2025 COMMUNITY HEALTH NEEDS ASSESSMENT

MORE
COMMUNITY VOICES

Living God's love by **inspiring health**, **wholeness** and hope.

IRS Section 501(r)(3) CHNA Compliance Checklist

1) A definition of the community served by the hospital facility and description of how the community was defined.	Page 8	4) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the criteria and process used in identifying certain health needs as significant as well as prioritizing and selecting those significant health needs.	Section IV. and V.
2) A description of the process and methods used to conduct the CHNA, including identification of information gaps that limit the hospital facility's ability to assess the community's health needs.	Section V.	5) A description of the resources potentially available to address the significant health needs identified through the CHNA.	Section IV. A
3) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	Section IV. B	6) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).	Page 11

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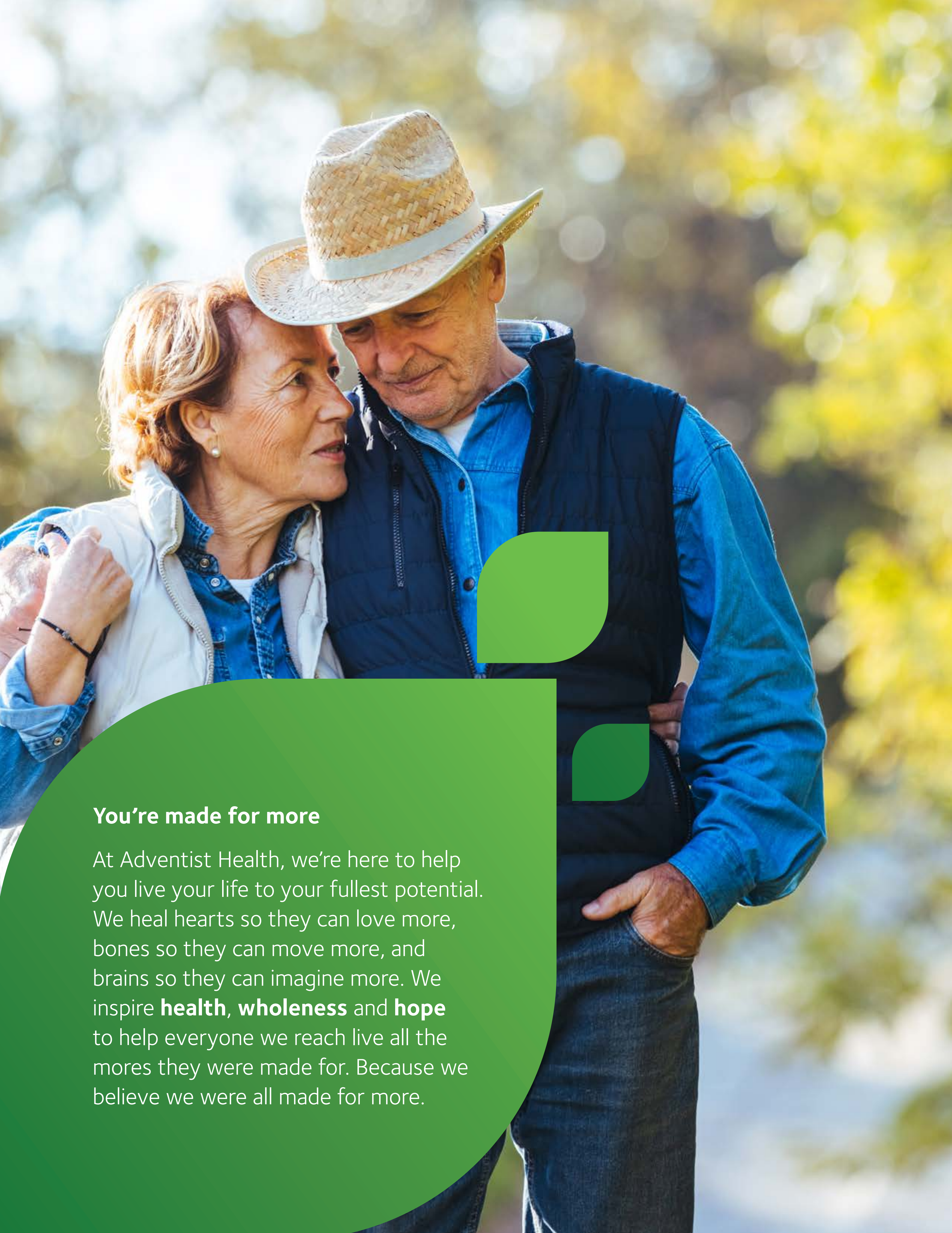


You’re made for more

At Adventist Health, we’re here to help you live your life to your fullest potential. We heal hearts so they can love more, bones so they can move more, and brains so they can imagine more. We inspire **health**, **wholeness** and **hope** to help everyone we reach live all the mores they were made for. Because we believe we were all made for more.

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public services to help improve the lives of the community members they serve. The Community Health Needs Assessment (CHNA) is conducted every three years to support this calling by helping nonprofit hospitals understand the health needs of the community. The CHNA is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify the health needs of their community. The CHNA process engages communities in identifying high priority health needs, and in aligning the resources of community-based organizations, public health services and Adventist Health to achieve improved health for all. Through this collective effort, communities collect data and identify resources to maximize their focus on meeting the most significant community health needs over the next three years.

For 2025, Adventist Health Sonora collaborated with community partners to create a concise report the entire community could contribute to and access, regardless of public health context or reading ability. Input was gathered from focus groups and key informants representing the broad interests of the community served by our hospital, and collaborative organizations. We intentionally prioritized gathering insights from local health officials with knowledge and expertise about community health needs, community-based organizations, medical providers, and members of medically underserved, low-income and minority populations.

Our assessment used a combination of primary and secondary data, providing the greatest understanding of community needs from the broadest range of perspectives. Primary data was collected from focus groups and key informant interviews conducted between May 2024 and July 2024. Eight significant health needs, which focused on the social determinants of health, were identified through in-depth analysis.

The local CHNA Steering Committee reviewed significant health needs, along with corresponding data, and prioritized needs based on severity, prevalence, alignment around common goals, feasibility of potential interventions and opportunities to maximize available resources over a three-year period. This collaborative effort resulted in the identification of the following high priority health needs:

Access to Care

Financial Stability

Mental Health

The following pages share opportunities where you, your family and your community can drive change for improved well-being. We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. In addition to our comprehensive written CHNA report, please explore our living CHNA dashboard below. The entire report is published online and available in print form free of charge by contacting community.benefit@ah.org.

Scan QR Code to explore the full live data report or visit: cares.page.link/TtTF

Transforming the health experience of our **communities** by **improving** physical, mental and spiritual **health**.

Identity of Steering Committee Hospital & Partner Organizations

To all that partnered with us, we say THANK YOU. To those now joining, we welcome you. Let's work together to inspire health, wholeness and hope in our community.

We thank the Sonora CHNA Steering Committee, who collaborated and partnered to create the 2025 CHNA. Through a series of three collaborative meetings, engagement of community members, and data review, each committee member brought their unique perspective as seen through their job and the work they performed during the CHNA process.

Jessi Abbot
Center for a Non Violent Community, Direct Services Director

Trinity Abila
Habitat for Humanity, Director/ Adventist Health Sonora Community Board

John Alexander
MACT Health Board, Executive Director

Dee Baldwin
Tuolumne Me Wuk Indian Health Center, Director of Quality and Patient Engagement

Jim Berglund
Discover Life, Senior Pastor/ Adventist Health Sonora Community Board

Robbie Bergstrom
Tuolumne County Economic Development, Senior Administrative Assistant

Dore Bietz
Tuolumne County Office of Emergency Services, Assistant Director

Joe Bors
Amador Tuolumne Community Action Agency (ATCAA), Executive Director

Kevin Day, Tuolumne Band of Me Wuk Indians, Tribal Chairman

Mario DeLise
Adventist Health Sonora, Director, Mission and Spiritual Care

Katie Dunn
Sonora Chamber of Commerce, Director

Mark Dyken
Resiliency Village, Director

Melissa Eads
City of Sonora, City Manager

Kim Freeman, MD
Tuolumne County Public Health, Public Health Officer

Sarah Garcia
First 5 Tuolumne, Director

Wynette Hilton
Big Oak Flat Groveland School District, Superintendent/ Preschool Director

Annie Hockett
Tuolumne County Health and Human Services Agency, Director

Michelle Jachetta
Tuolumne County Public Health, Director

Tami Mariscal
Tuolumne County Behavioral Health, Director

Fred Mathews
Adventist Health Sonora Rural Health Dental Clinic, Director

Greg McCulloch
Adventist Health Sonora, President

Kristin Milhoff
Area 12 Agency on Aging, Executive Director

Scott Nanik
Bret Harte High School and Angels Murphys Rotary, Superintendent/ Rotary Member

Tyler Newton
Adventist Health Sonora, Operations & Service Line Executive

Cathie Peacock
Sonora Area Foundation, Office Manager

Ed Pelfrey
Sonora Union High School District, Superintendent

Tessa Pelfrey
Jamestown School District/ Jamestown Family Resource Center, Superintendent

Darrell Slocum
Sonora Area Foundation, Executive Director

Laura Sunday
Tuolumne County Blue Zones Project, Executive Director

Dave Thoeny
Mother Lode Job Training, Executive Director/ Workforce Development Board/Adventist Health Sonora Community Board

Lena Tran
Columbia College, President

Karen Vail
Calaveras County Schools Office, Superintendent

Turu VanderWiel
City of Sonora, Police Chief

David Vasquez
Tuolumne County Sheriff's Office, Sheriff

Robert White
Yes Partnership, Executive Director

Colleen Whitlock
Tuolumne County Superintendent of Schools, Assistant Superintendent Student Support Services

A. CHNA Community Defined

Getting to Know Our Community

Located one hour north of Yosemite National Park, Sonora is a gateway to some of the West's greatest natural wonders, where you can enjoy outdoor activities like skiing, snowboarding, boating, hiking, mountain biking, whitewater rafting, and more – all paired with a lively downtown and friendly hometown atmosphere. Sonora is nestled in the heart of California's gold country and the Sierra Nevada Foothills, also known as "Queen of the Southern Mines." The community is rich with small businesses, artisans, festivals and events drawing visitors to admire the historic downtown and experience the local heritage.

While our region is blessed with natural beauty and cultural treasures, our population faces many challenges. Research suggests that up to 80% of health outcomes can be traced back to social determinants of health (SDOH), the nonmedical factors that influence health outcomes. For additional community context, below are a few SDOH data points:

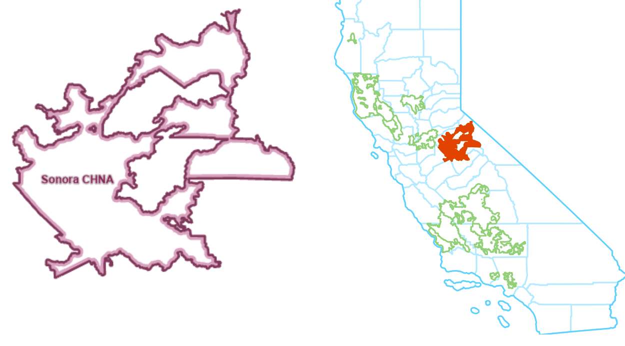
- High school graduation rate of 89.1%.
- 36.63% of the population hold an Associate's level degree or higher, compared to 43.82% in California.
- The unemployment rate is 7.2%.
- Based on the Area Median Income, residents spend 58.68% of their income on housing and transportation alone.

As a rural California community, Sonora faces unique challenges, but we are optimistic about opportunities to improve local health and well-being. In the following pages, we'll review lessons learned and accomplishments from the past three years. We'll dive deeper into the high priority needs, community voices and data that guided the Community Health Needs Assessment process.

Defining the Community We Serve

To define our community, we used the hospital's primary service area and vetted the zip codes with Steering Committee members. We also invited our Steering Committee members to expand the CHNA service area to include zip codes based on the constituents they serve.

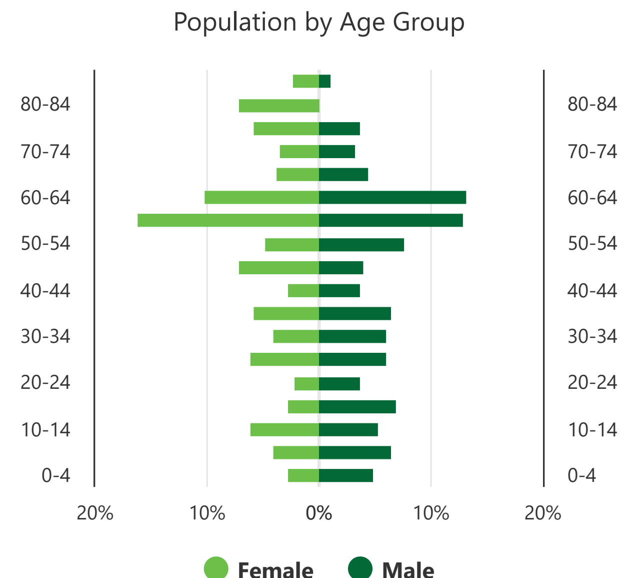
The report area is located in the state of California and includes a total population of 80,227 (based on the 2020 Decennial Census). The largest city in the report area is Sonora city, with a population of 5,003. The report area is comprised of the following ZIP codes: 95221, 95222, 95223, 95224, 95228, 95246, 95247, 95248, 95251, 95305, 95309, 95310, 95311, 95318, 95321, 95327, 95329, 95335, 95346, 95364, 95370, 95372, 95375, 95379, 95383.

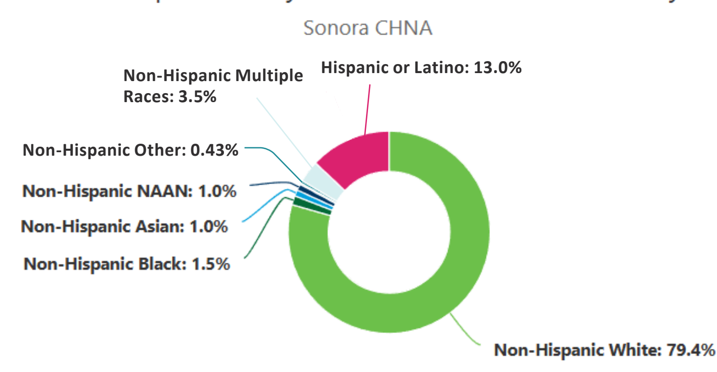


Total Population
80,227

The largest city in the service area is
Sonora
with a population of
5,003

Demographic Profile





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

Students Experiencing Homelessness, Percent
5.45%
California: 4.25%

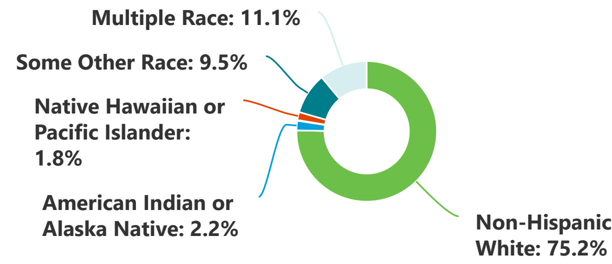
Associate's Degree or Higher
36.63%
California: 43.82%

Labor Force Participation Rate
49.73%
California: 63.82%

76.38%
California: 55.63%
of the population **owns** their home

23.62%
California: 44.37%
of the population **rents** their home

Data Source: US Census Bureau, American Community Survey. 2018-22.



Data Source: US Census Bureau, American Community Survey. 2018-22.

Childhood Poverty Rate
12.40%
California: 15.61%

II. About Us

Adventist Health

Adventist Health is a faith-based, nonprofit, integrated health system serving more than 100 communities on the West Coast and Hawai'i, with over 440 sites of care, including 27 acute care facilities. 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 more than 38,000 includes employees, physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Guided by our mission, Adventist Health supports purposeful work to address the social drivers of health, with a special focus on underserved members of the communities in which we operate. Together, we are transforming the healthcare experience of our communities with a whole-person focus on physical, mental, spiritual and social healing to support well-being.

Adventist Health Sonora

Adventist Health Sonora provides comprehensive healthcare services in Alpine, Calaveras, Mariposa, Stanislaus and Tuolumne County, with a team of skilled physicians and specialists, advanced medical technology, caring professionals and nationally recognized quality. We care for our community in a 72-bed acute care hospital, 68-bed long-term care facility and over 30 outpatient medical offices. From prevention and diagnosis to treatment and healing, our team provides welcoming, whole-person care for every patient and family we serve.

We offer a full continuum of inpatient and outpatient services, including:

- Addiction Medicine
- Behavioral Health
- Birth Center
- Cancer Care
- Dental Care
- Diabetes Care
- Ear, Nose & Throat (ENT) Care
- Emergency and Rapid Care
- Gastroenterology
- Heart Care, including Interventional Cardiology
- Home Oxygen and Medical Supplies
- House Calls
- Imaging
- Laboratory Services
- Occupational Health
- Orthopedics
- Pharmacy
- Primary Care
- Rehabilitation Services
- Rural Health Clinic
- Skilled Nursing
- Sleep Center
- Spine Care
- Surgical Services
- Urology
- Wound Care

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health Sonora focused on housing, financial stability and mental health. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS).

In collaboration with the community, we implemented strategies to address each high priority need. For example, in response to the priority area of mental health, we implemented the Mental Health First Aid training program, which enables crucial support for community members experiencing mental health challenges. We offer free training to staff and the public to equip community members with the skills to identify signs of mental distress in their friends, families and neighbors and provide support. This comprehensive training initiative not only increases the number of trained community members capable of responding to a person in crisis but also strengthens the social fabric of our rural community and creates a culture of empathy.

For a full and complete reporting of program and activities since the 2022 Community Health Needs Assessment, please visit this link: AdventistHealth.org/About-Us/Community-Benefit

A Look Forward: After the CHNA Report

The next step in our CHNA process is to complete a CHIS. The goal of the CHIS is to strategically implement programs using evidence-informed solutions that address the high priority needs identified in our 2025 CHNA. Together, Adventist Health Sonora, local public health officials, community-based organizations, medical providers, students, parents, and members of underserved, low-income and minority populations will develop a three-year strategic plan to work towards addressing the needs of our community.

We believe the power of community transformation lies in the hands of the community. We're calling for more collaboration to create intentional strategies that improve health needs for all. Everyone's voice matters, so we want to hear more of your ideas and partner closely with those who want to drive meaningful change. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

GEM e6
Adventist Health
Sonora
COURTESY SHUTTLE
209-536-5036

The following pages **reflect high priority needs** for our community, as identified by our **diverse** CHNA Steering Committee.

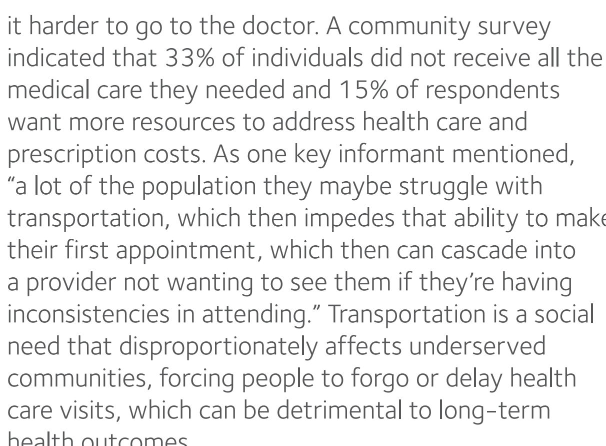
III. High Priority Health Needs

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, and accessibility for all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

In the United States, three in ten people do not have access to a reliable source of primary care (National Association of Community Health Centers) and the American Medical Association projects a shortage of 17,000 – 45,000 primary care doctors over the next decade. Additionally, factors such as being uninsured, lacking access to transportation, limited English proficiency and insufficient provider availability prevent people from receiving the services they need at the right time and place. Sonora residents face similar limiting factors, often to a greater extent, making access to care a priority need.

One of the many challenges in accessing health care is ensuring people can reach a service provider. Access to a vehicle or reliable public transportation is a primary barrier to accessing health care services. In Sonora, 16.86% of residents live within a half mile of public transit compared to 62.31% in California, making it harder to go to the doctor. A community survey indicated that 33% of individuals did not receive all the medical care they needed and 15% of respondents want more resources to address health care and prescription costs. As one key informant mentioned, "a lot of the population they maybe struggle with transportation, which then impedes that ability to make their first appointment, which then can cascade into a provider not wanting to see them if they're having inconsistencies in attending." Transportation is a social need that disproportionately affects underserved communities, forcing people to forgo or delay health care visits, which can be detrimental to long-term health outcomes.



Given that many Sonora residents live in underserved areas, increasing access and reducing barriers to healthcare in our community can improve health outcomes and reduce disparities. For additional data, see the secondary data summary.

Scan QR Code to explore the full live data report on Access to Care or visit: cares.page.link/jKnq

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

> *"People who go to the hospital and don't have a primary care, they come out of the hospital and they still don't have primary care and…their preventable problems aren't getting addressed…"*

"It takes two to three months to get appointments with some doctors…"

"A lot of people, especially in this community…they have had not enough transportation or somebody just didn't come and show up. Especially a professional Dial-A Ride or mode of care… They don't show up."

"You're talking about quality of care. We don't have enough phlebotomists in our area. A lot of people need blood monitoring."

"Shortage of doctors. That's all…shortage of doctors."

"…the areas of the county that are further out are cheaper to live in. Those areas of the county also don't receive public transportation…"

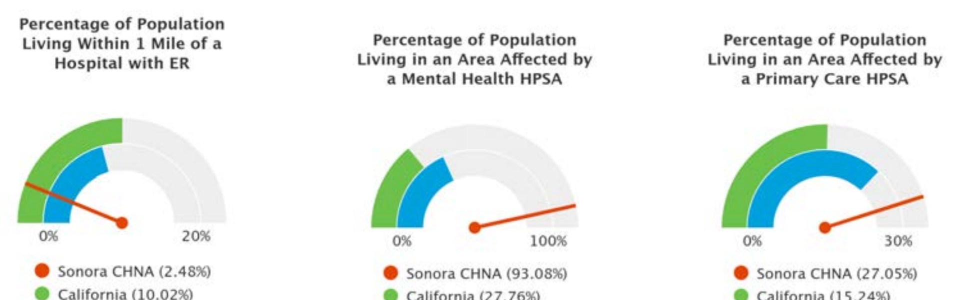
"…people of color, LGTBQ+community…there are existing stigmas…I think that the county and local healthcare system would greatly benefit from cultural education…and social bias training…"

"Many families have to seek care out of the county for any sort of specialty kind of pediatric issue…[that's] just the lack of providers in a small rural community."

"I think the lack of providers…we can get you in three months, that the soonest we can put you on a wait list. We just don't have enough people."

"I also find that technology is a big hurdle for our senior community. If that's the only way they can ascertain medical [care]…is to go online. You can almost guarantee that they will not do that…"

"…I think a lot of the population they maybe struggle with transportation, which then impedes their ability to make that first appointment, which then can cascade into a provider…not wanting to see them if they're having inconsistencies in attending…"



Community Resources

Administration for Community Living
acl.gov/programs/aging-and-disability-networks
800-677-1116

County Medical Services Program
tuolumnecounty.ca.gov/295/County-Medical-Services-Program
209-533-5711

Healthcare Enrollment Services
coveredca.com
800-300-1506

Tuolumne Me Wuk Indian Health Center
tmwihc.org
209-928-5400

Community Health Needs Assessment Full Report

Location

Sonora CHNA

Health Needs: Access to Care

Availability - Primary Care - Primary Care Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

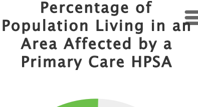
This indicator reports the total population in the report area that is living in a primary care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

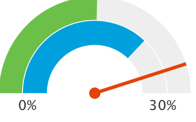
Percentage = [HPSA Population] / [Report Area Population] * 100

The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates.

Within the report area, there are 21,704 people living in a primary care Health Professional Shortage Area. This represents 27.05% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Primary Care HPSA	Percentage of HPSA Population Underserved
Sonora CHNA	80,228	21,704	27.05%	44.18%
Alpine County, CA	1,039	1,039	100.00%	100.00%
Calaveras County, CA	45,514	45,417	99.79%	40.47%
Mariposa County, CA	17,420	17,110	98.22%	79.56%
Stanislaus County, CA	543,194	69,861	12.86%	52.70%
Tuolumne County, CA	54,045	5,531	10.23%	36.72%
California	39,283,497	5,988,716	15.24%	45.23%
United States	324,697,795	72,230,619	22.25%	51.64%





Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.

View larger map

Primary Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Sonora CHNA

Availability - Mental Health Care - Mental Health Professional Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

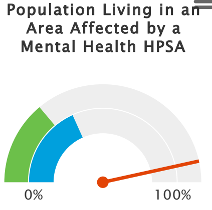
This indicator reports the total population in the report area that is living in a mental health care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there are 74,679 people living in a mental health care Health Professional Shortage Area. This represents 93.08% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Mental Health HPSA	Percentage of HPSA Population Underserved
Sonora CHNA	80,228	74,679	93.08%	50.11%
Alpine County, CA	1,039	0	0.00%	0.00%
Calaveras County, CA	45,514	45,051	98.98%	88.90%
Mariposa County, CA	17,420	17,221	98.86%	100.00%
Stanislaus County, CA	543,194	204,182	37.59%	87.64%
Tuolumne County, CA	54,045	50,532	93.50%	30.74%
California	39,283,497	10,907,014	27.76%	69.55%
United States	324,697,795	118,818,005	36.59%	62.78%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.

View larger map

Mental Health Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

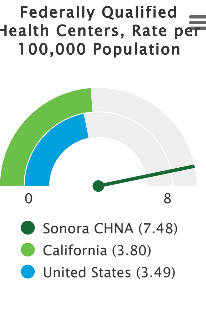
- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Sonora CHNA

Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within the report area, there are 6 Federally Qualified Heath Centers. This means there is a rate of 7.48 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Sonora CHNA	80,228	6	7.48
Alpine County, CA	1,204	0	0.00
Calaveras County, CA	45,292	1	2.21
Mariposa County, CA	17,131	2	11.67
Stanislaus County, CA	552,878	32	5.79
Tuolumne County, CA	55,620	4	7.19
California	39,538,223	1,504	3.80
United States	334,735,149	11,680	3.49



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.

View larger map

Federally Qualified Health Centers, POS December 2023

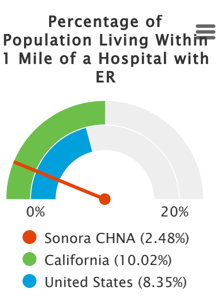
Federally Qualified Health Centers, POS December 2023
Sonora CHNA

Availability - Hospitals & Clinics - Proximity to Hospitals with ER

This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 80,228 total population, 1,990 or 2.48% live within 1 mile of a hospital with an emergency room. This is less than the state's reported rate of 10.02%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Sonora CHNA	80,228	1,990	2.48%
Alpine County, CA	1,204	0	0%
Calaveras County, CA	45,292	0	0%
Mariposa County, CA	17,131	1,143	6.67%
Stanislaus County, CA	552,878	47,341	8.56%
Tuolumne County, CA	55,620	1,990	3.58%
California	39,538,223	3,961,644	10.02%
United States	334,735,155	27,942,571	8.35%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.

View larger map

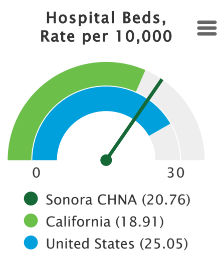
All Hospitals, POS December 2023

- All Hospitals, POS December 2023
- Sonora CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports hospital bed availability by estimating the number of hospital beds per 10,000 population. This calculation allocates the number of hospital beds at a given hospital (location) and assigns them to ZIP codes in the hospital service area based on the proportion of patients coming from each ZIP code. This provides an estimation of how hospital capacity (beds) affects the population in ZIP codes served by the hospital.

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Sonora CHNA	166	80,244	20.76
Alpine County, CA	1	1,204	8.31
Calaveras County, CA	85	45,292	18.77
Mariposa County, CA	67	17,131	39.11
Stanislaus County, CA	1,014	552,878	18.34
Tuolumne County, CA	121	55,620	21.75
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05

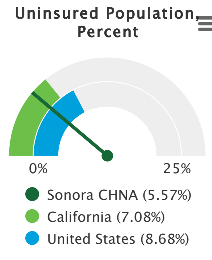


Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

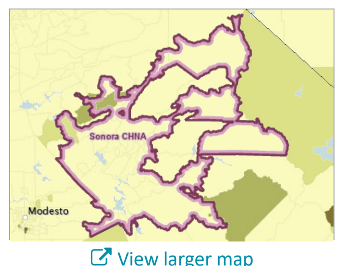
Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.
In the report area 5.57% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 7.08%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Sonora CHNA	75,134	4,187	5.57%
Alpine County, CA	1,515	97	6.40%
Calaveras County, CA	45,341	2,650	5.84%
Mariposa County, CA	16,990	1,228	7.23%
Stanislaus County, CA	549,226	33,408	6.08%
Tuolumne County, CA	52,419	3,146	6.00%
California	38,874,540	2,752,067	7.08%
United States	326,147,510	28,315,092	8.68%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

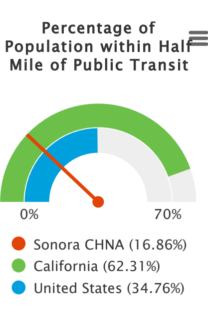
Uninsured Population, Percent by Tract, ACS 2018-22

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Sonora CHNA

Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Sonora CHNA	33,458	5,641	**16.86%**
Alpine County, CA	1,146	0	0%
Calaveras County, CA	45,235	3,850	8.51%
Mariposa County, CA	17,540	0	0%
Stanislaus County, CA	539,301	388,931	72.12%
Tuolumne County, CA	53,932	3,563	6.61%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%



Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.

View larger map

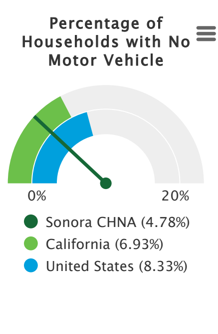
Distance to Nearest Transit Stop, (Meters) by Block Group, EPA SLD 2021

- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Sonora CHNA

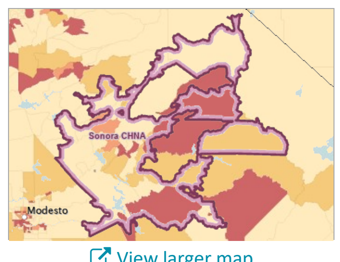
Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 34,694 total households in the report area, 1,657 or 4.78% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Sonora CHNA	34,694	1,657	4.78%
Alpine County, CA	435	15	3.45%
Calaveras County, CA	17,198	355	2.06%
Mariposa County, CA	7,597	393	5.17%
Stanislaus County, CA	175,747	9,523	5.42%
Tuolumne County, CA	22,831	1,266	5.55%
California	13,315,822	922,535	6.93%
United States	125,736,353	10,474,870	8.33%

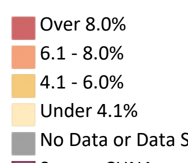


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

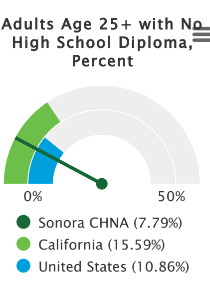
Households with No Vehicle, Percent by Tract, ACS 2018-22



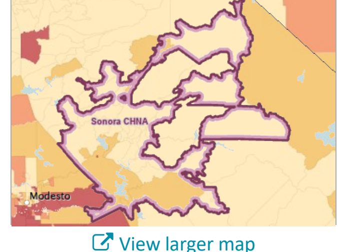
Barriers - Health Literacy - Educational Attainment

Within the report area there are 4,699 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 7.79% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Sonora CHNA	60,327	4,699	7.79%
Alpine County, CA	1,068	72	6.74%
Calaveras County, CA	35,412	2,637	7.45%
Mariposa County, CA	13,371	1,089	8.14%
Stanislaus County, CA	350,685	68,981	19.67%
Tuolumne County, CA	42,078	3,173	7.54%
California	26,842,698	4,185,710	15.59%
United States	226,600,992	24,599,698	10.86%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

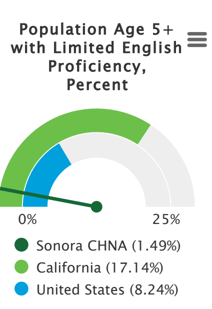
Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2018-22

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Sonora CHNA

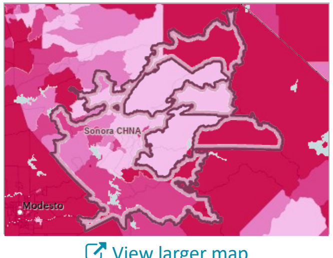
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 74,692 total population aged 5 and older in the report area, 1,114 or 1.49% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Sonora CHNA	74,692	1,114	**1.49%**
Alpine County, CA	1,380	84	6.09%
Calaveras County, CA	43,808	785	1.79%
Mariposa County, CA	16,532	631	3.82%
Stanislaus County, CA	514,227	80,105	15.58%
Tuolumne County, CA	52,610	765	1.45%
California	37,097,796	6,358,142	17.14%
United States	312,092,668	25,704,846	8.24%

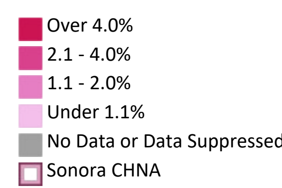


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

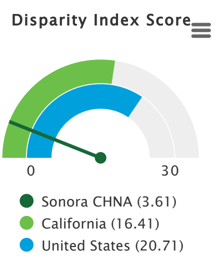
Population with Limited English Proficiency, Percent by Tract, ACS 2018-22



Barriers - Medical Insurance - Health Insurance Disparities

This indicator reports the percentage of the report area population that is uninsured by population race and ethnicity. The disparity index score is a relative measure which expresses the magnitude of disparity across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.

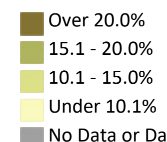
Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Sonora CHNA	5.44%	3.72%	3.07%	6.01%	3.61
Alpine County, CA	4.21%	7.98%	No data	10.83%	20.97
Calaveras County, CA	5.27%	9.33%	0.00%	9.80%	13.44
Mariposa County, CA	5.62%	13.26%	42.86%	10.74%	18.63
Stanislaus County, CA	3.68%	8.29%	4.88%	7.61%	13.75
Tuolumne County, CA	5.85%	4.31%	5.33%	5.91%	2.75
California	3.69%	11.60%	5.75%	8.84%	16.41
United States	5.87%	17.56%	9.76%	13.09%	20.71



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.

View larger map

Uninsured Population, Percent by Tract, ACS 2018-22

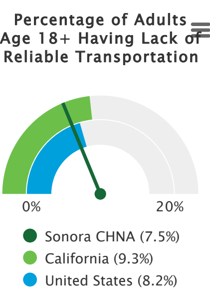


Barriers - Transportation - Lack of Reliable Transportation

This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 7.5% of adults 18 and older who rreport having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Sonora CHNA	80,185	7.5%	No data
Alpine County, CA	1,190	7.2%	8.3%
Calaveras County, CA	46,563	7.6%	9.2%
Mariposa County, CA	17,020	6.9%	8.5%
Stanislaus County, CA	551,275	11.8%	12.0%
Tuolumne County, CA	54,531	7.6%	8.9%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%



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. 2022.

View larger map

Lack of Reliable Transportation, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

- Over 29.1%
- 22.1% - 29.0%
- 15.1% - 22.0%
- Under 15.1%
- No Data or Data Suppressed
- Sonora CHNA

Finacial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation, while being able to handle unexpected expenses. Financial stability is a critical social determinant of health, as individuals with a steady income are more likely to access preventive care, afford nutritious food, maintain safe living conditions and plan for the future. People with steady jobs are more likely to be healthy and less likely to have an income below the poverty level (Healthy People 2030). However, many people face persistent financial instability impacting their health and well-being.

In the United States, 36.8 million Americans were living in poverty (US Census Bureau, 2023), and 28% of adults went without medical care in 2022 because they could not afford it (Federal Reserve). Factors like low-wage jobs, unemployment, poverty and wealth inequality leave millions of families living in a perpetual state of financial instability. Financial instability is linked to higher rates of chronic disease, mental health issues and shorter life expectancy due to limited access to health resources and higher exposure to stressors. In Sonora, primary and secondary data confirm that financial stability is a high priority need.

With a median household income of $72,010 compared to California's $91,905, achieving financial stability can be challenging. A community survey revealed that 15.5% of respondents attributed a high cost of living as a primary obstacle to living well. Focus group participants noted the high cost of living has particularly affected the senior community highlighting that they "can't afford housing, food, the basic necessities to live" and "there's [a] lot of people [...] that have left retirement and now have a completely different job to make ends meet."

Financial stability enables people to meet their basic needs, health needs and social needs. Interventions may include policies or programs that support employment and boost wages to improve family economic stability. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Financial Stability or visit: cares.page.link/rk5E

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"...being a smaller, rural poor community, you just see people on that fixed income with like one little thing that shifts and they are no longer [able] to kind of keep up with everything. So we do have a fair amount of elderly folks that are now experiencing homelessness for the first time."

"...we have senior citizens on fixed incomes that can no longer afford to just pay their rent, let alone their PGE bill."

"There's also a lot of people that I know personally that have left retirement and now have a completely different job to make ends meet."

"...they build new schools and now they can't even find kids to fill them because there's not young families coming up here to work because...there's very few good paying jobs in this county."

"They [seniors] can't afford housing, food, the basic necessities to live."

"Young people are being displaced from this county because there's only...minimum wage jobs that are available."

"...the county and the city...trying to look at the budget... and trying to figure out how it's possible to offer people a viable living. And also be able to fill these vacancies because most people would be qualified for the job but would rather go work in a county, two counties over where they get paid a lot more."

"...I just see a lot more people struggling even what would be considered middle class on being able to afford a home, renting or buying because the costs are so high."

Community Resources

ATCAA
atcaa.org/smart-money
209-223-1485 ext. 243

County Rental Assistance Program
tuolumnecounty.ca.gov/721/Rental-Assistance
209-557-2014

Jamestown Family Resource Center
jespanthers.org/jamestown-family-resource-center
209-984-4704

Tuolumne County Public Assistance
tuolumnecounty.ca.gov/292/Public-Assistance
209-533-5711

Community Health Needs Assessment Full Report

Location

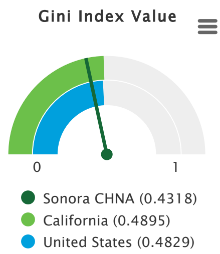
Sonora CHNA

Basic Needs: Financial Stability

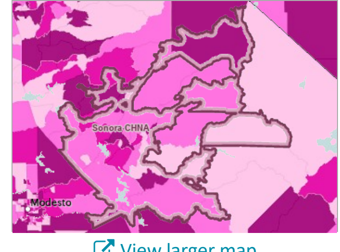
Income - Income Inequality

This indicator reports income inequality using the Gini coefficient. Gini index values range between zero and one. A value of one indicates perfect inequality where only one household has any income. A value of zero indicates perfect equality, where all households have equal income.
Note: Index values are acquired from the 2018-22 American Community Survey and are not available for custom report areas or multi-county areas.

Report Area	Total Households	Gini Index Value
Sonora CHNA	34,694	**0.4318**
Alpine County, CA	435	0.5733
Calaveras County, CA	17,198	0.4278
Mariposa County, CA	7,597	0.4371
Stanislaus County, CA	175,747	0.4418
Tuolumne County, CA	22,831	0.4533
California	13,315,822	0.4895
United States	125,736,353	0.4829

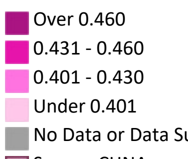


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Income Inequality (GINI), Index Value by Tract, ACS 2018-22



Income Inequality (GINI Index) by Year

This indicator reports the GINI index from 2012-16 to 2017-21.

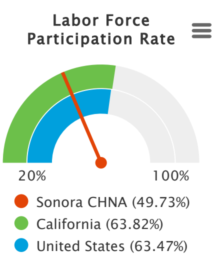
Report Area	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21	2018-22
Alpine County, CA	0.5054	0.4981	0.4967	0.4930	0.4470	0.4288	0.5733
Calaveras County, CA	0.4648	0.4608	0.4464	0.4414	0.4236	0.4326	0.4278
Mariposa County, CA	0.4562	0.4492	0.4349	0.4234	0.4329	0.4369	0.4371
Stanislaus County, CA	0.4504	0.4493	0.4451	0.4396	0.4397	0.4397	0.4418
Tuolumne County, CA	0.4795	0.4755	0.4881	0.4832	0.4686	0.4501	0.4533
California	0.4880	0.4889	0.4891	0.4886	0.4874	0.4874	0.4895
United States	0.4804	0.4815	0.4822	0.4823	0.4817	0.4818	0.4829

Data Source: US Census Bureau, American Community Survey. 2018-22.

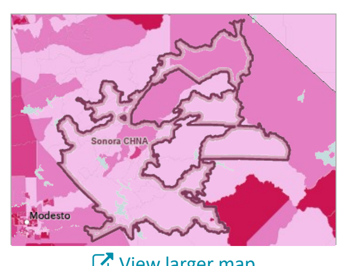
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2018 – 2022 American Community Survey, of the 70,559 working age population, 35,063 are included in the labor force. The labor force participation rate is 49.73%.

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Sonora CHNA	70,559	35,063	49.73%
Alpine County, CA	1,216	679	55.84%
Calaveras County, CA	39,074	18,537	47.44%
Mariposa County, CA	14,593	7,738	53.03%
Stanislaus County, CA	420,900	258,395	61.39%
Tuolumne County, CA	46,547	22,727	48.83%
California	31,601,862	20,168,662	63.82%
United States	266,411,973	169,093,585	63.47%

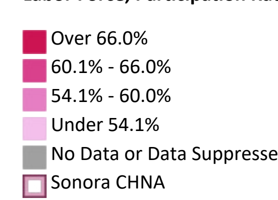


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

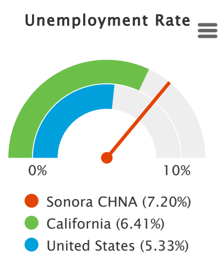
Labor Force, Participation Rate by Tract, ACS 2018-22



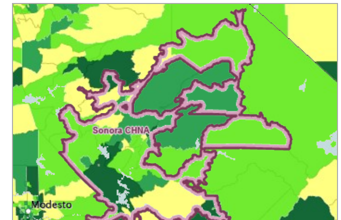
Employment - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 2,525, or 7.20% of the civilian labor force. 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	35,063	2,525	**7.20%**
Alpine County, CA	679	33	4.86%
Calaveras County, CA	18,537	1,150	6.21%
Mariposa County, CA	7,738	482	6.23%
Stanislaus County, CA	258,395	21,061	8.16%
Tuolumne County, CA	22,727	1,895	8.34%
California	20,168,662	1,282,055	6.41%
United States	169,093,585	8,944,003	5.33%

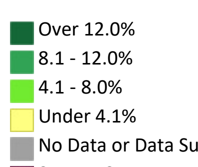


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Unemployed Workers, Percent by Tract, ACS 2018-22

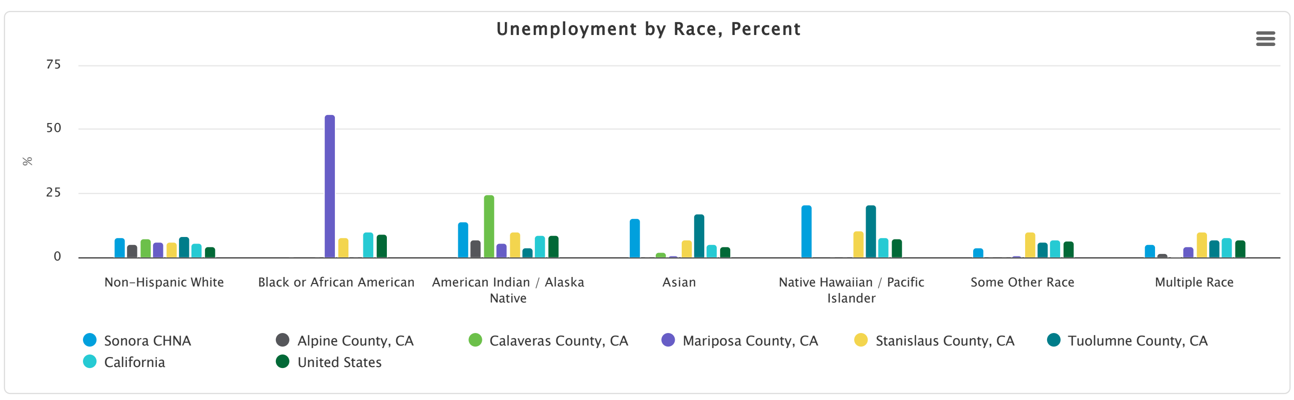


Unemployment by Race, Percent

This indicator reports the percentage of unemployed population in the report area by race. The values could be interpreted as, for example, *"Of all the Non-Hispanic White population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Sonora CHNA	7.62%	0.00%	13.78%	15.14%	20.73%	3.94%	4.98%
Alpine County, CA	4.86%	No data	6.84%	0.00%	No data	0.00%	1.59%
Calaveras County, CA	7.14%	0.00%	24.48%	1.92%	0.00%	0.00%	0.22%
Mariposa County, CA	5.88%	55.75%	5.31%	0.76%	0.00%	0.52%	4.13%
Stanislaus County, CA	6.17%	7.89%	9.83%	7.01%	10.48%	10.04%	9.93%
Tuolumne County, CA	8.29%	0.00%	3.61%	16.82%	20.73%	5.90%	6.85%
California	5.71%	9.82%	8.50%	4.90%	7.88%	6.83%	7.78%
United States	4.29%	8.87%	8.42%	4.36%	7.30%	6.37%	6.85%

Data Source: US Census Bureau, American Community Survey. 2018-22.

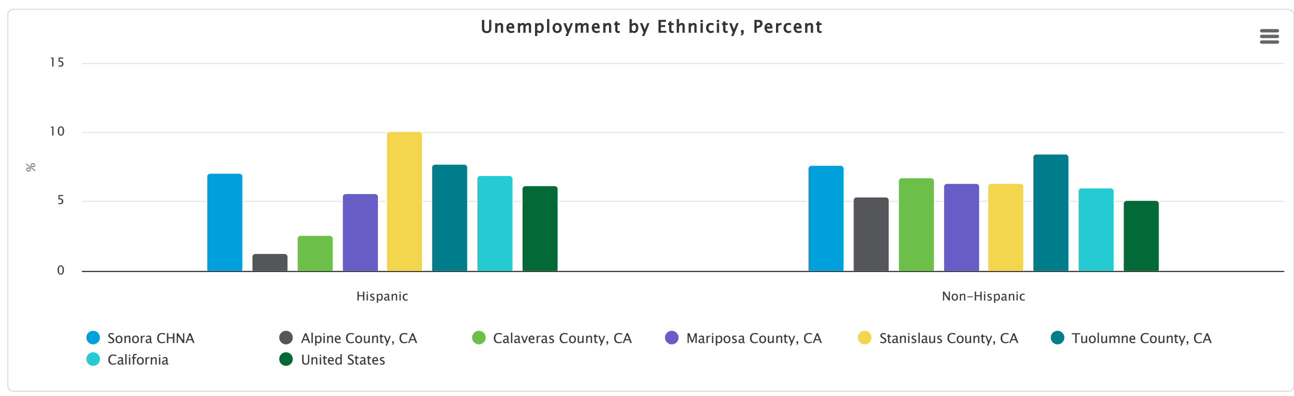


Unemployment by Ethnicity, Percent

This indicator reports the percentage of unemployed population in the report area by ethnicity. The values could be interpreted as, for example, *"Of all the Hispanic population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Hispanic	Non-Hispanic
Sonora CHNA	7.05%	7.65%
Alpine County, CA	1.27%	5.33%
Calaveras County, CA	2.60%	6.70%
Mariposa County, CA	5.59%	6.33%
Stanislaus County, CA	10.06%	6.35%
Tuolumne County, CA	7.74%	8.43%
California	6.91%	6.01%
United States	6.12%	5.10%

Data Source: US Census Bureau, American Community Survey. 2018-22.

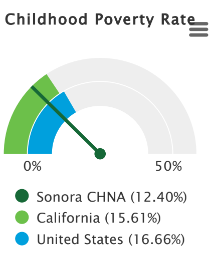


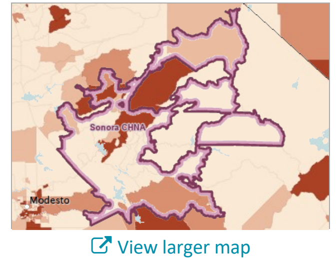
Income - Childhood Poverty Rate

In the report area 12.40% or 1,532 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population < Age 18	Population < Age 18 in Poverty	Childhood Poverty Rate
Sonora CHNA	74,545	12,364	1,532	12.40%
Alpine County, CA	1,515	345	52	15.07%
Calaveras County, CA	45,223	7,487	1,213	16.20%
Mariposa County, CA	16,960	2,890	880	30.45%
Stanislaus County, CA	547,303	146,238	26,549	18.15%
Tuolumne County, CA	51,779	8,908	1,000	11.23%
California	38,643,585	8,636,362	1,347,789	15.61%
United States	323,275,448	72,035,358	12,002,351	16.66%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





View larger map

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2018-22

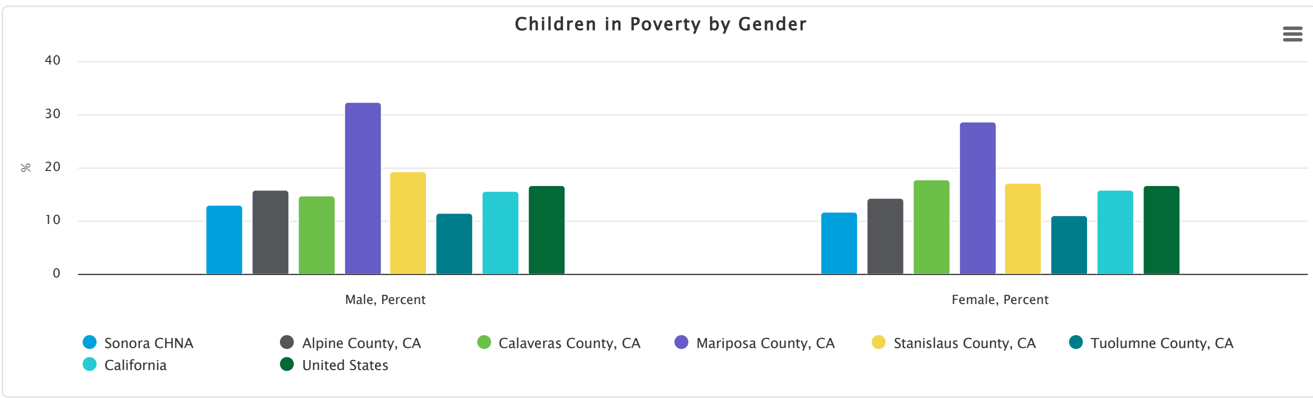
- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Sonora CHNA

Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender. The percentage values could be interpreted as, for example, *"Of all the boys under age 18 within the report area, the percentage of boys living in households with income below the federal poverty level is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Sonora CHNA	826	705	13.03%	11.73%
Alpine County, CA	31	21	15.66%	14.29%
Calaveras County, CA	537	676	14.58%	17.77%
Mariposa County, CA	451	429	32.38%	28.66%
Stanislaus County, CA	14,395	12,154	19.30%	16.97%
Tuolumne County, CA	513	487	11.39%	11.06%
California	684,184	663,605	15.47%	15.75%
United States	6,124,747	5,877,604	16.61%	16.72%

Data Source: US Census Bureau, American Community Survey. 2018-22.

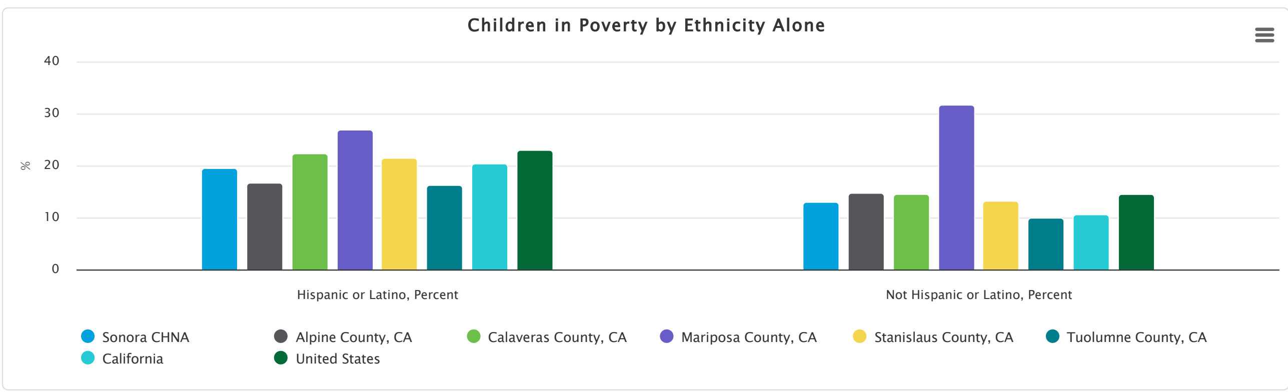


Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone. The percentage values could be interpreted as, for example, *"Of all the Hispanic children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Sonora CHNA	426	1,107	19.37%	12.92%
Alpine County, CA	13	39	16.67%	14.61%
Calaveras County, CA	361	852	22.39%	14.50%
Mariposa County, CA	175	705	26.76%	31.53%
Stanislaus County, CA	19,043	7,506	21.32%	13.19%
Tuolumne County, CA	294	706	16.12%	9.97%
California	908,098	439,691	20.37%	10.52%
United States	4,231,686	7,770,665	22.95%	14.50%

Data Source: US Census Bureau, American Community Survey. 2018-22.

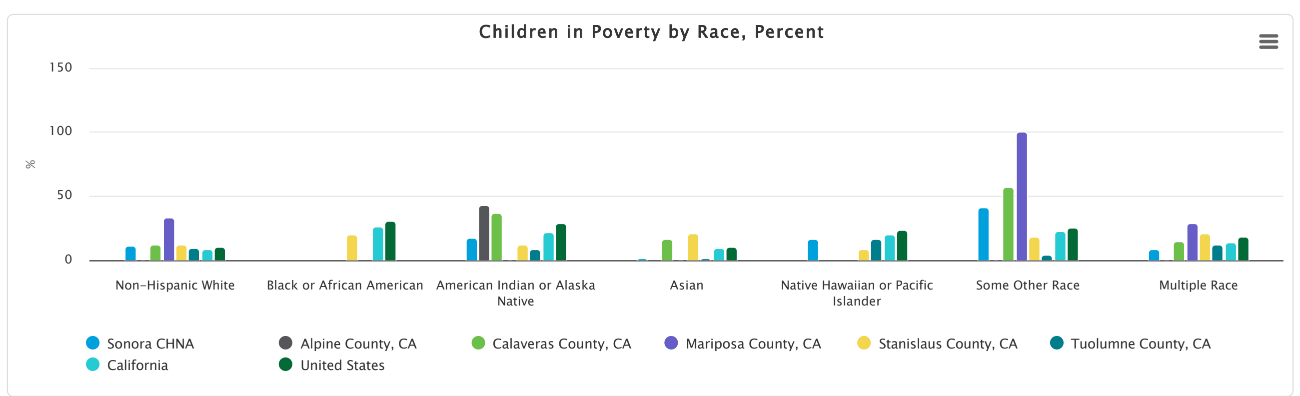


Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race. The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Sonora CHNA	11.25%	No data	16.77%	1.59%	16.33%	41.40%	8.57%
Alpine County, CA	0.00%	No data	42.62%	No data	No data	0.00%	0.00%
Calaveras County, CA	11.82%	No data	36.79%	16.22%	No data	56.84%	14.45%
Mariposa County, CA	32.85%	No data	0.00%	0.00%	No data	100.00%	29.05%
Stanislaus County, CA	12.03%	19.47%	11.52%	20.88%	8.17%	17.84%	21.13%
Tuolumne County, CA	9.50%	No data	8.33%	1.59%	16.33%	4.29%	11.68%
California	8.08%	25.76%	21.34%	9.50%	19.55%	22.88%	14.09%
United States	10.21%	30.62%	29.11%	10.17%	23.44%	25.46%	17.68%

Data Source: US Census Bureau, American Community Survey. 2018-22.

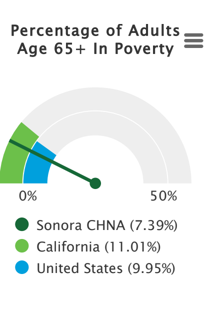


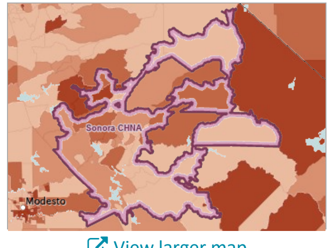
Income - Senior Poverty Rate

In the report area 7.39% or 1,615 older adults aged 65 or older are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Age 65+	Population Age 65+ in Poverty	Population Age 65+ in Poverty, Percent
Sonora CHNA	74,545	21,870	1,615	7.39%
Alpine County, CA	1,515	386	19	4.92%
Calaveras County, CA	45,223	13,071	1,353	10.35%
Mariposa County, CA	16,960	5,006	293	5.85%
Stanislaus County, CA	547,303	71,911	8,680	12.07%
Tuolumne County, CA	51,779	14,719	1,071	7.28%
California	38,643,585	5,761,476	634,473	11.01%
United States	323,275,448	53,352,363	5,309,452	9.95%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.





View larger map

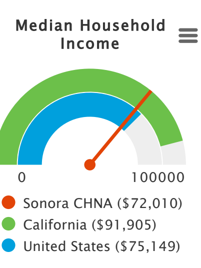
Population Below the Poverty Level, Senior (Age 65+), Percent by Tract, ACS 2018-22

- Over 17.0%
- 12.1 - 17.0%
- 7.1 - 12.0%
- Under 7.1%
- No Population Age 65+ Reported
- No Data or Data Suppressed
- Sonora CHNA

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 32,531 households in the report area, with an average income of $94,401 and a median income of $72,010.

Report Area	Total Households	Average Household Income	Median Household Income
Sonora CHNA	32,531	$94,401	**$72,010**
Alpine County, CA	435	$164,883	$101,125
Calaveras County, CA	17,198	$97,040	$77,526
Mariposa County, CA	7,597	$79,433	$60,021
Stanislaus County, CA	175,747	$97,409	$74,872
Tuolumne County, CA	22,831	$94,641	$70,432
California	13,315,822	$130,718	$91,905
United States	125,736,353	$105,833	$75,149



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.

Median Household Income by Tract, ACS 2018-22

- Over $70,000
- $60,000 - $70,000
- $50,000 - $59,999
- Under $50,000
- No Data or Data Suppressed
- Sonora CHNA

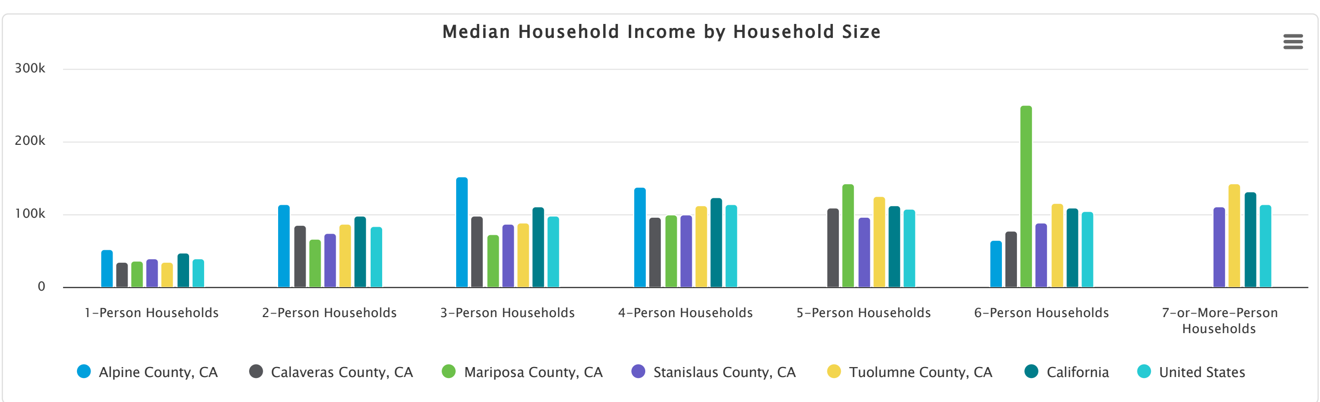
View larger map

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
Sonora CHNA	No data	No data	No data	No data	No data	No data	No data
Alpine County, CA	$52,321	$114,000	$151,250	$137,955	No data	$63,750	No data
Calaveras County, CA	$34,815	$85,532	$97,046	$96,548	$109,190	$76,486	No data
Mariposa County, CA	$35,734	$66,367	$71,632	$100,000	$142,702	$250,001	No data
Stanislaus County, CA	$39,124	$73,038	$86,541	$99,468	$95,464	$87,793	$109,612
Tuolumne County, CA	$34,272	$86,533	$88,570	$111,179	$124,537	$114,877	$142,619
California	$46,740	$98,299	$110,353	$123,339	$111,677	$108,747	$130,288
United States	$38,445	$83,185	$97,644	$113,664	$106,473	$104,420	$113,370

Data Source: US Census Bureau, American Community Survey. 2018-22.

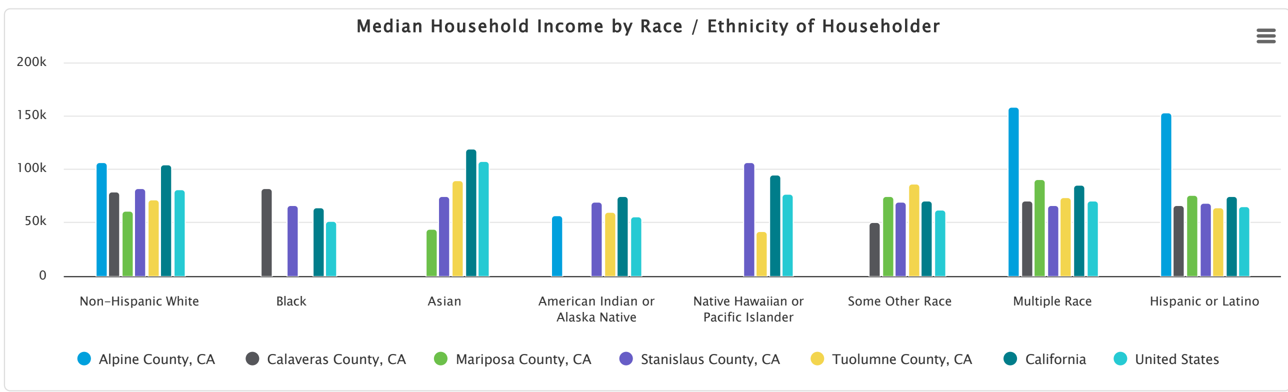


Median Household Income by Race / Ethnicity of Householder

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	$106,406	No data	No data	$56,875	No data	No data	$158,365	$153,250
Calaveras County, CA	$78,407	$81,525	No data	No data	No data	$50,250	$70,511	$66,619
Mariposa County, CA	$60,739	No data	$43,750	No data	No data	$75,028	$90,924	$76,167
Stanislaus County, CA	$81,938	$66,096	$74,854	$68,816	$105,858	$68,995	$65,905	$67,929
Tuolumne County, CA	$71,386	No data	$89,630	$59,671	$41,278	$86,591	$73,936	$63,849
California	$104,752	$64,513	$118,815	$75,076	$95,021	$70,612	$85,219	$74,517
United States	$81,423	$50,901	$107,637	$55,925	$76,568	$61,851	$70,596	$64,936

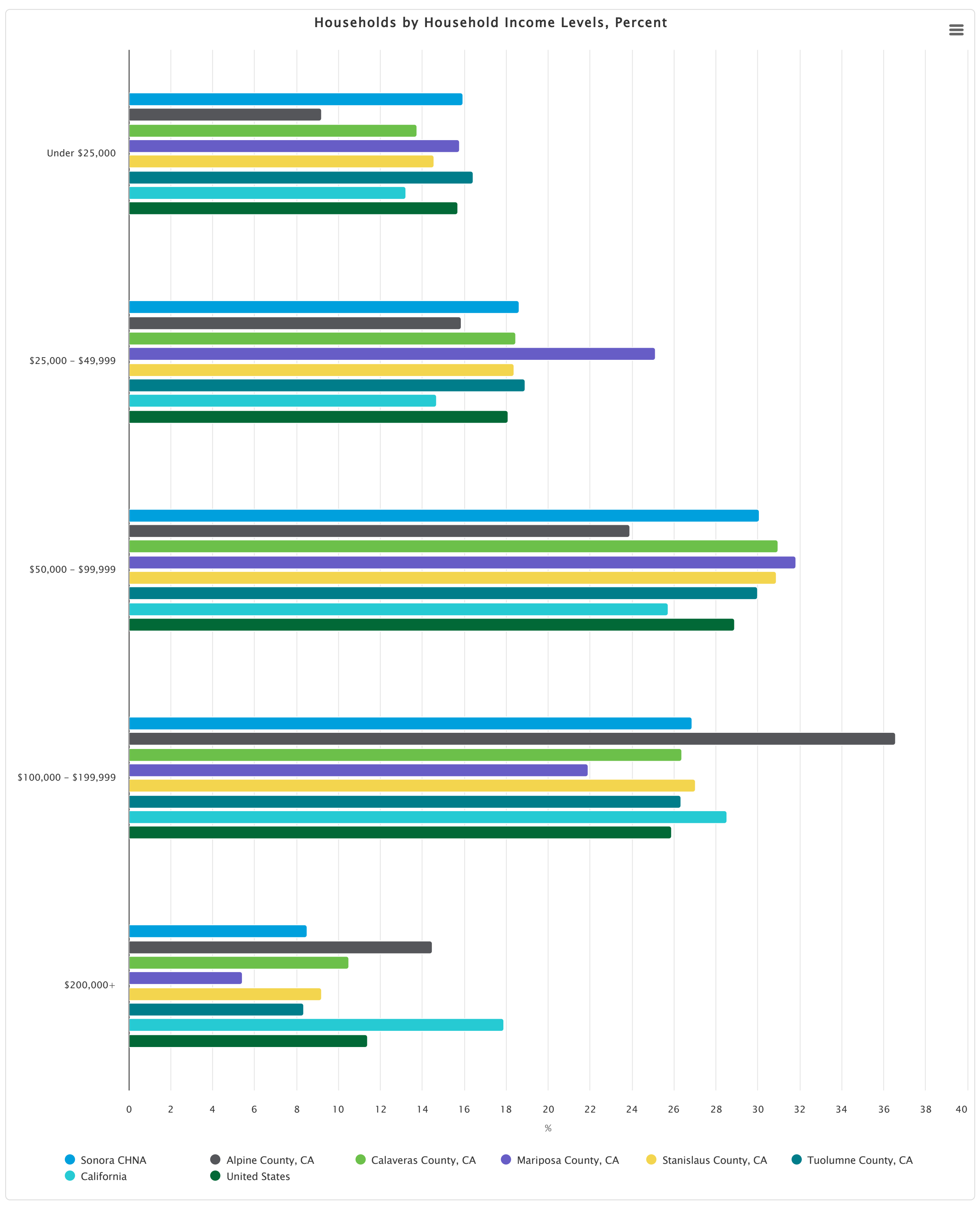
Data Source: US Census Bureau, American Community Survey. 2018-22.



Households by Household Income Levels, Percent

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Sonora CHNA	15.95%	18.61%	30.08%	26.87%	8.50%
Alpine County, CA	9.20%	15.86%	23.91%	36.55%	14.48%
Calaveras County, CA	13.73%	18.44%	30.97%	26.39%	10.48%
Mariposa County, CA	15.76%	25.10%	31.80%	21.90%	5.44%
Stanislaus County, CA	14.54%	18.36%	30.90%	27.02%	9.18%
Tuolumne County, CA	16.43%	18.89%	30.01%	26.35%	8.33%
California	13.20%	14.67%	25.72%	28.53%	17.88%
United States	15.71%	18.11%	28.88%	25.88%	11.41%

Data Source: US Census Bureau, American Community Survey. 2018-22.

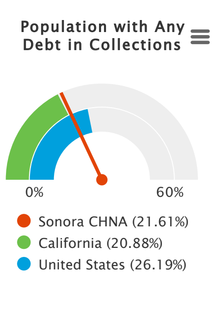

Households by Household Income Levels, Percent
Under $25,000
$25,000 - $49,999
$50,000 - $99,999
$100,000 - $199,999
$200,000+
0
2
4
6
8
10
12
14
16
18
20
22
24
26
28
30
32
34
36
38
40
%
Sonora CHNA
Alpine County, CA
Calaveras County, CA
Mariposa County, CA
Stanislaus County, CA
Tuolumne County, CA
California
United States

Security - Population with Debt

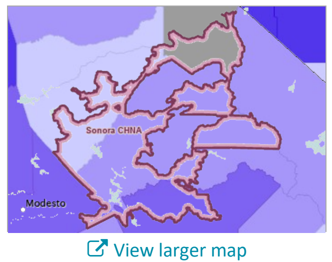
This indicator reports data from a 2 percent nationally representative panel of deidentified, consumer-level records from major credit bureau at the national, state, and county levels for the 50 states and Washington, DC, as of 2023, compiled by the Urban Institute. The share with any debt in collections and the median debt in collections within the report area are shown as below. The Share with Any Debt in Collections is defined as the share of people with a credit bureau record who have any debt in collections. This includes past-due credit lines that have been closed and charged-off on the creditor's books as well as unpaid bills reported to the credit bureaus that the creditor is attempting to collect. The Median Debt in Collections is the median amount of all debt in collections among those with any debt in collections.

Note: Credit bureau metrics are not reported when they are based on fewer than 50 people.

Report Area	Share with Any Debt in Collections	Median Debt in Collections
Sonora CHNA	**21.61%**	No data
Alpine County, CA	No data	No data
Calaveras County, CA	19.04%	$1,225.5
Mariposa County, CA	20.50%	$1,718.5
Stanislaus County, CA	25.34%	$1,761.5
Tuolumne County, CA	22.62%	$1,494
California	20.88%	$1,824
United States	26.19%	$1,739



Note: This indicator is compared to the state average.
Data Source: Debt in America, The Urban Institute. 2018-22.



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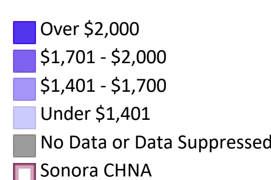
Debt in Collections, Median Amount (USD) by County, UI 2023

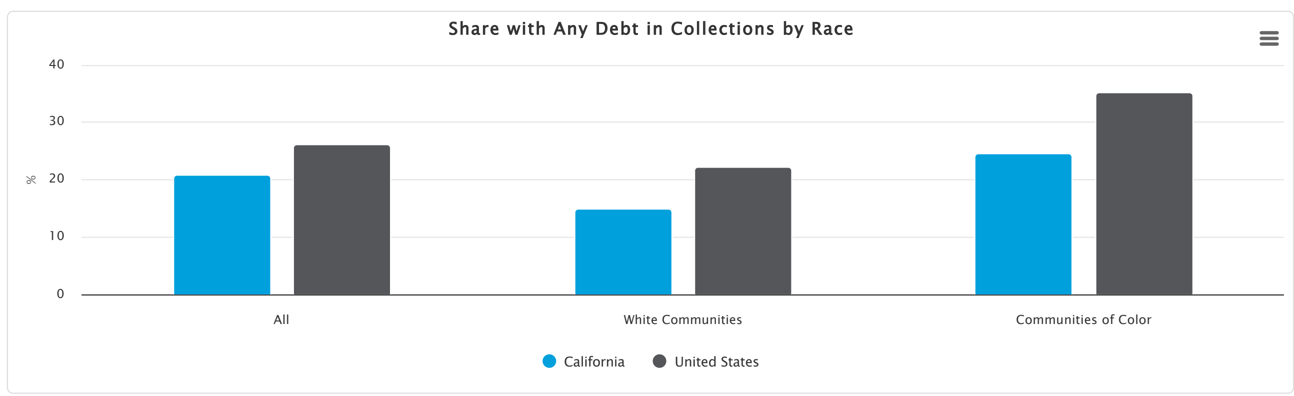


Share with Any Debt in Collections by Race

The table below reports how debt affects communities across the US in terms of race, i.e., the ratio of people with any debt in collections in white communities and the ratio in communities of color. White communities and communities of color are based on zip codes where most residents are white (at least 60 percent of the population are white) or most residents are people of color (at least 60 percent of the population are of color).

Report Area	Share with Any Debt in Collections, All	Share with Any Debt in Collections, White Communities	Share with Any Debt in Collections, Communities of Color
Alpine County, CA	No data	No data	No data
Calaveras County, CA	19.04%	19.08%	No data
Mariposa County, CA	20.50%	20.50%	No data
Stanislaus County, CA	25.34%	19.75%	27.57%
Tuolumne County, CA	22.62%	22.58%	No data
California	20.88%	14.78%	24.62%
United States	26.19%	22.07%	35.19%

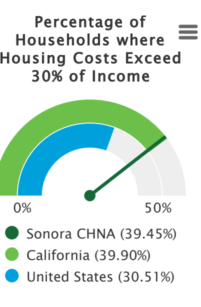
Data Source: Debt in America, The Urban Institute. 2018-22.



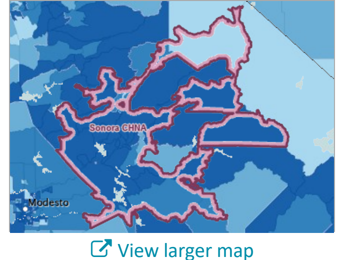
Security - Housing Cost Burden (30%)

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 32,531 total households in the report area, 12,833 or 39.45% of the population live in cost burdened households.

Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Sonora CHNA	32,531	12,833	39.45%
Alpine County, CA	435	76	17.47%
Calaveras County, CA	17,198	6,871	39.95%
Mariposa County, CA	7,597	2,514	33.09%
Stanislaus County, CA	175,747	64,084	36.46%
Tuolumne County, CA	22,831	9,240	40.47%
California	13,315,822	5,312,755	39.90%
United States	125,736,353	38,363,931	30.51%

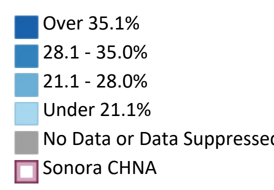


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2018-22

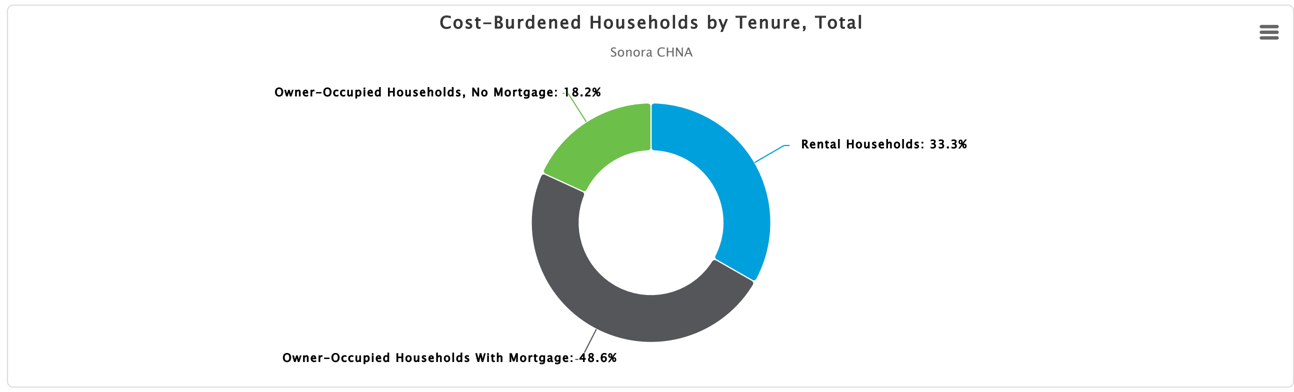


Cost-Burdened Households by Tenure, Total

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 13,408 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2018-2022 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.

Report Area	Cost-Burdened Households	Cost-Burdened Rental Households	Cost-Burdened Owner-Occupied Households w/ Mortgage	Cost-Burdened Owner-Occupied Households w/o Mortgage
Sonora CHNA	13,408	4,459	6,514	2,435
Alpine County, CA	76	10	45	21
Calaveras County, CA	6,871	1,609	3,868	1,394
Mariposa County, CA	2,514	1,010	1,135	369
Stanislaus County, CA	64,084	33,966	24,517	5,601
Tuolumne County, CA	9,240	3,136	4,457	1,647
California	5,312,755	3,050,389	1,894,888	367,478
United States	38,363,931	20,547,938	13,624,400	4,191,593

Data Source: US Census Bureau, American Community Survey. 2018-22.

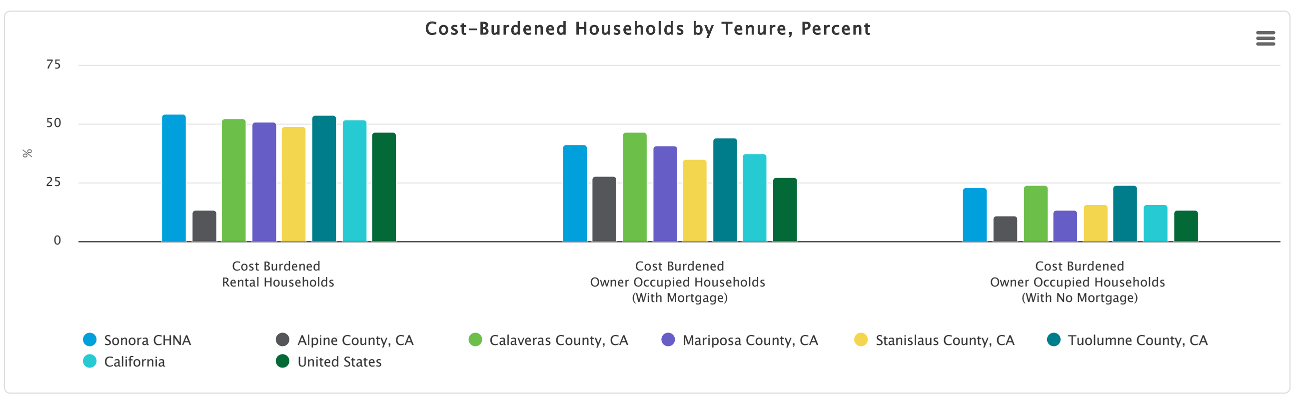


Cost-Burdened Households by Tenure, Percent

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 53.87% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2018-2022 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	Rental Households Cost-Burdened, Percent	Owner-Occupied Households w/ Mortgage	Owner-Occupied Households w/ Mortgage Cost-Burdened, Percent	Owner-Occupied Households w/o Mortgage	Owner-Occupied Households w/o Mortgage Cost-Burdened, Percent
Sonora CHNA	8,276	53.87%	15,782	41.28%	10,636	22.89%
Alpine County, CA	75	13.33%	163	27.61%	197	10.66%
Calaveras County, CA	3,084	52.17%	8,309	46.55%	5,805	24.01%
Mariposa County, CA	1,993	50.68%	2,808	40.42%	2,796	13.20%
Stanislaus County, CA	69,388	48.95%	70,378	34.84%	35,981	15.57%
Tuolumne County, CA	5,840	53.70%	10,089	44.18%	6,902	23.86%
California	5,908,461	51.63%	5,067,173	37.40%	2,340,188	15.70%
United States	44,238,593	46.45%	50,148,459	27.17%	31,349,301	13.37%

Data Source: US Census Bureau, American Community Survey. 2018-22.



Mental Health

Mental health is a state of well-being where individuals cope with life's challenges, work productively and contribute to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and social well-being.

Mental health is an important component of overall health and is interdependent with social determinants such as income, education, social support and access to healthcare. Mental health conditions can increase the risk of chronic health conditions such as diabetes, heart disease and stroke. For instance, depression can lead to poor self-care, which exacerbates certain health conditions (National Institute of Mental Health). Inversely, the presence of health conditions can increase the risk for mental illness as individuals with one or more chronic illnesses often experience higher levels of stress and anxiety, which can trigger mental health issues. According to the Substance Abuse and Mental Health Services Administration, 23.1% of U.S. adults (59.3 million) experienced a mental health condition in 2022. Living with a mental health condition can vary in severity, causing distress and negatively affecting personal, social and work life. For some, it can significantly impact their ability to carry out daily obligations.

The growing prevalence of mental health is an issue affecting many community residents. People note a wide variety of factors that contribute to poor mental health, like adverse childhood experiences or poverty. As one key informant noticed, there's a "correlation between struggling with mental illness and then corresponding health issues [...] and that recognition that [it] certainly leads to poorer health outcomes."

Another focus group participant described that "we have this population that has an underlying mental health issue, and then you add drugs and alcohol on top of that." Additionally, 93.08% of Sonora residents live in a Mental Health Professional Shortage Area (HPSA) compared to 27.76% in California, indicating that most people live in areas without sufficient mental health care professionals to meet the community's needs.

Despite increased risk factors, opportunities to address indicators of mental health do exist. Securing more resources and programming, along with sharing existing opportunities, can improve health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/G2UR

Community Resources

California Youth Crisis Hotline
800-843-5200

Crisis, Assessment, & Intervention Program (CAIP)
209-533-7000 or Toll free 800-630-1130

Managing Stress & Depression
calhope.org
833-317-4673 English
833-642-7696 Spanish

Tuolumne County Behavioral Health
tuolumnecounty.ca.gov/220/Behavioral-Health
209-533-6245

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

“…stress we know is one of the most dangerous health risks that we can encounter, especially toxic stress.”

“…Tuolumne County…our demographics have higher [self] harm and suicide rates [than] in the rest of California as well as opioid use…”

“And then they’re leaning into more fentanyl [use] because they’re using drugs just to overcome their depression.”

“…not a lot of access to mental health services…”

“We’ve been aware that depression exists, that anxiety exists. And during Covid, this extreme time of isolation at a point in time where people should have either been graduating college, maybe starting families and doing things, the world stopped for a year for younger generations. There’s not a lot of hope which kind of just perpetuates a lot of depression and anxiety.”

"It’s that trauma that turns you. And I’ve been homeless ever since.”

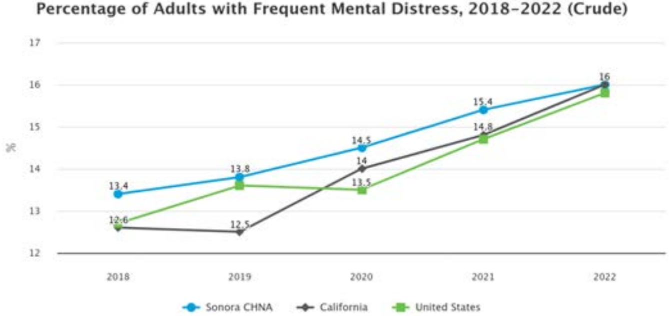
“…I do think there’s a…good correlation between struggling with mental illness and then just corresponding health issues. Our community has done a lot of work around ACES and trauma and that recognition that [it] certainly leads to poorer health outcomes.”

“…one of the biggest concerns that I hear repeatedly… individuals will come into the ED, be deemed appropriate for a 5150 and then there are just no beds in California. So people sit in the ED for three to four days…”

“…and so we have this population that has an underlying mental health issue and then you add drugs and alcohol on top of that.”

“…you could refer someone who’s close to crisis and not get an appointment in town at all, and not [one] out of town for four months.”

“Because what I don’t [want] to have is any more babies being born under bridges or in homeless camps, or 19 year olds dropping dead in the streets or [families] getting killed on the road because the person in the other car was high on fentanyl…It’s something we have to address and we have to take ownership of what our community is going to look like.”



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .
Downloaded from adventisthealth.engagementnetwork.org

Community Health Needs Assessment Full Report

Location

Sonora CHNA

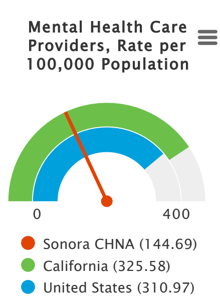
Health Needs: Mental Health

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

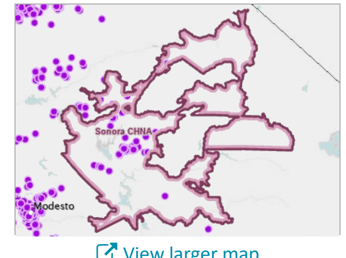
This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, 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 116 mental health providers with a CMS National Provider Identifier (NPI). This represents 144.69 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	80,223	13	116	**144.69**
Alpine County, CA	1,204	2	5	415.28
Calaveras County, CA	45,292	10	69	152.34
Mariposa County, CA	17,131	6	44	256.84
Stanislaus County, CA	552,878	91	1,359	245.80
Tuolumne County, CA	55,620	6	92	165.41
California	39,538,223	12,524	128,730	325.58
United States	334,735,155	140,375	1,040,934	310.97



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). November 2024.



View larger map

Mental Health Providers, CMS NPPES November 2024

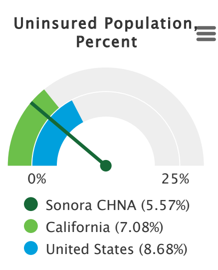
- Mental Health Providers, CMS NPPES November 2024
- Sonora CHNA

Risk Factors - Access to Care - Medical Insurance

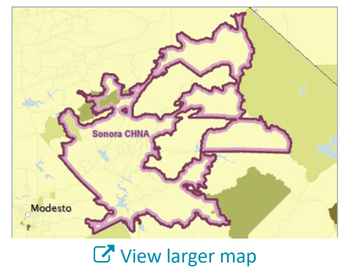
The lack of health insurance is considered a *key driver* of health status.

In the report area 5.57% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 7.08%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Sonora CHNA	75,134	4,187	5.57%
Alpine County, CA	1,515	97	6.40%
Calaveras County, CA	45,341	2,650	5.84%
Mariposa County, CA	16,990	1,228	7.23%
Stanislaus County, CA	549,226	33,408	6.08%
Tuolumne County, CA	52,419	3,146	6.00%
California	38,874,540	2,752,067	7.08%
United States	326,147,510	28,315,092	8.68%

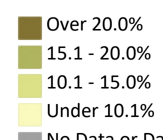


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Uninsured Population, Percent by Tract, ACS 2018-22

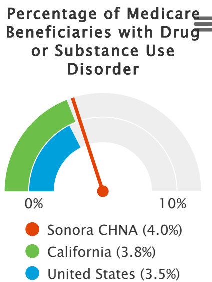


Over 20.0%
15.1 - 20.0%
10.1 - 15.0%
Under 10.1%
No Data or Data Suppressed
Sonora CHNA

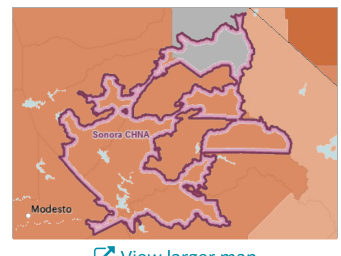
Risk Factors - Drugs & Alcohol - Substance Use Disorder

This indicator reports the percentage of the Medicare Fee-for-Service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program. Within the report area, there are a total of 781 beneficiaries with substance use disorder. This represents a 4.0% of the Medicare Fee-for-Service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Sonora CHNA	19,642	781	4.0%
Alpine County, CA	222	No data	No data
Calaveras County, CA	10,524	381	3.6%
Mariposa County, CA	4,085	155	3.8%
Stanislaus County, CA	39,638	1,570	4.0%
Tuolumne County, CA	13,970	575	4.1%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.



View larger map

Beneficiaries with Drug/Substance Use Disorder, Percent by County, CMS 2018

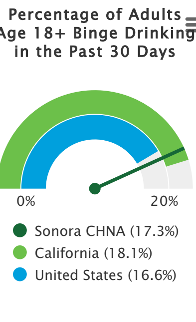
- Over 5.0%
- 3.1 - 5.0%
- 2.1 - 3.0%
- Under 2.1%
- No Data or Data Suppressed
- Sonora CHNA

Risk Factors - Drugs & Alcohol - Binge Drinking

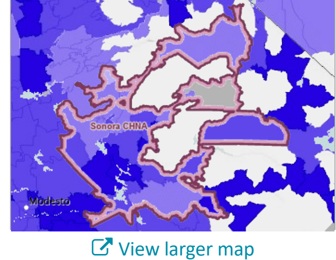
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 17.3% adults age 18+ who reported having four or more drinks in the last month of the total population age 18+.

Report Area	Total Population	Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)
Sonora CHNA	80,185	17.3%	No data
Alpine County, CA	1,190	19.4%	22.4%
Calaveras County, CA	46,563	16.3%	20.6%
Mariposa County, CA	17,020	16.1%	20.7%
Stanislaus County, CA	551,275	19.2%	19.4%
Tuolumne County, CA	54,531	18.5%	22.5%
California	39,029,342	18.1%	18.8%
United States	333,287,557	16.6%	18.0%



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. 2022 .



View larger map

Binge Drinking, Percent of Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

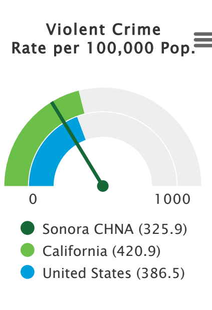
- Over 19.0%
- 16.1 - 19.0%
- 13.1 - 16.0%
- Under 13.1%
- No Data or Data Suppressed
- Sonora CHNA

Risk Factors - Stress & Trauma - Violent Crime Rate

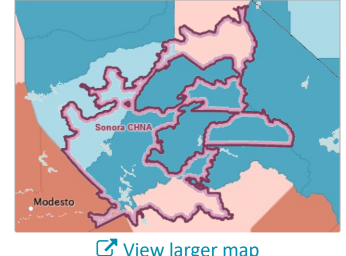
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and 2016 FBI Uniform Crime Reports. This indicator is relevant because it assesses community safety.

In the report area, 253 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 325.9 per 100,000 residents is lower than the statewide rate of 420.9 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50%of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Sonora CHNA	253	325.9
Alpine County, CA	5	442.5
Calaveras County, CA	146	327.2
Mariposa County, CA	76	431.4
Stanislaus County, CA	3,096	578.5
Tuolumne County, CA	169	316.2
California	164,253	420.9
United States	1,240,534	386.5



Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014&2016.



View larger map

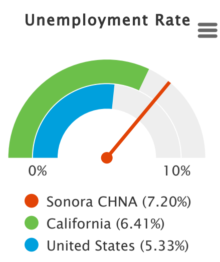
Violent Crime, Rank by County, County Health Rankings 2022

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1
- Sonora CHNA

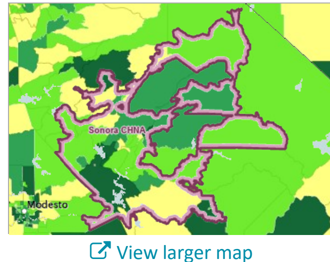
Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 2,525, or 7.20% of the civilian labor force. 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	35,063	2,525	**7.20%**
Alpine County, CA	679	33	4.86%
Calaveras County, CA	18,537	1,150	6.21%
Mariposa County, CA	7,738	482	6.23%
Stanislaus County, CA	258,395	21,061	8.16%
Tuolumne County, CA	22,727	1,895	8.34%
California	20,168,662	1,282,055	6.41%
United States	169,093,585	8,944,003	5.33%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



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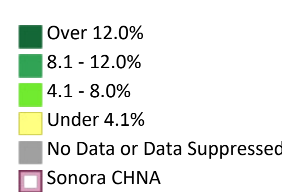
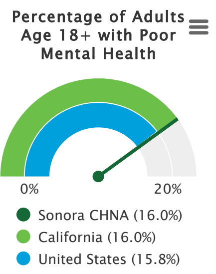


Health Outcomes - Anxiety & Depression - Poor Mental Health

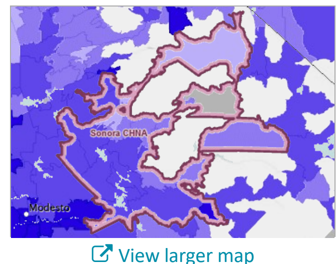
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Within the report area, there were 16.0% of adults 18 and older who reported poor mental health in the past month of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ with Poor Mental Health (Crude)	Adults Age 18+ with Poor Mental Health (Age-Adjusted)
Sonora CHNA	80,185	16.0%	No data
Alpine County, CA	1,190	15.8%	17.7%
Calaveras County, CA	46,563	16.2%	18.9%
Mariposa County, CA	17,020	17.0%	20.0%
Stanislaus County, CA	551,275	17.9%	18.0%
Tuolumne County, CA	54,531	15.7%	18.0%
California	39,029,342	16.0%	16.4%
United States	333,287,557	15.8%	16.4%

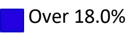


Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



View larger map

Frequent Mental Distress, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022



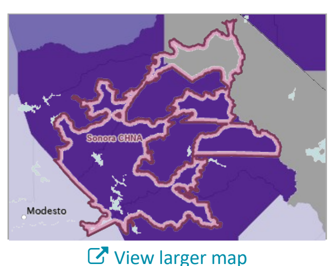
- Over 18.0%
- 16.1 - 18.0%
- 14.1 - 16.0%
- Under 14.1%
- No Data or Data Suppressed
- Sonora CHNA

Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2018-2022 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.
Within the report area, there are a total of 95 deaths due to suicide. This represents a crude death rate of 23.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

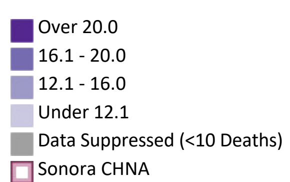
Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Sonora CHNA	79,767	95	23.8
Alpine County, CA	1,155	No data	No data
Calaveras County, CA	46,120	54	23.4
Mariposa County, CA	17,200	25	29.1
Stanislaus County, CA	550,966	315	11.4
Tuolumne County, CA	54,775	65	23.7
California	39,340,905	21,531	10.9
United States	330,014,476	239,493	14.5

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. 2018-2022.



View larger map

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2018-22



Health Outcomes - Deaths of Despair - Deaths of Despair

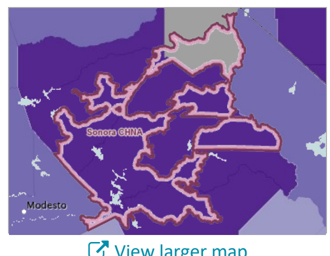
This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data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

Within the report area, there were 302 deaths of despair. This represents a crude death rate of 75.8 per every 100,000 total population.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

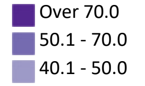
Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Sonora CHNA	79,767	302	75.8
Alpine County, CA	1,155	No data	No data
Calaveras County, CA	46,120	166	72.0
Mariposa County, CA	17,200	75	87.2
Stanislaus County, CA	550,966	1,486	53.9
Tuolumne County, CA	54,775	210	76.7
California	39,340,905	93,948	47.8
United States	330,014,476	922,513	55.9

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. 2018-2022.



View larger map

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2018-22



- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Sonora CHNA

From the **list** of significant health needs, Steering Committee members **identified** the following as high priorities. The remaining lower priority needs were also identified by **Steering Committee** members as important community needs to address.

A. Identified Significant Health Needs

The following lists all significant health needs identified during the 2025 CHNA process. Also included are links to resources related to each health need.

High Priority Needs

Access to Care

tuolumnecounty.ca.gov/295/County-Medical-Services-Program

Only 2.48% of the population lives within one mile of a hospital with an emergency room (U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, 2023), and more than one in four people (27.05%) live in a primary care health professional shortage area (U.S. Department of Health & Human Services, Health Resources and Services Administration, 2024).

Financial Stability

atcaa.org/smart-money

tuolumnecounty.ca.gov/292/Public-Assistance

The median household income is $72,010 compared to California's $91,905 (U.S. Census Bureau, 2022). Focus group participants noted that people are re-entering the workforce from retirement due to high costs of living.

Mental Health

tuolumnecounty.ca.gov/220/Behavioral-Health

In the Sonora service area, 16% of adults self-reported experiencing frequent mental distress (CDC, 2022) and 93.08% of residents live in a Mental Health Professional Shortage Area (HPSA) compared to 27.76% in California (Department of Health & Human Services, Center for Medicare & Medicaid Services, 2024).

Lower Priority Needs

Community Safety

tuolumnecounty.ca.gov/1526/Sheriffs-Office

The school suspension and expulsion rate is 19.91 per 1,000 students compared to a rate of 1.66 per 1,000 students in California (U.S. Department of Education, 2021). Focus group participants noted issues related to public safety and injuries where motor vehicle crash fatality occurs at a rate of 26.78 per 100,000 people compared to 20.9 per 100,000 people in California (U.S. Department of Transportation, 2022).

Health Conditions

tuolumnecounty.ca.gov/295/County-Medical-Services-Program

In the Sonora service area, 30.1% of adults are obese (CDC, 2022), 12.4% of adults have been diagnosed with diabetes (CDC, 2022), 11.5% of adults have been diagnosed with cancer (CDC, 2022), all of which were concerns mentioned by focus group participants and key informants.

Health Risk Behaviors

tuolumnecounty.ca.gov/DocumentCenter/View/8621/Services-Brochure--6-2022?bidId=

6.2% of total Medicare prescriptions are opioid drug claims compared to 3.7% in California (CMS, 2018). Key informants voiced concerns over opioid prescriptions as an issue for many years and focus group participants noted that tobacco and vaping have become widely prevalent. Additionally, 13.6% of adults self-reported as current smokers (CDC, 2022).

Housing

tuolumnecounty.ca.gov/721/Rental-Assistance

atcaa.org/housing

Based on the area median income, 58.68% of income is spent on housing and transportation alone (Partnership for Sustainable Communities, 2019) and focus group participants noted how the middle class struggles to afford the cost of a home or find housing options that fit their needs.

Social & Economic Context

atcaa.org

Key informants and focus group participants noted that living in a rural community brings challenges and voiced the need for more funding, especially among aging populations where 36.95% of adults 65+ live alone (U.S. Census Bureau, 2022), and may have challenges accessing basic needs, including health needs.

Scan QR Code to explore the full live data report or visit: cares.page.link/TtTF

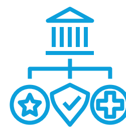
B. Description of Focus Groups & Key Informant Interviews

The CHNA Steering Committee identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations — the voices of those with chronic disease, low income and the underserved were heard. See below for more details regarding focus groups and key informant interviews. Themes and quotes from focus groups and key informant interviews are available in Section III. High Priority Health Needs.

Logistics

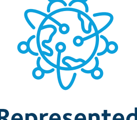
Five (5) focus groups with forty-three (43) people participating. Focus groups were in-person, typically running 90 minutes.

Four (4) key informant interviews. Interviews were conducted virtually, running 60 minutes.



Participating Organizations

- Blue Zones Project - Tuolumne County
- Educators, PS-College
- Food Bank - Amador Tuolumne Community Action Agency
- Nancy's Hope
- Sierra Senior Providers
- Sonora Union High School
- Tuolumne County Health and Human Services
- Tuolumne County Public Health
- Tuolumne County Sheriff's Office
- Workforce Development Board



Represented Race/Ethnicity

- Asian
- American Indian or Native American
- LatinX
- Multi-race
- Native Hawaiian or Pacific Islander
- White

Represented Populations

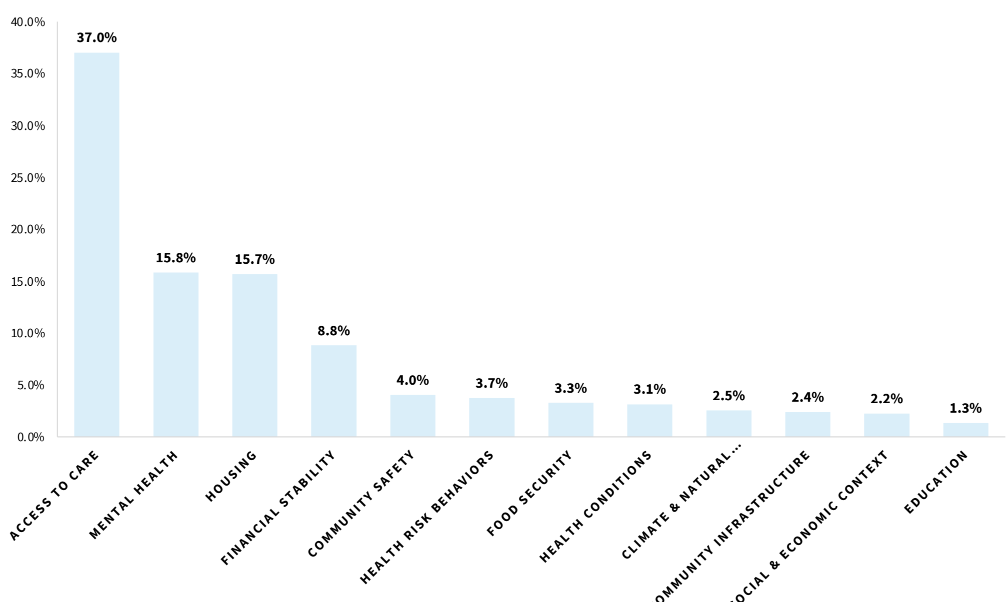
- Healthcare Consumer
- Low-income
- Medically Underserved
- Minority Population
- Older Adults
- Persons with Disability
- Substance Use Disorder
- Unhoused Population
- Youth

C. Focus Groups & Key Informant Interviews Results

The focus group and key informant interview charts below highlight the percentage of mentions for each selected need within the Community Impact Framework. For additional details on focus group and key informant interview methodology, see Section V. Process and Methods to Conduct the CHNA.

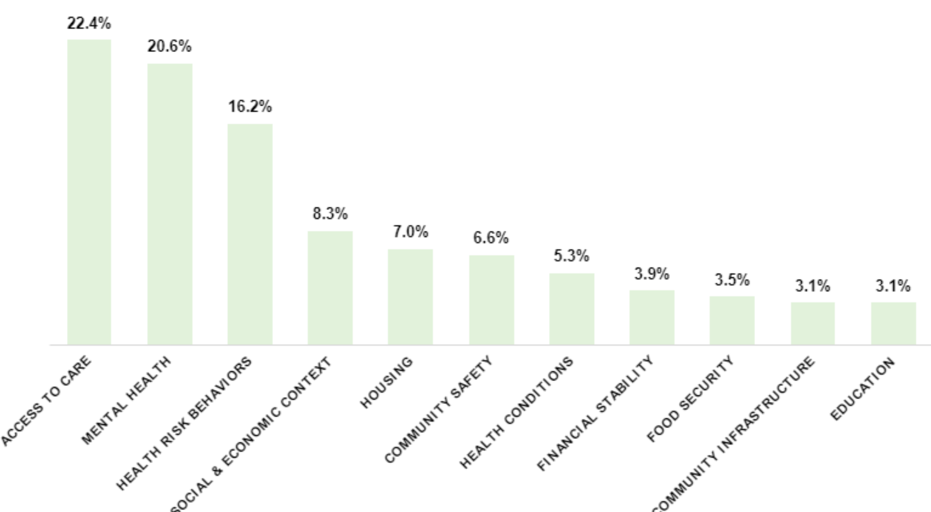
Focus Groups

The following chart details the percentage by which focus group participants mentioned or discussed the 12 categories from our Community Impact Framework.



Key Informant Interviews

The following chart details the percentage by which key informant interviews mentioned or discussed the 12 categories from our Community Impact Framework.



D. Secondary Data Results

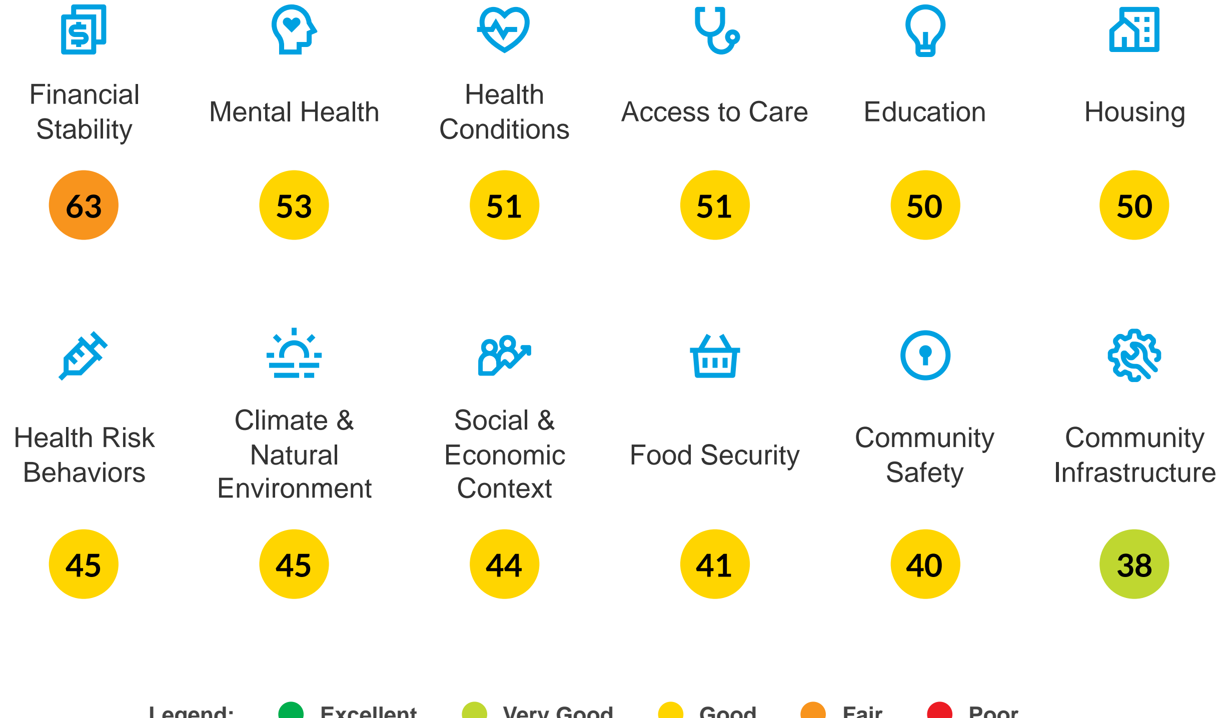
Below are the secondary data results that rank the 12 categories from our Community Impact Framework from 1 to 100. Higher scores have the greatest impact on life expectancy and general health status. For additional information on scoring methodology see Section V. Process and Methods to Conduct the CHNA.

Priority Health Needs

Health needs in Sonora CHNA were determined using quantitative analysis of data. Needs were identified based on their impact on short-term health (well-being) and long-term health (life expectancy), as well as prevalence in the market relative to state benchmarks. Priority areas are scored on a scale of 1 to 100, with higher scores indicating higher health needs.

Adults Age 18+ with Poor or Fair General Health (Crude)
18.9%
California: 18.8%

Life Expectancy at Birth (2010-2015)
79.82
California: 80.32



Legend: Excellent, Very Good, Good, Fair, Poor

E. Survey Results

Community surveys collect data from a broad population to understand real-time perspectives on health and well-being. Survey questions focus on gathering data related to major health issues, life satisfaction, access to medical care and community resources.

Primary Data Surveys

Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?

Step	%
10	9%
9	13%
8	23%
7	22%
6	12%
5	9%
4	5%
3	4%
2	2%
1	1%
0	1%

Would you say that in general your health is

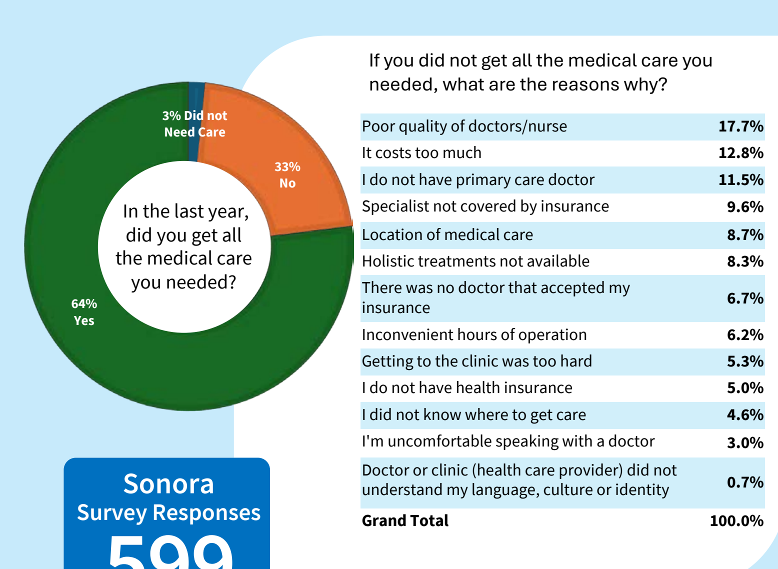
Response	%
Excellent	10%
Very Good	31%
Good	42%
Fair	14%
Poor	3%

Select 3-5 things that you believe make it hard to live and be well in this community.

Item	%
High cost of living	15.5%
Lack of affordable housing	15.1%
High risk for natural disasters (fire, floods, earthquakes)	10.8%
Can't get medical care	10.4%
Lack of safe roads, sidewalks, bike lanes	9.9%
Not enough good jobs	8.7%
Lack of transportation	6.4%
Access to affordable healthy food	6.3%
Racism	4.0%
Limited childcare options	3.9%
No friends or connection to community	2.9%
Limited access to social services for me or my family members	1.9%
Lack of good schools	1.6%
Unsafe community	1.4%
Bad air and/or water quality	1.1%
Grand Total	**100.00%**

Select 1-5 of the biggest health problems you're facing.

Item	%
Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	17.5%
Being overweight	14.4%
Mental Health problems (e.g. extreme sadness, fear, worry, anger or stress)	9.4%
High blood pressure	8.9%
Vision/hearing problems	8.3%
No health problems	7.0%
Teeth problems	6.5%
Poor eating habits	5.7%
Diabetes/Kidney Disease	4.0%
Problems with mobility	3.8%
Asthma/COPD	3.5%
illness that spreads (like flu, COVID, TB)	2.7%
Heart Disease/Stroke	2.1%
Cancer	1.8%
Respiratory/Lung Diseases	1.7%
Alcohol and/or drug misuse	1.2%
Learning problems	0.5%
Mother-Baby care	0.5%
Child/Partner Abuse	0.3%
Sexually Transmitted Disease (STDs)	0.2%
Grand Total	**100.0%**



If you did not get all the medical care you needed, what are the reasons why?

Reason	%
Poor quality of doctors/nurse	17.7%
It costs too much	12.8%
I do not have primary care doctor	11.5%
Specialist not covered by insurance	9.6%
Location of medical care	8.7%
Holistic treatments not available	8.3%
There was no doctor that accepted my insurance	6.7%
Inconvenient hours of operation	6.2%
Getting to the clinic was too hard	5.3%
I do not have health insurance	5.0%
I did not know where to get care	4.6%
I'm uncomfortable speaking with a doctor	3.0%
Doctor or clinic (health care provider) did not understand my language, culture or identity	0.7%
Grand Total	**100.0%**

Sonora
Survey Responses
599

Select the resources that your community needs more of to help you live better.

Resource	%
Healthcare & Prescription Costs	15.0%
Housing Options	14.7%
Utilities/Internet	12.8%
Childcare or Senior Care	12.4%
Parks, Recreation and Outdoor Activities	11.7%
Managing Stress and Depression	10.2%
Social/Community Events	7.6%
Neighborhood Safety	5.5%
Legal Services	3.7%
Personal Safety	3.5%
Local Food Banks	2.9%
Grand Total	**100.0%**

The following pages **reflect** the **process** and **methods** used to **conduct** this CHNA.

V. Process & Methods to Conduct the CHNA

A. Introduction

This Community Health Needs Assessment (CHNA) process aligns with the American Hospital Association Community Health Improvement (i.e. Healthy Communities) guidelines and was designed after an analysis of best practices for CHNAs, as defined by the Centers for Disease Control and Prevention (CDC), Community Commons, and the National Association of County & City Health Officials (NACCHO).

This CHNA was conducted using four distinct sources of primary and secondary data. This mixed methods approach is a preferred practice for needs assessments as it allows for data triangulation, providing the greatest understanding of community needs from the broadest range of perspectives. Having multiple avenues for contributing perspectives has been shown to better include the voices of all community members, particularly vulnerable and disadvantaged groups (Ravaghi et al., 2023).

For this CHNA process, a local Steering Committee was formed to help coordinate the collection of primary data, with an emphasis on incorporating the perspectives of underserved populations. Primary data collection involved focus group interviews, individual key informant interviews and surveys. Secondary data was also collected, involving a review of over 150 metrics from state and national sources which were analyzed to determine factors having the greatest impact on community health. All collected CHNA data was coded and analyzed according to a Community Impact Framework. Framework development, data types, data collection, analysis and prioritization methods are described in the following pages.

B. Community Impact Framework

To organize health findings throughout this CHNA, a multi-tiered Community Impact Framework was used to categorize data into community health needs. To develop the Community Impact Framework, an initial set of 12 conceptual health need areas were identified by reviewing an analysis of past cycle CHNAs, which was conducted by the American Hospital Association, and comparing to existing SDoH frameworks like Well-Being in the Nation (WIN) and Kaiser Family Foundation. After conducting an analysis of appropriate and available public, secondary data to measure each category, a set of sub-categories and subsequent indicators were codified to make up a systematic framework. 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 and Roadmaps
- 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. The final framework consists of more than 150 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022). For a full glossary of terms that include all 12 categories, see Appendix A. Glossary of Terms and Definitions of Health Needs.

Health Needs	Access to Care	Availability - Hospitals & Clinics | Availability - Mental Health Care | Availability - Primary Care | Availability - Specialty Care | Barriers - Health Literacy | Barriers - Medical Insurance | Barriers - Transportation
	Health Conditions	Asthma & COPD | Cancers | Chronic Brain Disorders | Heart Disease & Stroke | Kidney & Liver Diseases | Obesity & Diabetes | Impairments | Preventable Death Health Status | Aging Conditions
	Health Risk Behaviors	Alcohol | Diet & Nutrition | Illicit Drugs | Physical Inactivity | Preventative Care | Reproductive Health | STIs | Tobacco
	Mental Health	Health Outcomes - Anxiety & Depression | Health Outcomes - Deaths of Despair | Risk Factors - Access to Care | Risk Factors - Drugs & Alcohol | Risk Factors - Stress & Trauma
Basic Needs	Food Security	Economic Security | Food Access
	Education	Achievement | Attainment | Early Childhood
	Financial Stability	Employment | Income | Security
	Housing	Homelessness | Housing Costs | Housing Quality
Social Needs	Climate & Natural Environment	Physical Environment - Air & Water | Physical Environment - Heat & Climate
	Community Safety	Injuries | Public Safety | Risk Factors
	Community Infrastructure	Access to Childcare | Community Amenities | Internet & Technology | Transportation
	Social & Economic Context	Civic Engagement | Economic Vitality | Place Attachment | Social Inclusion | Socioeconomic Disadvantage

C. Data Overview: Description, Benefits & Limitations

The below information includes context related to each data source, to aid interpretation of the data included in the following sections.

Description

Key Informant Interviews

Qualitative data from semi-structured conversations with community leaders who possess specialized knowledge about a particular community. Key informants are selected based on their firsthand experience, expertise, or position within a specific community.

Focus Group

Qualitative data from structured, but fluid discussions led by a facilitator with a small group of community members who reside in that local area. Participants are chosen for their ability to represent the needs of underrepresented, underserved, or vulnerable populations within the community.

Survey

Quantitative data collected in real time for this report, representing health concerns and priorities across a broad sample of the community and patients. The survey consists of questions related to health status, health needs and resources available to the community.

Secondary Public Data

Quantitative data previously collected by government agencies, research institutions, or other organizations. This report references a pool of 150 data indicators curated by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES).

Benefits

Key Informant Interviews

- **In-depth Insight:** These interviews are designed to gather in-depth insights, perspectives and expertise that may not be readily available through other sources.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting key informant interviews can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs.

Focus Group

- **Interactive and In-depth Insights:** Community members are encouraged to interact with each other, which provides insights and generates discussion that uncover a range of needs and perspectives. Focus groups encourage participants to build on each other's responses, leading to richer, more detailed insights.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting focus groups can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs. We prioritized engaging underrepresented individuals who face negative socioeconomic or health effects, such as low-income populations, minorities and those with chronic health conditions.

Survey

- **Full Anonymity:** Personally identifiable information is not collected.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.
- **Cost-Effectiveness:** Surveys can be a relatively cost-effective method for reaching a large audience.

Secondary Public Data

- **Public Data:** Data is publicly available and therefore a cost-effective method for assessing health needs.
- **Diverse and Longitudinal Data:** The data includes a diverse set of 150 metrics spanning census data, economic indicators, and health statistics and publicly released survey results, allowing for the ability to conduct comparative analyses over time.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.

Limitations

Key Informant Interviews

- **Subjectivity and Perspective Bias:** Key informants who volunteer to participate may have their own biases or limited perspectives, which can shape their responses.
- **Limited Generalizability:** Informants may lack generalizability to the broader community since informants are selected based on involvement in specific area.

Focus Group

- **Limited Generalizability:** Findings from focus groups may not be broadly representative of the entire community due to the small sample size of volunteers.
- **Social Desirability Bias:** Participants may provide responses that they perceive as socially desirable or acceptable in a group setting, rather than fully disclosing less favorable or controversial information.

Survey

- **Sampling Bias:** Community members who choose to complete the survey may have their own biases or limited perspectives, which can shape their responses.
- **Distribution and Data Collection:** Surveys distributed digitally used a global online translation service, which may present challenges with the quality of understanding cultural nuances and word-for-word translation. Surveys were also distributed in paper form to local organizations who entered results from their constituents, which could affect the accuracy of the information collected.
- **Limited Depth of Responses:** Limited opportunity for participants to elaborate on their answers or provide context can result in responses that do not fully capture the complexities of health barriers.

Secondary Public Data

- **Timeliness:** The most recent public data that met our criteria (available across multiple states and, when possible, at the zip code level) was referenced. However, public data may not always be up-to-date or reflect real-time information.

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D. Focus Group & Key Informant Interview Methodology

Primary data collection was designed to gather first-person input on community health needs directly from community members. From May 2024 – November 2024, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides used for both types of interviews were nearly identical. The only variation between the focus group and key informant interview guides was the inclusion of additional prompting questions allowing for key informants to provide a greater depth of response.

The facilitators were a team of Adventist Health system staff who began all focus groups and key informant interviews by having participants identify up to five high priority community health needs from their perspective based on a social determinants of health framework with priority areas and subcategories. The facilitators then moved through a series of questions, focusing on depth of need, barriers, attempts at addressing the need historically, ways that different groups are affected and recent, emerging trends. Focus groups and key informant interviews were conducted in teams of two, with a lead facilitator and a notetaker, and all interviews were recorded. All focus groups were conducted in English or Spanish, with translation services provided as needed. Focus groups and key informant interviews were recorded with the consent of participating interviewees. All recordings were transcribed into English. In the spirit of collaboration, transcripts were shared with other non-profit hospitals within the same service area. To ensure the anonymity of participants was protected, all shared transcripts removed participant names. Remarks that detracted from the scope pertaining to community health needs were also removed.

E. Survey Methodology

A community survey was distributed as a primary data tool to gather real-time, quantitative data about the community's greatest health needs. To reflect the entire community, questions were designed to solicit responses at the individual, interpersonal and community levels. The selection process and criteria for the survey questions involved a rigorous review of other health systems' CHNAs, reputable government organizations such as the National Association of County and City Health Officials (NACCHO), the Centers for Medicare and Medicaid Services (CMS) Health-Related Social Needs Screening Tool, Healthy People 2030, and the Centers for Disease Control and Prevention (CDC). Additionally, the survey design was informed by interviewing techniques, collaboration with Steering Committee members from our previous CHNA cycle, a review of community health improvement toolkits, and the availability of state and national benchmarks.

The community survey comprised seven questions and took approximately five minutes to complete. To ensure accessibility, the questions were written at a fifth-grade reading level and translated into four languages using a global online translation service. The survey was distributed both in paper form and digitally via link, email, text, and QR code. Participation was voluntary, and responses were kept confidential. To maximize reach within the service area, the survey was shared with Steering Committee members, who then distributed it among their stakeholders, community-based organizations that volunteered to share it with their constituents, and patients at Adventist Health hospitals. For the full list of survey questions, see Appendix C.

F. Secondary Data Methodology

Basic Approach

Secondary data scoring comprised development of health needs index scores for each of the 12 categories included in the Community Impact framework. These index scores were determined using quantitative analysis of all secondary data referenced. 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 that best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to life expectancy and quality of life. 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.

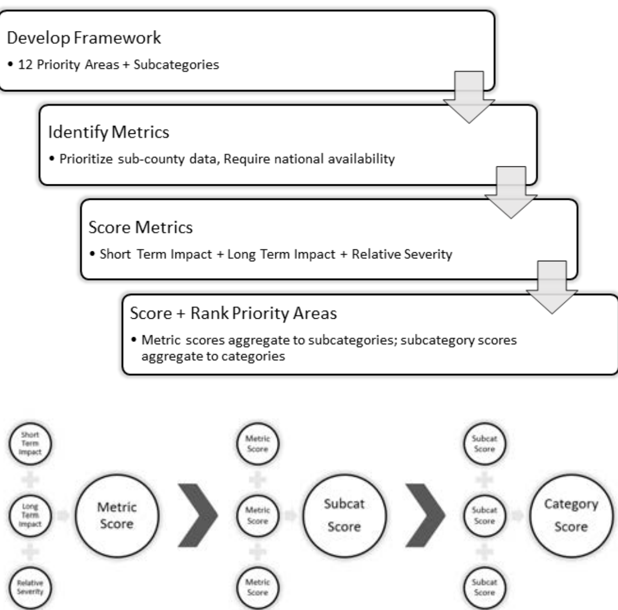

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

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 status) and a long-term goal (length of life, measured by life expectancy at birth).

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

To address the third criterion, 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.

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 that perform better than average for a metric will see scores adjusted down (lower priority), and communities that 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.

$SubC_c = \Sigma_c SubC/n$
$Cat_c = \Sigma SubC/n$

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 one 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.

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 a major driver 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 remain limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data 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. Work found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or U.S. 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 (summer 2024), the latest available data on health behaviors, outcomes, and social determinants represented the 2021 and 2022 calendar years, 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. Moreover, we incorporate a mix of other data sources to mitigate the data lag variance to take a standardized approach important for a mixed-methodology analysis.

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G. Data Analysis & Identification of Significant Health Needs

This CHNA deployed a mixed methodology combining the strengths of analyzing primary data with secondary data results. As demonstrated in steps two-four below, several actions were taken to analyze data and produce a list of significant health needs.

Preparation & Data Collection: Adventist Health staff, CARES team and CHNA Steering Committee

STEP 1: FRAMEWORK & CODEBOOK CREATION

- Map focus group and key informant interview questions to framework and codebook.
- Map secondary data indicators to framework.

STEP 2: DATA COLLECTION

- Primary Data: focus groups, key informant interviews and survey.
- Secondary Data: 150 indicators.

Data Analysis & Identification of Significant Health Needs: Adventist Health system staff and CARES team

STEP 3: AGGREGATION

- Code focus group and key informant interview groups to framework.
- Aggregate survey results per community.
- Score Secondary Data Index.

STEP 4: SYNTHESIS

- Identify list of Significant Health Needs based on:
  - Health need identified as top five across any data sources.
  - Health need is identified in two or more data sources.

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

- Rank “high” and “low” Priority Health Needs based on prioritization criteria.

Data Collection to Aggregation

After primary data collection, Adventist Health staff conducted a deductive coding of all focus group and key informant interview data to the Community Impact framework. Secondary public data was analyzed and index scores were created for ranking, according to the methodology outlined in Section V. Process and Methods to Conduct the CHNA.

To facilitate this coding process for focus groups and key informant interviews, as described in Step 3 of the infographic above, focus group and key informant interview transcript files were uploaded to a Microsoft AI coding solution, along with the Community Impact framework as the reference table. To generate an output, Adventist Health staff provided a written prompt to the AI solution:

You are an AI assistant tasked with analyzing and classifying provided conversational text from interviews conducted with community members regarding what they see as the top health needs in their community. The topics are related to Public Health and Social Determinants of Health (SDOH).

*Each piece of text (or excerpt) relevant to a public health need and/or social determinants of health should be classified into **all applicable** provided SDOH categories, at either the “subcategory” or “codename” levels using the following SDOH reference table: {reference table}.*

For each input text, your goal is:

*1. Identify **all relevant** (either directly or implied) SDOH-related excerpts from the provided text, based on the reference table. Use the excerpt examples, Subcategory and/or Codename Description, and code names from the SDOH reference table to assist in identifying which excerpts are relevant.*

2. Classify the excerpt under the appropriate SDOH categories. Include the entire excerpt text with accompanying context to illustrate how it corresponds with each classified category. If an excerpt cannot be coded to the code and codename level based on the reference table, use the most appropriate subcategory and leave code and codename blank. Excerpts must have two or more sentences. Excerpts must be relevant (direct or implied) to the current health needs/problems in the speaker's community.

*3. **For each classification, assign a confidence score between 0 and 1, where 1 indicates the highest confidence.***

The output was a CSV file with a list of excerpts that were coded to the category and subcategory levels of the Community Impact framework. These category and subcategory references were counted, and a percentage of excerpts coded to each category was generated to establish a ranking of top health need categories for focus groups and key informant interviews.

Data Synthesis and Identification of Significant Health Needs

Staff conducted axial coding by drawing connections between the top health needs across focus groups, key informant interviews and secondary public data. Adventist Health system staff produced a list of significant health needs and presented findings to CHNA Steering Committee, based on the following criteria:

- The health need comes up as a top five for at least one data source.
- The health need is referenced across at least two data sources.
- The health need as represented in the Community Impact framework corresponds with two or more secondary data indicators that perform worse than the CA state benchmark.

In addition to the list of significant health needs and the supporting data from axial coding of focus groups, key informant interviews and secondary public data, survey data was provided to CHNA Steering Committee for evaluation and corroboration before prioritization of significant health needs.

H. Criteria & Process Used for Identification & Prioritization of Health Need

Prioritized Criteria

The local Steering Committee was responsible for identifying and prioritizing the community health needs included in the CHNA. Steering Committee members are community stakeholders who lead and represent sectors such as local government, community-based organizations, health and human services, schools, public health and others. To facilitate the process of prioritizing health needs, Adventist Health system staff led a series of meetings held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

Prioritization Process and Selection of High Priority Needs

Following the identification of significant health needs through the analysis process, Adventist Health system staff conducted a 90-minute presentation to the Steering Committee, revealing primary and secondary data findings that led to the identification of these needs. During the presentation, staff emphasized the top five needs from each data source and the supporting data that justified their inclusion. After the data reveal meeting, Steering Committee members were provided with three prioritization tools, the presentation slides, and a secondary data report for review and discussion with organizational leadership. Additionally, members participated in a poll to identify the three to five needs they considered most critical, utilizing relevant local data sources as available.

The second part of the series involved a prioritization meeting aimed at building consensus around the community health needs identified as most critical by Steering Committee members. Steering Committee members, along with their staff, boards, and constituencies, reviewed and discussed the top five needs from each data source. They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, alignment with common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. The meeting concluded with committee members prioritizing the list of significant identified needs, typically selecting two to four as high-priority. See Appendix D for prioritization tools used.

I. Written Comments for 2025 CHNA

We value your input on 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.

J. CHNA Team Used to Conduct the Assessment

The Adventist Health Community Impact Team coordinates Community Health Needs Assessments for many of the communities we serve. The Community Impact Team convened community experts within each service area's steering committee, coordinated and/or conducted primary data collection, facilitated analysis, and wrote the report content. Team members listed below have diverse and relevant experience in healthcare, philanthropy, government, Medicaid managed care and quality improvement, public health, community health and community benefit reporting. Those team members include:

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

Additionally, Adventist Health system staff supported the data collection and analysis portion of the report:

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

Aldreen Venzon, Ph.D, MS, RN
Sr. Performance Analyst (System)

Cambria Wheeler
Director, Brand Engagement

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, 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 United States, 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 has background 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, CARES holds expertise in project management, user training and support, data documentation and client design sessions that directly supports a wide variety of projects.

Angela Johnson, MPH
Assistant Director,
University of Missouri CARES
(johnsonange@missouri.edu)

Zhengting He, MPA
Research Program Analyst,
University of Missouri CARES
(hezhen@missouri.edu)

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

You’re made for **more**. We’re here to help put **more** life in your **years**.

VI. APPROVAL PAGE

This Community Health Needs Assessment was adopted on September 18, 2025 by the Adventist Health System/West Board of Directors. The final report was made widely available to the public on December 31, 2025.

Thank you for reviewing our 2025 Community Health Needs Assessment. We are proud to serve our local community and are committed to making it a healthier place for all.

Greg McCulloch
President
1000 Greenley Road, Sonora, CA 95370

Appendix:

A. Glossary of Terms & Definitions of Health Needs

In 2020, Adventist Health analyzed the top priorities from 2019 CHNAs across all hospitals, compared these priorities against language from CHNAs across the country, and created a set of standard nomenclature categories to promote common language, referred elsewhere in this report as "Community Impact Framework". Below is a list of these categories, organized according to this framework, with the accompanying definitions. These categories and definitions are drafted based on context summarized from public health literature, community CHNAs, and national and multi-national healthcare organizations. Sources for definitions are listed below.

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, as well as the accessibility of these services to all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

Context/Source

Healthy People 2030. "Health Care Access and Quality"

World Health Organization (WHO). "Access to Care and Financial Protection"

Agency for Healthcare Research and Quality (AHRQ). "Access to Health Care"

Climate & Natural Environment

Climate and natural environment refers to the weather patterns, ecosystems and environmental conditions that impact the health of a community. This includes factors such as air and water quality, temperature extremes, green spaces and the frequency of natural disasters. These environmental elements shape health outcomes directly by influencing respiratory health, heat-related illnesses and exposure to pollutants, and indirectly through their effects on food security, housing stability and economic opportunities, all of which are crucial social determinants of health.

Climate change and environmental degradation can exacerbate existing health disparities, disproportionately affecting low-income communities and communities of color. Public health strategies aimed at addressing climate and environmental challenges focus on building climate resilience, reducing exposure to environmental hazards, and ensuring equitable access to resources like clean air, water and green spaces. By mitigating these environmental health risks and prioritizing sustainable practices, communities can improve both immediate health outcomes and long-term resilience in the face of climate-related impacts.

Context/Source

World Health Organization. "Climate"

National Institute of Environmental Health Sciences. "Climate Change and Human Health"

Centers for Disease Control and Prevention (CDC). "Climate and Health"

Community Infrastructure

Community infrastructure refers to the physical and organizational structures that support and enhance the health, safety and well-being of residents. This includes essential elements that people rely on every day such as transportation systems, internet access, healthcare facilities, schools, parks and water and sanitation systems. When community infrastructure is accessible, safe, and well-maintained, it supports healthier living conditions, reduces health disparities and promotes social determinants of health, such as stable housing, employment opportunities and environmental quality.

Community infrastructure is a foundation for equitable access to services and resources for a healthy lifestyle and to prevent disease. Investments in infrastructure that prioritize public health — like creating walkable neighborhoods, expanding green spaces and ensuring clean drinking water — can reduce chronic illnesses, improve mental health and enhance social connections within a community.

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

American Public Health Association. "Strengthen Public Health Infrastructure and Capacity"

Community Safety

In public health, community safety refers to the protection and well-being of individuals in a community, reducing exposure to violence, crime, environmental hazards and other risks that impact physical and mental health. Within CHNAs, community safety is examined as a determinant of health, affecting overall quality of life and contributing to disparities in health outcomes. Ensuring community safety is seen as essential for fostering environments where individuals can thrive without fear of harm. Community safety includes violence prevention, traffic safety, safe public spaces and youth engagement.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Violence Prevention"

Centers for Disease Control and Prevention (CDC). "About The Public Health Approach to Violence Prevention"

Education

Education refers to the access to quality learning opportunities that shape individuals' knowledge, skills and abilities, impacting their health and well-being. Education is a key social determinant of health because it influences health behaviors, employment opportunities and economic stability. Higher levels of education are associated with better health outcomes, including lower rates of chronic diseases, longer life expectancy and improved mental health. The link between education and health is also seen in the ability to access and understand healthcare information, which can affect decisions about diet, physical activity and preventive care.

Context/Source

American Public Health Association. "Education Health"

Centers for Disease Control and Prevention (CDC). "Education Access and Quality"

Robert Wood Johnson Foundation. "Why Education Matters to Health"

Financial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food and maintain safe living conditions. Financial instability and poverty are linked to higher rates of chronic disease, mental health issues and reduced life expectancy due to limited access to health resources and higher exposure to stressors.

Context/Source

Centers for Disease Control and Prevention (CDC). "Economic Stability"

Food Security

Food security refers to consistent access to sufficient, safe, and nutritious food that meets the dietary needs necessary for a healthy life. Access to healthy food is fundamental to preventing malnutrition, obesity and chronic diseases such as diabetes and heart disease. When individuals and families have reliable access to affordable, nutritious food, their overall health outcomes and quality of life improve significantly.

Food insecurity, or lack of reliable access to adequate food, disproportionately impacts low-income communities and contributes to health disparities. Public health efforts to improve food security often involve enhancing access to grocery stores, farmers' markets and community gardens, as well as supporting programs like the Supplemental Nutrition Assistance Program (SNAP). By addressing Food Security, public health initiatives aim to reduce health inequities, support economic stability and foster healthier communities.

Context/Source

World Health Organization. "Food Safety"

Centers for Disease Control and Prevention (CDC). "Diabetes and Food Insecurity"

American Public Health Association. "Food and Nutrition"

Health Conditions

Chronic health conditions are defined as long-lasting illnesses that persist for at least one year and require ongoing medical attention, lifestyle adjustments, or both. These conditions include heart disease, diabetes, cancer and chronic respiratory diseases, which are among the leading causes of death and disability worldwide. In the context of CHNAs, identifying and addressing chronic health conditions is crucial for understanding the health status of a population and guiding targeted interventions. Communities with the highest prevalence of chronic health conditions also typically face social, economic and environmental barriers that challenge prevention and management of the chronic condition, requiring interventions that focus on the complex interplay of behavioral and environmental factors described in this framework.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Chronic Diseases"

World Health Organization (WHO). "Noncommunicable Diseases"

Centers for Disease Control and Prevention (CDC). "Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area"

Health Risk Behaviors

Health risk behaviors are actions that increase the likelihood of adverse health outcomes, such as chronic disease, injury or premature death. Common examples include tobacco use, excessive alcohol consumption, physical inactivity, poor diet and risky sexual behaviors. These behaviors are significant focus areas for public health interventions because they are preventable and have broad implications for community health costs, healthcare systems and individual well-being. By identifying and targeting health risk behaviors, public health professionals aim to reduce the prevalence of diseases like heart disease, diabetes and certain cancers, promoting healthier, longer lives for populations.

For CHNAs, health risk behaviors are viewed within the context of social determinants of health, like access to resources, socioeconomic status and educational opportunities. Addressing these behaviors involves considering the social and environmental factors that make certain populations more vulnerable, such as limited access to healthy foods or safe recreational spaces. Community health approaches often implement evidence-based interventions that are culturally tailored and community-specific, recognizing that sustainable behavior change requires supportive environments and policies that mitigate risk factors and empower communities to adopt healthier lifestyles.

Context/Source

Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System (BRFSS)"

Centers for Disease Control and Prevention (CDC). "Health Risk Behaviors Measure Definitions PLACES: Local Data for Better Health

Centers for Disease Control and Prevention (CDC). "Sexual Risk Behaviors"

Housing

Housing refers to the availability, affordability, quality and stability of living environments. Safe, stable and affordable housing directly influences health outcomes by providing protection from physical hazards, reducing stress and enabling access to essential services. Poor housing conditions, such as overcrowding, exposure to pollutants and inadequate heating or cooling can lead to respiratory illnesses, injury risks and worsened mental health, especially among vulnerable populations.

Housing instability, including frequent moves, homelessness and the risk of eviction, contributes to health disparities by limiting access to consistent healthcare, educational opportunities and community resources.

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

American Public Health Association. "Housing and Homelessness as a Public Health Issue"

Centers for Disease Control and Prevention (CDC). "Homelessness and Health"

Mental Health

Mental health, within public health and community health frameworks, is understood as a state of well-being in which individuals can cope with life's challenges, work productively, and contribute meaningfully to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and fulfilling social connections. In public health, mental health is integral to overall health and is recognized as a critical factor influencing quality of life and socio-economic productivity, with both individual and social implications.

In the context of CHNAs, mental health is seen as interdependent with social determinants like income, education, social support, and access to healthcare. Health equity approaches prioritize the mental health of underserved communities, focusing on reducing stigma, expanding culturally appropriate services and advocating for policies that remove barriers to mental health resources. This framework recognizes that improving mental health outcomes requires collective action, community engagement and tailored support strategies that reflect the unique needs and values of diverse communities.

Context/Source

World Health Organization (WHO). "Mental Health"

Centers for Disease Control and Prevention (CDC). "Mental Health"

Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Wellness"

Social & Economic Context

Social and economic context in this report refers to specific social and economic aspects of an environment that can influence health and well-being of a population-place attachment, civic engagement, social inclusion, and economic vitality. Economic stability and supportive social conditions promote healthier lifestyles, reduce stress and improve access to healthcare, positively impacting health outcomes for individuals and communities.

Social and economic contexts are closely linked to health disparities, as individuals from lower-income or underserved backgrounds often face barriers to achieving home ownership, contributing to economic health, and participating in activities which support social inclusion.

Context/Source

Centers for Disease Control and Prevention (CDC). "Social Determinants of Health (SDOH)"

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

- We're going to do a brief exercise to start that will tell us the biggest problems you see related to your and your community's health needs.
  - Then we'll ask you questions about those problems.
  - As you look around the room you'll see three (3) posters on the wall.
  - They show photos of common problems people face, many of them related to health.
  - Please take a few minutes to vote using the five (5) 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.
- You can't use all your stickers under one photo but you can use them all in one poster.
- Which of these things causes the most problems for you or others who live here?
- We're interested in learning about things that make it hard for you, 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.
  - We'll give you 10 minutes to walk around.

Tallying, Engaging & Asking Questions:

- For focus groups, visually tally the votes and clearly call out the top five issues that were identified for the note-taker and audience to hear.
- Spend around 15 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same "Prompting Questions" for each of the five identified issues.

ACTIVITY EXPLANATION – Key Informant Interviews

- 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.
  - Here are some photos of common problems people face, many of them related to health.
  - Please take a few minutes to select five (5) problems that you think are the biggest difficulties in your community.
- We're interested in learning about things that make it hard for your organization to provide services and/or for your constituency 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.
  - We'll give you a few minutes to make your selection.

Engaging & Asking Questions:

- Spend around 10 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same Prompting Questions for each of the five identified issues.

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

1. Why do you see ___as a problem that's related to your family/community's health?
2. What do you think creates this issue?
3. How do you see the problem affecting your local friends, family or neighbors?

   Who is most affected by this?
4. What have people tried to do to address this problem? What has worked?

   What are the biggest barriers for _______ (policy/program)?

   What makes it hard to fix this problem in your community?
5. What has changed around this concern in the last 2 – 3 years?

   Are there any new emerging trends or areas of concern in the last few years?
6. If this problem got better, how would your community look different?

Closing question:

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

Conclusion:

- Thank you 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 that will summarize what we found, and that many people in your community will take action on.
    - If you would like us to send you a text or email with a link to that report, just provide us with your information.

Focus Groups Only: As a Thank you to you all we have a gift card for you as you leave.

C. Survey Questions:

1. **Would you say that in general your health is:**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

2. **Select 3 – 5 things that you believe make it hard to live and be well in this community.**
   - Can't get medical care
   - Not enough good jobs
   - Lack of affordable housing
   - Lack of good schools
   - Access to affordable healthy food
   - High cost of living
   - Unsafe community
   - Bad air and/or water quality
   - No friends or connection to community
   - High risk for natural disasters (fire, floods, earthquakes)
   - Lack of transportation
   - Lack of safe roads, sidewalks, bike lanes
   - Limited childcare options
   - Limited access to social services for me or my family members
   - Racism

3. **Select up to 5 of the biggest health problems you're facing.**
   - Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)
   - Alcohol and/or drug misuse
   - Asthma/COPD
   - Being overweight
   - Cancer
   - Child/Partner abuse
   - Diabetes/Kidney disease
   - Heart disease/Stroke
   - High blood pressure
   - Learning problems
   - Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)
   - Mother-baby care
   - Problems with mobility
   - Poor eating habits
   - Respiratory/Lung disease
   - Sexually transmitted diseases (STDs)
   - Dental problems
   - Vision/Hearing problems
   - No health problems

4. **Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?**
   - 10 (I'm living my best possible life)
   - 9
   - 8
   - 7
   - 6
   - 5
   - 4
   - 3
   - 2
   - 1
   - 0 (I'm living my worst possible life)

5. **In the last year, did you get all the medical care you needed?**
   - Yes
   - No
   - Did not need care

5b. **If you did not get all the medical care you needed, what do you think are the reasons why?**
   Check all that apply.
   - Doctor or clinic (healthcare provider) did not understand my language, culture or identity
   - I'm uncomfortable speaking with a doctor
   - I do not have health insurance
   - I do not have a primary care doctor
   - There was no doctor that accepted my insurance
   - I did not know where to get care
   - Getting to the clinic was too hard
   - It costs too much
   - Inconvenient hours of operation
   - Location of medical care
   - Holistic treatments not available
   - Specialists not covered by insurance
   - Poor quality of doctors/nurses

6. **Select the resources that your community needs more of to help you live better.**
   - Childcare or senior care
   - Healthcare and prescription costs
   - Housing options
   - Legal services
   - Local food banks
   - Managing stress and depression
   - Neighborhood safety
   - Parks, recreation and outdoor activities
   - Personal safety
   - Social/Community events
   - Utilities/Internet

7. **Please enter your zip code, if you don't want to share your zip code, enter 00000.**

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

Addressing the health needs of community members is complex and often requires more than one approach with coordination across multiple sectors.

Based on the primary and secondary data presented select 3 to 5 health needs that you see as needing to be addressed.

Write the name of the need at the top, use the questions to the left to evaluate side-by-side the current resources, political will, infrastructure and shared goals/focus of each need.

Use your findings to identify the needs that, through collaboration, can be thoughtfully and intentionally addressed by multiple community sector partners.

PRIORITY NEEDS COMPARISON	1		2		3		4		5		6		7	
OPERATIONS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Would tracked and shared progress/ data benefit multiple organizations and programs?														
Potentially, could there be 'quick wins' through collaboration and partnerships?														
Is there political willingness to act on this need?														
COMMUNITY PARTNERS/RESOURCES/ ASSETS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there existing organizations/ programs addressing all or parts of this need?														
Do CBOs' goals/strategic plans list this need as an area of focus?														
Is there community willingness to act on this need?														
FINANCE	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Does this need have government/public funding streams available for those applying collaboratively?														
Are there current grants that could support some or all of this need?														
Does this need meet the vision/ mission of established government or philanthropic partners?														
EQUITY	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there organizations/programs focused on addressing this need with safety-net, low-income and minority populations?														
Will everyone in the community equally benefit from this need being addressed?														
Would addressing this need lessen absenteeism at work/school for everyone?														
TOTAL YES RESPONSES														

2. Questions to Consider

Do we have any unifying objectives/goals?

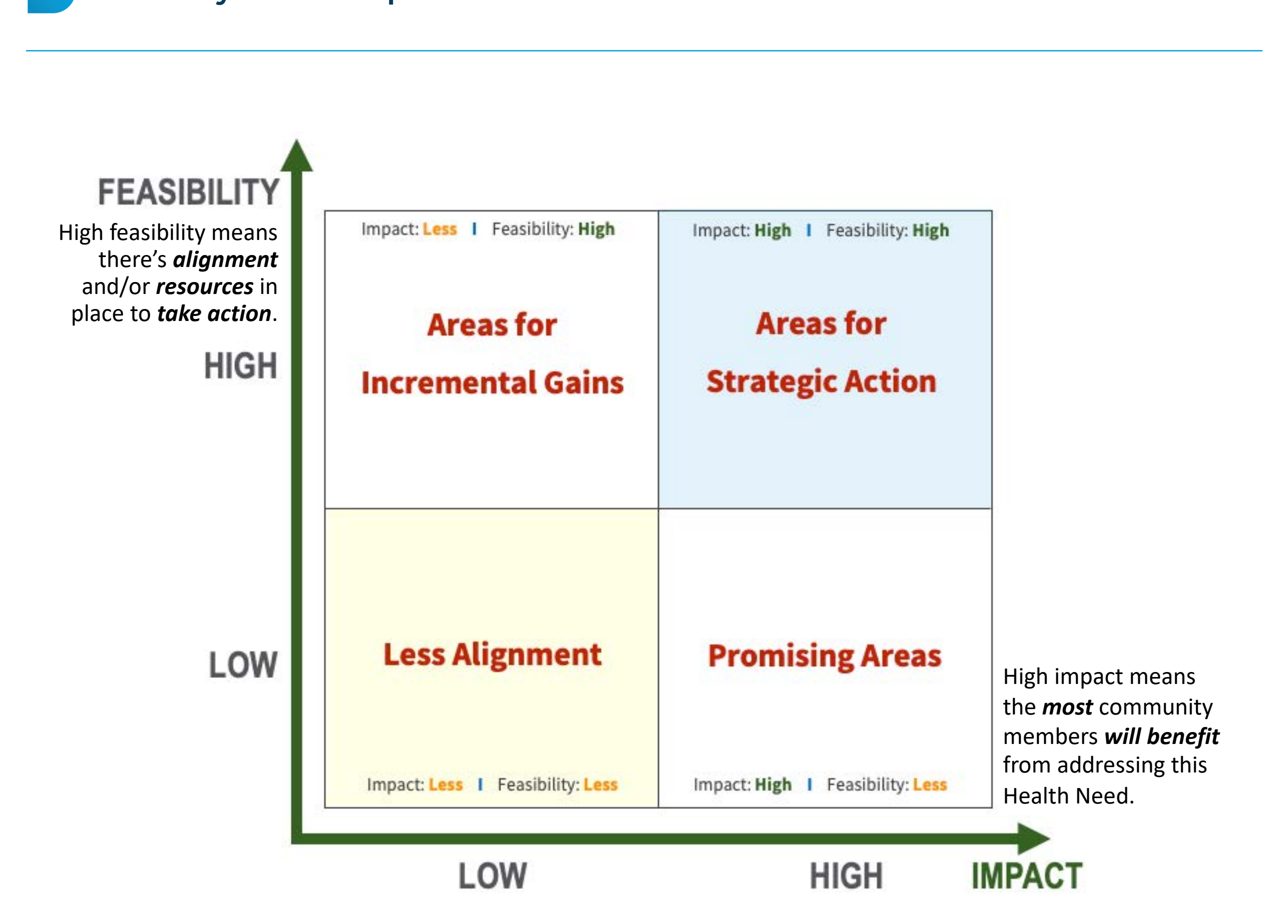
What does immediate success look like (1 - 3yrs)?

Is there available funding from grants or Quality Improvement Incentives (Payer) opportunities?

Would addressing this need free up resources for other community-wide needs?

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison



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