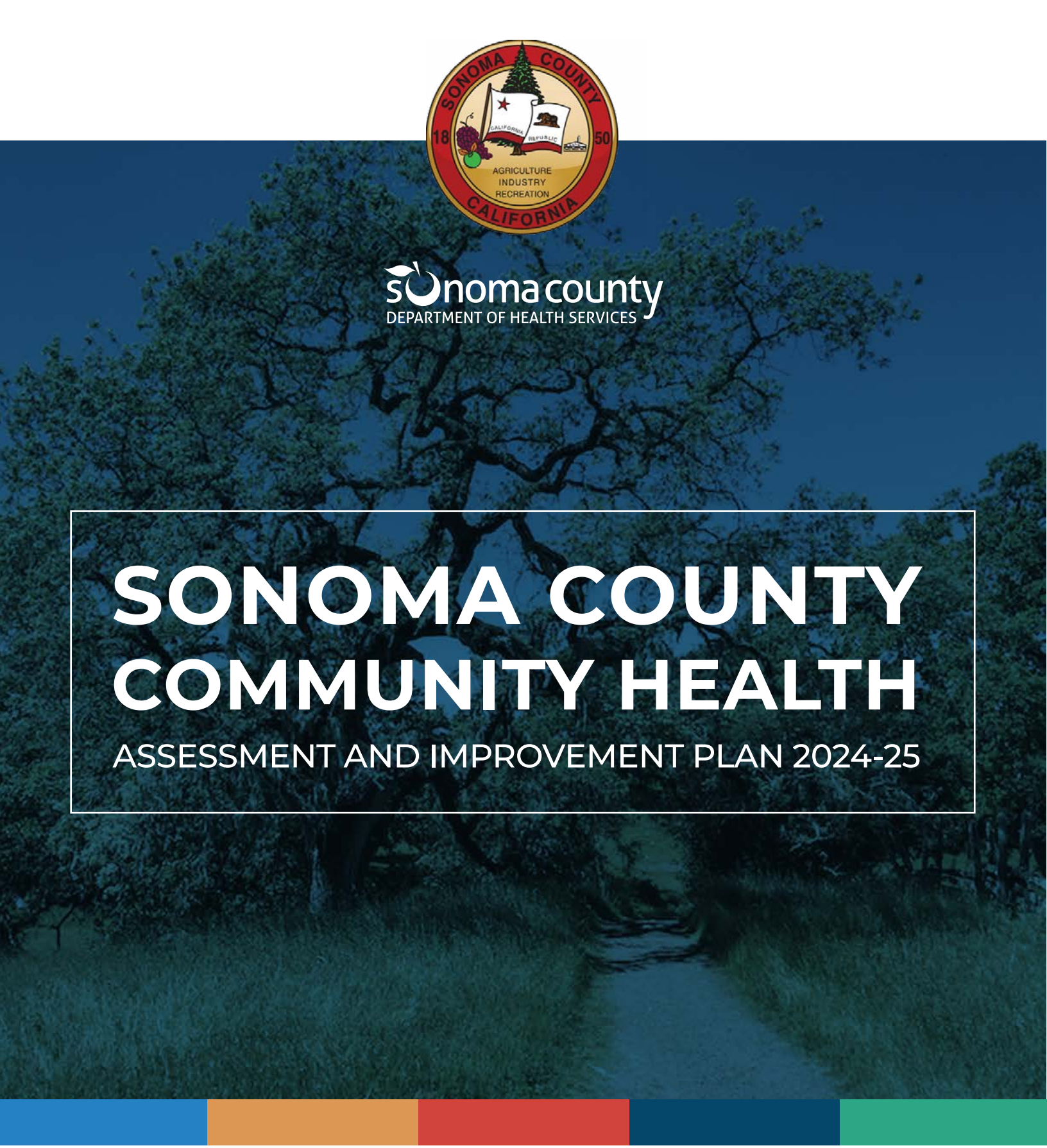

sonoma county
DEPARTMENT OF HEALTH SERVICES

SONOMA COUNTY COMMUNITY HEALTH

ASSESSMENT AND IMPROVEMENT PLAN 2024-25

FINAL

Prepared in partnership with
Applied Survey Research

CONTENTS

AT A GLANCE

SONOMA COUNTY'S COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) provide an opportunity to survey Sonoma County's strengths and challenges and create a plan to strategically address people's most pressing needs. The CHA and CHIP represent an ongoing and evolving evaluation process for the Sonoma County Department of Health Services (DHS). A documented community health assessment and improvement plan are required by California's Future of Public Health grant and Public Health Accreditation.

Two frameworks informed the health indicators that DHS focused on in the primary and secondary data collection and analyses: the Bay Area Regional Health Inequities Initiative (BARHII) framework and the life course approach. The BARHII framework illustrates and underscores the connections between structural racism, inequities within the social drivers of health, and downstream health outcomes and mortality. The life course approach is a theoretical structure in public health that considers the critical stages, transitions, and settings in people's lives where significant differences can be made in promoting or restoring health and well-being. DHS engaged internal and external partners for primary and secondary data collection and prioritization of community health needs and strategies. The efforts from this process resulted in the following sets of assets and challenges, grouped by domains of significant health factors. The priority health needs elevated in the health assessment were then operationalized by stakeholders and partners into four areas of focus for the community health improvement plan.

COMMUNITY HEALTH ASSESSMENT: ASSETS AND CHALLENGES

PHYSICAL ENVIRONMENT

PRIORITY 1: CLIMATE CHANGE

- ⊕ Community members have more access to green space and opportunities to exercise than most other counties in the State.
- ⊖ Sonoma County has the greatest projected increase in the proportion of properties at some risk of wildfire out of all California counties.

PRIORITY 2: HEALTHY FOOD ACCESS

- ⊕ Sonoma County has numerous food assistance and charitable feeding programs focusing on alleviating hunger and food insecurity.
- ⊖ In 2018, one-third of Sonoma County community members didn't have access to three healthy meals per day. That means about 60,000 people experienced food insecurity.

SOCIOECONOMIC FACTORS

PRIORITY 3: ECONOMIC SECURITY AND HOUSING

- ⊕ Unemployment rates (3%) are one percentage point below national averages and more than two percentage points below the state average.
- ⊖ Nearly half (45%) of families of four in Sonoma County do not make enough to make ends meet.

PRIORITY 4: EDUCATION

- ⊕ High school educational attainment rates in Sonoma County are higher than those of the State.
- ⊖ Only 1 in 5 (22%) Sonoma County children are prepared for a successful transition to kindergarten.

PRIORITY 5: STRUCTURAL RACISM

- ⊕ The Department of Health Services, along with multiple County departments, including the Sonoma County Office of Equity, and local collaboratives are addressing structural racism as a priority.
- ⊖ Drastic and harmful racial inequities persist in Sonoma County across the social drivers of health, including education and income, and impact physical and mental well-being and life expectancy.

[1] Sources for this at a glance section can be found in the Community Health Assessment: Assets, Challenges, and Inequities section and Appendices B-G.

HEALTH ACCESS

PRIORITY 6: ACCESS TO CLINICALLY AND CULTURALLY RESPONSIVE CARE

- (+) A safety net of community health centers provides care throughout Sonoma County and efforts are being made to diversify the healthcare workforce.
- (-) Affordable, accessible, and culturally responsive physical and mental healthcare services are hard to find, especially for Black, Indigenous, and People of Color (BIPOC), seniors, uninsured, underinsured, and non-English speakers.

PRIORITY 7: COORDINATED SYSTEMS OF CARE

- (+) Organizations in Sonoma County are collaborating to improve system of care coordination.
- (-) More collaboration is needed between health providers, government, and non-profit organizations to repair "fractured, siloed, and dysfunctional" systems of care.

PHYSICAL HEALTH

PRIORITY 8: CHRONIC DISEASE PREVENTION

- (+) Compared to Californians overall, more people in Sonoma County are physically active outside of their jobs.
- (-) Cancer and heart disease are among the leading causes of premature death in Sonoma County.

PRIORITY 9: COMMUNICABLE DISEASE PREVENTION

- (+) The response to COVID-19 was most effective when DHS recognized and addressed the role of social drivers of health in increasing risks for communicable disease and valued and deferred to the knowledge of the community in where and how to best provide services.
- (-) COVID-19 was the leading cause of death for Latinos in Sonoma County in 2021. HIV and syphilis cases are on the rise.

MENTAL HEALTH

PRIORITY 10: YOUTH MENTAL HEALTH

- (+) Local organizations are collaborating to increase access to community-based mental health services for youth.
- (-) Over a third of high school students in Sonoma County report feeling sad or hopeless.

PRIORITY 11: ADULT MENTAL HEALTH

- (+) Sonoma County has supportive services for various levels of mental health needs.
- (-) Suicide is the tenth leading cause of death in Sonoma County.

PRIORITY 12: SUBSTANCE USE

- (+) DHS's Behavioral Health Division partners with local agencies to provide substance use disorder treatment services.
- (-) From 2016 to 2021, drug overdose deaths in Sonoma County have increased dramatically due to the prevalence of fentanyl.

COMMUNITY HEALTH IMPROVEMENT PLAN SUMMARY

PRIORITY AREA 1:

ADDRESS STRUCTURAL AND INSTITUTIONAL RACISM

1.1. Establish bidirectional communication that fosters shared decision-making, trust, transparency, and accountability between DHS programs and the populations they serve.

1.2. All community members have a fair and equitable opportunity to attain their highest level of health.

1.3. DHS staff race/ethnicity demographics at all levels of the organization reflect those of Sonoma County community members.

1.4. All DHS staff and contractors with direct service responsibilities participate in ongoing training and reflection on racial equity and anti-racism.

1.5. Replace the Region's Housing Assessment and Prioritization process with a new equitable process

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PRIORITY AREA 2:

IMPROVE COMMUNITY MEMBERS' CONNECTION TO RESOURCES

2.1. All community members are supported in navigating health, social service, and other systems.

2.2. All community members have access to affordable, accessible, safe, healthy, and stable housing.

2.3. DHS staff are more knowledgeable about services and resources provided by the County and community partners, strengthening referral pathways and continuity of care.

2.4. Early intervention and prevention-oriented upstream services are promoted to improve downstream outcomes.

2.5. Culturally responsive services are available in trusted community locations.

PRIORITY AREA 3:

IMPROVE SYSTEM OF CARE COORDINATION

3.1. Health, social service, and community resource coordination of care is supported through use of technology.

3.2. DHS Public Health, Behavioral Health, and Homelessness Services division programs and services are less siloed.

3.3. DHS and health care system leadership are well connected and coordinated.

PRIORITY AREA 4:

STRENGTHEN CAPACITY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

4.1. The DHS Behavioral Health division is fully staffed.

4.2. Service gaps in the behavioral health landscape are identified through data analysis and community engagement.

4.3. Prevention, maintenance, and harm reduction services are prioritized to reduce drug overdose deaths, infectious disease transmission, and the need for crisis-oriented care.

4.4. Substance use treatment and treatment/housing options for individuals with co-occurring needs are expanded.

INTRODUCTION

The Community Health Assessment (CHA) is a survey of Sonoma County's assets, challenges, and inequities. The Community Health Improvement Plan (CHIP) strategically addresses the most pressing needs identified by the CHA. These are ongoing and evolving evaluation processes for the Sonoma County Department of Health Services (DHS). After careful consideration of the timeline and best practices in community engagement and equity-centered design, the DHS CHA CHIP Steering Committee agreed to begin this process by engaging leaders of large community-based organizations and health care systems in this first phase to meet grant and CDPH deadlines. They committed to engaging grassroots organizations and community members most impacted by inequities during a second phase in 2024. This two-phase approach allowed for the incorporation of community feedback from several concurrent community efforts that were completed later in 2024, including the creation of Agenda for Action (https://www.hatogether.org/agenda-for-action) to respond to the 2021 Portrait of Sonoma County (https://sonomacounty.ca.gov/health-and-human-services/health-services/about-us/portrait-of-sonoma-county). This assessment meets the requirements of California Department of Public Health Future of Public Health funding and the Public Health Accreditation Board.

FRAMEWORKS CONTRIBUTING TO CHA

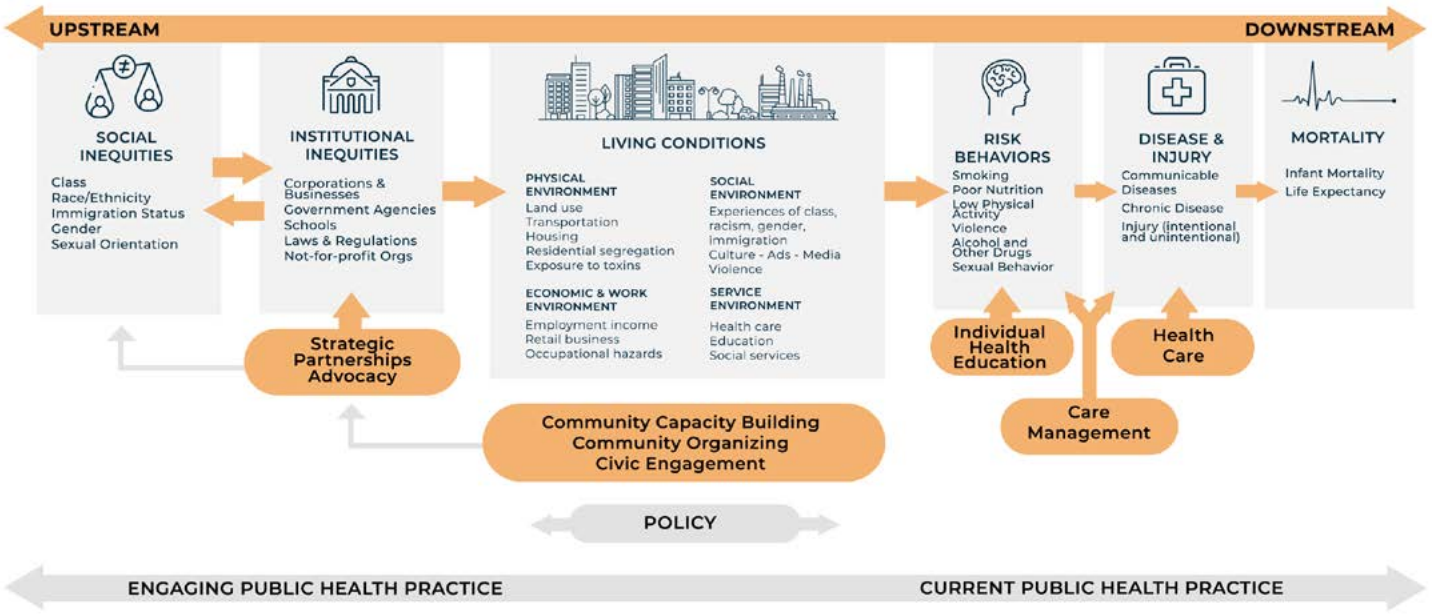
Two frameworks informed the health indicators that DHS focused on in the primary and secondary data collection: the Bay Area Regional Health Inequities Initiative (BARHII) framework and the life course approach. In utilizing these frameworks, DHS sought out and analyzed data on the impacts of structural racism and incorporated these data when presenting information to collaborators. DHS utilized the following definition of structural racism:

> *Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.*[2]

BARHII Framework

The BARHII framework illustrates the connections between structural racism, inequities within the social drivers of health, and downstream health outcomes and mortality. The framework is used by numerous state and county health systems to identify and address health inequities within their communities. This framework was the basis for decisions about which data from other sources to review, how to break down data to identify inequities and root causes, and how to approach stakeholder conversations, interviews, and analysis of informational data not represented by numbers.

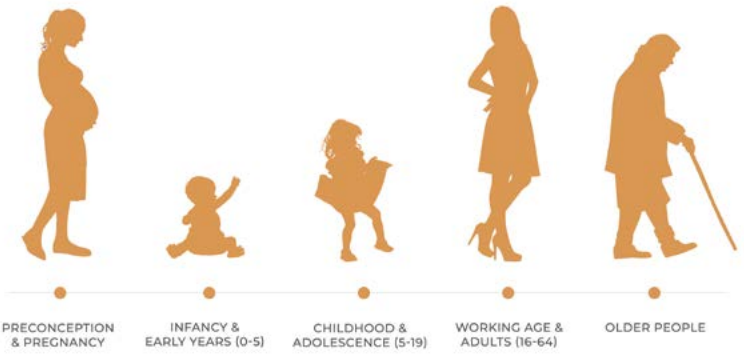
[2]Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., and Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. Lancet (London, England), 389(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X.



Source: Based on graphic from Bay Area Regional Health Inequities Initiative. (2023). Framework. Tide Centers. https://barhii.org/framework

Life Course Approach

The life course approach considers the critical stages, transitions, and settings in people's lives where significant differences can be made in promoting or restoring health and well-being. In Sonoma County, more than 20% of the population is age 65 or older and this population is projected to grow. Understanding the needs of older adults and recognizing differences in health risk factors, behaviors, and leading causes of death across the lifespan can improve the effectiveness and efficiency of outreach, prevention, and intervention efforts. Data from other sources were broken down by age where possible and findings from the local 2023 Area Agency on Aging needs assessment were integrated throughout this analysis



Source: Based on graphic from UK Health Security Agency. (2019, March). Health Matters: Prevention - A Life Course Approach. https://ukhsa.blog.gov.uk/2019/05/23/health-matters-prevention-a-life-course-approach/

COLLABORATIVE STRUCTURE AND PROCESS

Partners involved in Community Health Assessment Process

For the complete list of partners participating in the 2023 phase of the Community Health Assessment process, please see Appendix A. The partners involved in the input and data gathering of this community health assessment represented a wide cross section of agencies including:

- County of Sonoma Department of Health Services (Public Health, Behavioral Health, Administration, and Homelessness Divisions)
- Sonoma County Human Services Department (Adult and Aging and Family, Youth and Children's Services)
- Hospital systems (including Kaiser Permanente, Sutter Health, and Providence)
- Behavioral Health Providers (NAMI)
- Housing agencies
- Homelessness Services Providers
- Prenatal, Early Childhood and Education (Sonoma County Office of Education and First 5 Sonoma County, Maternal Child, and Adolescent Health)
- County of Sonoma Office of Equity
- Organizations serving, or focused on, populations disproportionately impacted by conditions creating poorer health outcomes (Federally Qualified Health Centers including Santa Rosa Community Health, West County Health, and Petaluma Health Center; Aliados Health; Sonoma Connect/Sonoma Unidos; Community Action Partnership of Sonoma County (now known as Sonoma Community Action Network); and Health Action Together).

Stakeholder Engagement Process and Roles

An internal steering committee that included the Public Health Division Director, the Health Policy, Planning, and Equity Manager and staff, the Health Equity Manager, and the manager and staff from the Health Data and Epidemiology Unit met weekly starting in January 2023. This internal team facilitated meetings with local health systems who were conducting or had recently conducted Community Health Needs Assessments to seek guidance and opportunities for partnership and collaboration. Providence health system was conducting a concurrent Community Health Needs Assessment (CHNA) and partnered with the steering committee by sharing their focus group data and providing input on analyses and community stakeholder feedback session materials. Sutter Health and Kaiser Permanente health systems completed CHNAs in 2022 and shared their focus group and interview data with DHS for integration.

To identify stakeholders to engage, the steering committee reviewed the elements of the BARHII Framework and life course approach, then drafted a list of representative agencies with expertise in providing services related to the social drivers of health (education, housing, access to health care, economic stability), risk behaviors, physical or mental health, inequities, and health challenges across the life span. Stakeholders were invited to engage in feedback sessions and interviews.

Applied Survey Research (ASR) assisted with the planning and facilitation of two large virtual feedback sessions in June and July 2023 with community leaders and DHS staff to review data, solicit feedback, and prioritize community health needs. Following these sessions, DHS staff interviewed 28 staff members with content expertise in a series of 60-minute individual and small group interviews to draft CHIP strategies. DHS and ASR facilitated a third virtual session with community leaders and DHS staff combined to refine CHIP strategies around the priority health needs. Please see Appendix A for a complete listing of participants in feedback sessions and interviews.

Secondary Data Collection

DHS analyzed secondary data from a variety of sources (see Appendices B-G). DHS concentrated on data that identified health inequities (see Appendix G – Health Inequity Data for further details).

Primary Data Collection

DHS staff analyzed interview notes, focus group notes, transcripts, and surveys collected by several CHA partnerships. These qualitative data included, but were not limited to, interviews and focus groups with community members and agencies serving individuals disproportionately experiencing the impacts of systemic racism and other inequities, a needs assessment of older adults, and a community mental health forum. Please see Appendix H for a full list of primary data sources.

Report Language

DHS staff recognize that individuals who identify as Hispanic, Latino, Latina, Latinx, or Latin-e may have different preferences related to these terms and may not all identify with the term Latino. The term Latino was selected for use in this report because while “Latinx” has been introduced as a more inclusive, non-gendered term, recent research has shown that more Latino persons identify as Latino over Latinx. This approach is in alignment with recommendations from the California Department of Public Health’s Health Equity Branch.

DEMOGRAPHIC PROFILE OF SONOMA COUNTY

DEMOGRAPHIC OVERVIEW

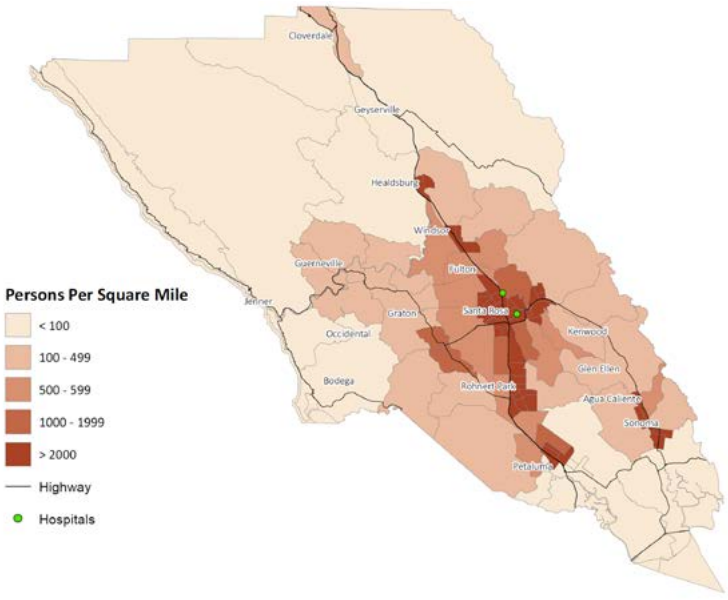
Sonoma County is a large county with an urban-rural Census classification, encompassing 1,575 square miles. The county's total population is estimated at 492,498.[3] People in Sonoma County inhabit nine cities and a large unincorporated area, including many geographically isolated communities.

GEOGRAPHY

Most of the county's population resides within its cities, the largest of which are clustered along the Highway 101 corridor (see Figure 1). Santa Rosa is the largest city with a population of 174,523 and is the service hub for the entire county and the location of the county's three major hospitals.[4]

Sonoma County's unincorporated areas are home to 134,570 people, 27.5% of the total population. A significant number of these individuals live in locations that are rural and geographically remote. Of the county's total senior population, age 60 and older, 17,953 (12%) are considered "geographically isolated" as defined by the Older Americans Act.[5]

Figure 1. Sonoma County Population Density by Census Tract



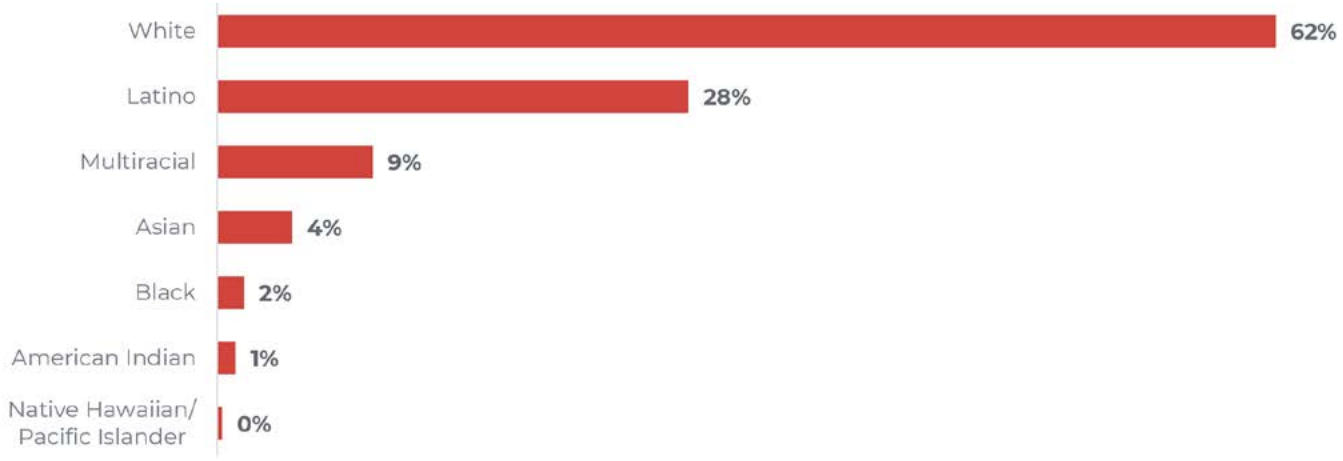
Source: U.S. Census Bureau. (n.d.). American Community Survey B01003. U.S. Department of Commerce. https://data.census.gov/table/ACSDT5Y2020.B01003?q=Population+Total&g=050XX00US06097,06097$1400000&tp=true

[3] U.S. Census Bureau. (n.d.). American Community Survey S010. U.S. Department of Commerce. https://data.census.gov/table/ACSST5Y2021.S0101?g=050XX00US06097
[4] State of California. (2023). Estimates-E1. California Department of Finance. https://dof.ca.gov/forecasting/demographics/estimates-e1/
[5] State of California. (2023). Data and Reports. California Department of Finance. https://www.aging.ca.gov/Data_and_Reports/

RACE, ETHNICITY, AND LANGUAGE

The racial and ethnic breakdown of people in Sonoma County is 61.7% White, 27.5% Latino, 4.4% Asian, 1.6% Black, 1.1% American Indian, 0.3% Native Hawaiian and other Pacific Islander, and 9.1% persons reporting two or more races (see Figure 2).[6]

Figure 2. Sonoma County Race and Ethnicity, 2021



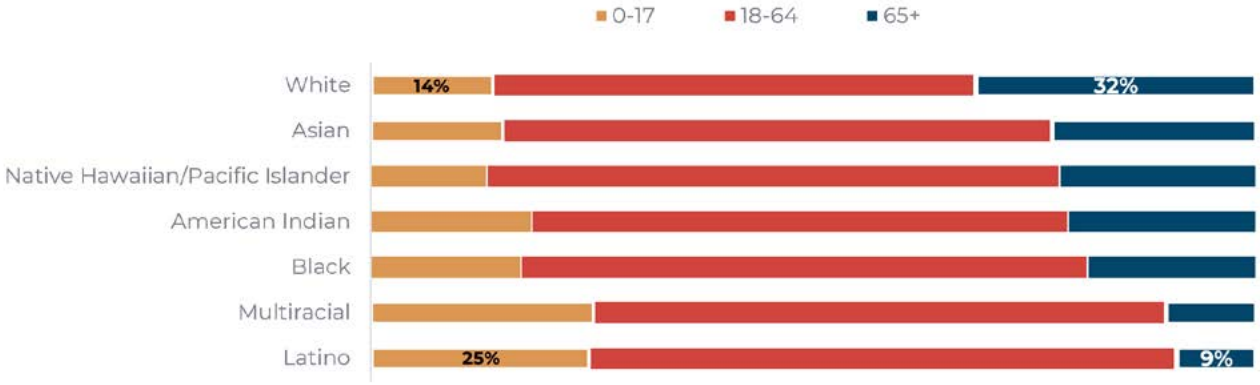
Source: U.S. Census Bureau. (2021, October). 2006-2010 ACS 5-year Estimates. U.S. Department of Commerce. https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2010/5-year.html?g=050XX00US06097

The 2021 Census estimates 88.2% of the county, age 5 and older, speak English fluently. With regards to language spoken at home, the American Community Survey reports 73.6% of county residents speak only English, 19.3% speak Spanish, 2.8% speak another Indo-European language, 3.2 % speak an Asian or Pacific language, and 1.1% speak another language at home. However, 11.8% of total population, are "linguistically isolated" (i.e., speaking a language other than English at home and speaking English less than "very well").[7]

AGE AND GENDER

On average, Sonoma County community members are older than Californians as a whole, with the median age in Sonoma County being 42.5 years versus California's median age of 37 years. Sonoma County seniors, age 65 and over, represent 19.9% of the total population as compared with a statewide figure of 14.4%. Of note is the difference in age between the county's older White population and its younger Latino population. Over 24.6% of Sonoma County Latino population are younger than 18, as compared to 13.5% for the White population. At the other end of the spectrum, 31.9% of the White population are seniors (age 65 and above) as compared with 8.6% of the Latino population (see Figure 3).[8]

Figure 3. Sonoma County Race and Ethnicity by Age, 2021

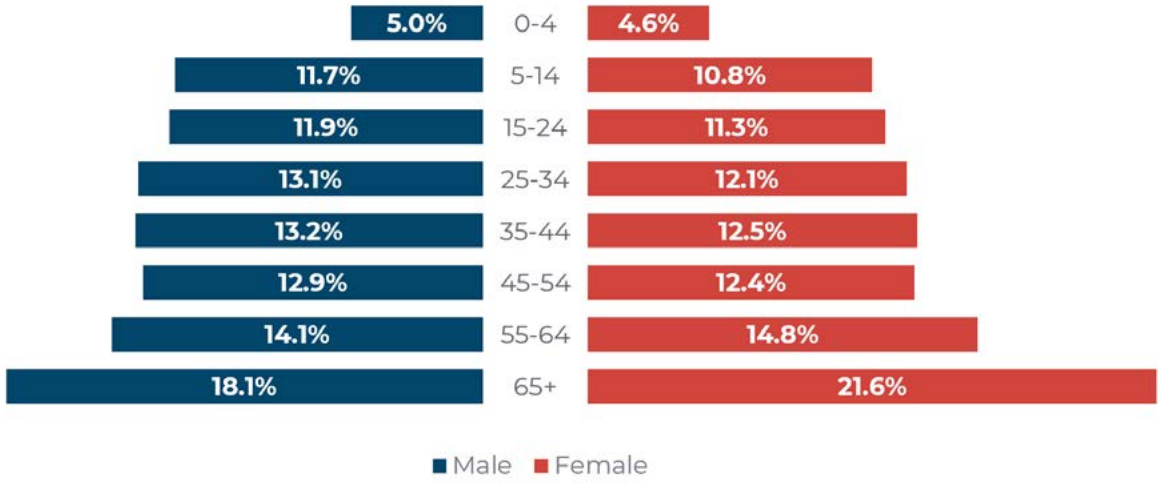


Source: County of Sonoma. (n.d.). Sonoma County Indicators. Economic Development Board. https://sonomaedb.org/data-center/indicators/economy?g=040XX00US06_050XX00US06097&tid=ACSST1Y2021.S0101

[6] U.S. Census Bureau. (2021, October). 2006-2010 ACS 5-year Estimates. U.S. Department of Commerce. https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2010/5-year.html?g=050XX00US06097
[7] U.S. Census Bureau. (n.d.). American Community Survey S1601. U.S. Department of Commerce. https://data.census.gov/table/ACSST5Y2021.S1601?q=S1601
[8] County of Sonoma. (n.d.). Sonoma County Indicators. Economic Development Board. https://sonomaedb.org/data-center/indicators/economy?g=040XX00US06_050XX00US06097&tid=ACSST1Y2021.S0101

Females in Sonoma County are older than males. Women in the county have a median age of 43.9 years compared to 41.2 years for men. About 22% of women are over age 65 years compared to 18% of men (see Figure 4).

Figure 4. Sonoma County Sex by Age, 2021

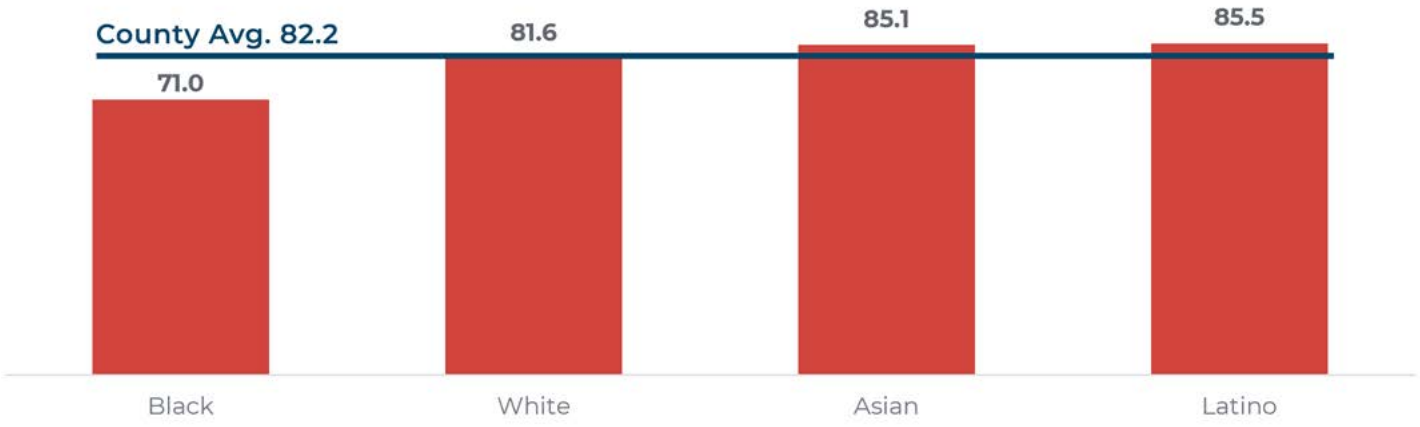


Source: County of Sonoma. (n.d.). Sonoma County Indicators. Economic Development Board.

LIFE EXPECTANCY

Average life expectancy in Sonoma County is currently 82.2 years (77th percentile in California) with considerable variation across demographics. Females average 84.2 years while males average 80.2 years. There is a 10-year difference in life expectancy between the county average and Black community members (71.0 years; see figure 5). The life expectancy of Latino and Asian community members (85.5 and 85.1 years, respectively) exceeds the average and that of White community members (81.6 years). Among census tracts, life expectancy in Sonoma County ranges from 73.2 years in one Southwest Santa Rosa census tract to 86.8 years in a census tract in Healdsburg, a difference of over 13 years.[9]

Figure 5. Sonoma County Life Expectancy by Race and Ethnicity, 2014-2019



Source: Portrait of Sonoma County, 2021

[9] Centers for Disease Control and Prevention. (2020, March). Life expectancy data viz. National Center for Health Statistics. https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html

COMMUNITY HEALTH ASSESSMENT

COMMUNITY HEALTH ASSESSMENT

ASSETS, CHALLENGES, AND INEQUITIES

This section of the report presents a synthesis of the quantitative and qualitative data and community stakeholder feedback that shaped the understanding of the current assets and health needs of Sonoma County. Feedback sessions with stakeholders and DHS staff contributed to the identification of priority health needs across five areas, including:

 PHYSICAL ENVIRONMENT	1	Climate Change
	2	Healthy Food Access
 SOCIOECONOMIC FACTORS	3	Economic Security and Housing
	4	Education
	5	Structural Racism
 HEALTH ACCESS	6	Access to Clinically and Culturally Responsive Care
	7	Coordinated Systems of Care
 PHYSICAL HEALTH	8	Chronic Disease Prevention
	9	Communicable Disease Prevention
 MENTAL HEALTH	10	Youth Mental Health
	11	Adult Mental Health
	12	Substance Use

COMMUNITY RESOURCES

Sonoma County has an array of community resources to address public health needs. As the needs and services are dynamic, 2-1-1 Sonoma County, a program of United Way of the Wine Country, provides an up-to-date and comprehensive list of community programs and resources. 2-1-1 can be accessed via landline, cell phone, text (898-211), or online at 211sonoma.org. Information is available on a variety of topics such as housing, food, health care, mental health, substance use, and education.

CLIMATE CHANGE

WHY IS THIS IMPORTANT?

Environmental pollutants can cause health problems like respiratory diseases, heart disease, and some types of cancer. People with low incomes are more likely to live in polluted areas and have unsafe drinking water, and children and pregnant women are at higher risk of health problems related to pollution. Climate change increases risk of wildfires and heat related illness.

COMMUNITY ASSET HIGHLIGHT

Sonoma County community members have more access to green space[10] and opportunities to exercise[11] than do residents in most other counties in California.

HEALTH CHALLENGES

Wildfires are a major concern in Sonoma County and have become more frequent with global warming. Between 2017-2020, there were four wildfires (Tubbs, Kincade, Walbridge, and Glass) in the county that burned over 50,000 acres each.[12] This trend will likely continue as Sonoma County has the greatest projected increase of wildfire risk among all counties in the State.[13] It is estimated that 93% of all properties in Sonoma County have some risk of being affected by wildfire over the next 30 years (see Figure 6).[14]

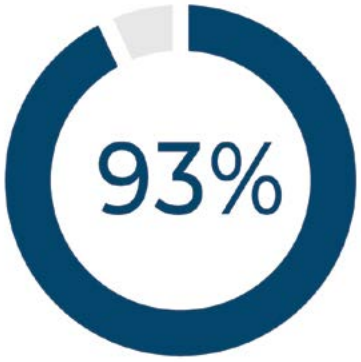
Interviews and focus groups with CBOs and systems partners noted the impact that fires and natural disasters have made on housing stock and housing access in the community, while also negatively impacting air quality, mental health, food access, and stress levels in the community. Additionally, health system partners and community-based organizations described fires and disasters as impacting the functioning and staffing levels of hospitals, health centers, and other health care services in the community.

HEALTH INEQUITY SPOTLIGHT

According to UC Davis researchers, children and those adults who work outdoors, such as agricultural workers, face elevated health risks due to exposure wildfire smoke.

Figure 6. Percent of Properties in Sonoma County at Some Risk for Wildfires Over the Next 30 Years

Sonoma County properties at some risk of wildfire



Source: Risk Factors. (n.d.). Does Sonoma County have Wildfire Risk? First Street Foundation. https://riskfactor.com/county/sonoma-county/6097_fsid/fire#wildfire_risk_overview

WHAT IS THE COMMUNITY SAYING?

"It's what I've been referring to and calling a cumulative economic trauma that is hitting our, not only just farmworkers, but our vulnerable communities, because it started with 2017 Tubbs fire, followed by the 2019 Kincade, followed by last year's Walbridge and Glass fire, followed by COVID. And then this year, people need to understand that our people are really suffering because last year with the Walbridge fire, our farmworkers lost all their income, not just partial income and that's what they live off of in November, December and January."

- Kaiser Permanente key informant interview, 2021

[10] Healthy Places Index, Community Conditions. 2017.
[11] RWJF County Health Rankings, 2021
[12] County of Sonoma. (2022). Emergency History Since 1986. Department of Emergency Management. https://sonomacounty.ca.gov/administrative-support-and-fiscal-services/emergency-management/organization/emergency-operations-center/recent-events
[13] First Street Foundation. Fire Factor. US Wildfire Risk Data, 2022.
[14] Risk Factors. (n.d.). Does Sonoma County have Wildfire Risk? First Street Foundation. https://riskfactor.com/county/sonoma-county/6097_fsid/fire#wildfire_risk_overview

HEALTHY FOOD ACCESS

WHY IS THIS IMPORTANT?

Having access to healthy food is a basic human need. Food security —having access to enough food for a healthy, active lifestyle —is associated with reduced risk for mental health disorders and chronic diseases. The ability to access safe places to be physically active is also important. Regular exercise helps improve mental health and reduces the risk of chronic disease and disability.

Source: https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html

COMMUNITY ASSET HIGHLIGHT

Several food assistance and charitable feeding programs focus on alleviating hunger and food insecurity for both adults and children. These programs include the federal food stamp program (CalFresh in California), the National School Lunch and School Breakfast Program, the special supplemental program for Women, Infants and Children (WIC), Redwood Empire Food Bank, and various nutrition and meal programs for low-income seniors. .

HEALTH CHALLENGES

Healthy food access is a need for many in the county. It is tied to a person's socioeconomic status by their ability to purchase food as well as the location of their homes in relation to grocery stores. In 2018, one third of Sonoma County community members did not have access to three healthy meals per day (see Figure 7).[15] That means about 60,000 people experienced food insecurity.

Within the community listening sessions, some participants highlighted that while school meals are important to many families, the food served is not always very healthy and can contribute to poor health.

WHAT IS THE COMMUNITY SAYING?

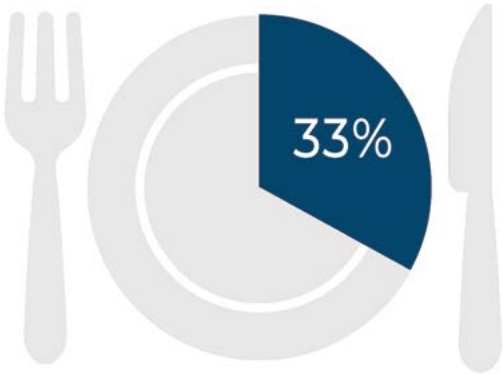
"[People] are still skipping meals despite having access to the food bank, despite maybe having access to CalFresh benefits. They're still not having enough money to get through the month."

- Kaiser Permanente key informant interview, 2021

HEALTH INEQUITY SPOTLIGHT

The 2023 Area Agency on Aging Needs Assessment highlighted gaps in food access among older adults. Needs included increased access to prepared food services, and greater access to food delivery services as well as places to purchase groceries, particularly in rural communities.

Figure 7. Sonoma County Residents Without Access to Three Healthy Meals per Day, 2018



33% of Sonoma residents do not have access to 3 healthy meals per day

Source: County of Sonoma. Department of Human Services. (2020, February 7). Annual Sonoma County Hunger Index Reports that 1/3 of Residents Went Hungry in 2018. https://sonomacounty.ca.gov/hunger-index-2019#

[15] County of Sonoma. Department of Human Services. (2020, February 7). Annual Sonoma County Hunger Index Reports that 1/3 of Residents Went Hungry in 2018. https://sonomacounty.ca.gov/hunger-index-2019#.

ECONOMIC SECURITY AND HOUSING

WHY IS THIS IMPORTANT?

Research suggests social and economic factors, such as income, education, employment, community safety, and social supports contribute to 40% of health outcomes and significantly affect how well and how long a person lives.

Source: University of Wisconsin. (2023). Social and Economic Factors. County Health Rankings and Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors

COMMUNITY ASSET HIGHLIGHT

Unemployment rates (3%) are one percentage point below national averages and more than two percentage points below the state average.[16]

HEALTH CHALLENGES

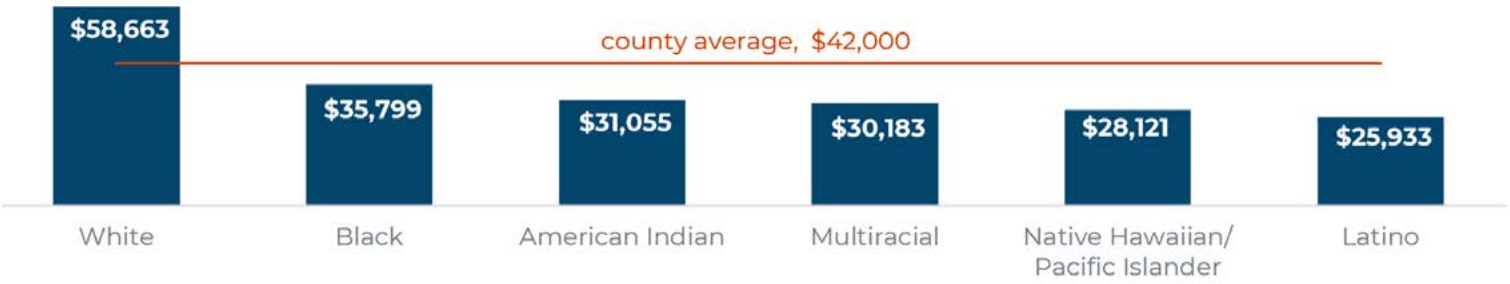
While median income is relatively high, more than 40% of families (37-80%) do not make enough to make ends meet (about $95,000 per year).[17] In some parts of Southeast Santa Rosa, the Russian River corridor, Sonoma Valley, Cloverdale, and unincorporated areas, one in three persons were below 300% FPL.[18]

HEALTH INEQUITY SPOTLIGHT

The median per capita annual income of White community members is more than $30,000 greater than that of Latino community members ($58,663 compared to $25,933, respectively; see Figure 8). Fewer than 14% of homeowners are Latinos while 76% of homeowners are White. This inequity is greater than that of California, where 24.6% of homeowners are Latino.

(Source: U.S. Census Bureau, 2017-2021 ACS 5-Year Estimates, Table DP04 Selected Housing Characteristics Table S2502 Demographic Characteristics for Occupied Housing Units)

Figure 8. Per Capita Income, by Race and Ethnicity, 2019



Source: U.S. Census Bureau. (n.d.). American Community Survey S1903. U.S. Department of Commerce. https://data.census.gov/table/ACSST1Y2021.S1903?q=S1903&g=050XX00US06097

WHAT IS THE COMMUNITY SAYING?

"Housing and just basic survival are a constant mental health stressor, especially in Sonoma County."

- Mental Health Services Act (MHSA) Community Program Planning (CPP) listening sessions, FY 2022-23

[16] U.S. Census Bureau. (2021, October). 2006-2010 ACS 5-year Estimates. U.S. Department of Commerce. https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2010/5-year.html?g=050XX00US06097
[17] Insight Center for Community Economic Development. (2021). The Cost of Being Californian 2021. https://insightcced.org/wp-content/uploads/2021/05/INSIGHT_Factsheets-Sonoma-2.pdf
[18] Insight Center. (2021). The Cost of Being Californian. https://insightcced.org/wp-content/uploads/2021/05/INSIGHT_Factsheets-Sonoma-2.pdf

EDUCATION

WHY IS THIS IMPORTANT?

Adults with more education tend to live longer, healthier lives. Education leads to higher income, the ability to live in safer neighborhoods, and gives people tools to make healthier decisions.

Source: Zajacova, A., and Lawrence, E. M. (2018). The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. Annual review of public health, 39, 273–289. https://doi.org/10.1146/annurev-publhealth-031816-044628

COMMUNITY ASSET HIGHLIGHT

Educational attainment rates in Sonoma County exceed State rates with 89% of people in Sonoma County 25 years and older having at least a high school diploma compared to the California rate of 84.5%.[19]

HEALTH CHALLENGES

In 2022, only 1 in 5 (22%) Sonoma County children were prepared for successful transition to kindergarten according to local assessments.[20] That number has decreased sharply since 2018 when 40% of children were kindergarten ready (see Figure 9).

Between school years 2018-19 and 2021-22, the percent of 3rd graders meeting/exceeding grade level standards decreased in the subjects of English (47.4% to 40.9%) and Math (47.8% to 41.5%).[21]

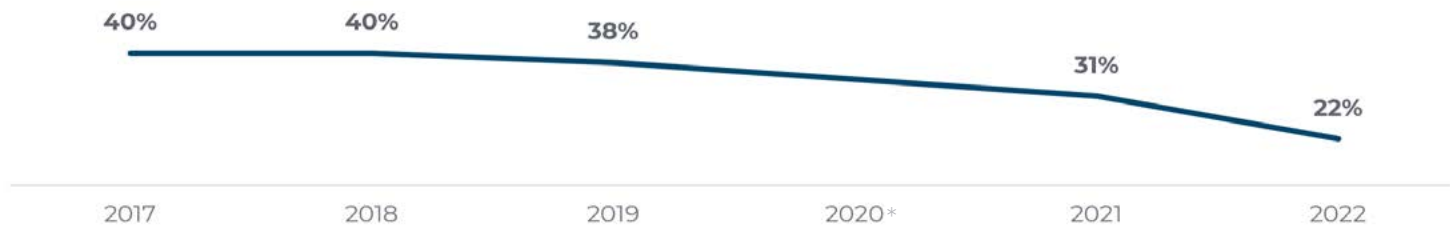
Forty-five percent (45%) of households with at most a high school education struggle to make ends meet financially in Sonoma County, compared to the 12% of households with a graduate education.[22]

HEALTH INEQUITY SPOTLIGHT

Among people 25 years and older, 44% and 42% of Asian and White community members, respectively, have a bachelor's degree, compared to 10% and 14% of American Indian and Latino community members, respectively.

Source: U.S. Census Bureau. (n.d.). American Community Survey DP02. U.S. Department of Commerce. https://data.census.gov/table?q=DP02

Figure 9. Percent of Children Prepared for Kindergarten



* Data for 2020-21 not available due to Fire and COVID impacts.
Source: County of Sonoma. (2023). Sonoma County Annual READY Report. https://first5sonomacounty.org/wp-content/uploads/READY-Annual-Report_2023.pdf

WHAT IS THE COMMUNITY SAYING?

"Across all listening sessions, participants advocated for supportive learning environments that enhance students' developmental, social, emotional, and academic learning. Parents reported concerns about the presence of racism, bullying, and student violence at school, and wondered if this may be due to the multiple impacts caused by the pandemic."

- Providence Health's Listening Session Report by On the Margins, 2023

[19]U.S. Census Bureau. (n.d.). American Community Survey S1501. U.S. Department of Commerce. https://data.census.gov/table/ACSST1Y2021.S1501
[20]County of Sonoma. (2023). Sonoma County Annual READY Report. https://first5sonomacounty.org/wp-content/uploads/READY-Annual-Report_2023.pdf
[21]California Assessment of Student Performance and Progress. (n.d.) English Language ArtsLiteracyand Mathematics. California Department of Education. https://caaspp-elpac.ets.org/caasppDashViewReportSB?ps=true&lstTestYear=2022&lstTestType=B&lstGroup=1&lstSubGroup=1&lstGrade=3&lstSchoolType=A&lstCounty=49&lstDistrict=00000&lstSchool=0000000&lstFocus=a
[22]Insight Center. (2021). The Cost of Being Californian. https://insightcced.org/wp-content/uploads/2021/05/INSIGHT_Factsheets-Sonoma-2.pdf

STRUCTURAL RACISM

WHY IS THIS IMPORTANT?

Race is a social construct that privileges those with lighter skin. These privileges have been institutionalized in our systems, creating unfair and unjust access to economic opportunity, healthcare, education, affordable housing, safe environments, and community support. Structural racism has a real impact on the health of BIPOC communities, including many of the health inequities addressed in this assessment.

Source: Phelan JC, Link BG. Is racism a fundamental cause of inequalities in health? Annu Rev Sociol. 2015; 41:311–330

COMMUNITY ASSET HIGHLIGHT

Sonoma County is home to many diverse and proud communities that contribute to the culture and richness of Sonoma County. Efforts to address structural racism and racial inequity, including recognizing and uplifting traditionally marginalized communities, have grown significantly in recent years. These include, but are not limited to, internal county efforts from the County of Sonoma Office of Equity and the DHS Health Equity Team, and community-based organizations such as Health Action Together.

HEALTH CHALLENGES

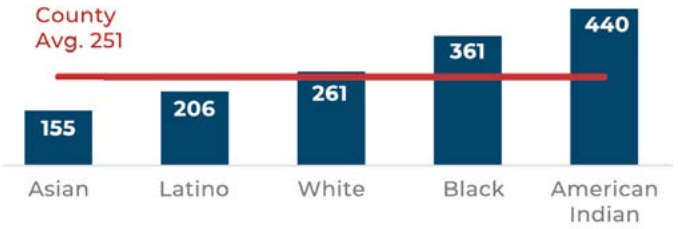
Racial inequities impact the social drivers of health. In Sonoma County, examples are readily found in:

- **Education:** The third grade reading proficiency of students who are White is 56% compared to 24% of students who are Native Hawaiian/Pacific Islander.[23] Among adults over age 25 years, 42% of White community members have at least a bachelor's degree as compared to 14% of Latino community members.[24]
- **Incarceration rates:** The incarceration rates of Latino community members are 1.9 times higher than those of White community members.[25]
- **Premature mortality rates:** The rate per 100,000 of premature death is highest for American Indian community members, followed by Black, White, Latino, and Asian community members (see Figure 10).[26]

HEALTH INEQUITY SPOTLIGHT

During the pandemic, Latino community members accounted for 42% of all COVID-19 cases while representing only 28.7% of the population in Sonoma County. The widening of existing disparities in the social drivers of health influenced which communities were most vulnerable to COVID-19 infection and health complications. For instance, Latino community members were, 1) more likely to be rent burdened making it more difficult to isolate or quarantine; 2) more likely to earn lower incomes and be represented in "essential work" which entailed greater risk of COVID-19 exposure and subsequent household transmission; and 3) less likely to have a usual place to go for care when sick or in need of care increasing risks of hospitalization and/or death.

Figure 10. Deaths Among Community Members Under Age 75, per 100,000, 2019-21



Source: California Comprehensive Death File, 2019-21

WHAT IS THE COMMUNITY SAYING?

"Some [focus group participants] indicated that teachers discipline BIPOC students more harshly, which they believe impacts their children's educational and health outcomes... Indigenous participants indicated that they and/or their children are often mocked, mistreated, and discriminated against. A couple of undocumented participants stated that their employers will often overwork them and exploit them given their immigration status, even when they are injured."

- Providence Health's Listening Session Report by On the Margins, 2023

[23] California Assessment of Student Performance and Progress. (n.d.) English Language Arts Literacy and Mathematics. California Department of Education. https://caaspp-elpac.ets.org/caaspp DashViewReportSB?ps=true&lstTestYear=2022&lstTestType=B&lstGroup=1&lstSubGroup=1&lstGrade=3&lstSchoolType=A&lstCounty=49&lstDistrict=00000&lstSchool=0000000&lstFocus=a
[24] U.S. Census Bureau. (n.d.). American Community Survey DP02. U.S. Department of Commerce. https://data.census.gov/table?q=DP02
[25] Healthy Places Index: Decision Layer. https://map.healthyplacesindex.org.
[26] California Comprehensive Death File, 2019-21

ACCESS TO CLINICALLY AND CULTURALLY RESPONSIVE CARE

WHY IS THIS IMPORTANT?

The ability to afford and access quality health care services that meet the social, cultural, and linguistic needs of patients can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

COMMUNITY ASSET HIGHLIGHT

DHS' multidisciplinary and multicultural home visiting programs help families access health insurance, establish a medical home, and connect with other community resources including WIC, counseling, legal and other support services. Additionally, efforts are being made to diversify the healthcare workforce and to bridge cultural and health literacy gaps in access to care for BIPOC community members. The DHS-led Community Health Workers for COVID Response and Resilience project is one of several collective efforts to train, certify, and support an expanding local workforce of Community Health Workers/ Promotores.

HEALTH INEQUITY SPOTLIGHT

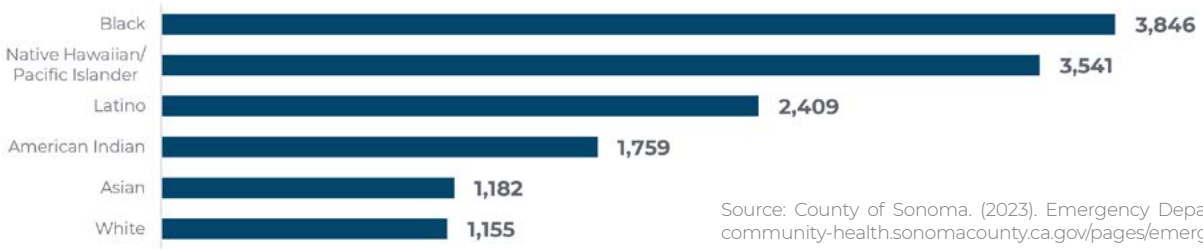
In the 2023 Area Agency on Aging Needs Assessment, older adults expressed concerns with transportation access and the ability to afford medications, medical/dental coverage, and caregiving support. Additionally, about half (49%) of older adults surveyed reported they were not aware of services available to them in the community.

HEALTH CHALLENGES

According to estimates compiled by the Sonoma County Department of Health Services, approximately 28,000 individuals (5.9% of total population) do not have healthcare insurance. Some individuals with health coverage are still considered "underinsured" because they can't afford high deductibles or large co-payments. They may also lack access to basic health care services (such as dental, mental health or specialty care) due to gaps in their insurance coverage for those services or inadequate reimbursement rates that local providers will not accept. Estimates of this population are not available. As a result of limited or a lack of access to care, visits to emergency departments can increase. Black and Native Hawaiian/ Pacific Islander community members visit the emergency departments at higher rates than would be expected based on population size. For example, Black community members have the highest rate of emergency department visits for Type II Diabetes (3,846 per 100,000) and make up 2% of the population (see Figures 2 and 11).

Overwhelmingly, qualitative data sources highlighted the need for improved access to health care, mental health, and substance use disorder services that are affordable, prompt, and culturally responsive – regardless of insurance status – and at the appropriate acuity level. Workforce challenges related to hiring and retaining staff were emphasized in the qualitative data, with hiring and retention challenges cited across many settings.

Figure 11. Age-adjusted Rate of Emergency Department Visits per 100,000 population for Type II Diabetes by Race and Ethnicity,



Source: County of Sonoma. (2023). Emergency Department Visits. https://gis-community-health.sonomacounty.ca.gov/pages/emergency-department-visits

WHAT IS THE COMMUNITY SAYING?

"We want people that we can trust… the most important characteristic for me when it comes to care is being culturally responsive, having people that look like us, that understand us."

- Mental Health Services Act (MHSA) Community Program Planning (CPP) Workgroup – Listening Sessions Draft Annual Report FY 2022-2023

[27] County of Sonoma. (2023). Health Insurance Coverage. https://gis-community-health.sonomacounty.ca.gov/pages/health-insurance-coverage
[28] County of Sonoma. (2023). Emergency Department Visits. https://gis-community-health.sonomacounty.ca.gov/pages/emergency-department-visits

COORDINATED SYSTEMS OF CARE

WHY IS THIS IMPORTANT?

Coordinated systems of care enable people to access necessary comprehensive services in a timely and seamless manner. At a systems level, a coordinated system of care also reduces duplication of services, leads to more efficient use of resources, and prevents clients from 'falling through the cracks.' .

COMMUNITY ASSET HIGHLIGHT

Organizations such as Sonoma Connect | Sonoma Unidos and Community Urgent Response and Aid (CURA) are collaborating to improve coordinated systems of care.

HEALTH CHALLENGES

Most of the focus groups and key informant interview participants with Sutter Health and Kaiser Permanente, as well as participants in the Mental Health Community Roundtable, identified the need for improved cross-system collaboration to improve what participants described as "fractured, siloed, and dysfunctional" systems. For example, key informant interview participants mentioned opportunities for partnerships between educational institutions and healthcare systems. Strategic coordination, they noted, is needed among behavioral health providers, hospitals and emergency departments, community-based organizations, the County, the education sector, and the criminal legal system.

WHAT IS THE COMMUNITY SAYING?

Focus group participants "recommend ongoing collaboration between healthcare facilities and community health workers to promote health equity, prioritizing communities with the greatest health risks. They indicated that mobile clinics, health fairs, and partnerships between organizations are helpful resources to their community."

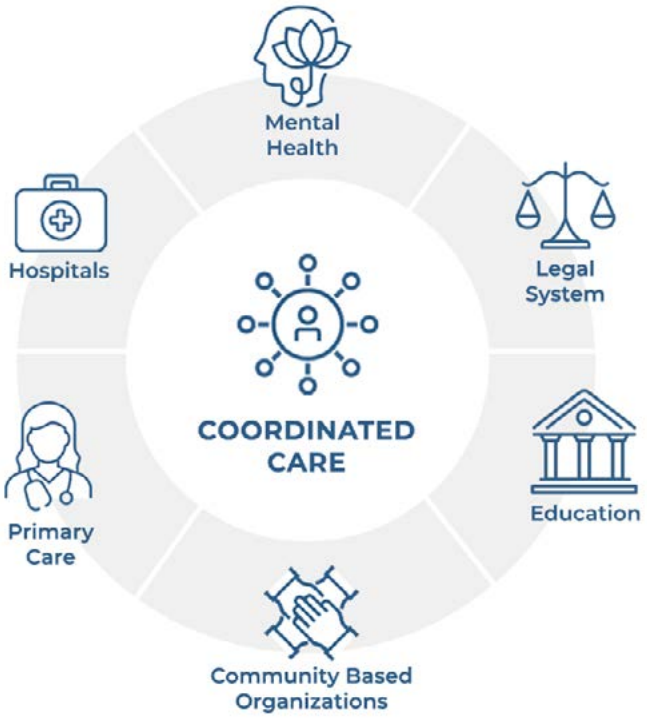
- Providence Health's Listening Session Report by On the Margins, 2023

HEALTH INEQUITY SPOTLIGHT

The lack of coordination of care impacts the efficiency of the health care system for everyone on Sonoma County, but can exacerbate existing inequities and challenges in accessing care especially for people who are BIPOC, over age 65, unhoused, and/or who have behavioral health needs.

DHS staff interviews, 2023

Figure 12. Coordinated Care



CHRONIC DISEASE PREVENTION

WHY IS THIS IMPORTANT?

The prevention of chronic disease is affected by access to resource and the availability of healthy options and healthcare in a community. Chronic diseases account for over 86% of health care costs. The adoption and maintenance of four primary health behaviors 1) regular physical activity, 2) healthy nutrition,3) abstaining from tobacco use, and 4) moderating alcohol consumption, reduce the risk of chronic disease, associated disability, and premature death.

Source: Health expenditures. Centers for Disease Control and Prevention website. https://www.cdc.gov/nchs/fastats/health-expenditures.htm. Updated May 3, 2017.

COMMUNITY ASSET HIGHLIGHT

Eighty-one percent (81%) of people in Sonoma County exercise outside of their work.[29] The DHS-led Community Health Workers for COVID Response and Resilience project is one of several collective efforts to train, certify, and support an expanding local workforce of Community Health Workers/ Promotores to better connect community members with information and resources to promote health.

HEALTH CHALLENGES

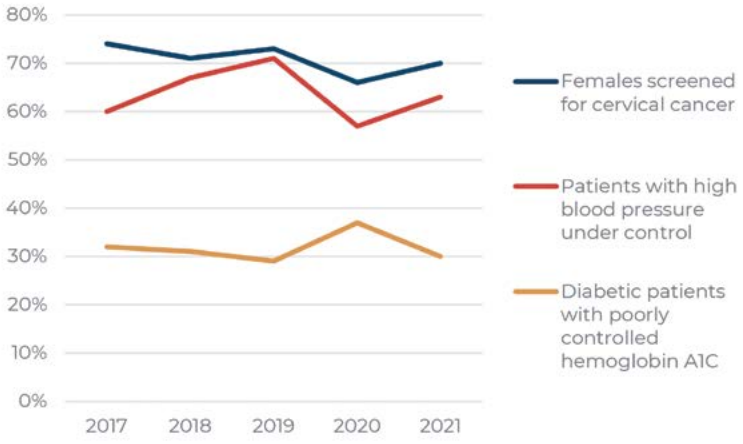
Unintentional injury, cancer, and heart disease were the top 3 leading causes of premature death in Sonoma County. Black community members are disproportionately affected by early death from unintentional injury and heart disease and people residing in the lowest resourced neighborhoods in the county (Healthy Places Index Quartile 1) have significantly higher premature death rates than people living in more resourced areas (Healthy Places Index Quartiles 2-4) for all three leading causes, 2020-2022.[30] Overall, cancer is most prevalent among White community members, followed by Black, Latino and Asian community members. Preventative screening and care related to chronic disease declined during the COVID-19 pandemic. As examples, in 2020 there were decreases in females screened for cervical cancer, a reduction in patients with high blood pressure under control and increases in diabetic patients with poorly controlled hemoglobin A1c (see Figure 13).[31]

HEALTH INEQUITY SPOTLIGHT

In 2021, Black and Native Hawaiian/ Pacific Islander community members experienced the highest rates of Emergency Department visits for cardiovascular disease and diabetes, as compared to all other racial/ethnic groups.

Source: County of Sonoma. (2023). Emergency Department Visits. https://gis-community-health.sonomacounty.ca.gov/pages/emergency-department-visits

Figure 13. Preventative Health Screenings and Care, 2017-2021



Source: County of Sonoma. (2023). Health Screenings. https://gis-community-health.sonomacounty.ca.gov/pages/health-screenings

WHAT IS THE COMMUNITY SAYING?

"I'm working with a lady right now ... she never knew she had diabetes so that means she never went to the doctor. She began to lose her vision. She went in, she had damaged her retina so much. They tried to do surgery ... About 90 days ago she went completely blind. Those are real health issues our farmworkers face."

- Kaiser Permanente key informant interview, 2021

[29] Healthy Places Index, Decision Support Layer, https://www.healthyplacesindex.org/
[30] County of Sonoma. (2023). Leading Causes of Deaths. https://gis-community-health.sonomacounty.ca.gov/pages/leading-causes-of-deaths
[31] County of Sonoma. (2023). Health Screenings. https://gis-community-health.sonomacounty.ca.gov/pages/health-screenings

COMMUNICABLE DISEASE PREVENTION

WHY IS THIS IMPORTANT?

The prevention and control of communicable diseases is essential to protect the community and reduce the potential for illness and death among people of all ages. There are certain groups of people who are generally considered at higher risk of becoming severely ill from communicable diseases that are targeted for prevention. These groups include children less than 2 years old, adults 65 years and older, people experiencing health or social inequities, and those with certain health conditions.

Source: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

COMMUNITY ASSET HIGHLIGHT

DHS had the greatest successes with response to COVID-19 when DHS centered cultural responsiveness, recognized and addressed the role of social drivers of health in increasing risks for communicable disease, and valued and deferred to the knowledge of the community in where and how to best provide services to community members. DHS has continued these effective strategies with the implementation of the American Rescue Plan Act (ARPA) funding.[32]

HEALTH INEQUITY SPOTLIGHT

COVID-19 was the number one leading cause of death for Latino community members in 2021, while it was the sixth leading cause for the community overall.

Source: County of Sonoma. (2023). Leading Causes of Deaths. https://gis-community-health.sonomacounty.ca.gov/pages/leading-causes-of-deaths

HEALTH CHALLENGES

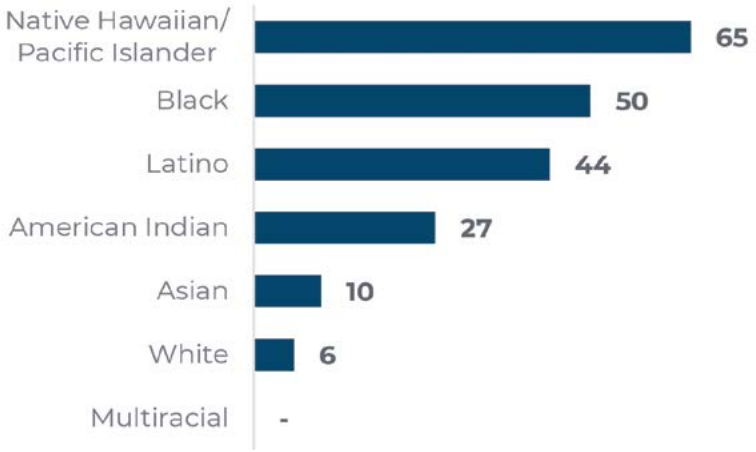
As of October 2023, 579 Sonoma County community members have died from COVID-19.[33] The life expectancy of community members has decreased by 1.7 years as compared to the 2017-2019 three year average.[34] From 2021 to 2022, HIV case rates in Sonoma County have almost doubled from six per 100,000 to 10 per 100,000.[35] The HIV case rate is highest for Native Hawaiian/Pacifica Islander, Black, and American Indian community members (see Figure 14). Early syphilis has increased as well, with rates in 2022 (34.2 per 100,000 persons) at the second highest in the last six years.[36]

WHAT IS THE COMMUNITY SAYING?

"In our community there is a fear that we are going to get sick and we will not know where to go... I think COVID affected many families. Many people are in a state of mind that has not healed. Right now we are processing everything we experienced, the fear we had, the suffering and grief of all those who died throughout this pandemic."

- Providence Health's Listening Session Report by On the Margins, 2023

Figure 14. HIV Case Rate by Race and Ethnicity per 100,000, 2022



Source: County of Sonoma. (2023). HIV/AIDS. https://gis-community-health.sonomacounty.ca.gov/pages/hiv-dashboard

[32] Upstream Investments Sonoma County. ARPA Community Resilience Programs. https://upstreaminvestments.org/impact-make-a-change/arpa-community-resilience-programs
[33] County of Sonoma. (2023). COVID-19 Data and Statistics. https://experience.arcgis.com/experience/1edbb41952a8417385652279305e878d/page/Hospitalizations-and-Deaths/?views=view_25
[34] CA Comprehensive Death File 2017-2021
[35] County of Sonoma. (2023). HIV/AIDS. https://gis-community-health.sonomacounty.ca.gov/pages/hiv-dashboard
[36] County of Sonoma. (2023). Sexually Transmitted Infections. https://gis-community-health.sonomacounty.ca.gov/pages/sexually-transmitted-infections

YOUTH MENTAL HEALTH

WHY IS THIS IMPORTANT?

Young people's mental health can impact their development, relationships, physical health, and decision-making, as well as the quality of life and longevity. Mental health influences school connectedness and grades, decision making, and overall health. Good mental health influences physical health and reduces the risk of drug use, experiencing violence, and higher risk sexual behaviors that can lead to disease. Because many health behaviors and habits are established in adolescence that will carry over into adult years, it is important to help youth develop good mental health.

Source: https://www.cdc.gov/healthyyouth/mental-health/index.htm#

COMMUNITY ASSET HIGHLIGHT

Teen Health Advocacy Coalition (THAC) is one local resource that collaborates to increase access to health information and resources for young people, such as counseling services.

HEALTH CHALLENGES

In 2023, 35% of high school students reported feeling so sad or hopeless almost every day for two weeks or more in the past year that they stopped doing usual activities.[37] Moreover, 13% of high school students considered attempting suicide in the last year.[38] Youth mental health was identified as a concern across qualitative data sources, with frequent acknowledgement that the pandemic and recent disasters have exacerbated and made more visible mental health concerns among youth.

HEALTH INEQUITY SPOTLIGHT

High school students who identified as being either bisexual or gay/lesbian were more likely to report feeling sad or hopeless than students who identified as heterosexual (see Figure 15).

Source: YouthTruth survey data, 2023

Figure 15. Youth Mental Health by Sexual Orientation, 2023

Proportion of Sonoma County high school students who reported feeling so sad or hopeless almost every day for two weeks or more in the past year that they stopped doing usual activities

Source: YouthTruth survey data from 2023

WHAT IS THE COMMUNITY SAYING?

"Participants identified grief, loss, isolation, anxiety, depression, and low self-esteem as some of the concerns currently experienced by their children."

- Providence Health's Listening Session Report by On the Margins, 2023

[37] YouthTruth survey data, 2023.
[38] YouthTruth survey data, 2023.

ADULT MENTAL HEALTH

WHY IS THIS IMPORTANT?

Mental health status, access to supportive services, and the presence or absence of behavioral risk factors impact individuals' quality of life and longevity. People's ability to live productive and fulfilling lives often depends on their mental health. Mental health affects a wide range of factors related to well-being including financial stability, employment and access to health insurance, educational success, substance use, and physical health. In addition, marginalized communities consistently experience inequities in mental health.

Source: https://publichealth.tulane.edu/blog/mental-health-public-health/

COMMUNITY ASSET HIGHLIGHT

Sonoma County offers supportive services for multiple levels of mental health needs. For example, Crisis Stabilization Unit and Crisis Residential Unit are valuable resources that offer 24-hour care for people experiencing mental health crises. Other community services such as the new Community Hub at Hanna offers counseling, classes, and other resources.

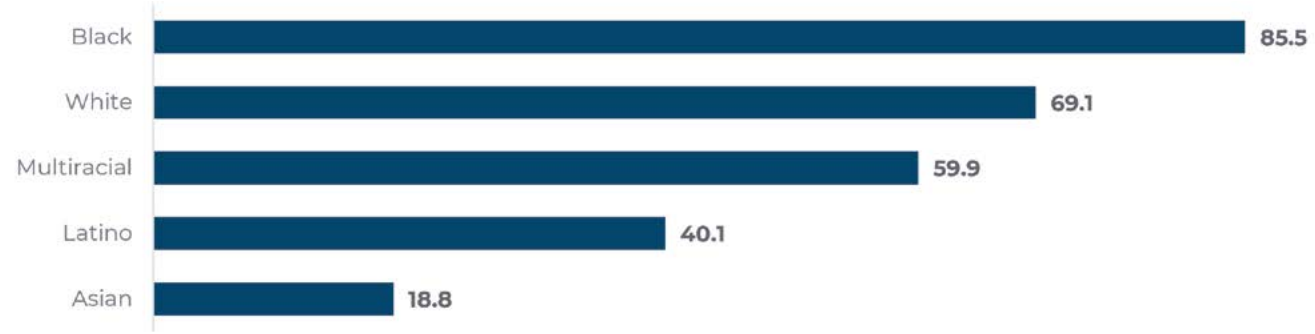
HEALTH CHALLENGES

Suicide was the tenth leading cause of death and responsible for 77 deaths in Sonoma County in 2022.[39] The age-adjusted death rate for suicide/self-harm has for the last twenty years been between about 10 and 20 per 100,000 people (higher than the state). In addition, a key theme from the qualitative data was a perceived increase in mental health concerns among community members over recent years, with increased social isolation, loneliness, stress, and depression, tied to recent natural disasters and the pandemic that exacerbated and laid bare mental health issues.

HEALTH INEQUITY SPOTLIGHT

Black community members are more likely to die from suicide, overdose, and alcohol-related causes (see Figure 16). That rate has increased dramatically in the last four years (from 30.3 per 100,000 population in 2017-2019 to 85.5 per 100,000 population in 2020-22).

Figure 16. Deaths of Despair[40] by Race/Ethnicity, Age-Adjusted Rate[41] per 100,000, 2020-22



Deaths of despair are those attributed to suicide and poisoning from alcohol and drugs.

WHAT IS THE COMMUNITY SAYING?

"I would like to know how to deal with stress because many of us, not just me, don't know where to go. We don't know what to do with the stress. We need support from psychologists."

- Providence Health's Listening Session Report by On the Margins, 2023

[39] County of Sonoma. (2023). Leading Causes of Deaths. https://gis-community-health.sonomacounty.ca.gov/pages/leading-causes-of-deaths
[40] Deaths of despair are those attributed to suicide and poisoning from alcohol and drugs.
[41] Age-adjusted rates the number of deaths per population standardized to the age distribution of the US population.

SUBSTANCE USE

WHY IS THIS IMPORTANT?

Substance use can impact individuals' and families' quality of life, including their physical and mental health. Substance use can make daily activities difficult and impair a person's ability to work, interact with family, and fulfill other major life functions. On average one death occurs every three days due to drug overdose in Sonoma County and it is the main contributor to unintentional injury, the leading cause of premature death.

Source: https://www.samhsa.gov/find-help/prevention

COMMUNITY ASSET HIGHLIGHT

DHS partners with syringe service providers to help expand services for injection drug users to include HIV rapid testing. The Behavioral Health Division of Sonoma County also partners with local agencies to provide substance use disorder treatment services.

HEALTH CHALLENGES

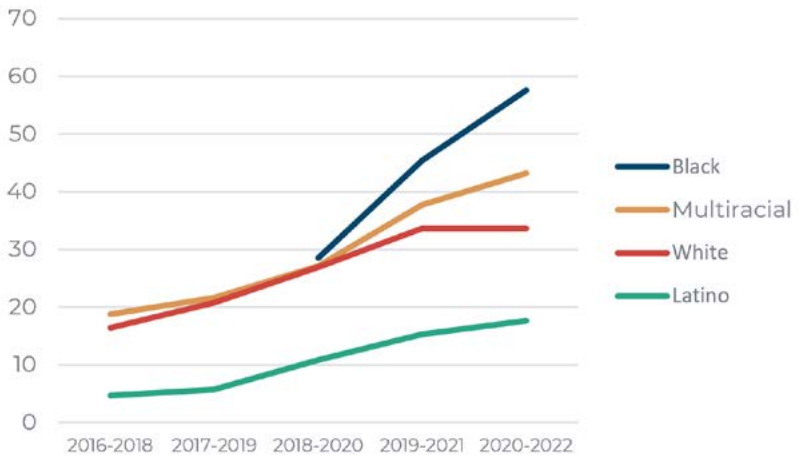
Concern about substance use is increasing in Sonoma County, as drug overdose deaths rose dramatically from 2016 to 2021.[42] In 2016 there were 58 deaths from drug overdose and 158 deaths from drug overdose in 2021. This increase is driven by opioid-involved overdose deaths, which account for 80% of drug overdose deaths. Of the opioid-involved overdose deaths, 87% involved fentanyl. There has been an alarming 2650% increase in fentanyl-involved overdose deaths between 2016 and 2021.

Focus groups highlighted gaps in mental health services, including a need for substance use treatment beyond 30 days; services for those with co-occurring needs (e.g., substance use disorder, mental health, neuro-diverse, unhoused); more licensed psychiatric facilities; education for youth and families; and increased capacity within the county's Crisis Stabilization Unit. Some interviewed pointed out that resources often get diverted to crisis level care, leaving fewer resources and staff for preventive work, fueling a cycle.

HEALTH INEQUITY SPOTLIGHT

The rate of Emergency Department visits by Black community members for opioid overdose more than doubled between 2020 and 2021 (from 74.4 per 100,000 population to 204.7 per 100,000 population). Black community members also have higher overdose death rates than do community members from other racial ethnic groups (see Figure 17).

Figure 17. Drug Overdose Deaths per 100,000 population by Race and Ethnicity, 2016-2022



Source: County of Sonoma. (2023). Mental Health-Related Deaths. https://gis-community-health.sonomacounty.ca.gov/pages/mental-health-related-deaths

WHAT IS THE COMMUNITY SAYING?

"We have people who come into housing at the shelter, or other places, and they want to work on their addiction, but all we have to offer them is an NA [Narcotics Anonymous] meeting, and that's not valueless, but a sober living facility, or a 72 hour program, or a 30 day program, are few and far between, and you've got to have good insurance in many cases, or cash, to afford that."

- Kaiser Permanente key informant interview, 2021

[42] CDPH, CA Comprehensive Death File, 2016-2022

COMMUNITY HEALTH IMPROVEMENT PLAN

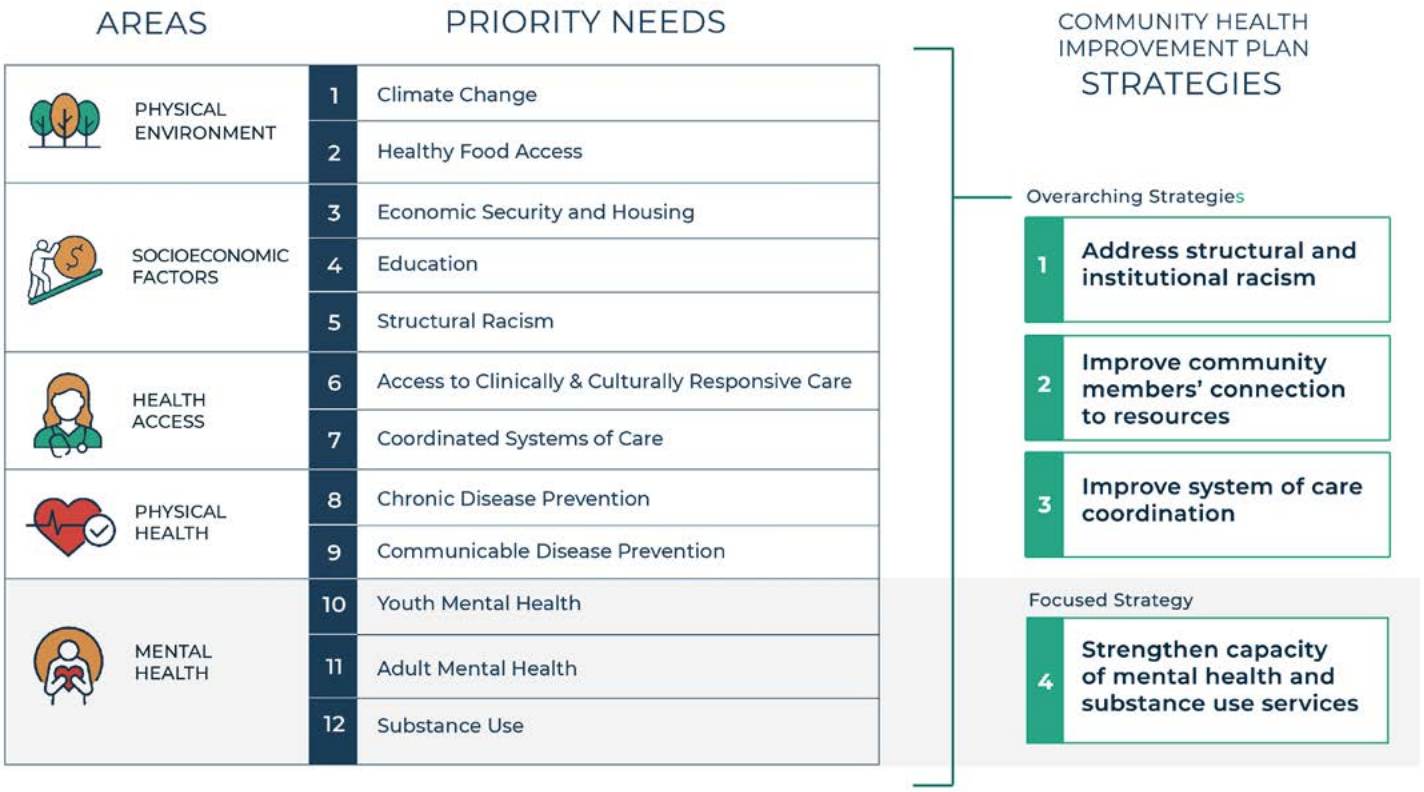
2024-25

COMMUNITY HEALTH IMPROVEMENT PLAN

CONNECTING NEEDS WITH STRATEGIES

The completion of the Community Health Assessment (CHA) in Sonoma County, specifically the identification of 12 priority needs across five areas of focus (see column of boxes on the left and middle, Figure 18), provided the framework for DHS to select a set of responsive strategies to address each prioritized need (see column of boxes on the right, Figure 18). DHS developed and refined the strategies in consultation with DHS staff and feedback from community stakeholders and built on DHS's strength as a connector and partner. As depicted in the figure, three overarching strategies and one focused strategy emerged as priorities for the Community Health Improvement Plan (CHIP): 1) Address structural and institutional racism, 2) Improve community members' access to resources, 3) Improve system of care coordination, and 4) Strengthen capacity of mental health and substance use prevention and treatment services. Each of these will be described in further detail as to why the strategy was selected and the desired outcomes, sub-strategies, and indicators of success. DHS will continue to align with community priorities called out in the Agenda for Action, as well as with complimentary internal plans around equity and community engagement.

Figure 18. Connecting Priority Health Needs with Responsive Strategies



CREATING AN EQUITABLE AND INCLUSIVE FUTURE FOR ALL

DHS MESSAGE TO THE COMMUNITY

The Sonoma County Department of Health Services (DHS) is deeply committed to listening to our community and working together to build a county where every person can experience optimal health and well-being. The Portrait of Sonoma County 2021 Update (https://sonomacounty.ca.gov/health-and-human-services/health-services/about-us/portrait-of-sonoma-county) highlighted that health disparities persist and, in some cases, continue to widen between different neighborhoods and groups of people. These inequalities are driven by historical and systemic factors, requiring meaningful change. DHS recognizes that institutions, including our own, historically have perpetuated these inequities, many rooted in historically racist practices. To move closer to our goal of fair and just service delivery, we must change from within, both individually as public servants and organizationally as a public agency. In response to this challenge, DHS is taking significant steps to ensure that our strategies align with the needs of our community, with an ongoing commitment to creating an equitable and inclusive future for all community members.

DHS is taking significant steps to ensure that our strategies align with the needs of our community...

Address structural and institutional racism.

Improve community members' access to resources.

Improve the system of care coordination.

Strengthen the capacity of mental health and substance use prevention and treatment services.

We are committed to transparency and improving how we serve all communities in Sonoma County. We are focused on achieving racial and cultural systemic change through authentic partnerships with community members. This commitment is reflected in this Community Health Assessment and Community Health Improvement Plan (CHA-CHIP), which serves as both a roadmap and a commitment to equitable health outcomes. As part of our ongoing efforts, we are aligning the CHA-CHIP with Health Action Together's community-driven Agenda for Action (https://www.hatogether.org/agenda-for-action), a set of recommendations co-created by grassroots organizations and community members directly impacted by health, economic, and social disparities. Released in September 2024, the Agenda for Action humanizes the data presented in the Portrait of Sonoma County, addressing underlying factors and amplifying the voices of those most affected by inequities.

The work that began in 2023 with the Phase 1 CHA-CHIP process focused on assessing health data and prioritizing needs. DHS worked closely with the three major hospital systems in the county to synthesize input from their recent community health assessments. This collaboration also included local health leaders, community-based organizations, and other county agencies to refine our collective priorities for improving health outcomes. The four priority areas identified in the Phase 1 CHA-CHIP continue to guide our collective action in addressing the most pressing health disparities.

The Agenda for Action has deepened this work by capturing the voices of Sonoma County residents who face the greatest challenges, further confirming and expanding upon the findings in the CHA-CHIP. This collaboration has produced clear Calls to Action for governments, funders, and stakeholders to strengthen policies, invest in health equity, and collaborate to create lasting change.

Several strategies from the Phase 1 2023 Community Health Improvement Plan (CHIP) align directly with community-identified priorities from the Agenda for Action. The table below shows the CHIP outcome and strategy that most aligns with the two Calls to Action in the Agenda for Action that the community has prioritized for implementation. DHS will focus initially on collaboratively implementing CHIP Strategy 2.5 with community members and work together on other areas of alignment in the future. On the following pages, other CHIP outcomes and strategies that align with Calls to Action are also identified with the Agenda for Action icon:

SHARED PRIORITIES

COMMUNITY HEALTH IMPROVEMENT PLAN Priority Area*	AGENDA FOR ACTION Priority Calls to Action
 **Improve community members' connection to resources** **DESIRED OUTCOME:** Culturally responsive services to be available in trusted community locations. **STRATEGY:** Offer place-based mental and physical health support services and resource connections in trusted community locations (Family Resource Centers, schools, home visiting, etc.)	**Increase access to high-quality, affordable, multilingual health and well-being services,** including preventative, specialized, and complex care provided in multiple modalities (in-person, digital, peer-led, school-based, etc.) without barriers related to immigration status, systems involvement, and/or ability to pay. **Promote community agency and increase access to centralized resources through community hubs in prioritized communities,** which are led and staffed by trained community members, and which provide affordable, strengths-based services and supports such as financial literacy, digital literacy, recreation, community-building, information sharing, and resource navigation among other services needed as identified by communities.

(*One of four priority areas identified in the 2023 CHIP)

The Agenda for Action emphasizes the need for community-led hubs that provide resources like financial literacy, recreation, and community-building. These hubs will be staffed by trained community members and will offer strengths-based services such as digital literacy, information sharing, and resource navigation, among others. This aligns with the priority area in the CHA-CHIP to promote community agency and increase access to centralized resources in prioritized communities (Call to Action #4 in the Agenda for Action).

Many other strategies in the CHIP are already underway and support community priorities in the Agenda for Action. DHS is developing internal performance measures to monitor and report on progress with CHIP strategies, as well as strengthening the Sonoma County Community Health Dashboard to track trends in population health indicators. These efforts are part of broader national and state initiatives to transform Medicaid/Medi-Cal and public health systems to better serve those most at risk. This commitment to ongoing assessment is rooted in a collaborative, three-year cycle of improvement, ensuring that DHS continues to work with the community to evolve strategies in response to emerging needs.

The alignment between the DHS CHA-CHIP and Health Action Together's Agenda for Action aims to be a transformative partnership with the community aimed at creating lasting change. Our vision is a coalition of community members, organizations, and both public and private institutions working together to advance health equity for all Sonoma County residents. We also recognize that the CHIP is one piece of a broader response needed to address the Agenda for Action's findings, as well as the community's calls for greater safety, equity, and justice. As the Sonoma County Office of Equity reminded us when presenting the Portrait of Sonoma County 2021 Update to the community, "The inequalities that exist today are not natural or inevitable, nor are they a product of chance; they are the result of policy decisions made by people in power. Different decisions can lead to better, fairer outcomes."

"The inequalities that exist today are not natural or inevitable, nor are they a product of chance; they are the result of policy decisions made by people in power. Different decisions can lead to better, fairer outcomes."

PRIORITY AREA #1

ADDRESS STRUCTURAL AND INSTITUTIONAL RACISM

WHY WAS THIS PRIORITY SELECTED?

Structural racism and systems of oppression are a root cause of the inequities in health outcomes and the social drivers of health. Notably, during the COVID-19 pandemic, people of color in Sonoma County faced significantly higher rates of infection, hospitalization, and death due to inequities in income, housing, education, and health access. In recognizing racism as a public health crisis, DHS seeks to elevate and learn from the voices of community members who have had the least access to resources that support health and well-being, and to look internally for opportunities to dismantle systems that perpetuate health inequities and unequal access to resources. While addressing structural racism and health inequities crosscuts all priority areas in this plan, this first area describes steps the Sonoma County Department of Health Services will take to directly address this root cause. It should be noted that there are several countywide plans that intersect with this priority area. These include County of Sonoma Racial Equity Action Plan, Community Engagement Plan, and Language Access Plan, as well as the Agenda for Action, a set of community-identified priority areas for attention and investment to ensure that community leaders, organizations, and local governments focus collective efforts on addressing those challenges that are creating the most harm in our communities. DHS has also created a Health Equity Action Plan aligned with the priorities, strategies, and best practices from these plans.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
1.1. Establish bidirectional communication that fosters shared decision-making, trust, transparency, and accountability between DHS programs and the populations they serve 	• Standardize Community Health Worker (CHW) certification, career pathways, training, and deployment within DHS, leveraging training developed through the Center for Well-Being. • Ensure all public communications are accessible and understandable to community members with respect to languages, reading level, health literacy, and tone. • Prioritize lived experience when selecting members for DHS advisory groups and support opportunities for community members' participation. • Develop and implement a process to solicit and incorporate feedback from community members most disproportionately impacted by inequities and publish a revised CHIP with that feedback in 2024; include alignment with Health Action Together's Agenda for Action.	• By 2026, Community Health Worker certification, career pathways, training and deployment with DHS are standardized.
1.2. All community members have a fair and equitable opportunity to attain their highest level of health 	• Inform and provide tools for community members to advocate for policy changes that address social drivers of health and structural racism through outreach and partnership with existing community-led groups, such as Health Action Together and the Tobacco Coalition.	• By 2026, DHS will support at least 2 community-led efforts to improve social drivers of health.
1.3. DHS staff race/ethnicity demographics at all levels of the organization reflect those of Sonoma County community members	• In collaboration with County HR, conduct a review/ audit of Minimum Qualifications requirements to change as necessary to value lived experience and non-formal education. • Create internship pathways and opportunities to promote awareness of County health career paths for community members. • Establish mentorship and support opportunities to promote retention and career advancement of BIPOC employees.	• By 2026, the race/ethnicity of DHS staff at all levels, including management, will more closely resemble the demographics of the community.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
1.4. All DHS staff and contractors with direct service responsibilities participate in ongoing training and reflection on racial equity and anti-racism	• Ensure all levels of DHS staff receive racial equity foundations training. • Encourage DHS contractors with direct service responsibilities to participate in racial equity and antiracism training. • Train DHS contract management staff and contractors in Anti-Racist Results Based Accountability and develop new contracts with these principles embedded. • Empower DHS Equity Circle members to lead their program areas in finding ways to address processes and practices that contribute to structural and institutional racism.	• By 2026, at least 90% of DHS staff have completed racial equity foundations training.
1.5. Replace the Region's Housing Assessment and Prioritization process with a new equitable process	• DHS Homelessness Services shall convene a working group with representation from Sonoma County BIPOC communities to replace the VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assessment Tool) and the Coordinated Entry prioritization process. • Homelessness Services will implement the new Assessment and Prioritization Tool within the Sonoma County Coordinated Entry process to address issues of bias within the existing tool.	• By the end of 2026, the proportion of unhoused BIPOC clients who receive housing through the Coordinated Entry process will increase compared to baseline.

PRIORITY AREA #2

IMPROVE COMMUNITY MEMBERS' CONNECTION TO RESOURCES

WHY WAS THIS PRIORITY SELECTED?

Data for Sonoma County show significant inequities in community members' socioeconomic resources, health outcomes, and mortality. Individuals in areas of the County with the least access to resources to support health and well-being are more likely to die from chronic and communicable disease complications and mental health-related causes. In addition, Sonoma County has a growing older adult population of community members aged 65+. Older adults are expressing concerns about their ability to afford and obtain prescription medicine, health care, transportation, and afford to remain in their homes as their health needs increase and nearly half (49%) of 1679 survey respondents in the Area Agency on Aging 2023 needs assessment reported not knowing what services are available to them. DHS staff can play an important role as a connector and navigator of available resources to help all community members access the resources needed to stay healthy and thrive.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
2.1. All community members are supported in navigating health, social service, and other systems 	• Strengthen coordination with existing CHW workforce and hire and onboard a team of five additional CHWs within DHS to help connect community members to culturally responsive care and resources. • Promote awareness of resource information lines such as 211 and mental health support lines including the suicide and crisis lifeline at 988 and the Sonoma County Crisis Hotline at (800) 746-8181 for mobile crisis support. • Work with hospital and jail staff to provide up-to-date information about DHS services available and facilitate resource connections and navigation through warm hand-offs. • Expand mechanisms to streamline client care coordination between DHS and HSD, including embedding eligibility workers and outreach workers into DHS programs/locations. • Support senior health goals and implement associated strategies in the Sonoma County Master Plan on Aging.	• By 2026, the proportion of income-eligible community members enrolled in social service benefit programs will increase as compared to baseline.
2.2. All community members have access to affordable, accessible, safe, healthy, and stable housing 	• Working alongside partner advocates, inform and empower community members to advocate for policy changes that promote fair and equitable housing practices and increased affordable housing development. • Expand homelessness prevention, housing units, and support services in accordance with the Continuum of Care Board's 2023-2027 5-year Homelessness Strategic Plan. • Connect community members to available support services such as SSI, JobLink, Coordinated Entry services, Homelessness Services programming, Sonoma County Housing Authority, etc. • Support tobacco regulations and ordinances that promote smoke-free environments. • Partner with CHWs to assist people in navigating and securing healthy, affordable, stable housing, including lead exposure prevention. • Support senior housing goals and implement associated strategies in the Sonoma County Master Plan on Aging.	• By 2026, the deficit in affordable rental housing available for low-income families in Sonoma County will decrease, compared to baseline. • By 2026, 600 permanent housing units (200 per year) will be added in accordance with the Continuum of Care strategic plan.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
2.3. DHS staff are more knowledgeable about services and resources provided by the County and community partners, strengthening referral pathways and continuity of care	• Develop internal mechanisms to keep staff informed of current services provided within the county and community to support "no wrong door" referrals. • Convene face-to-face interdepartmental and cross-agency workgroups of service providers to facilitate smooth referrals, communication and coordination of care leveraging existing cross-sector collaborative efforts.	• By 2026, additional strategies will be in place to promote staff awareness of County and community resources and facilitate no wrong door referral processes.
2.4. Early intervention and prevention-oriented upstream services are promoted to improve downstream outcomes	• Train staff and managers in trauma-informed care and leadership practices. • Seek funding to invest in and expand early intervention and prevention services such as early childhood home visiting programs, dental carries prevention, Drug-Free Babies, and preventative mental health services to improve educational and health outcomes and reduce long-term needs for crisis response.	• By 2026, the percent of children entering kindergarten ready will increase overall from 22% to 27%, with Black, Latino and Indigenous/ Native American youth experiencing the largest gains. • By 2026, needs for crisis care will decrease as evidenced by reduced referrals to the Crisis Stabilization Unit as compared to 2023 referral numbers.
2.5. Culturally responsive services are available in trusted community locations 	• Offer place-based mental and physical health support services and resource connections in trusted community locations (Family Resource Centers, schools, home visiting, etc.). • Seek funding to hire culturally and linguistically responsive peer support specialists to expand mental health support services. • Bring mental health services directly to clients through mobile support team services such as inRESPONSE and SAFE through implementation of MediCal Mobile Crisis Benefit.	• By 2026, additional mental health services will be provided across multiple locations including schools, family resource centers, and in the community via mobile response and peer support.

PRIORITY AREA #3

IMPROVE SYSTEM OF CARE COORDINATION

WHY WAS THIS PRIORITY SELECTED?

Most of the focus groups and key informant interviews with Sutter Health and Kaiser Permanente, as well as participants of the Mental Health Community Forum, identified the need for improved cross-system collaboration. Participants described fractured, siloed, and dysfunctional systems. Strategic coordination, they noted, is needed among behavioral health providers, hospitals and emergency departments, community-based organizations, the County, the education sector, and the criminal legal system. Some described specifically the need to build bridges across services and focus on high quality outreach and system navigation to engage the community. Opportunities to connect individuals with peer-based support was another strategy elevated by several qualitative data sources.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
3.1. Health, social service, and community resource coordination of care is supported through use of technology 	• Expand the use of data sharing and coordinated care through health information exchange systems such as Smart Care, and the development of community information exchange systems. • Work toward closed loop referrals, where referrals are delivered, tracked, and managed, to ensure clients are connected with services. • Utilize FirstWatch Emergency Medical Services pre-hospital condition data to inform resource planning and outreach around issues such as drug overdose, infectious disease, and injuries during disasters.	• By 2026, Smart Care will be fully connected to hospital and clinic records to facilitate care coordination. • By 2026, FirstWatch data will be actively used as a surveillance tool for drug overdose and other health conditions.
3.2. DHS Public Health, Behavioral Health, and Homelessness Services division programs and services are less siloed	• Hire Program Planning and Evaluation Analyst (PPEA) to identify areas of overlap and opportunities to increase resource coordination, efficiency, and collaboration. • Identify instances where DHS programs have multiple contracts with the same organizations for similar services to streamline contracting and increase resource efficiencies. • Coordinate across divisions and convene senior leadership regularly on efforts such as CalAIM Enhanced Care Management to increase efficiencies and the capacity of DHS to successfully seek and utilize grant funds.	• By 2026, at least three new projects will be established across program or division content areas to improve coordination.
3.3. DHS and health care system leadership are well connected and coordinated	• Provide backbone support and leadership participation in the new Committee on Healthcare Improvement (CHI) to provide a regular forum for health system coordination. • Convene interdepartmental and cross-agency care coordination meetings as needed to facilitate client care and resource connections. Map out existing meetings to avoid redundancies. • Partner with Sonoma County's managed Medi-Cal provider Partnership HealthPlan, in developing and implementing CalAIM Population Health Management.	• By 2026, CHI 2.0 relaunch is established and active, evidenced by major health system leadership buy-in, updated charter, regular meeting cadence, developed workplan, and identification/ launch of first collective impact initiative.

PRIORITY AREA #4

STRENGTHEN CAPACITY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

WHY WAS THIS PRIORITY SELECTED?

Drug overdose deaths and deaths of despair have increased at an alarming rate in Sonoma County, particular among Black community members and people living in the areas of the county with the least access to resources to support health and well-being. These deaths are occurring at higher rates in our county than seen in California overall. Qualitative data suggests needs for increased staff capacity (behavioral health has a 27% vacancy rate), a focus on prevention and harm reduction services, treatment options for co-occurring needs (ex: substance use disorder, mental health, neurodiversity, homelessness, medically fragile), substance use treatment beyond 30 days, and additional licensed psychiatric facilities. Youth mental health was identified as a concern across qualitative data sources, with frequent acknowledgement that the pandemic and recent disasters have exacerbated and made more visible mental health concerns among youth. Several focus groups and key informant interviews elevated gaps in available mental health services available for youth. BIPOC and LGBTQ+ youth were identified as particular groups in need of more supports and resources. Additionally, an emerging theme from the Mental Health Community Forum survey data emphasized: "Increased knowledge and education about mental health, substance use, and resources available is key to prevention, especially for youth."

DESIRED OUTCOMES	STRATEGIES	INDICATORS
4.1. The DHS Behavioral Health division is fully staffed	• Use strategies such as job fairs, outreach to schools/ colleges, recruitment postings, and hiring bonuses as strategies to attract qualified staff reflecting the communities which DHS serves. • Utilize best practices (e.g., flexible healthy work life balance, employee recognition, competitive salary/ benefits, and training and career advancement opportunities) to reduce staff stress and turnover. • Seek funding to hire culturally and linguistically responsive peer support specialists to expand mental health support services.	• By 2026, reduce staff vacancy rate by half (from 27% to 14%).
4.2. Service gaps in the behavioral health landscape are identified through data analysis and community engagement 	• Assess trends in the number, demographics, and wait-times of people arriving at emergency departments with psychiatric needs. • Conduct a transitional recovery analysis of individuals who are conserved to inform preventative and recovery services needed. • Monitor internal behavioral health quality improvement metrics to inform staffing and programming needs. • Learn from continuous feedback shared in community forums (e.g., MHSA workgroups), the 2024 evaluation around community needs and assets, and bidirectional communication through mechanisms such as Community Health Worker engagement.	• By 2026, data and community input are used to inform resource planning for mental health and substance use.

DESIRED OUTCOMES	STRATEGIES	INDICATORS
4.3. Prevention, maintenance, and harm reduction services are prioritized to reduce drug overdose deaths, infectious disease transmission, and the need for crisis-oriented care 	• Support youth mental health and substance use prevention through programs such as the Behavioral Health School Partnership. • Increase availability of naloxone ("Narcan") in County facilities. • Train and provide naloxone to all DHS field staff. • Help train community-based organizations and schools to administer naloxone to prevent drug overdose deaths and encourage all pharmacies to distribute naloxone. • Promote awareness of and participation in syringe services and medications take-back programming. • Implement Drug MediCal Organized Delivery System (DMC-ODS) plan to support a robust continuum of services. Expand mental health preventative and maintenance-oriented outpatient services including certified peer support specialists, group-based therapy, and telehealth options.	• By 2026, the rate of deaths of despair in Sonoma County will decrease as compared to baseline.
4.4. Substance use treatment and treatment/housing options for individuals with co-occurring needs are expanded	• Expand residential and outpatient youth and adult substance use disorder and co-occurring treatment options through funds such as Measure O, BHCIP Round 5, and implementation of DMC-ODS plan. • Implement interim housing through Behavioral Health Bridge Housing (BHBH) grant for adults experiencing both serious mental health challenges and homelessness. • In collaboration with area service providers, the DHS Homelessness Services Division will identify the approximate number of homeless clients in Sonoma County who have severe needs above the level of care that Permanent Supportive Housing (PSH) can provide and describe and quantify the need to area decision makers. • Seek funds and/or partnership opportunities to expand treatment facilities qualified to treat patients with co-occurring needs (substance use [methamphetamine, opioids, alcohol, etc.], mental health, neurodiversity, homelessness, medical needs). • Support network of providers to increase flexible housing and treatment options to serve clients with co-occurring needs.	• By 2026, the Bridge Housing location(s) serving unhoused adults experiencing serious mental health challenges will be delivering services. • By 2026, at least two additional service agencies will be providing substance use and co-occurring treatment for Sonoma County community members.

COMMUNITY AND DHS PARTNERS

PARTICIPANTS IN COMMUNITY STAKEHOLDER MEETINGS, DHS LARGE AND SMALL GROUP MEETINGS, AND INDIVIDUAL INTERVIEWS.

First Name	Last Name	Organization
Elizabeth	Pile	Alexander Valley Healthcare
Michelle	Rosaschi	Aliados Health (formerly Redwood Community Health Coalition)
Alyssa	Mullins	Applied Survey Research
Kim	Carpenter	Applied Survey Research
Erika	Klohe	Buckelew Programs
Jacob	Rich	Burbank Housing
Jessica	Hughes	Burbank Housing
Jennielynn	Holmes	Catholic Charities
Susan	Garcia	Center for Well-Being
Cynthia	King	Community Action Partnership Sonoma County
Adam	Borovkoff	Department of Health Services
Aileen	Rodriguez	Department of Health Services
Alea	Tantarelli	Department of Health Services
Amanda	Elderkin	Department of Health Services
Andrea	Picket	Department of Health Services
Anne-Marie	Zamora	Department of Health Services
Ariel	Thomas-Urlik	Department of Health Services
Brian	Whipple	Department of Health Services
Brittany	Lobo	Department of Health Services
Carley	Moore	Department of Health Services
Dave	Kiff	Department of Health Services
Fabiola	Acosta Lora	Department of Health Services
Fabiola	Espinosa	Department of Health Services
Gabriel	Kaplan	Department of Health Services
Gina	Pasquinelli	Department of Health Services

COMMUNITY AND DHS PARTNERS

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James	Alexander	Department of Health Services
James	Salvante	Department of Health Services
Jan	Cobaleda-Kegler	Department of Health Services
Jenny	Mercado	Department of Health Services
Karin	Sellite	Department of Health Services
Kate	Pack	Department of Health Services
Kem	Mahiri	Department of Health Services
Ken	Tasseff	Department of Health Services
Kimberly	Hammer	Department of Health Services
Kismet	Baldwin-Santana	Department of Health Services
Laura	Turner	Department of Health Services
Laurel	Chambers	Department of Health Services
Lauren	Reed	Department of Health Services
Leah	Benz	Department of Health Services
Lisa	Steinman	Department of Health Services
Lori	Houston	Department of Health Services
Lucinda	Hammond	Department of Health Services
Maricela	Lagunas Escobar	Department of Health Services
Mark	O'Neil	Department of Health Services
Martin	Rivarola	Department of Health Services
Melissa	Ladrech	Department of Health Services
Melissa	Struzzo	Department of Health Services
Michael	Gause	Department of Health Services
Miranda	Patrick	Department of Health Services
Nasim	Bahadorani	Department of Health Services
Noemi	Amador-Ortiz	Department of Health Services
Nora	Mallonee-Brand	Department of Health Services

APPENDIX A (CONTINUED)

COMMUNITY AND DHS PARTNERS

First Name	Last Name	Organization
Paola	Santos	Department of Health Services
Rachel	Rees	Department of Health Services
Rocio	Rodriguez	Department of Health Services
Ryann	Dehart	Department of Health Services
Samantha	Feld	Department of Health Services
Sid	McColley	Department of Health Services
Siobhan	MacIver	Department of Health Services
Stephen	Johnston	Department of Health Services
Terese	Voge	Department of Health Services
Tina	Rivera	Department of Health Services
Wendy	Wheelwright	Department of Health Services
Renee	Alger	First 5 Sonoma County
Jen	Klose	Generation Housing
Adriana	Arrizon	Health Action Together
Ramona	Faith	Healthy Petaluma
Paul	Dunaway	Human Services Department
Gary	Fontenot	Human Services Department
Katie	Parish	Human Services Department
Savenaca	Gasaiwai	Human Services Department
Sabrina	Johnson	Human Services Department
Alena	Wall	Kaiser Permanente
Andrea	Garcia	Kaiser Permanente
Mary-Frances	Walsh	NAMI Sonoma County
Karissa	Moreno	Northern California Center for Well-Being
Nurit	Licht	Petaluma Health Center
Chelene	Lopez	Providence Santa Rosa Memorial Hospital
Amy	Ramirez	Providence Santa Rosa Memorial Hospital
Becca	Acosta	Providence Santa Rosa Memorial Hospital

APPENDIX A (CONTINUED)

COMMUNITY AND DHS PARTNERS

First Name	Last Name	Organization
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Catherine	Romberger	Providence Santa Rosa Memorial Hospital
Dana	Swilley	Sonoma Connect
Saskia	Garcia	Sonoma Connect
Melissa	Valle	Sonoma County Office of Equity
Roxanne	Ezzet	Sonoma County Office of Equity
Dana	Condron	Providence Santa Rosa Memorial Hospital
Rubyd	Olvera	Sonoma County Office of Equity
Bindi	Gandhi	Sutter Santa Rosa Regional Hospital
Jason	Cunningham	West County Health Centers

With special thanks to Applied Survey Research for their expertise and guidance.

PHYSICAL ENVIRONMENT DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	DEFINITION	YEAR	#	YEAR	#	% Rank CA	SOURCED FROM	PRIMARY SOURCE
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity	2010 and 2019	94%	2010 and 2021	91%	70%	RWJF County Health Rankings	Calculated using Standard Industry Classification codes and ESRI map level data
Park access	Percent of people living within walkable distance (half-mile) of park, beach, or open space	2010	74%	2017	76%	59%	Healthy Places Index, Community Conditions	California Department of Public Health
Tree canopy	Percent of land with tree canopy (weighted by number of people by acre)			2011	15%	63%	Healthy Places Index, Community Conditions	California Department of Public Health
Drinking water contaminants	Index score information about 13 contaminants and 2 types of water quality violations that are sometimes found when drinking water samples are tested	2005-2013	492	2011-2019	331	73%	Healthy Places Index, Community Conditions	CalEnviroScreen 4.0; California State Water Resources Control Board
Extreme heat days above 90 degrees F (2035-2064)	Projected number of days above 90 degrees F in Mid-Century (2035 - 2064) under the RCP 8.5 scenario			2018	64.9 days	71%	Healthy Places Index, Decision Support Layer	CalAdapt_CanESM2_CNRM-CM5_HadGEM2-ES_MIROC5_LOCA_RCP8.5
Extreme heat days above 100 degrees F (2035-2064)	Projected number of days above 100 degrees F in Mid-Century (2035 - 2064) under the RCP 8.5 scenario			2018	13.8 days	71%	Healthy Places Index, Decision Support Layer	CalAdapt_CanESM2_CNRM-CM5_HadGEM2-ES_MIROC5_LOCA_RCP8.5
Extreme heat days above 90 degrees F (2070-2099)	Projected number of days above 90 degrees F in Mid-Century (2070 - 2099) under the RCP 8.5 scenario			2018	89.9 days	71%	Healthy Places Index, Decision Support Layer	CalAdapt_CanESM2_CNRM-CM5_HadGEM2-ES_MIROC5_LOCA_RCP8.5
Extreme heat days above 100 degrees F (2070-2099)	Projected number of days above 100 degrees F in Mid-Century (2070 - 2099) under the RCP 8.5 scenario			2018	23.9 days	76%	Healthy Places Index, Decision Support Layer	CalAdapt_CanESM2_CNRM-CM5_HadGEM2-ES_MIROC5_LOCA_RCP8.5

APPENDIX B (CONTINUED)
PHYSICAL ENVIRONMENT DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
PM 2.5	Yearly average of fine particulate matter concentrations measured in micrometers/meter^3	2012-2014	6.49 µg/m³	2015-2017	7.22 µg/m³	70%	Healthy Places Index, Community Conditions	CalEnviroScreen 4.0; California Air Resources Board
Ozone	Average amount of ozone in the air during the most polluted 8 hours of summer days, measures in ppm	2012-2014	0.031 ppm	2016-2018	0.034 ppm	91%	Healthy Places Index, Community Conditions	CalEnviroScreen 4.0; California Air Resources Board
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store	2015	4%	2019	3%	31%	RWJF County Health Rankings	USDA Food Environment Atlas
Supermarket access	Percent of people in urban areas who live less than a half mile from a supermarket/large grocery store, or less than 1 mile in rural areas	2015	38%	2017	42%	50%	Healthy Places Index, Decision Support Layer	USDA Food Access Research Atlas
Active commuting	Percent of workers (16 years and older) who commute to work by transit, walking, or cycling	2011-2015	7%	2015-2019	6%	61%	Healthy Places Index, Community Conditions	American Community Survey, Table DP04
Diesel particulate matter	Average daily amount of particulate pollution (very small particles) from diesel sources, measured in kg/day	2012	2.38 kg/day	2016	0.119 kg/day	46%	Healthy Places Index, Community Conditions	CalEnviroScreen 4.0; California Air Resources Board
Emergency department visits for heat-related illness	Residents who visit an ED due to a heat related illness; expressed as a rate per 100,000	2018	7.2	2020	10%	29.%	Tracking California ; Heat-related Illness	Calculated: CA Dept of Health Care Access and Information, Emergency Department Visit data, 2020
Wildfire risk	Percent of properties with at least 0.03% risk	2022	7%	30 years	48%	100%	Fire Factor, First Street US Wildfire Risk Data, 2022	-

SOCIOECONOMIC FACTOR DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	DEFINITION	YEAR	#	YEAR	#	% Rank CA	SOURCED FROM	PRIMARY SOURCE
Employment Rate	Percent of people aged 25-64 with a job	2011-2015	73%	2015-2019	77%	89%	Healthy Places Index, Community Conditions	American Community Survey Table S2301
Above Poverty	Percent of people earning more than 200% of FPL	2019	77%	2021	80%	85%	American Community Survey Table S1701	American Community Survey Table S1701
Broadband access	Percent of household population with an internet subscription (broadband of any type)			2015-2019	89%	84%	Healthy Places Index, Decision Support Layer	American Community Survey, Table B28009
Violent crime	Number of violent crimes including rape and sexual assault, robbery, assault and murder per 100,000 population			2019	405.7	51%	Public Policy Institute of California, Crime Rates by County, 2019; From Data Set: Crime Rates in California	
Child care cost burden	Cost for home or center child care as a percentage of median income	2018	39%	2021	39%		Annual Cost of Child Care, by Age Group and Facility Type - Kidsdata.org	California Childcare Portfolio
Food Insecurity	Percent of people experiencing a lack of access, at times, to enough food for an active healthy life	2019	9%	2021	8%		RWJF County Health Rankings	https://map.feedingamerica.org/county/2021/overall/california/county/sonoma
Incarceration	Rate of incarcerations per 100,000 people	2017	172	2020	196	29%	Healthy Places Index, Decision Support Layer	Processed By: Advancement Project California. Copyright Advancement Project California; RACE COUNTS; racecounts.org, 2020.
Automobile access	Percent of households with access to an automobile	2011-2015	95%	2015-2019	95%	70%	Healthy Places Index, Community Conditions	American Community Survey, Table DP04

SOCIOECONOMIC FACTOR DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
Preschool enrollment	Percent of 3- and 4-year-olds in school	2011-2015	51%	2015-2019	50%		Healthy Places Index, Community Conditions	American Community Survey, Table S1401
3rd grade English Language Arts	Percent of 3rd graders scoring proficient or better in English Language Arts	2018-2019	48%	2021-2022	41%			California Assessment of Student Performance and Progress, 2018-22
3rd grade math	Percent of 3rd graders scoring proficient or better in Math	2018-2019	48%	2021-2022	42%			California Assessment of Student Performance and Progress, 2018-22
High school enrollment	Percent of 15-17 year olds in school	2011-2015	98%	2015-2019	97%	29%	Healthy Places Index, Community Conditions	American Community Survey, Table S1401
High school graduation	Percent of graduated high school students in four-year adjusted cohort	2019-2020	81%	2020-2021	84%		https://dq.cde.ca.gov/dataquest/dqcensus/CohRate.aspx?	
Bachelor's degree or higher	Percent of people aged 25 and older with a bachelor's education or higher	2011-2015	33%	2015-2019	36%	78%	American Community Survey, Table DP02	American Community Survey, Table DP02
Student suspension rate	Rate of students suspended per 100 students			2017	4.5	49%	Healthy Places Index, Decision Support Layer	Processed By: Advancement Project California. Copyright Advancement Project California; RACE COUNTS; racecounts.org, 2020.

APPENDIX C (CONTINUED)
SOCIOECONOMIC FACTOR DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
Low-income homeowner severe housing cost burden	Percent of low-income homeowners who pay more than 50% of income on housing costs	2011-2015	6%	2015-2019	7%		Healthy Places Index, Community Conditions	HUD CHAS Table 8
Low-income renter severe housing cost burden	Percent of low-income renters who pay more than 50% of their income on housing costs	2011-2015	18%	2015-2019	19%		Healthy Places Index, Community Conditions	HUD CHAS Table 8
Homeowner-ship	Percent of people who own their home	2011-2015	59%	2017-2021	61%	50%	Healthy Places Index, Community Conditions	American Community Survey, Table DP04
Uncrowded housing	Percent of households that are not crowded (1 or fewer occupants per room)	2011-2015	95%	2015-2019	95%	52%	Healthy Places Index, Community Conditions	American Community Survey, Table DP04
Housing habitability	Percent of households with basic kitchen facilities and plumbing	2010-2014	99%	2013-2017	99%	61%	Healthy Places Index, Community Conditions	HUD CHAS Tables 15A-C
Homelessness	Number of persons experiencing homelessness counted during the annual point-in-time count.	2022	2,893	2023	2,266		Sonoma County Homeless Point in Time Count	Sonoma County Homeless Point in Time Count

HEALTH ACCESS DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	DEFINITION	YEAR	#	YEAR	#	% Rank CA	SOURCED FROM	PRIMARY SOURCE
Insured adults	Percent of adults aged 18-64 years with health insurance	2011-2015	84%	2015-2019	91%	76%	Healthy Places Index, Community Conditions	American Community Survey, Table S2701
Early Entry into Prenatal Care	Percent of births to women who initiated prenatal care in the first trimester of pregnancy	2017-2019	89%	2019-2021	92%		MCAH Data Dashboard	California Comprehensive Birth Master File, Access with Permission or limited Access through CDC Wonder
Preventable hospitaliza-tions	The number of preventable hospitalizations per 100,000 people. See CA HCAI Prevention Quality Indicator #92 for definition	2017	2,710	2019	2466	75%	RWJF County Health Rankings	Calculated: CA Dept of Health Care Access and Information, Patient Discharge data, 2021
Ratio of population to primary care physicians	Number of residents for every one primary care physician	2018	965:1	2019	977:1	84%	County Health Rankings	Area Health Resources Files (AHRF) 2020-2021
Ratio of population to mental health providers	Number of residents for every one mental health provider	2020	206:1	2021	194:1	81%	County Health Rankings	CMS, National Provider Identification
Cervical Screening	Number of Patients Screened for Cervical Cancer	2020	86%	2020	85%	96%	CDC Places	
Colorectal Screening	Number of Patients Screened for Colorectal Cancer men/women	2018	26.5%/ 26.6%	2020	41.3%/ 33.7%	86%/89%	CDC Places	

PHYSICAL HEALTH DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	DEFINITION	YEAR	#	YEAR	#	% Rank CA	SOURCED FROM	PRIMARY SOURCE
Physical Inactivity	Percent of people who do not exercise or participate in physical activities (outside of their regular job)	2018	19%	2020	19%	22%	Healthy Places Index, Decision Support Layer	CDC Places
Adult Obesity	Percent of adults aged >=18 years who have a body mass index (BMI) >=30.0 kg/m^2 calculated from self-reported weight and height	2018	25%	2020	25%	13%	CDC Places	CDC Places
Excessive Weight Gain in Pregnancy	Percent of births to women who gained more than the recommended amount of weight during pregnancy	2017-2019	47%	2019-2021	48%		MCAH Data Dashboard	California Comprehensive Birth Master File, Access with Permission or limited Access through CDC Wonder
Pre-pregnancy Overweight or Obese	Percent of births of women who had a BMI >24.9 kg/m2 before becoming pregnant	2017-2019	55%	2019-2021	58%		MCAH Data Dashboard	California Comprehensive Birth Master File, Access with Permission or limited Access through CDC Wonder
Preterm birth	Percent of births born <37 weeks gestation	2017-2019	7%	2019-2021	8%		MCAH Data Dashboard	California Comprehensive Birth Master File, Access with Permission or limited Access through CDC Wonder
Teen Births	Number of births to teen females 15-19 years per 1,000 females 15-19 years	2016-2018	8.8	2019-2021	7.2		MCAH Data Dashboard	California Comprehensive Birth Master File, Access with Permission or limited Access through CDC Wonder
Disability	Percent of the non-institutionalized population with a disability			2021	12%	38%	Healthy Places Index, Decision Support Layer	American Community Survey, Table S1810
Hemoglobin A1C Control	Diabetic Patients with Poorly Controlled Hemoglobin A1c (HbA1c > 9%) or No Test During Year							

PHYSICAL HEALTH DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
Hypertension Control	Patients with Hypertension (HTN) Whose Blood Pressure (BP) was Controlled (< 140/90 mmHg)	2017	49%	2019	0.501	81%	CDC Places	
High blood pressure	Adult >= 18 year ever told by a doctor they had high blood pressure	2014	27%	2018	26.1	13%	Healthy Places Index, Decision Support Layer	CDC Places
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population	2013-2019	9	2014-2020	9	62%	RWJF County Health Rankings	CDC Wonder
Leading causes of death	Top ranking cause s of death				See		CDC Wonder	CDC Wonder
Life expectancy	Average number of years a person can expect to live	2016-2018	82.0	2018-2020	82.0	77.4%	RWJF County Health Rankings	Calculated: CDC Wonder
Age-adjusted mortality rate	Number of deaths per 100,000 population adjusted for age						RWJF County Health Rankings	CDC Wonder
Neonatal abstinence syndrome	Newborns diagnosed with neonatal abstinence syndrome (NAS) for every 1,000 newborn hospital stays	2017-2019	4.1		5.3		MCAH Data Dashboard	Calculated: CA Dept of Health Care Access and Information , Patient Discharge Data, 2019-2021
Physical health not good	Percent of adults aged >=18 years who report 14 or more days during the past 30 days during which their physical health was not good	2018	12%	2020	9.1%	22%	Healthy Places Index, Decision Support Layer	CDC Places

PHYSICAL HEALTH DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCES	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
Premature mortality rate	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	2016-2018	243	2018-2020	250.7	77%	California Community Burden of Disease Engine	Calculated: California Comprehensive Death File, 2019-21
Adult Smoking	Percent of adults who currently smoke	2018	13%	2020	12%	72%	Healthy Places Index, Decision Support Layer	CDC Places
Coronary heart disease prevalence	Percent of adults aged >=18 years who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease	2018	5%	2020	5%	15%	CDC Places	CDC Places
Diagnosed diabetes	Percent of adults aged >=18 years who report ever been told by a doctor, nurse, or other health professional that they have diabetes other than diabetes during pregnancy	2018	8%	2020	8%	9%	Healthy Places Index, Decision Support Layer	CDC Places
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population	2018	451.20	2019	405.20	52%	RWJF County Health Rankings	National Center for AID/HIV, Viral Hepatitis, STD, TB Prevention

MENTAL HEALTH DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCE	
MEASURE	DEFINITION	YEAR	#	YEAR	#	% Rank CA	SOURCED FROM	PRIMARY SOURCE
Adverse Childhood Experiences (ACEs) and Toxic Stress	Percent of adults with four or more Adverse Childhood Experiences			2016-2019	21%	78%	Kidsdata.org	CA BRFSS
Perception of neighborhood safety	Percent of adults who reported feeling safe in their neighborhood all of the time			2017	92%	66%	Healthy Places Index, Decision Support Layer	Processed By: Advancement Project California. Copyright Advancement Project California; RACE COUNTS; racecounts.org, 2020.
Mental health not good	Percent of adults aged >=18 years who report 14 or more days during the past 30 days during which their mental health was not good	2018	13%	2020	14%	21%	CDC Places	CDC Places
Reoccurrence of Child Abuse Maltreatment	Percent of children ages 0-17 with substantiated cases of abuse or neglect with reoccurrence within 12 months	2019	7%	2021	6%		California Child Welfare Indicators Project	California Child Welfare Indicators Project
Substantiated Child Abuse	Number of children ages 0-17 with substantiated cases of abuse or neglect per 1,000 children	2016-2018	4.5	2020-2022	4.5		California Child Welfare Indicators Project	California Child Welfare Indicators Project
Average commute time to work	Time to get commute to work for workers 16 years or older who did not work from home	2019	26.1min	2021			Calculated	American Community Survey, Table B08012
Excessive Drinking	Percent of adults who drank 5 or more alcoholic drinks (men) or 4 or more alcoholic drinks (women) at least once within the past month	2014	20%	2020	20%	76%	Healthy Places Index, Decision Support Layer	CDC Places

MENTAL HEALTH DATA

		REFERENCE TIME POINT SONOMA COUNTY:		MEASURED TIME POINT SONOMA COUNTY:			RESOURCE	
MEASURE	**DEFINITION**	**YEAR**	**#**	**YEAR**	**#**	**% Rank CA**	**SOURCED FROM**	**PRIMARY SOURCE**
Alcohol-Impaired driving deaths	Percentage of driving deaths with alcohol involvement	2015-2019	33%	2016-2020	33%	33%	RWJF County Health Rankings	Fatal Analysis Reporting System
Drug overdose deaths	Number of drug poisoning deaths per 100,000 population	2017-2019	16	2018-2020	22	27%	RWJF County Health Rankings	CDC Wonder

HEALTH INEQUITY DATA

MEASURE	DEFINITION	YEAR	SONOMA COUNTY OVERALL	AMERICAN INDIAN	ASIAN	BLACK	HISPANIC/ LATINO	MULTI-RACIAL	NH/PI	WHITE
3rd grade English Language Arts	Percent of 3rd graders scoring proficient or better in English Language Arts	2021-2022	41%	31%	57%	31%	26%	49%	24%	56%
3rd grade math	Percent of 3rd graders scoring proficient or better in Mathematics	2021-2022	42%	31%	67%	29%	26%	49%	14%	57%
4-year cohort graduation rate	Percent of graduated high school students in four-year adjusted cohort	2020-2021	84%	70%	89%	65%	81%	87%	81%	88%
Above poverty	Percent of people earning more than 200% of FPL	2021	80%	91%	93%	79%	89%	90%	91%	93%
Bachelor's degree or higher	Percent of people over 25 with a bachelor's education or higher	2015-2019	36%	10%	44%	30%	14%	26%	25%	42%
Employed	Percent of people aged 25-64 with a job	2015-2019	77%	77%	75%	70%	86%	78%	79%	78%
Incarceration	Rate of incarcerations per 100,000 people	2020	172			127	257			133
Insured adults	Percent of adults aged 18-64 years with health insurance	2015-2019	91%	91%	93%	89%	83%	92%	78%	95%
Per capita income	Average income computed for every person in a particular group	2019	$42,000	$28,100	$39,200	$32,400	$22,100	$26,600	$28,100	$52,000

QUALITATIVE DATA SOURCES

Partnering Agency	Data Source	Population and Communities Represented/Served
Sutter	Key Informant Interviews and Focus Groups from 2022 CHNA (format: detailed notes)	Focus groups and interviews with representatives from the following agencies: • Corazon • DAAC and West County Health Centers • Homeless Services Providers (Catholic Charities, Committee on the Shelterless, Reach for Home, Community Support Network) • LGBTQ Connection • Latino Service Providers and Humanidad Therapy and Education Services • Latino Service Providers – Youth Promotores • Behavioral Health Providers (Side by Side, Buckelew, inRESPONSE, County Behavioral Health) • Redwood Community Health Coalition (Aliados Health) • Santa Rosa Community Health • Sutter Santa Rosa Care Coordination Team
Providence	3 listening sessions with community members in April 2023, conducted by On the Margins (format: final report)	• Petaluma (located at Petaluma Family Resource Center) n=13 o majority female, majority Latino, ages 19-45 • Santa Rosa (located at La Plaza, conducted in Spanish) n=11 o all female, all Spanish-speaking, almost half indigenous, ages 31-70 • Healdsburg (located at Corazon) n=14 o majority female, majority Latino, all speak Spanish, ages 34-54
Two DHS-led Community Stakeholder Meetings	Two 2-hour feedback sessions with health system and community partner (format: results of rankings of need, comments)	• See Appendix A for participant list
Kaiser Permanente Santa Rosa	2022 CHA assessment (Format: interview transcripts)	Interviews and focus groups were conducted in 2021 with staff/leaders from: • Committee on the Shelterless (COTS) • La Familia Sana (LFS) and Sonoma County Community Organizations Active in Disaster (COAD) • North Bay Organizing Project • Positive Images • Redwood Empire Food Bank • Santa Rosa City Schools and Sonoma County Office of Education • Santa Rosa Community Health • West County Community Services • CHOP's Teen Club

QUALITATIVE DATA SOURCES

Partnering Agency	Data Source	Population and Communities Represented/Served
HSD Adult and Aging	2023 Needs Assessment (Format: notes and an overall summary from 13 focus groups)	13 focus groups among senior groups: • Windsor Burbank Housing Vinecrest Apartments • Cloverdale Senior Center • Santa Rosa PEP Housing • Cotati Burbank Housing • La Luz • WCCS Russian River Senior Center • Windsor Mobile County Club • Roseland Library • Mendonoma Health Alliance • Virtual group among people with disabilities • Virtual group among caregivers and people with memory loss • Sonoma Valley Vintage House Senior Center • Petaluma PPSC Café Survey data from 1679 surveys were also shared with DHS.
DHS Mental Health Community Forum	Mental Health Community Forum Participant Survey, May 2023 (format: summary of findings)	Attendees included the Board of Supervisors, service providers, and community members. 64 individuals responded to the survey, providing open-ended survey responses. We do not have any information or demographics on the respondents.
DHS MHSA CPP	Mental Health Services Act (MHSA) Community Program Planning (CPP) Workgroup - Listening Sessions Draft Annual Report FY 2022-2023 (Format: report summarizing themes and providing illustrative quotes)	Listening Sessions were conducted by trained facilitators with populations in Sonoma County most likely to experience inequities in mental health status and access to and utilization of mental health services and program, including: • African American/Black • Asian American/Pacific Islander • Latino Youth (immigrant and US-born) • Latino Adults (immigrant) – Sonoma Valley • Latino Adults (immigrant) – Cloverdale • Latino Adults (low-wage earners) – Guerneville • LGBTQIA • Older Adults

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