

# Central Valley Health Care Landscape Study

**Under-Resourced and Underserved:**  
Health System Shortages, Barriers to  
Care, and Pathways Forward in  
California's Central Valley

January 2026



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Central Valley Health Care Landscape Study

**Under-Resourced and Underserved:**  
Health System Shortages, Barriers to  
Care, and Pathways Forward in  
California's Central Valley

January 2026



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Contents

<b>Executive Summary</b>	<b>4</b>
<b>Introduction</b>	<b>9</b>
<b>Regional Overview</b>	<b>11</b>
<b>The Medi-Cal Majority: Coverage Trends in the Central Valley</b>	<b>17</b>
<b>Half the Doctors: Health Care Workforce Shortages in the Central Valley</b>	<b>21</b>
<b>Overcrowded: Bed Capacity in the Central Valley</b>	<b>32</b>
<b>Under Pressure: Central Valley Hospital Financial Health</b>	<b>38</b>
<b>Why it Matters: Health Care Access in the Central Valley</b>	<b>44</b>
<b>Case Study: Maternity Care Crisis in the Central Valley</b>	<b>49</b>
<b>Recommendations to Strengthen the Central Valley's Health System</b>	<b>54</b>
<b>Conclusion</b>	<b>63</b>
<b>Acknowledgments</b>	<b>65</b>
<b>Endnotes</b>	<b>71</b>



# Executive Summary

Central Valley Health Care Landscape Study



# Executive Summary

## Background

**Generations of families in California’s Central Valley have powered the nation’s food supply, yet the communities at the heart of this region continue to face persistent poverty, limited education and economic opportunity, poor health outcomes, and barriers to health care. These inequities are compounded by health care workforce shortages, under-resourced health infrastructure, and rapid shifts in health policy.**

At this critical moment, the Central Valley Community Foundation commissioned this study to provide a regional overview of the health care landscape across seven Central Valley counties—Merced, Mariposa, Madera, Fresno, Kings, Tulare, and Kern. Informed by data and stakeholder input, the report identifies gaps in resources and access, explores drivers of under-resourcing, and offers recommendations to strengthen the region’s health care system.

This study drew upon publicly available data, input from a diverse advisory group, expert interviews, and six listening sessions conducted between April and October 2025. More than 150 stakeholders contributed to the research—including Central Valley legislators, business and health care leaders, public health officials, community health workers and advocates, and workforce development leaders.

## Critical Health System Gaps

Despite major coverage gains, the Central Valley’s health care infrastructure is stretched thin, with severe workforce shortages and mounting financial pressures that constrain access and worsen outcomes.

### Coverage and Access Challenges

- Medi-Cal covers 53% of residents in the Central Valley—far above the statewide average of 37%—placing extraordinary strain on providers due to Medi-Cal’s low reimbursement rates.<sup>1</sup>
- High rates of preventable hospitalizations underscore the urgent need for more timely and accessible primary and outpatient care. Half of residents report waiting longer than reasonable for a physical health appointment and 61% report waiting longer than reasonable for a mental health appointment.<sup>2</sup> Limited provider networks, affordability, distance and lack of transportation, language barriers, lack of trust, and the complexity of the system further limit access.

### Workforce Shortages

- The Central Valley has the smallest health care workforce relative to population in California. Eighty-five percent of residents live in primary care shortage areas, and the region has roughly half the specialists per capita compared to the state. Behavioral health providers, nurses, dentists, and allied health professionals are similarly scarce.<sup>3</sup>

### Hospitals Under Pressure

- Overcrowding is a significant challenge in Valley hospitals. With too few acute, emergency, long-term, and psychiatric care beds, residents face delays and diminished access to essential care.
- Many Central Valley hospitals face severe financial strain and are at risk of closing—or cutting critical services—due to heavy reliance on Medi-Cal, stagnant reimbursement rates, and rising labor and regulatory costs. About half of acute care hospitals in the region reported negative operating margins in 2023 and several hospitals have sustained financial losses for multiple years.<sup>4</sup>

- Madera Community Hospital abruptly closed in 2023, underscoring the fragility of Central Valley hospital finances. The closure left roughly 160,000 residents without nearby emergency, labor and delivery, or acute care services for more than two years, and caused substantial job loss in the community.<sup>5</sup>

### Maternity Care Crisis

- The Central Valley faces shrinking maternity care resources. The Valley’s supply of maternity care providers is 30% below federal guidelines and access to fetal and perinatal specialists is extremely limited, leaving high-risk pregnancies difficult to manage.<sup>6</sup> Labor and delivery department closures are accelerating, creating maternity care deserts in rural communities.<sup>7</sup>
- Amid these resource constraints, Central Valley maternal and infant outcomes are among the worst in California. The Valley’s infant mortality rate is 5.4 deaths per 1,000 live births—above the Healthy People 2030 target of 5.0 and significantly higher than California’s rate of 4.1.<sup>8</sup> Maternal mortality is also alarmingly high: in the Southern Central Valley (including the study region plus Stanislaus and Tuolumne counties), the rate is 27.2 deaths per 100,000 births, compared to 18.4 statewide—the highest regional rate in California.<sup>9</sup>

## Threats from Federal Cuts

H.R. 1 (One Big Beautiful Bill Act) became law on July 4, 2025, with some of its provisions retroactive to January 1, 2025. H.R.1 is projected to reduce federal funding to California for Medi-Cal by \$30 billion annually and potentially leave up to 3.4 million Californians without coverage.<sup>10</sup> The cuts include lower reimbursement rates for hospitals and providers and an increase in uncompensated care as more patients become uninsured. By destabilizing health systems, H.R. 1 could lead to more service line and facility closures, impacting everyone that lives in the region. As one stakeholder noted, the Central Valley’s health care system is “on life support,” and further cuts would be like “a dagger to the heart.”

## Bright Spots

Despite these challenges, the Central Valley demonstrates resilience and innovation, highlighting the potential for greater impact with sustained investment and coordination.

### Growing Pipeline of Locally-Trained Health Professionals

- The Valley welcomed its first standalone medical school, California Health Sciences University College of Osteopathic Medicine, producing more than 125 physicians in its first two graduating classes and on track for 150 more in 2026.
- The University of California has expanded undergraduate medical education through SJV PRIME+, a local BS-to-MD pathway, and is planning an independent medical school in the region.
- Hospitals and health centers have added or expanded residency programs over the past decade.
- K–16 pathways and initiatives like the Tulare-Kings Health Care Partnership connect local students to health careers and foster collaboration across education, employers, and workforce agencies.

### Diverse Approaches to Delivering Care

- Federally Qualified Health Centers (FQHCs) are a cornerstone of the Central Valley’s safety-net health system, serving nearly half of residents.<sup>11</sup> FQHCs’ presence in the region has expanded over time, buoyed by coverage gains.
- Mobile clinics, school-based health centers, and employer-based services bring care directly into communities.
- Community health workers, promotores, and doulas are increasingly integrated into the health care delivery system as trusted, culturally responsive providers.



## Strong Community Engagement and Advocacy

- The Valley benefits from a highly-engaged community that recognizes its challenges and collaborates to identify solutions, as well as legislative representatives with long-standing commitments to improving medical education, health care systems and population health outcomes.
- Across the region, advocates and community-based organizations are amplifying local voices, working to protect coverage and respond to emerging threats.

## Critical Focus Areas and Strategies for Impact

The Central Valley's health care system can be strengthened by focusing on four critical focus areas.

### 1. Catalyze Collaboration and Strategic Investment

- Secure and Align Resources at Scale: Create cross-sector tables that can unlock and align funding to fill gaps, seed innovation, and support regional priorities.
- Increase Representation and Regional Advocacy: Partner with health-focused legislators to co-develop policy agendas that support improvement, strengthen regional representation on planning and advocacy tables, engage advocates, and conduct communications campaigns to build political will.
- Fund Coordinating Infrastructure: Support dedicated organizations to coordinate strategy, data, communications, and advocacy across initiatives.

### 2. Sustain the Health Care Safety Net

- Protect Medi-Cal Coverage for All Income-Eligible Californians: Collectively advocate for continued Medi-Cal coverage for all income-eligible residents.
- Secure Sustainable Medi-Cal Rates: Ensure Medi-Cal reimbursement levels in the Central Valley are adequate and equitable, supporting the long-term sustainability of providers that serve significant Medi-Cal populations.

- Invest Upstream: Prioritize prevention and health promotion by funding public health, primary care, behavioral health, and post-acute supports, while addressing root drivers of health such as air quality, food access, and other community-identified needs.
- Support Rural and Safety Net Hospital Financial Resilience: Provide emergency relief and targeted funding for qualifying rural and safety-net hospitals and monitor and protect critical service lines such as labor and delivery.

### 3. Grow the Health Care Workforce

- Expand Local Training Programs and Pathways: Sustain, scale, and link “grow our own” programs that support local students and workers to join the health care workforce, including K-16 health pathway programs and local adult school and college-level health career training.
- Increase Medical Education Capacity: Continue expanding clinical rotations and local residency and fellowship training opportunities; sustain urgency and political will to bring a stand-alone University of California medical school to the Valley.
- Strengthen Recruitment and Retention: Offer competitive pay, loan forgiveness, housing support, and career pathways; promote and enhance regional assets; foster belonging through mentorship, inclusive workplaces, and social connections.

### 4. Reimagine Models of Care

- Coordinate Across Systems to Address Health and Social Needs: Foster collaboration between health care providers and social service and community-based organizations to address complex health and social needs, reduce duplication, and implement value-based population health approaches.

- **Fund and Integrate Community-Connected Providers:** Expand roles for community health workers, promotores, peer specialists, doulas, and other non-clinical providers, further integrating them into care teams with adequate payment and system support.
- **Diversify Maternity Care Models:** Explore coordinated, multi-pronged approaches including OB/GYN residencies, expanded access to doulas and team-based care models, telehealth and remote monitoring, and maternal homes to improve access and outcomes.
- **Expand Innovative Solutions for Rural Health Access:** Use telehealth, mobile units, employer-based clinics, transportation support, and community-connected providers to close persistent rural access gaps.

## Immediate Next Steps

The scale and urgency of these challenges are cause for alarm and call for coordinated, sustained action across organizations and sectors. The Central Valley lags behind on nearly every health-related measure, and California cannot afford to overlook this vital region. The following ideas offer a starting point for organizations to translate the report's recommendations into meaningful next steps.

- **Assess alignment:** Identify which focus areas and strategies match existing work and where you can contribute most.
- **Leverage data:** Use the report's findings to secure additional resources, raise awareness, and advocate for policies and programs that advance regional priorities.
- **Engage collaboratively:** Join cross-sector efforts to strengthen partnerships, establish shared goals, and coordinate action.
- **Plan, pilot, and evaluate:** Conduct further analysis, develop detailed implementation plans, test new approaches, and track progress to inform continuous improvement.





# Introduction

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Introduction

## Background

**California’s Central Valley has long been an agricultural powerhouse, supplying a substantial share of the nation’s fruits, nuts, and other produce. Yet, alongside this extraordinary productivity, the region carries a legacy of persistent poverty and profound inequities. The Economist once described the Central Valley as the “Appalachia of the West,” a characterization that highlights both the depth of its challenges and the urgency of finding solutions.<sup>12</sup>**

The Valley’s poverty is mirrored in its health care system. Compared with better-resourced parts of California, the Valley has fewer health care providers, more limited infrastructure, and worse access to care. This under-resourcing, compounded by social, economic, and environmental pressures, contributes to consistently poorer health outcomes for residents.

To better understand these dynamics and identify potential solutions, the [Central Valley Community Foundation](#) commissioned this study.

## Research Approach

This research was designed to:

- Consolidate knowledge of the Central Valley’s health care system, focusing on understanding resource gaps, key challenges, and pathways to improvement.
- Create new opportunities for regional stakeholders to connect, share perspectives, build awareness, and generate solutions together.
- Catalyze health care transformation efforts and attract additional investment in the region’s health system.

The project focused on a seven-county region of the Central Valley: Merced, Mariposa, Madera, Fresno, Kings, Tulare, and Kern.

It combined analysis of publicly available data with insights gathered from expert interviews and six listening sessions. The listening sessions brought together a wide range of perspectives, including Central Valley legislators, business leaders, public health directors and officers, hospital executives, workforce development leaders, advocates, and community health workers and promotores. A diverse advisory group – including representatives from health care providers and plans, public health, community-based organizations, education, policy, and commercial agriculture – guided the work and contributed qualitative insights. In total, more than 150 unique stakeholders contributed to the research. Findings reflect these activities, conducted between April and October 2025. More details on the stakeholders that participated in the research, and their roles, can be found in the appendix.

Research was conducted during a period of significant social, political, and health policy transition. While the primary focus was on capturing the current state of the health care system, some sections address the potential implications of looming insurance coverage and funding cuts. Although progress is difficult in the current climate, the disparities outlined in this report have developed over decades and will likewise require long-term commitment and investment to resolve.





# Regional Overview

Central Valley Health Care Landscape Study

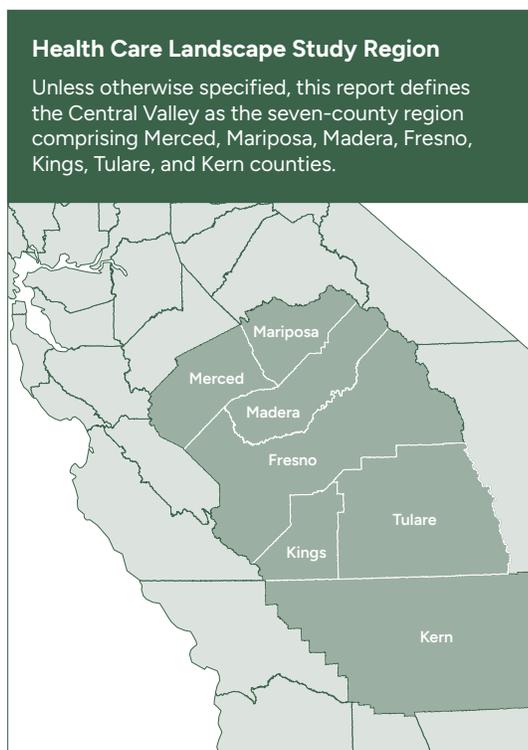


CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Regional Overview

The challenges and opportunities within the Central Valley’s health care system cannot be understood in isolation. Demographics, geography, and longstanding social and economic conditions set the stage for how health care is delivered and experienced across the region.

Figure 1. Health Care Landscape Study Region



## Demographics

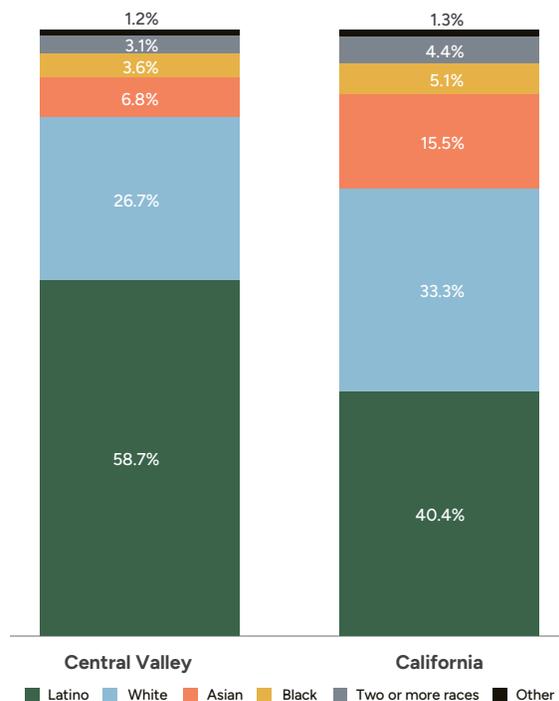
The Central Valley is home to a growing, diverse, and majority Latino population.

Between 2013 and 2023, the Valley’s population grew by approximately 6.2%, from 2.86 million to 3.03 million, while California’s overall population increased by just 1.7%.<sup>13</sup>

Latino residents comprise the majority of the Central Valley’s population, a proportion significantly higher than the California average. White residents are the next largest group, followed by Asian and Black populations, all at lower proportions than statewide.<sup>14</sup>

The Valley is linguistically diverse: about 46% speak a language other than English at home, and 17.5% have limited English proficiency.<sup>15</sup> Among students in grades K-12 in the region, the most common non-English language spoken is Spanish, followed by Hmong, Punjabi and Arabic.<sup>16</sup>

Figure 2: Race and Ethnicity Distribution, Central Valley and California, 2023



Sources: California Department of Finance (DOF), reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2023. One-year estimates were used for California and for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County.

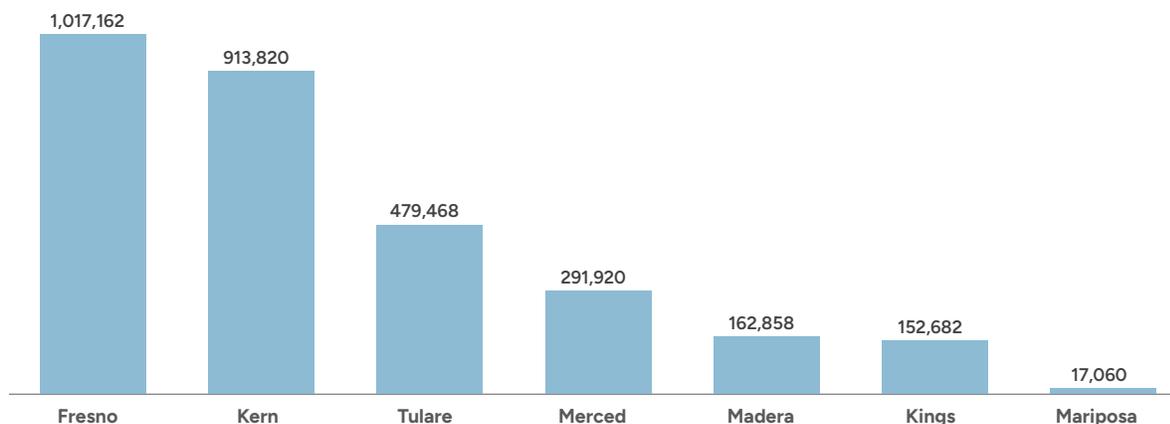
While the Central Valley remains younger than California overall, its population is aging, reflecting broader statewide trends. In Fresno County, for example, the median age increased by 2.5 years between 2013 and 2023, from 31.4 to 33.9. The California median rose by the same amount, from 35.7 to 38.2.<sup>17</sup> Projections estimate that the population of Valley residents aged 60 and older will grow by 79% between 2020 and 2060, increasing from around 475,000 to just under 850,000. In contrast, the total population is expected to increase by only 11% in the same time period. As a result, older adults are projected to represent 26% of the population in 2060, up from 16% in 2020, with Latinos making up a significantly larger share of the older population than they do today.<sup>18</sup>

## Geography and Population Distribution

**The Central Valley spans a vast geographic area, where distances between towns and cities create unique challenges for access to services and connectivity.**

Covering 24,441 square miles<sup>19</sup>—larger than 10 U.S. states and roughly the size of West Virginia—the region stretches from low, flat farmland in the west to the high peaks of the Sierra Nevada in the east. Driving across the Valley can take three to four hours.

Figure 3: Central Valley Population Size by County, 2023



Sources: *DOF*, reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2023. One-year estimates were used for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County.

The two largest metro areas are Fresno in Fresno County and Bakersfield in Kern County, followed by Visalia in Tulare County and Merced in Merced County. Hanford is the largest metro area in Kings County, and Madera is the largest in Madera County. Mariposa is a rural county and has no metro area.<sup>20</sup>

Population distribution largely aligns with the metro areas. Just under two-thirds of the Valley’s residents live in Fresno and Kern counties, 16% in Tulare, 10% in Merced, and 5% each in Kings and Madera. Only 1% of the Valley’s population resides in Mariposa.<sup>21</sup>

Outside these metro areas lies extensive farmland and undeveloped land, including Yosemite National Park in Madera and Mariposa Counties and Sequoia and Kings National Parks in Fresno and Tulare Counties. The Central Valley accounts for 16% of California’s land area but just 8% of the state’s population. Nearly 16% of Valley residents live in rural communities, compared to less than 6% statewide, with some counties more rural than others: 20% of Tulare residents, 39% of Madera residents, and 100% of Mariposa residents live in rural areas.<sup>22</sup>

## Social, Economic and Environmental Context

**The Central Valley faces long-standing and interconnected social, economic, and environmental challenges that shape the health of its residents.**

The challenges are not isolated but structural, cumulative, and mutually reinforcing. The 2025 *Central California Regional Health Equity Analysis* found that the broader Central Valley region performs worse than other California counties on nearly 70% of health-related indicators across multiple domains.<sup>23</sup> As one stakeholder interviewed for this project put it, “The challenge is there are so many challenges.”

Residents of the Central Valley experience disproportionately high levels of poverty and unemployment, leaving many individuals and families economically insecure. Nearly 18% of residents live below the federal poverty level, compared with 12% statewide. Per capita income in the Valley is roughly \$20,000 lower than the California average (\$29,414 versus \$48,013), and median household income is also lower. The Valley’s unemployment rate stands at 8.1%, well above the statewide rate of 5.5%.<sup>24</sup>

Residents of the Central Valley also face inequities in educational attainment. Approximately 23% of adults lack a high school diploma, compared to 15% statewide, and 14% have not completed ninth grade. Meanwhile, only 19.4% of residents hold a bachelor’s degree or higher, far below California average of 37.5%.<sup>25</sup>

*Table 1: Poverty and Educational Attainment Indicators, Central Valley and California, 2023*

	Central Valley	California
Percent of the population living below the Federal Poverty Level	17.7%	12.0%
Per capita income	\$29,413.5	\$48,013.0
Unemployment rate	8.1%	5.5%
Percent of the population without a high school degree	23.4%	15.2%
Percent of the population with a Bachelor’s or professional degree	19.4%	37.5%

*Sources: DOF, reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2023. One-year estimates were used for California and for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County.*

Housing in the Central Valley is more affordable than California overall. Home prices, relative to incomes, are lower in the Valley than in coastal cities, and a larger share of homes are considered affordable to median-income families. Overall, 56% of residents in the Valley believe that housing affordability is a big challenge in their part of the state, compared to 68% of Californians overall.<sup>26</sup>

Despite relative affordability, many households in the Valley face severe housing cost burdens at rates similar to the California average. Across the state, 79% of extremely low-income households pay more than half of their income toward housing costs;<sup>27</sup> in the Valley, rates

range from 73% to 84%, depending on the county.<sup>28</sup> Rents have risen sharply in recent years and Central Valley renters typically need to earn 1.4 to 1.6 times the minimum wage to afford the average asking rent in their county.<sup>29</sup> Reflecting these and other pressures, homelessness remains a significant concern: 62% of Valley residents report it as a major problem in their area, compared with 63% statewide.<sup>30</sup>

Environmental conditions pose another persistent and significant threat to health in the Central Valley. Heat stroke, Valley fever, and other illnesses are linked to rising temperatures, extreme weather, pesticide exposure, and poor air and water quality. Compared to



other California counties, the Valley has higher levels of particulate matter, ground-level ozone, drinking water violations, and extreme heat days.<sup>31</sup> In 2024, the Environmental Protection Agency projected that fewer than 1% of U.S. counties would fail to meet revised fine particle pollution standards – a group that included counties in the Central Valley.<sup>32</sup> Not surprisingly, residents in the Valley are more likely than the statewide population to express concern about the effects of weather and environmental conditions on their health, with poor and Latino residents reporting the greatest concern.<sup>33</sup>

**The Valley’s long history of inequity means these and other challenges are not experienced equally.**

Farmworkers, for example, have fewer social and economic protections than most other workers, leaving them especially vulnerable to exploitation, housing challenges,<sup>34</sup> heat- and pollution-related illness, and limited access to health and social services.<sup>35</sup> A 2021 California farmworker survey found that two-thirds of farmworker respondents expressed significant fear of family separation due to deportation—a fear that is certainly much more acute today.<sup>36</sup> This fear contributes to a broader lack of trust in institutions and service systems, which further limits access to health and social supports, exacerbating vulnerability.

Systematic underinvestment in infrastructure and community amenities, along with the intentional placement of undesirable and toxic industrial operations, has shaped health outcomes within metro areas. In Fresno, for instance, residents in a southwest ZIP code – with higher poverty rates and larger Latino and African American populations – have a life expectancy of 69 years. Just six miles away, in a northern ZIP code that is more affluent and predominantly White, life expectancy reaches 90 years. This stark disparity reflects more than a century of segregationist policies that divided the city along racial and economic lines.<sup>37</sup>

These overlapping social, economic, and environmental challenges directly influence the demand for health care and shape the capacity and outcomes of the region’s health system.

## Health Status and Outcomes

**Central Valley residents have poorer health and higher rates of chronic disease compared to Californians statewide.**

A higher percentage of Central Valley residents rate their health as fair or poor, and the region has higher rates of chronic disease than California overall – including for asthma, diabetes, heart disease and high blood pressure. Mental health is also a concern, as Valley adults report higher rates of serious psychological distress.<sup>38</sup>

**In most counties, the life expectancy is three to five years below the California average.**

Between 2020 and 2022, all-cause mortality was higher in every Central Valley county than the statewide average. Mortality rates due to cancer, diabetes, and coronary heart disease were also higher across all counties, compared to California overall, and Central Valley death rates from cancer and coronary heart disease exceeded the Healthy People 2030 targets. (There are no Healthy People 2030 targets for overall death rates, or death rates from diabetes.)<sup>39</sup>

Table 2: Health Status and Conditions Indicators, Central Valley and California, 2023

	Central Valley	California
Poor or fair health	16.2%	15.5%
Disabled due to physical, mental or emotional condition	24.9%	19.3%
Children with asthma	17.5%	12.1%
Adults with asthma	17.6%	16.7%
Adults with diabetes	14.3%	11.8%
Adults with high blood pressure	34.4%	27.2%
Adults with heart disease	7.4%	6.7%
Adults with serious psychological distress	15.8%	13.9%

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2023. Central Valley tabulations exclude Mariposa County.

Table 3: Life Expectancy and Mortality Indicators, Central Valley and California, 2020-2022

	Central Valley	California
Life expectancy (years)	74.2 - 78.3	79.4
Death rate due to all causes (per 100,000 population)	781.9 - 951.1	670.0
Death rate due to cancer (per 100,000 population)	128.1 - 139.0	122.0
Death rate due to diabetes (per 100,000 population)	24.9 - 48.8	23.6
Death rate due to coronary heart disease (per 100,000 population)	78.2 - 118.6	77.2

Sources: Life expectancy – University of Wisconsin Population Health Institute, County Health Rankings, 2025; data originally from the CDC National Center for Health Statistics, 2020-2022. Death rates – California Department of Public Health (CDPH), County Health Profiles, 2024. Rates are age adjusted. Ranges shown for the Central Valley reflect the lowest to highest county-level values across Fresno, Kern, Kings, Madera, Merced, and Tulare. Mariposa County is excluded.





# The Medi-Cal Majority: Coverage Trends in the Central Valley

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

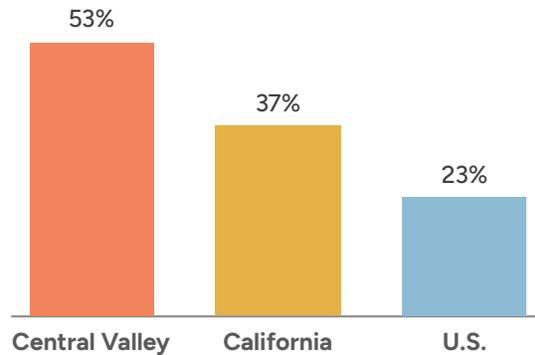
# The Medi-Cal Majority: Coverage Trends in the Central Valley

## More than half of Central Valley residents are covered by Medi-Cal.

Mirroring the higher rates of poverty in the Central Valley, more people have Medi-Cal or are uninsured compared to the statewide average, while fewer have commercial coverage. The region has one of the highest Medicaid enrollment rates in the country: Medi-Cal covers 53% of the population (1.6 million people) and more than 70% of children. Medi-Cal coverage is especially high in Tulare County, where 61% of adults and 78% of children are enrolled. By comparison, Medi-Cal covers 37% of Californians statewide.<sup>40</sup> Dual enrollment in Medicare and Medi-Cal is also more common in the Central Valley than in California overall. In 2024, 36% of Medicare beneficiaries in the Valley (more than 143,000 people) were dually eligible for both programs, compared to 28% statewide.<sup>41</sup>

This dependence on Medi-Cal underscores both the region's economic vulnerability and the central role Medi-Cal plays in keeping families connected to care. For hospitals and health care providers, it means they depend on Medi-Cal to a degree not seen elsewhere in California. Stakeholders that participated in this research stressed that Medi-Cal's dominance in the Central Valley shapes how the health care system operates—constraining financial viability, workforce recruitment and retention, and patient access to care.

Figure 4. Percent of Population Covered by Medi-Cal, 2025



Sources: California Department of Health Care Services (DHCS), *Medi-Cal Certified Eligibles Data by Month with Demographics, February 2025*; DOF, *Population and Housing Estimates for Cities, Counties, and the State, May 2025*; Pew Research Center, *What the Data Says About Medicaid (analysis of CMS enrollment data), 2025*. Central Valley and California rates were calculated using DHCS enrollment figures and DOF population estimates. U.S. coverage rates come from Pew's CMS analysis.

## Six Medi-Cal managed care plans administer Medi-Cal in the region.

There are six Medi-Cal managed care plans in the seven-county study region: CalViva Health, Kern Health Systems, Central California Alliance for Health, Anthem Blue Cross, Health Net, and Kaiser Permanente. CalViva Health, Kern Health Systems, and Anthem Blue Cross account for the largest shares of Medi-Cal enrollment in the region, covering 28%, 26%, and 25% of members, respectively. Anthem Blue Cross operates in the most counties, participating in five of the seven.<sup>42</sup>

Different health plans serve different markets within the region:<sup>43, 44</sup>

- Merced and Mariposa counties follow a County Organized Health System (COHS) model, with Central California Alliance for Health serving as the sole plan. This model and plan are new to Mariposa, which prior to 2024 had two commercial plan options.
- In Fresno, Madera, and Kings counties, the two-plan model pairs CalViva Health, the locally governed plan, with Anthem Blue Cross. CalViva holds the majority market share at 67%. While CalViva is locally governed, Health Net plays a major operational role as its contracted administrative partner.
- Kern County also uses the two-plan model, with Kern Health Systems as the locally governed plan and Anthem as the commercial option. Anthem replaced Health Net as the commercial plan in Kern in 2024. Kern Health Systems dominates the market with 85% of county enrollment.
- Tulare County offers two commercial options—Anthem and Health Net—which split enrollment roughly evenly.
- Kaiser Permanente began contracting directly with the state in January 2024 to provide Medi-Cal managed care in many California counties, including Fresno, Kern, Kings, Madera, Mariposa and Tulare (all counties in the study region except for Merced). Enrollment, however, is limited. Eligibility generally applies only to individuals with Kaiser coverage in the prior 12 months, those with a qualifying family member already enrolled in Kaiser, and certain special populations.<sup>45</sup> Kaiser’s overall Medi-Cal market share in the region is small at 2%, with its highest share in Kern County at 5%.<sup>46</sup>

**Uninsurance rates have fallen sharply over the past 15 years, but a higher share of Valley residents remains uninsured than in California overall.**

One notable bright spot related to access to care in the Central Valley has been the significant expansion of health insurance coverage rates, following the passage of the Affordable Care Act and the subsequent expansion of Medi-Cal eligibility to all income-eligible Californians, regardless of immigration status. Between 2012 and 2023, the estimated rate of uninsured in the Central Valley declined from 16.2% to 5.9%.<sup>47</sup>

Despite these gains, the Central Valley still has a higher estimated rate of uninsured than the state overall (5.9% versus 4.5% in 2023).<sup>48</sup> If the Valley’s uninsured rate matched California’s rate, around 40,000 more Valley residents would have health insurance. Farmworkers, in particular, face unique challenges that limit access to insurance. Common barriers to coverage include fear of applying for insurance, income thresholds that disqualify applicants, the high cost of private insurance, and employment under different names, which prevents access to employer-sponsored benefits. Additionally, many farmworkers lose their coverage during months when they are not working.<sup>49</sup>

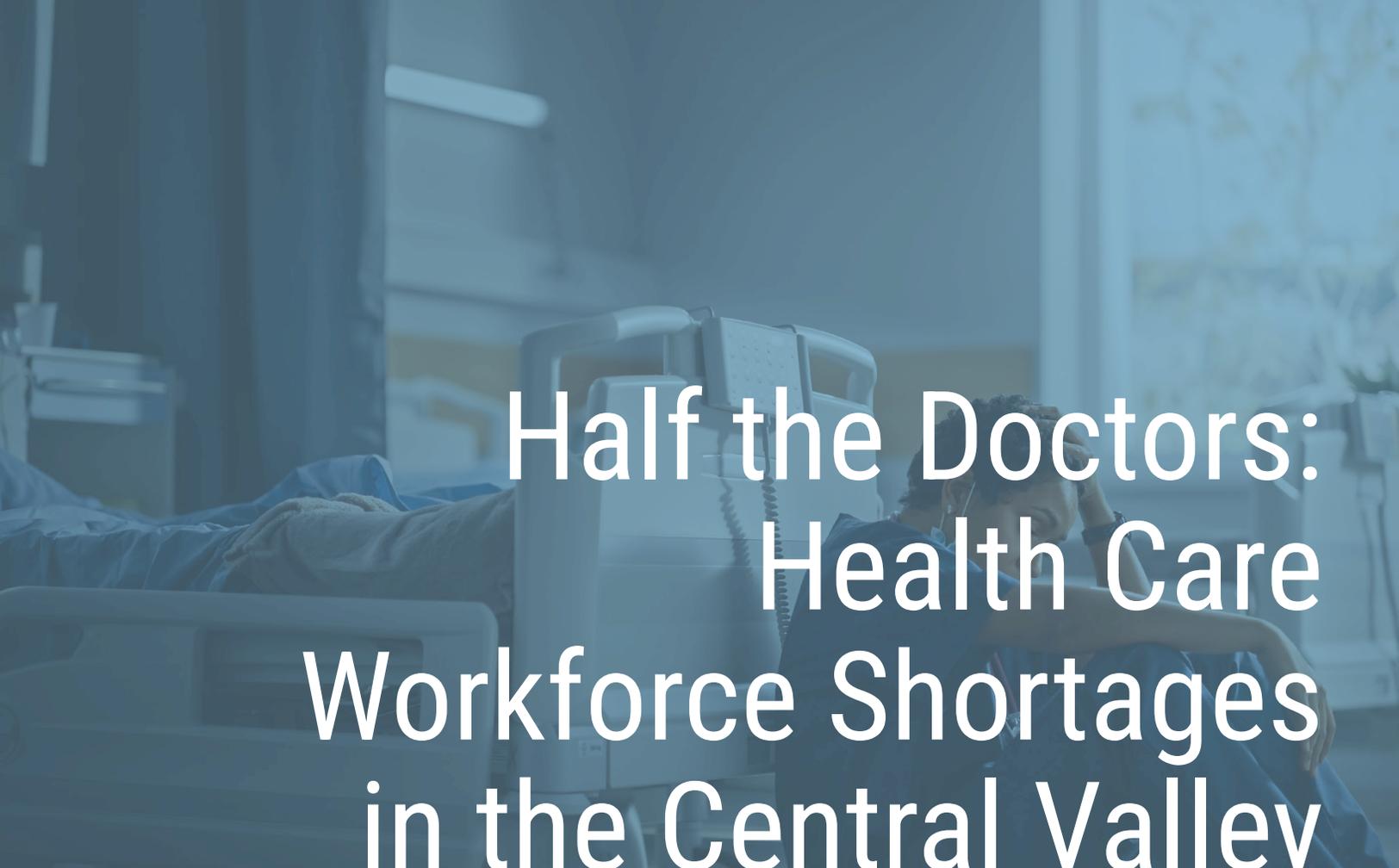
**Federal and state cuts threaten to unravel coverage gains.**

The passage of H.R. 1 (One Big Beautiful Bill Act) and state budget cuts will roll back many coverage expansion gains. By January 2027, Medicaid work requirements will take effect, obligating most adults to document 80 hours of work, schooling, or volunteering each month, with status verified twice a year. While exemptions exist, many are expected to lose coverage—both because of seasonal or unstable work and the added administrative hurdles.<sup>50</sup> The California Health and Human Services Agency (CalHHS) estimates that up to 3.4 million Medi-Cal members in California may lose coverage due to work requirements and other provisions under H.R. 1.<sup>51</sup> If that reduction occurred similarly across the state, about 376,000 Central Valley residents would lose Medi-Cal coverage.

At the same time, the scheduled expiration of enhanced ACA marketplace subsidies at the end of 2025 will trigger a sharp affordability crisis, likely pushing many

families out of coverage through Covered California.<sup>52</sup> Currently, there are 1.9 million Covered California enrollees statewide and 112,580 enrolled in the Central Valley.<sup>53</sup> Covered California estimates that average premium costs will increase by 10.3% in 2026, and that Californians who lose the enhanced premium tax cuts could see an additional net premium increase of 66%.<sup>54</sup> These high prices mean that as many as 660,000 Covered California enrollees could lose coverage statewide, which could translate into approximately 38,000 Central Valley residents losing coverage.<sup>55</sup>

Additional state-level cuts will lead to even more coverage loss. An estimated 136,000 Medi-Cal enrollees in the Central Valley were undocumented as of February 2025—about 8% of the region’s total Medi-Cal enrollees.<sup>56</sup> California plans to freeze new enrollment for undocumented adults starting in 2026 and require premiums for current enrollees beginning in 2027.<sup>57</sup>



# Half the Doctors: Health Care Workforce Shortages in the Central Valley

Central Valley **Health Care Landscape Study**



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

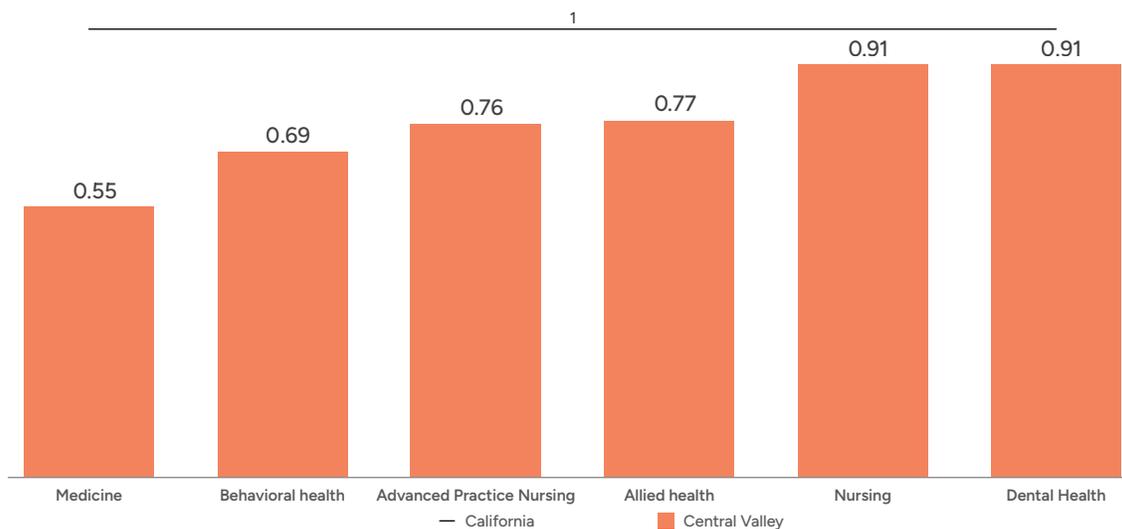
# Half the Doctors: Health Care Workforce Shortages in the Central Valley

Against a backdrop of population growth and diversity, geographic expanse, social and economic inequities, and a disproportionately high share of Medi-Cal coverage, the Central Valley faces persistent shortages in its health care workforce.

**The Central Valley’s share of the state’s health care workforce relative to population size is the lowest in California.**

Compared to California overall, the Central Valley has far fewer health care providers across key professions. In fact, the broader Valley region (including San Joaquin and Stanislaus counties) has the lowest number of health care workers in every category except dental health, relative to its share of the state’s population. The shortage of medical, osteopathy, and naturopathic doctors and physician assistants is particularly striking; the region’s share of medical licenses is nearly half its share of the total population.<sup>58</sup>

Figure 5: Health Workforce Distribution Index, Central Valley and California

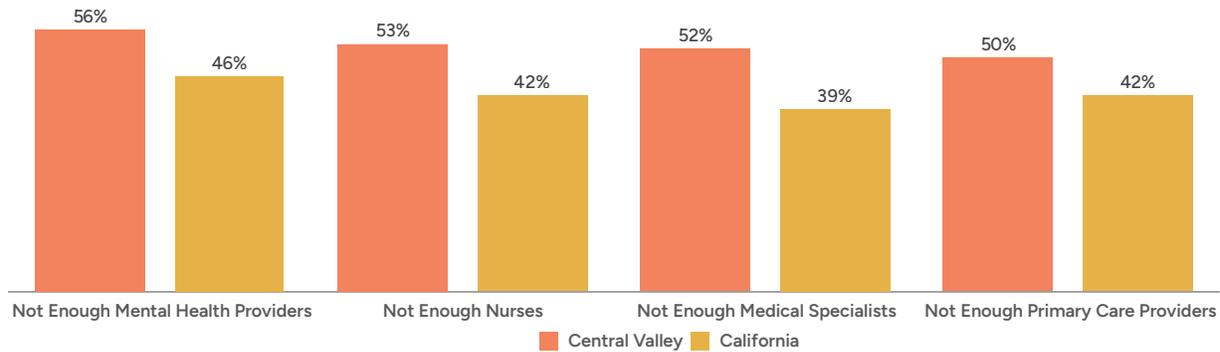


Source: California Department of Health Care Access and Information (HCAI), Health Workforce Research Data Center Annual Report to the Legislature, April 2025. A distribution index below one indicates a smaller share of licenses than population. E.g., 5% of state’s licenses and 10% of state’s population would equate to a distribution index of 0.5. Central Valley: Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare.

Central Valley residents feel these shortages and are more likely than California residents overall to say their communities do not have enough mental

health providers, nurses, specialists, and primary care providers.<sup>59</sup>

Figure 6: Percent of Residents to Say Their Community Does Not Have Enough Providers, Central Valley and California, 2024



Source: California Health Care Foundation (CHCF), The 2024 CHCF Central Valley Health Policy Survey, April 2024. CHCF, The 2024 CHCF California Health Policy Survey, January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties. Difference between CV and CA is statistically significant.

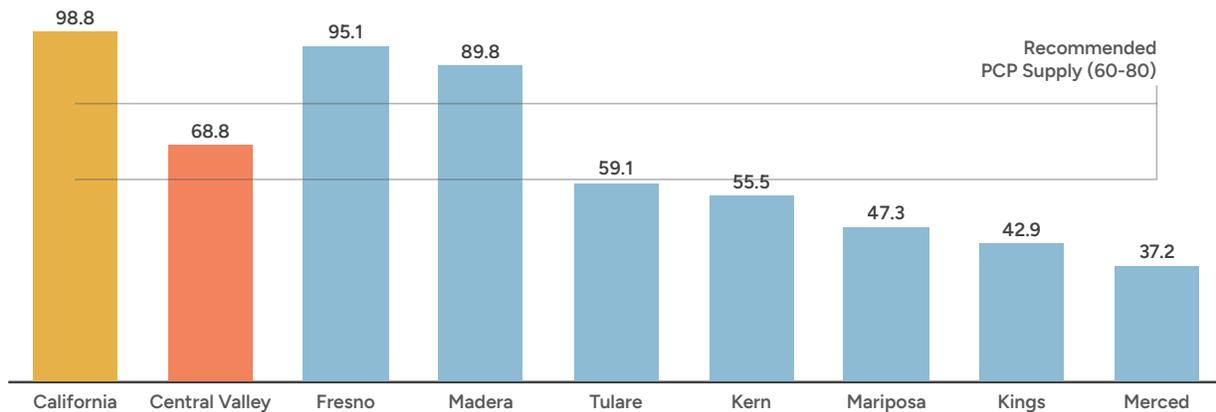
## Primary Care Supply

**Eighty-five percent of Valley residents live in primary care shortage areas, and the region has 30% fewer PCPs than statewide.**

In 2025, the Valley had 68.8 active patient care primary care providers (PCPs) per 100,000 population compared to 98.8 statewide. (Active PCPs are general

practice medicine, family medicine, geriatric, internal medicine, and pediatric MDs and DOs with at least 20 hours of patient care). While the Valley overall meets the lower end of the Council of Graduate Medical Education (COGME) recommended ratio of 60 to 80 PCPs per 100,000 population, Tulare, Kern, Kings, Mariposa, and Merced counties all fall below this benchmark.<sup>60</sup>

Figure 7: Active Patient Care PCP Supply Per 100,000 Population, 2025

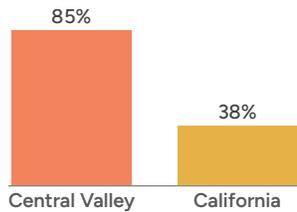


Sources: HCAI, Physicians Actively Working by Specialty and Activity Hours, July 2025; DOF, Population and Housing Estimates for Cities, Counties, and the State, May 2025. PCP supply per 100,000 population calculated by author. Active primary care physicians (PCPs) include MDs and DOs in general practice, family medicine, geriatrics, internal medicine, and pediatrics with at least 20 hours of patient care per week. Recommended PCP supply benchmark from the Council on Graduate Medical Education (COGME).

The growth of doctors of osteopathy (DOs) in the Central Valley has likely mitigated a worse shortage of PCPs, as the number of DOs in the Valley more than doubled from 290 in 2018 to 626 in 2023.<sup>61</sup> A recent [California Health Care Foundation report](#) shows that the San Joaquin Valley has the third lowest supply of active patient care primary care doctors of medicine (MDs) in the state at 47 PCPs per 100,000 population.<sup>62</sup>

Reflecting these shortages, 85% of Central Valley residents live in a primary care shortage area, compared to 38% of California residents overall. Notably, 100% of residents in Madera, Mariposa, Merced, and Tulare counties live in a primary care shortage area.<sup>63</sup>

**Figure 8: Percent of Population Living in a Primary Care Shortage Area, Central Valley and California, 2025**



*Source: California Healthline, California’s Primary Care Shortage Persists Despite Ambitious Moves To Close Gap, May 1, 2025. Regional percentage calculated by author.*

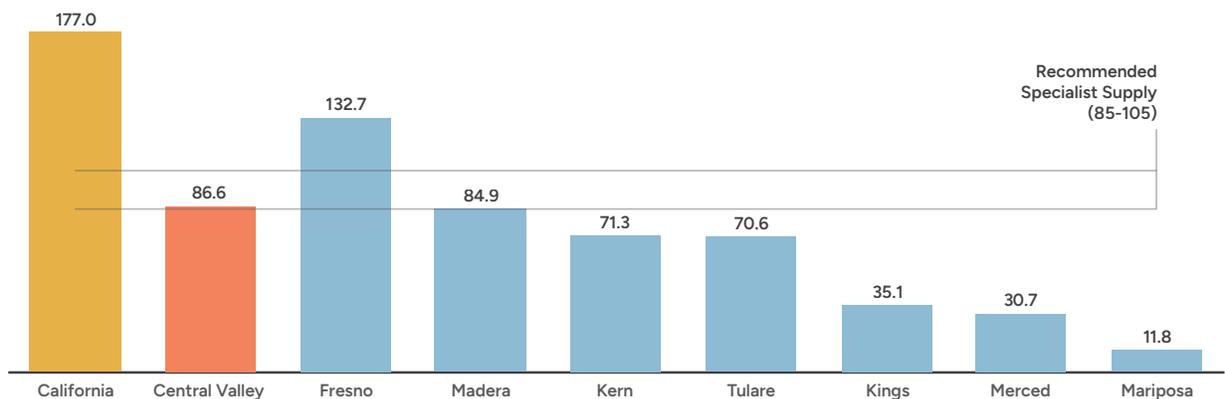
## Specialist Supply

**The Valley has only half the specialists per capita compared to the statewide average.**

The Central Valley has a critical shortage of specialist physicians (MDs and DOs), with half the supply of specialists per capita compared to California overall. In 2025, the Valley had 86.6 active patient care specialists per 100,000 population compared to 177 statewide. Only Fresno and Madera counties meet the COGME recommended ratio of 85 to 105 specialists per 100,000 population; the remaining counties have 71 or fewer specialists per 100,000 population.<sup>64</sup>

Stakeholders noted that while Fresno and Madera have a higher concentration of specialists than other counties, these physicians frequently serve patients from across the region. For example, Fresno hosts the region’s only level 1 trauma center and many Valley residents travel to Fresno for specialty care. Madera is home to Valley Children’s Hospital, which provides care to children from across Central California.

**Figure 9: Active Patient Care Specialist Supply per 100,000 Population, 2025**



*Sources: HCAI, Physicians Actively Working by Specialty and Activity Hours, July 2025; DOF, Population and Housing Estimates for Cities, Counties, and the State, May 2025. Specialist supply per 100,000 population calculated by author. Active specialists are physicians (MDs and DOs) with non-primary care specialties that spend at least 20 hours a week in patient care. Recommended specialist supply benchmark from the Council on Graduate Medical Education (COGME).*

The Central Valley has a lower supply of all specialty types compared to the state. Some notable specialties with especially low supply include anesthesiology, radiology, neurology, dermatology, and pathology. For each of these specialties, the Valley has 3% or less of the total supply of these specialists compared to having 7.8% of the state's residents.

In addition, various oncology specialties are in short supply in the Central Valley. There are only 18 radiation oncologists and 2 surgical oncologists to serve the entire Valley. And only 1.7 oncologists per 100,000 population compared to 4.1 statewide.<sup>65</sup>

In interviews and listening sessions, stakeholders shared challenges recruiting across a wide range of specialty types, including: otolaryngology, neurology, urology, gastroenterology, rheumatology, obstetrics and gynecology, pediatric anesthesia, endocrinology, dermatology, and oncology. In the face of these shortages, some hospitals have resorted to paying physician staffing companies to ensure sufficient coverage for the emergency department and specific service lines. The shortage of specialists also presents a barrier to medical education, as there are not sufficient physicians to serve as faculty for medical students and residents.

**Table 4: Active Patient Care Specialists by Specialty Type, 2025**

Specialty Type	Number of Specialists		Specialists Per 100,000 Population		Per Capita Percent Difference (CV vs. CA)
	CV	CA	CV	CA	
Emergency Medicine	320	6787	10.41	17.17	-39%
Psychiatry	286	6716	9.30	16.99	-45%
Obstetrics and Gynecology	261	5271	8.49	13.33	-36%
Anesthesiology	175	6380	5.69	16.14	-65%
General Surgery	145	2595	4.72	6.56	-28%
Cardiology	124	3324	4.03	8.41	-52%
Orthopedic Surgery	119	2757	3.87	6.97	-45%
Radiology	117	4010	3.81	10.14	-62%
Gastroenterology	89	2091	2.89	5.29	-45%
Ophthalmology	87	2595	2.83	6.56	-57%
Nephrology	67	1319	2.18	3.34	-35%
Critical Care	65	1117	2.11	2.83	-25%
Neurology	60	2076	1.95	5.25	-63%
Oncology	51	1615	1.66	4.09	-59%
Neonatal-Perinatal Medicine	47	930	1.53	2.35	-35%
Pulmonology	46	1135	1.50	2.87	-48%
Dermatology	45	2019	1.46	5.11	-71%
Physical Medicine and Rehabilitation	44	1176	1.43	2.98	-52%
Pathology	39	1462	1.27	3.70	-66%
Otolaryngology	37	1222	1.20	3.09	-61%
Urology	32	1247	1.04	3.15	-67%
Infectious Disease	32	822	1.04	2.08	-50%
Plastic Surgery	31	1219	1.01	3.08	-67%
Endocrinology	28	991	0.91	2.51	-64%
Occupational Medicine	28	399	0.91	1.01	-10%
Pain Medicine	26	682	0.85	1.73	-51%
Vascular Surgery	26	516	0.85	1.31	-35%
Rheumatology	25	750	0.81	1.90	-57%
Neurological Surgery	25	744	0.81	1.88	-57%
Allergy and Immunology	20	532	0.65	1.35	-52%
Thoracic Surgery	19	493	0.62	1.25	-50%
Radiation Oncology	18	663	0.59	1.68	-65%
Colon and Rectal Surgery	17	256	0.55	0.65	-15%
Sleep Medicine	16	201	0.52	0.51	2%
Neurology with Special Qualification in Child Neurology	9	302	0.29	0.76	-62%
Sports Medicine	7	317	0.23	0.80	-72%
Spine Surgery	3	179	0.10	0.45	-78%
Hematology	2	301	0.07	0.76	-91%
Surgical Oncology	2	294	0.07	0.74	-91%
Cosmetic Surgery	1	103	0.03	0.26	-88%
Facial, Plastic and Reconstructive Surgery	0	216	0.00	0.55	-100%
Nuclear Medicine	0	114	0.00	0.29	-100%

*Sources: HCAI, Physicians Actively Working by Specialty and Activity Hours, July 2025; DOF, Population and Housing Estimates for Cities, Counties, and the State, May 2025. Specialist supply per 100,000 population calculated by author. Active specialists are physicians (MDs and DOs) with non-primary care specialties that spend at least 20 hours a week in patient care. Table includes specialty type with at least 100 active care specialists in California.*

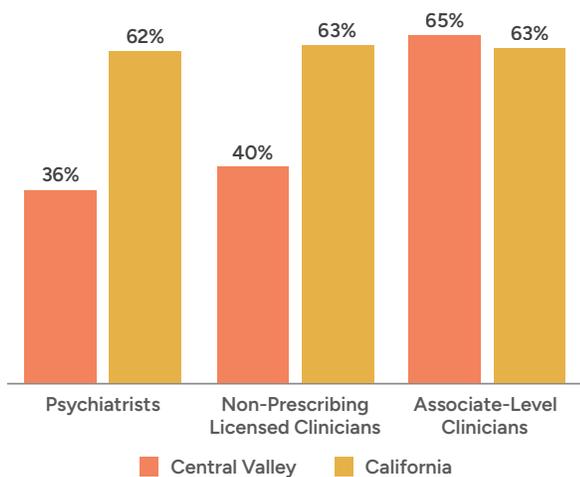


## Behavioral Health Provider Supply

**The Central Valley has less than half of the behavioral health providers it needs.**

The region is short an estimated 5,350 providers overall, including 275 psychiatrists, 4,210 non-prescribing licensed clinicians,<sup>66</sup> and 865 associate-level clinicians.<sup>67</sup> Behavioral health workforce shortages are a challenge across California, but the gaps are especially severe in the Central Valley. The Valley has only 36% of the psychiatrists needed to meet demand, compared to 62% statewide. It also has just 40% of the licensed therapists needed, versus 63% statewide.<sup>68</sup>

*Figure 10: Behavioral Health Workforce Supply as a Percent of Total Demand*



*Source: HCAI, Health Workforce Research Data Center Annual Report to the Legislature, April 2025.*

Stakeholders reported high vacancy and turnover rates among behavioral health clinicians. One leader observed that competitive salaries and remote work opportunities have drawn providers away from safety-net systems, where patient populations tend to have higher disease burdens and more complex conditions, and compensation is lower. Others highlighted a shortage of licensed Spanish-speaking behavioral health providers, which further limits access for the region’s sizable Spanish-speaking population. One stakeholder noted a severe shortage of psychiatrists

specializing in addiction – a gap that is expected to become even more critical with the implementation of Senate Bill 43, which expands conservatorship laws.<sup>69</sup>

## Nursing Supply

**Most Central Valley counties face registered nurse shortages, and the region has significantly fewer RNs per capita than the California average.**

The Central Valley had a shortage of 2,300 RNs in 2024, which represents 37% of the state’s overall shortage of about 6,100 RNs. HCAI projects that the Central Valley will face similar shortages in the future, with an overall regional shortage of 2,161 RNs in 2033.<sup>70</sup> A recent UCSF survey indicates that the Central Valley has 702 RNs employed in nursing per 100,000 population compared to 1,073 in California.<sup>71</sup>

The adequacy of RN supply varies across the region. Tulare and Mariposa counties have the most severe RN shortages, with Tulare needing a 30% increase and Mariposa a 40% increase to meet demand. Kern, Madera, and Merced counties also have shortages, though less severe than those in Tulare and Mariposa. Fresno County has no RN shortage, and Kings County has a small surplus.<sup>72</sup>

Some regional hospitals are struggling to meet nurse staffing demands. One hospital reported relying heavily on traveling nurses, needing 150 per day—down from 300 at the peak of the pandemic—but still creating significant financial challenges. Another hospital noted that nurses remain the hardest positions to recruit. Both hospitals have launched new internal nurse training programs to upskill their own workforce and address these staffing challenges.

The broader San Joaquin Valley (including San Joaquin and Stanislaus counties) also has an undersupply of advanced practice nurses. The region has only half the expected number of clinical nurse specialists, 78% of the expected number of nurse anesthetists, and 80% of the expected number of nurse practitioners based on population size.<sup>73</sup>

## Allied Health

**The Valley has the most severe shortage of allied health professionals in the state.**

The broader San Joaquin Valley has about three-quarters of the estimated workers it needs. Advanced practice pharmacists, audiologists, chiropractors, and occupational therapists are at roughly half the expected supply, while physical therapists and optometrists are slightly above half.<sup>74</sup> Stakeholders in interviews and listening sessions also reported shortages of occupational therapists, imaging and x-ray technicians, and medical assistants.

## Dental Workforce

**All Central Valley counties have fewer dentists per capita than the California average.**

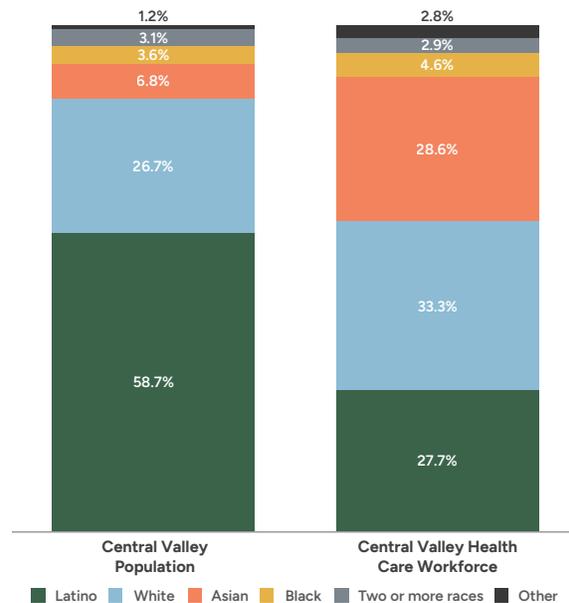
The broader San Joaquin Valley ranks third lowest in the state for dental workforce relative to population.<sup>75</sup> Stakeholders also reported shortages of registered dental assistants.

## Diversity of the Health Care Workforce

**The Central Valley’s health care workforce does not reflect the diversity of the population it serves.**

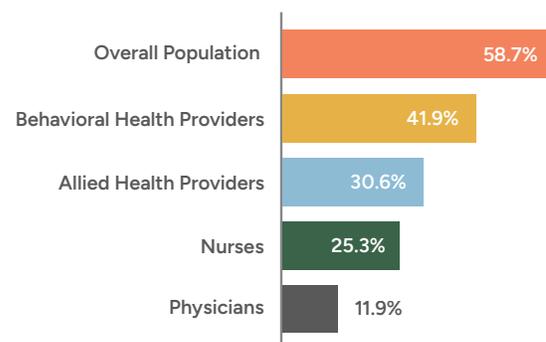
Across the broader San Joaquin Valley, Latinos are underrepresented among health care workers, with the greatest disparities seen among physicians.<sup>76</sup> This pattern reflects a broader national trend, in which Latino health professionals remain proportionally lower than their share of the U.S. population.

**Figure 11: Race and Ethnicity Distribution, Central Valley Population and Central Valley Health Care Workforce**



Sources: *DOF, reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2023. One-year estimates were used for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County. HCAI, Race & Ethnicity of California’s Health Workforce, licensure data collected by the Department of Consumer Affairs; data represent a snapshot of the active licensee population for 47 licensed health professions on December 3, 2024. Counties included in Central Valley Health Care Workforce: Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare.*

**Figure 12: Percent Latino in the Central Valley Overall and Across Health Workforce Roles, 2024**



Source: *HCAI, Race & Ethnicity of California’s Health Workforce, licensure data collected by the Department of Consumer Affairs; data represent a snapshot of the active licensee population on December 3, 2024. DOF, reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2023.*

## Drivers of Health Care Workforce Shortages

Stakeholders attribute the health care workforce shortages in the Central Valley to a combination of factors, including limited local education and training opportunities, economic pressures, challenging workplace conditions, and lifestyle considerations.

### **Limited education and training opportunities impede “grow our own” strategies.**

Education gaps remain a central barrier to growing and retaining the local health care workforce. Stakeholders consistently noted that individuals who train in the region – especially those originally from the Valley – are most likely to stay and work locally.

Historically, however, the Central Valley has lacked sufficient education opportunities, contributing to a shortage of physicians and other health care providers in the region.

Exemplifying both the historical underinvestment that contributed to these outcomes and the powerful impact of sustained advocacy, is the story of UC Merced. Most University of California (UC) campuses are concentrated in coastal and urban areas, and were established by 1965. It was not until 2005—40 years after the prior UC campus opened in Santa Cruz—that UC Merced became the first and only UC campus in the Valley. Its creation was the result of decades of persistent advocacy by local leaders, educators, and community groups, who highlighted the region’s lack of higher education access and the need for expanded opportunities for Valley students.

Despite significant progress, education and training capacity in the region remains insufficient. Stakeholders note that the challenge begins early, within the K–12 system. As highlighted earlier in this report, nearly one in four Valley residents lack a high school diploma, and only 20% hold a college degree, compared with 37.5% statewide. Many students in the Valley grow up with limited awareness of the full range of health care careers

available or the educational pathways required to pursue them. Even when students are aware, they often lack the confidence, guidance, resources, and support needed to successfully navigate those pathways. There are many examples of successful programs in the Valley that expose young people to health careers or provide early training, but these initiatives currently reach only a fraction of the student population. Stakeholders emphasized the importance of engaging students by middle school, as they need to take specific courses in high school to prepare for certain health careers. Some stakeholders also expressed frustration that some existing programs set the bar too low, emphasizing they would like to see initiatives encourage students to aim for health care roles that can substantially improve their economic opportunities.

For students who do pursue health profession pathways, local training programs are often oversubscribed. Nursing and allied health programs across the region struggle to keep up with demand, limited by faculty shortages and insufficient clinical placements. Recruiting nurse educators is especially challenging, since nurses can earn significantly more in practice than in teaching roles. Disagreements between two- and four-year institutions—particularly over whether community colleges should be authorized to offer BSNs—have further constrained program capacity and slowed workforce growth.

Compared to other regions in California, the Central Valley also has a shortage of undergraduate medical education (i.e. medical schools) and graduate medical education (i.e. GME or residency) programs. Progress toward a stand-alone UC medical school has been slow and the region lacks state-of-the-art training facilities and sub-specialty training opportunities compared to larger cities. While GME programs have grown in recent years, many hospitals in the region report they cannot further expand residency programs due to strained finances and Medicare funding caps for GME.

Stakeholders shared that behavioral health workforce development faces its own set of challenges, including licensure delays and a shortage of licensed supervisors,

which creates bottlenecks in fulfilling supervision requirements and slows the pipeline of new providers.

**Economic realities also make recruitment and retention difficult.**

Nationwide, there is a shortage of health care providers, especially physicians and nurses, which increases competition for these workers. Health care employers noted that care is not as profitable in the Valley and it is hard to match the salaries and sign-on bonuses offered in other parts of the state and country.

**Health care workers often face heavy caseloads and complex patient populations, which can contribute to burnout.**

The economic pressure of lower salaries for health care providers in the Valley is compounded by more challenging work conditions. Like many other areas, the Valley experienced a significant exodus of health care providers during the COVID-19 pandemic, and staffing gaps from that period persist. Fewer providers add to the workloads of those that remain, creating additional pressure and longer hours. High turnover among nurses and support staff, such as medical assistants, further intensifies strain on clinical teams.

Stakeholders also emphasized the unique experiences and challenges of serving individuals with complex health needs. While some providers find deep meaning and professional growth in supporting patients with complex health needs, many shared that the continuous demands of delivering high-quality care to this population in an under-resourced environment can lead to burnout.

**Lifestyle, community reputation, and lack of community connection pose significant barriers to recruiting and retaining health care workers from outside the Central Valley.**

Stakeholders noted the challenge of overcoming the perception that the Valley is an undesirable place to live. While many residents highlight the region's assets and express personal satisfaction with life in the Valley,

the area faces reputational hurdles. Compared to other parts of California, the Valley is geographically isolated, lacks beaches and professional sports teams, has fewer urban green spaces, limited high-end hotel and dining options, and frequently experiences poor air quality. Stakeholders also noted that potential newcomers also raise concerns about the quality of schools—particularly in rural areas—and limited housing options in certain communities. Recruitment is further complicated by the lack of employment opportunities for partners of health care workers.

Fostering a sense of welcome and belonging for new health care professionals is an ongoing challenge. Systemic bias and a lack of diversity in local institutions can make it difficult for people of color and newcomers to feel integrated. Stakeholders note that leadership within health care systems and other key institutions is not representative of the region's population, which contributes to difficulties attracting and retaining a diverse workforce, including physicians.

**Recruitment and retention can be particularly challenging in rural areas.**

Employers noted that while smaller towns provide important local services, professionals often prefer larger regional centers such as Fresno, Clovis, and Visalia, which offer more school options, cultural amenities, and opportunities to connect with peers and build professional networks.

## **Bright Spots: “Grow our Own” Solutions Have Momentum**

**Despite ongoing workforce challenges, the Central Valley has several promising programs and initiatives that provide a foundation to build upon.**

The Central Valley recently gained its very first medical school – the College of Osteopathic Medicine at California Health Sciences University (CHSU-COM) in Clovis – which graduated its first class in May 2024. The college plans to enroll 150 students per class, totaling roughly 600 students at any time. CHSU-COM is the



third College of Osteopathic Medicine in California and was founded by the Aseemi family, who privately funds the institution.

UCSF Fresno – while not a standalone medical school – plays a prominent role in undergraduate medical education in the Valley. School leaders estimate that 300 medical students rotate through UCSF Fresno’s program each year, including UCSF students and others completing training rotations and electives. Programs like SJV PRIME admit students from the Valley who spend 18 months in San Francisco before completing their medical school training in Fresno. SJV PRIME+, a new BS-to-MD program at UC Merced, guarantees medical school admission to UCSF after students complete their bachelor’s degree at UC Merced. The first 18 months of their medical school training occurs at UC Merced, and then they go to UCSF Fresno to complete training. While the SJV PRIME+ model is promising, initial cohort sizes are small.

While more are needed, residency programs and positions have grown in recent years in the Central Valley and in California.<sup>77</sup> For example, Kaweah Health started their GME journey in 2013 and has since added five additional residency programs. Saint Agnes Medical Center became an independent teaching hospital in 2018 with the approval of its Internal Medicine program. More recently, Bakersfield Memorial combined funding from state and local grants to launch an internal medicine residency this year in partnership with Morehouse School of Medicine, a historically Black medical college in Atlanta. United Health Centers also launched its own internal medicine residency program, adding further training opportunities to the region.<sup>78</sup> UCSF Fresno continues to be a significant GME powerhouse in the region, training approximately 340 residents and fellows every year.

K–16 (kindergarten through college) education-to-employment health pathways are prevalent in the region, offering early exposure to health careers and dual-enrollment opportunities between high schools and community colleges. The Central San Joaquin Valley K-16 Partnership is a collaboration initiative combining

the Fresno-Madera K-16 Collaborative and the Tulare-Kings College and Career Collaborative, which aims to strengthen educational pathways and workforce development across the four counties by aligning efforts and resources. According to the Partnership, about half of the high schools in the four-county region have a health pathway and 42% of those programs have recently expanded their capacity to accommodate more students, leveraging regional K-16 funds. A recent report from Healthforce Center at UCSF explores in greater detail how high school pathways and related programs are being used to grow the workforce in the Valley.<sup>79</sup>

The Tulare-Kings Health Care Partnership provides a useful example of health care employer–educator collaboration. The Partnership brings employers and educators together monthly to address regional workforce needs. Following the Next Gen Sector Partnership model—an industry-led approach supported by public partners, including local schools and colleges—the Partnership helps align education and training with employer demand. One education leader noted that the Partnership has been crucial to responding to workforce shortages, providing a monthly forum to hear directly from employers and strengthen relationships that link students more strategically to job opportunities. Established in 2010 with grant funding, the Partnership is facilitated by the Workforce Investment Board of Tulare County.

There are many more examples: stakeholders shared creative partnerships between health systems and schools to support clinical faculty, cooperative arrangements to expand clinical rotations, new employer-funded training programs, successful upskilling of incumbent workers, and innovative uses of simulation to support clinical training hours. While the examples highlighted here are not exhaustive, they demonstrate the Valley’s capacity to develop and retain a skilled health care workforce and illustrate the types of strategies and partnerships that can be expanded or replicated – with additional support – to improve health workforce numbers and access to care in the region.



# Overcrowded: Bed Capacity in the Central Valley

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Overcrowded: Bed Capacity in the Central Valley

**The Central Valley lacks bed capacity across the care continuum, with shortages spanning acute inpatient, emergency care, long-term care, and behavioral health.**

Capacity challenges are shaped not only by physical bed supply but also by the ability to staff and operate beds within sustainable financial and policy models. As one stakeholder noted, “capacity is not just space.”

## Acute Care Hospitals in the Central Valley

**The Central Valley includes 25 general acute care hospitals, spanning a wide range of size, ownership, and specialization.**

Most hospitals (17) are not-for-profit, four are district hospitals, one is county-owned, and three are investor-controlled. Nine are rural hospitals. More than half of Central Valley hospitals are located in Kern (9) and Fresno (7) counties. Tulare has three hospitals, Merced and Madera each have two, and Kings and Mariposa each have one. Fresno has fewer hospitals than Kern but accounts for the largest bed capacity overall. Hospitals range in size from 25 licensed beds to 921 licensed beds (or 11 to 812 staffed beds).<sup>80</sup>

Community Regional Medical Center in Fresno is the region’s largest hospital, with 921 licensed beds (812 staffed).<sup>81</sup> Owned by Community Health System, it is Fresno County’s primary safety-net hospital, only level 1 trauma center, and the teaching facility affiliated with UCSF Fresno. Community Health System also operates Clovis Community Medical Center in nearby Clovis.

Adventist Health operates seven of the region’s 25 hospitals including Adventist Health facilities in Bakersfield, Delano, Hanford, Reedley, Selma, Tehachapi Valley, and Tulare. A faith-based, not-for-profit health system, Adventist Health manages 27 hospitals across California, Oregon, and Hawaii, many of them in rural communities that might otherwise lack access to hospital care.<sup>82</sup> Most recently, the system re-opened the former Tulare Regional Medical Center, which closed in 2017 due to financial and operational difficulties. Adventist hospitals in the region are generally small to mid-sized. The Bakersfield hospital is the largest at 177 staffed beds and Tehachapi hospital is the smallest at 11 staffed beds. Overall, Adventist facilities account for 11.5% of the region’s staffed hospital beds.<sup>83</sup>

Other large hospitals in the region include Kaweah Health Medical Center in Visalia, the second-largest hospital in the region and the largest district-owned hospital in California. Saint Agnes Medical Center in Fresno is the third largest and is affiliated with Trinity Health, a national Catholic health system. In Kern County, Bakersfield Memorial Hospital is the largest hospital in the county and the fourth largest in the region. It is part of Dignity Health, which also operates Mercy Hospital in Bakersfield and Mercy Medical Center in Merced. Valley Children’s Hospital in Madera is the fifth largest by licensed beds. As the only pediatric hospital in the region, it serves a broad referral area. Kern Medical Center stands out as the only county-owned hospital in the region.<sup>84</sup>

Three hospitals in the region are investor controlled. American Advanced Management (AAM) took over Madera Community Hospital in 2024 and Coalinga

Regional Medical Center in 2020 after each hospital filed bankruptcy and closed. In the Madera example, there was some organized objection to AAM's takeover of the hospital, but eventually they prevailed.<sup>85</sup> AAM is based in Modesto and currently runs 10 rural acute care hospitals, nine of which are in California.<sup>86</sup> Good Samaritan Hospital in Bakersfield is the third investor-owned hospital in the region. Their website says the hospital is physician-owned and financial documents report Alliance Investment, Inc. as the owner.<sup>87</sup>

## Hospital Bed Supply

**The Central Valley and California have a low supply of acute care hospital beds.**

The Central Valley has fewer licensed and staffed hospital beds per 1,000 residents than California overall — and both fall well below national averages. (Licensed beds refer to the total number of hospital beds a facility is authorized to operate by state regulators; staffed beds are the number of beds that a hospital can actually use for patient care at a given time, based on available staff, equipment and resources.) The Central Valley has only 1.2 staffed beds and 1.8 licensed beds per 1,000 population in general acute care hospitals, compared to 1.3 staffed beds and 2.0 licensed beds per 1,000 population statewide.<sup>88</sup> California ranks 7th lowest of all states in hospital beds per 1,000 population according to the American Hospital Association.<sup>89</sup>

A [Trillian study](#) found bed shortages across Central Valley markets. Merced had the lowest hospital bed supply among health care markets with 250,000 to 500,000 residents. Fresno had the 5th lowest supply in markets with one million or more residents, and Bakersfield-Delano had the 14th lowest supply among markets with 500,000 to one million residents.<sup>90</sup>

Regionally, only 65% of licensed beds were staffed and ready to accept patients.<sup>91</sup> One hospital leader described bed capacity as “ridiculous,” noting patients wait in hallways for beds. Another said the current infrastructure would not withstand significant stress testing, such as a future pandemic or other surge event.

The average length of stay (ALOS) for Central Valley and California hospitals has been increasing, suggesting more complex patients and/or increasing discharge delays due to inadequate post-acute supply, lack of ambulance and other transportation resources, and payer authorization delays. The ALOS for patients with Medi-Cal coverage is much higher than for patients with private insurance in both the Central Valley (6.0 vs. 4.5 days) and California (6.2 vs. 4.5 days).<sup>92</sup>

## Emergency Department Services

**The supply of ED treatment stations in the Central Valley is similar to California overall, but ED utilization is higher.**

The Central Valley has 0.21 treatment stations per 1,000 residents, approximately equal to the California average of 0.22. However, the region experiences higher patient volumes per treatment station and more emergency department (ED) visits per capita than the state overall. General acute care hospitals in the Valley see 1,808 patients per ED treatment station, compared with 1,680 statewide.<sup>93</sup> Similarly, the Central Valley has 396 ED visits per 1,000 residents, versus 379 statewide, with Kings, Madera, and Kern counties experiencing particularly high ED utilization.<sup>94</sup>

The region has one level 1 trauma center, at Community Regional Medical Center in Fresno. The next closest trauma centers are in LA, the Inland Empire, Sacramento, and the Bay Area.

The emergency department has become a critical entry point for inpatient care. In the Central Valley, one in eight (12.5%) ED patients are admitted to the hospital, and two-thirds (67%) of all hospital admissions originate in the ED—trends that mirror statewide averages.<sup>95</sup>

There are signs that EDs in the Central Valley are over capacity. In 2023, 4.4% of Central Valley residents left the ED without being seen, compared to 3.1% statewide — a signal of long wait times. This means more than 52,000 Valley patients went without the care they sought that year.<sup>96</sup>

Specialist shortages and insufficient specialty coverage in EDs lead to patient transfers. One hospital stakeholder shared they can only cover urology for three to four days a week, so if a patient comes in with a urology need on the other days, they have to be transferred over 40 miles to another acute care hospital.

In an informal poll during a listening session with hospital executives, 65% said ED capacity is insufficient. Many cited the need for more trauma centers due to long transfer times. Other hospital executives stressed that expanding ED capacity alone may not solve demand, since a large share of episodic care could be better managed in primary or urgent care settings.

## Skilled Nursing Facilities (SNFs) and Long-Term Care Supply

**The Central Valley has limited long-term care capacity.**

The region has 6,173 beds in skilled nursing facilities (SNF) and similar numbers of SNF beds per capita (2.0 per 1,000 residents) as California overall (2.18 per 1,000 residents).<sup>97</sup> However, California overall has fewer SNF beds per capita than the U.S. average. According to an analysis by KFF, California ranked 41st out of 51 states (including the District of Columbia) in the number of SNF beds per 1,000 Medicare Part A enrollees, indicating a comparatively limited supply of skilled nursing capacity in both California and the Central Valley.<sup>98</sup>

In addition to LTC beds in SNFs, Central Valley hospitals have 625 long-term care (LTC) beds in their facilities to provide skilled nursing care and intermediate care. Valley hospitals with sizeable supply of LTC beds include: Ridgecrest Regional Hospital (125 beds), Coalinga Regional Medical Center (114 beds), Community Regional Medical Center (106 beds), Kern Valley Hospital District (74 beds), Kaweah Health Medical Center (70 beds), and Adventist Health Delano (59 beds). Other hospitals in the region with LTC capacity include Sierra View Medical Center, Adventist Health Reedley, John C. Fremont Healthcare District, Saint Agnes Medical Center, and Adventist Health Tehachapi Valley.<sup>99</sup>

Although just 7% of Central Valley hospital patients<sup>100</sup> are discharged to skilled nursing or intermediate care, hospital leaders that participated in this research reported that limited availability of these beds are creating significant discharge delays. Insurance coverage restrictions can exacerbate the challenge. For example, facilities may lack available beds for Medi-Cal patients. As a result, patients who are ready to leave remain in staffed hospital beds, creating bottlenecks that slow hospital admission for new patients.

An additional 2% of hospital patients are discharged to rehabilitation, another area where supply is limited both in the Central Valley and statewide. Across the region, hospitals operate just 295 licensed rehab beds. Kern County has two dedicated rehabilitation hospitals with a combined 136 beds, while Fresno has one facility with 62 beds.<sup>101</sup>

Access to long-term acute care (LTAC) beds is also constrained. LTAC facilities serve patients who require extended hospital-level care, such as ventilator support or complex wound management, yet the closest option for Valley residents is Central Valley Specialty Hospital in Modesto, with about 100 licensed beds. Stakeholders emphasized that the region needs more LTAC capacity.

## Drivers of Acute Bed Pressure

Stakeholders stressed that inadequate post-acute care capacity is a bottleneck to discharging inpatients on time and freeing up needed acute care beds. The Central Valley has an inadequate supply of skilled nursing and rehabilitation beds for Medicare and Medicaid patients. In addition, there are not sufficient resources to discharge people who are unhoused or have severe behavioral health conditions.

In many cases, delays in payer authorization contribute to a backlog in discharges, and some family members experience barriers to picking up patients who are medically ready to leave the hospital. Limited availability of ambulances for patient transfers further slows the movement of patients from acute care to post-acute or specialized facilities, exacerbating bed

shortages. One hospital executive stated that they are paying upwards of \$10,000 per month on Uber and Lyft to transfer discharged patients.

Stakeholders noted that insufficient access to primary care and outpatient specialty care has resulted in unnecessarily high ED utilization and complex health care needs in ED patients. On the one hand, many Central Valley residents who come to the ED have delayed getting care and thus present at the ED with complex needs. On the other, many people lack sufficient access to outpatient care and use the ED for non-urgent needs. And after their ED visit, many people cycle back for follow-up care because they cannot connect to ambulatory care easily. One hospital executive noted, “For us, the ER has become the front door to the hospital. There are so many restrictions on the back door - where patients can go and how to get them there.”

## Barriers to Expanding Bed Capacity

Beyond challenges impacting the ability to use hospital beds more efficiently, stakeholders identified several factors that affect hospitals’ ability to expand staffed bed capacity, including:

- Regulatory considerations: California’s regulatory environment presents multiple requirements that hospitals must meet, including seismic compliance and nurse staffing ratios.
- Workforce availability: Shortages of nurses and allied health staff, including therapists and technicians, limit the ability to open or operate additional beds.
- Labor costs: Rising wages, including the \$25/hour minimum wage, increase per-bed operating costs.
- Reimbursement constraints: Dependence on Medi-Cal reimbursement limits revenue and financial flexibility for infrastructure and staffing investments.
- Coordination and capacity management: Hospital leaders shared they lack a system to share real-time bed capacity information, and inter-hospital transfers can be challenging, leading emergency departments to serve as temporary inpatient units.

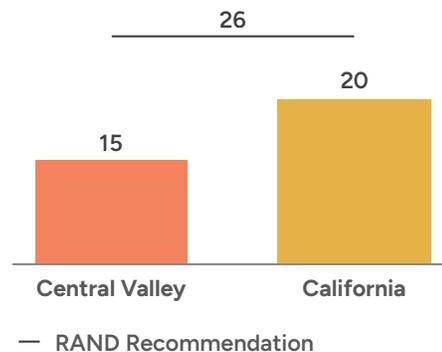
## Behavioral Health Beds

**The Central Valley has a critical shortage of psychiatric beds.**

The Central Valley has five dedicated psychiatric health facilities with 266 psych beds, plus 182 psychiatric beds in four acute care hospitals (Community Regional Medical Center, Kaweah Health Medical Center, Kern Medical Center, and Good Samaritan Hospital).<sup>102</sup> A recent RAND analysis projects that “growth in the need for psychiatric beds will be largest in the Northern and Southern San Joaquin Valley.”<sup>103</sup>

Acute psychiatric bed supply (i.e., psychiatric beds in acute care hospitals and in dedicated psychiatric health facilities) is very limited in the Central Valley and in California. Acute beds play a crucial role in behavioral health care by helping to stabilize patients with the highest acuity needs and by providing highly structured, 24/7 medically monitored inpatient care for individuals at heightened risk of harm to themselves or others. The Central Valley has only 448 acute psychiatric beds or 15 beds per 100,000 residents. RAND recommends 26 acute psychiatric beds per 100,000, which translates to an additional 333 acute psychiatric beds needed in the Central Valley.<sup>104</sup>

Figure 13: Acute Psychiatric Beds Per 100,000, Central Valley and California



Sources: HCAI, *Hospital Annual Financial Data, 2023 (October 7, 2024 extract)*. DOF, *Population and Housing Estimates for Cities, Counties, and the State, May 2025*. RAND, *Adult Psychiatric Bed Capacity, Need and Shortage Estimates in California – 2021, 2022*. Bed supply per 100,000 population calculated by author. Licensed psychiatric beds from general acute care hospitals and psychiatric health facilities were included in the analysis.

The Central Valley also has a significant shortage of subacute psychiatric care for patients with moderate-to high-acuity needs who require longer stays of up to multiple months in a controlled environment with significant supervision and monitoring. RAND estimates that the Southern San Joaquin Valley (Fresno, Kings, Tulare, Kern and Inyo Counties) has only 134 subacute beds and a shortfall of 311 subacute care beds (excluding state hospitals). The shortfall increases to 345 subacute beds when the region's prevalence of severe psychological distress is considered.<sup>105</sup>

Finally, the Central Valley also has a shortage of community residential beds, which are intended to address lower acuity and longer-term care (often multiple years) that is focused on patient recovery. RAND estimates that the Southern San Joaquin Valley

has only 59 community residential beds and a shortfall of 345 community residential beds. The shortfall increases to 378 when the region's prevalence of severe psychological disorder is considered.<sup>106</sup>

Stakeholders noted that psychiatric beds for youth are even more limited than for adults. There are no crisis residential treatment centers for children and no youth substance abuse facilities, with the result that youth with acute behavioral health needs are often transferred out of the Valley.

The new California law SB43 is expected to increase demand for inpatient psychiatric and substance use treatment beds, as the law expanded the criteria for involuntary inpatient psychiatric holds. The law went into effect in 2024, but counties had until January 2026 to implement the changes.



# Under Pressure: Central Valley Hospital Financial Health

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Under Pressure: Central Valley Hospital Financial Health

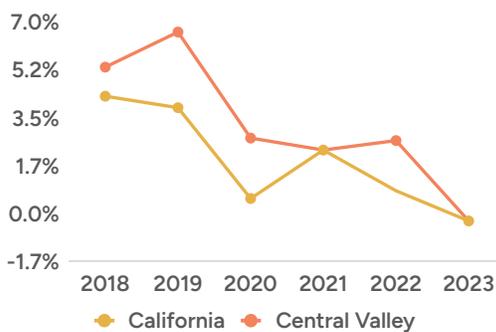
Workforce and bed shortages are only part of the picture. The 2023 closure of Madera Community Hospital underscored the fragility of Central Valley hospital financing and highlighted how essential hospitals are for maintaining community access. H.R. 1 (One Big Beautiful Bill Act) will lower hospital reimbursement and increase the risk of additional hospital and service line closures.

## Hospital Financial Pressures

Many Central Valley hospitals face significant financial pressures, driven by a high public payer mix, stagnant reimbursement rates, and rising labor and regulatory costs.

In 2023, the Central Valley’s aggregate acute care hospital operating margin was -0.15% (compared to -0.22% statewide), and its aggregate total margin was 3.21% (versus 4.96% statewide).<sup>107</sup> An operating margin near just above zero percent means hospitals, in aggregate, are just breaking even on patient care. Operating margins have been declining over time in both the Valley and California overall.<sup>108</sup>

Figure 14: Aggregate Operating Margin, Acute Care Hospitals, 2018-2023

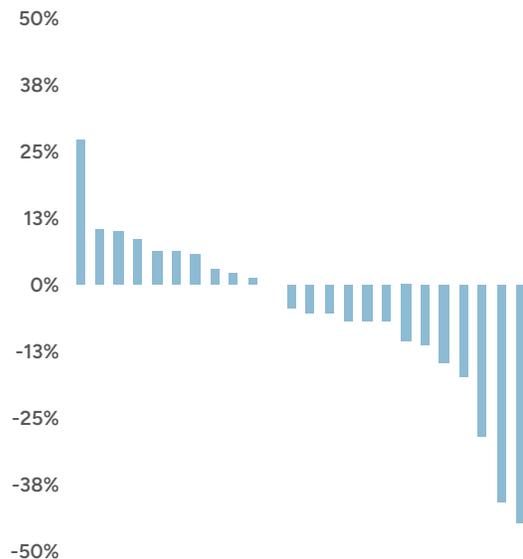


Source: HCAI, [Hospital Annual Financial Data, Pivot Tables – Hospital Annual Selected File, 2018 – 2023](#).

In 2023, over half of Central Valley hospitals operated at a loss.

Roughly half of Central Valley hospitals reported negative operating margins in 2023, with results ranging from +10.5% to -44.8%.<sup>109</sup> Ten hospitals in the region also reported negative net income. Net income provides a fuller picture than operating margin, since it accounts for both operating and non-operating revenue (such as investments, philanthropy, or one-time funds). In other words, a hospital might cover losses through outside revenue—even if its core operations are in the red. Among the 10 hospitals with negative net income in 2023, one has since closed, seven also posted losses in 2022, and five operated in the red for three consecutive years (2021–2023).<sup>110</sup>

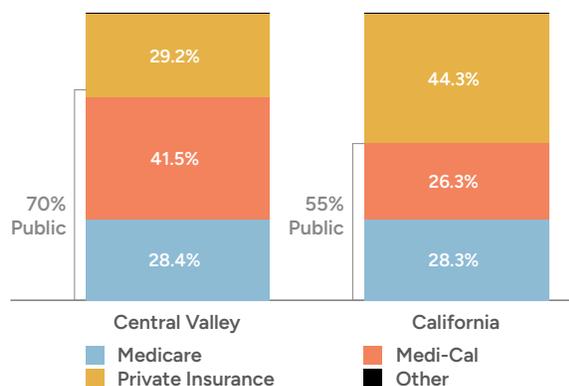
Figure 15: Operating Margins by Hospital, Central Valley, 2023



Source: HCAI, [Hospital Annual Financial Data, Pivot Table – Hospital Annual Selected File 2023 \(October 7, 2024 extract\)](#).

Hospital executives and other experts consistently point to the same core challenge: rising costs without matching reimbursement from health care payers. Hospitals in the Valley rely heavily on Medi-Cal, and evidence suggests that hospitals with high shares of Medicaid patients have operating margins below the national average, while those with higher shares of commercial patients fare better. This is intuitive as commercial insurers pay much higher rates – an average of 267% of Medicare rates nationwide, and 329% in California, though rates vary widely even within the same metro area.<sup>111</sup> In 2023, Medi-Cal accounted for 41.5% of hospital revenue in the Central Valley, compared with 26.3% statewide, and more than half (55.5%) of Valley emergency department visits were covered by Medi-Cal, compared to 42.3% statewide.<sup>112</sup>

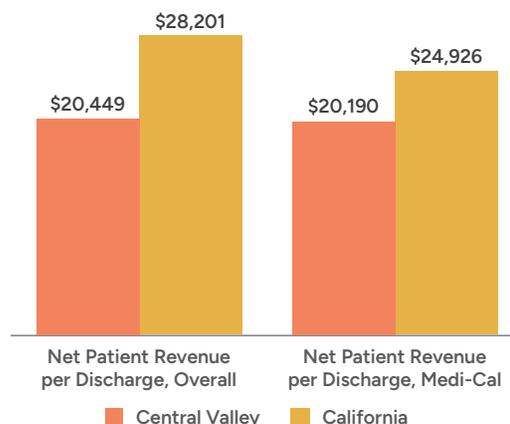
Figure 16: Hospital Net Patient Revenue by Payer, Central Valley and California, 2023



Source: HCAI, *Hospital Annual Financial Data, 2023 (October 7, 2024 extract)*. Each category includes traditional and managed care revenue. Private insurance is other third-party sources (e.g., commercial insurance through an employer). Other category includes county indigent, other indigent, and other payers including self-pay.

Once Medicare is included, many hospitals in the region have payer mixes exceeding 80% public payers, limiting their ability to offset losses through higher commercial reimbursement. Reflecting this less profitable payer mix, net patient revenue per discharge in the Valley was \$20,449 in 2023, compared with \$28,201 statewide. For Medi-Cal discharges specifically, Central Valley hospitals received nearly \$5,000 less per discharge in 2023 than the statewide average.<sup>113</sup>

Figure 17: Hospital Revenue Per Discharge, Central Valley and California, 2023



Source: HCAI, *Hospital Annual Financial Data, 2023 (October 7, 2024 extract)*.

The proportion of discharges covered by Medi-Cal varies widely across the region’s hospitals. For fiscal year 2023, Valley Children’s Hospital had the highest proportion of Medi-Cal discharges at 74%, while Kaiser Foundation Hospital – Fresno had the lowest at 2%. In Fresno County, Community Regional Medical Center had 54% Medi-Cal discharges, compared to 30% at Saint Agnes and 28% at Clovis Community Medical Center. In Kern County, Kern Medical Center—the county-owned hospital—had 70% Medi-Cal discharges, compared with Bakersfield Memorial Hospital at 48%, Mercy Hospital – Bakersfield at 38%, and Adventist Health Bakersfield at 26%. Kaweah Health Medical Center in Visalia reports 51% Medi-Cal discharges, while Mercy Medical Center in Merced reports 44%, and Adventist Health Hanford in Kings County reports 37%.

In addition to payer mix and low Medi-Cal rates, hospital executives shared several other revenue-related concerns. They voiced frustration with delays in the disbursement of Proposition 35 funds—approved by voters in 2024 to raise Medi-Cal reimbursement rates—emphasizing that these dollars are vital for vulnerable hospitals. They also raised concerns about cost-control targets set by the California Office of Health Care Affordability (OHCA),<sup>114</sup> which they fear will cap revenues at levels that fail to keep pace with rising costs or reflect hospitals’ overall financial positions.

One executive added that commercial insurers are also limiting rate increases to align with OHCA targets, further constraining hospitals' ability to raise commercial pay to balance losses from public payers.

On the cost side, pressures are also mounting. Labor costs are climbing, accelerated by Senate Bill 525, which established a minimum wage for health care workers and has added millions in expenses to hospital and other health care providers. Even local hospitals not directly subject to the fastest wage hikes felt compelled to increase wages to stay competitive in a tight labor market. Additionally, staffing shortages force reliance on overtime and costly travel nurses, while recruiting physicians—especially specialists—requires offering top-of-market compensation that local payer mixes cannot support. Central Valley hospitals report subsidizing physician salaries or relying on expensive locum agencies to cover critical specialty gaps.

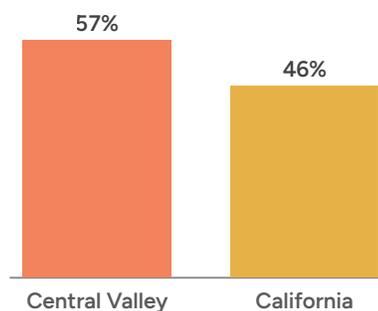
Other cost drivers include inflation (for supplies, drugs, and energy), regulatory requirements, aging infrastructure, and seismic retrofit mandates. Some Valley hospital executives noted that they lack the capital needed to comply with seismic requirements before the 2030 deadline, raising concerns that noncompliance could force bed closures and further reduce access. Others reported feeling overburdened by the magnitude of regulatory requirements in general (e.g., audits), noting that these demands divert resources away from patient care and operations.

## Hospital Closures

**Rural hospitals are closing across the country and in the Central Valley, disrupting access to care and stability in local communities.**

A significant concern among stakeholders is the possibility of more hospital closures, whether entire facilities or unprofitable service lines such as labor and delivery (L&D). Central Valley residents are more concerned about hospital closures than Californians overall.<sup>115</sup>

*Figure 18: Percent of Residents Worried About Hospital Closures in Their Community, Central Valley and California, 2024*



*Source: CHCF, The 2024 CHCF Central Valley Health Policy Survey, April 2024. CHCF, The 2024 CHCF California Health Policy Survey, January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties. Difference between CV and rest of CA is statistically significant.*

Nationally, hospitals are closing faster than they are opening. In the U.S. between 2010 and 2023, 300 hospitals closed and 192 opened. The situation is worse in rural areas: from 2017 to 2023, 61 hospitals closed and 11 opened, a total loss of 50 rural hospitals over 6 years. In urban areas over the same time period, the net loss was 13 hospitals.<sup>116</sup>

In the Central Valley, several hospitals have closed permanently or temporarily in the last two decades.<sup>117</sup> Those that have re-opened have often done so with more limited services.

- Madera Community Hospital in 2023 (Madera County) - re-opened with AAMC management (L&D not re-opened)
- Coalinga Regional Medical Center in 2018 (Fresno County) – re-opened with AAMC management
- Tulare Regional Medical Center in 2017 (Tulare County) – re-opened in partnership with Adventist Health
- Corcoran District Hospital in 2013 (Kings County)<sup>118</sup>
- Kingsburg Medical Center in 2010 (Fresno County)<sup>119</sup>

- Chowchilla District Memorial Hospital in 2006 (Madera County)
- Dos Palos Memorial Hospital in 2006 (Merced County)<sup>120</sup>

A recent report found that 759 rural U.S. hospitals are at risk of closure due to financial problems, with about 40% of those hospitals at immediate risk of closure. Thirty-four percent of rural hospitals in California (20 hospitals total) are at risk of closing, and 10% (6 hospitals) are at immediate risk of closing in the next 2-3 years. The specific hospitals determined to be at-risk were not listed in the report.<sup>121</sup>

In every case, hospital closures place a heavy strain on the communities in which they are located. When Kingsburg Medical Center closed in 2010, it left the 11,000-resident town without local acute care—forcing residents to rely on a drive of up to 20 miles to reach the nearest hospital in Fresno. This not only raised serious risks during time-critical emergencies but also eroded the community’s sense of security and economic vitality. Businesses became hesitant to locate in Kingsburg without nearby hospital access—a sentiment echoed throughout rural California, where hospital closures have generated long-term financial and social consequences.<sup>122</sup>

Most recently, in 2023, the closure of Madera Community Hospital – which closed after years of financial difficulty – highlighted how consequential a hospital shutdown can be for a community. As the only hospital in Madera County (excluding Valley Children’s), its closure left approximately 160,000 residents without nearby emergency or acute care services, forcing some patients to travel up to 45 minutes to reach care.<sup>123</sup> The closure also led to significant job losses, with over 900 healthcare workers displaced,<sup>124</sup> and neighboring hospitals experienced increased patient volumes, longer wait times, and added strain on resources.<sup>125</sup>

Stakeholders characterized the closure as abrupt and shocking. The major Federally Qualified Health Center (FQHC) in the region, Camarena Health, received only a few weeks’ notice and, almost overnight, was assigned

thousands of additional Medi-Cal patients, who had been receiving primary care through the hospital-affiliated rural health centers. They rapidly brought on providers from the local rural health centers that had been run by the hospital, while also expanding urgent and specialty care capacity. In addition to the loss of the ED, the loss of maternity services was felt immediately. Camarena began sending more patients to Saint Agnes in Fresno County (22 miles away from Madera Community Hospital) to deliver their babies. Stakeholders reported hearing about many more instances of deliveries at home, in cars, or in ambulances on the way to the hospital. Public health was also disrupted by the closure, since the hospital had been a key partner in tracking disease trends in the county.

In response to Madera Community Hospital’s closure, the California Legislature established the Distressed Hospital Loan Program, allocating \$57 million to facilitate the hospital’s reopening.<sup>126</sup> Madera Community Hospital reopened on March 18, 2025, restoring critical health care access. Since reopening, stakeholders have characterized having a local emergency department as “tremendous,” but noted that specialty services remain insufficient to meet community needs, and there is currently no clear pathway to restore L&D services.

**H.R. 1 (One Big Beautiful Bill Act) puts hospital stability—and patient access—at significant risk**

H.R. 1 (One Big Beautiful Bill Act) will intensify the hospital financial crisis and push many facilities – especially those in rural communities – toward closure. The bill will slash annual federal funding for Medi-Cal by an estimated \$30 billion.<sup>127</sup> Hospitals will see lower reimbursement rates due to caps on state directed payments, cuts to Medicare rates, loss of MCO tax revenue, and a higher share of uninsured patients, leading to more uncompensated care. In total, these combined effects will mean an estimated loss between \$66 and \$128 billion (18-34% of total revenue) over 10 years to California hospitals.<sup>128</sup> For Central Valley hospitals already operating on the brink, these cuts

could be devastating, accelerating facility and service line closures and cutting off critical access to care. Although H.R. 1 creates a Rural Health Transformation Fund, experts warn it's not enough money to offset the losses.

## Financial Sustainability of Other Health Care Organizations

We focused on hospitals in our research given their size, 'too-big-to-fail' status, and the well-documented struggles of rural hospitals both in California and nationally. That said, financial pressures extend across the entire health care system. In the Central Valley, many providers must contend with low Medi-Cal payment rates, which often force them to limit how many Medi-Cal patients they can see to stay financially viable, or in some cases, to opt out of seeing Medi-Cal patients altogether.

Compared to hospitals in the region, Central Valley FQHCs are currently in a stronger financial position. In 2023, the aggregate operating margin for Valley FQHCs and FQHC look-alikes was 3.7%, versus 1.8% statewide.<sup>129</sup> Stakeholders describe FQHCs as relatively stable for now, but warned that looming federal cuts under H.R. 1 (One Big Beautiful Bill Act) could place them under significant strain. FQHCs are mandated to

serve all patients regardless of ability to pay and play a critical role in helping people stay enrolled in coverage. H.R. 1 would increase the administrative burden of maintaining Medi-Cal enrollment and drive up the share of uninsured patients - undermining one of the key strengths that supported FQHC resilience following Medi-Cal expansion.

Public health departments, meanwhile, report facing immediate and deep funding cuts, partly driven by the expiration of COVID-era funds and the elimination of all disparities-related funding in 2025. Leaders described a growing gap between expectations and resources, often feeling they are asked to do "\$100 worth of work for \$1."

Community-based organizations also continue to struggle with limited funding. Those partnering with health systems emphasized that higher payment rates are essential to sustain collaborations and deliver critical services.

With health care resources already stretched thin, H.R. 1, state budget cuts and ongoing uncertainty, threaten to further destabilize the Valley's interconnected health care ecosystem, putting hospitals, clinics, and community providers at risk and jeopardizing patient access across the region.

A photograph of a person with long dark hair, seen from behind, sitting in a wheelchair in a hospital room. The room has light blue walls, a window with sheer curtains, and a hospital bed with blue linens. The overall tone is blue and somewhat somber.

# Why it Matters: Health Care Access in the Central Valley

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Why it Matters: Health Care Access in the Central Valley

**Workforce shortages and limited hospital capacity are not just operational challenges—they have real consequences for Central Valley patients. These constraints shape who can access care, how quickly they receive it, and the quality and outcomes of the care provided.**

## Limited Access to Care

**Appointment wait times and long travel distances limit access, especially for rural and other underserved communities.**

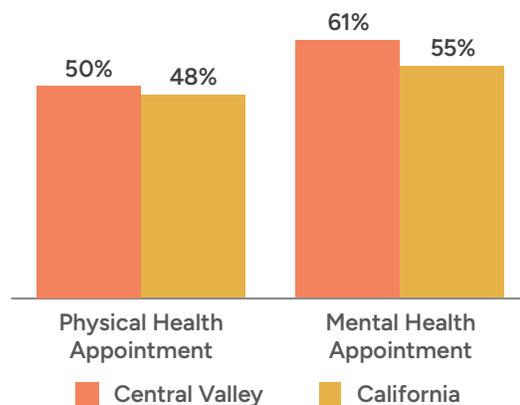
Access to care was one of the most common concerns in stakeholder interviews and listening sessions, and it consistently ranks among the top issues identified in community needs assessments. While all Central Valley community members experience some barriers, certain populations are disproportionately affected, including rural residents, farmworkers, unhoused individuals, people with limited English literacy, and those who are uninsured or have Medi-Cal coverage. The stakes of limited access are high. As one regional leader emphasized at a community event last year: “Delayed care is delayed treatment; it’s premature death.”<sup>130</sup>

Stakeholders reported that provider shortages in the Central Valley contribute to long wait times for both primary care and specialty appointments, as well as shorter visits, since providers seeing large numbers of patients have limited time to address preventive and other needs.

Survey findings offer a mixed picture, with Central Valley residents reporting slightly better access on some measures compared to the state overall. For example, 12.7% of Valley residents report that they delayed or went without needed medical care, versus

16.2% statewide. Difficulty finding a primary care provider was reported by 8% in the Valley compared to 12.1% statewide, and 17.8% of Valley residents had difficulty accessing specialty care, versus 22.5% statewide.<sup>131</sup> Meanwhile, 50% of Valley residents who tried to make a physical health appointment and 61% who tried to make a mental health appointment in the past year reported waiting longer than reasonable, slightly higher than the statewide rates of 48% and 55%, respectively.<sup>132</sup> Unfortunately, there is not reliable data that assesses wait times and delayed care directly.

*Figure 19: Percent of Residents That Waited Longer Than Reasonable for a Health Care Appointment, Central Valley and California, 2024*



*Source: CHCF, The 2024 CHCF Central Valley Health Policy Survey, April 2024. CHCF, The 2024 CHCF California Health Policy Survey, January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.*

For residents of rural areas, distance to health care presents significant challenges. Limited providers and clinics, combined with long travel distances, make accessing care difficult. Public transportation options are minimal in the Valley, and many lower-income residents lack reliable transportation for medical visits. While Medi-Cal health plans provide transportation

services, community health workers and promotores (CHW/Ps) report that these services are often hard to access and unreliable. Long workdays and lack of paid time off further limit the ability of many residents to attend appointments. These barriers contribute to delayed care and higher drop-off rates for follow-up visits.

**People with Medi-Cal have worse access than those covered by Medicare or private insurance.**

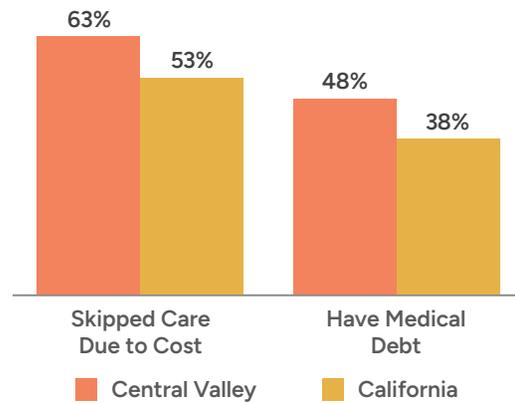
Stakeholders reported that many providers—especially specialists—either do not accept Medi-Cal or strictly limit the number of Medi-Cal patients they see. Prior studies back this up. A 2014 analysis found that while 74% of Central Valley primary care physicians accepted Medi-Cal, only 52% were willing to take new Medi-Cal patients. Among specialists, 77% accepted Medi-Cal, but just 68% accepted new Medi-Cal patients.<sup>133</sup> Given workforce shortages and growing numbers of Medi-Cal beneficiaries, these access rates are most likely even lower today.

In contrast, residents with commercial insurance and adequate resources frequently use concierge services or travel to Los Angeles and the Bay Area for specialty care. Although this travel is still burdensome, it highlights stark differences in access and vulnerability across the region’s populations.

**Affordability is another critical barrier in the Central Valley.**

Nearly two-thirds of residents (63%) report skipping care due to cost, compared to 52% statewide. Three in four are concerned about paying out-of-pocket costs or unexpected medical bills, and 69% worry about affording health insurance premiums. Nearly half of Valley residents (48%) report medical debt, compared with 36% statewide.<sup>134</sup>

Figure 20: Health Care Affordability, Central Valley and California, 2024



Source: *CHCF, The 2024 CHCF Central Valley Health Policy Survey, April 2024. CHCF, The 2024 CHCF California Health Policy Survey, January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties. Differences between the Central Valley and the rest of California are statistically significant.*

**Other access barriers include trust, language, and system complexity.**

Long-standing distrust of health institutions among marginalized groups often leads people to delay care until conditions become dangerous. This distrust has been exacerbated by raids across the region and country, which have created widespread fear of law enforcement violence and deportation among the immigrant community, increasing hesitancy to access services. Stakeholders emphasized that these raids have been devastating for many families and communities in the Central Valley and health care providers participating in this research reported higher no-show rates among patients without legal documentation.

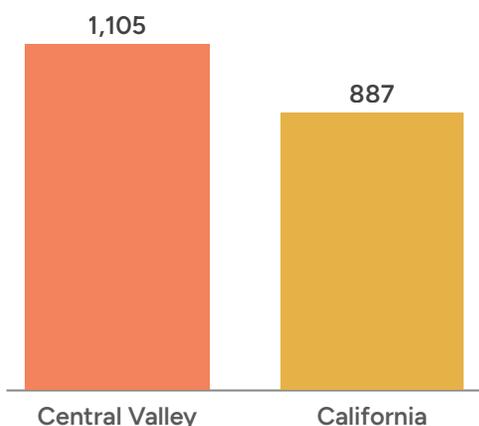
In addition to fear or lack of trust, language barriers further limit access, especially for monolingual patients who do not speak English or Spanish. CHW/Ps report many facilities lack in-person interpreters or use uncertified interpreters who sometimes provide inaccurate translations.

Navigating the health care system itself is a major obstacle—eligibility rules, insurance plan differences, prior authorizations, and confusing referral pathways can overwhelm patients.

**High preventable hospitalizations in the Central Valley suggest the need for better access to primary and outpatient care.**

Based on a composite measure of hospital admission rates for 10 ambulatory-sensitive conditions, 1,105 hospitalizations per 100,000 Central Valley adults were potentially preventable through effective chronic care management and access to high-quality primary care in 2023.<sup>135</sup> This rate is 25% higher than the overall rate statewide (887 hospitalizations per 100,000 California adults). In addition, a recent [HCAI analysis](#) of physician supply and preventable hospitalizations shows that Central Valley counties have low physician supply and high preventable hospitalizations for specific conditions. All seven Central Valley counties have low physician supply (in the relevant specialties) and high preventable hospitalizations for diabetes, COPD, pneumonia, and heart failure.<sup>136</sup>

*Figure 21: Preventable Hospitalizations Per 100,000, Central Valley and California, 2023*



*Source: HCAI, [Rates of Preventable Hospitalizations for Selected Medical Conditions by County, 2023](#).*

## Bright Spots: Promising Models to Improve Access

**Community Health Workers and Promotores are essential to access and equity, but need greater funding and health care system integration.**

CHW/P models are proven strategies for closing gaps in access to care. CHW/Ps help patients navigate the health system, overcome cultural and language barriers, and build trust with providers. Although these models have existed for decades, they remain under-supported and poorly integrated into the traditional health care system—for example, CHW/Ps who participated in this research noted that many health care workers do not fully understand their roles.

Stakeholders in the Central Valley expressed strong enthusiasm for CHW/Ps, emphasizing that the model is integral to advancing health equity in the region.

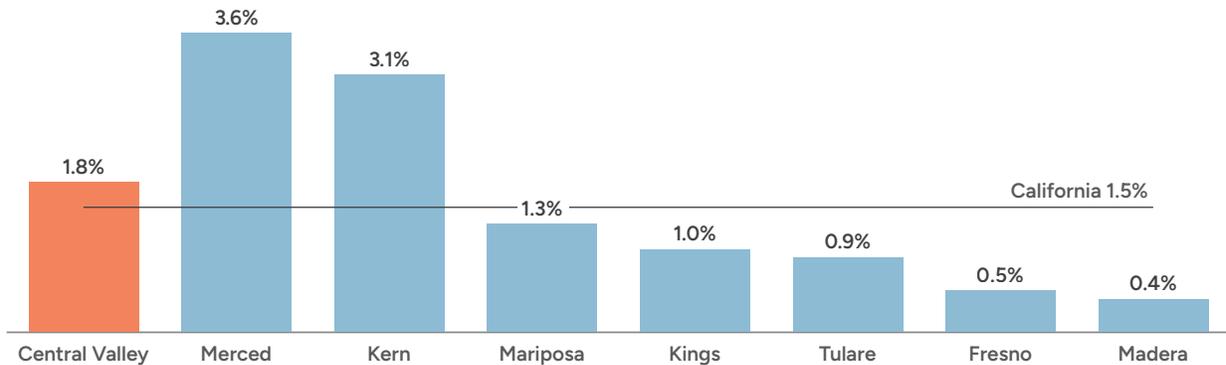
Efforts are underway to better align health care dollars with CHW/P services and to embed these roles in whole-person, team-based care. In 2022, Medi-Cal started covering CHW/P services for its enrollees. Yet, low Medi-Cal reimbursement rates and complex administrative requirements have slowed progress. In the Central Valley, some employers have relied on public health funding instead of Medi-Cal dollars; when federal COVID-era funds expired this year, some CHW/Ps lost their jobs. Nonprofits are working to braid together multiple funding streams and connect CHW/P services to Medi-Cal benefits and programs, but integration remains limited and uneven.

**Enhanced Care Management focuses on access for select Medi-Cal beneficiaries with complex needs.**

Enhanced Care Management (ECM), launched under California Advancing and Innovating Medi-Cal (CalAIM), offers high-touch, team-based care coordination for Medi-Cal members with complex medical and social needs. Uptake has been very low, though it is improving over time. In 2024, 1.5% of Medi-Cal members

statewide and 1.8% in the Central Valley were served by ECM. Rates vary by county: in Merced and Kern, more than 3% of members received ECM, compared to just 0.5% in Fresno and 0.4% in Madera.<sup>137</sup> Even with this growth, health system leaders report that low payment rates and workforce constraints continue to limit broader adoption.

Figure 22: CalAIM Enhanced Care Management Penetration Rates, Central Valley Region and Counties, October 2023 – September 2024



Source: DHCS, *ECM and Community Supports Quarterly Implementation Report, ECM Penetration Rates by County, percent of Medi-Cal managed care plan members enrolled in ECM in 12-month period (10/1/2023 – 9/30/2024)*. There are no explicit targets for ECM penetration rates at this time. While DHCS expects that 3-5% of the Medi-Cal membership will be eligible for ECM, this will vary based off of local demographics and not all eligible members may want to participate in the program, so penetration rates are expected to be significantly lower than 3-5%.

**Delivering services where patients live and work is an effective approach.**

Stakeholders repeatedly emphasized the importance of delivering services directly in patients’ communities. This approach is central to CHW/P models and is increasingly being adopted by FQHCs through mobile clinics and school-based health centers. Large agricultural employers also reported providing health care services for their employees, typically at the work site and at company expense.

**FQHCs are central to maintaining access in the Valley.**

FQHCs are a cornerstone of the Central Valley’s safety-net health system. Nearly half of Central Valley residents are patients of FQHCs, and the FQHC presence in the region has expanded over time. As of 2023, the seven-county study area had 158 FQHC sites. The region’s largest FQHCs include Family HealthCare Network, United Health Centers of the San Joaquin Valley, Clinica Sierra Vista, Omni Family Health, and Camarena Health. Each serve between 100,000 and 400,000 patients annually and records 300,000 to more than one million encounters per year. Other sizable FQHCs in the region are Altura Centers for Health, Golden Valley Health Centers, Aria Community Health Center, Valley Health Team, Castle Family Health Center, and Livingston Community Clinic. In addition, Central Valley Indian Health – an Indian Health Service provider – operates in Fresno, Madera, and Kings counties, providing care for American Indian communities.<sup>138</sup>



# Case Study: Maternity Care Crisis in the Central Valley

Central Valley **Health Care Landscape Study**



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

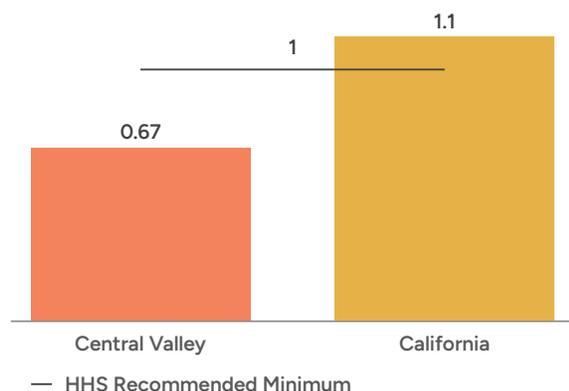
# Case Study: Maternity Care Crisis in the Central Valley

## Maternity Care Provider Shortages

**The Central Valley faces a severe shortage of maternity care providers.**

Federal guidelines from the U.S. Department of Health and Human Services recommend at least one OB/GYN or certified nurse midwife for every 1,500 women of childbearing age (15–44).<sup>139</sup> In the Valley, the ratio is just 0.7 providers per 1,500 women—about 30% below the minimum—and no county in the region meets the standard.<sup>140</sup> OB/GYN supply also lags well behind the state: there are 39 OB/GYNs per 100,000 women of childbearing age in the Valley compared with 65 statewide.<sup>141</sup>

Figure 23: OB/GYNs and CNMs per 1,500 Women Age 15 to 44, Central Valley and California, 2025



Sources: HCAI, [Physicians Actively Working by Specialty and Activity Hours, July 2025](#); DOF, [Population and Housing Estimates for Cities, Counties, and the State, May 2025](#); California Department of Consumer Affairs, [Active Licenses by County Interactive Map](#), accessed July 29, 2025; *Provider supply per 1,500 women age 15-44 (2024 data) calculated by author based on active OB/GYNs (MDs and DOs) that spend at least 20 hours a week in patient care (2025 data) and NMs with an active California license and a California address of record (2023 data).*

Stakeholders reported significant challenges in recruiting OB/GYNs to the region, noting that in some counties long-standing OB/GYN practices have dissolved in recent years. Hospital executives identified several factors contributing to shortages, including limited residency opportunities, an aging workforce approaching retirement, increasing preference for work-life balance and reduced on-call duties, and higher malpractice risk compared to other specialties.

In response, hospitals are paying high rates to staff their L&D units. One hospital reported paying extra to incentivize local OBs to be on call, and another reported contracting with an OB hospitalist group—an expensive but necessary step to keep its L&D unit open.

Multiple stakeholders raised concerns about limited access to maternal-fetal medicine specialists, emphasizing that high-risk obstetric care is extremely difficult to obtain in the region. Anecdotally, hospitals are seeing more high-risk patients present with complications—such as uncontrolled diabetes—that might have been managed earlier with timely diagnosis and specialty care. Data from HCAI show that the Central Valley has 35% fewer neonatal-perinatal specialists than California overall (1.53 per 100,000 population versus 2.35 statewide).<sup>142</sup>

## Labor and Delivery Closures

**Labor and delivery closures also threaten access.**

In addition to workforce shortages, the instability and closure of hospital L&D units pose a serious threat to maternity care access, particularly in rural communities where closures often leave entire areas without nearby services—creating “maternity care deserts.” This trend is national, has accelerated across California, and

is acutely felt in the Central Valley. Since 2012, 56 California hospitals—representing 16% of the state’s general acute care hospitals—have stopped delivering babies. Four Central Valley hospitals have closed L&D services since 2012. Three closures occurred in 2023 and 2024.<sup>143</sup>

- **Ridgecrest Regional Hospital** in Kern County shuttered its L&D unit in spring 2024 after 65 years of operation, citing a shortage of obstetric clinicians and annual financial losses of \$5–6 million. The closure was especially disruptive for the community surrounding Naval Air Weapons Station China Lake, where patients were forced to travel up to two hours to give birth. With emergency funding from the U.S. Navy, the hospital was able to resume services later that year, but the long-term sustainability of L&D services at the hospital remains uncertain.<sup>144</sup>
- **Adventist Health Tulare** closed its L&D unit in 2024 after experiencing a steady decline in births over the prior two years. The hospital had previously shut down entirely in 2017 before reopening under Adventist Health in 2018. During the earlier closure, many physicians shifted to delivering babies at nearby hospitals in Porterville and Visalia, and community providers began referring patients elsewhere. Those patterns continued even after the hospital reopened, contributing to the eventual loss of its maternity services.
- **Madera Community Hospital** closed entirely in 2023, disrupting access to care across the county. When it later reopened, L&D services were not restored, leaving Madera County without local maternity care. Stakeholders interviewed for this study expressed concern and some resignation that the county may remain without L&D services indefinitely.
- **Adventist Health Selma** provided L&D services from 1962 until the unit closed in 2014, which was prompted by a decline in newborn deliveries. At the time, the hospital was handling approximately 66 deliveries per month. Most of the staff subsequently transferred to the Adventist hospital in Reedley.<sup>145</sup>

Closures of L&D units are driven by multiple, interrelated factors, including workforce shortages, declining birth rates, and financial instability. When hospitals cannot adequately staff an L&D unit, closure may become unavoidable. Declining patient volumes create financial pressures and also make it harder to recruit providers. Fewer deliveries can also raise safety concerns, since maternity providers require regular practice to maintain proficiency, especially during emergencies or complications. Medi-Cal is a major payer for maternity care, covering 62% of births in the Valley compared with 40% statewide. With low reimbursement and high costs, many hospitals report that their L&D units operate at a loss, contributing to the financial vulnerability of the hospital overall.<sup>146</sup>

L&D closures disproportionately impact people living in rural communities because they increase the travel distance to deliver. Because hospitals are often providers of high-risk obstetric care, L&D closures can also limit access to the appropriate level of perinatal care in higher risk pregnancies. In 2019, 85% of California women lived within 15 minutes of a hospital that offered maternity care. In 2024, that number dropped to 79% because of L&D closures in the state. In Madera County, the median travel time to maternity services is 31 minutes, and in Mariposa County it is 70 minutes. The risks from more travel depend on many factors. Some studies have found outcomes improve because women are reaching better-resourced hospitals. Others have found negative impacts like reduced prenatal care rates and increases in preterm birth.<sup>147</sup> Stakeholders participating in this research anecdotally reported seeing more patients arriving at emergency departments to deliver their babies—many with high-risk pregnancies or complications.

The state government has begun to take notice. Senate Bill 1300 (2024) now requires hospitals to provide counties with 120 days’ notice before closing an L&D or psychiatric unit, and it mandates a public hearing as part of the process.<sup>148</sup> Another proposal that was ultimately vetoed, Assembly Bill 1895, would have gone further by requiring hospitals to notify the state if they were at risk

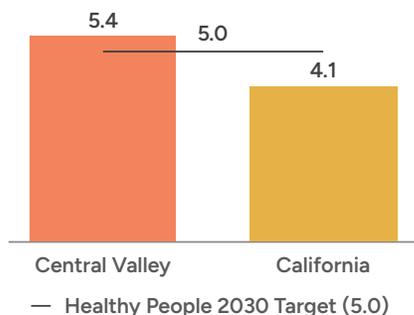
of closing maternity services and directing the state to assess the impact on surrounding communities. While these measures increase transparency and planning, they do not address the underlying financial pressures that lead hospitals to close L&D units.

## Maternity Care Quality and Outcomes

**The Valley faces shrinking maternity resources at a time of great need, reflected in persistently high maternal and infant mortality rates.**

Both infant and maternal mortality far exceed statewide averages and national goals. The Valley’s infant mortality rate is 5.4 deaths per 1,000 live births—above the Healthy People 2030 target of 5.0 and significantly higher than California’s rate of 4.1. One public health leader described infant mortality as a “canary measure,” reflecting the broad range of social and health system factors that contribute to the outcome.

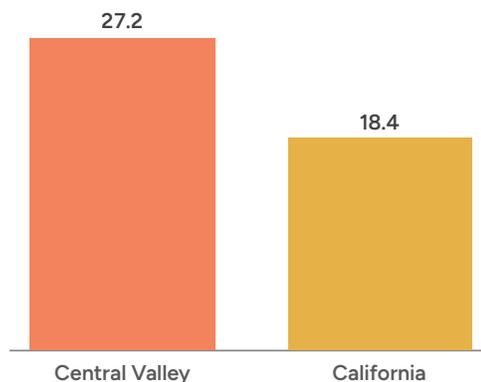
*Figure 24: Infant Mortality Rate per 1,000, Central Valley and California, 2021*



*Source: CDPH, Infant Mortality Dashboard, 2021.*

Maternal mortality is also alarmingly high: in the Southern Central Valley (including the study region plus Stanislaus and Tuolumne counties), the rate is 27.2 deaths per 100,000 births, compared to 18.4 statewide—the highest regional rate in California.

*Figure 25: Pregnancy-Related Mortality Rate per 100,000, Central Valley and California, 2020-2022*



*Source: CDPH, Pregnancy-Related Mortality Dashboard, 2020-2022. Central Valley includes study region, plus Stanislaus and Tuolumne counties.*

Racial inequities are stark. While regional data are unavailable, statewide figures show Black mothers experience a maternal mortality rate of 56.5 per 100,000—more than triple the rates for Latino (18.4), White (15.0), and Asian (14.2) mothers.<sup>149</sup> Infant mortality follows a similar pattern, with the highest rates among Black mothers (8.91 per 1,000 live births) and elevated rates for Latino mothers (4.09) compared to White (2.92) and Asian (2.89) mothers.<sup>150</sup>

**Prenatal care rates in the Central Valley fall short of national goals and highlight persistent disparities.**

The Healthy People 2030 target calls for 80.5% of births to be preceded by adequate prenatal care—defined as care initiated within the first four months of pregnancy with at least 80% of expected visits. Both California (75%) and the Central Valley (77.5%) fall below this benchmark. Within the Valley, rates are especially low in Mariposa (67.5%), Merced (69.5%), and Madera (70.6%) counties. Early prenatal care—initiated during the first trimester—also lags behind, with 79% of Valley births meeting this standard compared to 85% statewide. Merced again stands out with a particularly low rate of 71.4%.

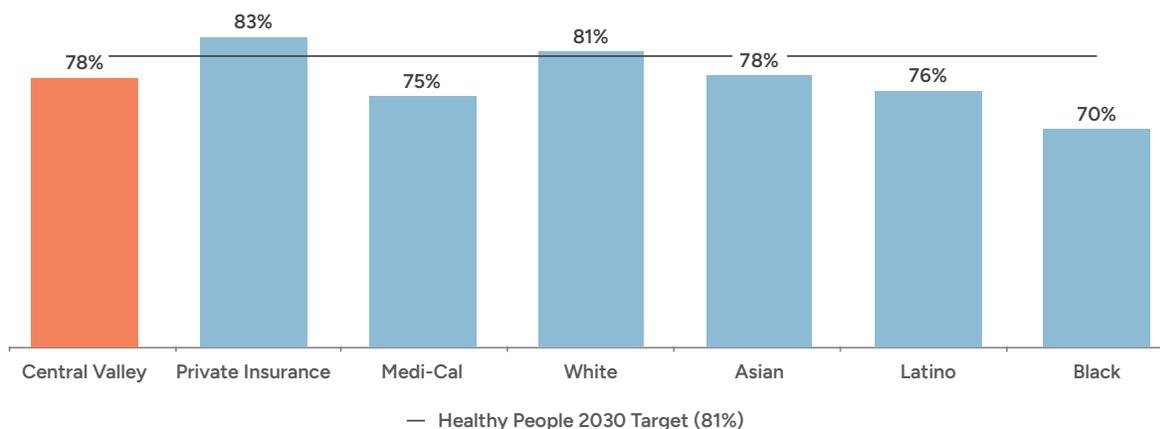
Insurance type and race further influence prenatal care outcomes. Black mothers in the Central Valley—and, to a lesser extent, Latino mothers—are less likely to receive adequate or timely prenatal care compared to White and Asian mothers. Insurance coverage also plays a significant role: Central Valley mothers with private insurance have rates of early and adequate prenatal care that are more than eight percentage points higher than those with Medi-Cal coverage.<sup>151</sup>

Congenital syphilis, a rare but serious condition that can be prevented via timely and adequate prenatal care, is also prevalent in the Central Valley. Nineteen percent of California cases are in the Valley, compared to just 10% of births. Kern County has the 4<sup>th</sup> highest rate of congenital syphilis in the state.<sup>152</sup> An analysis by the Central Valley Public Health Consortium found that congenital syphilis rates are 76% higher in Central California compared to other California counties.<sup>153</sup>

## Bright Spots: New Maternity Care Models

Since 2023, Medi-Cal has covered doula services, opening the door for broader access. In Fresno, the BLACK Doula Network (BDN) operates as a social enterprise dedicated to providing culturally responsive care for Black mothers. BDN not only trains doulas through its own curriculum but also serves as an administrative backbone, offering the legal and operational support doulas need to practice.<sup>154</sup> Other efforts are emerging across the region. For example, the Central California Alliance for Health has awarded grants in Mariposa and surrounding counties to support doulas during their first year as Medi-Cal providers. These grants aim to build on existing community ties by enabling trusted doulas to care for Medi-Cal members.<sup>155</sup> As with CHW/Ps, doulas have been supporting maternity care for decades, but funding the model at scale and effectively integrating it into the health care system, will require sustained collaboration, investment and infrastructure.

Figure 26: Rates of Adequate Prenatal Care in the Central Valley, by Race and Insurance Type, 2023



Source: CDPH, Prenatal Care Dashboard, 2023.

A photograph of three healthcare professionals (two men and one woman) seen from behind, walking down a brightly lit hospital hallway. They are wearing scrubs. The image is overlaid with a semi-transparent blue filter.

# Recommendations to Strengthen the Central Valley's Health System

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Recommendations to Strengthen the Central Valley's Health System

**Between May and October 2025, more than 150 stakeholders – including health policy advocates, hospital executives, health care providers, public health officials, legislators, academics, educators, business leaders, philanthropy, and community health workers and promotores – contributed their expertise and lived experience to this research.**

Their collective voices conveyed the urgency of addressing the region's health care challenges and underscored the need to advance bold, coordinated solutions. The following recommendations are informed by the insights and priorities of these stakeholders.

The recommendations are interconnected and intended to be pursued simultaneously rather than sequentially. They are not exhaustive or prescriptive; instead, they provide a strategic framework to guide future planning and collective action aimed at strengthening the Central Valley's health care system. Acting on these recommendations is critical. Without sustained commitment and shared investment, inequities will deepen, and communities will continue to face preventable barriers to care.

## Focus Area 1: Catalyze Collaboration and Strategic Investment

While focus areas 2-4 define what must be done, this first focus area addresses how to get it done. The Central Valley faces complex, large-scale health care challenges that demand bold, coordinated action, significant investment, and strong leadership. Meeting these challenges will require major financial

commitments, robust legislative support, and active engagement from the entire community.

### 1. Secure and Align Resources at Scale

Strengthening the Central Valley health system requires significant financial investment. It will be essential to leverage philanthropic, private sector, and public funding to fill gaps, seed innovation, and strategically support regional priorities.

Creating cross-sector tables—such as a regional community benefit table including hospitals, providers, health plans, funders, business leaders (including agriculture and real estate developers) and community organizations—can:

- Unlock untapped funding streams
- Pool and align funding across sectors
- Ensure investments reflect local priorities
- Support coordinated strategies that advance equity and sustainability

### 2. Increase Representation and Regional Advocacy

Collective advocacy and stronger state-level representation can help advance priorities from Focus Areas 2-4.

Specific strategies include:

- Partner with health-focused legislators: Collaborate with local and national lawmakers already working to improve health care access and outcomes in the

Valley to co-develop a policy agenda that supports regional health care improvements.

- Increase Valley representation on statewide planning tables: Advocate for broad, coordinated representation across counties, urban and rural areas, and diverse communities to ensure statewide policies and funding decisions reflect the full scope of regional needs.
- Engage regional advocates: Work with local advocates to educate residents about health care inequities and the urgency of addressing them, creating political will to transform the system.
- Conduct a communications and mobilization campaign: Launch an education and community engagement campaign to raise awareness of health care inequities and the urgent need for systemic transformation.

### 3. Fund Coordinating Infrastructure

Sustained, coordinated action requires dedicated infrastructure to support partnerships, strategy development, data sharing, communications, and advocacy. Given the scale and complexity of the region's health challenges, multiple coordinating structures may be needed, each tailored to specific efforts—e.g., workforce development, prevention programs, maternity access. Effective coordination ensures alignment across organizations, tracks progress, maintains accountability, and reduces duplication. Stakeholders emphasized that long-term funding and staffing are essential, drawing on both philanthropic and public resources to sustain this critical infrastructure.

## Focus Area 2: Sustain the Health Care Safety Net

The Central Valley's health care safety net faces persistent pressures from high Medi-Cal enrollment, low Medi-Cal reimbursement rates, and underinvestment in prevention and primary care. Looming threats to Medi-Cal coverage and other health care funding heighten the urgency of sustaining the safety net. Strengthening this

system requires policies and investments that protect coverage, financially stabilize vulnerable hospitals and providers, and expand upstream interventions to improve health for the Valley's most vulnerable residents.

### 1. Protect Medi-Cal Coverage for All Income-Eligible Californians

This project took place during a period of significant cuts to federal and state health care coverage. Stakeholders emphasized the need for sustained advocacy to reverse or mitigate these reductions. Access to coverage is fundamental to sustaining the regional health care safety net and access to care. Advocates are working to lift up local voices, educate legislators, and advocate for revenue generation to support maintaining coverage. This effort will require sustained funding and collaboration across regional and statewide groups.

### 2. Secure Sustainable Medi-Cal Rates

High Medi-Cal coverage, combined with low reimbursement rates, fundamentally disadvantages the Central Valley. Many stakeholders identified this as a root cause of the region's health system vulnerabilities. More equitable rates would help sustain providers serving predominantly Medi-Cal-covered populations, attract and retain health care professionals to the region, and reduce the number of providers that limit or don't accept Medi-Cal patients.

Stakeholders recommended adjusting Medi-Cal reimbursement rates to reflect local income levels and payer mix, so that hospitals and providers in the Valley are not placed at a financial disadvantage compared to providers in higher-income regions like Los Angeles or the Bay Area. At a minimum, providers in the Central Valley should have Medi-Cal reimbursement levels that are on par with statewide averages.

Stakeholders also suggested exploring supplemental funding models inspired by other sectors—for example, school funding formulas that allocate additional resources to high-need populations—as a way to strengthen community-based primary and specialty

care providers, many of whom currently avoid Medi-Cal patients due to low reimbursement.

Finally, stakeholders emphasized the importance of developing innovative, value-based payment systems in Medi-Cal that promote long-term sustainability for safety net providers.

### **3. Invest Upstream**

Stakeholders emphasized that the Central Valley’s health system remains overly crisis-driven, with significant resources directed toward emergency and acute care. Many chronic and behavioral health conditions could be prevented or better managed if addressed earlier, but underinvestment in prevention and primary care worsens outcomes and places unsustainable pressure on hospitals and emergency departments.

Rather than expanding hospital capacity, health system leaders stressed the need to invest in upstream interventions—such as primary care, prevention programs, and behavioral health services—as well as post-acute supports like skilled nursing and rehabilitation beds, which are critical for smooth transitions from hospital to home and for reducing readmissions. Investments should also address root causes of poor health, such as air quality, food access, and other locally-identified community health priorities, to keep people healthy and out of the hospital.

Public health departments are eager to take a more proactive role, but stable, long-term funding is essential. Promising strategies include reframing public health as part of the public safety infrastructure, aligning its messaging with other essential services such as police and fire, and clearly communicating the value of prevention-focused investments to policymakers.

### **4. Support Rural and Safety Net Hospital Financial Resilience**

In the wake of Madera Community Hospital’s closure in 2023, and heading into a period of additional funding cuts, stakeholders emphasized the importance

of helping safety-net and rural hospitals maintain financial stability, recognizing the important role these institutions play in providing critical emergency and specialty care services to their communities. While some hospitals in the region are financially stable, an equal number are struggling.

Stakeholders identified several immediate strategies to strengthen the fiscal health of struggling safety net hospitals. First, they emphasized the importance of fully disbursing Proposition 35 funds as intended by voters. Although the measure, approved in 2024, was designed to raise Medi-Cal reimbursement rates and improve access to care, implementation has been slow, and the Governor’s revised budget proposed diverting a portion of revenues to broader Medi-Cal costs.

Second, stakeholders pointed to the need for emergency programs and targeted relief. Extending or replicating initiatives like the distressed hospital loan program could provide a critical lifeline for under-resourced institutions. Targeted relief from seismic retrofit requirements – through deadline extensions or state-supported capital investments – could also help struggling hospitals remain viable.

Finally, hospital leaders called for more nuanced cost control strategies. They noted that OHCA’s health care spending targets may not fully account for rising labor and supply expenses. Adjustments to timing, targets, and enforcement may be necessary to balance affordability with sustaining struggling hospitals.

In terms of service lines, hospital leaders warned that L&D units are among the most vulnerable hospital-based services in the coming years. Looming Medi-Cal cuts could push already struggling units to the breaking point, and even larger hospitals are finding it difficult to make their L&D services financially viable. The closure of any unit would have a significant impact on the local market and on access to care. Stakeholders emphasized that the state should monitor this issue closely and develop strategies to maintain solvency and mitigate harm from potential closures.

## Focus Area 3: Grow the Health Care Workforce

The Central Valley faces persistent shortages across nearly all health professions, creating critical gaps in care. Strengthening the region’s health care workforce requires both long-term investments in local training and education and short-term strategies to attract and retain skilled professionals. Stakeholders emphasized that building a workforce rooted in the Valley not only addresses staffing needs but also fosters cultural and linguistic alignment, strengthens trust, and improves patient outcomes. This focus area outlines strategies to expand local training pathways, grow medical education capacity, and support recruitment and retention across the region.

### 1. Expand Local Training Programs and Pathways

Stakeholders emphasized a “grow our own” approach—prioritizing the recruitment, training, and retention of individuals with ties to the Central Valley. Evidence shows two factors increase the likelihood that health professionals remain in the region: having roots in the Valley and receiving training in the Valley. By focusing on training local people through local programs, the Valley invests in the workforce that is most likely to stay long-term, while also creating needed economic mobility pathways for local residents. As described earlier in the report, there is significant momentum on which to build, including robust K-16 education to employment pathways, expanded training capacity at local colleges, new employer-driven pathways, and several examples of regional employer-educator collaborations.

Workforce leaders suggested strategies for greater impact, including:

- Conduct further research on the Central Valley health care workforce to gain deeper insights into gaps, challenges, and opportunities for improvement.
- Scale current programs to reach more people through increased investment and stable, long-term funding models.

- Link pathways more closely and strengthen employer connections at the end of the pathway.
- Provide additional support for local students and incumbent workers pursuing health careers (e.g., scholarships, paid internships, case management).
- Increase clinical training placements and expand use of simulation to enhance training.
- Pool resources where appropriate (e.g., consortium model for simulation lab, shared clinical faculty).
- Raise salaries for clinical educators at local colleges to improve recruitment and retention.
- Better align education with employer needs through employer-led planning tables (i.e., replicate the Tulare-Kings Health Care Partnership model).
- Encourage local students and incumbent workers to pursue more advanced health careers.
- Promote a wide range of health care roles—including clinical technologists, occupational therapy, dietetics, IT, accounting, public health, behavioral health, and health management/policy.
- Strengthen data quality and ensure timely access to accurate workforce shortage information.

Policies such as [SB1183](#) – which add “living in a medically underserved area” to the approved list of considerations for admission to community college nursing and allied health programs – may support “grow our own” approaches by increasing enrollment of local students in these programs.

### 2. Increase Medical Education Capacity

Building the region’s medical education and training capacity is critical to addressing persistent physician shortages in the Central Valley. Expanding local training opportunities not only produces more physicians but also increases the likelihood they remain in the region.

Progress is being made. As described earlier, the Central Valley gained its first medical school in 2020 –



the College of Osteopathic Medicine at California Health Sciences University (CHSU-COM) in Clovis – which has produced more than 125 new physicians in its first two graduating classes and plans to graduate 150 new doctors per year beginning in 2026. And UCSF Fresno and UC Merced have several programs that support medical education in the Valley. Additionally, the number of medical residency programs and positions has increased over time.

To build upon this momentum, regional leaders would like to see an independent UC medical school in the Central Valley. Efforts to establish such a school have been underway for nearly two decades, and stakeholders stressed the need to sustain urgency and political will to move the initiative forward. An independent UC medical school could be transformative for the region— attracting physicians and faculty, expanding the local health workforce, retaining trainees, strengthening community partnerships, and building research and clinical capacity. Key challenges include securing state and federal funding, establishing sustainable affiliations with local health systems, and navigating federal residency caps. Coordinated advocacy and strategic planning will be essential to realizing this vision. In the near term, aligning efforts with the San Joaquin Valley Coalition for Medical Education and expanding capacity within the existing SJV Prime programs (promising models that currently train a small number of students) would help advance this goal.

Additionally, regional leaders stress that more Graduate Medical Education (GME) – residency training – is essential. Evidence shows that the location where trainees complete residency is one of the strongest predictors of where they will practice long-term. California retains the highest share of its medical residents nationwide, with 78% remaining in the state after completing residency training, compared to 54% nationwide.<sup>156</sup> If a new doctor must pursue a type of graduate medical training that isn't available locally, they are forced to leave the Valley. Likewise, shortages in certain specialty residencies make it harder to address workforce gaps in those areas.

Stakeholders identified several strategies to expand GME training in the Central Valley:

- Stabilize and expand state funding for GME programs, especially programs in underserved regions of the state.<sup>157</sup>
- Advocate for increased federal spending for residency.<sup>158</sup>
- Monitor local GME trends – track growth in local programs and positions, the percentage of first-year slots filled, and compare to local specialty shortages.<sup>159</sup>
- Support collaborative planning and resource sharing among GME providers to align residency opportunities with community needs.
- Leverage state initiatives such as [SB 246](#) to establish new residency programs at district hospitals.
- Develop fellowship opportunities that enable providers to remain in the Valley for advanced training post-residency.

### **3. Strengthen Recruitment and Retention**

While long-term pipeline programs are essential, the Central Valley also needs short-term strategies to attract and retain health professionals. Stakeholders emphasized approaches such as increasing pay, offering loan forgiveness tied to service commitment, providing clear career advancement pathways, and using targeted incentives—like retention bonuses, housing stipends and subsidies, or tax relief for first-time homebuyers—to encourage providers to stay and establish long-term careers locally.

Stakeholders noted that the Central Valley's reputation can be a barrier to recruitment. Strategic efforts to highlight the region's assets—such as Fresno's downtown revitalization, Clovis's recognition as one of the best places to live in California, and comparatively affordable housing—can improve perceptions among prospective health care workers and even encourage local students to pursue health careers in the Valley. Efforts to strengthen regional assets, such as investing in urban green spaces, local schools, and amenities like

hotels and restaurants, will further support recruitment and retention.

Creating a sense of belonging and community integration is also critical to retaining health professionals and their families. Professional isolation, limited local connections, and feeling unwelcome in the community can drive turnover. Stakeholders emphasized fostering inclusive workplace cultures, supporting social and cultural connections for health care workers and their families, and offering mentorship, peer networks, and other opportunities to connect with colleagues locally.

## Focus Area 4: Reimagine Models of Care

The Central Valley faces persistent gaps in health care access and coordination, particularly for high-need populations, low-income and rural communities, and pregnant individuals. Fragmented services, siloed funding, and workforce shortages leave residents' health and social needs unmet, driving avoidable emergency department visits and hospitalizations and worsening outcomes. Transforming care requires more than additional resources—it calls for reimagining service delivery by integrating community-connected providers, piloting innovative care models, and coordinating across health and social systems to create a more accessible, culturally responsive, and resilient health system.

### 1. Coordinate Across Systems to Address Complex Health and Social Needs

Stakeholders highlighted that many patients in the Central Valley end up in emergency departments due to unmet social needs, limited access to timely primary and specialty care, and poor care coordination. After discharge, patients are often referred to specialists but face long waits, complex navigation, and gaps in follow-up, creating a cycle of “churn” back into the hospital system.

Stakeholders emphasized that these complex challenges cannot be solved by individual organizations

alone. Effective solutions require cross-sector collaboration that brings together health care providers, social service agencies, and community-based organizations to coordinate resources, reduce duplication, and address the full spectrum of barriers faced by people with complex needs. Collaboration must be inclusive, engaging a diverse set of participants, and foster shared understanding of programs, funding streams, and population challenges.

Strategies include moving toward value-based population health management, integrating community-connected providers into care teams, and leveraging technology, such as AI tools, to monitor and manage population health. Effective implementation also depends on robust data exchange to track patients across settings, support care coordination, and measure outcomes.

To strengthen hospital-level coordination, the region would benefit from a dedicated system for real-time sharing of ED treatment status and hospital bed availability. Such a platform would facilitate timely inter-hospital transfers, optimize patient flow, and ensure patients receive the appropriate level of care with fewer delays, complementing broader cross-sector efforts to coordinate health and social services.

State-level initiatives like [CaAIM](#) offer opportunities to align funding and services for targeted populations, such as justice-involved youth, but require flexible financing and infrastructure to maximize impact. Looking ahead, fostering regional collaboration, advocating for funding flexibility, and building integrated systems that address health and social needs holistically are critical for improving outcomes in the Central Valley.

### 2. Fund and Integrate Community-Connected Providers

Stakeholders highlighted the need to strengthen the Central Valley health system by expanding both the supply of and access to community-connected providers, including community health workers and promotores (CHW/Ps), peer support specialists, lay counselors, and doulas. These providers often share

lived experiences with the people they serve and are valued for their ability to build trust, engage diverse communities, and support individuals with limited English proficiency. Integrating them into care teams can improve care coordination, support physical and behavioral health needs, and tackle social determinants of health.

There is strong evidence and widespread enthusiasm for these models, as well as new Medi-Cal funding streams. Yet payment rates are low, and accessing these funds is challenging for many providers and the community-based organizations that employ them. Stakeholders emphasized that state government must simplify bureaucratic processes at the county and managed-care level to connect non-clinical, community-based organizations and workers directly to funding.

Beyond payment, integrating these workforce roles into traditional health systems presents additional hurdles. Many physicians and care team members lack a clear understanding of how these roles function and contribute to patient care. Even routine processes – such as documenting encounters in EHRs not designed for these providers – can create delays and roadblocks. Without cooperative systems changes—like standard discharge practices that link eligible patients to CHWs, or shared protocols defining the doula’s role during delivery—these roles will be hamstrung and unable to achieve their full impact.

### **3. Diversify Maternity Care Models**

As outlined in the maternity care section of this report, the region faces considerable challenges with workforce shortages and L&D unit closures. Recruiting and retaining providers and sustaining, or even re-opening, L&D units will be essential—but likely not enough on their own. Stakeholders stressed the need for a multi-pronged approach that combines workforce efforts with innovative models of care.

Promising strategies to explore include:

- Build models of care that incorporate community-connected health workers, especially doulas.
- Build additional OB/GYN residency programs in the region.
- Create clinical training locations in rural communities.
- Expand the use of midwives and family physicians trained in obstetrics.
- Establish midwifery-led birth centers for low-risk deliveries.
- Leverage telehealth and remote patient monitoring.
- Expand remote specialty support for rural maternity care teams.
- Develop maternal home models, where expectant mothers can temporarily live in hospital-based housing before delivery.
- Create innovative training and rotation opportunities that help rural providers maintain obstetric skills.
- Foster regional partnerships that align the strengths of FQHCs, hospitals, and community-based organizations to build a more coordinated and cohesive system of care.

A recent California Hospital Association maternity care report profiled the Maniilaq Health Center in Alaska, which illustrates how a team-based, technology-supported model can sustain maternity services in highly rural settings. Certified nurse midwives provide care to 11 isolated communities through telemedicine and periodic in-person visits, working alongside community health aides (medically trained local residents) and with centralized support from OB/GYNs at a regional facility. With no roads connecting the communities, expectant mothers fly in for quarterly visits and relocate near the delivery site at 36 weeks—whether to the health center for low-risk pregnancies or to a regional hospital for higher-risk cases. To maintain their clinical skills, midwives periodically travel to Anchorage for several weeks to deliver as many babies as possible.<sup>160</sup>

#### 4. Expand Innovative Solutions for Rural Health Access

Improving access to health care in rural communities emerged as a high priority among stakeholders that participated in this research. Achieving this will require creative approaches that go beyond traditional clinic-based care.

Promising strategies include:

- Technology-enabled solutions such as telehealth, eConsult, and remote patient monitoring to connect patients with timely primary and specialty care, regardless of distance.
- Mobile health units that can bring services directly to rural communities.
- Investments in more accessible transportation support to help residents reach care when local options are limited.
- Expanding the community-connected workforce in rural communities (see recommendation 12).
- Increasing employer-funded clinics located near agricultural worksites to reduce barriers and bring services directly to where people live and work.
  - Most local stakeholders were unfamiliar with agricultural employer health care clinics and expressed interest in learning more. Additional research about their role in the ecosystem, including the extent to which they improve worker access to care and health care outcomes, and interact with other health care systems in the Valley, could be useful.





# Conclusion

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Conclusion

The Central Valley's health care system is fragile and under-resourced compared to wealthier parts of California. Stakeholders consistently pointed to the Valley's agricultural economy—built on low-wage labor, limited worker protections, and chronic underinvestment in health, education, and infrastructure—as the root of many present-day disparities. This legacy continues to shape health outcomes and the capacity of the Valley's health system today.

Federal cuts under H.R. 1 (One Big Beautiful Bill Act) pose a severe threat to health care access in the Valley. The legislation is projected to reduce federal Medi-Cal funding by \$30 billion annually and could leave up to 3.4 million Californians without Medi-Cal coverage.<sup>161</sup> These cuts would lower hospital and provider reimbursements while increasing uncompensated care as more patients lose insurance. Without decisive action, the impacts on the Central Valley—where over half the population is covered by Medi-Cal and many hospitals already operate in the red—could be devastating. As one stakeholder warned, the region's health system is “on life support,” and further cuts would be “a dagger to the heart.”

Despite these challenges, the Valley remains a place of deep pride, resilience and connection. Across perspectives, there was a clear call to action: to catalyze collaboration and investment, sustain the health care safety net, grow the health care workforce and reimagine models of care. Achieving progress will require turning these priorities into coordinated, sustained action.

The following ideas offer a starting point for organizations and coalitions across the Valley to translate the report's recommendations into meaningful next steps:

- **Assess alignment:** Identify which recommendations align with existing work and capabilities, and determine where your organization or coalition is best positioned to contribute to regional progress. Incorporate aligned recommendations into goals, strategic plans, and initiatives.
- **Leverage the report's data:** Use findings to build support for initiatives, secure funding, guide resource allocation, raise awareness among staff, boards, and funders, and advocate for supportive policies and programs at the local, state, or federal level.
- **Engage in collaborative, cross-sector efforts:** Support, lead or participate in inclusive processes to prioritize next steps, establish shared regional goals, strengthen partnerships, and coordinate through task forces or committees to align efforts and sustain momentum.
- **Plan, pilot, and evaluate interventions:** Conduct additional analysis and develop implementation roadmaps for prioritized strategies, test new approaches to gather lessons, and establish metrics and regional mechanisms to monitor progress over time.

The Central Valley's health challenges are urgent, interconnected, and unlike those faced elsewhere in California. Meeting this moment will require unified leadership and collective will—working across silos, systems, and sectors—to build a stronger, more equitable health care system for every community in the Valley.





# Acknowledgments

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Acknowledgments

**Report prepared by:** Jess Thacher Consulting

**Authors:** Jess Thacher, MPH, Jen Joynt, and Wendy Todd, MPH

## About the Authors:

*Jess Thacher, MPH – Founder, Jess Thacher Consulting*

Jess Thacher specializes in strengthening safety-net health care systems, primarily in California. She applies facilitative and data-driven approaches to help organizations create value amidst ambiguity, build effective strategies and systems, and continuously improve existing programs. Her work spans quality improvement, strategy, program development and implementation, and research and evaluation.

*Jen Joynt – Independent Health Care Consultant*

Jen Joynt specializes in health care research, writing, and project management. Her areas of expertise include health care consumer experiences; quality of care; hospital organization, strategy, and operations; health care workforce; and the California health care marketplace.

*Wendy Todd, MPH – Founder, Wendy Todd Consulting*

Wendy Todd is a seasoned consultant and public health leader with a proven track record of driving successful cross-sector partnerships, improving processes, shaping policies, and launching innovative community initiatives. She helps organizations learn, plan, and collaborate to increase equitable access to nature, health care, social services and other vital resources for better health and well-being.



Central Valley Community Foundation Project Lead: Elize M. Bradley, DrPH, JD, Senior Health Equity Fellow

The Central Valley Community Foundation would like to thank Blue Cross of California, dba Anthem Blue Cross, for contributing funding for this Study.

Special thanks to the Hospital Council—Northern & Central California, and David Bacci, Regional Vice President, who served as a consultant on this project. His expertise was truly valued and appreciated.

## About the Foundation:

The Central Valley Community Foundation has been a trusted leader in local philanthropy for nearly 60 years. As the only nationally accredited community foundation serving Merced, Mariposa, Madera, Fresno, Tulare and Kings counties, we are exclusively dedicated to this region. We believe big change is possible in our region and invite the community to join us in building a just and thriving Central Valley!

No barriers. Just opportunity. All people.

## About our Logo:



Our logo expresses and emphasizes the strength of our Valley and the Foundation's vision, mission, and impact.

- Our place. The landscape design (sun, sky, horizon, field) and colors represent the Valley and why so many have come here to work and prosper.
- Our vision. Equity (the equal sign) is at the center of all we do. We believe an equitable society supports true transformation—of systems, communities and lives—and spans generations.
- Our mission. The Foundation is continuously evolving to navigate complex systems and find new ways to connect communities and capital for a just and thriving Central Valley.
- Our impact. The circle represents interconnectedness and long-lasting change.
- Our strength. The brick pattern illustrates our ability to empower communities and rebuild the Central Valley.

### **Advisory Group Members**

- Dr. Jose Barral-Sanchez, Vice Dean, UCSF Fresno
- David Bacci, Regional Vice President, Hospital Council – Northern & Central California
- Dena Bullard, Senior Director for Health Sciences and Workforce Innovations, UC Health
- Dr. Venise Curry, Physician Consultant, N/A
- Bryn Forhan, Consultant, The Forhan Company
- Paul Gibson, CEO, Eaton Gibson Family Fund / E & G Farming
- Alyssa Gurney, Chief Strategy Officer, Central Valley Health Network
- Clay Ipsen, President, HealthForce / True North Physician Agency
- Alyssa Kennett, Director, Central California Public Health Consortium
- Jim Maxwell, CEO, Agriland
- Traco Matthews, Chief Health Equity Officer, Kern Health Systems
- Brandi Muro, Executive Director, Fresno Community Health Improvement Partnership
- Stephanie Nathan, CEO, United Way Fresno/Madera
- Jeffrey Nkansah, CEO, CalViva Health
- Dr. Tania Pacheco-Werner, Executive Director, Central Valley Health Policy Institute
- Rose Mary Rahn, Public Health Director, Kings County, Kings County Public Health Department
- Yolanda Randles, Executive Director, West Fresno Family Resource Center
- Dr. David Riggs, MD, Executive Medical Officer, The Wonderful Company / Fiji
- Chris Rodriguez, Chief of Human Resources, Agriland
- Dr. Carmela Sosa, Associate Program Director, Valley Children’s Pediatric Residency Program, Valley Children’s Healthcare
- Kiyoshi Tomono, Partnership Executive, Adventist Health
- Dr. Margo Vener, Assistant Dean, Undergraduate Medical Education at UC Merced, UCSF
- Brett Zall, Vice President of Human Resources, Fowler Packing
- Pao Yang, President & CEO, The Fresno Center

### **Interview Participants**

- Amy Arambula, lawyer/advocate
- Dr. Raul Ayala, Ambulatory Medical Officer, Adventist Health
- Lynne Ashbeck, Chief Community Impact Officer, Valley Children’s Healthcare
- Dr. Jose Barral-Sanchez, Vice Dean, UCSF Fresno
- Shantay Davies-Balch, CEO, BLACK Wellness & Prosperity Center
- Bryn Forhan, Consultant, Forhan Consulting
- Paul Gibson, CEO, Eaton Gibson Family Fund, E.G. Farming
- Trina Gonzalez, Vice President, Policy, California Hospital Association
- Dr. John Graneto, Dean, CHSU College of Osteopathic Medicine
- Alyssa Gurney, Chief Strategy Officer, Central Valley Health Network
- Karri Hammerstrom, Executive Director, Fresno-Madera K-16 Collaborative
- Gary K. Herbst, CEO, Kaweah Health
- Kerry Hydash, CEO, Family HealthCare Network
- Clay Ipsen, President, HealthForce / True North Physician Agency
- Genoveva Islas, Executive Director, Cultiva la Salud
- Ben Johnson, Group Vice President, Financial Policy, California Hospital Association
- Dr. Gurvinder Kaur, President, Saint Agnes Medical Center
- Alyssa Kennett, Director, Central California Public Health Consortium
- Traco Matthews, Chief Health Equity Officer, Kern Health Systems
- Patience Milrod, Esq. lawyer/advocate
- Nichole Mosqueda, Chief Strategy Officer, Camarena Health
- Brandi Muro, Executive Director, Fresno Community Health Improvement Partnership
- Jeffrey Nkansah, CEO, CalViva Health
- Reyna Olaguez, CEO, Building Healthy Communities Kern
- Rose Mary Rahn, Director, Kings County Department of Public Health
- Dr. Emma Rasmussen, Deputy Director, Fresno County Behavioral Health

- Dr. David Riggs, Wonderful Wellness Medical Director, The Wonderful Company
- Sophia Salinas, HOPE Program Director, Fresno Community Health Improvement Partnership
- Dr. Stacy Sawtelle, Assistant Dean for GME, UCSF Fresno
- Rosalba Serrano, MSW, Behavioral Health Director, Camarena Health
- Reyna Villalobos, Managing Director of Regional Programs, The Center at Sierra Health Foundation
- Craig Wagoner, CEO, Community Health System

### **Legislator and Business Leader Roundtable Meeting**

- Lynne Ashbeck, Valley Children's
- Dr. Raul Ayala, Adventist Health
- David Bacci, Hospital Council
- Dr. Kenny Banh, UCSF Fresno
- Vanessa Barraza, Office of Assemblymember Esmeralda Soria
- Cary Catalano, Catalano Fenske and Associates
- Maria Cortez, Stanislaus Community Foundation
- Guadalupe Cruz, The Maddy Institute
- Tim Curley, Valley Children's
- Lauren Day, Adventist Health
- Joan Eaton, E&G Farming
- Aaron Falk, Kern Community Foundation
- Blake Zante, The Maddy Institute
- Bryn Forhan, The Forhan Company
- Paul Gibson, E&G Farming
- Omar Hernandez, Office of Congressman Adam Gray
- Ish Herrera, CA FWD
- Marian Kaanon, Stanislaus Community Foundation
- Brixton Layne, Office of Congressman Tom McClintock
- Maria Lemus, Office of Assemblymember Joaquin Arambula
- Cori Lucero, UC Merced
- Michael Lukens, Fresno State
- Kathy Mahan, Senator Adam Schiff
- Shannon Major, Office of CA Senator Shannon Grove
- Brady Matoian, OK Produce
- Angel Moreno, California Department of Justice
- Dan Moreno, Office of Assemblymember David Tangipa

- Amy Nelson, San Joaquin Community Foundation
- Linda Nguyen, Microsoft TechSpark
- Dr. Tania Pacheco-Werner, Central Valley Health Policy Institute
- Danielle Parnagian, Board of Directors - Valley Children's & CVCF
- Patience Milrod, Esq., lawyer/advocate
- Alexandra Rizo, Office of Assemblymember Soria
- Miguel Ramirez, SoCalGas
- Aldi Ramirez, Shehadey Family Foods
- Neisha Rhodes, Stanislaus State
- Robin Woodward, Chevron
- David Santos, Office of Senator Anna Caballero
- Dr. Stacy Sawtelle Vohra, UCSF Fresno
- Courtney Shapiro, CalViva Health
- Larry Salinas, Congressman Jim Costa
- Dr. Carmela Sosa, Valley Children's
- Dorothy Thomas, Community West Bank
- Kiyoshi Tomono, Adventist Health
- Matthew Tuttle, Office of Assemblymember Alexandra Macedo
- Justin Vartanian, Ameriprise Financial Services
- Dr. Tania Pacheco-Werner, Central Valley Health Policy Institute
- Tim Curley, Valley Children's

### **Public Health Officer and Director Listening Session**

- Staci Chastain, Deputy Director, Tulare County Public Health
- Karen Elliott, Director, Tulare County Public Health
- David Luchini, Director, Fresno County Public Health
- Stacey Lynch, Division Director of Health Services, Mariposa County Public Health
- Dr. Thomas Overton, Deputy Public Health Officer, Tulare County Public Health
- Dr. Simon Paul, Health Officer, Madera County Public Health
- Joe Prado, Assistant Director, Fresno County Public Health
- Rose Mary Rahn, Director, Kings County Public Health
- Dr. Kristynn Sullivan, Director, Merced County Public Health
- Dr. Asman Tariq, Health Officer, Tulare County Public Health



### **Hospital Executive Listening Session**

- Tracy Bertagnole, COO, Kaiser Permanente Fresno Medical Center
- Patrick Dantzler, VP, Chief Nursing Officer, Community Regional Medical Center
- Danny Davis, Division President, Hospitals, Community Health System
- Minty Dillon, CEO, Good Samaritan Hospital
- Froylan Garza, Executive Director/CEO, VA Central California Health Care System
- Dr. Donna J. Hefner, President and CEO, Sierra View Medical Center
- Gary K. Herbst, CEO, Kaweah Health
- Gayle Holman, Director of Public Affairs and Government Relations, Community Health System
- Dr. Gurvinder Kaur, President, Saint Agnes Medical Center
- Ken Keller, President and CEO, Bakersfield Memorial Hospital
- Jenny Lavers, Network Operations Executive, Adventist Health
- Kristie Marion, CEO, Sutter Memorial Hospital Los Banos
- Timothy McGlew, CEO, Kern Valley Healthcare District
- Amir Meshreky, Associate Administrator, Business Development Director, Encompass Health Rehabilitation Hospital of Bakersfield
- Shayne Perkovich, CEO, Central California Rehabilitation Hospital
- Patrick Ramirez, Division President, Provider Network, Community Health System
- Simon Ratliff, President and CEO, Bakersfield Mercy Hospitals
- Pat Ryan, former interim CEO, John C. Fremont Healthcare District
- Martha Samora, CEO, Encompass Health Rehabilitation Hospital of Bakersfield
- Nikkel Sherell, Director of Business Development, Central California Rehabilitation Hospital
- Scott Thygerson, CEO, Kern Medical
- Dr. Heather Van Housen, Patient Care Executive, Adventist Health Central California Network
- Michelle Von Tersch, Senior Vice President, Chief of Staff, Community Health System
- Craig A. Wagoner, President and CEO, Community Health System

### **Community Health Worker / Promotora Listening Session**

- Araceli Albizu, Aria Community Health Center
- Livia Alejo, Cultiva La Salud
- Erica Basurto, Cultiva La Salud
- Jocelyn Chavez, Aria Community Health Center
- Maura Cordoba Castellon, Cultiva La Salud
- Marissa Corpus, Reading and Beyond
- Amye Cortez, Cultiva La Salud
- Genesis Gonzalez, Catholic Charities
- Shang Her, The Fresno Center
- Maria Hernandez, Reading and Beyond
- Julia Pacheco, Cultiva La Salud
- Ann Parola, Valley Center for the Blind
- Alma Pineda, The Fresno Center
- Joseline Rodriguez, Cultiva La Salud
- Elma Vargas, Cultiva La Salud
- Angela Vasquez, Valley Center for the Blind
- Estefany Torres, Family HealthCare Network
- Thai Vang, The Fresno Center

### **Workforce Leaders Listening Session**

- Julia Alvarez, Assistant Teaching Professor, UC Merced Department of Medical Education
- Yasmine Bahena, HR Business Partner, Dignity Health
- Dr. Jose Barral-Sanchez, Vice Dean, UCSF Fresno
- Kim Behrens, Associate Dean of Health Careers, Porterville College
- Staci Chastain, Deputy Director of Public Health Operations, Tulare County Health & Human Services Agency
- John Cusick, UC Merced Department of Medical Education
- Jorge Espinosa, Lead Business Services Specialist, Workforce Development Board of Madera County
- Erick Flores, Workforce Development Board of Madera County
- Carla Gard, Executive Dean of Nursing and Allied Health, Bakersfield College
- JD Garza, Associate Program Director, California AHEC Program Office, UCSF Fresno
- Natalee Garrett, Vice President of Strategic Development, Kern Medical

- Marie Gilbert, Director, Central California Center for Excellence in Nursing, Fresno State
- John Gonzalez, Business Services Manager, Workforce Investment Board for Tulare County
- Dr. John Graneto, Dean, CHSU College of Osteopathic Medicine
- Karri Hammerstrom, Executive Director, Fresno-Madera K-16 Collaborative
- Sally Hernandez Jimenez, Vice Principal, Fresno Adult School
- Jeffrey Hudson-Covolo, Nurse Executive / Strategy Advisor, Sierra View Medical Center
- Esther Igboerika, Chief Nursing Officer and BSN Program Director, Fresno Pacific University
- Clay Ipsen, President, HealthForce / True North Physician Agency
- Brandy Irwin, Administrative Director of Acute Care and Outpatient Services, Sierra View Medical Center
- Dr. Gurvinder Kaur, President, Saint Agnes Medical Center
- Belen Kersten, Director of Nursing, College of the Sequoias
- Kristie Marion, CEO, Sutter Memorial Hospital Los Banos
- Amir Meshreky, Associate Administrator, Business Development Director, Encompass Health Rehabilitation Hospital of Bakersfield
- Alison Millhollen, Regional Manager Recruitment/Talen Acquisition, Saint Agnes Medical Center
- Joe Serena, Dean of Allied Health and Public Safety, Merced College
- Jonna Schengel, Dean, Career Technical Education, Nursing and Allied Health, College of the Sequoias
- Lorraine Smith, Dean of Instruction, Allied Health, Physical Education and Athletics Division, Fresno City College
- Scott Sailor, Professor, Fresno State
- Simon Ratliff, President and CEO, Bakersfield Mercy Hospitals
- Scott Thygerson, CEO, Kern Medical
- Luke Torossian, Business Services Coordinator, Fresno Regional Workforce Development Board
- Kiyoshi Tomono, Partnership Executive, Adventist Health
- Maiknue Vang, Executive Director, Madera County Workforce Investment Corporation
- Gloria Yang, Chief, Education Service, Veterans Administration

- Debra Wilson, Chair, Department of Nursing, Cal State Bakersfield
- Kara Zografos, Dean, College of Health and Human Services, Fresno State

### **Health Care Advocates Listening Session**

- Amy Arambula, Esq., lawyer/advocate
- Christine Barker, Executive Director, Fresno Interdenominational Refugee Ministries
- Norma Benitez, Network Director, Vision y Compromiso
- Diana Camacho, Senior Program Officer, California Health Care Foundation
- Sandra Celedon, CEO, Fresno Building Healthy Communities
- Dennis Cuevas-Romero, Vice President of Government Affairs, California Primary Care Association
- Seleny Diaz, Program Manager, Health Access
- Rebecca Donabed, Community Organizer, Resources for Independence Central Valley
- Andrew C. Lee, Senior California Policy Manager, Southeast Asia Resource Action Center
- Ruth Lopez, Executive Director, Valley Voices
- Andrea Mackey, Associate Organizing Director, California Pan-Ethnic Health Network
- Amiee Mallet, Workforce Development Director, Central Valley Health Network
- Deborah Nankivell, Esq., CEO, Fresno Stewardship Foundation
- Mike Odeh, Senior Director of Health Policy, Children Now
- Dr. Tania Pacheco-Werner, Executive Director, Central Valley Health Policy Institute
- Noé Páramo, Director, Sustainable Rural Communities Project, California Rural Legal Assistance Foundation
- Yolanda Randles, Executive Director, West Fresno Family Resource Center
- Sophia Salinas, HOPE Program Director, Fresno Community Health Improvement Partnership
- Nataly Santamaria, Central Valley Promotora Network Manager, Vision y Compromiso
- Norma Trinidad-Diaz, Community Organizer, Central Valley Immigrant Integration Collaborative
- Sheri Wiedenhoefer, Director, Community Justice Center
- Blake Zante, Executive Director, The Maddy Institute





# Endnotes

Central Valley Health Care Landscape Study



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

# Endnotes

- 1 California Department of Health Care Services (DHCS), [Medi-Cal Certified Eligibles Data by Month with Demographics](#), February 2025; California Department of Finance (DOF), [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Central Valley and California rates were calculated using DHCS enrollment figures and DOF population estimates.
- 2 California Health Care Foundation (CHCF), [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. CHCF, [The 2024 CHCF California Health Policy Survey](#), January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties. California Department of Managed Health Care. [“Timely Access to Care.”](#) DMHC, 2025.
- 3 California Department of Health Care Access and Information (HCAI), [Health Workforce Research Data Center Annual Report to the Legislature](#), April 2025; California Healthline, [California’s Primary Care Shortage Persists Despite Ambitious Moves To Close Gap](#), May 1, 2025; HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025; DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Specialist supply per 100,000 population calculated by author. Active specialists are physicians (MDs and DOs) with non-primary care specialties that spend at least 20 hours a week in patient care.
- 4 HCAI, [Hospital Annual Financial Data, 2021-2023](#).
- 5 Los Angeles Times, [This rural California county lost its only hospital, leaving residents with dire healthcare choices](#), June 3, 2023; The City of Madera, [Madera Community Hospital reopens, restoring critical healthcare access](#), The City of Madera, March 18, 2025.
- 6 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025. DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. California Department of Consumer Affairs, [Active Licenses by County Interactive Map](#), accessed July 29, 2025. Provider supply per 1,500 women age 15-44 (2024 data) calculated by author based on active OB/GYNs (MDs and DOs) that spend at least 20 hours a week in patient care (2025 data) and NMs with an active California license and a California address of record (2023 data).
- 7 CalMatters, [As hospitals close labor wards, large stretches of California are without maternity care](#), November 15, 2023. CalMatters, [California’s maternity care crisis is worsening as Newsom decides on bills to slow closures](#), September 16, 2024.
- 8 California Department of Public Health (CDPH), [Infant Mortality Dashboard](#), 2021.
- 9 CDPH, [Pregnancy-Related Mortality Dashboard, 2020-2022](#). Central Valley includes study region, plus Stanislaus and Tuolumne counties.
- 10 California Budget & Policy Center, [How Federal Funding Cuts Threaten the Health of Californians](#), September 2025.
- 11 HCAI, [2023 Primary Care Clinic Annual Utilization Data \(November 2024\)](#).
- 12 The Economist, [The Appalachia of the West: California’s Agricultural Heartland Threatens to Become a Wasteland](#), January 21, 2010.
- 13 California Department of Finance (DOF), reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2013 and 2023. One-year estimates were used for California and for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County.
- 14 DOF, ACS 1-Year and 5-Year Estimates, 2023.
- 15 California Department of Finance (DOF), reports from U.S. Census Bureau American Community Survey (ACS) 1-Year and 5-Year Estimates, 2023. One-year estimates were used for California and for Fresno, Kern, Kings, Madera, Merced, and Tulare Counties; five-year estimates were used for Mariposa County.
- 16 California Department of Education, [English Learner Students by Language by Grade](#): Reports for Fresno, Kern, Kings, Madera, Mariposa, Merced, and Tulare Counties, 2024–2025.
- 17 California Department of Finance (DOF), reports from U.S. Census Bureau American Community Survey 1-Year and 5-Year Estimates, 2013 and 2023.
- 18 DOF, [CA Master Plan for Aging Data Dashboard](#), California Population Profile, Adults Age 60 and Older, Version 2025.04.25.
- 19 U.S. Census Bureau, [Profiles](#) for Fresno, Kern, Kings, Madera, Mariposa, Merced and Tulare counties, accessed September 2025.
- 20 DOF, ACS 1-year and 5-year estimates, 2023.
- 21 Ibid.



- 22 Public Policy Institute of California, [Rural California Factsheet](#), March 2024.
- 23 Central California Public Health Consortium, [Central California Regional Health Equity Analysis](#), 2025. Central California includes counties of Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Benito, San Joaquin, Stanislaus, Tulare, and Tuolumne.
- 24 DOF, ACS 1-year and 5-year estimates, 2023.
- 25 Ibid.
- 26 Public Policy Institute of California, [Californians and the Housing Crisis](#), 2019 data, accessed September 2025.
- 27 California Housing Partnership, [California Affordable Housing Needs Report](#), 2025.
- 28 California Housing Partnership, [Housing Needs Reports](#) – County-level reports for Fresno, Kern, Kings, Madera, Mariposa, Merced and Tulare counties, 2025.
- 29 Ibid.
- 30 Public Policy Institute of California, [Californians and the Housing Crisis](#), 2019 data, accessed September 2025.
- 31 Central California Public Health Consortium, [Central California Regional Health Equity Analysis](#), 2025. Central California includes counties of Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Benito, San Joaquin, Stanislaus, Tulare, and Tuolumne.
- 32 U.S. Environmental Protection Agency, [EPA Projects More than 99% of Counties would Meet the Revised Fine Particle Standard; Projection of Counties with Monitors that would not Meet in 2032](#), 2024.
- 33 CHCF, [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.
- 34 CalMatters, [State inspectors are supposed to visit all farmworker housing to ensure its safety. Sometimes they use FaceTime Instead](#), July 1, 2024.
- 35 UC Merced Community and Labor Center, [Farmworker Health in California: Health in a Time of Contagion, Drought, and Climate Change](#), 2022.
- 36 Ibid.
- 37 UC Berkeley Graduate School of Journalism New Media Program, [Unequal from Birth](#), accessed September 2025.
- 38 UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2023. Central Valley tabulations exclude Mariposa County.
- 39 CDPH, [County Health Profiles](#), 2024.
- 40 California Department of Health Care Services (DHCS), [Medi-Cal Certified Eligibles Data by Month with Demographics](#), February 2025; California Department of Finance (DOF), [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Central Valley and California rates were calculated using DHCS enrollment figures and DOF population estimates.
- 41 Centers for Medicare & Medicaid Services. [Medicare Monthly Enrollment](#), 2024 annual counts, published May 2025. Total Medicare beneficiaries limited to those with Part A and B.
- 42 DHCS, Medi-Cal Managed Care Enrollment Report, July 2025.
- 43 Ibid.
- 44 CHCF, [Medi-Cal Explained: 2024 Managed Care Plans](#), June 2023.
- 45 DHCS, [Notice of Additional Information – Medi-Cal Managed Care Plan Transition](#), accessed September 2025.
- 46 DHCS, Medi-Cal Managed Care Enrollment Report, July 2025.
- 47 CHIS, 2012-2023. Central Valley tabulations exclude Mariposa County.
- 48 CHIS, 2023. Central Valley tabulations exclude Mariposa County.
- 49 UC Merced Community and Labor Center, [Farmworker Health in California: Health in a Time of Contagion, Drought, and Climate Change](#), 2022.
- 50 KFF, [A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law](#), July 30, 2025.
- 51 California Health and Human Services (CalHHS), [President Trump’s “Big Beautiful Bill: Millions of Californians to Lose Access to Health Care and Food](#), July 19, 2025.
- 52 Georgetown University Center on Health Insurance Reforms, [After H.R.1, Millions More Could Lose Marketplace Coverage](#), September 4, 2025.
- 53 Covered California, [Active Member Profiles](#), June 2025.
- 54 Covered California, [Covered California Rates and Plans for 2026: Consumer Affordability on the Line with Uncertainty Surrounding Federal Premium Tax Credit Extension](#), August 14, 2025.

55 CalHHS, [President Trump’s “Big Beautiful Bill: Millions of Californians to Lose Access to Health Care and Food](#), July 19, 2025.

56 DHCS, [Medi-Cal Adult Full Scope Expansion Programs, Full Scope Medi-Cal for All Children Enrollment, Medi-Cal Certified Eligibles Data by Month with Demographics](#), February 2025. CHCF, [Medi-Cal Enrollment Tracking Tool](#). Estimate of undocumented based on 4 expansion groups (children, young adults, adults, older adults).

57 AP News, [California Legislature OKs Proposal to Freeze Health Care Access for Some Immigrants](#), Jun 13, 2025.

58 HCAI, [Health Workforce Research Data Center Annual Report to the Legislature](#), April 2025.

59 CHCF, [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. CHCF, [The 2024 CHCF California Health Policy Survey](#), January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.

60 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025. DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Active primary care physicians (PCPs) include MDs and DOs in general practice, family medicine, geriatrics, internal medicine, and pediatrics with at least 20 hours of patient care per week. Recommended PCP supply benchmark from the Council on Graduate Medical Education (COGME).

61 California Department of Consumer Affairs, [DCA Active License Population by County: Interactive Maps](#), accessed May 2, 2025.

62 CHCF, [California Physicians Almanac](#), 2025.

63 California Healthline, [California’s Primary Care Shortage Persists Despite Ambitious Moves To Close Gap](#), May 1, 2025.

64 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025; DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Specialist supply per 100,000 population calculated by author. Active specialists are physicians (MDs and DOs) with non-primary care specialties that spend at least 20 hours a week in patient care. Recommended specialist supply benchmark from the Council on Graduate Medical Education (COGME).

65 Ibid.

66 Licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical social worker, and psychologist.

67 Associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, and registered psychological associate.

68 HCAI, [Health Workforce Research Data Center Annual Report to the Legislature](#), April 2025.

69 Governor Gavin Newsom, [Modernizing Conservatorship Law to Better Help & Protect Californians Most in Need of Care](#), October 2023.

70 HCAI, [Health Workforce Research Data Center Annual Report to the Legislature](#), April 2025.

71 UCSF Philip R. Lee Institute for Health Policy Studies, [California Board of Registered Nursing 2022 Survey of Registered Nurses](#), January 2024.

72 HCAI, [Health Workforce Research Data Center Annual Report to the Legislature](#), April 2025.

73 Ibid.

74 Ibid.

75 Ibid.

76 HCAI, [Race & Ethnicity of California’s Health Workforce](#), licensure data collected by the Department of Consumer Affairs; data represent a snapshot of the active licensee population on December 3, 2024.

77 CHSU College of Osteopathic Medicine, [Graduate Medical Education: GME residency positions available to students right here in the Central Valley](#), accessed October 2025. Healthforce Center at UCSF, [Annual Report: Update on California’s Physician Workforce](#), August 2023. CHCF, [Graduate Medical Education Expansion in California: A Progress Update: 2013-2023](#), October 2024.

78 Kaweah Health, [GME Residency Programs History](#), accessed September 2024. KVPR, [Saint Agnes To Become A Teaching Hospital](#), September 28, 2017. Dignity Health, Bakersfield Memorial Hospital, [Graduate Medical Education](#), accessed September 2024. United Health Centers, [UHC Graduate Medical Education](#), accessed September 2024.

79 Healthforce Center at UCSF, [From the Valley, for the Valley: Insights on Health Care Workforce Development in the San Joaquin Valley](#), August 2025.

- 80 HCAI, Hospital Annual Financial Data, 2023 Pivot Table – Hospital Annual Selected File (April 21, 2025 extract). Adventist Selma is not included in the data set because it was consolidated under Hanford’s license. Since it is a separate campus, it was manually added to the total count of hospitals in the region, in Fresno County and to the count of rural and non-profit hospitals. Madera Community Hospital is identified as a nonprofit in the dataset, but it has since reopened under investor ownership, so is classified as such in the report.
- 81 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 82 Adventist Health, [Locations](#), accessed September 2025.
- 83 HCAI, Hospital Annual Financial Data, 2023 Pivot Table – Hospital Annual Selected File (April 2025 Extract).
- 84 Ibid.
- 85 California Healthline, [Modesto Company Poised for Madera Hospital Takeover After Uphill Battle](#), April 11, 2024.
- 86 American Advanced Management, Inc., [About Us](#), accessed September 2025.
- 87 Good Samaritan Hospital, [About Us](#), accessed September 2025.
- 88 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract). DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Analysis is limited to general acute care hospitals and excludes hospitals whose primary care delivery is rehabilitation, long-term care, or psychiatric care.
- 89 KFF, [Total Hospital Beds](#), 2023, based on American Hospital Association data.
- 90 Trilliant Health, [Whether a Market Has an Oversupply or Undersupply of Hospital Beds is Defined by Market – Level Demographic and Demand Characteristics](#), September 14, 2024.
- 91 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 92 Ibid.
- 93 HCAI, [2023 Calendar Year Hospital Utilization Pivot Table](#). DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025.
- 94 HCAI, [2023 Hospital Emergency Department - Characteristics by Facility \(Pivot Profile\)](#). DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025.
- 95 HCAI, [2023 Hospital Emergency Department - Characteristics by Facility \(Pivot Profile\)](#).
- 96 Ibid.
- 97 HCAI, [2023 Pivot Profile \(As Submitted\) - Long-Term Care Annual Financial Data](#) (September 2024 extract). DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025.
- 98 KFF, [Number of Medicare Skilled Nursing Facilities](#), 2021, accessed October 2025.
- 99 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 100 HCAI, [Hospital Inpatient Characteristics - Disposition by Patient County of Residence](#), 2023.
- 101 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 102 Ibid.
- 103 RAND, [Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California - 2021](#), January 18, 2022.
- 104 HCAI, Hospital Annual Financial Data, 2023 (October 7, 2024 extract). DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. Psychiatric beds from general acute care hospitals and psychiatric health facilities were included in the analysis.
- 105 RAND, [Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California - 2021](#), January 18, 2022.
- 106 Ibid.
- 107 HCAI, [Hospital Annual Financial Data](#), Pivot Table – Hospital Annual Selected File, 2023 (April 21, 2025 extract).
- 108 HCAI, [Hospital Annual Financial Data](#), Pivot Table – Hospital Annual Selected File, 2018 – 2023.
- 109 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 110 HCAI, [Hospital Annual Financial Data](#), Pivot Table – Hospital Annual Selected File, 2023 (April 21, 2025 extract), 2022, 2021.
- 111 KFF, [Key Facts About Hospitals](#), February 19, 2025.
- 112 HCAI, [Hospital Annual Financial Data](#), 2023 (October 7, 2024 extract).
- 113 Ibid.

- 114 Office of Health Care Affordability (OHCA), [Hospital Sector Spending Target Values](#), accessed September 2025.
- 115 CHCF, [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. CHCF, [The 2024 CHCF California Health Policy Survey](#), January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.
- 116 KFF, [Key Facts About Hospitals](#), February 19, 2025.
- 117 UNC The Cecil G Sheps Center for Health Services Research, [Rural Hospital Closures: 195 Rural Hospital Closures and Conversions since January 2005](#), accessed September 2025.
- 118 The Sentinel, [Adventist Nears Deal with Corcoran Hospital](#), September 9, 2023.
- 119 USC Center for Health Journalism, [What Hospital Closures Mean for Rural California](#), September 5, 2016.
- 120 Ibid.
- 121 Becker's Hospital Review, [759 hospitals at risk of closure, state by state](#), June 30, 2025.
- 122 USC Center for Health Journalism, [What Hospital Closures Mean for Rural California](#), September 5, 2016.
- 123 Los Angeles Times, [This rural California county lost its only hospital, leaving residents with dire healthcare choices](#), June 3, 2023.
- 124 The City of Madera, [Madera Community Hospital reopens, restoring critical healthcare access](#), The City of Madera, March 18, 2025.
- 125 MISSING FROM ORIGINAL DOCUMENT
- 126 HCAI, [California Approves \\$57 Million Loan to Help Re-Open Madera Community Hospital](#), April 8, 2024.
- 127 California Budget & Policy Center, [How Federal Funding Cuts Threaten the Health of Californians](#), September 2025.
- 128 California Hospital Association, [One Big Beautiful Act: Summary and Impact Analysis](#), accessed October 2025.
- 129 HCAI, [Primary Care Clinics Utilization Pivot](#), 2023.
- 130 CHCF, [Convening: Understanding and Improving Health Care in the Central Valley](#), May 14, 2024.
- 131 CHIS, 2021-2023. Central Valley tabulations exclude Mariposa County.
- 132 CHCF, [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. CHCF, [The 2024 CHCF California Health Policy Survey](#), January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.
- 133 CHCF, [Physician Participation in Medi-Cal: Ready for the Enrollment Boom?](#), August 2014.
- 134 CHCF, [The 2024 CHCF Central Valley Health Policy Survey](#), April 2024. CHCF, [The 2024 CHCF California Health Policy Survey](#), January 2024. Central Valley includes: Fresno, Kings, Madera, Mariposa, and Tulare Counties.
- 135 HCAI, [Rates of Preventable Hospitalizations for Selected Medical Conditions by County](#), 2023.
- 136 HCAI, [Physician Supply and Preventable Hospitalizations by County](#), 2020.
- 137 DHCS, [ECM and Community Supports Quarterly Implementation Report](#), ECM Penetration Rates by County, percent of Medi-Cal managed care plan members enrolled in ECM in 12-month period (10/1/2023 – 9/30/2024).
- 138 HCAI, [2023 Primary Care Clinic Annual Utilization Data \(November 2024\)](#).
- 139 Federal Register, [Criteria for Determining Maternity Care Health Professional Target Areas](#), May 2022.
- 140 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025. DOF, [Population and Housing Estimates for Cities, Counties, and the State](#), May 2025. California Department of Consumer Affairs, [Active Licenses by County Interactive Map](#), accessed July 29, 2025. Provider supply per 1,500 women age 15-44 (2024 data) calculated by author based on active OB/GYNs (MDs and DOs) that spend at least 20 hours a week in patient care (2025 data) and NMs with an active California license and a California address of record (2023 data).
- 141 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025. DOF, [Total Estimated and Projected Population by 5-year Age Group and Sex for California Counties: July 1, 2020 to 2070](#), April 2025.
- 142 HCAI, [Physicians Actively Working by Specialty and Activity Hours](#), July 2025. Includes physicians with 20+ hours of patient care per week.
- 143 CalMatters, [As hospitals close labor wards, large stretches of California are without maternity care](#), November 15, 2023. CalMatters, [California's maternity care crisis is worsening as Newsom decides on bills to slow closures](#), September 16, 2024.



- 144 California Hospital Association, [Maternity Care in California: An Environmental Scan](#), 2025.
- 145 The Sentinel, [Selma Hospital obstetrics moves to Reedley](#), May 14, 2014.
- 146 California Hospital Association, [Maternity Care in California: An Environmental Scan](#), 2025.
- 147 Public Policy Institute of California, [Cuts to Hospital Maternity Care Raise Concerns about Access](#), February 12, 2025.
- 148 CalMatters, [After CalMatters Investigation, Newsom signs law to shed light on maternity ward closures](#), September 24, 2023.
- 149 CDPH, [Pregnancy-Related Mortality Dashboard, 2020-2022](#).
- 150 CDPH, [Infant Mortality Dashboard](#), 2022.
- 151 CDPH, [Prenatal Care Dashboard](#), 2023.
- 152 CDPH, Sexually Transmitted Disease Control Branch, [Sexually Transmitted Infection Data](#), 2023 STI Surveillance Report.
- 153 Central California Public Health Consortium, [Central California Regional Health Equity Analysis](#), 2025. Analysis of 2023 CDPH data. Central California includes counties of Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Benito, San Joaquin, Stanislaus, Tulare, and Tuolumne.
- 154 BLACK Wellness & Prosperity Center, [BLACK Doula Network](#), accessed September 2025.
- 155 KVPR, [Mariposa County is a Maternity Care Desert. Doulas are Bridging the Gap](#), June 27, 2025.
- 156 Association of American Medical Colleges (AAMC), [Physician Retention in State of Residency Training, by State, Residents Who Completed Training, 2008-17](#), accessed September 2025.
- 157 CHCF, [The Role of State and Federal Funding for Graduate Medical Education](#), October 2024.
- 158 U.S. Congress (2025-2026), H.R.3890 – [Resident Physician Shortage Reduction Act of 2025](#).
- 159 Healthforce Center at UCSF, [Annual Report: Update on California's Physician Workforce](#), August 2023.
- 160 California Hospital Association, [Maternity Care in California: An Environmental Scan](#), 2025.
- 161 California Budget & Policy Center, [How Federal Funding Cuts Threaten the Health of Californians](#), September 2025.



CENTRAL  
VALLEY  
COMMUNITY  
FOUNDATION

1260 Fulton Street, Suite 200 • Fresno, CA 93721 • [CENTRALVALLEYCF.ORG](http://CENTRALVALLEYCF.ORG)

   @centralvalleycf