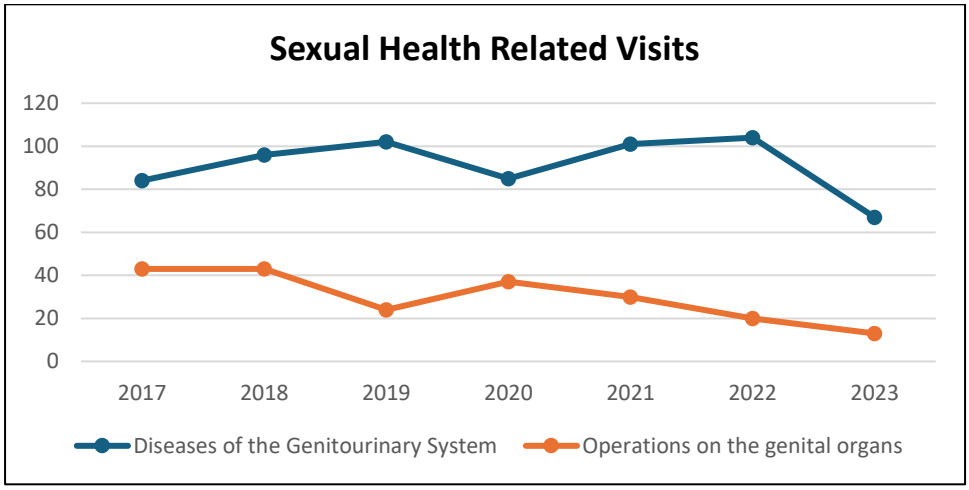
Age Groups of Inpatient Visitors	Inpatient Visits (2023)	Ridgecrest Population	California Population
0 - 9	20.6%	14.3%	11.6%
10 - 19	2.1%	14.2%	13.2%
20 - 29	10.5%	12.7%	13.8%
30 - 39	12.0%	14.1%	14.7%
40 - 49	4.8%	11.4%	12.9%
50 - 59	7.4%	11.7%	12.6%
60 - 69	12.2%	10.5%	10.9%
70 - 79	14.6%	7.2%	6.7%
80+	15.9%	4.0%	3.6%

Source: U.S. Census Bureau, ACS, 2019-2023.
Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/

Sexual Health

Priority: Moderate - Low

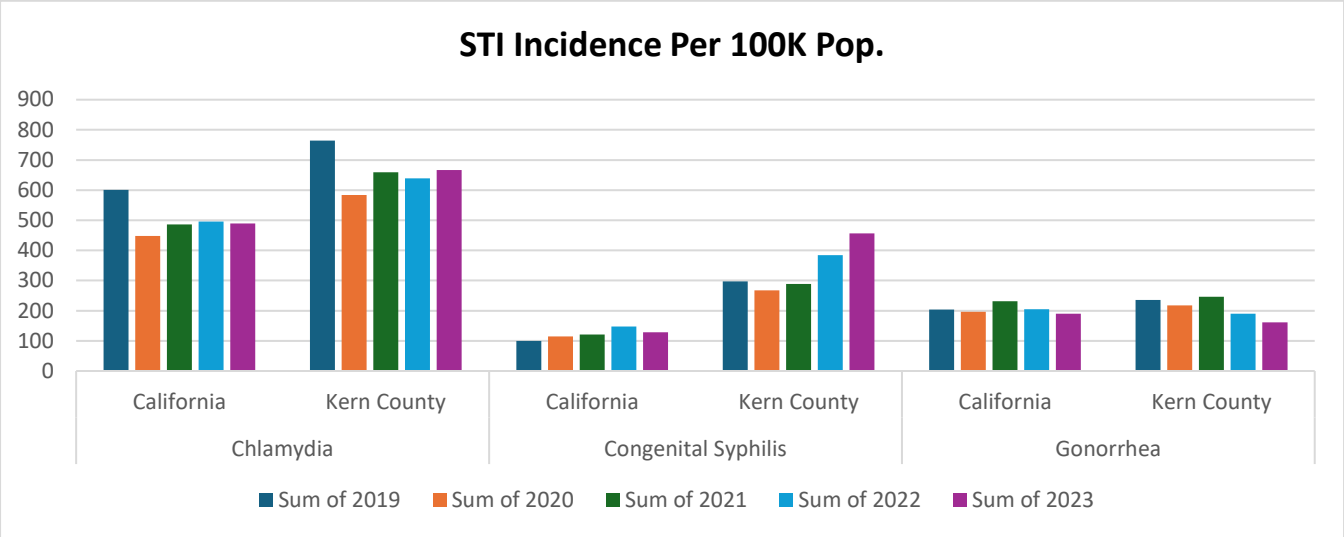
The only available local data on sexual health at RRH comes from inpatient visits for genitourinary diseases and operations on the genital organs. These visits remained fairly steady from 2017 through 2022 but declined in 2023. While this recent drop may reflect positive trends, it could also indicate other shifts related to patient access, or changes in hospital service capacity and could be further examined.



Source: Department of Health Care Access and Information (HCAI), 2017-2023. https://hcai.ca.gov/.

County-level data provides additional insight. Kern County has consistently higher rates of Chlamydia, Gonorrhea, and Congenital Syphilis compared to California. Notably, the rate of congenital syphilis in Kern County is more than double the state average and has been increasing steadily since 2019. This points to persistent gaps in prenatal care

access and STI prevention among pregnant individuals in the region. Recently, Kern County has seen a slight increase of new HIV cases, with 215 new cases in 2023. This represents a 40% increase from 2018.[4]



Source: California Department of Public Health, STD Control Branch (data as reported through 8/6/2024).

Health Education, Wellness, and Disease Prevention

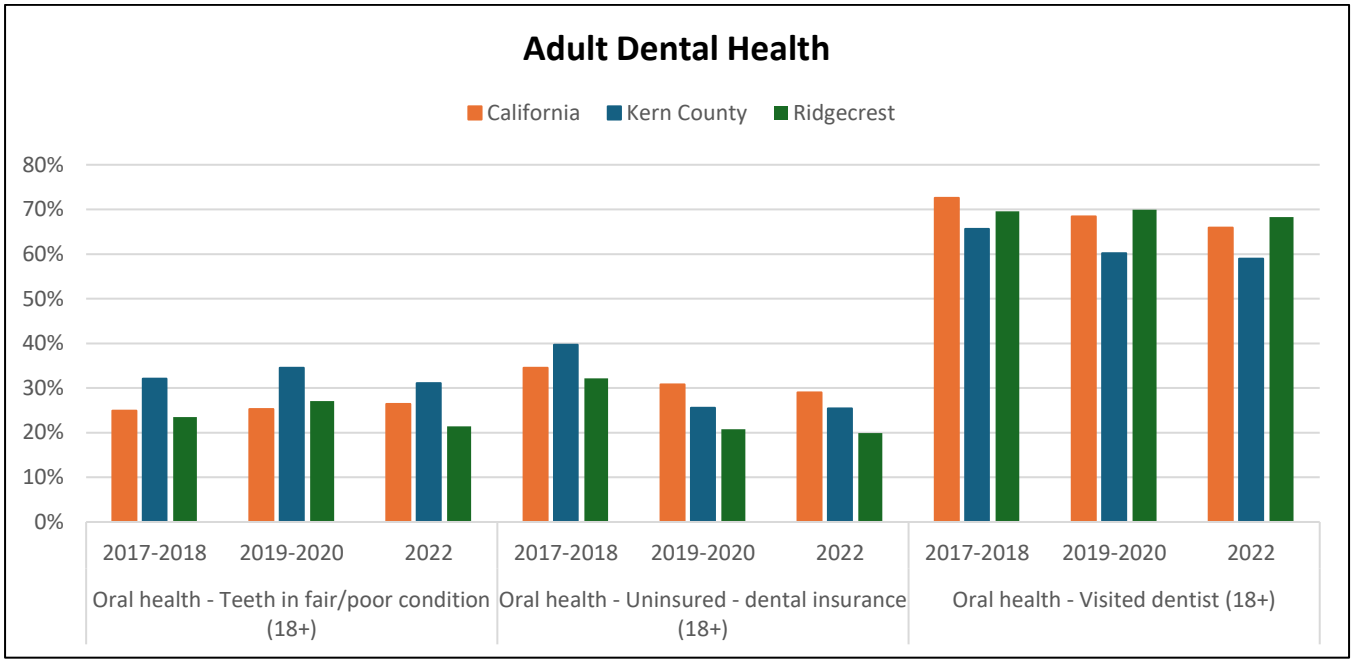
Priority: Low

Extant Data on Health education, Wellness, and Disease Prevention - three categories:

1. Adult Dental Health
2. Youth immunization rates for local schools
3. Prevalence of obesity and individuals who are overweight

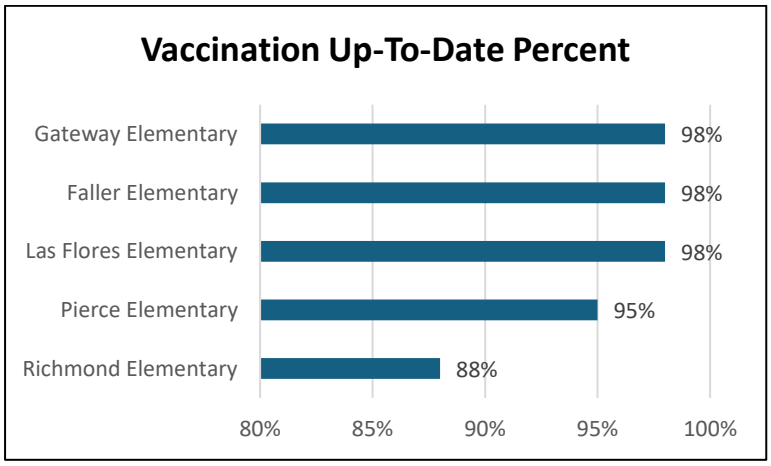
Based on 2022 data, Ridgecrest has good dental metrics. Approximately 1-in-5 adults in Ridgecrest report having teeth in "fair/poor" condition. This rate is better than county and state rates. Similarly, the rate of adults without dental insurance in Ridgecrest is approximately 20%, which is also better than both county and state averages. Nearly 70% of Ridgecrest adults have visited a dentist in the past year, outperforming county and state rates.

[4] Price, R. (2025, May 26). *Kern County HIV cases at an all-time high, public health director says, and federal funding cuts could make it worse quickly*. KGET 17 News. https://www.kget.com/health/kern-county-hiv-cases-at-an-all-time-high-public-health-director-says-and-federal-funding-cuts-could-make-it-worse-quickly/



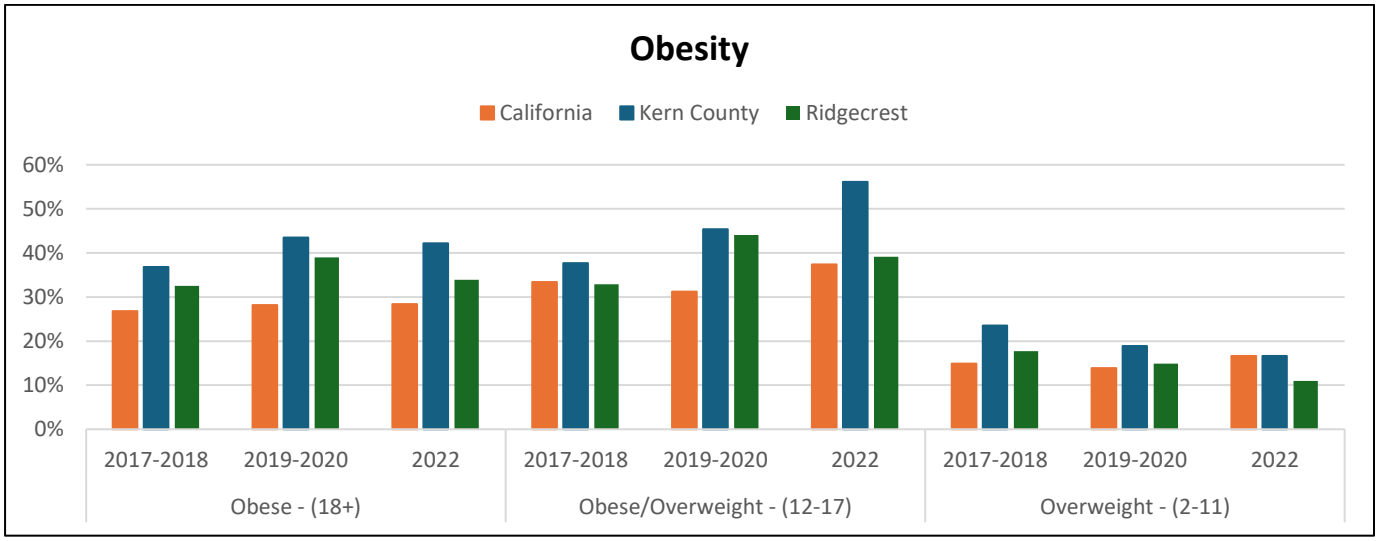
Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2017-2022. http://healthpolicy.ucla.edu/
Note: Data is missing from source for 2021.

Youth immunization rates are defined here as the percent of students who are "up to date" on required vaccines at each elementary school within the SSUSD. These vaccines include Varicella (chickenpox), Hepatitis B, Measles-Mumps-Rubella (MMR), Polio, and Diphtheria-Tetanus-Pertussis (DTP). According to the latest data, immunization rates range from 88% at Richmond Elementary to 98% at Gateway, Faller, and Las Flores Elementary Schools. Pierce Elementary also reported a strong rate of 95%. These high rates suggest that most schools in the district are maintaining strong compliance with California's school immunization requirements.



Source: California Department of Public Health, 2022-2023. https://www.cdph.ca.gov/.

In 2022, approximately one-third of the population (34%) of adults in Ridgecrest were considered obese. This rate was notably better than Kern County's rate of 42% but elevated compared to California's 28%. Among youth aged 12-17, 39% in Ridgecrest were classified as obese or overweight, an improvement to Kern County's 56%, and similar to California's 37%. For children under age 12, approximately 11%, in Ridgecrest, were considered overweight, which was slightly better than both Kern County and California, each reporting 17%.



Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2017-2022. http://healthpolicy.ucla.edu/
Note: Data is missing from source for 2021.

The Impact of Obesity on Health

Obesity is widely recognized as a major public health concern due to its far-reaching impact on both individual and community well-being. Carrying excess body weight does not simply affect appearance or self-esteem, it profoundly increases the risk for a host of chronic diseases that can reduce quality of life, increase healthcare costs, and shorten lifespan.

- Type 2 Diabetes: Obesity is the leading risk factor for type 2 diabetes. Excess fat, particularly around the abdomen, causes the body's cells to become resistant to insulin, disrupting blood sugar regulation and increasing the risk of developing diabetes.
- Cardiovascular Disease: Elevated body weight raises blood pressure, cholesterol, and triglyceride levels, all of which contribute to the development of heart disease and stroke. Obesity is also linked to the buildup of plaque in arteries, which can lead to heart attacks.
- High Blood Pressure (Hypertension): Extra weight puts additional strain on the heart and blood vessels, making hypertension more likely. Chronic high blood pressure can damage blood vessels and vital organs over time.
- Certain Cancers: Obesity increases the risk of several types of cancer, including breast, colon, endometrial, kidney, and esophageal cancers. The reasons are complex, involving hormone levels, inflammation, and metabolic changes, but the association is clear.
- Sleep Apnea: Excess body fat, especially around the neck, can obstruct the airway during sleep, causing breathing interruptions (sleep apnea). This condition leads to poor sleep quality and is associated with increased risk of heart disease and stroke.
- Joint and Mobility Issues: The extra weight exacerbates wear and tear on joints, especially the knees, hips, and lower back, often leading to osteoarthritis and chronic pain.
- Fatty Liver Disease: Non-alcoholic fatty liver disease is common in individuals with obesity and can lead to serious liver damage or failure.
- Mental Health Concerns: Obesity is also associated with increased rates of depression, anxiety, and social isolation, compounding its physical impacts with emotional and psychological challenges.

The cumulative effect of these conditions is profound. Obesity not only increases the risk of premature death, but also leads to years lived with disability, chronic illness, and dependence on healthcare resources. Because so many common and costly diseases are tied directly to excess body weight, addressing obesity is crucial. Interventions that reduce obesity rates through improved nutrition, increased physical activity, and community support, can help prevent or mitigate these health conditions, resulting in healthier, more vibrant communities.

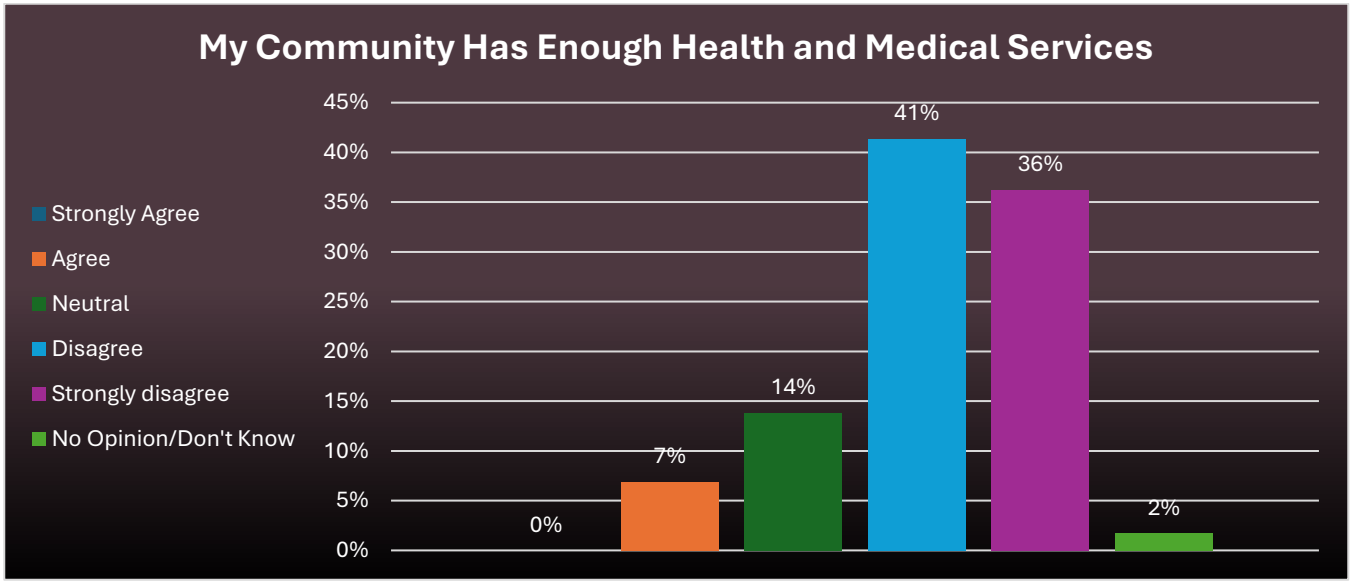
Summary of 2025 Results and Feedback

The community survey was designed to collect feedback from both healthcare providers and community members. With a combination of open and closed-ended questions, the survey aimed to assess the overall healthcare situation in terms of primary, mental, and specialty care. The open-ended questions sought to gather insights into areas that require improvement and potential changes that could enhance the healthcare experience. The following summary will present the findings in this sequence: first, the overall health assessment results, followed by the responses to the open-ended questions.

Survey Results from Healthcare Providers:

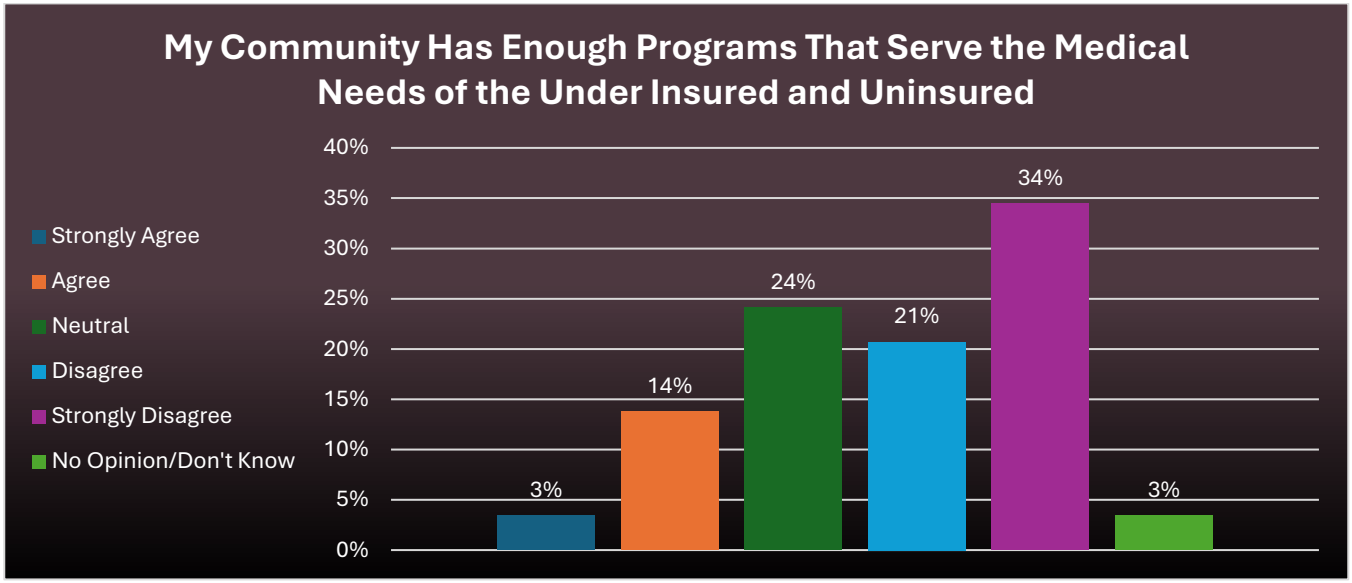
Approximately 3/4 of the providers (77%) thought the community needed more health and medical services. Only 7% of providers agreed with the statement, while none strongly agreed. It is important to note that these healthcare providers include various professionals, not limited to just physicians.

Question 1:



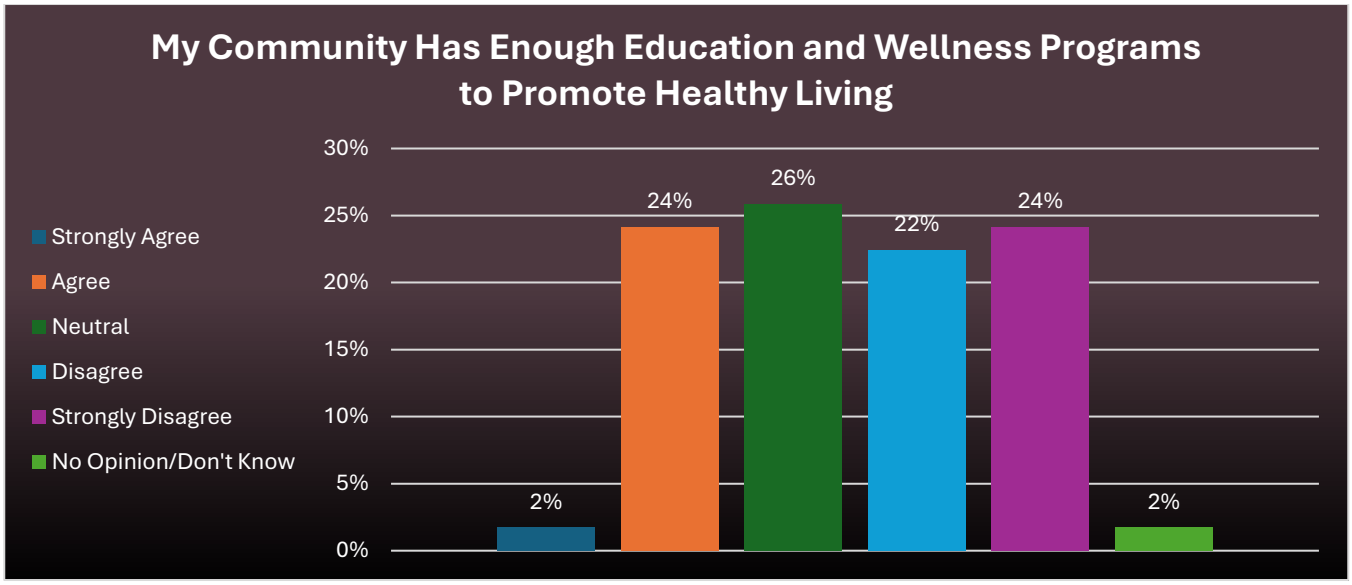
Over half of providers (55%) thought more services were needed for underinsured and uninsured patients. Only 17% of providers agreed or strongly agreed, while approximately 24% of providers were neutral or uncertain.

Question 2:



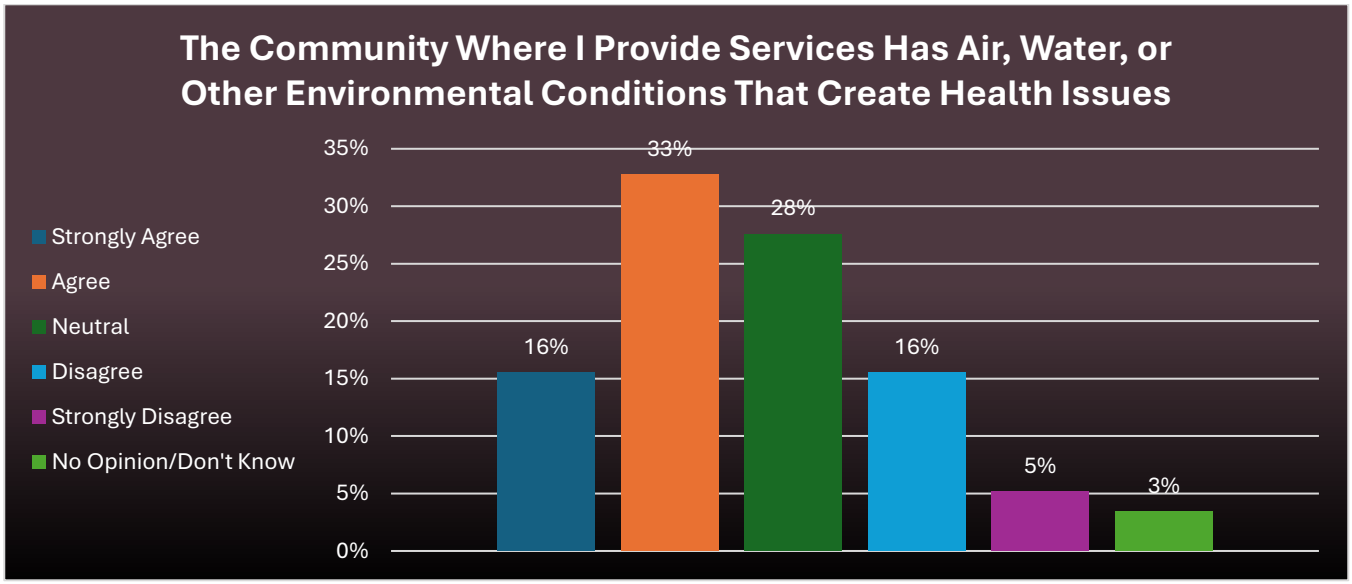
Almost half of the providers felt the community needed more education and wellness programs to promote healthy living. Around a quarter of the providers, however, believed that the community already had enough such programs in place.

Question 3:



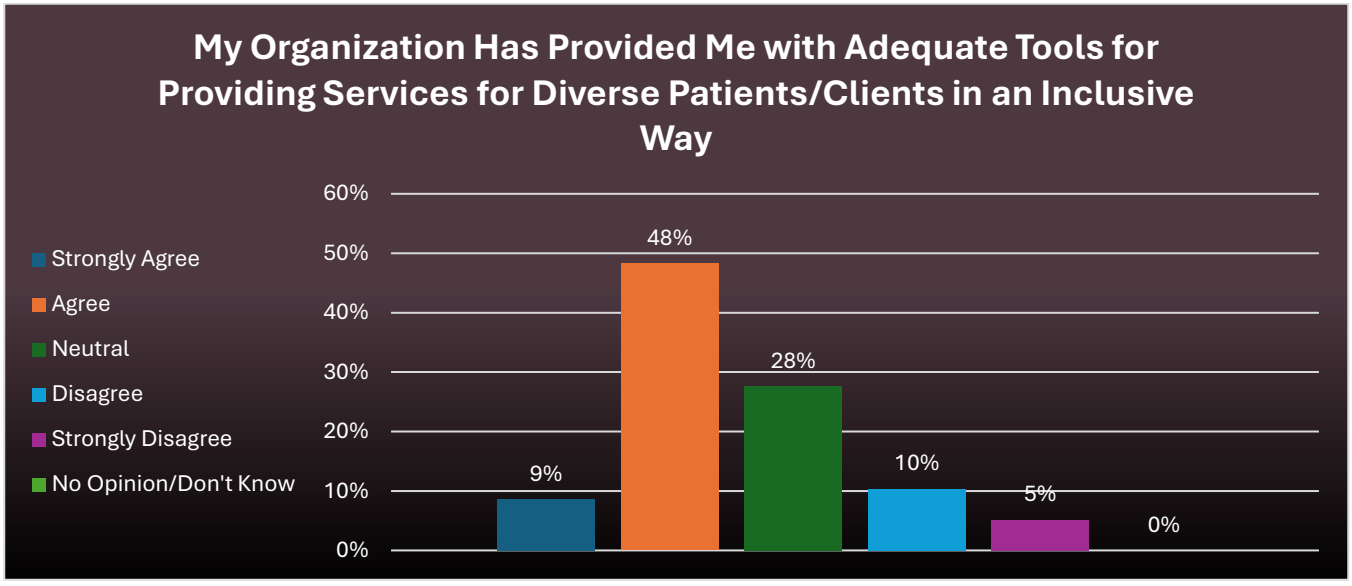
Almost half of the providers believe there are environmental conditions creating health issues.

Question 4:



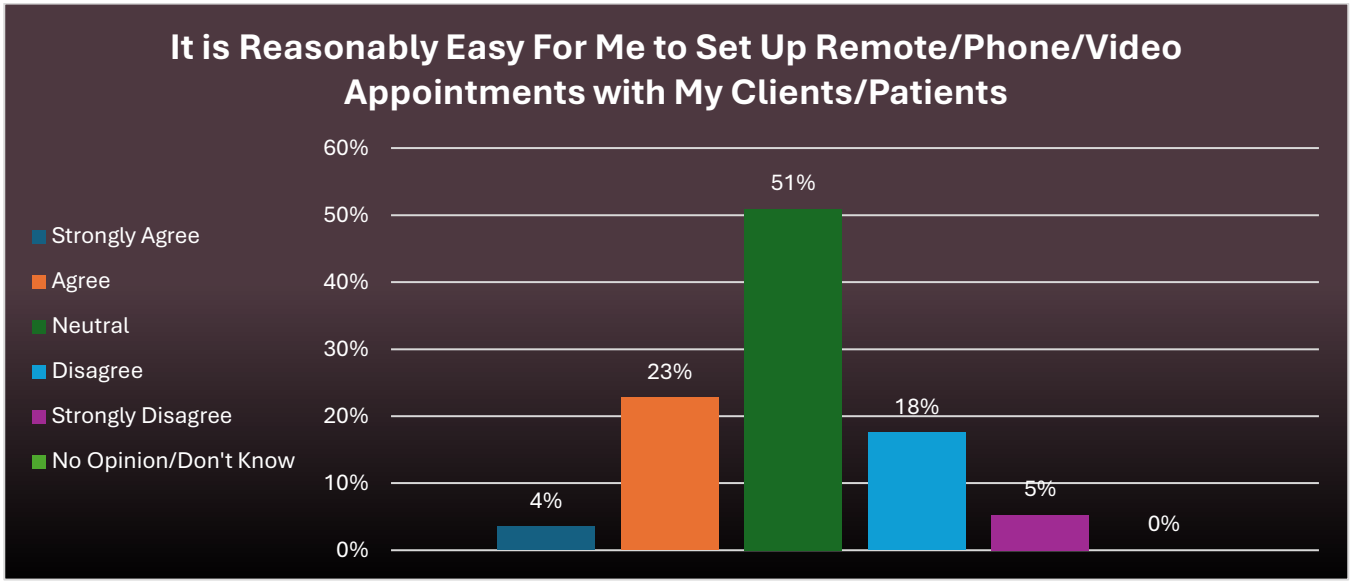
Approximately 57% of providers feel that their organization has equipped them with the necessary tools to provide services to diverse patients and clients in an inclusive manner. Overall, 85% of providers are either neutral or confident in having the required tools, while 15% feel they could benefit from additional resources.

Question 5:



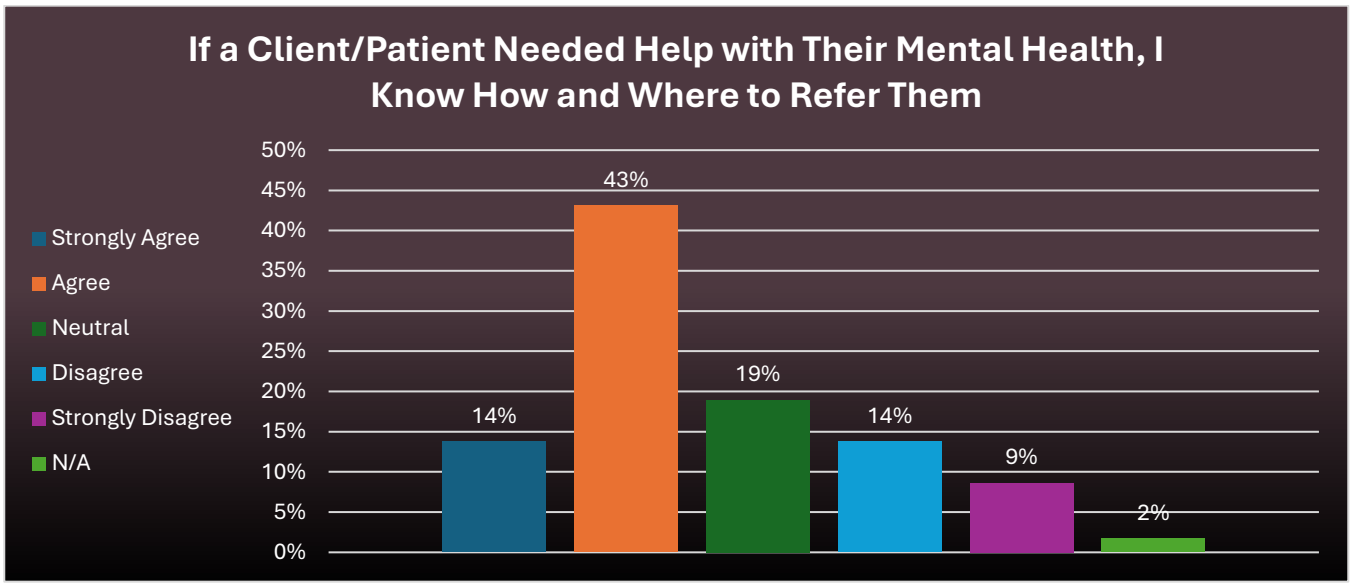
Among surveyed providers, approximately one quarter reported that it is reasonably easy to set up remote, phone, or video appointments with their patients. Just over half remained neutral, while about one quarter indicated some level of difficulty. Given the socioeconomic challenges and rural nature of the region, these results are positive.

Question 6:



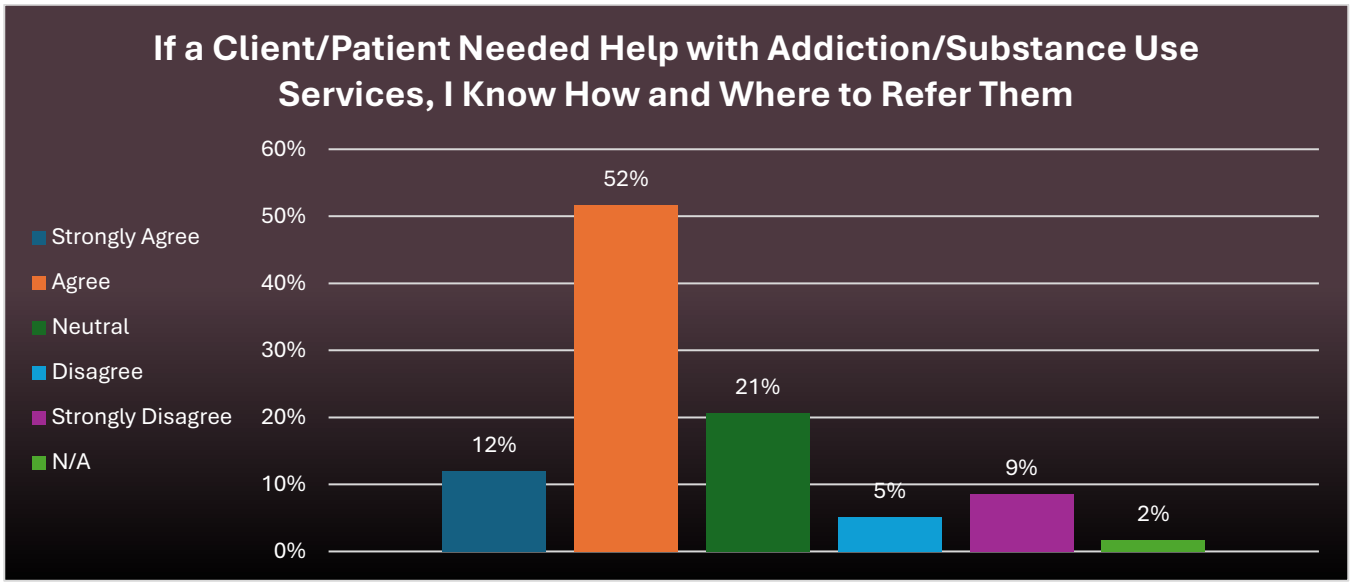
One-in-five providers (22%) did not know how and where to refer a patient for mental health support. Around 57% expressed confidence in their ability to make a referral, while the remaining 21% were either neutral or felt the question was not applicable to their role.

Question 7:



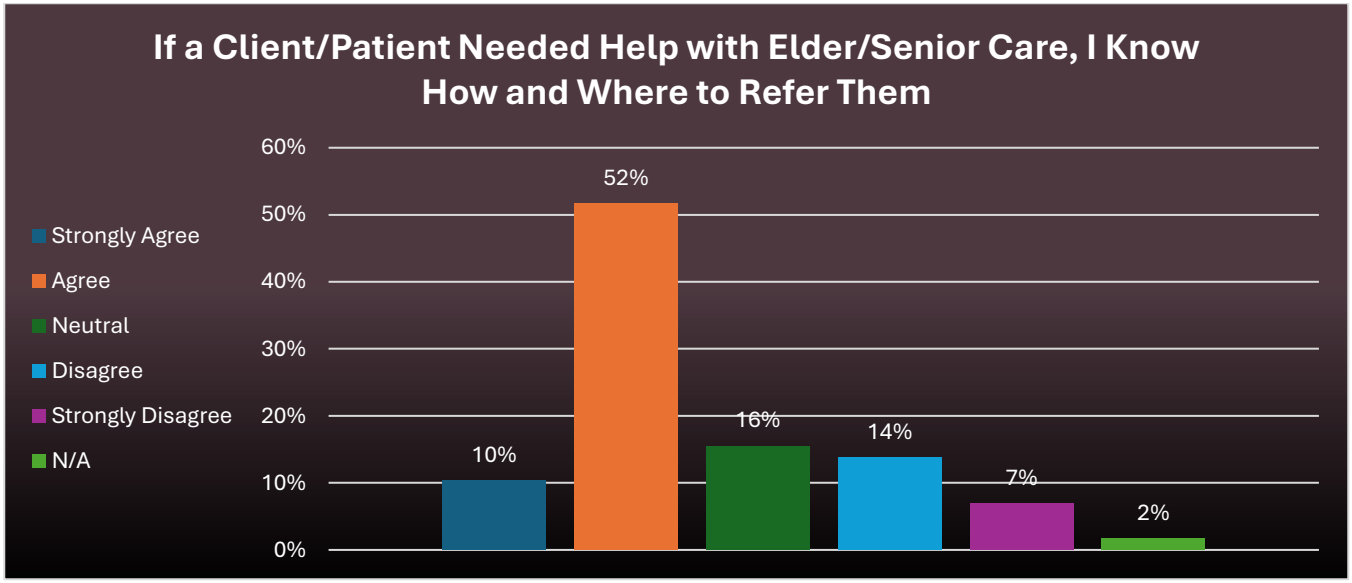
When asked about their ability to refer patients for addiction or substance use services, about 18% of providers indicated they were unsure how or where to refer someone in need. A majority, roughly 63% of providers reported they knew how to facilitate a referral, while nearly a quarter were either neutral, or felt the question did not apply to their role. It's important to note that the survey included a wide range of provider types across multiple lines of service. For example, not all healthcare roles, such as radiology technicians, are responsible for making behavioral health referrals. What matters most is that a strong majority of providers are equipped to guide patients to the appropriate care when needed. If the healthcare culture looks to all providers as healthcare stewards this marks room for improvement.

Question 8:



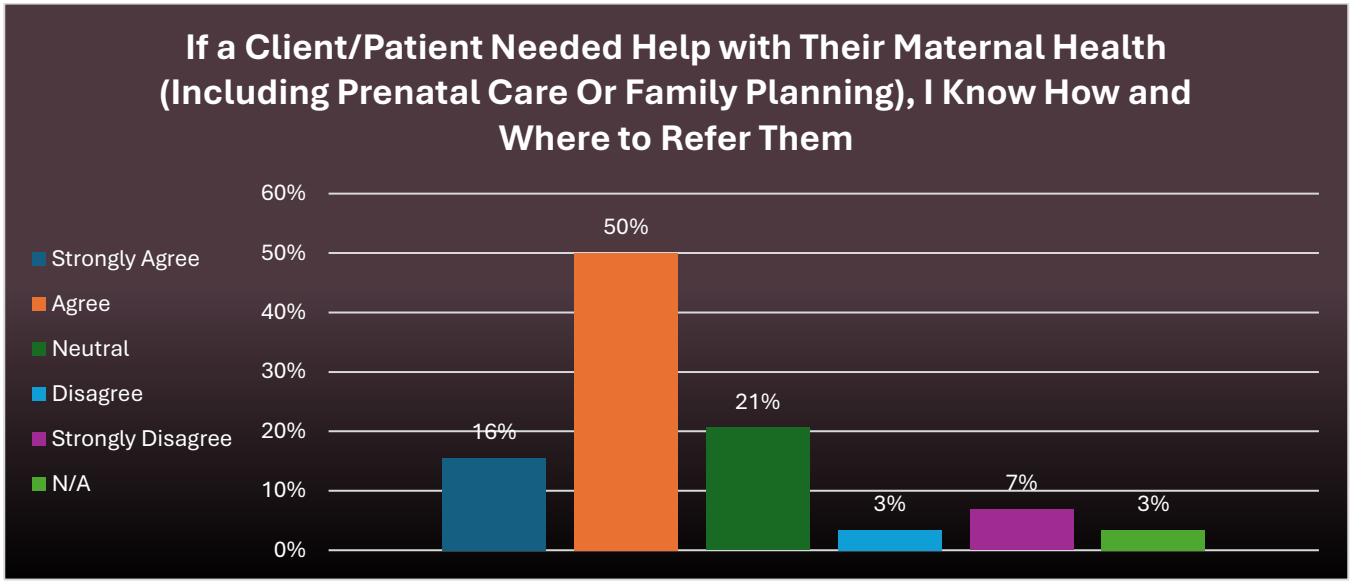
One-in-five providers (21%) did not know how and where to refer patients for elder care. Roughly 62% knew where to send patients.

Question 9:



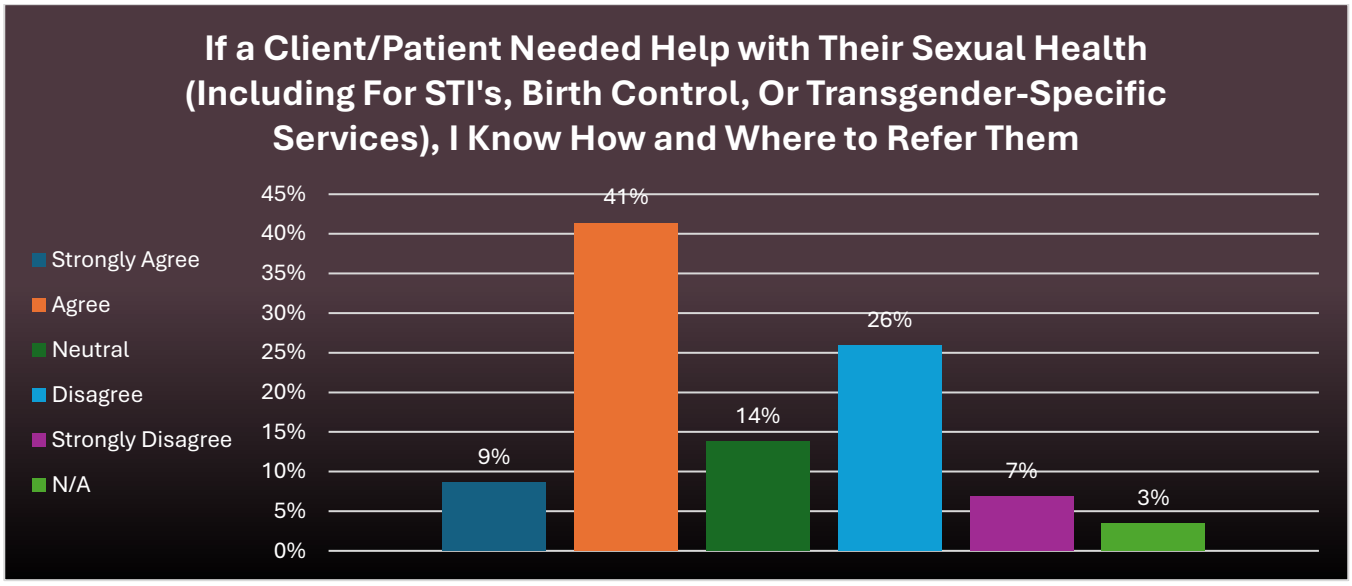
Approximately 10% of providers in the survey did not know where to recommend patients who needed help with their maternal health. Roughly 66% of providers agree/strongly agree with this question, while nearly 24% remained neutral or it was not applicable.

Question 10:



About one-third of providers (33%) indicated they were unsure how or where to refer patients for sexual health services, including support for STI testing, birth control, or transgender-specific care. Approximately half of the respondents reported they were confident in making appropriate referrals for these needs.

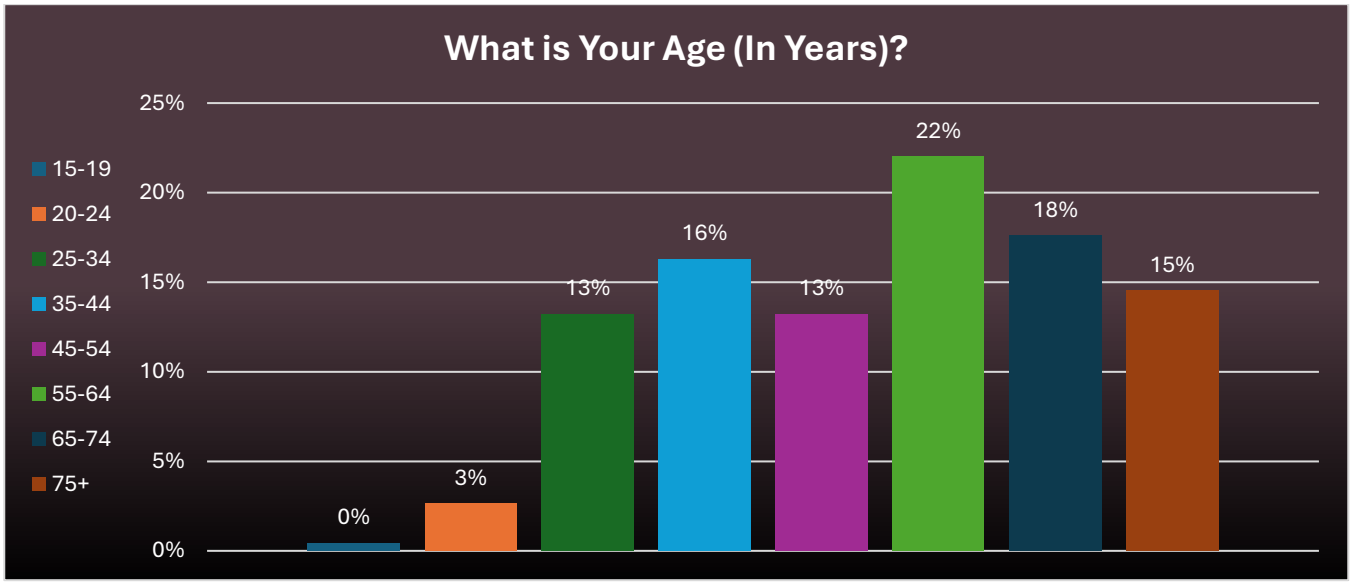
Question 11:



Survey Results from Community Members:

Before digging into the insights from the community members, it is worth discussing the representativeness of the sample relative to the population. The survey captured a broad range of age groups except those under the age of 25, who were notably underrepresented. Out of 345 respondents who answered the age question, only 7 (3%) were aged 20-24 and less than 1% were in the age range 15-19. This is not unexpected, as individuals in these ranges tend to access healthcare services less frequently. In contrast, participation from all other age groups was well distributed with the 55–64 group making up the largest share at 22%, followed by strong representation from the 65–74 (18%) and 75+ (15%) age groups. The 25–34 bracket had 13% of responses, offering a reasonable sample for those in early adulthood (30 response size).

Question 19:



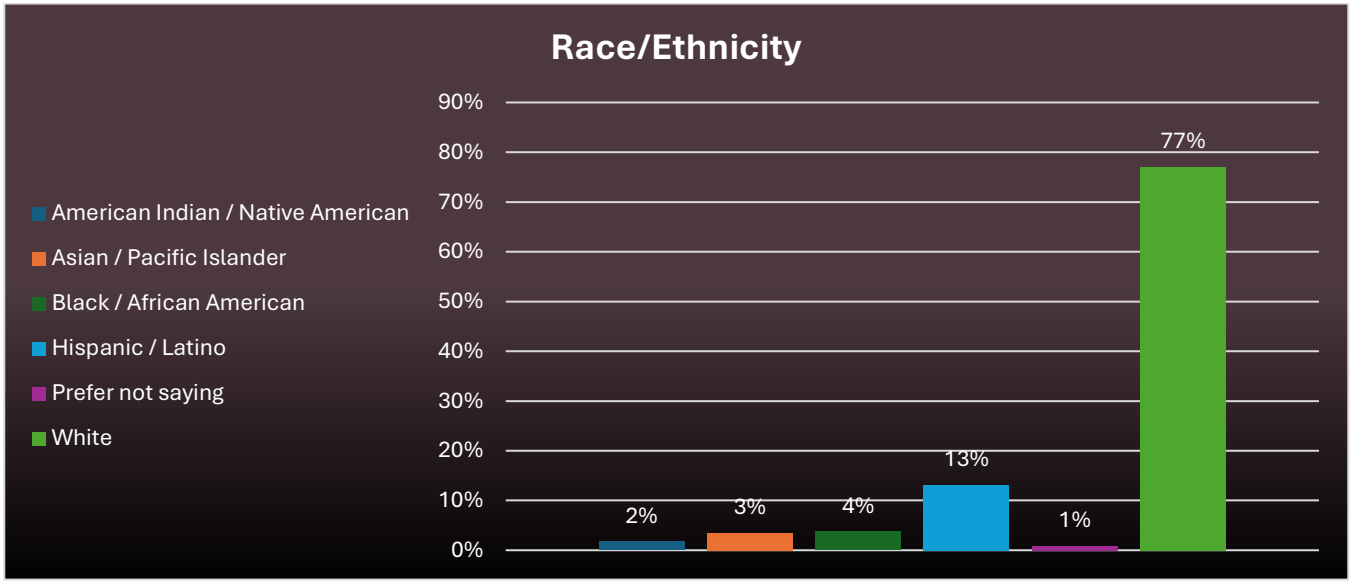
Approximately 77% of respondents identified as White, making it the most represented racial group in the survey. The next largest group was Hispanic/Latino at 13%. In a previous demographic table that separated race and ethnicity, 66% identified as White (not of Hispanic ethnicity), whereas 19% identified as Hispanic ethnicity, and another 6% identified as two or more races.

This question was answered by 344 community members. Among them, 2% identified as Native Americans (5 individuals) and 4% Black or African America (8 individuals).

A total of 42 responses were received from Hispanic residents. This exceeds the commonly accepted minimum of 30 for normality based on the Central Limit Theorem, which states that the sampling distribution of the mean approximates a normal distribution with a sample size of 30 or more, regardless of the shape of the population distribution. This is why 30 is often cited as the minimum for parametric tests assuming normality. While the Hispanic/Latino response rate was solid, it fell seven short of a target of 50, which was set to strengthen statistical power and ensure meaningful representation of diverse populations.

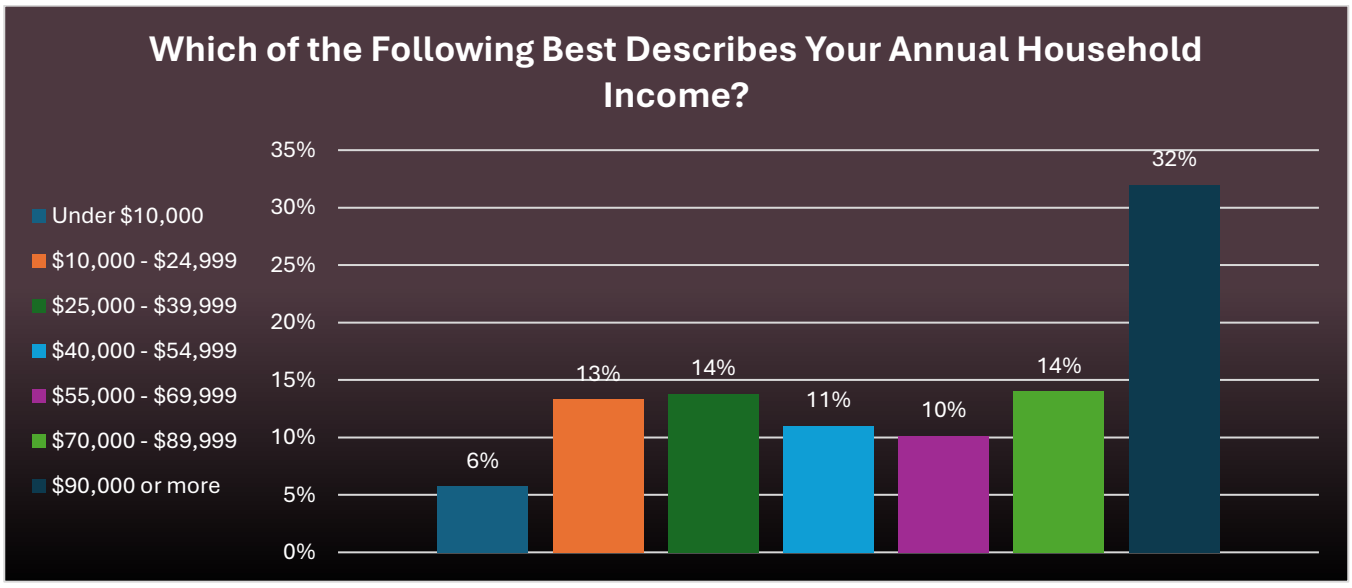
Responses from other minority populations were limited, which reflects their smaller share of the overall population. However, their input still offers valuable anecdotal insights and contributes meaningfully to the broader strategic healthcare planning process.

Question 20:



The greatest proportion of respondents, roughly 32%, had an annual household income of over $90,000. The remaining income categories each accounted for an average of 12% of respondents, except for the 'under $10,000' category, which represented only 6% of all respondents.

Question 21:



The income question was answered by 334 community members. Of those, 124 respondents reported earning less than $55,000, which falls under the low-income level (200% FPL). This group represents 38% of all responses. In the Ridgecrest area, approximately 12.7% of the population lives below the poverty line and 28.7% live below 200% of the poverty line, commonly referred to as the low-income level.

Using the $55,000 as a general estimate for the 200% FPL cutoff, the data suggests that the survey participation among low-income households is already higher than their proportion (28.7%) in the general population. For those living at-or-below the poverty line, there were 51 responses with reported incomes under $25,000, making up 15% of total responses. These response rates exceed the 12.7% of the local population estimated to live in poverty. The response rate over 50 exceeds the minimum recommended to ensure a reasonable level of statistical power and representativeness, especially when the population is diverse.

The logic for setting these thresholds is based on household size. On average, there are 3.62 residents per family in Kern County but 3.28 individuals per household. Following the FPL guidelines from HHS.gov, we can estimate the poverty and income levels accordingly:

Family Size	100% FPL	200% FPL
3	$26,650	$53,300
3.28	$28,190	$56,380
3.5	$29,400	$58,800
3.62	$30,060	$60,120
4	$32,150	$64,300

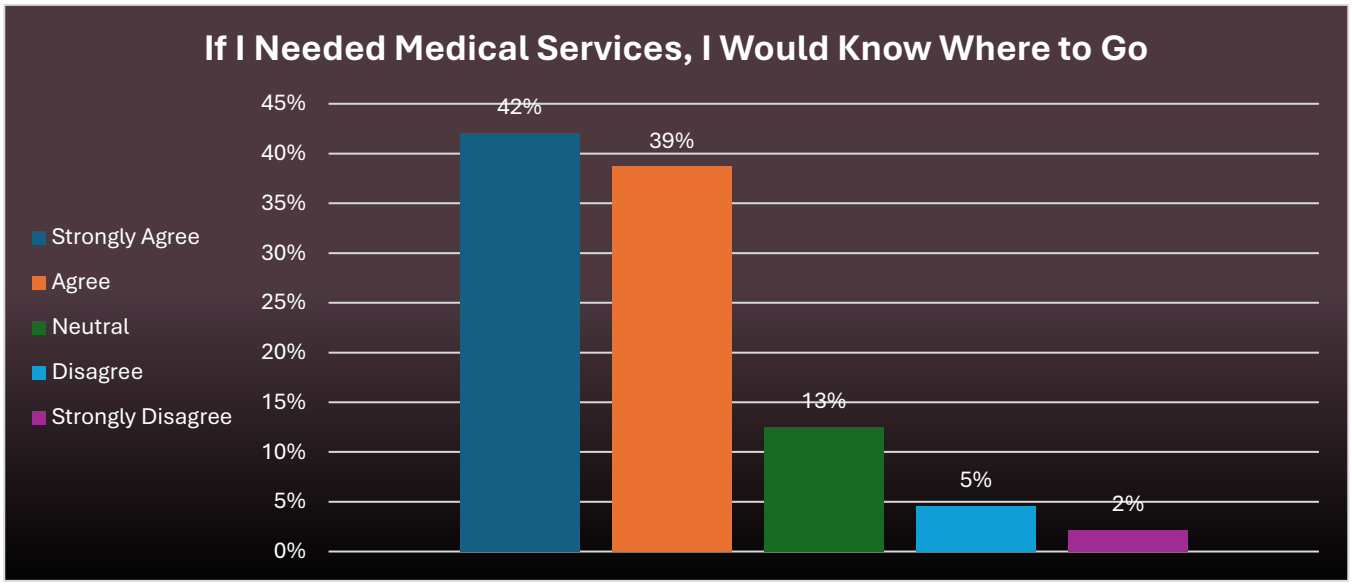
Source: Kern County, California - Census Bureau Profile, Kern County, CA Demographics | BestNeighborhood.org

Knowing that HHS clocks the low-income line for family size of 4 at $64,300 and a family size of 3 at $53,300 and knowing that the Ridgecrest family size falls somewhere in the middle of that range, we can assume income below $55,000 for approximating residents below the low-income line (200% FPL). Because we have significantly more than 50 responses in the category, we are assured we will have an adequate sample to draw conclusions.

Therefore, we assume adequate representation based on income, age, and race. The survey data should give us trustworthy answers and a firm grasp of perceived healthcare needs from the community.

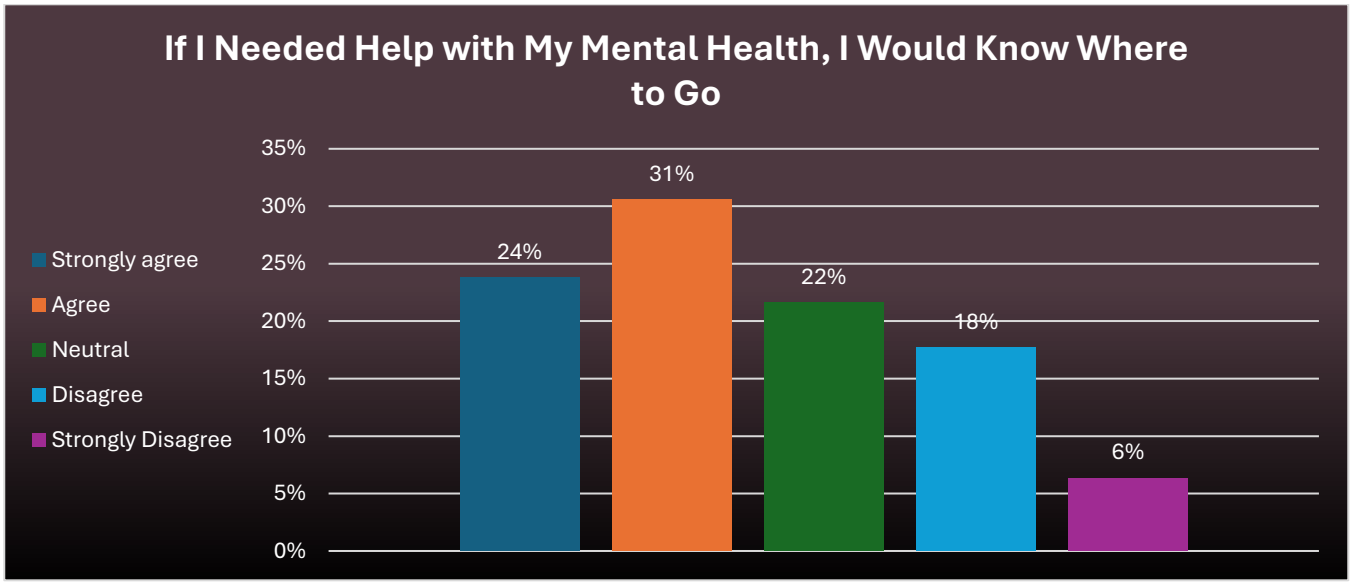
Approximately 7% of community members surveyed did not know where to go for (primary care) medical services, while roughly 81% reported they did. It should be noted that these surveys were made available through hospital-affiliated medical services. Logically, this gained participation from those already using the medical services. Consequently, this sample may underrepresent those who are not regularly accessing routine or acute medical services.

Question 1:



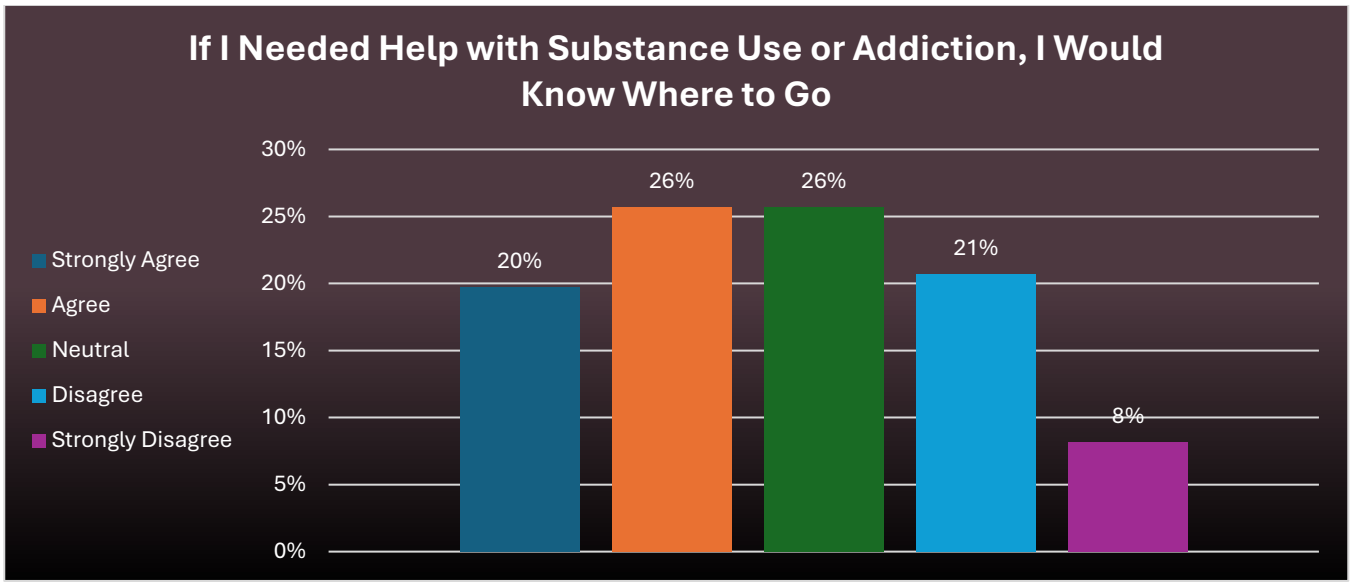
A quarter of residents reported they did not know where to go should they need Mental Health services, while over half knew where to find services. The remaining 22% who were neutral seemingly could find it should the need arise.

Question 2:



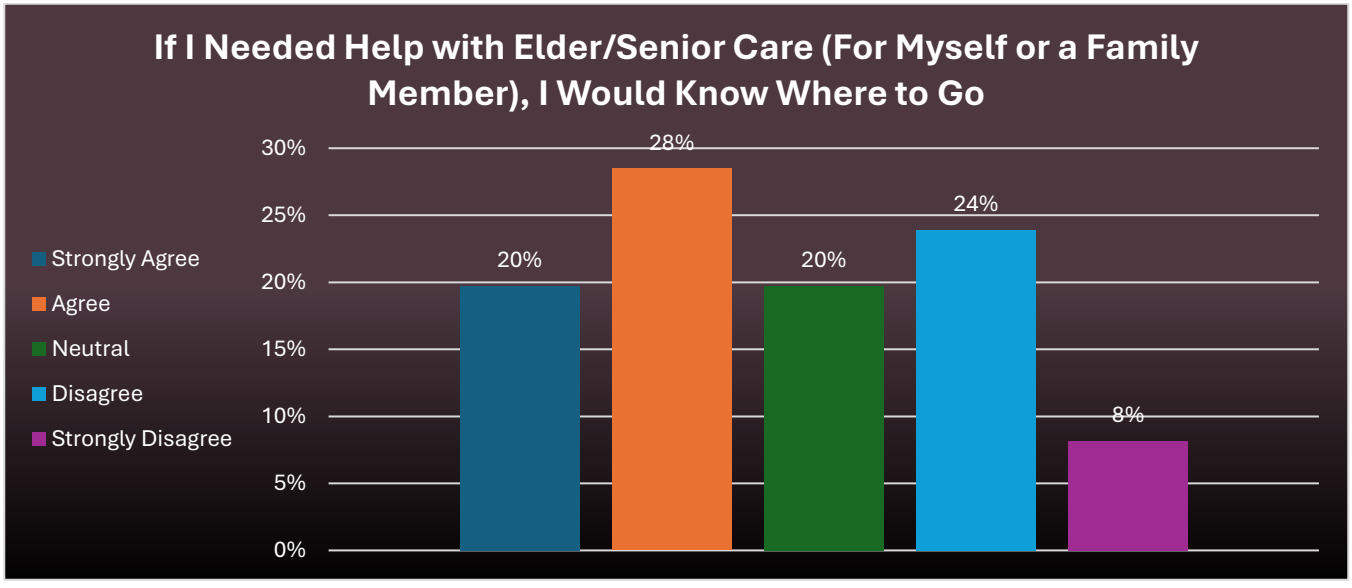
Approximately 29% of community members did not know where to go for substance use or addiction. Roughly half knew where to go while another quarter remained neutral.

Question 3:



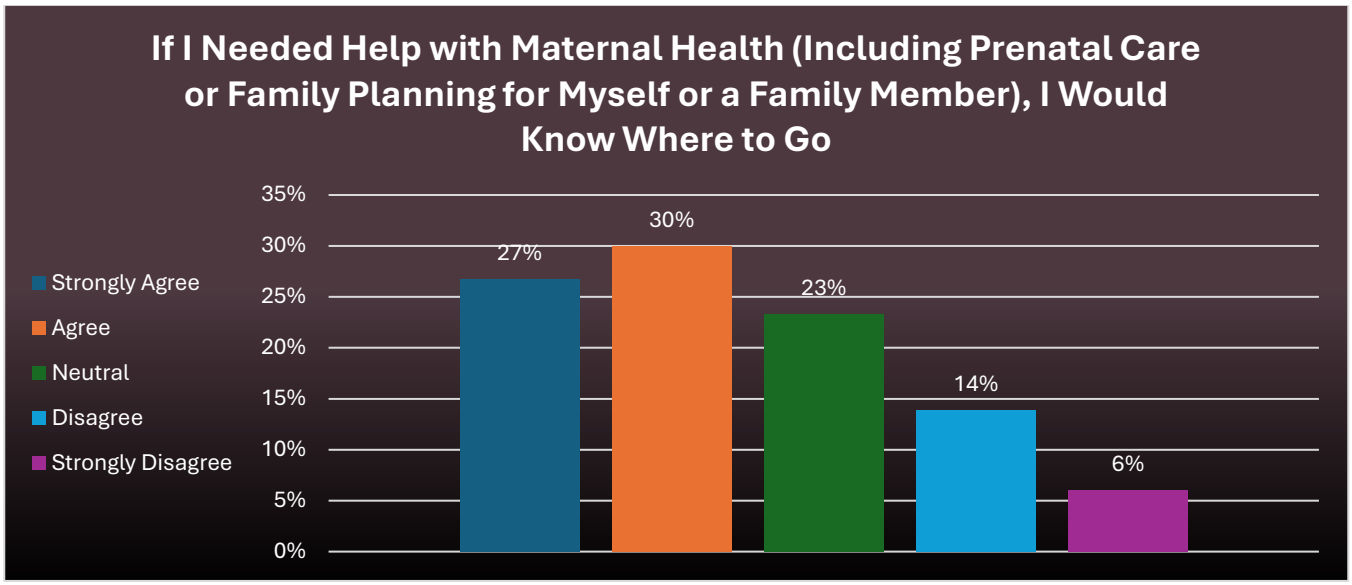
Approximately 32% of community members did not know where to go for elderly care. Half of the community members knew, and one-fifth remained neutral – they could find services if they needed.

Question 4:



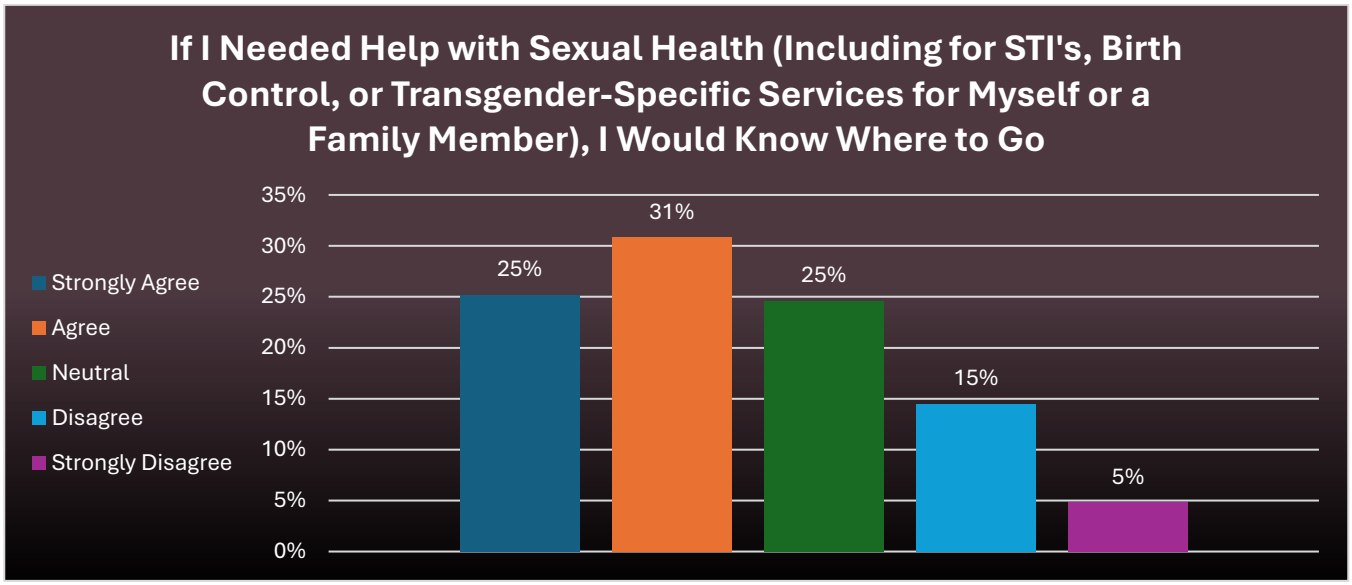
Approximately 20% of community members did not know where to go for maternal health. Roughly 57% of those surveyed knew where to go, while 23% remained neutral.

Question 5:



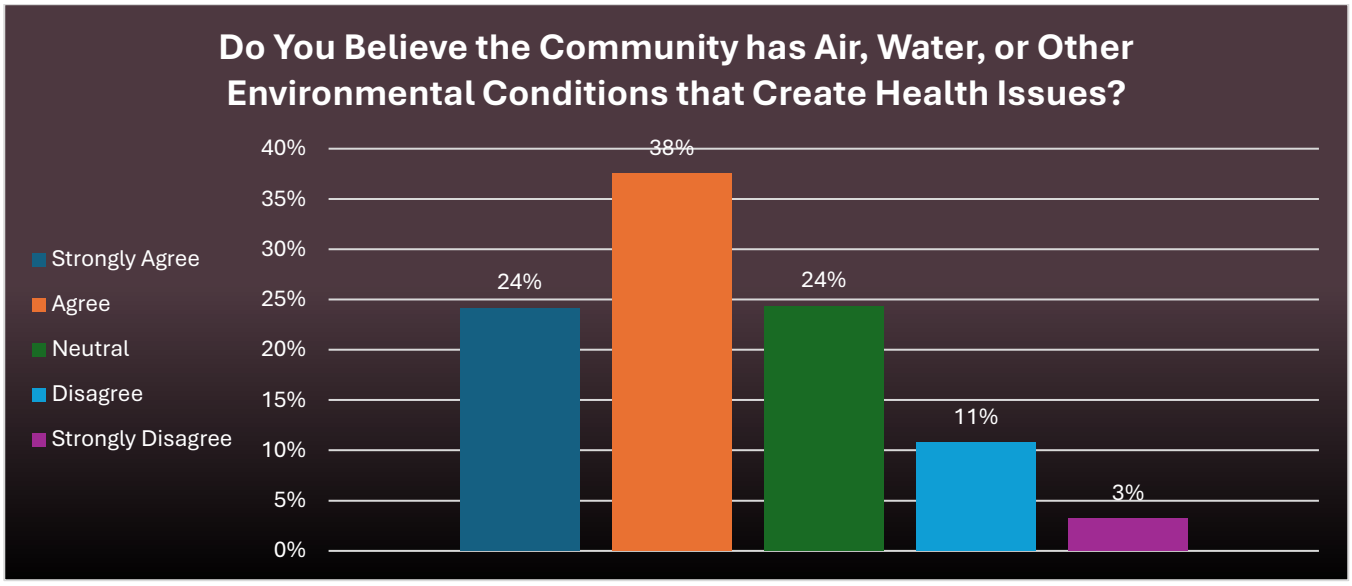
One in five community members did not know where to go for help with sexual health. Roughly 56% knew where to go for help, and a quarter remained neutral.

Question 6:



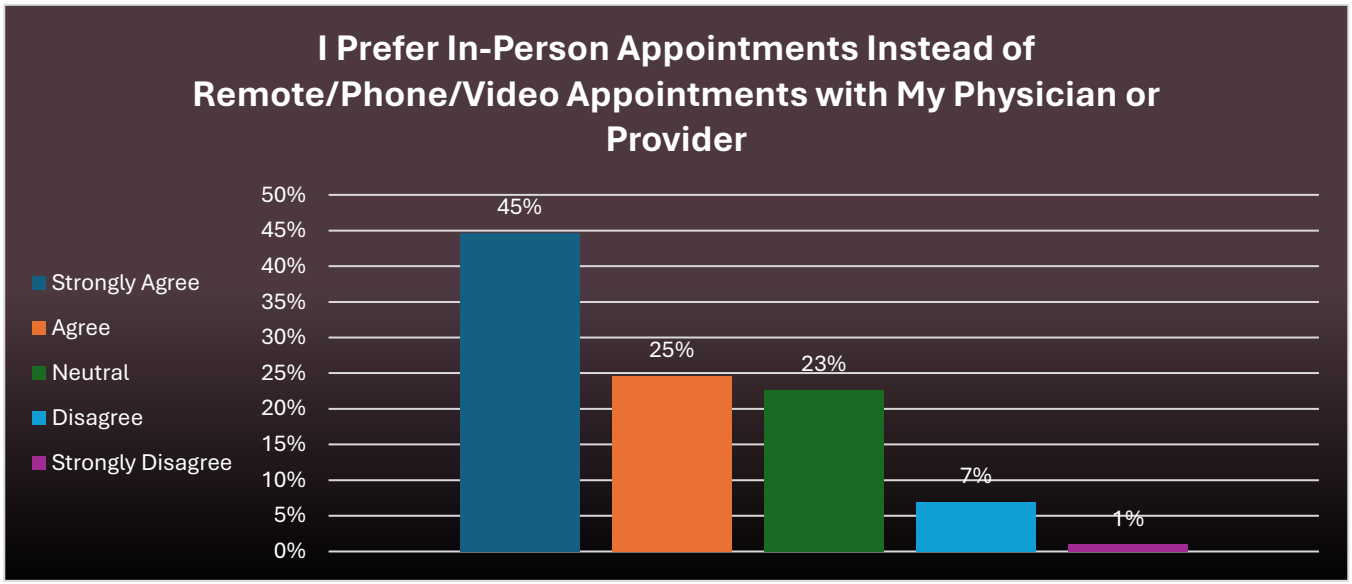
Nearly two of every three community members believe that environmental conditions are contributing to health issues. About a quarter remained neutral, and 14% of community members did not think there were any issues. This is an important area for further research and should be thoughtfully addressed in the strategic planning that follows this CHNA, even if it is a perceived concern not backed by data.

Question 7:



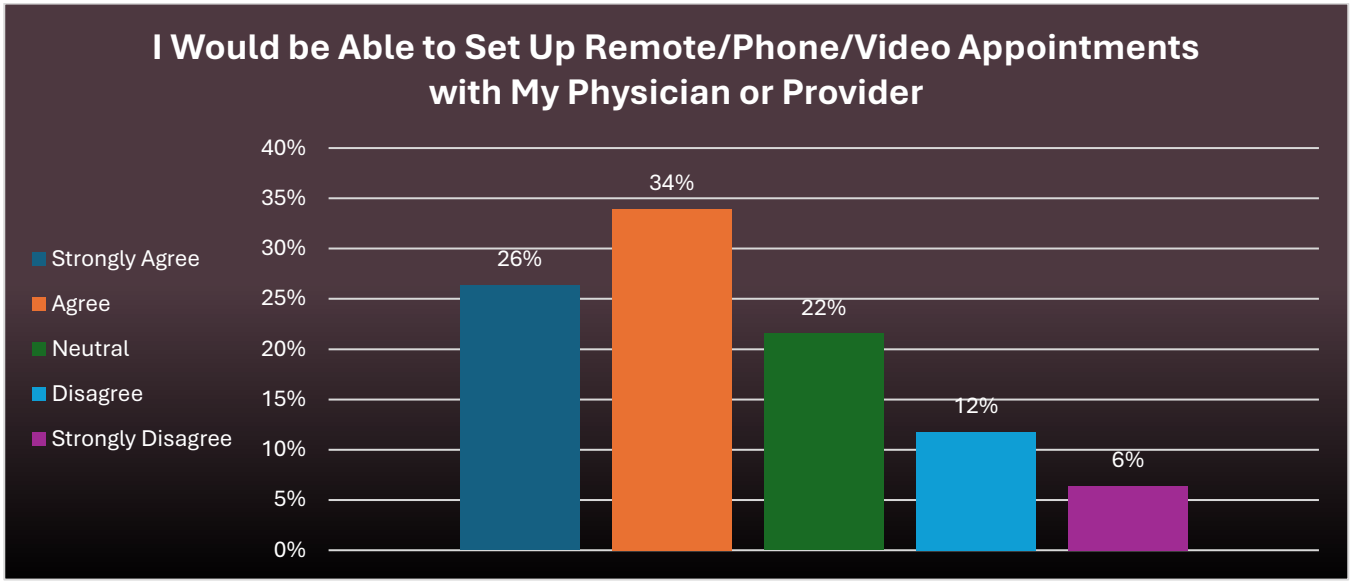
Approximately 8% of public respondents prefer remote/phone/video appointments instead of in-person. Approximately a quarter are neutral and could be influenced in their preference. Another quarter would prefer in-person. Less than half are firmly committed to in-person appointments. Almost a third are open to remote/phone/video appointments.

Question 8:



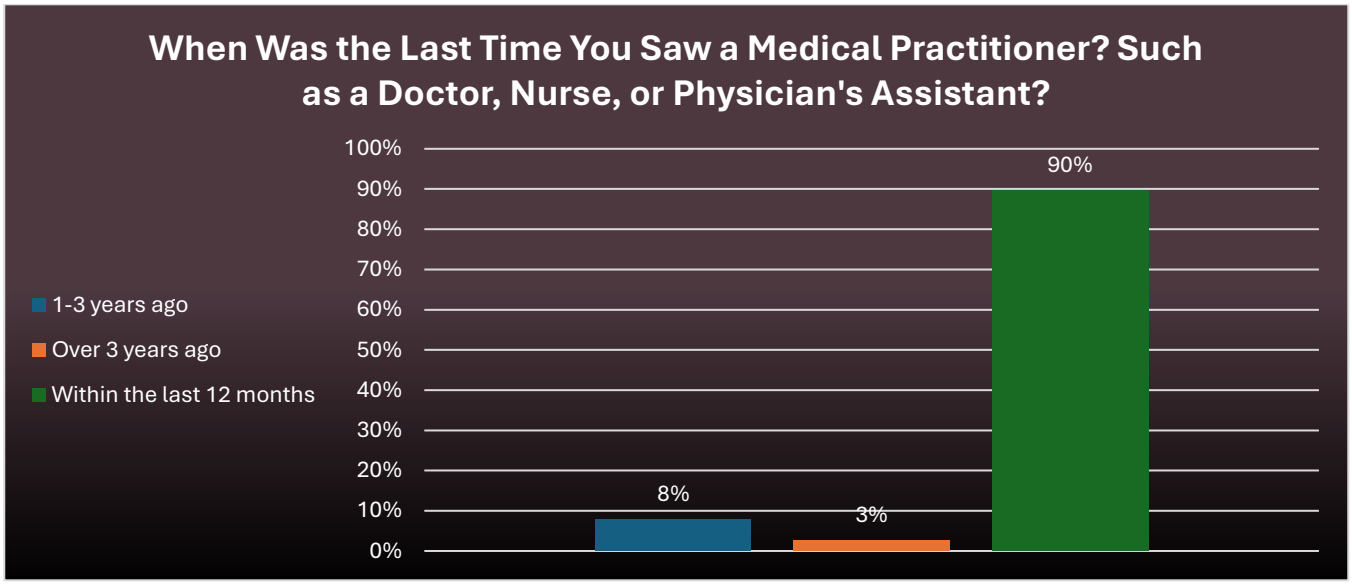
Roughly 60% were agreeable to set up remote/phone/video appointments and another 22% were neutral, which accounts for 82% of community respondents open to the option. Fewer than 1-in-5 community respondents were unwilling to consider this alternative.

Question 9:



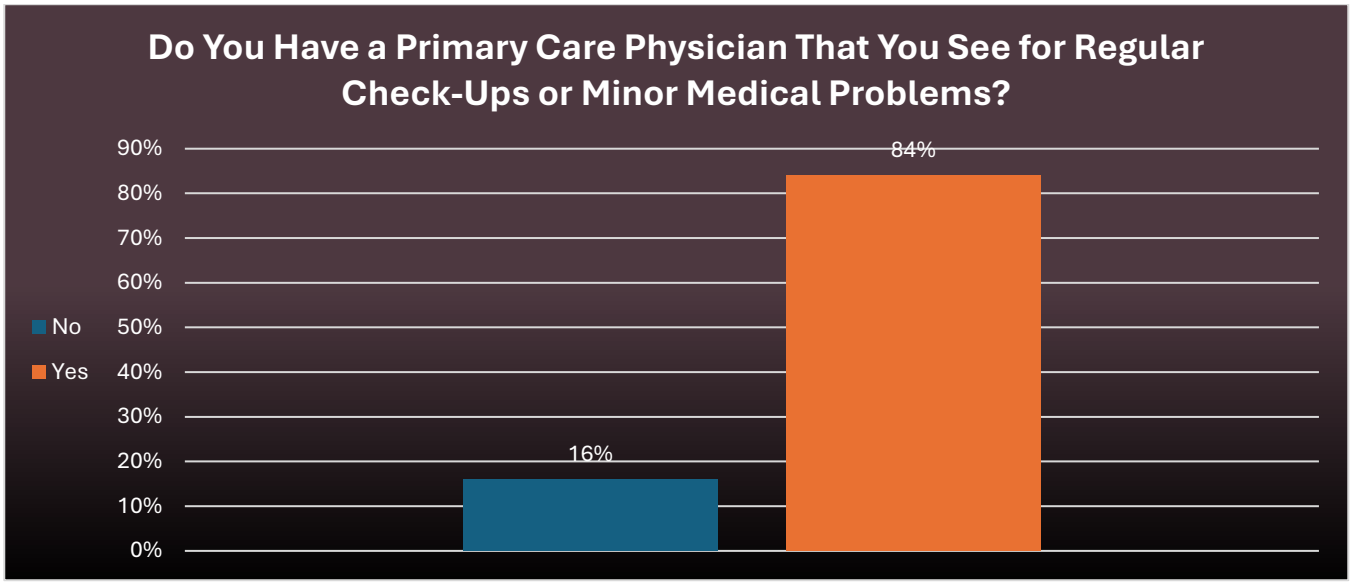
When asked about their most recent visit with a medical practitioner, such as a doctor, nurse, or physician's assistant, 9 out of 10 community members reported seeing a healthcare professional within the last 12 months. Roughly 8% indicated their last visit occurred between 1-3 years ago, while 3% had not seen a provider in over three years. By comparison, the most recent national data from the National Health Interview Survey shows that 85.2% of U.S. adults and 95.1% of children had visited a healthcare provider within the past 12 months.

Question 10:



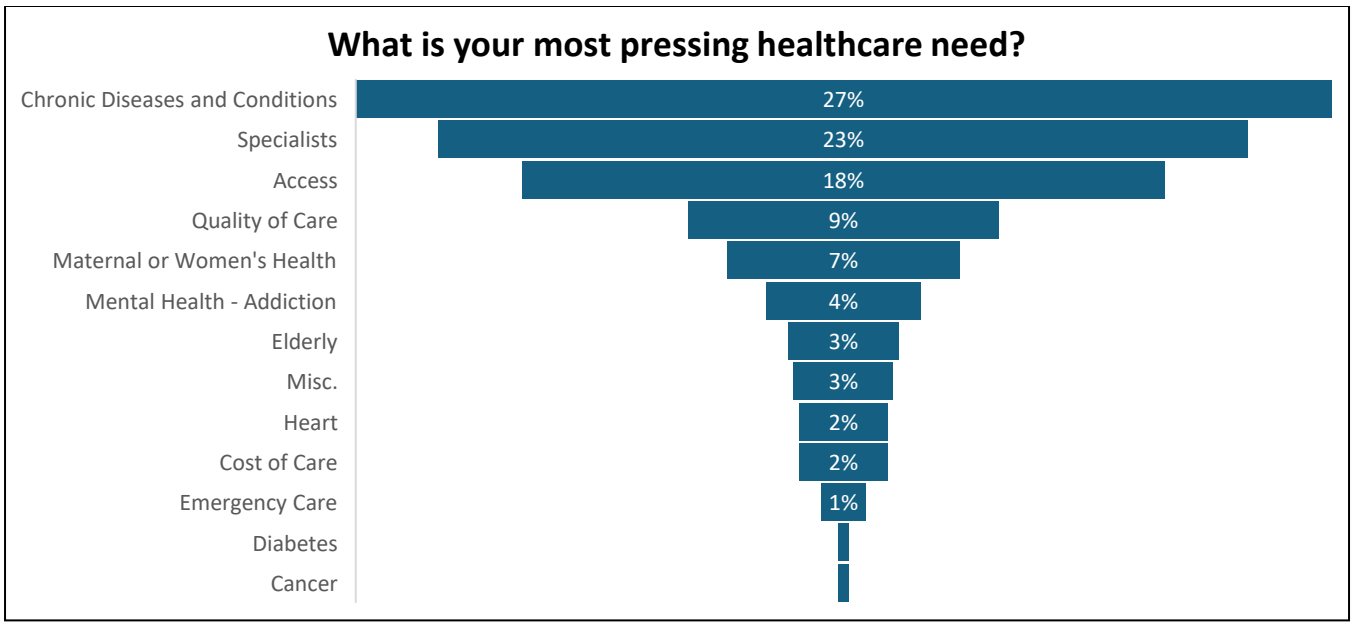
When asked whether they have a primary care physician for regular check-ups or minor medical problems, approximately 84% of respondents said yes. This is higher than the national figures. According to the 2023 NACHC report cited by *USA Today*, about one third of American's do not have a primary care provider, highlighting a stronger connection to primary care in the greater Ridgecrest community compared to the national average.[5]

Question 11:



Most Pressing Healthcare Needs

When asked about the most pressing healthcare needs, Chronic Diseases and Conditions came up as the top category. This was an amalgamation of everything from general pain to rare conditions. The loud message from this question was the second and third categories: need for more providers, both primary care and specialists. The community feels the shortage of providers in the excessive wait-times for appointments, in the rushed pace of care, in the attrition of providers with whom they are just starting to build relationships. They feel it is the quality of care from the providers bedside-manner all the way to the receptionist's failure to return calls.

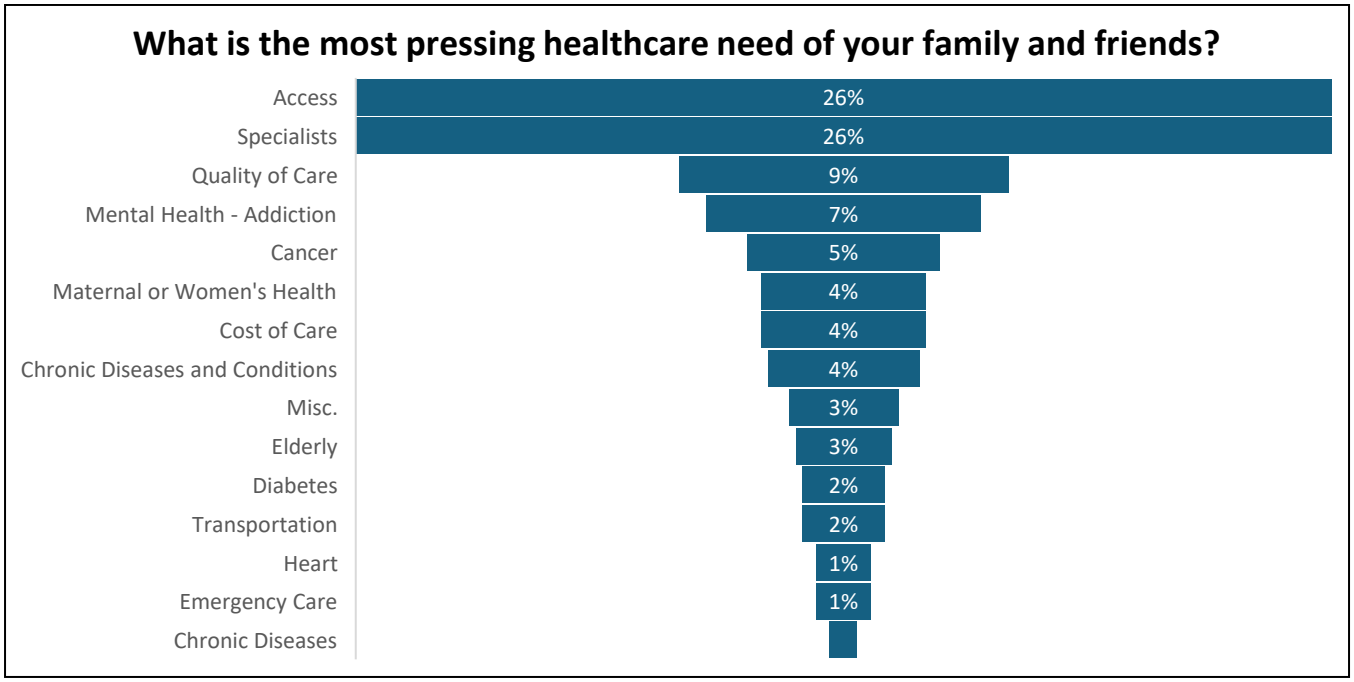


[5] Mason, B. (2023, March 1). USA Today: A Third of American's Don't Have a Primary Care Provider, according to NACHC Report. NACHC. https://www.nachc.org/usa-today-a-third-of-americans-dont-have-a-primary-care-provider-according-to-nachc-report/

Based on survey efforts, the community respondents perceive the network of healthcare providers as overburdened and strained. This challenge is exacerbated by the realities of a rural desert setting, where attracting and retaining medical personnel is inherently difficult. Many newly trained physicians prefer urban environments, drawn by the amenities, conveniences, and entertainment that come with densely populated areas.

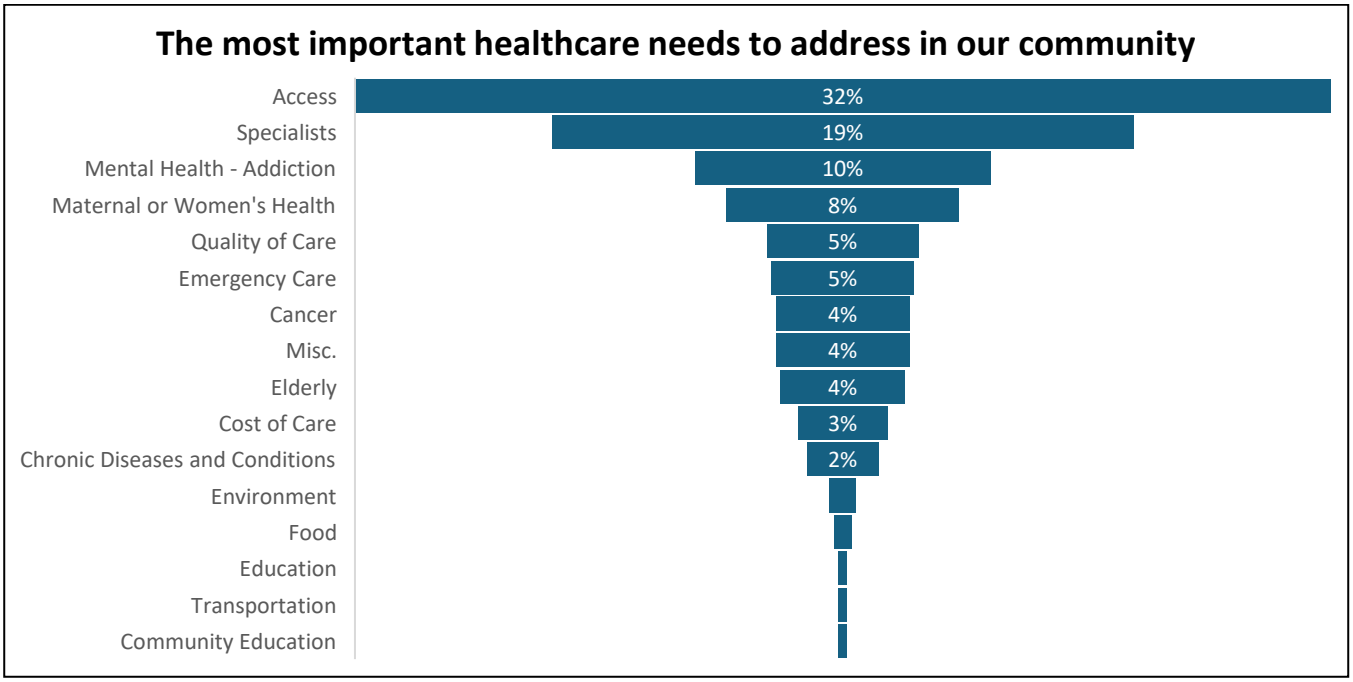
To address these concerns, the importance of strategic recruitment and ensuring a good fit between provider and community becomes evident. Some regions utilize community foundations to keep track of scholarship recipients who pursue careers in healthcare, hoping to eventually bring these professionals back to their hometowns. Federal and state student loan repayment programs can also serve as incentives, offering two or four-year commitments with the goal of encouraging providers to establish roots locally.

Beyond recruitment, telehealth services, contracting specialty groups, and hospital affiliations offer alternative solutions, though these approaches often raise operational costs. The challenge remains to ensure sufficient patient volume to make specialist positions sustainable; it is difficult to persuade providers to relocate when there is not enough demand to support them full-time. Most of this recruitment responsibility falls to the hospital, which must carefully balance its budget while investing in the continued search for qualified healthcare providers, many of whom will not be direct hospital employees, but are still essential to the community's access to care.

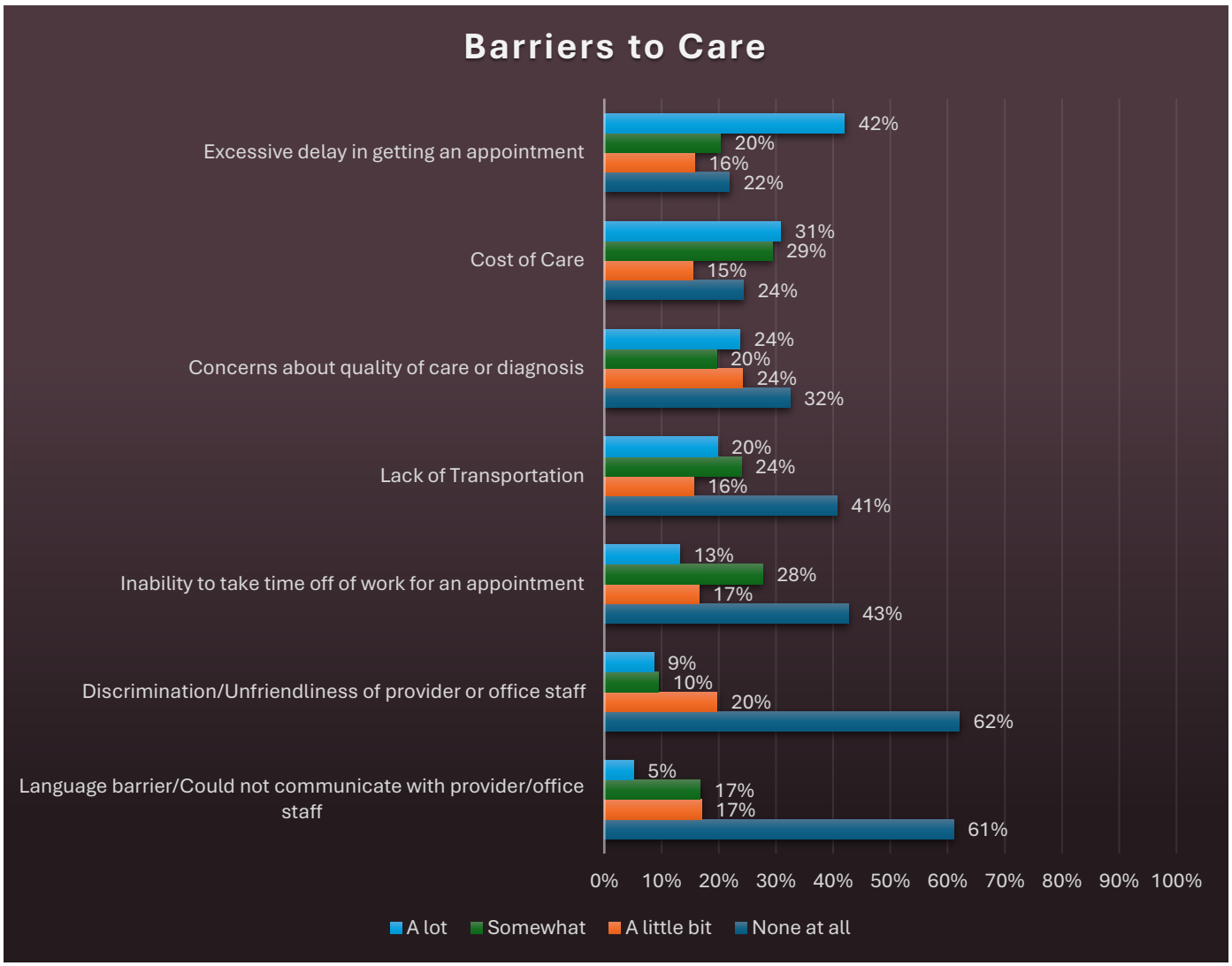


When respondents considered the most pressing healthcare needs for their families and friends, their answers overwhelmingly mirrored their own concerns. Although the questions appeared repetitive—asking individuals to reflect not only on their personal needs, but also those of their family and broader community—this approach encouraged participants to examine healthcare challenges from multiple viewpoints. By prompting people to think about the needs at different levels, the survey provided a more comprehensive and nuanced portrait of the healthcare landscape in the community.

In addition to access to primary care providers and more specialists, Maternal or Women's health and Mental Health were the other top categories of comments for these three sections. Here is the community needs table below, 10% of the community members thought mental health needs were a top issue.



Barriers to Care



Excessive Delays in Appointments

Approximately 42% of respondents identified excessive delays in appointment times as a significant barrier to healthcare, labeling it as impacting them “a lot.” Another 36% felt these delays affected them “a little bit” or “somewhat,” while 22% noted no impact. This issue emerged as the most prominent barrier to care within the community. This is being addressed and needs further focus to repair the damage to the healthcare image.

Cost of Care

About 31% of those surveyed reported that the cost of care posed “a lot” of a barrier, while 45% viewed it as somewhat or a little bit of an issue. For 24%, cost was not a barrier. Although one-third of respondents see it as a major issue, 94% of local patients have health insurance. Hospital initiatives, including charity care programs for the uninsured and underinsured, have helped to mitigate cost-related barriers.

Quality of Care

For 24% of respondents, the quality of care was considered "a lot" of a barrier, and 44% said it had some or a little impact. However, 32% said it was not an issue. This category includes perceptions of proper diagnosis and competence, and, while it focuses on quality, there may be some overlap with concerns about bedside manner and customer service.

Transportation Issues

One in five respondents (20%) found lack of transportation to be a significant barrier. Approximately 40% said it had a little or some impact, and 41% said it had no effect. Despite 97.7% of Ridgecrest residents having access to at least one vehicle, transportation concerns remain—particularly among the third of respondents who are of retirement age. Issues such as reluctance to drive or lack of access to a vehicle can result in delayed care.

Difficulty Taking Time Off Work

Approximate 13% of respondents cited time off work as “a lot” of a barrier, while 44% felt it had some or a little effect, and 43% noted no impact. This appears to be a natural barrier at a level that is generally considered acceptable and does not warrant further intervention.

Discrimination or Unfriendliness of Providers or Staff

About 9% of respondents viewed discrimination or unfriendliness from providers or staff as a major barrier, with 30% experiencing this "a little bit" or "somewhat." Sixty-two percent reported no impact. While any discrimination is unacceptable, this category also encompasses general unfriendliness. Concerns over quality of care and reports of curt staff or unreturned calls suggest a need for improved patient service. Enhanced patient service training could help address these perceptions and improve the medical network's reputation.

Language and Communication Barriers

Five percent of those surveyed identified language or communication issues as a significant barrier, with 34% experiencing it to a lesser degree and 61% unaffected. In a diverse state like California, language barriers are an ongoing concern. School statistics show that 5.6% of students are still learning English, while 94% of residents speak either English (82%) or Spanish (12%). The hospital and its outpatient services provide translation services, particularly in Spanish, though some self-employed physicians may not offer these services.

Community Survey – Long Answer Section

The previous tables provided a clear summary of the overall needs of the community. This section synthesizes the long answer sections, categorized by healthcare providers and community members.

Providers were asked for three opinions: what do the providers need, what do the patients need, and do you have any additional suggestions. The consistent theme across responses was that provider shortages had increased wait times, customer service issues, and a growing burden on the existing provider base. Providers emphasized the need to recruit both primary care and specialty care professionals, ideally with a focus on providers who were aligned with the pace and lifestyle of the community to increase chances of long-term retention. They also recommended recruiting not only physicians but advanced practitioners as well. To boost retention, there were suggestions for increased pay and benefits, along with expanded opportunities for continuing education. They spoke of the value of community education, and cross training, and the value of collaboration with the nursing teams.

Providers' Perspectives on Healthcare Needs

Overall, the suggestions shared by healthcare providers closely mirror the concerns raised by community members, underscoring the need for comprehensive solutions to meet Ridgecrest's evolving healthcare needs.

It is important to emphasize that while there is a real and pressing healthcare challenge in Ridgecrest, the responsibility does not lie solely with the hospital. RRH is acutely aware of these concerns and is actively recruiting staff to fill the gaps identified by both providers and community members. However, attracting healthcare professionals (particularly specialists) to a small community presents significant hurdles. The limited patient population makes it difficult to sustain specialist practices, and rural areas like Ridgecrest cannot always offer the amenities and lifestyle found in larger cities. These factors combine with making recruitment an ongoing challenge to find the providers that appreciate the area for its virtues. The hospital's efforts reflect a commitment to improvement, but the broader context and complexities of rural healthcare mean that solutions often require more than determination alone.

Community Members' Most Pressing Healthcare Needs

The Ridgecrest community has voiced several pressing healthcare needs throughout the CHNA. These needs reflect a broad spectrum of concerns, ranging from access to care and quality of services to specific medical specialties and support systems.

Access to Care and Quality of Services

A significant number of community members expressed frustration with the accessibility and quality of healthcare services. Many reported long wait times for appointments, difficulty in getting referrals to specialists, and challenges in contacting healthcare providers for medication refills or follow-up care. There is a strong demand for more local primary care physicians and specialists to reduce the need for traveling long distances for medical care. Additionally, the community highlighted the need for better customer service and more compassionate care from healthcare providers.

Specific Medical Specialties

Several respondents emphasized the need for more specialists in areas such as orthopedics, pain management, psychiatry, and gynecology. The lack of local specialists often forces patients to seek care outside of Ridgecrest, which can be burdensome and costly. There is also a call for more physical therapists, particularly those specializing in orthopedic care, to address the needs of recovering patients.

Emergency and Urgent Care
The community expressed concerns about the quality and efficiency of emergency and urgent care services. Reports of long wait times, inadequate care, and unprofessional behavior from emergency room staff were common. There is a need for improvements in the emergency department, including better privacy measures, more qualified staff, and faster service.

Women's Health Services
Women's health services were identified as a critical area needing improvement. Community members pointed out the absence of local obstetric and gynecological care. There is a strong demand for better access to maternal health services.

Mental Health and Substance Use
Mental health services are another priority. The community highlighted the importance of having more mental health professionals who can provide both therapy and medication management. There is also a need for better substance use treatment programs, including support for individuals struggling with addiction.

Elder/Senior Care
Elder care is a growing concern, with many community members emphasizing the need for more services tailored to the elderly population. This includes better access to in-home care, transportation services for medical appointments, and specialized care for chronic conditions common among seniors.

Additional Concerns
Other notable concerns include the need for improved dental care, better communication and follow-up from healthcare providers, and more support for veterans navigating the healthcare system. Community members also expressed a desire for more health education and wellness programs to promote preventive care and healthy lifestyles.

Strategies and Comparisons from the Previous CHNA

The previous report listed the following as potential concerns for the community served by RRH.

- Access to Care - High
- Mental Health - High
- Health Education, Wellness, and Disease Prevention - Moderate - High
- Substance Use or Addiction - Moderate - High
- Sexual Health - Moderate
- Maternal Health - Moderate
- Chronic Disease - Moderate - Low
- Elder/Senior Care - Moderate - Low
- Acute Illness and Injury - Low
- Environmental Conditions - Low

Access to Care	
Previous Strategy	**Status**
Provide incentives to attract/recruit specialists to area.	Need to update this text, need clarification.
Develop partnerships instead of having on-site specialists.	Need to update this text, need clarification.
Rework office schedules to expand availability.	Need to update this text, need clarification.

Mental Health	
Previous Strategy	**Status**
Provide incentives to recruit/retain therapists.	Need to update this text, need clarification.
Offer groups for support with mental health and/or substance use.	Since the study, programs have been implemented to address these concerns.
Partner with schools to streamline/coordinate mental health services for youth.	Need to update this text, need clarification.

Health Education, Wellness, and Disease Prevention	
Previous Strategy	**Status**
Improve patient engagement with care through portals or navigator programs.	Need to update this text, need clarification.
Offer groups on wellness or other prevention-related topics (e.g. obesity).	Since the study, programs have been implemented to address these concerns.
Expand low-cost healthy food and indoor exercise options (potentially through partnerships).	Since the study, programs have been implemented to address these concerns.

Substance Use or Addiction	
Previous Strategy	**Status**
Provide education focused on substance use prevention.	Need to update this text, need clarification.
Offer groups for support with mental health and/or substance use.	Need to update this text, need clarification.

Sexual Health	
Previous Strategy	**Status**
	Foster a positive environment and encourage providers to understand where services can be provided.

Maternal Health	
Previous Strategy	**Status**
	Maternal care has since expanded from the previous stuff. Determine if expanding programs for maternal care and gynecology are required.

Chronic Disease and Acute Illness	
Previous Strategy	**Status**
	Since the study, some programs have been established to enhance the well-being and education of the community. Further and continued outreach programs are recommended for continued improvements.

Elder/Senior Care	
Previous Strategy	**Status**
	Expand home health care, transportation to medical appointments, and chronic disease management for elderly residents

Environmental Conditions	
Previous Strategy	**Status**
	Air and water quality generally meet standards, localized issues and community perceptions underscore the importance of ongoing surveillance and education. Water, soil, and air tests prior to filtration would help in the education process.

Summary and Conclusion:
Key Health Issues, Priorities, and Strategic Recommendations

Summary of Key Health Issues

Situated in the eastern third of Kern County, a region defined by its desert geography, rural expanse, and singular hospital facility, Ridgecrest stands as the principal community and healthcare access point for the area. While most residents live in Ridgecrest itself, the broader region's healthcare needs merit careful assessment due to its unique circumstances. Demographically, Ridgecrest features a normal population skewed towards younger ages, an evenly balanced male-to-female ratio, and moderate levels of poverty. Racially, about two-thirds of residents are White (66%), with Hispanic individuals comprising nearly one-fifth (19%). Notably, 15% of the population are military veterans, a distinctive characteristic in comparison to other communities. Around 70% have gone to college, even if they did not finish. The area has average crime rates, with a higher incidence of assault, and generally positive health statistics.

There are, however, ongoing and new health concerns that need to be addressed:

- Chronic Diseases: Diabetes, lung disease, heart disease, obesity, high cholesterol, hypertension, are notably prevalent, often exceeding state averages. Cancer is in line with state average mortality but a top cause of mortality in the US, therefore included in planning.
- Access to Care: Long wait times, provider shortages, and limited specialist availability compel many residents to travel for essential healthcare, impacting both quality and postponement of care.
- Mental Health: Around 30% of adults indicate a need for mental health support, but inpatient utilization remains low. This encourages the hospital to assess if there is a gap in outpatient and preventive services.
- Emergency and Urgent Care: Community feedback highlights inefficiency, privacy concerns, and the need for additional qualified staff in emergency services.
- Women's Health: Shortfalls in support for maternal health, and gynecological care were strongly noted.
- Substance Use Disorders: Opioid use and the effects of substance abuse are rising in the county, particularly among vulnerable populations.
- Senior/Elder Care: A growing elderly population faces barriers to in-home, specialty, and transportation services for chronic illnesses and daily needs.
- Environmental and Social Determinants: While air and water quality generally meet standards, localized issues and community perceptions underscore the importance of ongoing surveillance and education. Water, soil, and air tests prior to filtration would help in the education process.

Priorities for Action

Based on community and provider responses, the following priorities have emerged as the most urgent for Ridgecrest:

- Expand access to primary care and specialist providers to reduce wait-times and travel burdens.
- Enhance mental health and substance use disorder services, emphasizing outpatient and preventive care.
- Improve emergency department efficiency, privacy, and staffing to deliver timely, high-quality urgent care.
- Strengthen women's health resources, including on-site maternal health services. Give reception sensitivity training.
- Promote healthy behaviors to address obesity and related chronic conditions through education, wellness initiatives, and community engagement.
- Increase options and support for elder care, focusing on in-home, transportation, and specialized chronic disease management.
- Address barriers to care such as cost, transportation, and awareness of available services through targeted outreach and navigation support.

Conclusion

Ridgecrest Regional Hospital remains a reliable and effective provider of health services within the region. Elevated mortality rates have been observed for diabetes and lung disease, while heart disease and cancer continue to be leading causes of death in the nation and are consistently prioritized for intervention. As such, the primary causes of mortality identified are diabetes, lung disease, heart disease, and cancer.

The most prevalent morbidities include obesity, high cholesterol, and hypertension. Chronic obstructive pulmonary disease (COPD), heart disease, and cancer have also been highlighted as areas requiring ongoing focus and improvement.

Ridgecrest faces the distinct challenge of recruiting healthcare providers to its desert location. Through targeted efforts in recruitment, enhancement of patient services, optimization of emergency care, expansion of telehealth capabilities, and the development of strategic partnerships, Ridgecrest Regional Hospital is well-equipped to address both actual and perceived provider shortages.

Furthermore, achieving meaningful progress in reducing the widespread incidence of obesity, diabetes, high cholesterol, and hypertension - which significantly contribute to various health complications - will require a broader cultural transformation. Active engagement and collaboration among community stakeholders will be essential to foster lasting change at the local level.