

Heart-to-Heart Lake County

Cardiac Community Needs Assessment

Collaborative for Equity in Cardiac Care

Lake County, California | Year 1

September 2026

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Prepared by



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1. Welcome and How to Use This Assessment

Heart-to-Heart: Collaborative for Equity in Cardiac Care is a partnership of health care providers, Tribal health programs, community organizations, and community members working together to strengthen heart-related care in Lake County. The program serves Medi-Cal-eligible adults ages 18 and over across the county, and it is grounded in the knowledge and experiences of community members and the people who provide their care.

This assessment belongs to the whole partnership. It is written for community members, the organizations and providers who serve them, Tribal partners, and the collaborative as it plans the years ahead. Community members shaped this assessment throughout: they took the surveys, sat for the interviews, joined the group discussions, and named the priorities in these pages. Their knowledge is the foundation of everything that follows.

This is an asset-based needs assessment. It starts with what Lake County already has: trusted clinics and programs, community health workers and family advocates who walk alongside people, Tribal health systems grounded in culture and community, and neighbors who help each other get to appointments. From that foundation, it identifies where partners will strengthen heart-related care together, so that improvement builds on strength.

Use this assessment as a guide to heart-related care in Lake County. The Executive Summary presents the central findings in brief. Section 5 presents the full findings, organized by domain, drawing on what community members and providers shared through surveys, interviews, and group discussions. The closing sections lay out how the collaborative will act on what was learned.

Looking for a shorter, visual overview?

We created [infographics](#) that highlight key findings from the assessment in an easy-to-use format. These resources offer another way to explore and share what we learned from community members and providers across Lake County.

[View the Heart-to-Heart Community Needs Assessment Infographics](#)

2. Executive Summary

Heart-to-Heart: Collaborative for Equity in Cardiac Care is a five-year initiative serving Medi-Cal-eligible adults 18 and older in Lake County, California. In its first year, the collaborative conducted this community needs assessment to establish how residents experience heart-related care, where the care system supports them, where it falls short, and what the collaborative should do first. The assessment draws on four sources: published county-level data, a community member survey, a provider survey, and interviews and group discussions with providers.

The community member survey reached 120 respondents and the provider survey reached 44. Twelve sessions, eleven interviews, and one group discussion were held between June and August 2026 across five provider audiences: community health workers, direct clinical providers, service providers, Tribal health providers, and system leaders and planners. Participants were reached through community events, partner sites, and direct outreach, and the findings describe the experiences of those who took part. Community member interviews and group discussions are scheduled for Year 2.

Lake County carries one of the heaviest cardiovascular burdens in California. The county's age-adjusted death rate from coronary heart disease, 119.5 deaths per 100,000 residents in 2021 to 2023, is the highest reliable county rate in the state and 1.7 times the California rate of 72.2. A county rate is reliable when it is based on enough deaths to be statistically stable from year to year; the smallest counties' rates are published with an unreliability flag. Two in five adults (39.6%) have been told they have high blood pressure, and coronary heart disease has been diagnosed in 8.9% of adults, compared with 3.0% statewide. Half of residents in Lake County (49.5%) are enrolled in Medi-Cal, median household income is \$60,621 compared with \$99,122 statewide, and 61.1% of residents live in a primary care Health Professional Shortage Area.

The assessment found a county with real assets. Heart health is a present concern that residents act on: 68% of community survey respondents said they or someone they know needed heart-related care in the past 12 months. Lake County Tribal Health Consortium provides a home base for care where culturally responsive practices are standard. Community health workers, community health representatives, and

promotores (community health workers) are the workforce that community members and providers alike identify as effective, a finding supported by all four data sources. The county's organizations already collaborate across systems on outreach and events.

The needs intersect across sources. Transportation is the most common barrier community members reported in the survey (35%) and the top reason surveyed providers see referrals fail (44%). Difficulty getting appointments follows (34%), and direct clinical providers and community members reported one- to two-month waits to a first cardiology visit and even establishing primary care. The referral loop is not visible to the people working in it: 51% of surveyed providers could not say what happens to a cardiac referral after it is placed, and 42% did not know how referral status is tracked. Language access and culturally responsive care were named in 11 of 12 provider interviews and group discussions. Coverage is broad but not complete: 6.9% of residents have no health insurance, and the share rises to 22.1% among American Indian or Alaska Native residents.

The collaborative moves next into implementation. Beginning in October 2026, it will convene a health system subcommittee and Community Advisory meetings where community members and partners review progress and shape decisions. It will also train community health workers and representatives in cardiac care prevention, screening, and referral. In partnership with Kno'Qoti Native Wellness and Latinos United, this initiative will offer trainings in local Tribal history, Bi-National and Latino health, and culturally responsive care while adopting a hiring standard that builds bilingual, bicultural, and lived experience representation in that workforce. This initiative will also develop referral workflows and a cardiac service map that make existing Medi-Cal benefits visible to providers and residents. More than 25 Medi-Cal members will be connected with community health worker navigators at the Clearlake and Kelseyville clinic sites, with at least three encounters per month. Lastly, community member interviews and group discussions will extend this assessment's community voice beyond the survey. An evaluation will measure this work against the baseline in this report, so the collaborative and the community will know what changed.

Every figure in this summary appears again in the body of the report with its source and year.

3. About Lake County and the People Heart-to-Heart Serves

3.1 Who Lives in Lake County

Lake County is a rural county in Northern California organized around Clear Lake, with two incorporated cities, Lakeport and Clearlake, and many small, unincorporated communities along the lake and in the surrounding hills. The county is home to 68,152 residents.¹ Nearly one in four residents (23.9%) is 65 or older, compared to 17.5% statewide, and the median age is 44.1 years compared with 37.9 statewide.¹ Adults 35 to 64, the ages at which cardiovascular risk accumulates, make up 36.8% of residents.¹ Table 1 presents the population characteristics that shape heart health and access to care in the county.

Seven federally recognized tribes are located in Lake County: Big Valley Band of Pomo Indians, Elem Indian Colony, Habematolel Pomo of Upper Lake, Koi Nation of Northern California, Middletown Rancheria of Pomo Indians, Robinson Rancheria of Pomo Indians, and Scotts Valley Band of Pomo Indians. Tribal governments and Tribal health programs are a foundation of the county's care system and of this collaborative. In census data, 3.0% of residents identify as American Indian or Alaska Native alone, compared with 1.3% statewide.¹ Census categories understate Tribal community membership, because residents who identify as American Indian or Alaska Native together with another race are counted under two or more races, a group that includes 5.6% of residents.¹

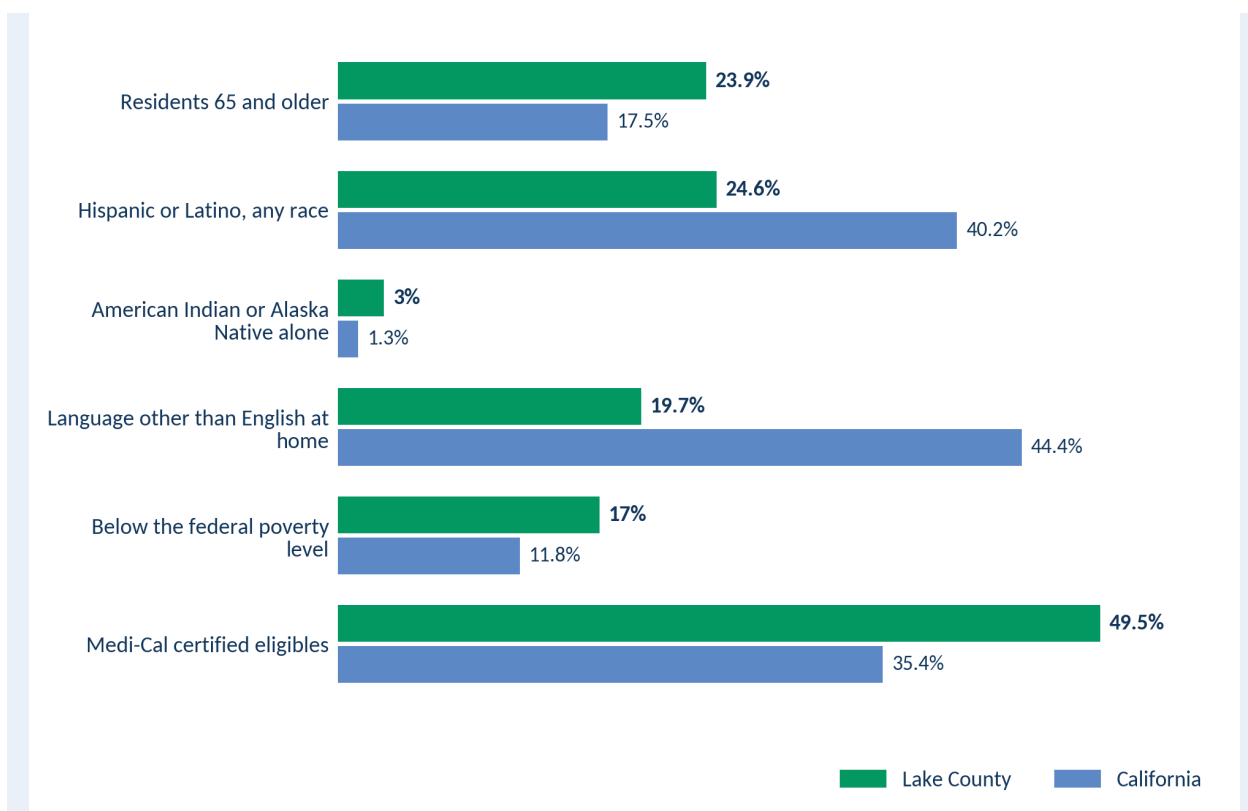
Hispanic or Latino residents make up one in four Lake County residents, 24.6% of the population, or 16,796 people.¹ The Hispanic or Latino population grew from 13,667 to 16,796 residents between the five-year estimates ending in 2020 and 2024, accounting for most of the county's growth of about 3,900 residents over the same period.¹ One in five residents ages 5 and older (19.7%) speaks a language other than English at home, compared with 44.4% statewide.¹

Household resources in Lake County are well below the state level. Median household income is \$60,621, compared with \$99,122 statewide, and 17.0% of residents live below the federal poverty level, compared with 11.8% statewide.¹ The January 2024 Point-in-Time count identified 604 people experiencing homelessness in the county,

435 of them unsheltered, a rate of 89 per 10,000 residents, nearly double the statewide rate of 48 per 10,000.² Community members experiencing homelessness are a population this assessment identifies as carrying a distinct cardiac burden.

Half of Lake County residents are enrolled in Medi-Cal. In January 2026, 33,195 residents were certified eligible for Medi-Cal, 49.5% of the county population, compared with 35.4% statewide.³ Among residents 19 and older, 43.3% of the adult population were Medi-Cal eligible.³ These adults are the population Heart-to-Heart serves.

Figure 1. Population characteristics, Lake County and California, percent



Sources: ACS 2020 to 2024¹; Point-in-Time count, January 2024²; DHCS, January 2026³

Table 1. Population characteristics, Lake County and California

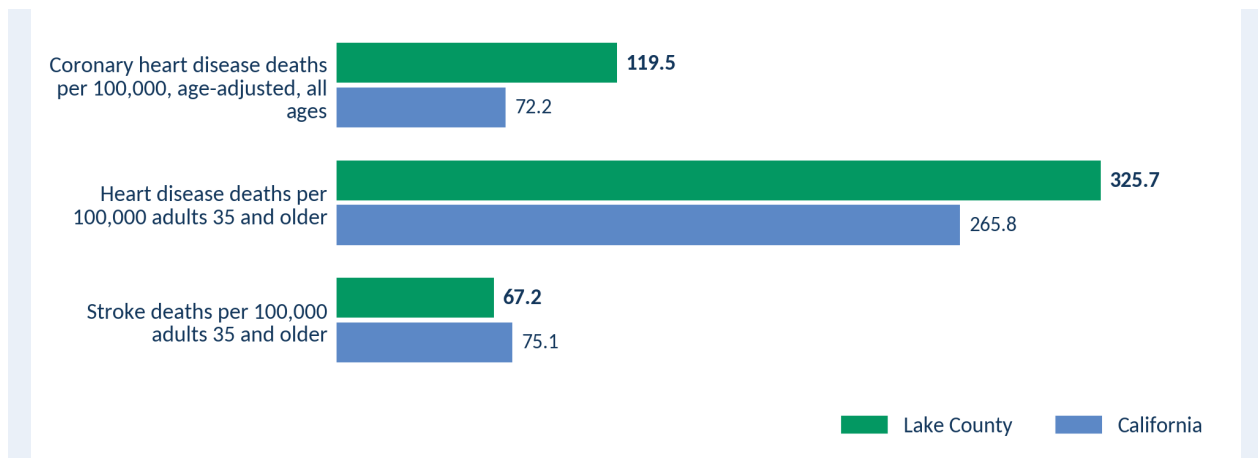
Characteristic	Lake County	California	Source, year
Total population	68,152	39,287,377	ACS 2020 to 2024 ¹
Residents 65 and older	23.9%	17.5%	ACS 2020 to 2024 ¹
Median age (years)	44.1	37.9	ACS 2020 to 2024 ¹

Characteristic	Lake County	California	Source, year
Hispanic or Latino, any race	24.6%	40.2%	ACS 2020 to 2024 ¹
White alone, not Hispanic or Latino	64.0%	33.8%	ACS 2020 to 2024 ¹
American Indian or Alaska Native alone, any ethnicity	3.0%	1.3%	ACS 2020 to 2024 ¹
Asian alone, not Hispanic or Latino	1.4%	15.3%	ACS 2020 to 2024 ¹
Language other than English spoken at home, ages 5 and older	19.7%	44.4%	ACS 2020 to 2024 ¹
Median household income	\$60,621	\$99,122	ACS 2020 to 2024 ¹
Residents below the federal poverty level	17.0%	11.8%	ACS 2020 to 2024 ¹
People experiencing homelessness, per 10,000 residents	89	48	Point-in-Time count, January 2024 ²
Medi-Cal certified eligibles, share of population	49.5% (33,195)	35.4%	DHCS, January 2026 ³

3.2 Heart Health in Lake County

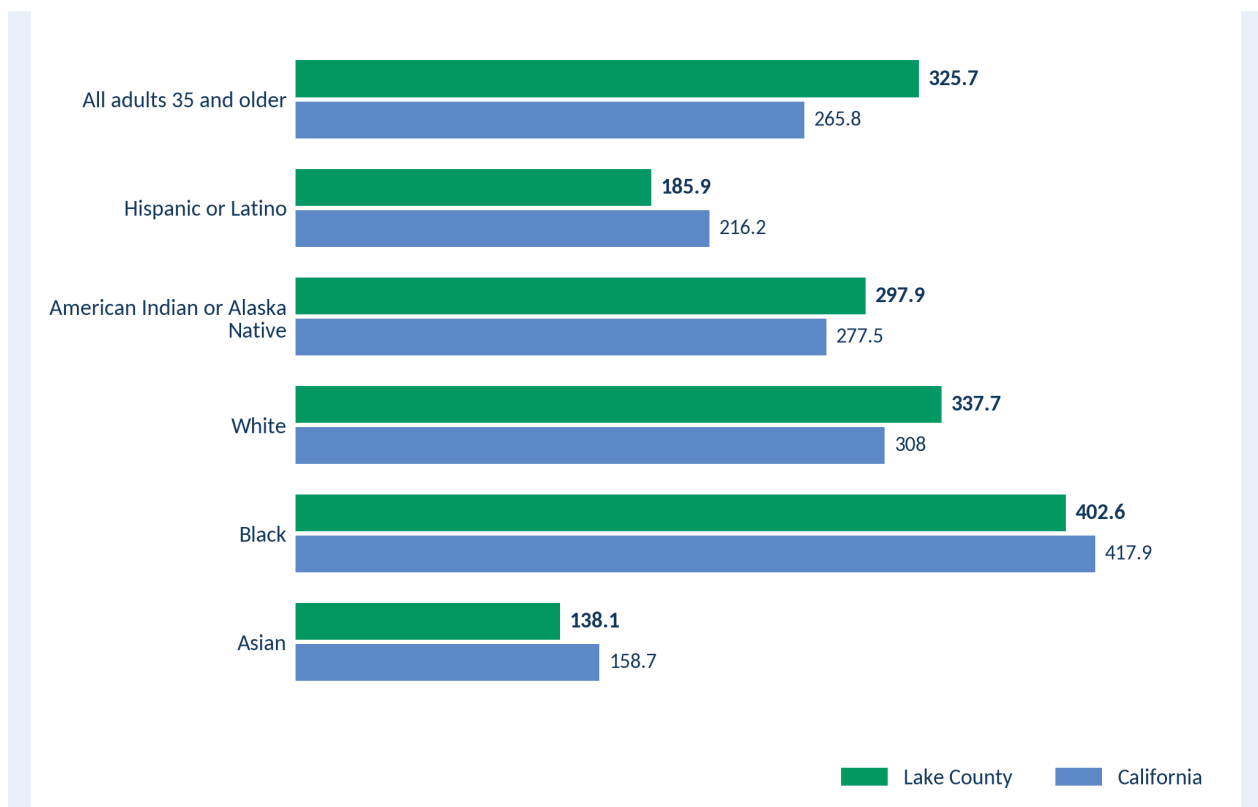
Lake County carries one of the heaviest cardiovascular burdens in California. The county's age-adjusted death rate (adjusted so that counties with older and younger populations can be compared fairly) from coronary heart disease, 119.5 deaths per 100,000 residents in 2021 to 2023, is the highest reliable county rate in the state and is 1.7 times higher than the California rate of 72.2 deaths statewide.⁴ Among adults 35 and older, the age-adjusted heart disease death rate in 2022 to 2024 was 325.7 per 100,000 people, compared with 265.8 statewide.⁵ Fewer adults aged 35 and older die from strokes compared to the rest of the state (67.2 vs 75.1 deaths per 100,000 adults).⁵ Heart disease mortality in the county is highest among Black adults (402.6) and White adults (337.7). The rate among American Indian or Alaska Native adults is also above the statewide rate, while the rate among Hispanic or Latino adults is lower than the statewide rate.⁵ Figures 2 to 4 and Table 2 present the mortality and prevalence measures.

Figure 2. Cardiovascular death rates per 100,000, Lake County and California



Sources: County Health Status Profiles 2025, 2021 to 2023⁴; CDC Interactive Atlas, 2022 to 2024⁵

Figure 3. Heart disease death rates per 100,000 adults 35 and older by race and ethnicity, 2022 to 2024

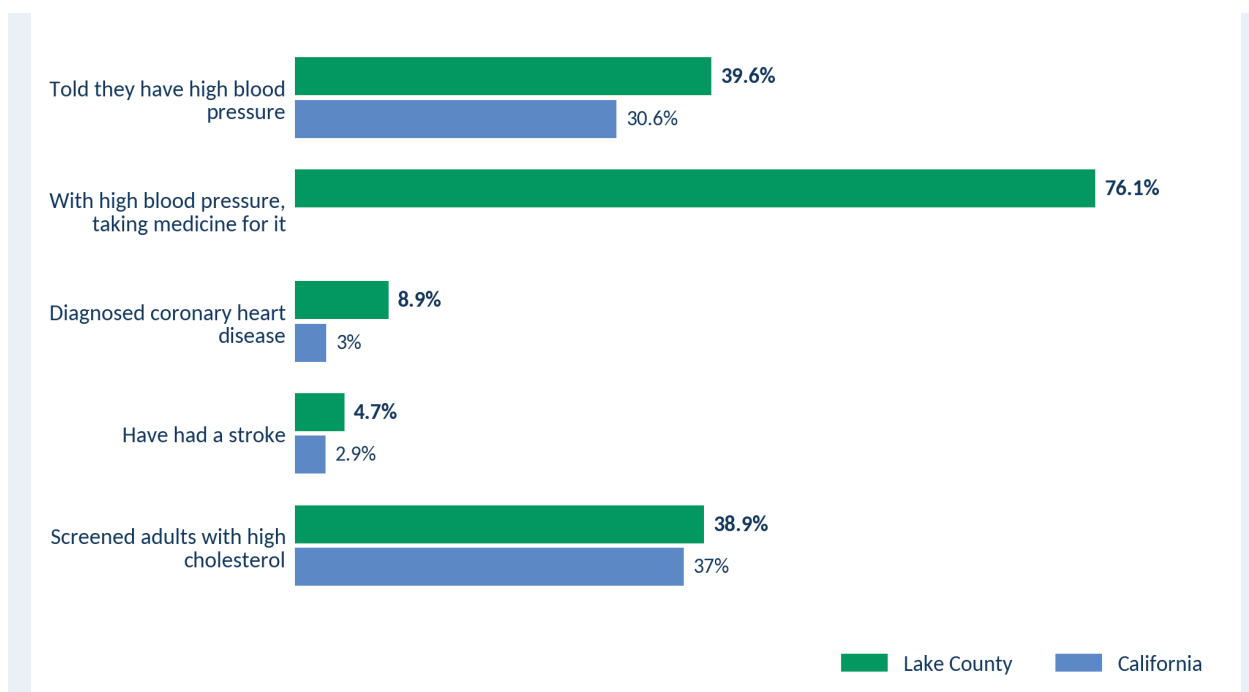


Source: CDC Interactive Atlas of Heart Disease and Stroke⁵

High blood pressure is the most common cardiovascular condition in the county. Two in five adults (39.6%) have been told they have high blood pressure, compared with

30.6% of California adults, and three in four adults with high blood pressure (76.1%) take medicine to control it.^{6,7} Coronary heart disease has been diagnosed in 8.9% of adults, nearly three times the 3.0% statewide, and stroke and high cholesterol also sit at or above the statewide level; Figure 4 presents each condition.^{6,7}

Figure 4. Cardiovascular conditions among adults, percent, Lake County and California, 2023



Sources: CDC PLACES⁶; BRFSS California⁷

The conditions that drive cardiovascular disease are present at higher levels in Lake County than in California as a whole, and Figure 5 presents each measure. The widest gaps are current cigarette smoking, at nearly twice the statewide share (15.2% compared with 8.5%), and no leisure-time physical activity (27.8% compared with 22.9%); diabetes and obesity also sit above the statewide level.^{6,7} These conditions sit within county conditions that shape daily life. In 2023, 16.3% of residents, 11,120 people, experienced food insecurity, compared with 13.7% of Californians.⁸ One in seven adults (14.4%) experienced housing insecurity in the past year, and 11.1% lacked reliable transportation.⁶ One in four adults (26.3%) rate their health as fair or poor, compared with 20.8% statewide, and 18.1% report frequent mental distress, compared with 14.7% statewide.^{6,7}

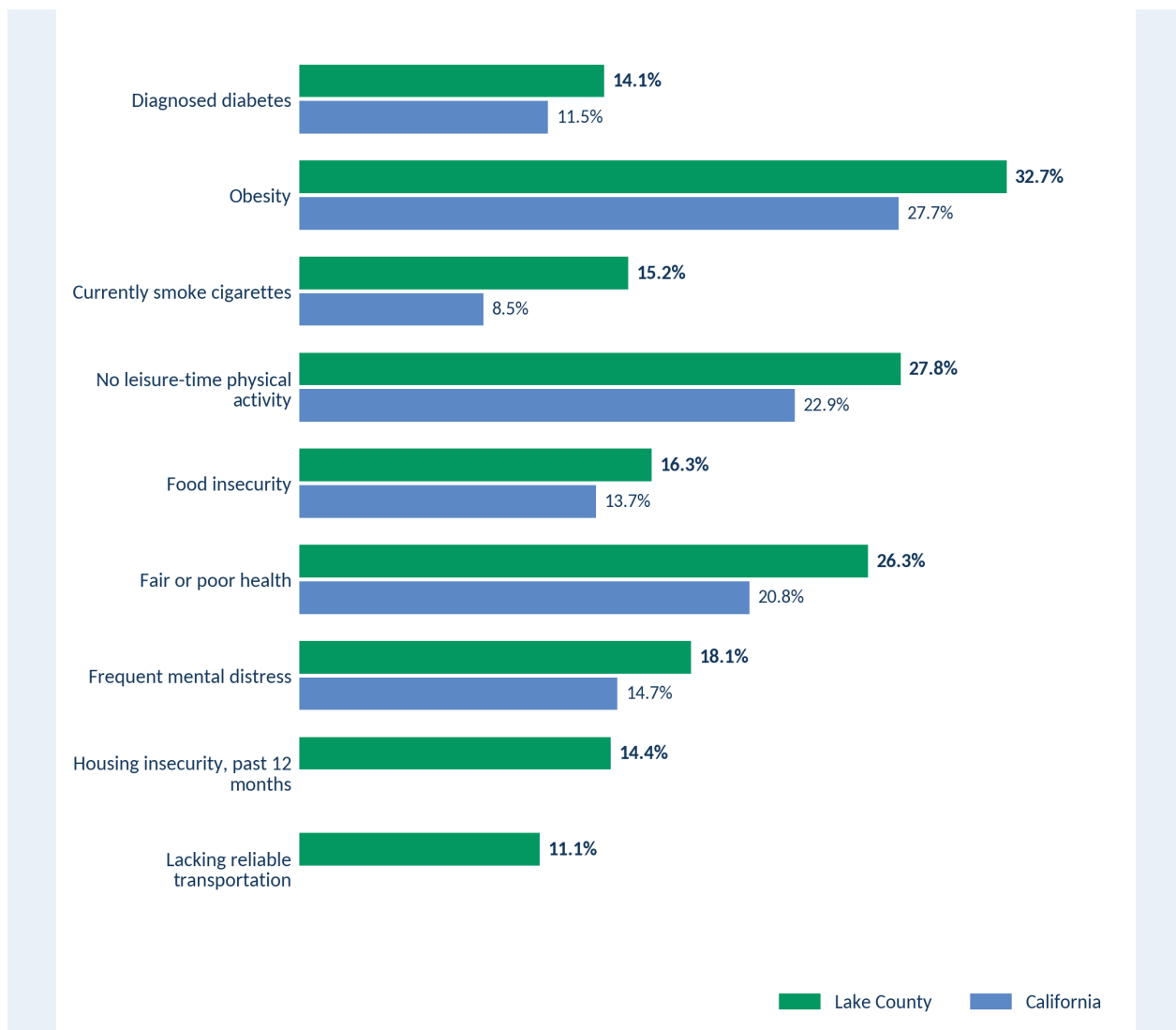
Published county-level data on cardiovascular conditions among American Indian and Alaska Native residents is limited, and statewide data provide the available context. Among American Indian and Alaska Native adults in California, one in four (25%) reports hypertension and a further 9% reports borderline or pre-hypertension, for 34% with elevated blood pressure; 6% reports heart disease and 12% reports diabetes.⁹ Nearly one in three (32%) live with at least one of these three conditions.⁹ These are California figures, not Lake County figures, and closing that gap is part of the collaborative's data work with Tribal partners.

Table 2. Cardiovascular mortality and prevalence, Lake County and California

Measure	Lake County	California	Source, year
Coronary heart disease deaths per 100,000, age-adjusted	119.5	72.2	County Health Status Profiles 2025, 2021 to 2023 ⁴
Heart disease deaths per 100,000 adults 35 and older, age-adjusted	325.7	265.8	CDC Interactive Atlas, 2022 to 2024 ⁵
Heart disease deaths per 100,000 adults 35 and older, Hispanic or Latino	185.9	216.2	CDC Interactive Atlas, 2022 to 2024 ⁵
Heart disease deaths per 100,000 adults 35 and older, American Indian or Alaska Native	297.9	277.5	CDC Interactive Atlas, 2022 to 2024 ⁵
Heart disease deaths per 100,000 adults 35 and older, White	337.7	308.0	CDC Interactive Atlas, 2022 to 2024 ⁵
Stroke deaths per 100,000 adults 35 and older, age-adjusted	67.2	75.1	CDC Interactive Atlas, 2022 to 2024 ⁵
Adults told they have high blood pressure	39.6%	30.6%	CDC PLACES and BRFSS, 2023 ^{6,7}
Adults with high blood pressure taking medicine for it	76.1%	Not published	CDC PLACES, 2023 ⁶
Adults with diagnosed coronary heart disease	8.9%	3.0%	CDC PLACES and BRFSS, 2023 ^{6,7}
Adults who have had a stroke	4.7%	2.9%	CDC PLACES and BRFSS, 2023 ^{6,7}
Screened adults with high cholesterol	38.9%	37.0%	CDC PLACES and BRFSS, 2023 ^{6,7}

Measure	Lake County	California	Source, year
Hypertension among American Indian and Alaska Native adults	Not published	25%	CHIS 2020 to 2024 ⁹
Heart disease among American Indian and Alaska Native adults	Not published	6%	CHIS 2020 to 2024 ⁹

Figure 5. Cardiometabolic and structural conditions, percent, Lake County and California, 2023



Sources: CDC PLACES⁶; BRFSS California⁷; Feeding America Map the Meal Gap 2025⁸

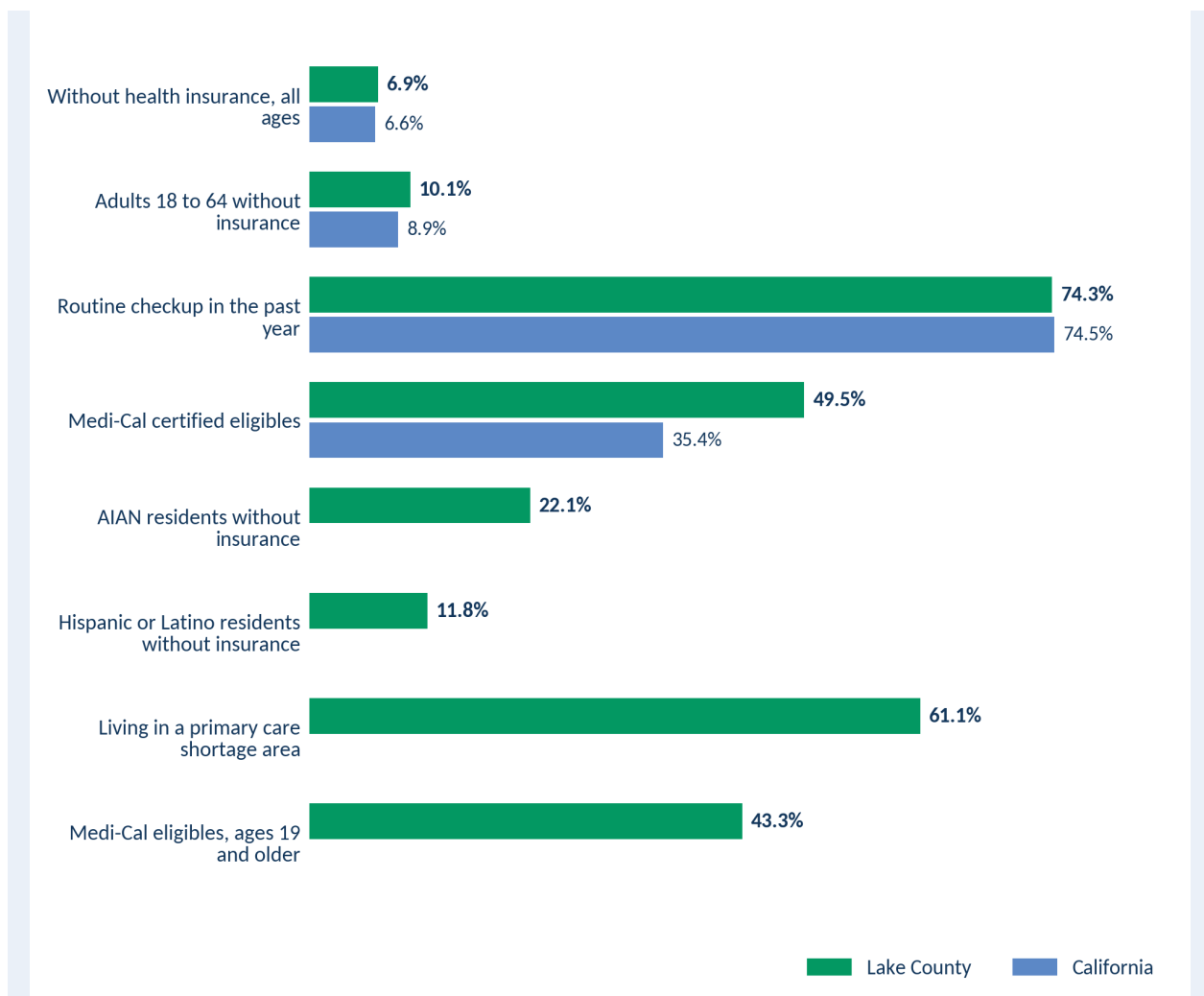
3.3 The Care Landscape

Lake County residents have a care system to build on. Adventist Health Clear Lake, in Clearlake, is the collaborative's clinical partner and operates the hospital, family medicine and primary care clinics in Clearlake and Kelseyville, the Hope Center, Restoration House, and a mobile shower trailer that together reach residents connected to primary care and residents reached through street medicine and services for people experiencing homelessness. Sutter Lakeside Hospital, in Lakeport, is the county's second hospital. Lake County Tribal Health serves Tribal members and the wider community as a culturally aligned entry point to care, and community health workers, community health representatives, promotores and promotoras, and family advocates carry residents through the care pathway. Partnership HealthPlan of California administers Medi-Cal managed care in the county.

The system operates within a rural workforce shortage. An estimated 41,623 residents, 61.1% of the county population, live in a primary care Health Professional Shortage Area.¹⁰ Coverage is broad but not universal: 6.9% of residents have no health insurance, compared with 6.6% statewide, and among adults 18 to 64 the percent without insurance is 10.1%, compared with 8.9% statewide.^{1,6,7} The uninsured share is higher among American Indian or Alaska Native residents (22.1%) and Hispanic or Latino residents (11.8%).¹ Three in four adults (74.3%) had a routine checkup in the past year, the same share as California adults (74.5%).^{6,7} Figure 6 and Table 3 present the access measures.

Adventist Health Clear Lake's 2025 Community Health Needs Assessment identified eight significant health needs in its service area and selected three, education, housing, and social and economic context, for its 2026 implementation strategy; access to care, climate and natural environment, community safety, financial stability, and mental health were identified and not selected.¹¹ The conditions named in that assessment, and the county figures in this section, describe the environment in which heart-related care is delivered. They are county conditions, not community deficits, and the findings in Section 5 show how residents and providers work within them.

Figure 6. Access to care, percent, Lake County and California



Sources: ACS 2020 to 2024¹; CDC PLACES⁶; BRFSS California⁷; DHCS, January 2026³

Table 3. Access to care, Lake County and California

Measure	Lake County	California	Source, year
Residents living in a primary care Health Professional Shortage Area	61.1% (41,623)	Not published	HRSA via Adventist Health CHNA platform, 2026 ¹⁰
Residents without health insurance, all ages	6.9%	6.6%	ACS 2020 to 2024 ¹
Adults 18 to 64 without health insurance	10.1%	8.9%	CDC PLACES and BRFSS, 2023 ^{6,7}

Measure	Lake County	California	Source, year
American Indian or Alaska Native residents without health insurance	22.1%	Not published	ACS 2020 to 2024 ¹
Hispanic or Latino residents without health insurance	11.8%	Not published	ACS 2020 to 2024 ¹
Adults with a routine checkup in the past year	74.3%	74.5%	CDC PLACES and BRFSS, 2023 ^{6,7}
Medi-Cal certified eligibles, ages 19 and older	43.3% (22,081)	Not published	DHCS, January 2026 ³

The figures in this section describe Lake County as the published record shows it: an older, rural county where half of residents rely on Medi-Cal, where coronary heart disease takes lives at the highest reliable rate in California, and where the conditions that drive heart disease, from diabetes and high blood pressure to food insecurity and transportation, are present at levels above the state's. These figures provide important context, but they do not capture how heart-related care is experienced: where residents first turn when they have a symptom, what happens to a referral once it is made, which relationships and programs carry people through the pathway, and what community members and providers believe needs to change. Those answers come from the people of Lake County. Section 4 describes how the collaborative listened, through two surveys, interviews, and group discussions, and Section 5 presents what was heard.

4. How We Listened

This assessment anchors Heart-to-Heart's first year. The program committed Year 1 to understanding Lake County's cardiac care landscape in depth: mapping the resources available for heart-related care, tracing how community members move from initial concern through screening, diagnosis, specialty care, and follow-up, identifying gaps in access and delays in referral, and assessing the conditions that shape whether care is reachable and complete, including transportation, housing, language access, and insurance. The assessment establishes what the county's care system does well, where it breaks down, and what community members and providers prioritize for improvement. Its findings directly inform the program's design: the cardiac care

pathway, community health worker training and integration, referral protocols, and the priorities the collaborative carries into implementation.

Data Sources

The assessment draws on four sources of evidence gathered between May and August 2026. Two surveys established the breadth of experience across the county: one completed by community members who use health care services in Lake County or the surrounding area, and one completed by the providers, care coordinators, community health workers, and partner organization staff who deliver and support that care. Interviews and group discussions added depth, giving participants space to describe how care unfolds in practice and why the patterns in the survey data occur. Existing county data situates both within the population and health conditions of Lake County as a whole. Together, these sources describe heart-related care from the vantage points of the people who receive it, the people who provide it, and the county conditions that shape both. Table 4 summarizes each source.

Table 4. Data sources

Source	Who participated	How data were collected	Period	Total
Community member survey	Adults 18 and over who use health care services in Lake County or the surrounding area	Electronic and paper, English and Spanish, at community events and partner sites across the county; 8 completed in Spanish	June to August 2026	120
Provider survey	Providers, care coordinators, community health workers and representatives, promotores and promotoras, and partner organization staff serving Lake County	Electronic	May to July 2026	44 responded, 38 completed

Source	Who participated	How data were collected	Period	Total
Interviews and group discussions	Five provider audiences	Virtual sessions, 60 to 90 minutes, recorded with permission and transcribed	June to August 2026	11 interviews, 1 group discussion, 18 participants
County data	Lake County and California population, health, and health care indicators	Published sources, values reported as published	Most recent available year	11 sources

County indicators come from the American Community Survey, CDC PLACES and the Behavioral Risk Factor Surveillance System, the California Department of Public Health County Health Status Profiles, the CDC Interactive Atlas of Heart Disease and Stroke, the California Department of Health Care Services, Feeding America, the California Health Interview Survey, and the Adventist Health Clear Lake Community Health Needs Assessment. Lake County and California values appear side by side when both are available from the source. Results from these indicators appear in Section 3.

Sampling and Recruitment

Community member survey collection combined countywide reach with purposive sampling at sites serving populations central to the program’s focus. Community health workers supported collection at community events and public sites across Lake County, partner organizations shared the survey link and QR code through their networks, and the team sampled purposively at Adventist Health Clear Lake, Adventist Health Kelseyville, Adventist Health Hope Center, Adventist Health Restoration House, and the Adventist Health mobile shower trailer. This approach reached community members connected to primary care and hospital services alongside those reached through street medicine and services for people experiencing homelessness, a population this assessment identifies as carrying distinct cardiac burden.

The provider survey and the interviews and group discussions used purposive sampling across five provider audiences and partner organizations, selected to represent the range of roles involved in heart-related care in Lake County: community

health workers, direct clinical providers, service providers, Tribal health providers, and system leaders and planners. Partner organizations supported recruitment within each audience.

Instrument Development

The collaborative developed four sets of instruments for this assessment: a community member survey, a provider survey, and interview and group discussion guides for each participant audience. All four were built around the six assessment domains so that findings from different sources could be compared against a common structure.

The two surveys were designed as companions. Each covers the same domains from its respondent's vantage point, and several items are deliberately matched: where community members were asked what happened with a referral they received, providers were asked what commonly happens to the referrals they initiate, and both were asked parallel questions about coordination, communication, and trust. This design allows the assessment to compare how the same aspects of the care system are experienced by those receiving care and those providing it. Surveys combined closed-ended questions, agreement scales, and open-ended questions inviting participants to describe experiences in their own words.

The interview and group discussion guides followed the same six domains while adapting to each audience's role in heart-related care, so that community health workers, direct clinical providers, service providers, Tribal health providers, system leaders and planners, and community members were each asked about the parts of the care pathway they know firsthand. Partner organizations reviewed the instruments during development, and community member instruments were produced in English and Spanish.

The Public Health Institute Institutional Review Board reviewed and approved the assessment protocol and all instruments before data collection began.

Respondent Inclusion

A single inclusion rule was applied to both surveys so that the two remain comparable. Partial responses were retained where a respondent answered at least one substantive

question, since a respondent who answered about referrals and barriers before stopping contributed real evidence to those questions.

Table 5. Survey inclusion criteria

Survey	Included	Excluded
Community member survey	Respondents who met eligibility criteria, provided consent, and answered at least one substantive question	Respondents who did not meet eligibility criteria or did not provide consent
Provider survey	Respondents who met eligibility criteria and answered at least one substantive question	Respondents who did not meet eligibility criteria or answered no substantive questions

Because respondents skipped individual questions, every result reports the number answering that specific item rather than the survey total.

Assessment Domains

Six domains organize this assessment. They were developed to follow the course of heart-related care, from the conditions and burden present in the community, through the pathway community members travel to reach care, to the coordination that pathway depends on, the barriers that interrupt it, the assets that sustain it, and the improvements participants prioritize. The same six domains shaped the survey instruments and the interview and group discussion guides, organized the summaries prepared from each session, and structured the findings in Section 5, which allows evidence from different sources to be compared against a common frame.

Table 6. Assessment domains

Domain	What it covers	What we asked about
Population Context and Cardiac Burden	Who is affected by heart-related conditions in Lake County, which conditions and comorbidities are most common, and how burden concentrates	Heart-related conditions community members live with or care for; comorbidities including diabetes, hypertension, and substance use; which groups providers see carrying the greatest burden; how burden differs across the county
Care Pathway and Service Flow	How community members move from initial concern through screening, diagnosis, specialty care, and follow-up	Where people go first with a heart concern; how referrals are initiated and what happens to them; wait times from referral to specialty care; what happens

Domain	What it covers	What we asked about
		after a visit or hospitalization; where people fall out of the pathway
Coordination and Communication	How information moves across providers and organizations, and how care is coordinated across systems	Whether records and results are visible across organizations; how referrals are confirmed and tracked; how providers communicate with each other and with community members; handoffs between clinical and community services; whether people receive consistent guidance
Access Barriers	Structural, cultural, and practical conditions that interrupt access to heart-related care	Transportation, distance, and appointment availability; cost and insurance; language access and interpretation; trust in providers and the health system; housing instability; competing demands and time; stress and discouragement navigating the health system
Assets and What Works	Programs, roles, relationships, and resources that support heart-related care today	Where people go when they need help navigating care; the role of community health workers, representatives, and family; trusted clinics and programs; transportation and support services already available; what providers say works well
Improvement Priorities	Changes community members and providers identify as most needed	What would most improve heart-related care; what would make referrals more reliable; what supports are missing; what providers need to serve community members well

Analysis

Analysis was descriptive throughout. The assessment reports what community members and providers described rather than testing statistical relationships. This choice follows from how participants were reached and from the size of each group. These results characterize the people who participated, and descriptive reporting represents them accurately without implying precision the design does not support.

The two surveys were analyzed separately. Community members and providers responded to different instruments about different vantage points on the same care system, and combining them would obscure the comparison the instruments were built to enable. Findings from each survey are reported on their own terms, then set side by side where the mirrored items allow. Table 7 states the approach and reporting conventions applied to each source.

Table 7. Analysis approach

Source	Approach	Reporting conventions
Surveys	Descriptive statistics, analyzed separately for each survey	Agreement items reported as the share of respondents who agree; results for American Indian or Alaska Native and Hispanic or Latino respondents shown alongside the overall figure where at least ten answered the item; provider results reported at three tiers (Community Health Workforce; Clinical and Care Team; System Leaders and Planners) where at least ten answered, with Tribal-setting providers described in words; counts of five or fewer not reported
Interviews and group discussions	Structured summary of each session organized by the six domains, capturing what participants described alongside direct quotes; summaries compared across audiences	Findings attributed to the audience that described them
County data	Existing published indicators, county-level and most recent available	Values reported as published, with source and year; each source numbered at first appearance and listed in the References

Participation and Protections

Participation in every part of this assessment was voluntary, and participants provided informed consent before taking part. Survey responses and session recordings were collected and stored confidentially, and results are reported so that no individual participant can be identified. When the number of respondents in a group is small enough that reporting a specific figure could identify an individual, the figure is suppressed and the pattern described in words instead. Community members who participated received an appreciation for their time and knowledge.

What This Assessment Can and Cannot Tell Us

Community members and providers were reached through community events, partner sites, and direct outreach rather than random selection. The findings describe the

experiences of those who participated and are evidence of what people encounter in Lake County, not estimates of countywide rates. The provider survey reflects a smaller group, and those findings represent the perspective of the providers and partner staff who responded. Survey responses and interview accounts describe participants' own experience and observation of the care system.

Published county-level data on heart health among American Indian and Alaska Native residents is limited to mortality. County estimates of hypertension, heart disease, and diabetes prevalence among American Indian and Alaska Native adults are not published, so statewide estimates are used and labeled as such, and closing that gap is part of the collaborative's ongoing data work with Tribal partners.

These conditions define how the findings are read. Four separate sources, gathered from different people by different methods, converge on a consistent account of how heart-related care works in Lake County, and that convergence is the basis for confidence in the patterns this assessment identifies.

5. What We Heard: Findings by Domain

This section presents what community members and providers described, organized by the six assessment domains. Each domain opens with what it covers and names the strengths that exist before identifying the gaps. Findings draw from four sources: the community member survey (120 respondents) and provider survey (44 respondents), which show how widely an experience is shared; eleven interviews and one group discussion with community health workers, direct clinical providers, service providers, Tribal health providers, and system leaders and planners, which provide insight into how and why those experiences occur; and the county data in Section 3, which provides additional context on the scale of a finding. Survey results report the number answering each item. Where fewer than six respondents chose an answer, the pattern is described in words. Results for American Indian or Alaska Native respondents (20) and Hispanic or Latino respondents (22) appear alongside the overall figure where at least ten answered. Quotations are attributed to the audience that spoke, and participants are not named.

5.1 Population Context and Cardiac Burden

This domain covers who is affected by heart conditions in Lake County, which conditions and comorbidities are most common, and where burden concentrates.

Heart-related care is a present concern for most people who took the survey. Two in three community member respondents (68% of 119) said that they or someone they know needed heart-related care in the past 12 months; 30% currently receive care for a heart condition, 26% have received it in the past, and 26% help a family member with heart-related needs (of 119). Three in five (59%, of 120) are covered by Partnership HealthPlan or Medi-Cal, and one in five (21%) by Medicare. The respondents live with the county burden that Section 3 describes: the highest reliable coronary heart disease death rate among California counties (119.5 per 100,000, against 72.2 statewide) and high blood pressure among two in five adults (39.6%).^{4,6} Table 8 presents the survey profile.

Providers describe three populations carrying burden in distinct ways, and their accounts match the county figures for diabetes (14.1% of adults), food insecurity (16.3% of residents), and homelessness (604 people counted in January 2024).^{6,8,2} Among community members experiencing homelessness, direct clinical providers and community health workers describe congestive heart failure in a younger population, driven by substance use rather than by coronary disease, with severity high enough that people leave the hospital with instructions to see cardiology within days. Among American Indian and Alaska Native community members, Tribal health providers name diabetes and hypertension as the dominant drivers, with chronic stress and the effects of generational trauma underneath both. Among Hispanic or Latino community members, service providers describe high blood pressure and diabetes that go undiagnosed until an emergency room visit, because many adults have no primary care provider, no full-scope coverage, or a habit of seeking care only when very sick. Across all three populations, providers describe food access and cost, housing, and poverty as the conditions that produce the burden.

“I did not realize it, being hospital-based, but coming out into the community, how prevalent the heart disease is, and harder to access care. So we have a large portion of our people that come here that have congestive heart failure, a lot of it is substance use.” - Direct clinical provider

"...60% of our Native American patients probably have diabetes, but about 80% of our CHR patients, our community health reps patients have diabetes, and they're directly linked and related to, you know, all those heart-related symptoms." -Tribal health provider

"If you don't have insurance, you really don't go to the doctor. And when you do go, it's usually an emergency room, and you're still not getting your needs for it as far as your health goes." -Community health worker

"If you walk into Safeway right now to buy, let's say, a lettuce, a head of lettuce or a head of cabbage, it's going to cost you between three and \$5 ... it's hard to eat healthy when you can't afford to." -Service provider

"...there's more demand for housing than there is houses to have so that really leads to that pressure of, you know, stress, right, physical stress, and not being housed, but also the ability to have some place to recover, should you have a cardiac episode, or be obese, or that have the ability to cook yourself a decent meal, rather than, you know, buying something from the fast food restaurant" -Service provider

Providers also describe other health conditions and needs that can affect heart health, including substance use and dental health among people experiencing homelessness, unaddressed mental health needs among older Hispanic or Latino residents, and sleep apnea and family history among Tribal community members. A system leader described the county's health as poor across the board rather than specific to cardiac health and connected these challenges to generational poverty. That framing reflects the broader context presented in Section 3: Lake County's income, poverty, and food insecurity measures differ substantially from statewide figures and provide important context for understanding the county's cardiac health burden.

Table 8. Community survey respondents and their relationship to heart-related care

Item	Response	n	Percent
Needed heart-related care in the past 12 months, self or someone known (119)	Yes	81	68%
Relationship to heart-related care, select all (119)	Currently get care for a heart-related condition	36	30%
	Received heart-related care in the past	31	26%

Item	Response	n	Percent
	Care for or help a family member with heart-related needs	31	26%
	None of the above	36	30%
Health insurance, select all (120)	Partnership HealthPlan or Medi-Cal	71	59%
	Health insurance through work	27	22%
	Medicare	25	21%
Race and ethnicity, select all (120)	White	68	57%
	Hispanic or Latino	22	18%
	American Indian or Alaska Native	20	17%
Preferred language for health information, select all (118)	English	107	91%
	Spanish	17	14%
Area of Lake County (119)	Clearlake	56	47%
	Lakeport	19	16%
	Kelseyville	14	12%

5.2 Care Pathway and Service Flow

This domain covers how community members move from an initial health concern through screening, diagnosis, specialty care, and follow-up, and where the sequence breaks.

The pathway has parts that work. Community members who needed heart-related care most often went to a primary care clinic (33% of 114), a cardiologist (32%), or the emergency room (27%); one in five went to a Tribal health program or clinic (18%). Three in five (61% of 118) were referred for heart-related care, testing, or a specialist visit in the past year, and among those referred, seven in ten (71% of 70) completed the visit or test. Direct clinical providers report that once a patient is established with cardiology, echocardiograms, stress tests, and other diagnostic testing are typically completed within the month. Tribal health providers describe a referral pathway with a

48-hour follow-up standard for community members enrolled with a community health representative, who then transports and attends every heart-related visit and briefs the provider before the next one. Adventist Health's rapid care offers a primary care visit within a week or two, and staff at recuperative care and behavioral health programs chase referrals by phone when a callback does not arrive.

"Once the CHRs are tasked with, you know, this patient, we have 48 hours to follow up with care, and so we'll go out to the patient's home, and we begin our in developing our communication with them at that standpoint." Tribal health provider

The pathway breaks at four points, and providers across every audience name the same four. The first is entry: establishing care with a primary care provider takes months for someone who has not seen a provider in years, and a person cannot be referred to cardiology without one. Community health workers described an instance in which a caller seeking care in early August was offered the clinic's first available appointment in December. The second is the callback: after a referral is placed, the cardiology office calls the patient to schedule, and people without a working phone, a stable number, or a voicemail box never receive the call. The third is the wait: direct clinical providers describe one to two months to a first cardiology visit even when the hospital has asked for follow-up in seven to ten days, and Tribal health providers describe two to three weeks even for urgent appointments. The fourth is the reschedule cascade: a provider cancellation or a missed ride pushes the next appointment out by months, and each rescheduled visit is another chance for the person to fall out. Tribal health providers add a fifth break specific to referrals that leave the Tribal system: faxed referrals reported as not received, with no confirmation loop, and referral paperwork that routes patients to a hospital main line that does not book cardiology.

"...getting in to see a cardiologist for the first time, we're talking, you know, a month or two out, even if they've been hospitalized, and the hospital is saying, hey, you need to see a cardiologist in the next, you know, seven to 10 days." Direct clinical provider

"The appointments are so far out that these people's minds are no longer thinking about it the time that appointment gets here, and we're talking

months. Some of these people are waiting months just to initiate a doctor's appointment.” Community health worker

“I waited a few days, called Adventist Health back again, they said they hadn't received it [a referral], so they would have to make me an appointment. That appointment with the cardiologist wasn't going to be until September 22 [about three months out from time of the interview].”

Tribal health provider

For Hispanic or Latino community members without coverage, service providers describe a pathway that begins and ends in the emergency room: a high A1c or blood pressure reading is found there, and after discharge there is no primary care provider to follow up with, no affordable medication, and no route to specialty care. For community members experiencing homelessness, community health workers describe the pathway breaking before it starts, when coverage lapses because a renewal notice never reached a person without an address. When cardiac needs exceed what the county's two emergency departments can hold, patients are flown out; service providers and system leaders describe transfers to Santa Rosa, St. Helena, Napa, UC Davis, and, for children, UCSF, and note that each transfer out of county lowers the share of people who complete the care they were sent for.

The survey shows the same picture from both sides. Among community members referred in the past year, 14% had scheduled but not yet gone and 10% had tried and could not get an appointment. Among providers, half (51% of 39) could not say what most commonly happens to a cardiac referral; of those who could, the most common answers were that referrals are scheduled but delayed by availability (21%) or not completed because of transportation or logistics (18%). Two in five providers (42% of 40) did not know how referral status is tracked in their workflow, and 22% named EHR referral tracking tools. Table 9 presents the referral items from both surveys.

Table 9. Referral experience, community members and providers

Survey	Item	Response	n	Percent
Community	Where you or someone you know went for heart-related care or questions, past 12 months, select all (114)	Primary care clinic	38	33%
		Heart specialist (cardiology)	37	32%

Survey	Item	Response	n	Percent
		Emergency room	31	27%
		Tribal health program or clinic	20	18%
		Have not gotten care	19	17%
		Urgent care	16	14%
Community	Referred for heart-related care, testing, or a specialist in the past 12 months (118)	Yes	72	61%
Community	What happened with the referral (70)	Completed the visit or test	50	71%
		Scheduled, not yet gone	10	14%
		Tried to schedule, could not get an appointment	7	10%
Provider	What most commonly happens when a cardiac referral is placed (39)	Not sure or varies widely	20	51%
		Scheduled but delayed by availability	8	21%
		Not completed because of transportation or logistics	7	18%
Provider	Services most difficult to access in a timely way, select all (40)	Not sure	25	62%
		Cardiology consult or visit	8	20%
		Follow-up after abnormal findings	7	18%
		Medication management follow-up	6	15%
Provider	How referral status is tracked, select all (40)	Not sure	17	42%
		EHR referral tracking tools	9	22%

5.3 Coordination and Communication

This domain covers how information moves across providers and organizations, whether records are visible, how people communicate, and where coordination breaks down.

Coordination in Lake County runs on relationships, and the relationships work. Every provider audience named the warm handoff, a phone call from one known person to another with the patient present, as the practice that gets people through. Service providers described a county behavioral health referral link with a defined intake and response, standing meetings twice a month across health entities, a reentry collaborative of about a dozen organizations meeting monthly, and substance use navigators in both emergency departments. Community health workers at Adventist Health can see orders and scheduled appointments in the chart, call a provider's office with the client on the line, and locate people in person through two shelters, a shower trailer, and an outreach team when phones fail. Tribal health providers described unusually close access to their own clinicians and an electronic health record that now pulls outside CTs, MRIs, and cardiac biomarkers through a special access code. In the provider survey, the mechanisms named most often as supporting coordination were care coordinators, community health workers, and navigators (32%, of 37), direct provider-to-provider communication (32%), referral coordinators and schedulers (27%), and shared EHR access (24%).

"...the way that is most effective is just person to person handoff. I mean, of course, we have communications such as forms, referrals, things of that nature. ... People get lost in the paperwork. People get lost in the shuffle."

Community health worker

What does not work is the system around those relationships. Direct clinical providers named communication as the most fragile element of the whole pathway and cross-system record visibility as the largest gap: staff at Adventist Health programs cannot see Sutter or Tribal health records, so they do not know whether a referral was made, where it sits, or whether an appointment exists unless the resident tells them, and even within Adventist Health some specialty appointments are not visible. Telephone remains the primary channel, EHR messaging is underused, and fax and mail are still standard for referrals. Providers often do not know that a patient already has a community health worker or is enrolled in community supports, so they do not ask for help reaching a hard-to-contact patient. Tribal health providers described referrals

that stall because they lack specificity, authorizations that wait on provider sign-off, consultation notes that cannot be located, and specialty offices that rebook appointments with the patient without telling the community health representative who arranged transport. A Tribal health partner described cross-sector meetings held at the executive level that have not changed how frontline schedulers and referral coordinators work, and system leaders described three health systems that coordinate at a high level while competing for patients and that refer out of county when it serves a network rather than a patient.

"A significant amount of our residents are Sutter patients or Tribal health patients, so we can't see their records at all. So, when they're there, we don't know, unless the resident tells us. We don't know that a referral has been made, or where we are in that process, or if they have an appointment somewhere, or any of that. There's no countywide communication..." Direct clinical provider

"...maybe the provider doesn't realize they're working with a CHW or that they're working with community supports, and they could reach out to our team and say, hey, you know, this person needs an appointment. How can we work together?" Community health worker

"Easy line communication...if we have one person over here, one person over there that continuously talk back and forth, I think there would be a lot of the waiting and miscommunication and missed referrals and things that wouldn't happen." Tribal health provider

The two surveys show how differently the same system looks from each side. Half of community members agree that different parts of the health care system communicate well (50% of 117) and that care is well connected across clinics, providers, and programs (53%). Provider responses point to gaps in communication and coordination across services. Of 37 providers, five or fewer agreed that communication between referring and receiving services is timely and sufficient, that results and next steps are communicated back to the referring setting, that patients receive consistent guidance as they move between systems, or that care feels coordinated overall. In addition, 22% agreed that referral pathways are clear within their setting. Community members judge the system by whether their own care came together, which it often did through a person who chased it. Providers judge it by whether the system would have come together without that person, and they say it would not. For Hispanic or Latino

community members, service providers add a communication gap inside the visit: phone interpreter lines make rapport hard to build, letters and instructions arrive in English, and a healthcare worker or staff member who is bilingual and bicultural is understood where a translation line is not. Table 10 presents the paired items.

Table 10. Coordination and communication, paired survey items (percent agree)

Aspect	Community members (of 117)	Providers (of 37)
Referral clarity	Referrals for heart-related care are clear and easy to follow: 53% (of 116)	Referral pathways for cardiac-related care are clear in my setting: 22%
Cross-system communication	Different parts of the health care system communicate well with each other: 50%	Communication between referring and receiving services is timely and sufficient: fewer than six agree
Results return	Not asked	Results and recommended next steps are consistently returned to the referring setting: fewer than six agree
Consistent guidance	Care is well connected across clinics, providers, or programs: 53%	Patients receive consistent guidance when moving between clinics, programs, or systems: fewer than six agree
Coordination overall	Not asked	Overall, care feels coordinated across clinics, providers, or programs: fewer than six agree
Mechanisms supporting coordination (providers, select all, of 37)	Not asked	Care coordinators, CHWs, navigators 32%; direct provider-to-provider communication 32%; referral coordinators and schedulers 27%; shared EHR access 24%; case conferences 19%; not sure 41%

5.4 Access Barriers

This domain covers the structural, cultural, and practical conditions that interrupt access to heart-related care.

The barriers community members and providers name are conditions of the county and its care system, and the two groups name the same ones in the same order. For community members, the most common things that made heart-related care harder were transportation (35% of 117), difficulty getting appointments or long waits (34%), and cost or insurance problems (23%), followed by stress or discouragement (19%),

lack of trust or bad past experiences (19%), feeling overwhelmed by appointments and next steps (17%), unclear referral steps (14%), and language or communication problems (12%). One in five (21%) reported none of these. Providers identified limited specialty capacity (58% of 38 respondents), geographic distance between patients and services (47%), transportation infrastructure (45%), and limited after-hours options (29%) as the factors that most limit timely cardiac care. Among 39 providers, the most commonly reported reasons for incomplete referrals were transportation barriers (44%), appointment availability (36%), patients feeling overwhelmed (31%), and difficulty reaching patients (26%). Table 11 sets the two lists side by side.

Transportation is the barrier that runs through every interview. Lake County is about 111 miles around; the two hospitals with emergency rooms sit at opposite ends of the lake, cardiology and most specialty care sit outside the county, and public transit runs two or three times a day on routes that do not align with appointment times. Service providers described a trip from Nice to Clearlake that takes 25 minutes by car and two hours by bus, a taxi from Clearlake to Lakeport at \$60, and people stranded out of county when a return ride falls through. The Medi-Cal transportation benefit exists and is used, and providers describe its limits precisely: rides must be booked five days ahead, the confirmation call often does not come, drivers arrive about 70% of the time, and there is no consequence when they do not. In the county as a whole, 11.1% of adults lacked reliable transportation in the past year.⁶

"...they have to rely on partnership rides to get them there, and they show up 70% of the time; they are better. I used to say 50, but now there may be 70% of the time that partnership rides shows up, but if you're waiting for that cardiac appointment for the last three months, and they don't show up on that day, it's a huge deal." Direct clinical provider

"if your appointment is early in the morning and that route doesn't go that time, then you can't get to the appointment...or if it's a later appointment and then that route doesn't go anymore, then you are stuck there and you can't get home." Service provider

Workforce and capacity are the second structural barrier. Three in five residents live in a primary care Health Professional Shortage Area,¹⁰ and every audience described provider turnover as its own barrier: each departure forces a patient to establish care again, retell a history, and often repeat labs and imaging, and system leaders

described a health system with an appointment cancellation and no-show rate above 40%. Service providers tied retention to housing, noting that more than three-quarters of the county has burned since 2015 and that physicians who are recruited cannot find a place to live. Cost and coverage form the third: 6.9% of residents and 10.1% of adults 18 to 64 have no insurance, and the uninsured share is 22.1% among American Indian or Alaska Native residents and 11.8% among Hispanic or Latino residents.^{1,6} Community health workers described a wave of coverage loss in recent months among people whose renewal notices never arrived, and service providers described the cycle that follows an air transfer: a helicopter bill of \$30,000 to \$60,000, damaged credit, and a lost chance at affordable housing.

"...it is hard to get in into our facilities in our county because a lot of our doctors also leave. So you establish with one doctor, and then all of a sudden that doctor doesn't like to live in Lake County anymore, and then they leave, and so then you have a new doctor to establish." Community health worker

"But for the most part, cardiac related needs, I would say that just in general, just the finding even just a primary doctor just to find out what your health is. You know that's kind of one of the bigger things" Community health worker

"...trying to retain and maintain and acquire doctors and physicians is hard, right. It's a, it's a never-ending cycle door of doctors and physicians, because a, it's remote, b, it takes a special type of person to want to live up in this type of area, and then they have to have housing, so it's not even the low to moderate income housing, it's the workforce housing that then is not available for multitudes of reasons..." - Service provider

Cultural and trust barriers differ by population, and providers described each in their own terms. For American Indian and Alaska Native community members, Tribal health providers described a sharp drop in culturally responsive care once a person leaves the Tribal system: providers outside it who do not know the community, poor bedside manner, and clinical language that lands as a threat. One Tribal health provider described intentionally avoiding the term "non-compliant" because of its association with probation and parole, where it can signal a violation. The provider noted that this language can cause patients to disengage from conversations about their care. For Hispanic or Latino community members, service providers described language as the first barrier, phone interpreters as a poor substitute for a bilingual staff member, fear

that enrolling in Medi-Cal or entering a hospital will expose immigration status, work that cannot be missed, and a cultural pattern of not asking questions or calling back about a referral for fear of being a bother or simply not going to the doctors until it's an emergency. Service providers also described being made to feel unwelcome or humiliated when asking a question, comments about where a person lives, and demographic forms with no Hispanic or Latino category. For community members experiencing homelessness, direct clinical providers described an unhoused culture distinct from race or ethnicity, marked by disengagement from the medical system and difficulty understanding clinical communication, and the attribution of cardiac symptoms such as fatigue and shortness of breath to sleeping outside.

"the first thing that they tell you when you go to, you know, probation or parole is you're non-compliant, so we're violating, and so it triggers something, and your patients start to shut down so I use non-adhering." Tribal health provider

"I think when they go to the doctor a lot of people have that mentality that it's just like we're just going to be told what to do, and I can't ask questions... it's almost like they're feeling like they're going to get reprimanded or in trouble" Service provider

"And I think that as a culture, we tend not to go to the doctors as much here because we don't want to know. We don't want to know what's wrong." Service provider

"Okay, you just told me my heart's bad, and if I don't do something about it, I'm gonna die, but I'm sleeping outside in the bush, you know, I see that all the time, all the time, we have people that sleep in behind our building in the fields" Service provider

"...a lot of our Latino community is undocumented, and so they don't have Medicaid [Medi-Cal] and they don't have access to insurance... They just don't go to the doctor because they can't or they think they can't. Or when it's too late, and now they're in the emergency room, and you know those bills are horrendous. And then that's when they discover, you know, maybe they've got diabetes or you know high blood pressure, and now it's like, well, how do I follow up if I don't have insurance? Who do I go see if I don't have insurance? And yeah, a little different when you know in the ER, they have to see you, and it's a little scarier to go to a clinic and be like, I don't have money to pay..." - Service provider

The provider survey confirms trust as a shared concern: 46% (of 37) agree that lack of trust is a meaningful barrier for some patients, and the factors they see most often are prior negative experiences with health care (57%), poor communication or feeling dismissed (54%), perceived disrespect or discrimination (41%), system complexity (38%), and language barriers (35%). Among community members, 64% agree that providers and staff treat people in their community with respect, and 48% agree that heart-related care feels culturally responsive; among Hispanic or Latino respondents, both figures are 45% (of 20). Two knowledge barriers close the domain. Direct clinical providers named education about early cardiac warning signs as a major upstream barrier and observed that women's presentations, with anxiety, nausea, and vague symptoms, are missed more often than the classic pattern. Tribal health providers and service providers described low awareness of the transportation, gas card, sliding scale, and rapid care options that already exist. The food environment is the last condition: service providers described a county where produce costs more than fast food, where a grocery store closing removes the anchor that affordable housing rules require, and where 16.3% of residents and 14.4% of adults experienced food and housing insecurity in the past year.^{8,6}

Table 11. Barriers to heart-related care, community members and providers

Community members: what made care harder, select all (117)	Percent	Providers: constraints and reasons referrals are not completed, select all	Percent
Transportation	35%	Limited specialty capacity (of 38)	58%
Hard to get appointments or long wait times	34%	Geographic distance between services and patients (of 38)	47%
Cost or insurance problems	23%	Transportation infrastructure (of 38)	45%
None of the above	21%	Limited after-hours options (of 38)	29%
Stress, anxiety, or feeling discouraged	19%	Transportation barriers, reason not completed (of 39)	44%
Lack of trust or bad past experiences	19%	Appointment availability or long waits, reason not completed (of 39)	36%
Feeling overwhelmed with appointments or next steps	17%	Patients feel overwhelmed or unsure of next steps (of 39)	31%
Referral steps were not clear	14%	Patients cannot be reached (of 39)	26%

Community members: what made care harder, select all (117)	Percent	Providers: constraints and reasons referrals are not completed, select all	Percent
Language or communication problems	12%	Stress, anxiety, or depression interfere (of 39)	21%
Not knowing where to start	11%	Cost or insurance coverage (of 39)	18%
Hard to get time off work or find childcare	10%	Factors reducing trust: prior negative experiences (of 37)	57%
Problems using technology	9%	Poor communication or feeling dismissed (of 37)	54%
		Perceived disrespect or discrimination (of 37)	41%
		Language barriers (of 37)	35%

5.5 Assets and What Works

This domain covers the programs, roles, relationships, and resources that support heart-related care in Lake County today.

Community members know where to go. Nearly three in four (72% of 118) agree they know where in their community to get help with heart-related care, including 79% of American Indian or Alaska Native respondents (of 19); 65% know who to contact with questions; 64% feel comfortable getting heart-related care when they need it; and 61% describe their experiences with heart-related care as positive overall. When asked what helped them get care or follow through, community members named clinic staff who helped with scheduling and referrals (36% of 112), family and friends (31%), a care coordinator or community health worker or representative (28%), clear written instructions or reminders (21%), and help with transportation (21%). Table 12 presents these items.

The interviews name the assets behind those numbers. The first is the Tribal health system. Lake County Tribal Health Consortium is described by every audience as a trusted, culturally aligned home base: it screens at nearly every community event, retains providers longer than the other systems, offers rides, and, through its community health representative program, delivers a full accompaniment model with a 48-hour home visit, clinical monitoring, transport to and presence in every heart-related visit, a briefing to the provider before the next appointment, and reminder

calls timed for people with dementia. One Tribal health provider described a community member whose A1c fell from about 14 to 6.7 and who returned to managing his own care. Tribal health providers reframe non-adherence as a system failure, propose a behavioral health referral when adherence falters, and deliver trauma-informed training internally to providers first and staff second.

"Their A 1c was like a 14... we got this individual all the way down to like a 6.7 from like a 14, and their medication regimen adherence was through the roof... The individual didn't really necessarily need us anymore because they were able to self manage their care." Tribal health provider

"...if you're starting at Lake County Tribal Health, or if you're at Consolidated or Round Valley, or you know any of these other Tribal health systems, those doctors are with our population day in and day out. They understand our culture and our traditions." Tribal health provider

The second asset is the people who carry residents through the pathway: community health workers, community health representatives, promotores and promotoras, family advocates, patient advocates, substance use navigators, and case managers.

Community health workers at Adventist Health locate people in the field, sit with them while they call a provider's office, arrange shuttles, taxis, and bus passes, and see clients weekly. Service providers described what these roles do that a clinic cannot: they come to a person's home without a badge or a county car, they explain a letter the person could not read, they call ahead of a specialist visit to say what will happen, and they are believed because they have been through the system themselves. Providers across audiences named lived experience as the credential that builds trust, and named the family-centered, multigenerational households of Tribal and Hispanic or Latino communities as an asset that care can be built around.

"Already, people if they see you driving a county car, or if they see you with the badge, right? That's already kind of like a power differential, right? But when you come to their house, that's something different, right? It's like truly caring ... We're going to them. That's true service, right? And I think CHWs do that with their patients." Service provider

"I believe they're [CHWs] the future of healthcare, and they are the, you know, they're the boots on the ground. So, they see what's going on in a home. They see some of the challenges in the home or in the community, so

I think a lot of the navigation of the cardiac care is coming through the CHWs and the case managers...” Community health worker

The third asset is the network of programs and places that meet people where they are. Adventist Health’s Hope Center and Project Restoration provide people experiencing homelessness with a place to recover, Blue Zones-approved meals, enhanced case management, and, for those who qualify, palliative care. A street medicine van staffed by a provider is also preparing to launch, and Mendocino Community Health Centers has begun offering shelter medicine hours. Rapid care options, including a \$35 walk-in visit in Lakeport, provide additional alternatives to the emergency room for non-emergency needs. Service providers named the Lakeview clinic’s sliding fee scale and payment plans, free phone distributions, bus vouchers and ride programs, the neighborhood food pantry network with the county’s monthly pantry list, gleaners, and Simple Gesture, a nonprofit that redirects its own grant funds to fresh produce for food banks and senior centers. Bilingual staff has grown in clinics because bilingual pay is incentivized, and a Latino community organization’s Facebook page and meetings function as a trusted information hub built during COVID-19 vaccination outreach. Community events, from the county fair to pear season in the fields, are where residents who will not attend a formal meeting will stop and talk.

The fourth asset is the county’s strong foundation of collaboration. Providers described regular meetings across health care organizations, a reentry collaborative, a countywide referral link, and cultural competency training already in place. They also highlighted efforts to strengthen the local workforce pipeline, including Adventist Health’s community health worker curriculum at the community college and tuition support for medical assistants and nursing assistants through the Office of Education. The Heart Hub on Sutter’s campus provides another example of this collaboration, offering a training and simulation center for middle and high school students with support from all three health systems. System leaders and community health workers both described a shift toward collaboration across the county as new and real. Blue Zones is credited with lowering smoking; the county’s tobacco retail license is an existing policy foundation. In the words of one community health worker, people across local agencies are already working to address these challenges. This collaborative builds on those existing efforts rather than starting from scratch.

Table 12. What helped community members get care or follow through, select all (112)

Support	n	Percent
Help from clinic staff, such as scheduling or referrals	40	36%
Help from family or friends	35	31%
Help from a care coordinator or community health worker or representative	31	28%
Clear written instructions or reminders	24	21%
Help with transportation	23	21%
No supports available	15	13%
Prefer not to say	12	11%
Support from a community-based or Tribal program	9	8%
Language interpretation or bilingual services	9	8%

5.6 Improvement Priorities

This domain covers the changes community members and providers identified as most needed, and the constraints they named.

The priorities converge. In the provider survey, the supports that would most improve referral completion and follow-up are transportation supports (57% of 35), closed-loop referral tracking with confirmation, status updates, and results return (40%), increased community health worker and navigation capacity (29%), and patient education on what to expect (29%). Asked for the one process Heart-to-Heart should improve, providers split between strengthening coordination between systems (16% of 37) and strengthening navigation and support services (16%), with 30% unsure. Community members' open-text responses ask for more providers and cardiologists in the county and for appointments that come in weeks rather than months. Table 13 presents the provider items.

The interviews turn those priorities into specific asks, and the asks fall into six groups. The first, named first by direct clinical providers and endorsed across audiences, is countywide closed-loop referral tracking: any provider can see that a referral was made, where it sits, and who holds it, regardless of which system placed it. Tribal health providers paired this with a 24-hour response norm for callbacks and emails, a

named point of contact for cardiology referrals in each system, and an appointment date assigned at the time of referral even when the date is far out. Tribal health providers added referral specificity, faster authorization sign-off, reliable availability of consultation notes, and a single scheduling channel or mandatory notification back to the community health representative team.

“...the number one thing is being able to see where we are in the referral process, see that the referral has been made, where is it in the process, and who has gotten the referral, something that could be countywide, not service provider like Tribal or Sutter or Adventist” Direct clinical provider

“...just even getting appointments on the calendar for people and if we could do that in a quicker something way I think that would be beneficial...it's not to say that it's going to be like I'm calling today, and I'm going to have an appointment Monday, but I'm calling today, and I have an appointment on the calendar for some time by Wednesday” Tribal health provider

The second group shortens the cardiology wait. Direct clinical providers proposed that patients have contact with the cardiology office within two weeks of referral. A cardiac-trained nurse, nurse practitioner, or physician assistant could conduct an initial screening and order needed tests so that the diagnostic workup is completed before the cardiology appointment, which may occur six to eight weeks later. During that wait, providers also recommended bridge referrals to services such as a dietitian, social worker, electrophysiologist, physical therapist, dentist, or pharmacist for medication review. System leaders proposed that the three health systems agree on which services each provides locally and refer to one another rather than out of county and visiting specialist arrangements with Santa Rosa or San Francisco once or twice a week.

The third group of recommendations focuses on building the workforce needed to support people throughout their care journey. Providers called for more community health workers and patient advocates, including a community health worker embedded within the cardiac department and more people with lived experience serving as community health workers, promotores, and community health representatives. They also emphasized recruiting more Spanish-speaking staff, including through word-of-mouth outreach by bilingual staff already working in the community. Providers recommended expanding navigation services into evenings and

weekends to better serve working families and ensuring sufficient funding so community health workers can maintain manageable caseloads and provide meaningful support. Service providers and community health workers named burnout and funding as the binding constraints on this group, and system leaders named a grow-your-own pipeline through schools as the durable answer to turnover.

"I would focus on finding those lived experience people, and if they are not employed, get them employed as a CHW, as a promotora, as a health representative, or whatever, because they're gonna be able to elevate not only the navigation, but also the coordination and the service delivery, right? Because they're gonna build the trust with the people...because they've already been there." Service provider

The fourth group fixes transportation at the point of referral: ask at the time a referral is placed whether the person needs a ride, arrange it from the clinic rather than leaving the patient to call an 800 number, let the transport line pull appointment details from the clinic, and create accountability when a ride does not come. The fifth group focuses on communication before, during, and after care. Providers recommended plain-language, Spanish-language heart health education delivered by trusted community members, beginning early in schools. They also suggested contacting patients before specialist visits to explain what to expect and providing written information that a trusted person can review with an older adult. At intake or discharge, a flag in the patient's chart could prompt support from an advocate, interpreter, or family member when appropriate. Providers also recommended that new providers review a patient's chart before the first visit to reduce the need for patients to repeatedly share their medical history or undergo duplicate testing. The sixth group is the one that makes the others possible. Tribal health providers proposed a countywide convening of every health care organization in Lake County to agree on one shared model for cardiac care, because no forum for that alignment exists. They asked that trauma-informed and culturally responsive training for non-Tribal systems be taught by people from the population, providers first, and that community health representatives sit at the table. Community health workers asked for a communication hub joining the provider team, a social worker, and a community health worker around each patient. Service providers asked that year one begin with what can move now: bolster the food pantry network, translate every project material,

and listen to the community survey before designing anything. Providers defined success one year out in the same terms: people get on the schedule and know where their referral stands, fewer people wait for a cardiac appointment, fewer are hospitalized twice, and providers stay.

"I would love to see a conference, but like a conference specifically centered on all organizations coming together at that conference... you could just kind of pull a little bit from each one and tailor it specifically to the same modality, the same model, and say we're going to all follow this model." Tribal health provider

Table 13. Provider-identified supports and process priorities

Item	Response	n	Percent
Supports that would most improve referral completion and follow-up, select all (35)	Transportation supports	20	57%
	Closed-loop referral tracking	14	40%
	Increased CHW and navigation capacity	10	29%
	Patient education materials on what to expect	10	29%
	Clear referral criteria and standardized templates	6	17%
	Faster access to diagnostics	6	17%
One process Heart-to-Heart should improve (37)	Not sure	11	30%
	Strengthening coordination between systems	6	16%
	Strengthening navigation and support services	6	16%
Can identify specific improvements to better support AIAN and Hispanic or Latino patients (36)	Agree	8	22%

The six domains describe one care system from four vantage points. Community members and providers name the same conditions in the same order: transportation, the wait to establish care and to reach cardiology, cost and coverage, and communication that depends on a person rather than a system. They also name the

same strengths: a Tribal health system that is trusted and holds its providers, a workforce of community health workers, representatives, promotores, and advocates who carry people through the pathway, and a county that has begun to work across its organizations. The survey shows how widely each experience is shared, the interviews show how it happens, and the county data in Section 3 show its size. The next step is to consider how consistently each finding appears across the different sources: which findings are supported across all sources and which emerged most strongly from a single source but remain important to understanding the community's experience. Section 6 takes up that question.

6. Bringing It Together

Heart-to-Heart set out to build its program on what Lake County already knows about its own care. Four sources were gathered so that no single voice, site, or method would carry a finding alone: community members described their experience in the survey, providers described the system from inside it in a second survey and in interviews and group discussions, and the county record set both against the conditions of the county as a whole. When those sources point the same way, the collaborative has a finding it can design around, fund, and hold itself accountable to, and partners who did not take part can see why. When a finding rests on one source, it is named here rather than set aside, because the interviews in particular reached conditions a short survey cannot, and those conditions shape whether the program's pathway, community health worker model, and referral protocols will work as intended.

The work begins from strength, and four strengths hold across every source. Community members know where to go for heart-related care, and most describe their experiences as positive. The Tribal health system is trusted by the people it serves and by the providers around it. Community health workers, community health representatives, promotores, and advocates are named by community members as the help that worked and by providers as the people who carry the pathway. The county's organizations have begun to work together, in standing meetings, shared referral points, and a workforce pipeline. Table 14 shows how each source supports these strengths. They are what the collaborative builds on.

Table 14. Strengths, by source

Strength	Community member survey	Provider survey	Interviews and group discussions	County data
People know where to go and value the care they receive	72% know where to go for help; 64% feel comfortable getting care; 61% rate experiences positive	Not asked	Named in 9 of 12 sessions: rapid care, event screenings, clinic staff who help	74.3% of adults had a routine checkup, the same as California ^{6,7}
Tribal health as a trusted, culturally aligned home base	18% used a Tribal health program; AIAN respondents 79% know where to go	Not asked	Named in 8 of 12 sessions, by Tribal health providers and by every other audience	3.0% of residents identify as AIAN alone; seven federally recognized tribes ¹
Community health workers, representatives, promotores, and advocates	28% helped by a CHW or CHR; 36% by clinic staff; 31% by family	32% name CHWs and navigators as the mechanism that supports coordination	Named in every session; CHR accompaniment model described in detail	Not published
A county that works together	Not asked	27% name referral coordinators and schedulers; 24% shared EHR access	Standing meetings, reentry collaborative, county referral link, CHW curriculum, the Heart Hub, and informal working relationships across organizations, named in 9 of 12 sessions	Not published

Nine needs were identified across the four sources. Table 15 presents the evidence for each. Six needs are supported by all four sources: transportation; the time required to establish primary care and to reach cardiology; cost and coverage; language access and culturally responsive care; workforce and navigation capacity; and food, housing, and living conditions. Community members and providers each identified transportation and the time to care as the two most common barriers. Two needs, the

referral process and trust, are supported by both surveys and the interviews. No published county measure addresses either. Cross-system coordination is the one need on which the sources differ. Half of community members agree that the health care system communicates well across settings. Fewer than one in six providers agree. Providers observe what happens to a referral after it leaves their setting, and community members observe whether their own care was completed. Both observations are accurate. Care was often completed because an individual staff member followed the referral through, and providers report that the system does not complete referrals without that individual effort.

Table 15. Needs, by source and consistency

Need	Community member survey	Provider survey	Interviews and group discussions	County data	How consistently it came through
Transportation to care, in and out of county	35%: the most common barrier (of 117)	45% name transportation infrastructure; 44% the top reason referrals fail; 57% the top support wanted	Named in all 12 sessions; Medi-Cal ride limits, transit routing, out-of-county return trips	11.1% of adults lack reliable transportation; two ER hospitals at opposite ends of the lake ⁶	All four sources; same rank from both surveys
Establishing primary care and reaching cardiology	34%: hard to get appointments or long waits	58% name limited specialty capacity; 21% say referrals are scheduled but delayed	Named in all 12 sessions; months to establish care, one to two months to cardiology	61.1% live in a primary care shortage area; highest reliable county CHD death rate in California ^{10,4}	All four sources; same rank from both surveys
Referral loop: confirmation, callback, tracking	14% scheduled but not gone; 10% could not get an appointment; 14% referral steps unclear	51% cannot say what happens to a referral; 42% do not know how status is tracked; 40% want closed-loop tracking	Named in 10 of 12 sessions; callback drop-off, faxes not received, no countywide visibility	Not published	Three sources, no county measure; the top named priority in interviews

Need	Community member survey	Provider survey	Interviews and group discussions	County data	How consistently it came through
Cross-system coordination and record visibility	50% agree parts of the system communicate well; 53% agree care is connected	Fewer than six of 37 agree communication is timely, results return, guidance is consistent, or care is coordinated	Named in all 12 sessions; record invisibility across the three systems described by direct clinical, Tribal health, and community health worker audiences	Not published	Three sources, no county measure; community members divided, providers nearly unanimous
Cost and coverage	23%: cost or insurance problems	18% name cost; coverage complexity fewer than six	Named in 11 of 12 sessions; coverage loss, emergency-only Medi-Cal, air transport bills	6.9% uninsured; AIAN 22.1%; Hispanic or Latino 11.8%; adults 18 to 64 10.1% ^{1,6}	All four sources; strongest for AIAN and Hispanic or Latino residents
Language access and culturally responsive care	48% agree care is culturally responsive; 12% language problems; Hispanic or Latino respondents 45% on respect and responsiveness	16% agree care is culturally responsive; 35% name language barriers as reducing trust	Named in 11 of 12 sessions; phone interpreters, drop in responsiveness outside Tribal systems, clinical language	19.7% speak a language other than English at home ¹	All four sources; described differently for AIAN and Hispanic or Latino residents
Trust and respect in care settings	19%: lack of trust or bad past experiences; 64% agree people are treated with respect	46% agree lack of trust is a barrier; 57% prior negative experiences; 54% feeling dismissed; 41% disrespect	Named in 11 of 12 sessions; feeling unwelcome, immigration fear, unhoused culture, fear of procedures	Not published	Three sources, no county measure; providers rate it more strongly than community members

Need	Community member survey	Provider survey	Interviews and group discussions	County data	How consistently it came through
Workforce and navigation capacity	13% had no supports available	18% staffing limitations; 18% navigation capacity; 29% want more CHW capacity	Named in all 12 sessions; turnover, burnout, one patient advocate, CHR reach limited to 76	61.1% in a primary care shortage area ¹⁰	All four sources; providers and county data strongest
Food, housing, and living conditions	19% stress or discouragement; 10% time off work or childcare	31% patients overwhelmed; 21% stress or depression interferes	Named in 10 of 12 sessions; produce cost, store closures, housing loss to fire, homelessness	16.3% food insecure; 14.4% housing insecure; 604 people experiencing homelessness ^{8, 6, 2}	All four sources; county data and interviews strongest, surveys indirect

Five findings were reported by a single source and are recorded here because each describes a specific condition that affects heart-related care. Direct clinical providers reported that heart symptoms in women, which often present as anxiety, nausea, or general discomfort, are recognized less often than the chest pain pattern. The same providers described a distinct experience among community members who are unhoused, in which fatigue and shortness of breath are attributed to living outdoors rather than to a heart condition. Tribal health providers reported that limited broadband and cellular service interrupts telephone and telehealth visits in parts of the county, and that Tribal disenrollment can place families beyond the reach of community health representative outreach. Service providers reported that intake and demographic forms in some settings have no Hispanic or Latino category, so that community is undercounted in the data the county relies on. These conditions were not measured by the surveys or the county data. Each can be confirmed directly, and each has a bearing on how the collaborative designs its pathway, its community health worker model, and its outreach.

Community members contributed to this assessment through the survey, including its open-ended responses. The interviews and group discussions were held with

providers. Where a need is supported by interviews and county data but not by the community survey, the survey did not ask about it; the absence is not evidence that community members disagree. Interviews and group discussions with community members continue as part of the program's evaluation, and the findings presented will be reviewed against them when they are complete. Together, the strengths and needs identified describe the conditions the collaborative is working within and the assets it will build on.

6.1 Reflecting the Findings Back to the Community

On September 23, 2026, the collaborative presented this assessment's findings to its strategic advisory committee as an interactive data walk, in English and Spanish. Eighteen participants, including community members, providers and frontline staff, and partner organization leaders, responded in writing to prompts at each finding and marked their priorities. The converged needs held. Community members described the same referral breaks providers reported, including keeping their own records of interactions to prove to a provider they are in the system, starred transportation as a priority on two boards, named community health workers, community health representatives, and case managers as who helps them through heart care, independently raised the labeling of patients as non-compliant, and confirmed the coverage barriers facing undocumented residents that Section 5 reports from provider interviews. Participants also endorsed responses this assessment proposes, including the cross-health-system agreements.

Participants added findings this assessment now carries forward. Transportation has an emotional dimension: a person going to a first cardiac appointment is frightened, and the ride and emotional support are needed together. Missed appointments run in both directions, because cancellations are often made by the provider's office. The wait for cardiology can be filled with supports participants named: starting medication where possible, staff check-ins, and a call from the cardiology office before the first visit explaining what will happen. Language service through a tablet is insufficient, and in-person service in a person's primary language is the ask. Appointment access outside traditional hours, farm labor work schedules, elders who put themselves last in multigenerational households, the price of healthy food, and awareness of heart failure symptoms were named as conditions the surveys did not measure.

Participants placed 21 priority dots across the six commitment areas drawn from this assessment. Growing the community health workforce received the most (7), followed by transportation arranged at the point of referral (5), one shared model of cardiac care (4), plain language communication (3), and a shorter wait to cardiology (2). Referral visibility, the improvement providers named first in the interviews, received none. The two results describe the same system from different positions: the people closest to patients put their priorities on people and rides, and the people closest to referral workflows put theirs on seeing the referral. The Year 2 work plan carries both, and the advisory structure where these priorities were marked is where their sequencing will be decided.

7. What This Means for Heart-to-Heart

The findings describe one care system rather than a list of separate problems. A resident with a heart concern in Lake County enters a pathway that runs through three health systems, two hospitals at opposite ends of the lake, cardiology and most specialty care outside the county, and a Medi-Cal transportation benefit that residents must arrange for themselves. Each break in that pathway compounds the next. A referral placed by fax is not confirmed; the cardiology office calls a phone number that no longer works; a ride booked five days ahead does not arrive; the missed visit is rebooked months out; and the next provider, who cannot see the record from the last one, repeats the history and the tests. Community members experience this sequence as care that came together only when a specific person carried it. Providers experience it as a system that does not complete referrals on its own. Both are describing coordination, and coordination is the condition that Heart-to-Heart is built to change.

The county is not short of resources in the way the findings might first suggest. Every source names assets that already exist: a Tribal health system that is trusted and retains its providers, rapid care and recuperative care, a community health representative program with a working accompaniment model, transport and gas card programs, a Medi-Cal transportation benefit, standing meetings across agencies, a workforce pipeline, and a growing bilingual workforce. What the findings show is that these assets are not connected or visible to the people who need them. Residents do not know the transport benefit exists; providers do not know a patient has a community health worker; a referral leaves one system and cannot be seen from

another. The collaborative's work is to connect what is present, and the three components of its model each answer a specific break the assessment identified. Table 16 sets each need against the component that addresses it and the evidence and policy basis for that component.

7.1 A Community Health Worker Centered Model

Community health workers, community health representatives, and promotores are the one element of the care system that community members and providers both identified as effective. Community members named help from a care coordinator or community health worker as the third most common support that helped them complete care, after clinic staff and family. Providers named community health workers and navigators as the mechanism that most often supports coordination, and every interview audience described the roles that carry residents through the pathway: locating people in the field, arranging rides, sitting with a person while a provider's office is called, explaining a letter, and attending the visit. The Tribal health community health representative program demonstrates the full model in the county today, with a 48-hour follow-up standard, transport to and presence in every heart-related visit, and a briefing to the provider before the next appointment.

The evidence base supports building a cardiac care model on this workforce. The Community Preventive Services Task Force recommends interventions that engage community health workers for cardiovascular disease prevention on the basis of strong evidence, with improvements in blood pressure control and cholesterol, gains in appropriate use of health care services, and a median cost per quality-adjusted life year well below accepted cost-effectiveness thresholds.¹² The American Heart Association's rural health advisory documents urban-rural disparities in cardiovascular outcomes and attributes them to three groups of factors: individual factors, social determinants of health, and health delivery system factors, which are the same three groups of conditions this assessment found in Lake County.¹³ The findings in this assessment specify how the model must be built in Lake County: with people hired from the communities they serve, including Spanish-speaking staff and staff with lived experience of heart disease; with a community health worker embedded in the cardiac pathway rather than only in community supports; with caseloads small enough to allow

weekly contact; and with a defined role in the referral loop so that a provider knows a community health worker is involved and can ask for help reaching a patient.

7.2 Street Medicine and an Emergency Department Navigator

Two populations enter heart-related care through routes that a clinic-based pathway does not reach. Community members experiencing homelessness carry congestive heart failure at younger ages and at high severity, lose coverage when renewal notices do not reach them, and cannot receive a scheduling call on a phone they no longer have. Hispanic or Latino community members without full-scope coverage receive a first diagnosis of high blood pressure or diabetes in the emergency department and leave without a primary care provider, affordable medication, or a route to specialty care. For the first group, the collaborative's street medicine component brings evaluation, referral, and follow-up to where people are, and the assessment found the county already moving in that direction with a street medicine van about to begin and shelter medicine hours under way. California's Medi-Cal program permits managed care plans to contract with street medicine providers as assigned primary care providers, Enhanced Care Management providers, or as treating providers for members experiencing unsheltered homelessness, which allows the component to be reimbursed rather than grant-dependent.¹⁴ Most street medicine programs in California operate in Los Angeles County and the San Francisco Bay Area; a program serving a rural county of 68,000 residents is among the few of its kind in the state.¹⁵

For the second group, an emergency department navigator addresses the point at which the assessment found the pathway most often ends. More than one in four community members who needed heart-related care went to the emergency room, and providers described the emergency department as the entry point for uninsured residents and the exit point when no follow-up is arranged. A navigator present at discharge who establishes a primary care appointment, connects the person to a community health worker, screens for coverage and sliding scale eligibility, and arranges transportation converts an emergency visit into an entry to ongoing care. The chart flag at intake or discharge that community health workers proposed, which triggers an advocate, an interpreter, or family presence, is the mechanism that makes the navigator's work systematic rather than incidental.

7.3 Sustainability Through Medi-Cal

Half of Lake County residents, and 43% of adults, are enrolled in Medi-Cal, and 59% of community survey respondents are covered by Partnership HealthPlan or Medi-Cal.³ The program's model is aligned with benefits that Medi-Cal now pays for. Community health worker services have been a Medi-Cal covered benefit since July 1, 2022, covering preventive services for chronic disease control and prevention, behavioral health conditions, and other areas, when provided under a supervising provider.¹⁶ Enhanced Care Management provides a dedicated lead care manager for members with complex needs, and Community Supports cover housing assistance, medically tailored meals, and related services for eligible members regardless of Enhanced Care Management enrollment.¹⁷ Medi-Cal covers non-medical and non-emergency medical transportation to covered appointments, arranged through the member's managed care plan.¹⁸ The transportation findings in this assessment describe how that benefit performs in practice: rides that must be booked five days ahead, confirmation calls that do not arrive, and drivers who appear about 70% of the time, with no consequence when they do not. The collaborative's transportation work therefore begins with the benefit that exists, by arranging the ride at the point of referral, by giving the transport line the appointment details from the clinic, and by working with the managed care plan on accountability, rather than by building a parallel service.

These benefits make the community health worker, street medicine, and navigation components reimbursable services rather than time-limited grant activities. They also set the terms on which the model reaches people. Residents without full-scope Medi-Cal, including undocumented adults who qualify only for emergency coverage, are outside the benefit, and the assessment identified them as the population most likely to enter care through the emergency department. The collaborative's sliding scale, community event screening, and bilingual navigation components carry that population until coverage policy changes.

7.4 What the Model Addresses and What It Depends On

The collaborative's model addresses coordination: the referral loop, the callback, the ride, the handoff between systems, and the visibility of a community health worker's involvement. Three conditions the assessment identified sit outside the model's direct reach and determine how far it can go. The first is specialty capacity. Providers identified limited specialty capacity as the constraint that most limits timely cardiac

care, and the wait to a first cardiology visit of one to two months is a function of the number of cardiologists available to the county. The collaborative's proposals for a two-week contact by a cardiac-trained nurse practitioner or physician assistant, bridge referrals during the wait, visiting specialist arrangements, and a service-line agreement among the three health systems each work within that constraint rather than remove it. The second is provider retention, which every audience tied to housing and to the county's economy, and which the collaborative addresses through the workforce pipeline rather than through its own hiring. The third is the food and housing environment, which produces the burden the county carries and which the collaborative addresses through partnership with the food pantry network, Blue Zones, and housing programs rather than through clinical services.

The strengths the assessment identified are the collaborative's starting position. Community members know where to go; the Tribal health system holds trust; the community health workforce is present and effective; and the county's organizations have begun to meet. The collaborative's contribution is a shared model that connects these assets across the three health systems, a referral loop that every system can see, and a workforce funded through Medi-Cal to carry residents through it. Table 16 summarizes the fit.

Table 16. Needs identified in the assessment and the components of the Heart-to-Heart model that address them

Need	Model component	What it does	Evidence and policy basis
Referral loop: confirmation, callback, tracking	Countywide closed-loop referral tracking; named points of contact; community health worker in the loop	Every system can see that a referral was placed, where it stands, and who holds it; a 24-hour response norm and an appointment date at the time of referral	Top named priority across provider audiences; 40% of surveyed providers name closed-loop tracking as the support that would most improve completion
Transportation	Ride arranged at referral through the Medi-Cal transportation benefit; accountability with the managed care plan	Removes the five-day booking and the patient-initiated call; ties the ride to the appointment record	Medi-Cal non-medical and non-emergency medical transportation benefit ¹⁸ ; 57% of surveyed providers name transportation supports first

Need	Model component	What it does	Evidence and policy basis
Establishing care and reaching cardiology	Emergency department navigator; two-week cardiology office contact by a cardiac-trained nurse practitioner or physician assistant; bridge referrals	Converts an emergency visit into an entry to care; completes the workup during the wait	Emergency room was the care site for 27% of community members who needed heart-related care; one to two month cardiology wait reported by direct clinical providers
Workforce and navigation capacity	Community health worker centered model with staff hired from the communities served	Locates, accompanies, explains, and follows up; embedded in the cardiac pathway	Community Preventive Services Task Force strong evidence recommendation ¹² ; Medi-Cal community health worker benefit ¹⁶
Community members experiencing homelessness	Street medicine	Brings evaluation, referral, and follow-up to encampments, shelters, and the shower trailer	Medi-Cal managed care contracting with street medicine providers ¹⁴ ; California street medicine programs ¹⁵
Cost and coverage	Coverage screening at every contact; sliding scale referral; Enhanced Care Management and Community Supports enrollment	Restores lapsed coverage; connects eligible members to a lead care manager and to housing and food supports	Enhanced Care Management and Community Supports ¹⁷
Language access and culturally responsive care	Bilingual, bicultural community health workers and navigators; trauma-informed training delivered by community members; plain-language materials in Spanish	Replaces phone interpretation with a trusted person; prepares non-Tribal settings to serve Tribal community members	Tribal health providers' training model; 11 of 12 sessions named language or cultural responsiveness
Trust and respect	Lived-experience hiring; pre-visit contact; chart flag for advocate, interpreter, or family presence	Makes a trusted person part of the visit rather than an exception	46% of surveyed providers identify lack of trust as a barrier; prior negative experience the most cited cause

Need	Model component	What it does	Evidence and policy basis
Cross-system coordination	Countywide convening on one shared cardiac care model; standing frontline coordination among schedulers and referral coordinators	Creates the forum that does not exist and moves coordination from executive meetings to the people who book appointments	Named by Tribal health providers as the first priority; fewer than six of 37 surveyed providers agree care is coordinated

The assessment gives the collaborative a clear account of the care system it is entering: where the pathway holds, where it breaks, which assets are in place, and which conditions lie beyond the reach of any single program. The model described answers that account point by point, and each component has a funding basis in Medi-Cal and an evidence basis in public health practice. The next step is putting the model into practice: sequencing its components against the county's capacity, agreeing on shared processes with the three health systems and the Tribal partners, and returning to the community with a plan it can recognize as its own. The steps that follow set out how the collaborative will do that, beginning with the findings that every source supports.

8. Where We Go From Here

Heart-to-Heart is a five-year initiative. Year 1 was the planning and assessment year, and this report is its product: a verified county data baseline, two surveys, twelve provider sessions, and the strengths and needs they establish. Year 2, running October 2026 through September 2027, is the first implementation year. The collaborative's Year 2 work plan sets five goals, and each one acts on findings documented in this assessment. Years 3 through 5 extend that work, and the decisions that shape them will be made with the community advisory structures that Year 2 builds. This section states what the collaborative will do, which finding each commitment answers, and how the assessment continues to be used.

8.1 The Year 2 Work Plan and the Findings It Answers

The first goal builds community governance and takes the first steps on referral visibility. The collaborative will meet quarterly with its core planning partners—Kno'Qoti Native Wellness, Latinos United of Lake County, and Adventist Health Clear Lake—to review implementation progress. It will also establish a health system subcommittee made up of managers who oversee community health worker and

community health representative activities at Adventist Health and Lake County Tribal Health Consortium. In addition, the collaborative will co-host two Community Advisory meetings, with at least 70% of participants representing local cultural communities, including Tribal and Hispanic or Latino communities. The goal also includes referral work. The collaborative will map the county's referral networks and data tracking systems, including how each health care provider uses the Lake County Community Hub, the county's shared platform for sending and tracking service referrals. The health system subcommittee will then define requirements for countywide closed-loop referral visibility, including referral confirmation, status tracking, and designated points of contact across health systems. The collaborative will also develop recommendations to reduce the time between a referral and a patient's first contact with cardiology. These recommendations will build on strategies proposed in this report, including initial contact within two weeks with a cardiac-trained nurse practitioner or physician assistant, bridge referrals to supportive services while patients wait, and service agreements among the three health systems. The requirements document and the cardiology recommendations go to the Advisory Group with each health system's response to inform the Year 3 work plan. These actions respond directly to several findings from the assessment. No countywide forum currently exists for health care organizations to align around a shared model of cardiac care, and providers described cross-organization coordination occurring at the executive level without consistently shaping the day-to-day work of frontline schedulers and referral coordinators. In addition, 51% of surveyed providers could not say what happens to a cardiac referral after it is placed. Direct clinical providers reported waits of one to two months for a first cardiology visit, while difficulty getting appointments was the second most commonly reported barrier among community members (34%).

The second goal trains the community health workforce. The collaborative will develop a Heart-to-Heart implementation model for community health workers and community health representatives based on the findings of this assessment. It will also hold a training event on cardiac care prevention, early intervention, screening, and referral processes, reaching at least 25 community health workers, community health representatives, and other providers. Additional trainings will focus on local Tribal history, Bi-National and Latino health, and culturally responsive care. The collaborative will also conduct at least two trainings that build on the CalAIM 101 sessions with

Tribal-serving community-based organizations and further integrate Lake County Tribal Health's community health representatives into local learning and solution-building. To strengthen the workforce, the collaborative will adopt hiring and recruitment standards that increase bilingual, bicultural, and lived-experience representation, including recruitment through the networks of Latinos United of Lake County and Kno'Qoti Native Wellness. These actions respond to findings across all four sources that community health workers, community health representatives, and promotores are viewed by both community members and providers as effective sources of support. They also address concerns that culturally responsive care can become less consistent when community members receive care outside Tribal health settings. Across 11 of 12 provider sessions, participants also identified language access and culturally responsive care as important factors in whether people access and continue to use care. Hiring staff with lived experience is the mechanism providers identified as building trust, and the hiring standard makes it a documented practice.

The third goal gives the health systems the information to use existing Medi-Cal benefits. The collaborative will develop referral workflow materials covering Enhanced Care Management, the community health worker benefit, and Community Supports, along with an updated local service map specific to cardiac care. It will also develop clinic tools that identify local screening and diagnostic services and host a learning event reaching at least 15 health system administrators.

The collaborative will assess awareness and current use of Medi-Cal's Non-Emergency Medical Transportation and Non-Medical Transportation benefits and use the findings to identify opportunities to increase referrals to these services. Providers and health system administrators will also receive training on local Tribal history, Bi-National and Latino health, and culturally responsive care. This answers the finding that the county's assets are present but not visible to the people who need them: 51% of surveyed providers could not say what happens to a cardiac referral after it is placed, 42% did not know how referral status is tracked, and providers and residents alike were unaware of transportation and coverage benefits that already exist. Transportation is the most common barrier community members reported in the survey (35%), and the top reason surveyed providers see referrals fail (44%), and the transportation commitment addresses it with benefits Medi-Cal already covers.

The fourth goal begins direct service. The collaborative will map workflows connecting street medicine and mobile clinic services with the Clearlake and Kelseyville clinic sites and document those workflows in the new Epic electronic health record system.

Primary care clinicians will be equipped to refer patients to community health workers, with the goal of connecting more than 25 Medi-Cal members with a community health worker navigator and providing at least three encounters per month for each referred patient. The collaborative will also coordinate Adventist Health's street medicine program and Lake County Tribal Health's mobile clinic by comparing service offerings, locations, and schedules. This coordination will help identify opportunities to expand access and address transportation barriers. Each element answers a documented break in the pathway: the months-long wait to establish care, the scheduling call that does not reach patients without stable phones, the ride that does not arrive, and the referral that no one tracks. The encounter standard applies the practice this assessment found working in the county: the community health representative model of scheduled, repeated, in-person contact.

The fifth goal builds the evaluation, and it holds two evaluations. The collaborative will execute the data use agreements circulated for partner review in Year 1 and complete the governance documentation that keeps data practices transparent to participants. It will complete the community member interviews and group discussions that were not conducted in Year 1: six sessions, three Tribal discussion groups and three Latino discussion groups, co-hosted with partner organizations using the approved guides, with six-domain summaries produced and this report's convergence findings reviewed against them. It will implement the cohort-wide cross-site evaluation led by the National Program Office at Johns Hopkins, collecting the patient-level Common Data Elements (demographic, clinical, and patient-reported measures) at baseline and follow-up and sharing the collaborative's data dictionary with the Johns Hopkins team by October 15, 2026. The collaborative will also implement its own system-wide evaluation, aligned with the PRISM framework, which measures what the patient-level clinical evaluation does not: referral completion, wait time to first cardiology contact, cross-system coordination, workforce capacity, and community engagement. This report is the baseline for both. The county measures in Section 3 and the survey and session findings in Sections 4 through 6 are the reference against which change is

measured, and county-level data gaps for American Indian and Alaska Native residents are addressed through the data governance work with Tribal partners.

Table 17. Year 2 work plan goals and the assessment findings each answers

Year 2 goal	Commitments	Assessment finding it answers
1. Co-create solutions with local advisors	Quarterly core partner meetings; health system subcommittee; two Community Advisory meetings with at least 70% local cultural representation; referral network and Lake County Community Hub mapping; written requirements for countywide closed-loop referral visibility; cardiology wait time recommendations; updated governance frameworks	No countywide forum exists for aligning on one cardiac care model; coordination happens at the executive level without reaching frontline schedulers and referral coordinators; 51% of providers cannot say what happens to a referral; providers report one to two month waits to a first cardiology visit
2. Train community health workers and representatives	Implementation model built from this assessment; training event reaching at least 25 participants; Tribal history and Bi-National/Latino health trainings by KNWI and Latinos United; at least two additional trainings building on CalAIM 101; bilingual, bicultural, and lived experience hiring standard	The community health workforce is the asset every source supports; culturally responsive care declines outside Tribal health settings; language and culturally responsive care were named in 11 of 12 sessions; lived experience hiring builds trust
3. Produce Medi-Cal policy and referral materials	Referral workflows for ECM, the CHW benefit, and Community Supports; cardiac service map; administrator learning event reaching at least 15 participants; clinic screening and diagnostic tools; Medi-Cal transportation benefit awareness and utilization; culturally responsive care training for providers and administrators	51% of providers cannot say what happens to a referral; 42% do not know how status is tracked; transportation is the most common community barrier (35%) and the top reason providers see referrals fail (44%); existing benefits and services are unknown to residents and providers
4. Engage Medi-Cal members in direct services	Street medicine and mobile clinic workflows at the Clearlake and Kelseyville sites documented in the new Epic system; more than 25 members connected to a CHW navigator; at least three encounters per month per referred patient;	The pathway breaks at establishing care, the scheduling callback, the ride, and the untracked referral; the community health representative model of scheduled, repeated, in-person contact is the practice this assessment found working

Year 2 goal	Commitments	Assessment finding it answers
	coordinated mobile clinic schedules across the two health systems	
5. Build the community-centered evaluation	Data use agreements and governance documentation; six community member sessions (three Tribal and three Latino discussion groups); cohort-wide cross-site evaluation using the patient-level Common Data Elements, with the data dictionary shared with the Johns Hopkins team by October 15, 2026; system-wide PRISM-aligned evaluation	Community member interviews and group discussions remain to be conducted; county data on AIAN heart health is limited to mortality; this report is the baseline for measuring change

8.2 Years 3 Through 5

The Year 2 work plan is the first year of implementation, not the whole of it. The two largest changes this assessment supports require agreement among three health systems, and the work plan sequences them deliberately: Year 2 produces the analysis and the recommendation, and Years 3 through 5 carry the build. For countywide closed-loop referral tracking, Year 2 will focus on mapping referral networks, defining written requirements for referral confirmation, status visibility, and designated points of contact, and presenting recommendations to the Advisory Group. Building shared referral visibility across Adventist Health, Sutter Health, and Lake County Tribal Health Consortium will occur in later years. Cardiology wait times follow the same sequence: Year 2 presents the proposed responses with each health system's documented position, and the changes in specialty capacity they require are implemented in Years 3 through 5. Transportation arranged at the point of referral requires an agreement with the Medi-Cal managed care plan on booking and accountability; Year 2 establishes current awareness and use of the Non-Emergency Medical Transportation and Non-Medical Transportation benefits, and the point-of-referral arrangement is a recommendation for the advisory structure to bring to the plan. Each of these will be presented to the Community Advisory structure with the evidence in this report, and the recommendations that structure produces will shape the Year 3 work plan.

8.3 How This Assessment Continues to Be Used

This report is the collaborative's baseline and its shared reference. The implementation model and training materials built in Year 2 return the findings to the community health workers and representatives whose work they describe. The data walk at the September 2026 advisory meeting returned the findings to the partners and community members who provided them, and their responses are part of the record in Section 6. The system-wide evaluation measures Year 2 commitments against the numbers documented: the share of referrals completed, the wait to a first appointment, the share of adults with a routine checkup, and the barriers community members report. The cohort-wide evaluation measures change for the members served, in the clinical and patient-reported measures the Common Data Elements record. The community needs assessment will be repeated in the program's later years with community member interviews and group discussions included, and the comparison between that assessment and this one is how the collaborative, its funder, and the community will know what changed in Lake County.

9. With Gratitude: In the Community's Words

This assessment belongs to the people of Lake County who gave their time and their knowledge to it. One hundred twenty community members completed the community survey at events, clinics, shelters, and the mobile shower trailer across the county, in English and in Spanish, and told the collaborative where they go for heart-related care, what has helped, and what has stood in the way. Forty-four providers, care coordinators, community health workers and representatives, promotores and promotoras, and partner organization staff completed the provider survey. Eighteen people sat for eleven interviews and one group discussion between June and August 2026 and described the care system from inside it. Their accounts are the substance of this report, and the collaborative's first obligation is to act on them.

Heart-to-Heart is a partnership, and the assessment was carried out as one. Kno'Qoti Native Wellness and Native Spirit Consulting supported recruitment and community engagement. Adventist Health Clear Lake made its clinics, the Hope Center, Restoration House, and the mobile shower trailer available as survey collection sites. Its community health workers also supported survey outreach and collection at community events and public sites across the county. The Population Health

Innovation Lab at the Public Health Institute led the design, data collection, and analysis of the assessment.

The collaborative also thanks the organizations whose staff took part in the interviews and group discussions and whose work appears throughout the findings: Tribal health, behavioral health, education, community health, social service, reentry, and municipal organizations across Lake County. To protect the confidentiality of the people who spoke, these organizations are described by sector rather than by name. Their staff described the care system with candor, and this assessment is more accurate because they did. The collaborative also thanks the Medi-Cal managed care plan whose coverage most of the people this program serves rely on, the county's wider hospital and clinic system, and the evaluation partner that will carry these findings into the program's evaluation.

The collaborative honors its partnership with the Tribal nations and Tribal-serving organizations of Lake County. That partnership shapes what comes next: the Tribal community discussion groups and the shared decision-making structures of Year 2 are commitments made with Tribal partners, and the collaborative is accountable to them for carrying each one out.

This report is a shared baseline. It will be returned to the community in a form the community can use, and the collaborative will report back on what changes as a result. The people who took part in this assessment are its authors, and the work that follows is accountable to them.

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Appendices

Supporting materials for the Heart-to-Heart Cardiac Community Needs Assessment are available in a [separate appendix document](#). The appendices provide detailed methodology, data collection instruments, and additional supporting materials referenced throughout this report, including:

Appendix A. Methods

Appendix B. Assessment Domain Framework

Appendix C. Secondary Data Sources

Appendix D. Convergence Method

Appendix E. Data Collection Instruments

[View the full Heart-to-Heart Cardiac Community Needs Assessment Appendices](#)



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