



ADVENTIST HEALTH
SONORA

COMMUNITY HEALTH
NEEDS ASSESSMENT

2022

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public service to help improve their community members' lives. One area of public service where these entities share responsibility is ensuring all community members have the opportunity to live a healthy life.

The Community Health Needs Assessment (CHNA) is one way public service agencies support the health of their communities. These assessments are required of non-profit hospitals and public health departments every three and five years, respectively, to understand the health needs of the communities they serve. The purpose of this assessment is to engage the communities in identifying community health needs, and to align resources across the community benefit functions of a non-profit hospital, strategies of public health, and services of community-based organizations to drive towards improved health for all.

For 2022, Adventist Health Sonora took this requirement one step further with the vision of designing a story-centric and people-centric CHNA. We envisioned a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. This process involved input from key informant interviews representing the broad interests of the community served by hospitals and collaborative organizations. In addition, input was gathered from local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community.

To conduct this assessment, we used secondary and primary data from key informant interviews conducted between October 2021 – January 2022. A local Steering Committee (see Section I.E) reviewed data and prioritized community health needs over the course of three meetings (data collection planning, data review and needs prioritization) taking place between October 2021 – March 2022. This group determined the following final community health priority areas:

Financial Stability

Housing

Mental Health

In this report, you will first find a Community Summary that introduces the community served by our hospital and lists the prioritized community health needs. The Community Summary is a brief overview of the main points from the CHNA followed by an in-depth and detailed report including:

Our Partners: CHNA Steering Committee (see Section I.E)

Description of Hospital and Community Served (see Section II)

Significant Identified Health Needs and Priority Areas Selected (see Section III)

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. The entire report is published online and available in print form by contacting community.benefit@ah.org.

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What if ...

Families and individuals had jobs and the financial resources they needed to live a safe and healthy life?

Housing was available to the unhoused, providing security and the opportunity for new beginnings?

Everyone had someone to talk to about their mental well-being?



Community Vision Summary

Taking a step toward a healthier, better life

This is the vision of the future as seen through the Community Health Needs Assessment, or CHNA. The goal of the CHNA is to leverage community stakeholders and data to identify and maximize resources and to focus on meeting the most significant health needs of our community over the next three years.

Members of the CHNA Steering Committee – comprised of healthcare, civic, public, and business leaders – led this process of identifying and addressing health needs for a healthier community. These members took a deep look at where people live, learn, work and play to discover areas of opportunity that, through collaboration, could be strengthened and lead to a healthier you, stronger families and safer communities.

This CHNA involved interviews with civic leadership, community-based organizations, education, faith-based, healthcare, Health & Human Services, Public Health, public safety and senior-based organizations. We also conducted a community survey and gathered public data. Through this process, we learned about our community members' current state of health and listened to their greatest concerns for their friends and family.

There were nine significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, covid, education, food security, health conditions, health risk behaviors–illicit drugs, and housing–cost.

The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period, which were: financial stability, housing and mental health.

The following pages share opportunities where you, your family and your community can drive change for improved well-being.

Join us to activate our diverse community, improve lives, and make a “what if” dream into a powerful “what is” reality.

What if . . .

Families and individuals had jobs and the financial resources they needed to live safe and healthy lives, with access to organizations that can help when needed to ensure **Financial Stability**

Housing was available to the unhoused, providing security and the opportunity for new beginnings through **Housing security**

Everyone had someone to talk to about their mental well-being, with accessible programs addressing **Mental Health**

Getting to know our CHNA Sonora service area*

Located in the heart of California's gold country, Tuolumne County is nestled in the Sierra Nevada Foothills and is the gateway to the world-famous Yosemite National Park. Founded during the California Gold Rush, Sonora, has a rich heritage, small town feel, and historic charm. These are all communities represented in the Sonora CHNA service area where the largest age group is over age 55 (45.13%). The community is vibrant and cultured with art, galleries, festivals, events and small businesses. Of the population, 12.57% are Hispanic and 74.74% own their home.

The median household income is \$58,959 of which 58.6% is spent on housing and transportation. Among this population, 15.2% of

children live in poverty and 5.45% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

Let's begin with an overview of the last three years including a closer look at community member comments, priorities, and numbers that guided the decision-making process towards a path to better health, wholeness and hope.

**This service area represents Adventist Health Sonora's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Sonora CHNA service area.*



What if our community worked together and made life all-around better?
What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

CHNA 2019 successes and lessons learned



Before we look ahead, let's look back at a few highlights from our 2019 CHNA prioritized health needs to see what we've accomplished and learned since then. Over the last three years, we've focused on financial stability, housing security—unhoused and mental health.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for Sonora residents. In partnership with Project

HOPE, we were able to increase access to medical and social services, administer over 9,700 COVID-19 vaccinations, and provide community members with financial assistance. Through the implementation of our Adverse Childhood Experiences (ACEs) pilot program, we were able to screen more than 250 children. In addition to these initiatives, we were able to sponsor the Resiliency Village, which included closing escrow on a permanent house for unhoused

individuals seeking a path to better health, wholeness and hope.

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health Sonora, leading us to pivot our focus to helping patients and families stop the spread of the virus and provide access to free vaccines throughout the county.

Financial Stability

COMMUNITY VOICES

- Rental assistance, developed with landlords, is seen as an important way to help people out.
- The low median income is pointed to as an indicator of the financial struggles of many residents.
- The limited housing supply, and excessive costs, cause many to move from the region.
- Families are forced to live in areas that are not safe, an interviewee noted.
- Low wages are also seen as a driver to economic instability.



Financial stability in Sonora is a challenge. Concerns regarding health, income and labor force participation impact whether a community will thrive or struggle. Sonora is not unusual, still there are areas of concern that the community is working to address for families of today and tomorrow.

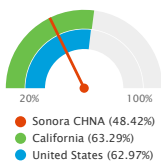
A community survey provided important yet concerning information, including families sharing that they are forced to

live in unsafe areas. Residents have been forced to move due to limited housing supply and excessive costs. The low median income is an additional indicator of financial struggles.

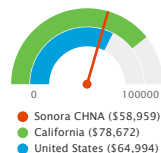
The labor force participation rate in Sonora is 48.4%, which is much lower than that of California (63.3%) and the United States (63%). The unemployment rate is 6.54%, which is higher than the United States

SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



Median Household Income



Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Sonora CHNA	6.86%	0.00%	7.79%	11.03%	0.97%	7.18%
Alpine County, CA	8.65%	100.00%	14.43%	No data	0.00%	1.82%
Calaveras County, CA	5.21%	47.95%	0.00%	1.77%	0.00%	7.20%
Mariposa County, CA	7.07%	85.34%	5.35%	3.03%	1.12%	13.05%
Stanislaus County, CA	6.82%	8.63%	8.18%	7.82%	10.39%	12.84%
Tuolumne County, CA	7.30%	0.00%	10.83%	15.65%	1.04%	3.87%
California	5.36%	10.08%	9.25%	4.65%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.43%	7.76%

Community Health Needs Survey:

Central Valley* 76% of those surveyed selected Financial Stability as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Financial Stability resources in your community to live better, longer.

Amador Tuolumne Community Action Agency

209-533-1397 ext.290, atcaa.org/smart-money

Tuolumne County Department of Social Services

209-533-5711, tuolumnecounty.ca.gov/277/Social-Services

Blue Zones Project - Tuolumne County: Improve your health, live longer, and learn about Blue Zones Project, tuo.bluezonesproject.com/home

Tuolumne Community Resources Guide

tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite

as a whole (5.4%). Participants in this survey reported that 76% of respondents selected financial stability as a significant need due to low wages.

While the data may be daunting, residents know what their families need to thrive. Collaboration is the key today to a brighter tomorrow.

Cost Burdened Households by Tenure, Percent

Report Area	Rental Households	Percentage of Rental Households that are Cost Burdened	Owner Occupied Households (With Mortgage)	Percentage of Owner Occupied Households w/ Mortgages that are Cost Burdened	Owner Occupied Households (No Mortgage)	Percentage of Owner Occupied Households w/o Mortgages that are Cost Burdened
Sonora CHNA	9,446	52.66%	16,318	40.98%	11,493	19.62%
Alpine County, CA	76	9.21%	170	32.35%	151	7.95%
Calaveras County, CA	3,466	55.02%	8,137	47.97%	5,355	20.35%
Mariposa County, CA	2,326	53.70%	2,755	42.29%	2,765	13.35%
Stanislaus County, CA	72,151	48.68%	69,085	35.59%	33,590	15.45%
Tuolumne County, CA	6,051	50.90%	10,179	41.84%	6,707	21.41%
California	5,861,796	51.51%	5,035,650	37.85%	2,205,668	15.01%
United States	43,552,843	45.66%	48,974,364	27.25%	29,827,012	13.07%

Housing

COMMUNITY VOICES

- There may be some resistance in the community to increasing shelter beds in new locations.
- Mistrust in the population needing help was identified as a barrier to addressing this issue.
- Homeless shelters have restriction on who can be in the shelter, limiting access for some in need.
- It takes years off your life. Poverty charges interest, one interviewee stated.



Sonora is a charming community featuring local restaurants, galleries, events and festivals. Beyond the downtown area are parks, trails and beautiful mountains, yet the community faces very real challenges.

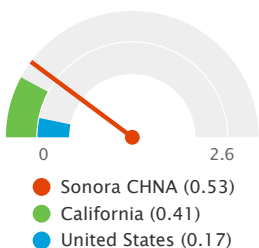
Securing stable housing and facing the increased risk of homelessness are realities for many Sonora residents. Housing is limited, so available homes come with high home and rental costs.

The rate of homelessness is 0.53 per 100 people, which is higher than that of California (0.41) and the U.S. (0.17). Homelessness among public school students is 5.5%, compared to California at 4.3% and 2.8%.

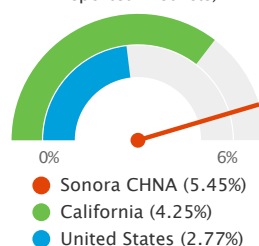
The percentage of income spent on housing and transportation in Sonora is higher (58.6%) than in California (50%).

SECONDARY DATA INFOGRAPHIC STATS:

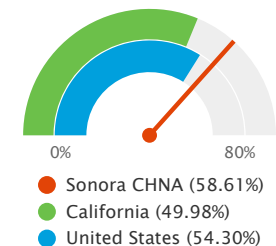
Homeless Rate per 100 Pop.
2020



Rate of Homelessness Among
Public School Students (in
Reported Districts)



Percentage of Income Spent on
Housing and Transportation



Community Health Needs Survey:

Central Valley* 55% of those surveyed selected Housing as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Residents share their concerns, including growth in unhoused populations and shelter restrictions that limit access. Poverty “takes years off your life,” one resident noted, and another reflected on the need for programs designed to help people who have been released from jail

The range of concerns is daunting. But there is hope and help available for those in need, leading to revived, restored lives.

Find Housing resources in your community to live better, longer.

Tuolumne County Department of Social Services

209-533-5711, tuolumnecounty.ca.gov/277/Social-Services

Resiliency Village

209-396-5554, resiliencyvillage.org/contact

Blue Zones Project – Tuolumne County: Improve your health, live longer, and learn about Blue Zones Project, tuo.bluezonesproject.com/home

Tuolumne Community Resources Guide

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Substandard Housing: Households Lacking Complete Plumbing Facilities

Report Area	Occupied Housing Units	Housing Units Lacking Complete Plumbing Facilities	Housing Units Lacking Complete Plumbing Facilities, Percent
Sonora CHNA	34,496	244	0.71%
Alpine County, CA	397	0	0.00%
Calaveras County, CA	16,958	65	0.38%
Mariposa County, CA	7,846	83	1.06%
Stanislaus County, CA	174,826	569	0.33%
Tuolumne County, CA	22,937	143	0.62%
California	13,103,114	54,342	0.41%
United States	122,354,219	460,275	0.38%

Mental Health

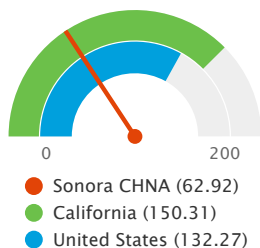
COMMUNITY VOICES

- People noted a disconnect between available services and the kids who need them, but no clear explanation why access has been difficult.
- Resources within rural and small communities are limited.
- Mental health professionals are struggling with the demand on services.
- Some are not seen until there is a full-blown mental health crisis due to a lack of lower-level care.

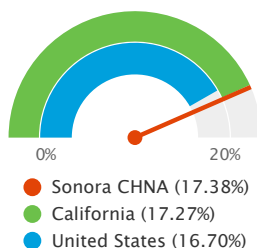


SECONDARY DATA INFOGRAPHIC STATS:

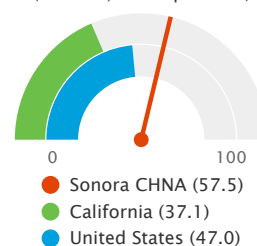
Mental Health Care Providers,
Rate per 100,000 Population



Percentage of Adults Binge
Drinking in the Past 30 Days



Deaths of Despair,
Age-Adjusted Death Rate
(Per 100,000 Population)



Community Health Needs Survey:

Central Valley* 49% of those surveyed selected Mental Health as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Mental Health resources in your community to live better, longer.

Mother Lode Wellness Program

209-396-6953, mymotherlode.com/news/health/health-wellness

Tuolumne County Behavioral Health Department

209-533-5246, tuolumnecounty.ca.gov/220/Behavioral-Health

Blue Zones Project – Tuolumne County: Improve your health, live longer, and learn about Blue Zones Project, tuo.bluezonesproject.com/home

Tuolumne Community Resources Guide

tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite

An in-depth review of community data provides important information on how to help and understand the impacts of mental health issues.

In Sonora, there are 62.9 mental health care providers per 100,000 people, compared to 150.31 in California and 132.27 in the United States. The lack of providers is a problem due to the

reality of how mental health issues can impact home, work and community life.

Publicly available data shows that 13.9% of the adult population in Sonora reports having poor mental health, compared to 12.5% in California and 13.6% in the United States. Instability in the home life can create mental health and substance abuse

concerns, some interviewees noted.

According to surveys, 49% of respondents selected mental health as a significant need, but the community's commitment is real and focused on making change.

Unemployment by Race, Total

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Sonora CHNA	6.86%	0.00%	7.79%	11.03%	0.97%	7.18%
Alpine County, CA	8.65%	100.00%	14.43%	No data	0.00%	1.82%
Calaveras County, CA	5.21%	47.95%	0.00%	1.77%	0.00%	7.20%
Mariposa County, CA	7.07%	85.34%	5.35%	3.03%	1.12%	13.05%
Stanislaus County, CA	6.82%	8.63%	8.18%	7.82%	10.39%	12.84%
Tuolumne County, CA	7.30%	0.00%	10.83%	15.65%	1.04%	3.87%
California	5.36%	10.08%	9.25%	4.65%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.43%	7.76%

What if ...

It's not a prescription that changes your health?
Instead, it's a collaboration between you and
your care providers?

And it's community-based organizations
working together to support you?

Many of us have given away the condition of our health to doctors, hospitals and health programs. But in reality, it's not any one plan or pill that will change your well-being. It's you. It's us, together with our community, working to create equitable opportunities so we can all actively move more, eat well, and be connected to community life, friends and family.

It took many committed community members to help create the 2022 CHNA. Steering Committee members shared their ideas and concerns and worked – and continue to work – to create a new vision.

Proudly, we share that this CHNA is part of a county-wide collaboration—but these community organizations can't do it alone. It takes collaboration, partnership, consistency and teamwork.

People of all walks of life offered ideas for the 2022 CHNA, helping to lead the way by focusing on needs otherwise too often overlooked. The final efforts are proving to be useful and enlightening – potentially leading to new directions and new opportunities.



To all who helped, we say **THANK YOU**. To those who now see the needs and opportunities, we welcome you. Change changes. Let's work together to inspire health, wholeness and hope in our community.

We thank the Adventist Health Sonora CHNA Steering Committee, which collaborated and partnered to create the 2022 CHNA. Through a series of three collaborative meetings, engagement of community members, and reviewing data, each committee member brought their unique perspective and view as seen through their job and the work they performed during the development of the CHNA.

Joe Bors

Executive Director, ATCAA

Frank Canizales

MiWUK Tribe of Social Services

Heather Carter

Co-Director, Center for Non-Violent Community

Mario DeLise

Adventist Health Sonora

Mark Dyken

Executive Director, Resiliency Village

Dr. Kimberly Freeman

Tuolumne County Health Officer

Annie Hockett

Manager, Tuolumne County Probation

Michelle Jachetta

Director of Public Health

Nathan Levering

Sierra Bible Church

Dr. Fred Mathews

Lloyd Mathiesen

Tribal Chairman, Chicken Ranch

Tyler Newton

Adventist Health Sonora

Cathy Parker

Superintendent of Schools, Tuolumne County Office of Education

Cathie Peacock

Director, Interfaith

Bill Pooley

Sheriff

Cole Przybyla

Andrea Reich

Tribal Chair, Tuolumne Band of Me Wuk

Tracie Riggs

County Administrator

Mary Rose Rutikanga

Sonora City Administrator

Darrell Slocum

Executive Director, Sonora Area Foundation

Tyler Summerset

Executive Director, Blue Zones Project Tuolumne County

Laura Sunday

Co-Director, Center for A Non-Violent Community

Dave Thoeny

Executive Director, Mother Lode Job Training

Robert White

Executive Director, Yes Partnership

II. About Us

A. Adventist Health Sonora

Adventist Health Sonora (AHSR) is located in the city of Sonora in Tuolumne County. Tuolumne County is in the beautiful Sierra Nevada foothills and is at the gateway to Gold Country. A 152-bed medical center in Sonora, California, serving the residents of Calaveras and Tuolumne counties with key health care services and a large network of primary care, rapid care and specialty medical offices.



B. Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

C. Adventist Health Community Benefit & Well-Being Approach to CHNA

Adventist Health is committed to health, wholeness and hope in the communities across our system, which includes improving well-being. Diseases of despair including mental health, substance abuse, suicide and chronic illness continue to escalate.

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet some of the most important indicators, like how long we live, are areas where we don't make the top 25. It's time we stop thinking of health as something we get at the doctor's office and rather as something that

starts within our families, schools, places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it.

The conditions in which we live, work and play have an enormous impact on our health long before we ever see a doctor—these are the principles of well-being. A key aspect of our strategy to support individual, organizational and community well-being is our relationship with Blue Zones®, a pioneer in taking a systemic and environmental approach to improving the well-being of entire cities and communities. Together, we have built the Well-Being Division, an entity within our organization that exists to empower everyone, everywhere to live longer, better lives.

D. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Sonora's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health Sonora CHNA market has a total population of 84,499 (based on the 2020 Decennial Census). The largest city in the service area is Sonora, with a population of 4,904. The service area is comprised of the following zip codes: 95311, 95310, 95248, 95251, 95224, 95318, 95223, 95370, 95383, 95321, 95364, 95247, 95329, 95222, 95372, 95305, 95346, 95379, 95375, 95233, 95327, 95335, 95228, 95249, 95246.



Total Population

84,499

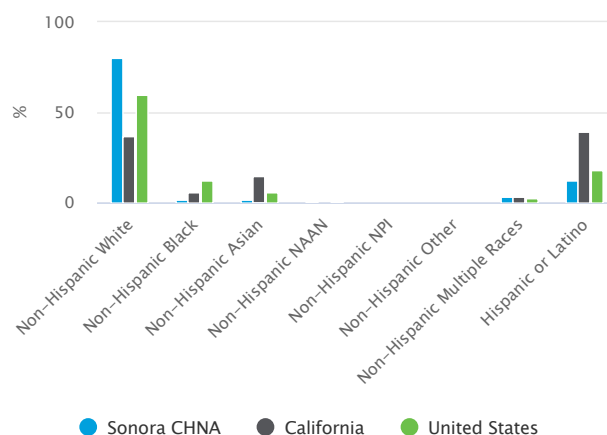
74.74%

of the population owns their home

25.26%

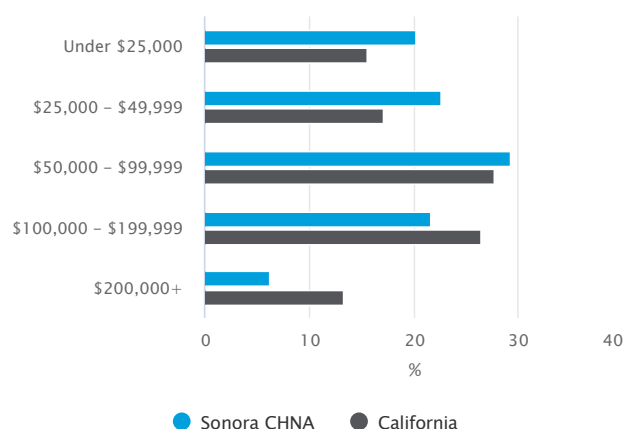
of the population rents their home

Population by Combined Race and Ethnicity



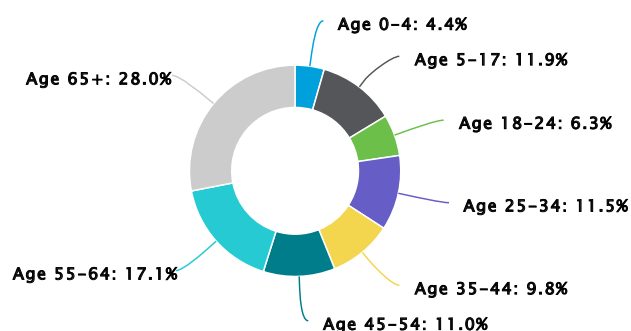
Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

Household Income Levels



Total Population by Age Groups, Total

Sonora CHNA



III. Significant Identified Health Needs, Primary, Secondary Data & Written Comments

A. Significant Identified Health Needs

Steering Committee members, alongside their staff, boards and constituencies reviewed and discussed a presentation of significant identified health needs, which was a list of the top five needs across each data source (see section V for methodology). They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. From the list of significant identified health needs in the table, the following three health needs were prioritized as a high priority need, based on the criteria considered (see Section IV. A. for full prioritization methodology): Access to Care, Health Risk Behaviors and Mental Health.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Mental Health	See Sections III.C - E
Financial Stability	See Sections III.C - E
Housing	See Sections III.C - E
Lower Priority Needs	
Access to Care tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	There is a limited number of primary care doctors in the community, and even fewer specialists. This requires people to travel long distances to get services.
Health Risk Behaviors tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	Only 30% of residents 65 years or older are up-to-date on core preventative services, and the average spending on fruits and vegetables is below state averages. There is a belief among interviewees that illicit drug use is a pervasive community problem.
Health Conditions tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	Obesity, heart disease, cancer, and diabetes rates are higher than state averages, as are rates of liver and lung disease mortality.
Education tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	More than half of 4 th graders tested below the proficiency level, and one-third of the population has some kind of college degree.
COVID tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	46% of surveyed residents identified COVID as a community health need.
Food Security tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	The high cost of living and low wages makes food security a challenge for many. Only 78% of the population has adequate food access.

B. Primary, Secondary, and Survey Data Overview

This Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and utilized here.

Qualitative primary data collection involved individual key informant interviews with local leaders. These were conducted in person and virtually. This information was collected by the Adventist Health Community Well-Being team and evaluation consultants from the Center for

Behavioral Health Integration. Secondary data was amassed and analyzed across 45 different data sets by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). Finally, survey data sets of registered voters in the community were collected and analyzed by UC Berkeley Institute of Governmental Studies (IGS). A detailed explanation of data collection methodology can be found in Sections IV and V.

In total, 14 key informant interviews were held. Survey data was gathered from the Central Valley region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

The CHNA Steering Committee (membership found in Section I. E) identified vulnerable populations and worked with local organizations to coordinate key informant interviews to ensure that minority populations – the voices of those with chronic disease, low incomes and the underserved – were heard. Analytical methods for focus groups and key informant interviews found in Section IV. B.

KEY INFORMANTS

► Fourteen (14) individual interviews

PARTICIPATING ORGANIZATIONS

Adventist Health Sonora, Amador Tuolumne Community Action Agency, Area 12 Agency on Aging, Center for Non-Violent Community, Groveland Trial Heads, Interfaith, Mathiesen Memorial Health Clinic, Mother Lode Workforce, Resiliency Village, Sierra Bible Church Tuolumne County, Tuolumne County Department of Public Health, Tuolumne County Office of Education and Tuolumne County Sheriff's Department

REPRESENTED RACE/ETHNICITIES

Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Civic government, community-based healthcare workers focusing on behavioral health, faith, law enforcement, low-income, medically underserved, minority populations, older adults, providers and unhoused populations.

The three high-priority health needs are described in further detail on the following pages.

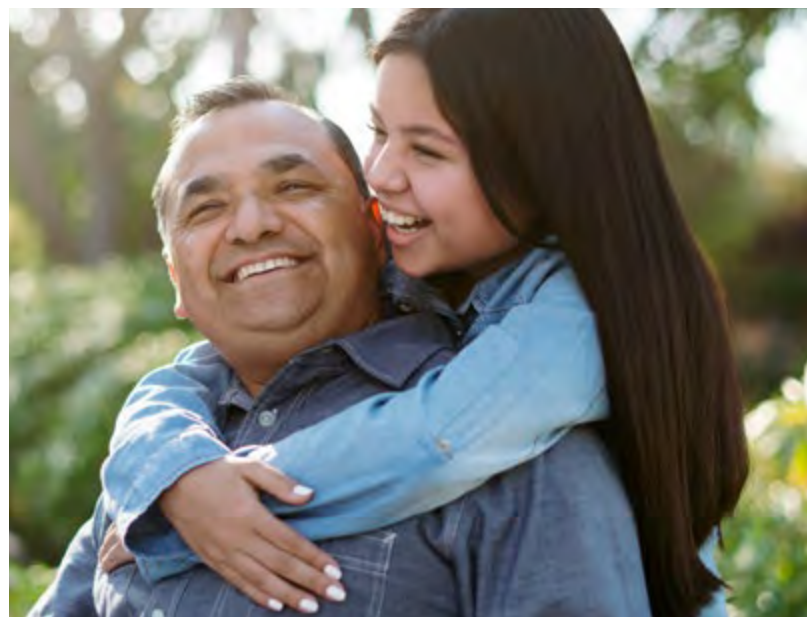
SURVEY RESULTS

REGION & STATEWIDE SUMMARY

Central Valley: Survey Results of Top Needs

See Section V. B. for more information.

Needs	Sonora	Statewide
Financial Stability- Cost of Living	76%	83%
Housing- Cost	55%	63%
Housing-Unhoused	54%	55%
Mental Health	49%	48%
COVID	46%	47%
Food Security	34%	31%
Education	27%	24%
Employment	25%	22%
Access to Care-Primary	13%	23%
Access to Care-Senior	16%	15%
Environment & Infrastructure	15%	15%





C. Financial Stability

Many of the health needs in Sonora are directly or indirectly related to financial stability. When an individual or family is struggling financially, it greatly affects their ability to maintain adequate physical and mental health. There are many challenges to financial stability for community members, and progress in any given community need should be measured with that in mind.

The labor force participation rate in Sonora is 48.4% and is much lower than that of California (63.3%) and the United States (63%). The unemployment rate is 6.54% and is higher than the United States as a whole (5.4%). The Asian

population is experiencing an 11% unemployment rate in Sonora. 31% of Hispanic or Latino children aged 0 to 17 live in households with income below the federal poverty level. 42.7% of Native American or Alaska Native and 26.4% of Multiple race children live in poverty.

The median income per household is \$58,959 and is lower than that in California (\$78,672) and the US (\$64,994). 24.3% of people have a debt in collection. Added together, these factors represent major challenges for many residents.



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PRIMARY COMMENTS

KEY INFORMANT COMMENT

- Rental assistance, developed with landlords, is seen as an important way to help people out
- The low median income is pointed to as an indicator of the financial struggles of many residents.
- The limited housing supply, and excessive costs, cause many to move from the region.
- Families are forced to live in areas that are not safe, an interviewee noted.
- Low wages are also seen as a driver to economic instability
- The limited housing supply, and excessive costs, cause many to move from the region
- Interviewees reported that the area seems to have high populations with families with unstable living environments.
- Seniors are finding it especially hard to get into housing.
- Many don't have money for good food.
- Eating fresh salad and soup is prohibitively expensive for some
- There is believed to be not a lot of options for affordable housing for doctors, making recruiting difficult.
- The median house prices is \$350K, which is too much for many people, an interviewee noted
- People who have COVID often miss so much work that they lose their jobs
- There is a belief that the limited housing stock is being purchased by people from the Bay Area.

Secondary Data Summary

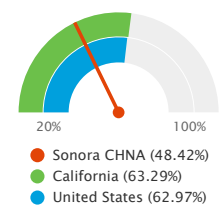
Financial Stability

Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2016 – 2020 American Community Survey, of the 75,803 working age population, 36,705 are included in the labor force. The labor force participation rate is 48.42%.

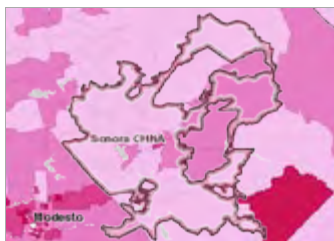
Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Sonora CHNA	75,803	36,705	48.42%
Alpine County, CA	925	451	48.76%
Calaveras County, CA	39,273	18,213	46.38%
Mariposa County, CA	14,749	7,575	51.36%
Stanislaus County, CA	414,340	253,400	61.16%
Tuolumne County, CA	46,155	22,555	48.87%
California	31,403,964	19,875,973	63.29%
United States	261,649,873	164,759,496	62.97%

Labor Force Participation Rate

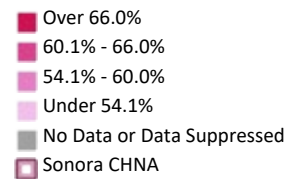


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#). 2016-20. Source geography: County



Labor Force, Participation Rate by Tract, ACS 2016-20



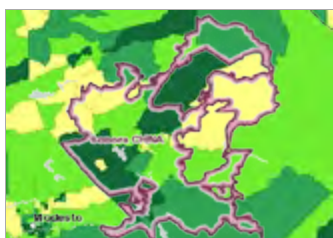
Employment - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 2,401, or 6.54% of the civilian non-institutionalized population age 16 and older. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

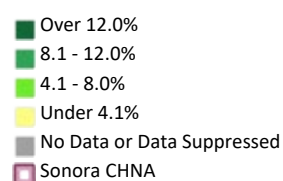
Report Area	Labor Force	Number Unemployed	Unemployment Rate
Sonora CHNA	36,705	2,401	6.54%
Alpine County, CA	451	45	9.98%
Calaveras County, CA	18,213	949	5.21%
Mariposa County, CA	7,575	661	8.73%
Stanislaus County, CA	253,400	22,357	8.82%
Tuolumne County, CA	22,555	1,646	7.30%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

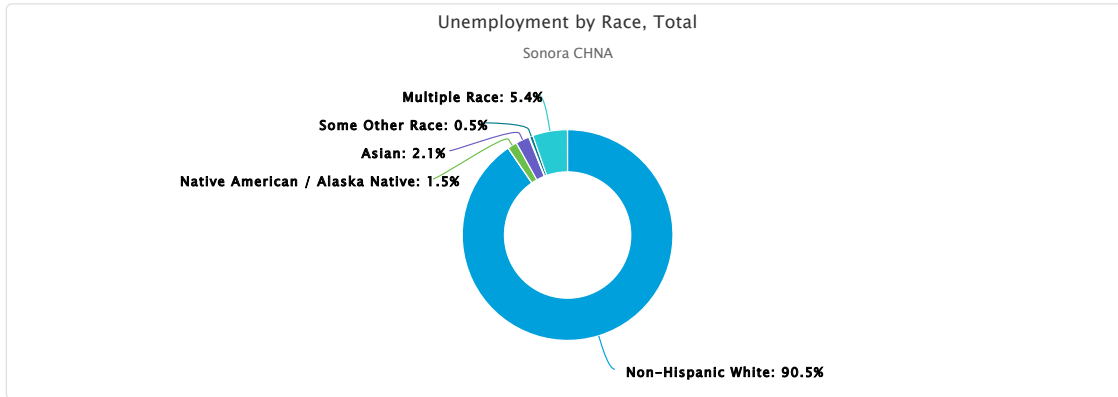
Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract



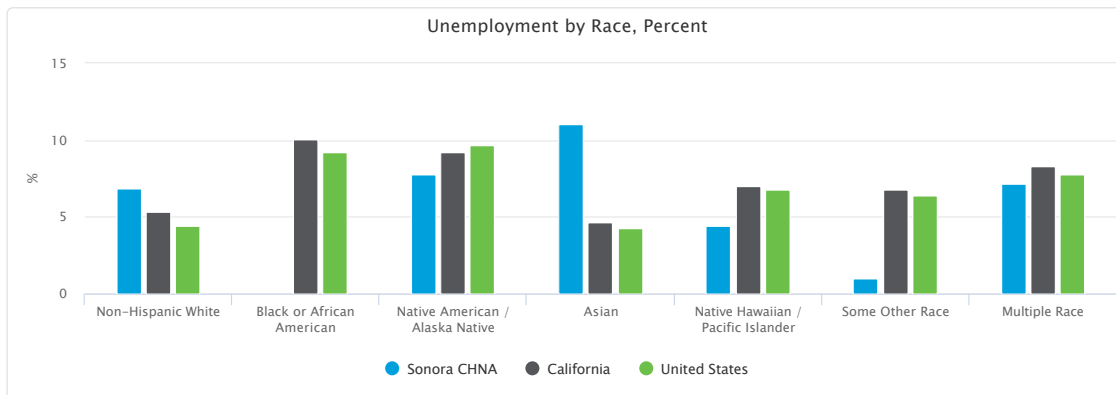
Unemployed Workers, Percent by Tract, ACS 2016-20





Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Sonora CHNA	6.86%	0.00%	7.79%	11.03%	4.44%	0.97%	7.18%
Alpine County, CA	8.65%	100.00%	14.43%	No data	0.00%	0.00%	1.82%
Calaveras County, CA	5.21%	47.95%	0.00%	1.77%	No data	0.00%	7.20%
Mariposa County, CA	7.07%	85.34%	5.35%	3.03%	No data	1.12%	13.05%
Stanislaus County, CA	6.82%	8.63%	8.18%	7.82%	4.52%	10.39%	12.84%
Tuolumne County, CA	7.30%	0.00%	10.83%	15.65%	4.44%	1.04%	3.87%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%

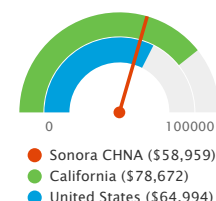


Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 34,496 households in the report area, with an average income of \$81,650 and median income of \$58,959.

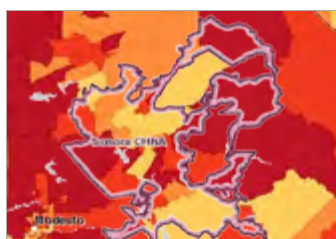
Report Area	Total Households	Average Household Income	Median Household Income
Sonora CHNA	34,496	\$81,650	\$58,959
Alpine County, CA	397	\$107,737	\$85,750
Calaveras County, CA	16,958	\$84,164	\$67,054
Mariposa County, CA	7,846	\$64,323	\$50,960
Stanislaus County, CA	174,826	\$82,369	\$62,873
Tuolumne County, CA	22,937	\$83,401	\$60,509
California	13,103,114	\$111,622	\$78,672
United States	122,354,219	\$91,547	\$64,994

Median Household Income

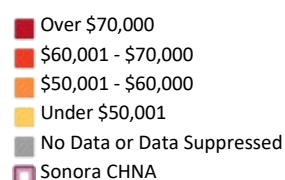


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract



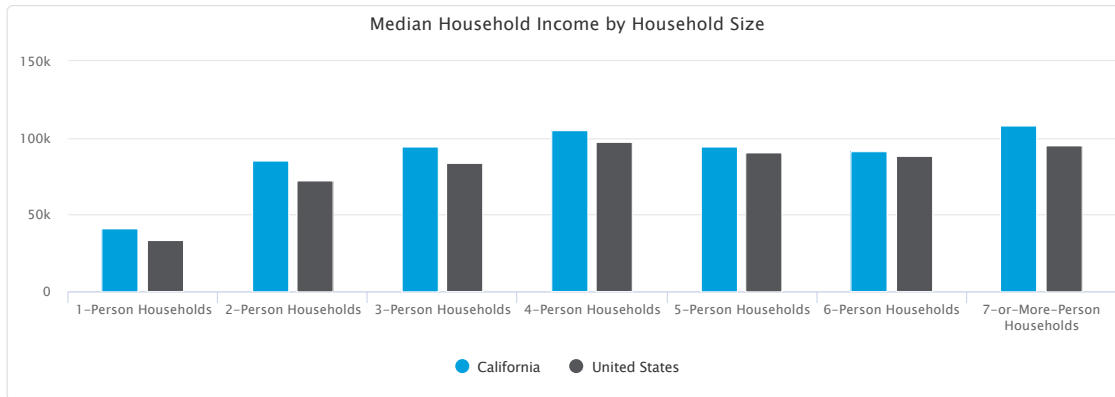
Median Household Income by Tract, ACS 2016-20



Median Household Income by Household Size

This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Alpine County, CA	\$45,875	\$92,500	No data	\$124,583	No data	\$56,250	No data
Calaveras County, CA	\$31,293	\$75,588	\$86,513	\$89,750	\$85,764	No data	No data
Mariposa County, CA	\$28,109	\$56,006	\$64,669	\$78,064	\$62,596	\$85,221	No data
Stanislaus County, CA	\$32,118	\$62,173	\$72,467	\$79,758	\$79,664	\$75,077	\$92,500
Tuolumne County, CA	\$29,101	\$73,756	\$79,028	\$104,957	\$117,407	\$98,724	\$149,063
California	\$40,788	\$85,056	\$94,221	\$104,973	\$94,232	\$91,578	\$107,797
United States	\$33,265	\$72,238	\$84,033	\$97,660	\$90,979	\$88,413	\$94,924



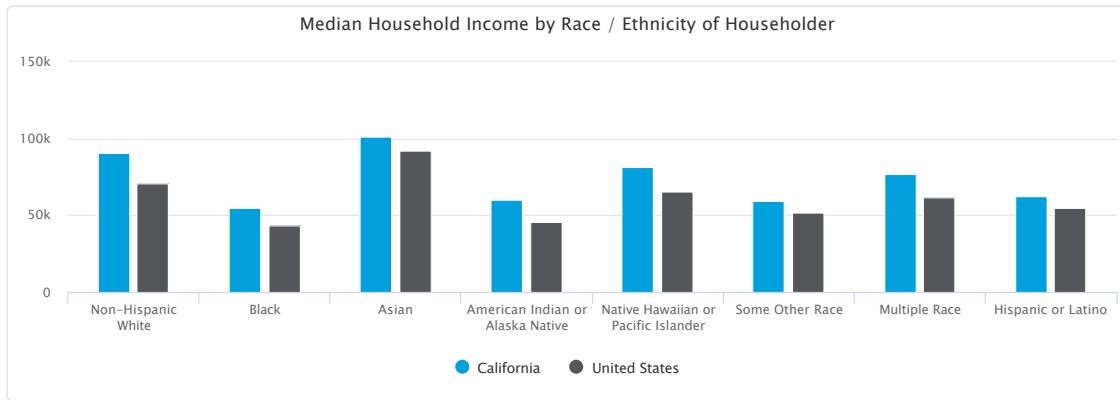
Household Income Levels

Report Area	Under \$25,000	\$25,000 - \$49,999	\$50,000 - \$99,999	\$100,000 - \$199,999	\$200,000+
Sonora CHNA	20.24%	22.62%	29.30%	21.62%	6.22%
Alpine County, CA	9.57%	18.64%	28.97%	35.52%	7.30%
Calaveras County, CA	15.97%	21.54%	32.79%	23.67%	6.03%
Mariposa County, CA	23.15%	25.50%	33.19%	15.28%	2.88%
Stanislaus County, CA	17.47%	22.24%	31.87%	22.58%	5.83%
Tuolumne County, CA	20.01%	21.25%	30.00%	22.61%	6.13%
California	15.51%	17.14%	27.66%	26.42%	13.27%
United States	18.41%	20.64%	29.95%	22.73%	8.26%

Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

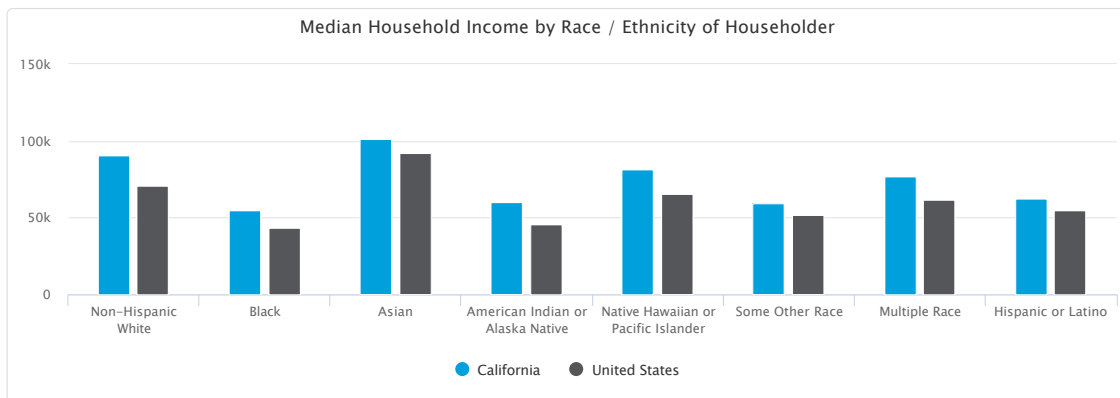
Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Sonora CHNA	No data	No data	No data	No data	No data	No data	No data	No data
Alpine County, CA	\$90,000	No data	No data	\$47,321	No data	No data	\$136,103	\$135,441
Calaveras County, CA	\$67,385	\$71,650	\$72,563	No data	No data	\$52,396	\$62,981	\$52,440
Mariposa County, CA	\$53,008	No data	No data	No data	No data	No data	\$54,107	\$38,549
Stanislaus County, CA	\$68,369	\$63,542	\$65,979	\$48,761	\$66,184	\$58,755	\$54,116	\$56,279
Tuolumne County, CA	\$60,978	No data	\$77,667	\$36,379	No data	\$93,750	\$61,120	\$56,595
California	\$90,496	\$54,976	\$101,380	\$60,182	\$81,682	\$59,287	\$76,733	\$62,330
United States	\$70,843	\$43,674	\$91,775	\$45,877	\$65,804	\$51,900	\$61,870	\$54,632



Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Alpine County, CA	\$90,000	No data	No data	\$47,321	No data	No data	\$136,103	\$135,441
Calaveras County, CA	\$67,385	\$71,650	\$72,563	No data	No data	\$52,396	\$62,981	\$52,440
Mariposa County, CA	\$53,008	No data	No data	No data	No data	No data	\$54,107	\$38,549
Stanislaus County, CA	\$68,369	\$63,542	\$65,979	\$48,761	\$66,184	\$58,755	\$54,116	\$56,279
Tuolumne County, CA	\$60,978	No data	\$77,667	\$36,379	No data	\$93,750	\$61,120	\$56,595
California	\$90,496	\$54,976	\$101,380	\$60,182	\$81,682	\$59,287	\$76,733	\$62,330
United States	\$70,843	\$43,674	\$91,775	\$45,877	\$65,804	\$51,900	\$61,870	\$54,632

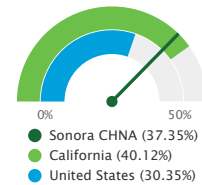


Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 37,257 total households in the report area, 13,916 or 37.35% of the population live in cost burdened households.

Report Area	Total Households	Cost Burdened Households (Housing Costs Exceed 30% of Income)	Cost Burdened Households, Percent
Sonora CHNA	37,257	13,916	37.35%
Alpine County, CA	397	74	18.64%
Calaveras County, CA	16,958	6,900	40.69%
Mariposa County, CA	7,846	2,783	35.47%
Stanislaus County, CA	174,826	64,902	37.12%
Tuolumne County, CA	22,937	8,775	38.26%
California	13,103,114	5,256,527	40.12%
United States	122,354,219	37,128,748	30.35%

Percentage of Households where Housing Costs Exceed 30% of Income

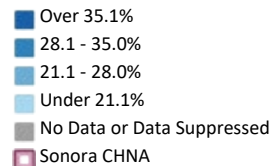


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract

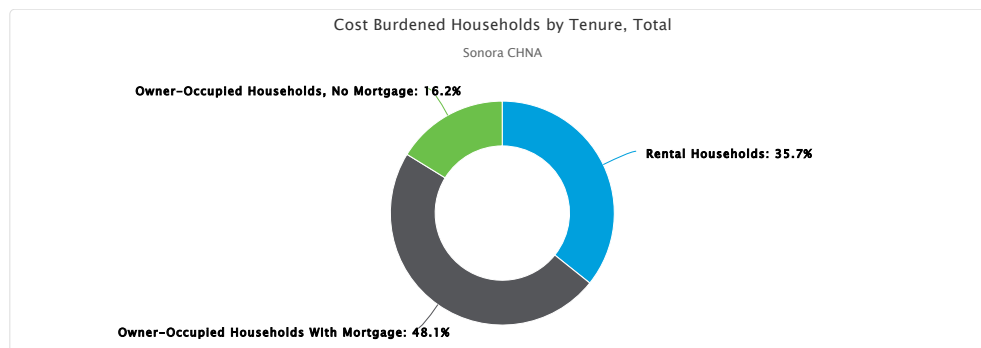


Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2016-20



Cost Burdened Households by Tenure, Total

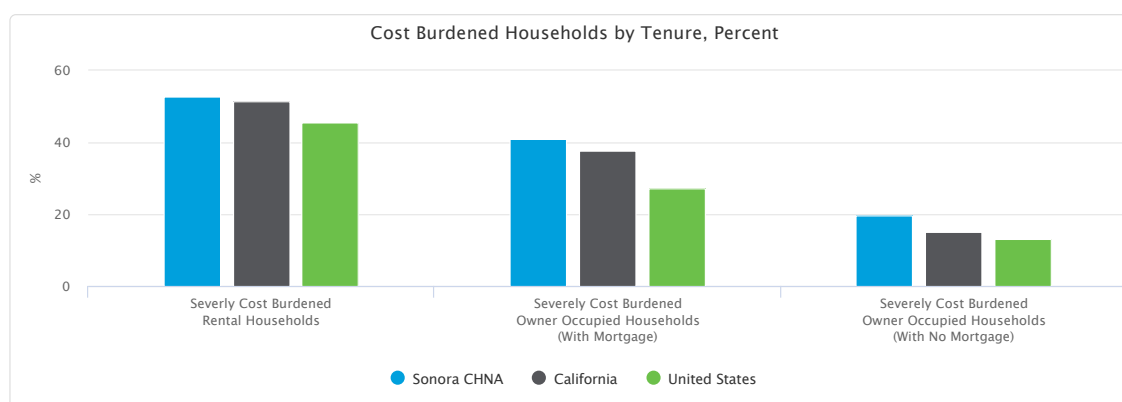
These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 13,916 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.



Cost Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 52.66% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2016-2020 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Percentage of Rental Households that are Cost Burdened	Owner Occupied Households (With Mortgage)	Percentage of Owner Occupied Households w/ Mortgages that are Cost Burdened	Owner Occupied Households (No Mortgage)	Percentage of Owner Occupied Households w/o Mortgages that are Cost Burdened
Sonora CHNA	9,446	52.66%	16,318	40.98%	11,493	19.62%
Alpine County, CA	76	9.21%	170	32.35%	151	7.95%
Calaveras County, CA	3,466	55.02%	8,137	47.97%	5,355	20.35%
Mariposa County, CA	2,326	53.70%	2,755	42.29%	2,765	13.35%
Stanislaus County, CA	72,151	48.68%	69,085	35.59%	33,590	15.45%
Tuolumne County, CA	6,051	50.90%	10,179	41.84%	6,707	21.41%
California	5,861,796	51.51%	5,035,650	37.85%	2,205,668	15.01%
United States	43,552,843	45.66%	48,974,364	27.25%	29,827,012	13.07%



D. Housing

Challenges with stable housing and increased risk of homelessness are a reality for many in the Sonora community. The limited housing stock coupled with exceedingly high home and rent costs are a major contributor to financial instability. When community members lose housing it also becomes much more difficult to regain it.

The rate of homelessness is 0.53 per 100 people and is higher than that of California (0.41) and the United States (0.17). The percent of renters living in substandard housing (more than one-third) is 6% higher than the rest of county. The rate of homelessness among public school students is 5.5%, compared to California at 4.3% and 2.8%.

The percentage of income spent on housing and transportation in Sonora is higher (58.6%) than in California (50%) and in the United States (54.3%). These factors contribute heavily to why residents become and stay unhoused in this community.



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PRIMARY COMMENTS

KEY INFORMANT COMMENTS

- There may be some resistance in the community to increasing shelter beds in new locations.
- Mistrust in the population needing help was identified as a barrier to addressing this issue.
- Homeless shelters have restriction on who can be in the shelter, limiting access for some in need.
- It takes years off your life. Poverty charges interest, one interviewee stated.
- Short-term housing is helpful, but still leaves unstably housed families with a crisis to contend with.
- It was pointed out that many who are unstably housed do not meet the stereotype of being a single, drug-addicted male.
- Homeless issues are growing, no programs after people are released from jail.
- Numerous people noted not knowing how to help decrease homelessness
- Short-term housing is helpful, but still leaves unstably housed families with a crisis to contend with.
- Job loss is seen as a major driver towards losing sustainable housing.



Secondary Data Summary

Housing

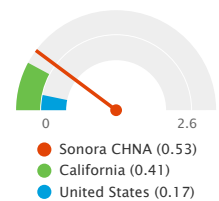
Homelessness - Homeless Population

This indicator reports the total homeless population as estimated from Point-in-Time (PIT) count in 2020. Data is obtained from HUD's Annual Homeless Assessment Report (AHAR).

As of year 2020, the homeless population is 445 in total or 0.53 per 100 total population within the report area. This rate is higher than the state's reported homeless rate of 0.41 per 100 population.

Report Area	CoC Name	Total Population 2020	Overall Homeless 2020	Homeless Rate per 100 Pop.
Sonora CHNA	No data	84,701	445	0.53
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	33,923	184	0.54
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	157,285	834	0.53
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	157,285	834	0.53
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	514,453	2,107	0.41
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	157,285	834	0.53
California	No data	39,538,223	161,548	0.41
United States	No data	334,735,155	578,165	0.17

Homeless Rate per 100 Pop. 2020



Note: This indicator is compared to the state average.

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR), 2020. Source geography: CoC

Population Change 2019-2020: Overall Chronically Homeless

Report Area	CoC Name	Overall Chronically Homeless 2019	Overall Chronically Homeless 2020	Difference	% Difference
Sonora CHNA	No data	141	134	-7	0.0%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	85	31	-54	-0.6%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	264	252	-12	0.0%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	264	252	-12	0.0%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	285	336	51	0.2%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	264	252	-12	0.0%
California	No data	41,557	51,785	10,228	0.2%
United States	No data	105,352	120,134	14,782	0.1%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Overall Homeless Individuals

Report Area	CoC Name	Overall Homeless Individuals 2019	Overall Homeless Individuals 2020	Difference	% Difference
Sonora CHNA	No data	354	365	12	0.0%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	198	155	-43	-0.2%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	663	685	22	0.0%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	663	685	22	0.0%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	1,514	1,742	228	0.2%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	663	685	22	0.0%
California	No data	128,777	135,771	6,994	0.1%
United States	No data	395,050	407,988	12,938	0.0%

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

Population Change 2019-2020: Overall Homeless People in Families

Report Area	CoC Name	Overall Homeless People in Families 2019	Overall Homeless People in Families 2020	Difference	% Difference
Sonora CHNA	No data	97	79	-17	-0.2%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	16	29	13	0.8%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	182	149	-33	-0.2%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	182	149	-33	-0.2%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	409	365	-44	-0.1%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	182	149	-33	-0.2%
California	No data	22,501	25,777	3,276	0.1%
United States	No data	169,669	170,177	508	0.0%

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

Population Change 2019-2020: Overall Homeless Veterans

Report Area	CoC Name	Overall Homeless Veterans 2019	Overall Homeless Veterans 2020	Difference	% Difference
Sonora CHNA	No data	35	34	-1	0.0%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	12	16	4	0.3%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	65	63	-2	0.0%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	65	63	-2	0.0%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	133	110	-23	-0.2%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	65	63	-2	0.0%
California	No data	10,980	11,401	421	0.0%
United States	No data	37,045	37,209	164	0.0%

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

Population Change 2019-2020: Unsheltered Homeless

Report Area	CoC Name	Unsheltered Homeless 2019	Unsheltered Homeless 2020	Difference	% Difference
Sonora CHNA	No data	366	366	0	0.0%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	197	162	-35	-0.2%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	687	687	0	0.0%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	687	687	0	0.0%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	1,088	1,087	-1	0.0%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	687	687	0	0.0%
California	No data	108,432	113,660	5,228	0.0%
United States	No data	208,510	223,961	15,451	0.1%

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

Population Change 2019-2020: Overall Homeless

Report Area	CoC Name	Overall Homeless 2019	Overall Homeless 2020	Difference	% Difference
Sonora CHNA	No data	451	445	-6	0.0%
Alpine County, CA	Alpine, Inyo, Mono Counties CoC	214	184	-30	-0.1%
Calaveras County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	845	834	-11	0.0%
Mariposa County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	845	834	-11	0.0%
Stanislaus County, CA	Turlock, Modesto/Stanislaus County CoC	1,923	2,107	184	0.1%
Tuolumne County, CA	Amador, Calaveras, Mariposa, Tuolumne Counties CoC	845	834	-11	0.0%
California	No data	151,278	161,548	10,270	0.1%
United States	No data	564,719	578,165	13,446	0.0%

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

Overall Homeless Trend over Time, 2007 through 2020

This indicator reports the 2007 to 2020 trend of the Point-in-Time count of overall homeless population by state.

Report Area	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	138,986	136,531	123,678	123,480	125,128	120,098	118,552	113,952	115,738	118,142	131,532	129,972	151,278	161,548

Note: No county data available. See data source and methodology for more details.

Data Source: U.S. Department of Housing and Urban Development, [HUD Annual Homeless Assessment Report \(AHAR\)](#).

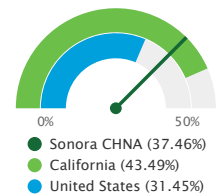


Housing Quality - Substandard Housing

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard. Of the 37,326 total occupied housing units in the report area, 13,984 or 37.46% have one or more substandard conditions.

Report Area	Total Occupied Housing Units	Occupied Housing Units with One or More Substandard Conditions	Occupied Housing Units with One or More Substandard Conditions, Percent
Sonora CHNA	37,326	13,984	37.46%
Alpine County, CA	397	85	21.41%
Calaveras County, CA	16,958	6,631	39.10%
Mariposa County, CA	7,846	2,901	36.97%
Stanislaus County, CA	174,826	70,591	40.38%
Tuolumne County, CA	22,937	8,697	37.92%
California	13,103,114	5,698,977	43.49%
United States	122,354,219	38,476,032	31.45%

Occupied Housing Units with One or More Substandard Conditions, Percent

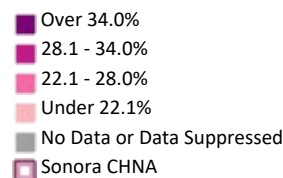


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, *American Community Survey*, 2016-20. Source geography: Tract



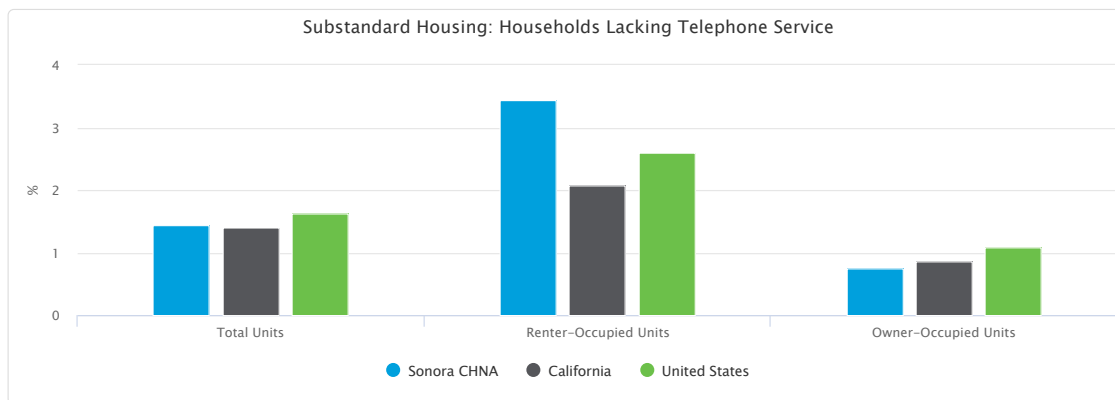
Substandard Housing Units, Percent of Total by Tract, ACS 2016-20



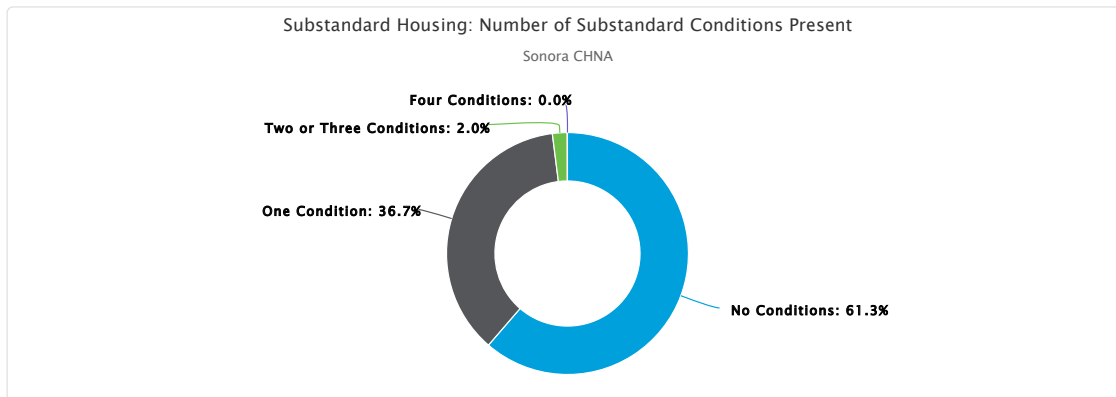
Substandard Housing: Households Lacking Telephone Service

A telephone must be in working order and service available in the house, apartment, or mobile home that allows the respondent to both make and receive calls. Households that have cell-phones (no land-line) are counted as having telephone service available. Households whose service has been discontinued for nonpayment or other reasons are not counted as having telephone service available.

Report Area	Housing Units Lacking Telephone Service	Housing Units Lacking Telephone Service	Owner-Occupied Units Lacking Telephone Service	Owner-Occupied Units Lacking Telephone Service	Renter-Occupied Units Lacking Telephone Service	Renter-Occupied Units Lacking Telephone Service
Sonora CHNA	493	1.43%	194	0.75%	299	3.43%
Alpine County, CA	13	3.27%	1	0.31%	12	15.79%
Calaveras County, CA	212	1.25%	112	0.83%	100	2.89%
Mariposa County, CA	145	1.85%	128	2.32%	17	0.73%
Stanislaus County, CA	1,808	1.03%	690	0.67%	1,118	1.55%
Tuolumne County, CA	333	1.45%	134	0.79%	199	3.29%
California	184,117	1.41%	62,251	0.86%	121,866	2.08%
United States	1,976,696	1.62%	848,369	1.08%	1,128,327	2.59%



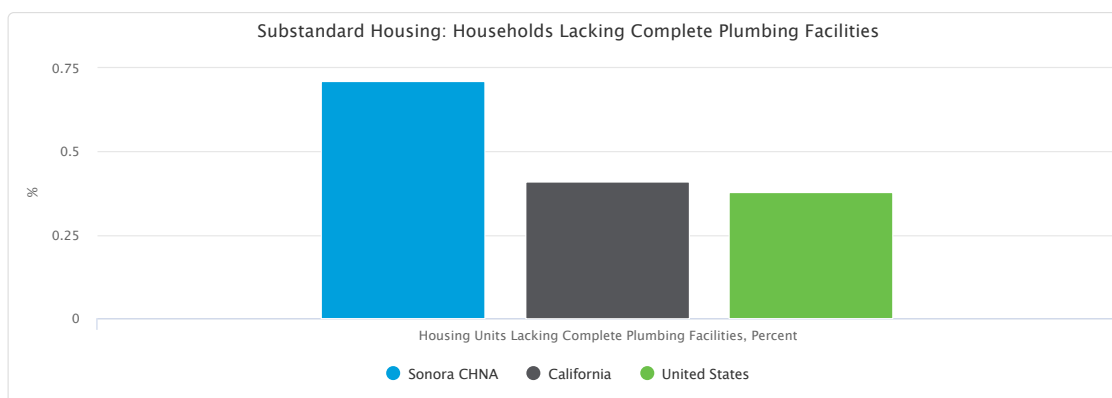
Report Area	No Conditions	One Condition	Two or Three Conditions	Four Conditions
Sonora CHNA	61.34%	36.67%	2.00%	0.00%
Alpine County, CA	78.59%	21.41%	0.00%	0.00%
Calaveras County, CA	60.90%	38.35%	0.75%	0.00%
Mariposa County, CA	63.03%	33.90%	3.07%	0.00%
Stanislaus County, CA	59.62%	37.27%	3.10%	0.01%
Tuolumne County, CA	62.08%	35.72%	2.20%	0.00%
California	56.51%	39.11%	4.37%	0.01%
United States	68.55%	29.63%	1.81%	0.01%



Substandard Housing: Households Lacking Complete Plumbing Facilities

Complete plumbing facilities include: (a) hot and cold running water, (b) a flush toilet, and (c) a bathtub or shower. All three facilities must be located inside the house, apartment, or mobile home, but not necessarily in the same room. Housing units are classified as lacking complete plumbing facilities when any of the three facilities is not present.

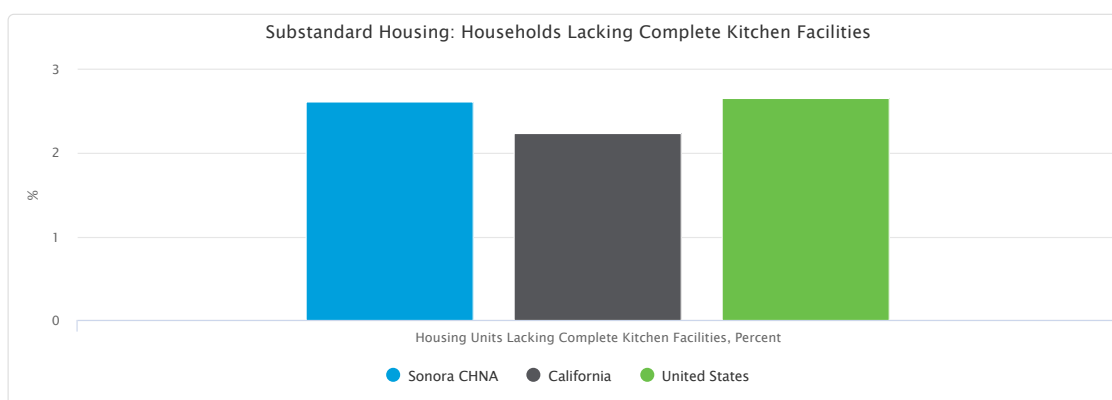
Report Area	Occupied Housing Units	Housing Units Lacking Complete Plumbing Facilities	Housing Units Lacking Complete Plumbing Facilities, Percent
Sonora CHNA	34,496	244	0.71%
Alpine County, CA	397	0	0.00%
Calaveras County, CA	16,958	65	0.38%
Mariposa County, CA	7,846	83	1.06%
Stanislaus County, CA	174,826	569	0.33%
Tuolumne County, CA	22,937	143	0.62%
California	13,103,114	54,342	0.41%
United States	122,354,219	460,275	0.38%



Substandard Housing: Households Lacking Complete Kitchen Facilities

A unit has complete kitchen facilities when it has all three of the following facilities: (a) a sink with a faucet, (b) a stove or range, and (c) a refrigerator. All kitchen facilities must be located in the house, apartment, or mobile home, but they need not be in the same room. A housing unit having only a microwave or portable heating equipment such as a hot plate or camping stove should not be considered as having complete kitchen facilities. An icebox is not considered to be a refrigerator.

Report Area	Occupied Housing Units	Housing Units Lacking Complete Kitchen Facilities	Housing Units Lacking Complete Kitchen Facilities, Percent
Sonora CHNA	52,795	1,385	2.62%
Alpine County, CA	1,794	8	0.45%
Calaveras County, CA	28,096	924	3.29%
Mariposa County, CA	10,525	389	3.70%
Stanislaus County, CA	182,239	3,271	1.79%
Tuolumne County, CA	31,572	609	1.93%
California	14,210,945	319,063	2.25%
United States	138,432,751	3,689,695	2.67%



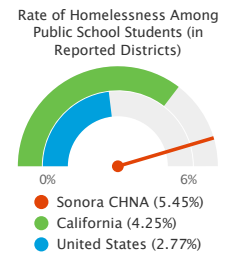
Homelessness - Homeless Students

This indicator reports the number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels, or camping grounds, in emergency transitional shelters, or may be unsheltered. Data are aggregated to the report-area level based on school-district summaries where three or more homeless children are counted.

In the report area, of all the 7,696 students enrolled in reported districts during the school year 2019-2020, there were 419 or 5.45% homeless students, which is higher than the statewide rate of 4.25%.

Note: Data are available for 94.12% school districts in the report area, representing 90.96% of the public school student population.

Report Area	Students in Reported Districts	Homeless Students	Homeless Students, Percent	Districts Reporting	Students in Reported Districts
Sonora CHNA	7,696	419	5.45%	94.12%	90.96%
Alpine County, CA	70	24	34.30%	100.00%	100.00%
Calaveras County, CA	4,243	191	4.50%	66.70%	81.90%
Mariposa County, CA	1,700	155	9.10%	100.00%	100.00%
Stanislaus County, CA	87,579	1,459	1.70%	85.70%	97.40%
Tuolumne County, CA	3,782	270	7.10%	100.00%	100.00%
California	5,893,946	250,501	4.25%	86.04%	98.28%
United States	47,386,316	1,311,089	2.77%	86.95%	97.47%

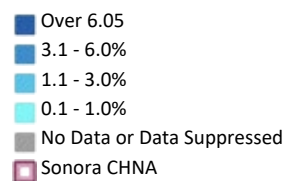


Note: This indicator is compared to the state average.

Data Source: US Department of Education, [EDFacts](#). Additional data analysis by [CARES](#). 2019-2020. Source geography: School District



Homeless Students, Percent by School District (Elementary), EDFacts 2019-20

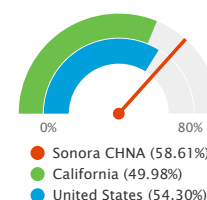


Housing Costs - Housing + Transportation Affordability Index

This indicator reports information about location affordability. Affordability is calculated by estimating the percentage of household income needed for combined housing and transportation costs for a family earning the Area Median Income (AMI). The expected values for housing and transportation are modelled by the US Department of Housing and Urban Development (HUD) using data from the US Census Bureau and the US Department of Transportation.

Report Area	Total Households	Median Household Income	Percentage of Income Spent on Housing	Percentage of Income Spent on Transportation	Percentage of Income Spent on Housing and Transportation
Sonora CHNA	33,929	51,517	25.35%	33.26%	58.61%
Alpine County, CA	343	62,375	27.25%	29.60%	56.85%
Calaveras County, CA	17,713	53,502	25.48%	32.97%	58.45%
Mariposa County, CA	7,255	49,265	25.11%	34.95%	60.06%
Stanislaus County, CA	170,328	51,591	26.20%	29.44%	55.64%
Tuolumne County, CA	22,083	50,731	25.30%	33.38%	58.68%
California	12,807,387	65,551	26.97%	23.01%	49.98%
United States	117,716,237	57,081	26.36%	27.93%	54.30%

Percentage of Income Spent on Housing and Transportation

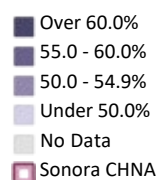


Note: This indicator is compared to the state average.

Data Source: Partnership for Sustainable Communities (HUD, DOT, and EPA), [Location Affordability Portal](#), 2012-16. Source geography: Tract



Location Affordability Index, Family at AMI, Percent Income Spent on Housing and Transportation by Tract, HUD & DOT 2012-16





E. Mental Health

The community in Sonora has significantly fewer mental health resources than most places. There are fewer mental health providers, including licensed clinical social workers, and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health. In Sonora, there are 62.92 mental health care providers per 100k people, compared to 150.31 in California and 132.27 in the United States.

The lack of providers is a major problem in part because the factors that contribute to needing mental health services are also considerable. Among risk factors, the percentage of Medicare

beneficiaries with a drug or substance use disorder is slightly elevated (4%). Similarly, the percentage of adults who binge drink is also slightly higher. The unemployment rate is at 6.5%, which is higher than the national rate (5.4%). The rate increases significantly for Asian members of the community, with an 11% unemployment rate.

Of the population of adults in Sonora, 13.9% report having poor mental health, compared to 12.5% in California and 13.6% in the United States. The suicide mortality rate in Sonora is somewhat higher, with 20 deaths by suicide per 100k people versus 10.5 in California and 13.8 in the United States. The rate of deaths of despair, including

intentional self-harm, alcohol-related disease, and drug overdoses, is also increased in Sonora at 57.5 per 100k persons. The rate is 37.1 in California and 47 in the United States as a whole.



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PRIMARY COMMENTS

KEY INFORMANT COMMENTS

- People noted a disconnect between available services and the kids who need them, but no clear explanation why access has been difficult.
- Resources within rural and small communities are limited.
- Mental health professionals are struggling with the demand on services.
- Some are not seen until there is a full-blown mental health crisis due to a lack of lower-level care.
- Exposure to traumas and multi-generational poverty are seen as increasing the need for mental health services in youth.
- Severity of mental health cases are greater in recent years.
- Instability in the home life creates challenges with mental health and substance abuse and school attendance in the eyes of interviewees.
- There is a need for more MAT and substance abuse services.
- De-stigmatizing education and outreach is needed.
- Shortage of services for those in need.
- The number of people needing crisis and inpatient services to seen as having grown.

Secondary Data Summary

Mental Health

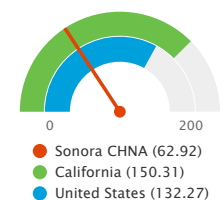
Risk Factors - Access to Care - Access to Mental Health Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counselling, or child, adolescent, or adult mental health. The number of facilities that specialize in mental health are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Within the report area there are 53 mental health providers with a CMS National Provider Identifier (NPI). This represents 62.92 providers per 100,000 total population.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Sonora CHNA	84,495	8	53	62.92
Alpine County, CA	1,204	2	0	0.00
Calaveras County, CA	45,292	3	21	46.37
Mariposa County, CA	17,131	2	22	128.42
Stanislaus County, CA	552,878	39	402	72.71
Tuolumne County, CA	55,620	6	38	68.32
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

Mental Health Care Providers, Rate per 100,000 Population



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: Address



Mental Health Providers, All, CMS NPPES July 2022

- Mental Health Providers, All, CMS NPPES July 2022
- Sonora CHNA

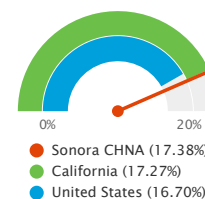
Risk Factors - Drugs & Alcohol - Binge Drinking

This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 17.38% adults who reported having four or more drinks in the last month of the total population.

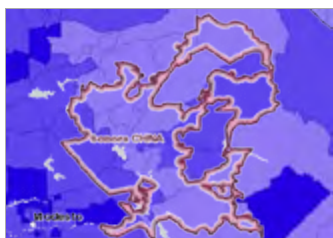
Report Area	Total Population (2019)	Percentage of Adults Binge Drinking in the Past 30 Days
Sonora CHNA	85,278	17.38%
Alpine County, CA	1,129	15.90%
Calaveras County, CA	45,905	15.90%
Mariposa County, CA	17,203	16.00%
Stanislaus County, CA	550,660	18.60%
Tuolumne County, CA	54,478	17.20%
California	39,512,223	17.27%
United States	328,239,523	16.70%

Percentage of Adults Binge Drinking in the Past 30 Days

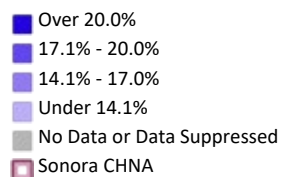


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, [Behavioral Risk Factor Surveillance System](#). Accessed via the [PLACES Data Portal](#). 2019. Source geography: Tract



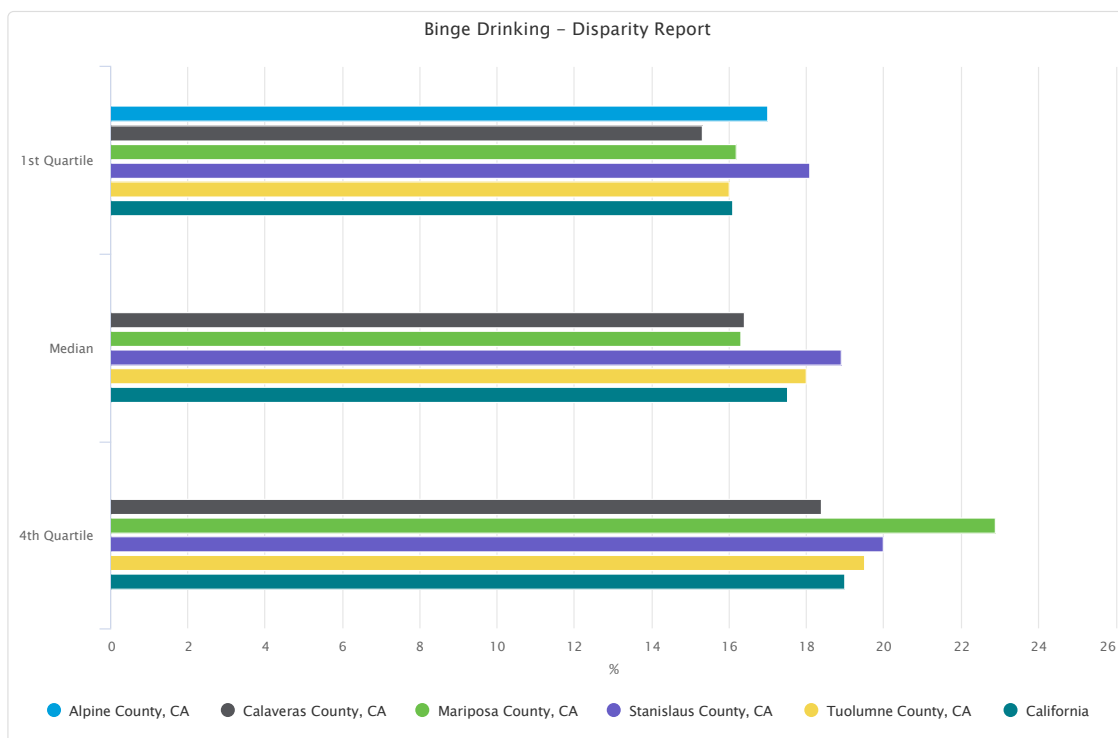
Binge Drinking, Percentage of Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019



Binge Drinking - Disparity Report

The table and chart below display the median and interquartile ranges for census tract values related to the indicator.

Report Area	1st Quartile	Median	4th Quartile
Alpine County, CA	17.00%	No data	No data
Calaveras County, CA	15.30%	16.40%	18.40%
Mariposa County, CA	16.20%	16.30%	22.90%
Stanislaus County, CA	18.10%	18.90%	20.00%
Tuolumne County, CA	16.00%	18.00%	19.50%
California	16.10%	17.50%	19.00%



Risk Factors - Stress & Trauma - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 2,401, or 6.54% of the civilian non-institutionalized population age 16 and older. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

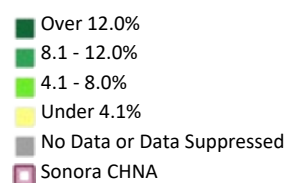
Report Area	Labor Force	Number Unemployed	Unemployment Rate
Sonora CHNA	36,705	2,401	6.54%
Alpine County, CA	451	45	9.98%
Calaveras County, CA	18,213	949	5.21%
Mariposa County, CA	7,575	661	8.73%
Stanislaus County, CA	253,400	22,357	8.82%
Tuolumne County, CA	22,555	1,646	7.30%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#). 2016-20. Source geography: Tract



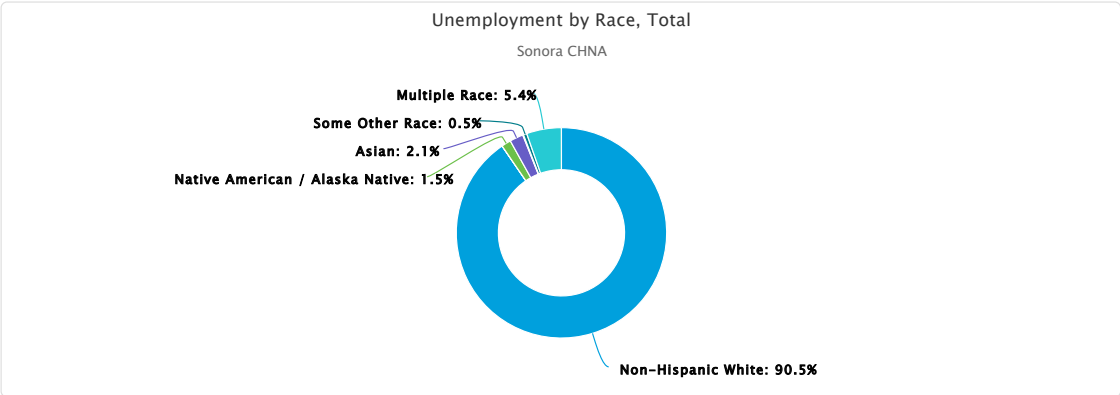
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

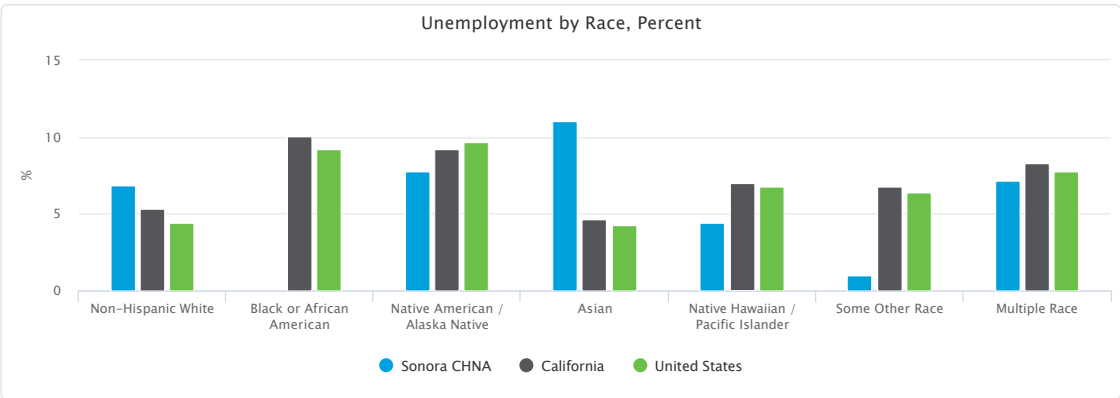
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Sonora CHNA	1,860	0	30	43	2	11	110
Alpine County, CA	23	5	14	0	0	0	1
Calaveras County, CA	784	35	0	7	0	0	65
Mariposa County, CA	420	99	10	2	0	3	50
Stanislaus County, CA	7,274	632	166	1,216	77	2,856	2,558
Tuolumne County, CA	1,346	0	30	36	2	8	42
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122



Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Sonora CHNA	6.86%	0.00%	7.79%	11.03%	4.44%	0.97%	7.18%
Alpine County, CA	8.65%	100.00%	14.43%	No data	0.00%	0.00%	1.82%
Calaveras County, CA	5.21%	47.95%	0.00%	1.77%	No data	0.00%	7.20%
Mariposa County, CA	7.07%	85.34%	5.35%	3.03%	No data	1.12%	13.05%
Stanislaus County, CA	6.82%	8.63%	8.18%	7.82%	4.52%	10.39%	12.84%
Tuolumne County, CA	7.30%	0.00%	10.83%	15.65%	4.44%	1.04%	3.87%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%

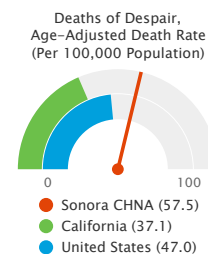


Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

Within the report area, there were 285 deaths of despair. This represents an age-adjusted death rate of 57.5 per every 100,000 total population.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Sonora CHNA	83,475	285	68.5	57.5
Alpine County, CA	1,108	No data	No data	No data
Calaveras County, CA	45,731	149	65.2	52.1
Mariposa County, CA	17,363	58	66.8	64.9
Stanislaus County, CA	548,003	1,246	45.5	45.1
Tuolumne County, CA	54,317	191	70.3	59.6
California	39,444,803	78,447	39.8	37.1
United States	326,747,554	806,246	49.4	47.0

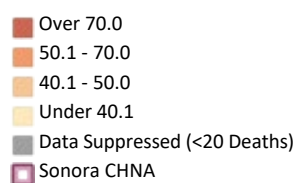


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER, 2016-2020. Source geography: County



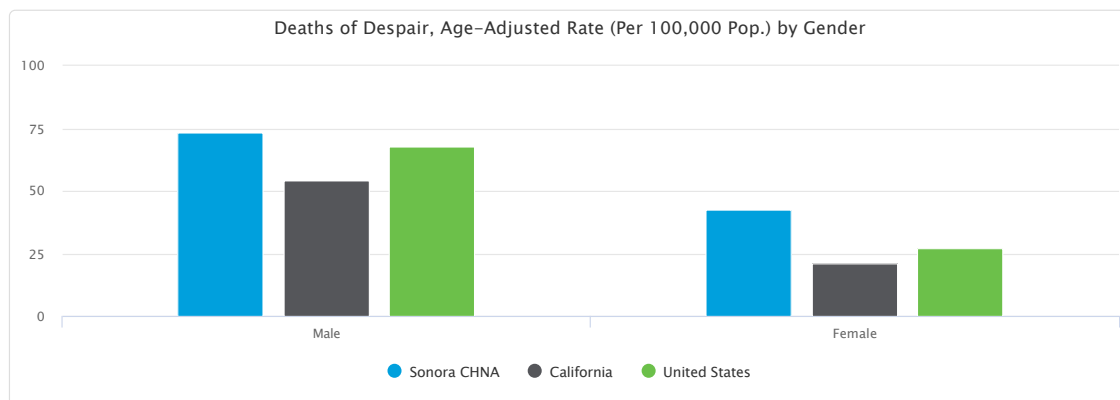
Deaths of Despair, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20



Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 people for the 5-year period 2016-2020 by gender.

Report Area	Male	Female
Sonora CHNA	73.5	42.4
Alpine County, CA	No data	No data
Calaveras County, CA	69.6	34.8
Mariposa County, CA	97.2	No data
Stanislaus County, CA	65.0	26.3
Tuolumne County, CA	73.7	46.2
California	54.0	20.9
United States	67.7	27.3



Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 people for the 5-year period 2016-2020 by race and by Hispanic origin.

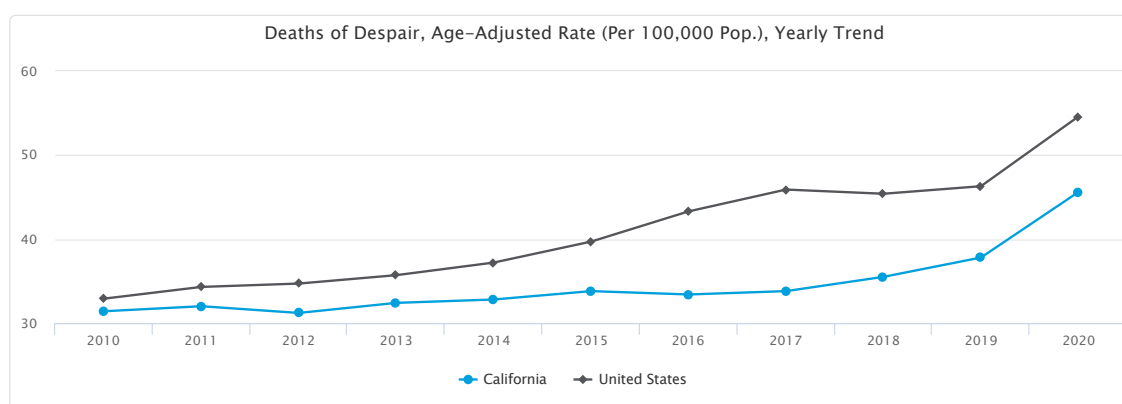
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Sonora CHNA	64.9	52.6	20.9	32.7	36.8
Alpine County, CA	No data	No data	No data	No data	No data
Calaveras County, CA	57.3	No data	No data	No data	No data
Mariposa County, CA	76.4	No data	No data	No data	No data
Stanislaus County, CA	57.9	52.6	21.0	32.7	36.8
Tuolumne County, CA	67.7	No data	No data	No data	No data
California	48.9	42.6	13.5	32.3	34.0
United States	55.6	38.6	14.3	64.3	34.6

Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

The table below shows age-adjusted death rates due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 population over time.

Report Area	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	31.4	32.0	31.2	32.4	32.8	33.8	33.4	33.8	35.5	37.8	45.6
United States	32.9	34.3	34.7	35.7	37.2	39.7	43.3	45.9	45.4	46.3	54.6

Note: No county data available. See data source and methodology for more details.



F. Written Comments

We value your input in our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA Report or adopted implementation strategy were received.

G. Data Limitations

Key informant interviews were conducted solely with volunteers, which could affect the representativeness of the information collected. Some of the secondary data sets used in this needs assessment were collected prior to COVID-19. The survey only sampled registered voters, leaving out a fully representative sample. As a result, it is not possible to know the full impact COVID-19 has had on the lives of the communities studied or the impact it had on data collection. Despite these limitations, the data provided can be seen as an accurate reflection of community health needs.



Scan the QR code for the
full Secondary Data Report





IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

The local Steering Committee (membership found in Section I. E) was responsible for identifying the community health needs to include in the new CHNA. To facilitate this process, a series of meetings were held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included key informant interviews and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a 90-minute data presentation of

these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization meeting. The poll allowed them to

identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

The prioritization meetings were designed to build consensus around the high priority community health needs identified by the steering committee members. The meetings were facilitated by Adventist Health System staff and relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded with committee members prioritizing the list of significant identified needs (with typically three-to-five needs selected as high-priority).

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

PRIORITIZATION TOOL #1



CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations Tracked and shared progress/data 'Quick Wins' through collaboration Political willingness	Partners Resources Assets Existing orgs/programs addressing all/parts of Need CBO's are focused on this Need Community willingness	Finance Gov. or public funding available when applying collaboratively Available grants for this Need Need meets the vision/mission of Gov. or philanthropic orgs	Equity Current Orgs/programs addressing Need with Safety-Net pop. Everyone will benefit Addressing Need could lessen absenteeism at work/school
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PRIORITIZATION TOOL #2

Feasibility: High feasibility means there is alignment and/or resources in place to take actional steps to address this Need in a 1-3 year timeframe. Low feasibility means it will take more than 3 years to show a community benefit by addressing this Need.

Impact: High impact means the most community members, or the community members most in need, will benefit from addressing this Need. Low impact means this priority will not benefit a large part of the community, or that the people who will benefit are not in need.

example

	Less Impact	High Impact
High Feasibility	● Community Vitality	● Education ● Food Security ● Housing
Less Feasibility	● Environment & Infrastructure	● Mental Health

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology



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Introduction

Since the passage of the 2010 Patient Protection and Affordable Care Act, non-profit hospitals are required to complete a community health needs assessment (CHNA) at least every three years. The purpose of the CHNA is to better align the community benefit functions of non-profit hospitals with the needs of the communities which they serve. To this end, requirements for completing a CHNA are broadly defined by the Internal Revenue Service (IRS)¹ to include “identifying and prioritizing community health needs” (Pennel, 2015), which must involve the input from “broad interests of that community” (IRS). Best practices for CHNAs as defined by the CDC, the AHA Community Health Improvement (AHCI) and others all specify the inclusion of both primary and secondary data (Barnett, 2012; Institute of Medicine, 2010; Stoto & Ryan-Smith, 2015; AHCI, 2017). In practice, however, there is little consensus on how this data is used to define community health needs.

While much research exists on the subject of population health measurement, research findings specific to quantitative analysis in Community Health Needs Assessments are limited. Among the existing literature, authors find “wide-ranging diversity in CHNA approaches and report quality”.

Best practices for utilizing secondary data

One reason for this is the lack of guidelines or even requirements for incorporating secondary data into an assessment of community needs. Despite this, evaluators agree that utilizing both primary and secondary data to prioritize community health needs is a “best practice”.

Several common issues with secondary data which hinder its ability to define health priorities have been defined in the literature. These include the lack of data availability at the appropriate levels of disaggregation (both geographic and for population subgroups), the lack of real-time or current data, and the lack of appropriate benchmarks (Stoto, Davis, & Atkins, 2019).

This document describes the methodological approach used to identify health needs using secondary data.

Basic Approach

Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected which best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to the mission of “helping people live longer, better.” These criteria include: impact on short-term health (well-being); impact on long-term health (life expectancy); and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being

and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

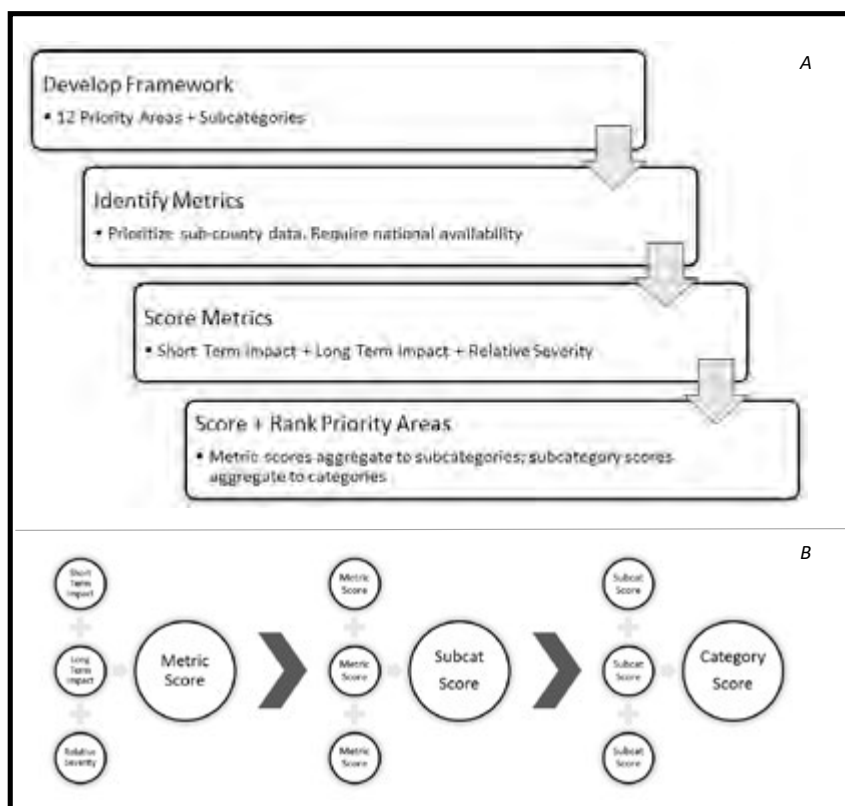


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

A set of 12 priority conceptual areas were identified from a review of past cycle CHNAs. In order to generate a score or rank for these priority needs areas, our first task was to operationalize them by selecting appropriate data by which to measure each one. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well-Being
- County Health Rankings & Roadmaps

¹ <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>



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- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period, and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency, and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. Indicators which did not correspond into the 12 categories were not included in the analysis. Additionally, indicators representing similar concepts (e.g., poverty, childhood poverty, household poverty) were reduced to a single metric.

Next, indicators were grouped into subcategories within each priority health needs category. The final framework consists of more than 100 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022).

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life, and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status²) and a long-term goal (length of life, measured by life expectancy at birth³). This approach was adopted in part to reflect the hospital system's mission of "helping people live longer, better".

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework⁴.

To address the third criterium, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

² Source: BRFSS PLACES 2018 Poor Mental Health Days + Poor Physical Health Days

³ Source: CDC NCHS USA LEEP

⁴ Removal was preferred over inverting the score direction since indicators were selected which theoretically represented conditions for good health. One example of this removal occurred with the metric "access to grocery stores", where a lower density of grocery stores correlated with a higher life expectancy and well-being. It is predicted that this relationship is due to confounding factors or a limitation of the measurement definition selected, and not an indication that a higher density of grocery stores causes worse health.



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Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a *final* score for each metric, we calculate the weighted average of the short-term and long-term score and apply the z-score as an adjustment factor.

$$M_c = (ST_s + LT_s) * Z_{cs}$$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short-term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long-term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities which perform better than average for a metric will see scores adjusted down (lower priority), and communities which perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$$SubC_c = \sum_c \frac{SubC}{n}$$

$$Cat_c = \sum_c \frac{SubC}{n}$$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and 1 is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum “real” subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores, category scores may be compared with category scores; however subcategory scores and category scores cannot be compared.



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Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are major drivers of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community-level, availability of data to represent some priority health need concepts are limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data sets that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Data analysis found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or US total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (Spring, 2022), the latest available data on health behaviors, outcomes, and social determinants represented the 2019 calendar year, and in some cases, data were older still. Since the first aim of this work is to measure the *relationship* between certain factors and well-being and life expectancy, this temporal lag is of less importance. However, the significant events of 2020 and 2021 (e.g., the COVID-19 pandemic) are largely unrepresented in these data.

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B. Survey Methodology and Questions

The Berkeley IGS Poll is a regularly scheduled non-partisan survey of California public opinion conducted by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. A component of the University of California system's flagship Berkeley campus, IGS is the oldest organized research unit in the UC system and the state's oldest public policy research center.

METHODOLOGY: The poll is administered online by distributing email invitations to stratified random samples of California registered voters. The invitation provides respondents with a short summary of the poll's purpose, its sponsorship, how long the survey is likely to take and how the recipient's email was obtained.

The statistical tabulations in this volume are based on a Berkeley IGS Poll completed online in English and Spanish July 18-24, 2021, among 5,795 California registered voters by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. Funding for the poll was provided in part by the Los Angeles Times.

The survey distributed email invitations to stratified random samples of the state's registered voters. Each email invited voters to participate in a non-partisan survey conducted by the University and provided a link to the IGS website where the survey was housed. Reminder emails were distributed to non-responding voters, and an opt-out link was offered to voters not wishing to participate and not wanting to receive further email invitations.

Samples of registered voters with email addresses were provided to IGS by Political Data, Inc., a leading supplier of registered voter lists in California. The email addresses of voters were derived from information contained on the state's official voter registration rolls. Prior to the distribution of the emails, the overall sample was stratified by age and gender in an attempt to obtain a proper balance of survey respondents across all major segments of the registered voter population.

To protect the anonymity of survey respondents, voters' email addresses and all other personally identifiable information derived from the original voter listing were purged from the data file and replaced with a unique and anonymous identification number during data processing. In addition, post-stratification weights were applied to align the overall sample of the registered voters to population characteristics of the state's registered voters.

The sampling error associated with the results from the survey is difficult to calculate precisely due to the effects of sample stratification and the post-stratification weighting. Nevertheless, it is likely that the results from the overall sample of registered voters are subject to a sampling error of approximately +/- 2 %age points at the 95% confidence level.

The survey question response options were based on the community health needs framework that also defined this work's secondary and primary data collection. In addition, survey response language was adjusted to be accessible to all community members.

The following list shows how response options correspond to the community needs framework.

SURVEY QUESTION

Please choose the five things from this list that make it hard for you and others in your community to be healthy.

- ▶ Not being able to see a doctor or go to a hospital
- ▶ Not enough good jobs
- ▶ Lack of transportation
- ▶ Lack of senior care
- ▶ Poor schools
- ▶ Not enough affordable housing
- ▶ Limited affordable, healthy food
- ▶ COVID-19
- ▶ Homelessness
- ▶ Mental Health
- ▶ Cost of Living

NEEDS CROSSWALK

- ▶ Access to Care-Primary Care
- ▶ Financial Stability-Employment
- ▶ Environment & Infrastructure-Transportation
- ▶ Access to Care-Senior Care
- ▶ Education
- ▶ Housing-Cost
- ▶ Food Security
- ▶ COVID
- ▶ Housing-Unhoused
- ▶ Mental Health
- ▶ Financial Stability-Cost of Living

C. Key Informant Methodology and Guide

Primary data collection was designed to gather first-person input on community health needs directly from the community. Between October 2021 – January 2022, key informant interviews were conducted with community leaders in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling interviews. Any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from and representing underserved and minority populations whenever possible.

The semi-structured interview guide (see Section V) used for interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need, attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. A notetaker was present for each key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis.

Deductive analysis of all key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CAREs. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments were rolled up to the major category level. Axial coding, where common and highly relevant data codes were combined into themes, was conducted on all category and subcategory data, and major themes were developed for each of the top five-to-six categories/subcategories based on relative importance determined by the number of total codes and the review by the axial coding team.

Once major themes were identified, the primary data team, comprised of both facilitators and qualitative data analysts, reviewed themes and supporting data to determine the final community needs to include in the Steering Committee data reveal. The final needs were the themes that occurred most frequently, both in terms of the number of times specific needs were identified and the urgency, frequency, and intensity of the related comments. Combined with the identified survey and secondary data needs (the five largest needs of the 12 on which secondary data was collected), these themes represented the findings the Steering Committee used to determine (described in

Section IV) the final set of high priority health needs included in this CHNA report. Primary interview data was presented as identified needs, a summary of the need, and supporting data taken from the qualitative analysis. Wherever possible, the supporting data was provided in the form of direct quotes from participants.

FACILITATOR'S SCRIPT▶ **Duration**

- Spend the next 60 minutes together (key informant).

▶ **Share the “why” they are here and “what” we’re asking of them**

- You’re here today because we want to hear your opinions about the health needs of your community.
- Every community has things that help people be healthy and things that make it harder to stay healthy.
- This is part of a larger plan, and your input will be put together with comments from others in your community into a Community Health Needs Assessment report. This will help your community organizations and leaders as they work toward identifying the challenges and barriers you’re seeing so they can work to fix the problems you’re facing in trying to stay healthy.

▶ **More about a Community Health Needs Assessment report**

- The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.

▶ **Your Acknowledgment**

- We’ll be asking you questions today and you’re free to answer only the questions you’re comfortable with.
- Please know that notable quotes/comments from today’s meeting could appear in the CHNA and will be labeled as

an Anonymous Community Quote – please rest assured that we won’t share any names.

- *“Today’s discussion is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the individuals name.”*

ACTIVITY EXPLANATION

- ▶ We’re going to do a brief exercise to start that will tell us what the biggest problems you see are.
- Then we’ll ask you questions about those problems.
- As you look around the room, you’ll see three posters on the wall.
- They show photos of common problems people face, many of them related to health. (Editorial note: these photos portrayed social determinants of health, for participants to select from. In some cases participants were given printed versions of the photos when they requested them. This allowed all participants to be involved regardless of mobility.
- Please take a few minutes to vote with the stickers you were given when you walked in.
- *Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.*
- *Which of these things causes the most problems for you or others who live here?*
- *We’re specifically interested in learning about things that make it hard for you or your family and friends to have good physical and mental health, and a good quality of life.*

- Some of the descriptions are one word and really meant for you to share more with us about that – for instance, doctor – it could be, I can’t get an appointment, there isn’t a pediatrician near me.
- We’ll give you 10 minutes to walk around.

TALLY RESPONSES:

- ▶ Visually tally the votes and clearly call out the top five issues that were identified for the notetaker and audience to hear.
- ▶ Spend around 15 minutes going through these questions and the topic-specific follow-up questions.
- ▶ Repeat for as many problems as time allows, leaving five minutes to wrap-up at the end.
- ▶ Use the same prompting questions for each of the five identified issues.

Question Prompts

- 1 One of the topics that many people identified is _____. For those of you that think this is a health problem in your community:
- 2 Another topic many people identified is _____. For those of you that think this is a health problem in your community:
- 3 You also said that _____ is a problem. For those of you that think this is a health problem in your community:

QUESTIONS:

- ▶ Why is this a big concern?
- ▶ How do you see it affecting people around you?
- ▶ What have people tried to do to address this problem?
- ▶ What else do you think should be done?
- ▶ What are the biggest barriers to fixing this problem?
- ▶ If this problem got better, how would your community look different in 3 years?
- ▶ How has this problem been affected by COVID-19?
- ▶ Do you think this problem affects everyone in your community equally?
If not, why is that?
Who is most affected by this?

CLOSING QUESTION:

- ▶ Are there other important health needs in your community that we have not already addressed?
- ▶ (Let individual introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.)

CONCLUSION:

- ▶ Thank you all very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- ▶ Next year, we will publish the Community Health Needs Assessment, summarizing our findings and action plans identified with the community.
If you would like us to send you a text or email with a link to that report, just provide us with your information on the way out.
- ▶ Good health to you all!

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

What are the main things that stop people from seeing the doctor when they need to?

CHRONIC CONDITIONS/PHYSICAL HEALTH

What are the most common medical conditions that people have in your community?

How do you know?

HEALTH RISK BEHAVIORS

Personal choices can affect people's health at times. These can include not exercising enough, an unhealthy diet, smoking, drug use, unsafe driving habits, and many others.

What risky health behaviors do you think might affect your community?

MENTAL HEALTH

How can you tell that mental health problems are showing up in your community?

FOOD SECURITY

What examples have you seen of people struggling to have enough food to eat?

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

What are the biggest threats to your safety in your community?

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

What about for people going to college or going back to school?

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

What examples are there of times when diversity issues were not handled well?

D. Adventist Health Sonora 2019 Implementation Strategy Evaluation of Impact



Scan QR Code to read more
about the full Community
Health Plan Update

E. Purpose of the Community Health Needs Assessment (CHNA) Report

The Community Health Needs Assessment (CHNA) is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address

key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement

that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (<https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf>). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

The Adventist Health Community Well-Being Team coordinated the data collection, analysis and writing for these reports. The Community Well-Being team members listed below encompass highly relevant and diverse experience in healthcare, philanthropy and foundation, Medicaid managed care and quality improvement, public health and community health, consumer insights research and community benefit reporting. Those team members include:

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit “Amy” Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

Berkeley IGS promotes research, educational activities, and public service in the areas of American and California politics and broad domains of public policy. The Berkeley IGS Poll is a periodic survey of California public opinion on important matters of politics, public policy, and public issues. The poll, which is disseminated widely,

seeks to provide a broad measure of contemporary public opinion, and to generate data for subsequent scholarly analysis.

The Matsui Center provides students with internships and real-world learning opportunities. The faculty-led research groups develop and support state-of-the-art research on critical issues facing the nation today. The Berkeley IGS Poll provides accurate, unbiased information on what California residents think and vote on.

UC Berkeley remains central to the most important governance actions and conversations unfolding today. American democracy faces deep and systemic challenges; by training the next generation of leaders and citizens, incubating policy-relevant research, and elevating critical public discussions IGS is determined to be a part of the solution.

G. Cristina Mora & Eric Schickler...IGS
Co-Directors
igs@berkeley.edu
510-642-4465

Mark Di Camillo
Berkeley IGS Poll Director
mdicamillo@berkeley.edu

www.igs.berkeley.edu/about

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting, and collaboration systems that enable public, private, and nonprofit sector organizations to effectively address issues across topics like agriculture, the environment, business, community, health, safety, and youth. The CARES

team integrates data, mapping, visualizations, and engagement tools to better serve communities and regions across the US, including vulnerable, rural, and underserved populations. CARES web-based technologies help organizations and policy makers make more informed decisions about access, address issues of equity, and support the allocation of public and private resources.

CARES staff have backgrounds in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration, and web-based content management. Additionally, significant experience in project management, user training and support, data documentation, and client design sessions directly support the wide variety of projects at CARES.

Chris Barnett
(barnettc@missouri.edu) serves as director for CARES.

Angela Johnson
(johnsonange@missouri.edu) serves as assistant director and lead research project analyst for CARES.

For more information, please visit careshq.org/about/

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

The Center for Behavioral Health Integration is a small collaborative of mental health professionals and researchers providing evaluation, training, and program implementation support to human service organizations.

www.c4bhi.org

Project Lead: Patrick Kinner

Evaluation Consultant

Oct 2018 – Present 3 years 8 months

New England

Providing evaluation, research, writing, and strategic planning support throughout the world of human services.

Patrick Kinner joins Adventist Health as an Evaluation Consultant with more than 10 years of experience helping organizations collect high-quality data to improve their services and share their successes. He holds a vast background working with large health systems, state public health offices, and with innovative entrepreneurs and organizations to improve systems and services across the human service spectrum. Every passionate and committed organization has a gap between what they hope to accomplish and what they actually accomplish. As an evaluation consultant, Kinner identifies those gaps to collect data to understand the causes and help you use that data to change minds and turn heads. This can take the form of small-scale internal evaluation projects or long-term research efforts to test, validate, and publish your theory of change. His work has been instrumental in helping organizations secure additional funding and partnerships, and in making major structural changes in initiatives when necessary.



Project Lead: Keren Meital Kinner

Evaluation Consultant

January 2019 – Present

New England

Providing evaluation, data analysis and visualization services to human service organizations.

Keren's experience in the fields of mental health, education, and software development intersect as she helps organizations collect, understand, and act upon performance and cultural improvement data. In her role as a program evaluator, she focuses on quantitative and qualitative data analysis as well as data visualization through Tableau. With the help of regular and timely data visualization cycles, she helps organizations easily access and understand the latest information, inspect progress and back draw, and help identify new themes, gaps, learnings, and enhancements. Keren regularly works with universities, hospitals, health centers, and innovative entrepreneurs.

VI. Glossary of Terms, Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation and access through mobile health options can help them find the care they need.

COMMUNITY SAFETY:

Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes, safe people and safe children.

COMMUNITY VITALITY:

A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences, and where businesses can thrive ... this is the definition of community vitality. These are a few of the aspects of what makes a community a community, with neighbors supporting neighbors and preserving the quality of life for all to share.

EDUCATION:

Educational opportunities can deeply impact choices, quality of life and life span, from children to adults. Studies have documented that educational attainment affects health and develops a healthy sense of empowerment. As school-aged children grow in knowledge, so can parents – touching multiple generations with opportunities. Whether it is a kindergartener or a newcomer to the United States, education can improve futures.

ENVIRONMENT & INFRASTRUCTURE:

Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking requires safe sidewalks and roads. In a digital world where access to high-speed internet provides opportunities to attend school, work, go to a doctor and conduct daily tasks, high-speed internet access is also an infrastructure necessity.

FINANCIAL STABILITY:

The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families from securing the care

and resources they need. Over time, the lack of financial means impacts health and physical, emotional, and social well-being.

FOOD SECURITY:

Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase preferred affordable healthy foods, cook and store them.

Today, that is a goal and a challenge, as costs increase, and access to finding affordable healthy options is limited.

HEALTH CONDITIONS:

Obesity, heart disease, cancer and diabetes – examples of chronic diseases – are the leading causes of death and disability in the United States. The conditions in which we live contribute to our well-being and influence our choices that can lead to potentially serious diseases. Access to clean and healthy food, water, air, safe schools, affordable housing, and reliable safety-net programs play a major role in the health and well-being of a community. These small choices can make a significant difference in combatting the leading causes of death and disability in the United States, such as obesity, heart disease, cancer and diabetes.

HEALTH RISK BEHAVIORS:

Each day, decisions are made that impact lives – directly and indirectly. These manners range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of behavior that can be a life threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, when supported by financial stability, equitable social conditions, and a healthy natural and built environment, offer the opportunity to change direction and live healthier lives. Sometimes, it's our opportunities and choices that lead to some of these serious diseases. Often, the conditions in which we live can influence and contribute to our health. Access to healthy foods, green space for exercise, quality of our air and schools, affordable housing and the reliability of safety net programs often play a role in community health.

HOUSING:

The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions.



INCLUSION & EQUITY:

The definition of inclusion and equity includes fairness, justice, prosperity, and opportunity – for all people of all ages to feel welcomed, with a fair chance to participate, thrive, and reach their full potential. Inclusion and equity reflect those social conditions, systems, and policies make it so all individuals in a community have equal opportunities to live good lives.

MENTAL HEALTH:

Mental health includes our psychological, social and emotional well-being. It affects how we think, feel and act, and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults and families feeling alone and helpless.

VII. Approval Page

2022 CHNA Approval

This community health needs assessment was adopted on October 20, 2022 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2022.



Thank you for reviewing our 2022 Community Health Needs Assessment. We are proud to serve our local community, and are committed to making it a healthier place for all.

Michelle Fuentes

Adventist Health Sonora

COMMUNITY HEALTH NEEDS ASSESSMENT