MORE
COMMUNITY VOICES

Adventist Health
Lodi Memorial

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

Adventist Health Lodi Memorial Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public services to help improve the lives of the community members they serve. The Community Health Needs Assessment (CHNA) is conducted every three years to support this calling by helping non-profit hospitals understand the health needs of the community.

For 2025, Adventist Health Lodi Memorial was part of the Healthier San Joaquin Collaborative to create the 2025 CHNA. This collaborative effort resulted in the following high priority health needs:

Access to Care
Mental and Behavioral Health including Substance Use
Chronic Disease/Healthy Eating, Active Living (HEAL)

About Us

You're made for more

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

Adventist Health

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

Adventist Health Lodi Memorial

Adventist Health Lodi Memorial, located in San Joaquin County, is one of the region's premier nonprofit healthcare providers that has been serving the community since 1952. Over the decades, Adventist Health Lodi Memorial is a 194-bed acute care hospital that has become a community pillar and has expanded to now include three primary care medical practices, an urgent care clinic and 16 specialty medical practices. Our continuum of care network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- Cardiology
- Endocrinology
- Gastroenterology
- Gynecology/Women's Health
- Hyperbaric Medicine
- Neurology
- Occupational Medicine
- Orthopedics, Sports Medicine
- Orthopedics, Total Joint
- Outpatient Therapy Services
- Pediatrics
- Physical Medicine & Rehabilitation
- Prenatal
- Radiation Oncology
- Surgical Care
- Wound Care

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health Lodi Memorial focused on access to care, financial stability and mental health through community projects and partnerships. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS). In collaboration with the community, we implemented goals, actions, solutions and programs to address each high priority need.

We're proud of our efforts to address the interweaving community health needs of access to care, financial stability and mental health through the Substance Use Navigator (SUN) behavioral health program. Adventist Health Lodi Memorial has continued to utilize the funds from the California Department of Health Care Services' Behavioral Health Pilot Project to support a Substance Use Navigator (SUN) in the emergency department. In 2023, the SUN at Adventist Health Lodi Memorial provided service to 356 patients in emergency department/inpatient care. Of these, 177 patients accepted referrals to medication-assisted treatment (MAT), substance use treatment and behavioral health with scheduled appointments as they were discharged from the ED or inpatient hospital setting. Our SUN coordinated the direct transfer of at least eight patients directly from the hospital inpatient setting to community residential treatment programs for a seamless course of care for their conditions.

We encourage future collaboration with other community organizations to build and scale the work in addressing community health needs. For a full and complete reporting of program and activities since the 2022 Community Health Needs Assessment, please visit www.adventisthealth.org/lodi-memorial/about-us/community-benefit

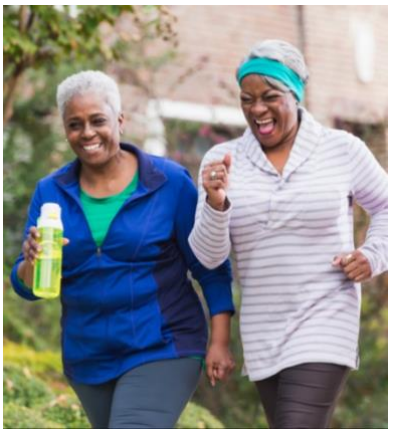
A Look Forward: After the CHNA Report

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

The CHNA highlights where you, your family and your community can drive change for improved wellbeing We hope it is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all.

The full collaborative CHNA report is available in the following pages. It is also published online and available in print form by contacting community.benefit@ah.org




San Joaquin County 2025 Community Health Needs Assessment

April 2025

Table of Contents

Executive Summary

Introduction

San Joaquin County is one of California's fastest growing counties; it encompasses 1,426 square miles, with 35 square miles of water and waterways, and includes eight cities, many small towns, and several rural farm and ranching communities that are home to diverse racial and ethnic populations. San Joaquin is a county of contrasts, home to enormous economic wealth and community growth opportunities and a variety of assets and resources to support health, while facing significant challenges in terms of economic and health disparities.

CHNA Background

The San Joaquin County 2025 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions that impact health in the County. The overall goal of the CHNA is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents. From data collection and analysis to the identification of prioritized needs, the development of the CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and broadly representative Steering Committee, with input from hundreds of community residents. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

Conducting a CHNA every three years fulfills a long-standing California requirement for nonprofit hospitals as well as a federal mandate to maintain tax-exempt status; in addition, it is a requirement for Public Health Accreditation and satisfies mandates for Managed Care Plans. San Joaquin County's CHNA is unique in that all its non-profit hospitals, the county Managed Care Plans, the local health department and key stakeholders join together to support one countywide assessment. The process in 2025 included interviews with 12 key informants, 40 focus group discussions with 350 community residents, and data analyses of over 100 indicators, creating a robust picture of the issues affecting people's health where they live, work, and play.

The CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health, in addition to exploring factors related to diseases, clinical care, and physical and mental health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the County. This CHNA report places particular emphasis on the health issues and contributing factors that impact populations that have poor health outcomes across multiple health needs. It identified specific geographic areas referred to as "Priority Neighborhoods" and explores health disparities

for populations residing in them, as well as disparities among the entire County's diverse population. These analyses will inform intervention strategies to promote health equity.

Highest priority health needs

Through a comprehensive process combining findings from demographic and health data, as well as community leader and resident input, ten health needs were identified (see box). A multi-step prioritization method identified the following three health needs as the highest priorities for San Joaquin County. See Section 7 for the full Health Need Profiles and Appendix A and B for secondary data descriptions, sources, and dates.

CHNA Health Needs

Highest Priority
- Access to Care
- Mental/Behavioral Health including Substance Use
- Chronic Disease/HEAL

Medium Priority
- Housing
- Economics
- Social Support

Lower Priority
- Community Safety
- Education
- Food Security
- Transportation

Access to Care: Access to comprehensive, quality healthcare is important for health and for increasing and maintaining a high quality of life. In San Joaquin County, residents have access to significantly fewer health care providers (including mental health providers) than the California average, which contributes to long wait time for appointments, limited clinic hours, the need to travel for specialty care, and frustration with and distrust of the medical system. Lack of prenatal care and lower rates of health insurance, especially among women of color, can be linked to the higher percentage of poor outcomes for infants. Key informants and focus group participants emphasized the need for culturally and linguistically competent providers, as well as assistance with insurance applications and other healthcare paperwork. Key informants and focus group participants noted the success of pop-up and mobile COVID-19 vaccination and testing clinics established in partnership with community-based organizations, which created access points for other health care services in underserved areas; they suggested that this model be maintained and expanded to address a variety of health needs.

Mental Health Including Substance Use: Mental health affects all areas of life, including a person's physical well-being and ability to work, to perform well in school, and to participate fully in family and community activities. Residents of San Joaquin County have a higher rate of deaths by suicide, drug overdose, and alcohol poisoning combined than the California average, with significantly fewer mental health care providers available. Participants in almost two-thirds of the focus groups described mental health as the number one health issue within their communities, and, along with key

informants, expressed particular concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens. Key informants and focus group participants pointed out the intersection of mental health needs, substance use, and homelessness, and stressed the urgent necessity for diverse providers, timely crisis intervention services, improved access to mental health care in rural areas, and services tailored to the needs of underserved groups.

Chronic Disease/Healthy Eating, Active Living (HEAL): Chronic diseases are a primary cause of poor health outcomes and death and a leading driver of health care costs. The rates of diabetes and obesity among adults in San Joaquin County are higher than California overall, as are the rates of heart disease and stroke deaths – all conditions that have persisted for many years. Black/African American County residents have the highest rates of diabetes, pediatric asthma prevalence, and hospitalizations for cardiovascular disease, and the highest incidence of colorectal and lung cancer among all ethnicities/races. Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare. These are especially present in communities/neighborhoods with a high percentage of low-income residents, people of color, and immigrants.

Next steps

San Joaquin County will use the results of this CHNA to drive the development of a Community Health Improvement Plan (CHIP). The CHIP will identify strategies and actions to address health needs using a collaborative approach. It will leverage resources and skills from a variety of County organizations and agencies to maximize the potential for collective impact that results in sustainable changes for County residents.

The hospitals involved in the CHNA will each develop a complementary Implementation Strategy (IS) plan to outline how they will address priority health needs. These strategies will build on a hospital's own assets and resources, as well as on evidence-based strategies and best practices, wherever possible. Their IS reports will be filed with the Internal Revenue Service. Both the San Joaquin County CHNA and the IS reports, once finalized, will be posted publicly on each of the hospitals' websites.

The 2025 CHNA report and the subsequent CHIP will be available at www.healthiersanjoaquin.org

I. Introduction/Background

The San Joaquin County 2025 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions and challenges that impact health in the County. The overall goal is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents.

The San Joaquin County community has a long tradition of working collaboratively and has conducted a joint triennial CHNA for many years. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

San Joaquin County will use the results of this CHNA to drive the development of a joint Community Health Improvement Plan (CHIP), which will identify long-term, systematic strategies and actions to address health needs. Community partners across the County will work together to set priorities and coordinate and target resources. The 2025 CHNA report will be available at www.healthiersanjoaquin.org.

The hospitals involved in the CHNA will each develop an Implementation Strategy (IS) plan to outline how they will be addressing priority health needs. These strategies will build on a hospital's own assets and resources, as well as on evidence-based strategies and best practices, wherever possible. Their IS reports will be filed with the Internal Revenue Service.[1] Both the CHNA and the IS reports, once finalized, will be posted publicly on each of the hospitals' websites.

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

Conducting a triennial CHNA has been a California requirement for nonprofit hospitals for more than 30 years (SB 697).[2] The Patient Protection and Affordable Care Act (ACA) adopted a federal model similar to regulations already in place in California, making the CHNA a national mandate for nonprofit hospitals to maintain their tax-exempt status. Section 501(r) of the Internal Revenue Code now requires all nonprofit hospitals to conduct a CHNA and develop an IS every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

Additionally, this 2025 San Joaquin County CHNA fulfills San Joaquin County Public Health Services' requirement to maintain its national Public Health Accreditation.[3] This report also fulfills the mandate for Managed Care Plans (MCPs) to meet standards for

[1] Charitable hospitals - general requirements for tax-exemption under Section 501(c)(3) | Internal Revenue Service

[2] Hospital Community Benefits Plan - HCAI

[3] Standards & Measures for Reaccreditation Version 2022

Population Health Management programs and National Committee for Quality Assurance (NCQA) Health Plan Accreditation.[4,5] By 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation, with the goal of ensuring equitable, coordinated, and person-centered services, and improving health outcomes.

From data collection and analysis to the identification of prioritized needs, the development of the CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and a broadly representative Steering Committee. Opinions were sought from decision makers and key stakeholders and more importantly, from a diverse cross-section of residents whose voices are not often heard. As many community members as possible were engaged in the CHNA process.

B. Description of the CHNA Process

The CHNA was a collaborative examination of health in San Joaquin County, updating and building on work done in prior years, including many of the themes identified in previous CHNA cycles. The CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the County.

The CHNA assessed the health issues and contributing factors with greatest impact among populations that have poor health outcomes across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas referred to as "Priority Neighborhoods", as well as disparities among the County's diverse ethnic populations. These analyses will inform intervention strategies to promote health equity.

The CHNA utilized a mixed-methods approach. San Joaquin County Public Health Services epidemiologists compiled a comprehensive set of secondary data from national, statewide, and local sources to provide a multi-faceted picture of health in San Joaquin County. These data were compared to benchmark data and analyzed to identify potential areas of need. In addition, Ad Lucem Consulting, in concert with the Core Team, collected primary data via key informant interviews and focus groups that offered a wide range of opinions about issues that most impact the health of the community, as well as examples of existing resources that work to address those needs, and suggestions for continued progress in improving these issues. The analyzed

[4] CALAIM: Population Health Management (Phm) Policy Guide
[5] Population Health Management

quantitative and qualitative data were triangulated to identify the top health needs in the County. A summary health need profile was then created for each of these.

Health needs were ranked as highest, medium, and lower priority based on the points received after scoring each health need on quantitative and qualitative dimensions. These methods, the data collected, and the resulting prioritized community health needs are presented in this report and in the appendices.

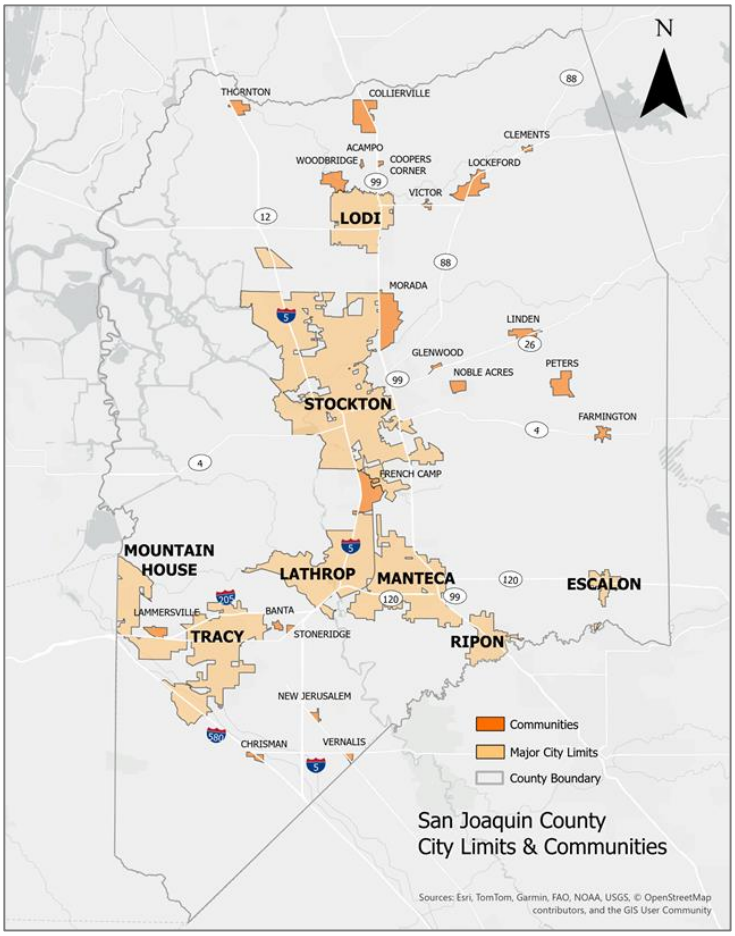
II. Community Served

A. Definition of Community Served

Each hospital participating in the San Joaquin County CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. For this joint CHNA, the hospital partners chose San Joaquin County as the primary service area.

B. Map and Description of Community Served

Figure 1. Map of San Joaquin County



i. Geographic Description of the Community Served

San Joaquin County, in the Central Valley of California, is roughly 60 miles east of San Francisco and 35 miles south of Sacramento, with a total population of 779,445 (2022). Historically, agriculture has been a strong driver of the economy, and many migrants and immigrants have settled in the County to work as farm laborers, in agricultural processing, or in shipping. The County encompasses an area of 1,426 square miles, with 35 square miles of water and waterways, and includes 8 cities (Escalon, Lathrop, Lodi, Manteca, Mountain House, Ripon, Stockton, and Tracy) as well as many ranching and farming communities scattered across the County (Figure 1).

ii. Climate and Environment of the Community Served

San Joaquin County's climate is shaped by its location on the northern end of the San Joaquin Valley, an area bounded by mountains to the north and east and the Sacramento-San Joaquin River Delta to the west. The region's weather is characterized by hot, dry summers and mild, wet winters. Risks to health from a changing climate are a growing concern in San Joaquin County, as environmental extremes – such as drought, heat, flooding and pollution-related catastrophes – increase in frequency and intensity (Table 1). The County performs substantially worse than California overall on a number of climate measures.

Table 1. Climate and environmental measures – San Joaquin County

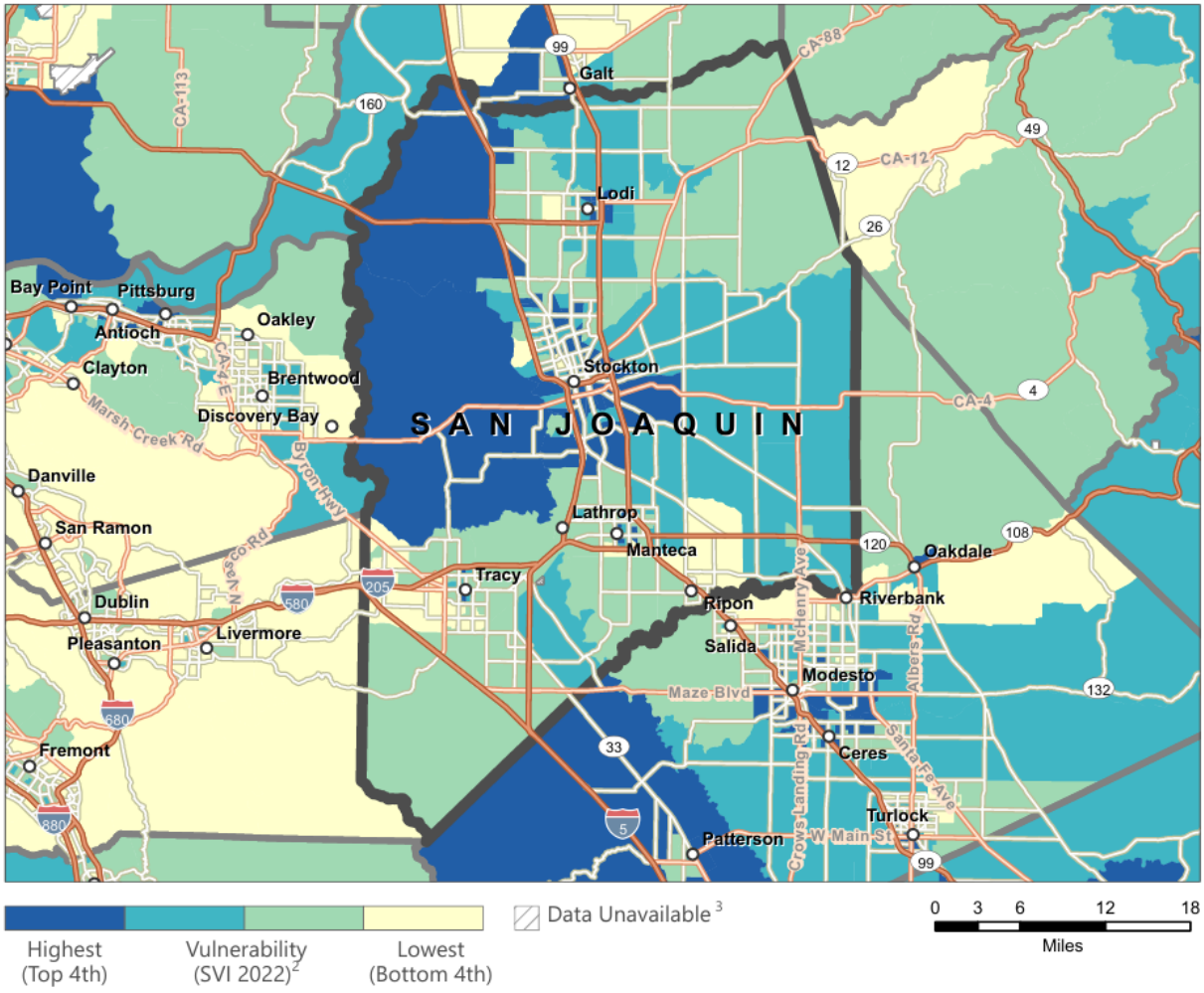
	SJC Measure	CA Measure	SJC Significantly Worse than CA
Drought risk *	100	3	Yes
Heat wave risk *	96	8	Yes
Air pollution: PM2.5 concentration ‡	11	10	No
Water Contaminants ‡	661	478	Yes
River flooding risk ∞	58	29	Yes

Sources: *FEMA National Risk Index, ‡CalEnviroscreen 4.0, ∞Kaiser Permanente Community Health Data Platform, 2025

Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The CDC/ATSDR Social Vulnerability Index County Map (Figure 2) depicts the social vulnerability of communities, at census tract level, within San Joaquin County. The SVI groups sixteen factors into four themes that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and

vehicle access. Overall social vulnerability combines all the variables to provide a comprehensive assessment. The map below indicates that large areas of western and eastern San Joaquin County fall into the two highest vulnerability categories.

Figure 2. Social Vulnerability Index Map – San Joaquin County



Source: Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry SVI Interactive Map, California2022_San Joaquin County.pdf, 2022

iii. Demographic Profile of the Community Served

San Joaquin County is one of California's fastest growing counties, home to diverse racial and ethnic populations. San Joaquin is a county of contrasts; there is enormous economic wealth and community growth opportunities and a variety of assets and resources to support health, however, San Joaquin County faces significant challenges in terms of economic and health disparities. A plurality of residents is Hispanic/Latino, and almost a quarter of residents are foreign-born. While many within the County are economically secure, nearly 13% of residents live in poverty. Children have a poverty

rate of over 17%, and more than 1 in 10 residents aged 65 years and older live in poverty. The educational attainment of San Joaquin County residents is much lower than California residents; about 20% of County adults have no high school diploma, compared to 16% of adult Californians, and a much bigger gaps exists between the percent of County residents with a college degree (20%) versus California overall (36%). See Table 2 for a summary of County population demographics.

Table 2. Demographic Profile – San Joaquin County

Race/ethnicity*	
Total Population	**779,445**
Hispanic/Latino	**43%**
Non-Hispanic/Latino	**57%**
White	*29%*
Asian	*17%*
Black/African American	*7%*
Multiple races	*4%*
Pacific Islander/Native Hawaiian	*1%*
American Indian/Alaska Native	*0.2%*

Source: US Census, 2022
*Percentages may not equal 100% due to rounding

Median household income	$82,837
Living in poverty (<100% Federal poverty level)	13%
Children in poverty	17%
Older adults (ages 65+) in poverty	11%
Employed (ages 16+)	57%
Medicaid/public insurance enrollment	43%
Insured (ages 19-64 years)	91%
Adults with no high school diploma	20%
Bachelor's Education or higher	20%

Source: US Census, 2022

Many languages are spoken in San Joaquin County (Table 3), with almost half of the population speaking a language other than English at home. The top five non-English languages spoken at home are Spanish, Tagalog (incl. Filipino), Punjabi, Khmer, and Vietnamese. Of the Asian and Pacific Island languages, more than half of Chinese (64%), Korean (57%), Vietnamese (54%), and other languages of Asia (72%) speakers communicate in English less than "Very Well".

Table 3. Languages Spoken at Home[6] and Ability to Speak English (Population 5 Years and Older) – San Joaquin County

	Number of Speakers	Percent of Speakers	Speak English less than "Very Well"	Percent Who Speak English less than "Very Well"
Population 5 years and over	735,401	n/a	133,872	18%
Speak only English at home	412,408	56%	n/a	n/a
Speak a language other than English at home	337,724	46%	133,872	40%
Non-English languages spoken at home*				
Spanish	209,017	28%	83,806	40%
Punjabi	20,251	35%	8,391	41%
Chinese (incl. Mandarin, Cantonese)	6,353	10%	4,034	64%
Hmong	5,813	9%	2,450	42%
Vietnamese	7,999	12%	4,328	54%
Khmer	8,794	13%	4,378	50%
Tagalog (incl. Filipino)	27,539	41%	11,206	41%
Ilocano, Samoan, Hawaiian, or other Austronesian languages	5,597	8%	2,382	43%

Source: U.S. Census Bureau, 2023 American Community Survey 1–Year Estimates, Table B16001.
* This table includes only languages spoken by 5000 or more county residents; for more information contact Public Health Services.

iv. Hospitals and Health Professional Shortages in the Community Served

Residents of San Joaquin County have access to hospitals and medical centers, including:

- Adventist Health Lodi Memorial
- Dameron Hospital
- Doctors Hospital of Manteca
- Kaiser Permanente Manteca Medical Center
- San Joaquin General Hospital
- St. Joseph's Medical Center
- Sutter Tracy Community Hospital

[6]Only languages with 5000 or more speakers included in the table. For additional information on languages spoken at home in SJC, please contact San Joaquin County Public Health Services.

Several of the above facilities have representation on the CHNA Core Team.

San Joaquin County has 16 Health Professional Shortage Areas (HPSA) and one Medically Underserved Area/population (MUA/P) (Table 4), covering specific populations and health care facilities.[7] The San Joaquin County populations included in the HPSA designations include low income, homeless, migrant, and farmworker populations, and the facilities include Federally Qualified Health Centers; Federally Qualified Health Centers Look-Alikes; and Indian Health Service, Tribal Health, and Urban Indian Health Organizations. The majority of the County's HPSAs and the MUA/P are in non-rural areas.

Table 4. HPSAs and MUA/Ps – San Joaquin County

Number of HPSAs	
Primary Care	6
Dental Health	5
Mental Health	5
Number of MUA/Ps	
Primary Care	1

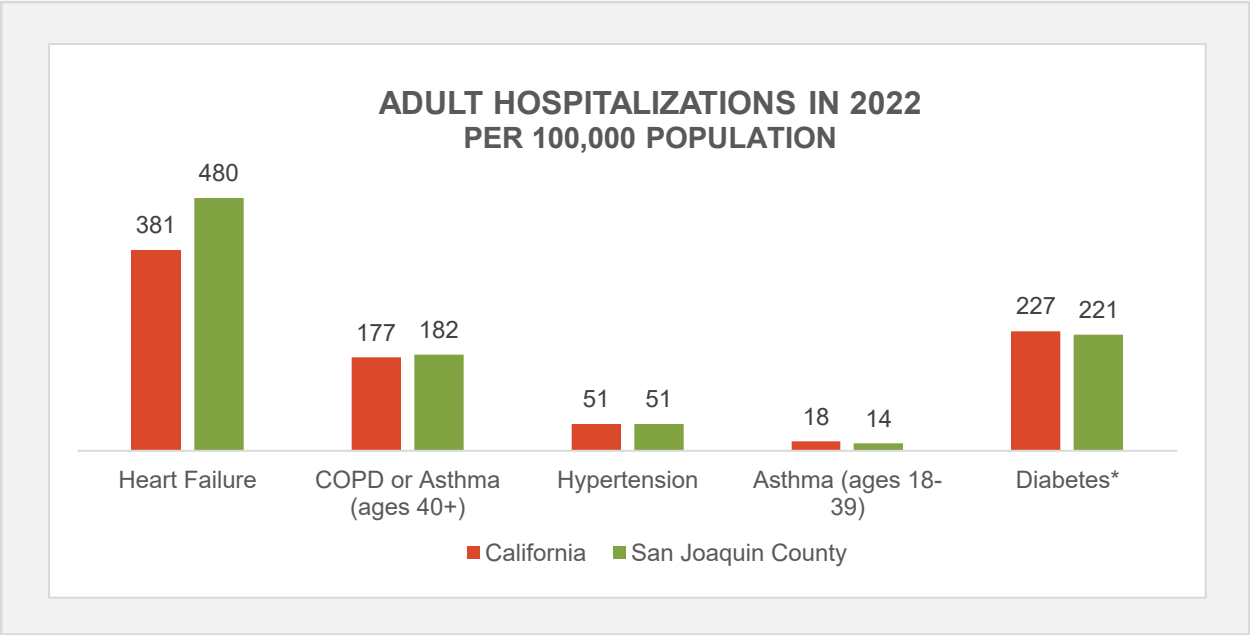
Source: HPSA Find, 2021-2024

v. Hospitalizations and Leading Causes of Deaths of the Community Served

The California Health and Human Services Agency tracks the rates of hospitalizations for common chronic conditions for each county. San Joaquin County had higher (risk-adjusted) rates of adult hospitalization for heart failure and COPD/asthma (ages 40+) than California overall, and a comparable rate of hospitalization for hypertension in 2022 (Figure 3). Many of these hospitalizations could potentially be avoidable through access to high-quality outpatient care.

[7] A Health Professional Shortage Area (HPSA) is a federal designation created by the National Health Service Corps for a geographic area, population, or facility with a shortage of primary, dental, or mental health care providers. Medically Underserved Areas/Populations (MUA/P) identify geographic areas and populations with a lack of access to primary care services. These designations help distribute personnel and resources where they're needed most, and establish health maintenance organizations or community health centers, respectively.

Figure 3. Adult Hospitalizations – San Joaquin County and California



Source: CA Health and Human Services Open Data Portal

*Composite of short term, long term, and uncontrolled diabetes hospitalizations, as well as diabetes-related amputations

From 2019 to 2023, the top five causes of death in San Joaquin County were heart disease, cancer, COVID-19, unintentional injuries, and stroke (Table 5). The top five causes of death differed by race/ethnicity. Heart disease and cancer were among the top five causes of death for all racial/ethnic groups, but unlike other racial/ethnic groups in the County, cancer was the leading cause of death among Asian and Hispanic/Latino residents. Unintentional injuries were in the top five causes of death for Black/African American, White, multiracial, and residents of unknown race/ethnicity. COVID-19 was a leading cause of death for all races/ethnicities except for White residents. Deaths of despair (deaths due to suicide, alcohol related disease, and drug overdoses) primarily affected White, multiracial, and residents of unknown race/ethnicity, while diabetes mortality was among the top five causes of death only for Asian and Native Hawaiian/Pacific Islander residents.

Table 5. Top Five Causes of Death – San Joaquin County*

	San Joaquin County	Asian	Black/ African/ American	Hispanic	American Indian/ Alaska Native	Native Hawaiian/ Pacific Islander	White	Multiple Races	Other Unknown
1	Heart Disease	Cancer	Heart Disease	Cancer	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Heart Disease	Cancer	Heart Disease	Cancer	Stroke	Cancer	Cancer	Cancer
3	COVID-19	Stroke	Unintentional Injuries	COVID-19	Stroke	Cancer	Unintentional Injuries	Unintentional Injuries	Deaths of Despair
4	Unintentional Injuries	COVID-19	COVID-19	Unintentional Injuries	COVID-19	COVID-19	Deaths of Despair	Deaths of Despair	Unintentional Injuries
5	Stroke	Diabetes	Stroke	Stroke	Lung Disease	Diabetes	Lung Disease	COVID-19	COVID-19

Source: San Joaquin County Public Health Services
*The death data is a 5-year average, age-adjusted rate, 2019-2023

III. Who Was Involved in the Assessment?

A. Identity of Partner Organizations that Collaborated on the Assessment

The San Joaquin County CHNA was an effort of the Healthier San Joaquin Collaborative that included San Joaquin Public Health Services, San Joaquin's Managed Care Plans and nonprofit hospitals as well as many partner organizations and individuals throughout the community. The CHNA was led by a Core Team that was responsible for planning and key decision-making, including providing input on data collection instruments, working alongside Ad Lucem Consulting to collect and analyze data, and reviewing and commenting on this report. The broadly representative CHNA Steering Committee supported the process by collecting primary data and participating in data review and interpretation.

i. Core Team Members

- Adventist Health Lodi Memorial
- Behavioral Health Services
- Community Foundation of San Joaquin
- Community Medical Centers
- Dameron Hospital
- Dignity Health St. Joseph's Medical Center
- First 5 San Joaquin
- Health Net
- Health Plan of San Joaquin
- Kaiser Permanente
- Reinvent South Stockton Coalition
- San Joaquin County Public Health Services
- SJ Health
- Sutter Health
- University of the Pacific

ii. Steering Committee Members

- 211 San Joaquin
- Adventist Health Lodi Memorial*
- Amelia Adams Whole Life Center
- Asian Pacific Self-Development and Residential Association (APSARA)
- Behavioral Health Services*
- Boys and Girls Club
- Catholic Charities Diocese of Stockton
- Child Abuse Prevention Council
- City of Stockton
  - Office of the Mayor
  - Office of Violence Prevention
- Community Foundation of San Joaquin*
- Community Medical Centers*
- Dameron Hospital*
- LOVE Inc. Manteca
- Mary Magdalene Community Services Public Health Advocates
- Reinvent South Stockton Coalition*
- San Joaquin Community Foundation
- San Joaquin PRIDE Center
- Sierra Vista Homes, Residents Council
- SJC Behavioral Health Services
- SJC Children's Alliance
- SJC Council of Governments
- SJC Office of Education
  - Early Childhood Education
  - Comprehensive Health Programs
- SJC Health Care Services Agency

- Data Co-op
- Delta Health Care
- Department of Health and Human Services, Region 9
- Dignity Health, St. Joseph's Medical Center and Behavioral Health Center*
- El Concilio
- Emergency Food Bank
- Faith in the Valley
- First 5 San Joaquin*
- Health Force Partners
- Health Net*
- Health Plan of San Joaquin*
- Hispanic Chamber of Commerce
- Kaiser Permanente*
- Little Manila Rising
- SJC Human Services Agency: Aging and Community Services
- SJC Public Health Services*
- SJ Health*
- St. Mary's Dining Room
- Stocktonians Taking Action to Neutralize Drugs (STAND)
- Stockton NAACP
- Sutter Health*
- Third City Coalition
- University of the Pacific, School of Health Sciences*
- Visionary Home Builders
- Women's Center and Youth Services Agency

**Core Team Member*

iii. San Joaquin County Community Residents

The San Joaquin County CHNA would not have been possible without the support and engagement of County residents. Three hundred and fifty community residents volunteered their time as focus group participants to provide the critical perspectives of residents living, working, and raising families in County communities.

Other County residents supported the CHNA process by providing feedback/validation of the preliminary findings during meetings with community groups; participants in these meetings agreed with the health challenges and opportunities that emerged from the CHNA analysis.

B. Identity and Qualifications of Consultants Used to Conduct the Assessment

The Healthier San Joaquin Collaborative contracted with Ad Lucem Consulting, a public health consulting firm, to conduct the San Joaquin County CHNA.

Ad Lucem Consulting has developed CHNA reports and Implementation Strategy Plans for hospitals and health departments including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies.

To learn more about Ad Lucem Consulting, visit www.adlucemconsulting.com.

IV. Process and Methods Used to Conduct the CHNA

A. Secondary Data

i. Sources and Dates of Secondary Data Used in the Assessment

The data used for this CHNA was compiled by San Joaquin County Public Health Services (PHS) and generally follows the health needs organization and indicators found in the Kaiser Permanente (KP) Community Health Data Platform (KP Platform)[8]. The most up-to-date data were included (e.g. American Community Survey 2022, Vital Records Business Intelligence System 2019-2023, etc.), and data by race/ethnicity were also compiled, as well as a number of additional demographic indicators.

For details on specific definitions, sources and dates of the data used, please see Appendix A. Data for health status, behavior, and risk factor indicators can be found in Appendix B.

ii. Methodology for Collection, Interpretation, and Analysis of Secondary Data

The data included in this CHNA presents a focused set of community health indicators that allows readers to understand what is driving health outcomes in San Joaquin County, including understanding racial/ethnic disparities and comparing local indicators with state benchmarks.

The KP Platform "Health Topics" were used as a general framework for the CHNA measures. The KP Platform did not have measures by race/ethnicity, therefore, PHS staff attempted to gather the information from the defined data sources.

The main goals for secondary data collection and analysis were the following:

- To compare San Joaquin County values to state values and measure divergence (% above or below).
- To gather San Joaquin County indicator data by racial/ethnic group and measure divergence from the San Joaquin County benchmark and the White population.
- To compare Priority Neighborhood values to San Joaquin County values and measure divergence (% above or below).
- To track change over time between the 2022 CHNA and 2025 CHNA.
- To show rate stability by calculating statistical significance for each measure, if available.

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[8] Kaiser Permanente. (2025). *Community Health Data Platform.* Oakland, CA. 2025 Community Health Needs Dashboard | Tableau Public

Analysis of the secondary data included assigning a score to each health need (4: very high, 3: high, 2: medium, 1: lower) based on the number of indicators within the health need that were statistically significantly worse than state benchmarks. The majority of health needs had at least one indicator for which racial/ethnic disparity data were available; an additional score was assigned to each health need based on the number of racial/ethnic groups for whom each indicator was significantly worse than for White residents.

B. Community Input

i. Description of Who Was Consulted

Community input was provided by a broad range of community members using key informant interviews, focus groups and community meetings. The Steering Committee engaged community-based organizations to reach individuals with the knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from local governmental and public health agencies; community-based organizations; and leaders, representatives, and members of underserved, low income, unhoused, and racial/ethnic populations. Additionally, where applicable, other individuals with expertise on local health needs were consulted. For a complete list of individuals who provided input, see Appendix C.

ii. Methodology for Collection and Interpretation

Key Informant Interview Methodology

Ad Lucem Consulting conducted key informant interviews with 12 individuals representing diverse sectors including: public health, health care, community-based organizations, and social services. The key informants were identified by Healthier San Joaquin Collaborative Core Team members.

All interviews were conducted by telephone in English and took approximately 30-45 minutes to complete. The interviews followed a standard set of interview questions and the interviewer took detailed notes during the call. At the beginning of the interview, confidentiality was assured, and the respondents were invited to skip questions that were not applicable to the respondent's experience.

Interview topics: Interview questions were developed by Ad Lucem Consulting with input from Core Team members. For the complete list of interview questions, see Appendix D. Questions addressed the following topics:

1. Top health issues in San Joaquin County
2. Factors and challenges that contribute to the top health issues, including lasting impacts of the COVID-19 pandemic

3. Populations most impacted by the top health needs (e.g., low income, racial/ethnic subpopulations)
4. Successful strategies and community assets to address top health issues
5. Notable gaps in services or assets

Data Analysis: Ad Lucem Consulting used software to code and analyze responses by health need. The number of mentions for all themes related to a particular health need were tallied to develop an interview data score. Health needs were assigned points based on the frequency of mentions of the health need by key informants. Points for each health need were tallied across interviewees to develop interview scores for health need priority, racial/ethnic disparities, geographic or other disparities.

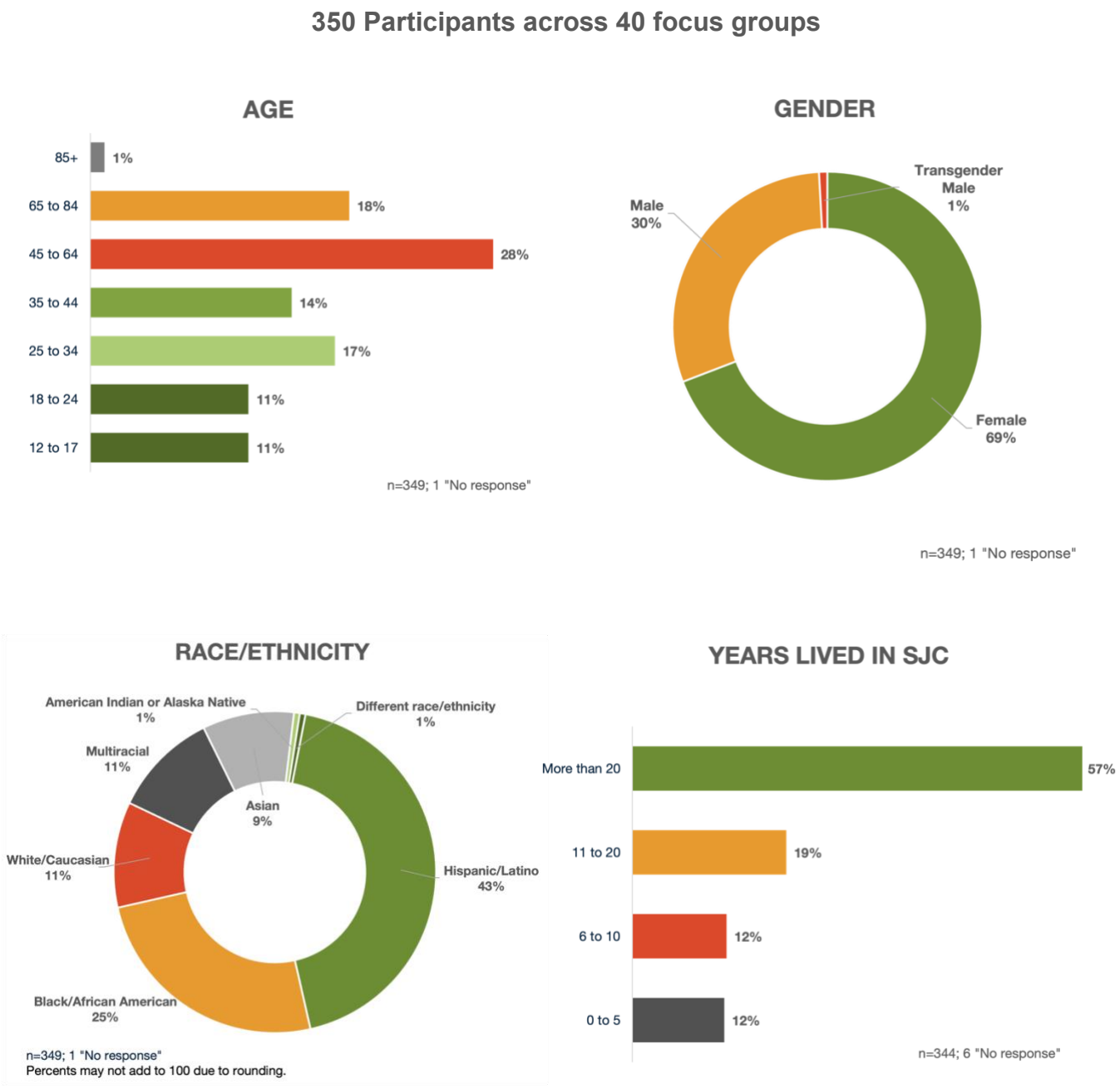
Focus Group Methodology

Forty community resident focus groups were conducted in geographic areas within San Joaquin County, including Stockton, Lodi, Tracy, Manteca, French Camp, and Thornton. Most groups were conducted in English; four groups were conducted in Spanish, two in Hmong and one in Cambodian. Participants included teens, adults, and older adults who represented underserved, low income and racial/ethnic communities. Figure 4 presents the demographic characteristics of the focus group participants.

Communities/populations participating in focus groups:

- Adults
- Black/African American community
- Cambodian community
- Foodbank users
- Hispanic/Latino community
- Justice system involved residents
- Migrant workers
- LGBTQIA+ community
- Opioid safety stakeholders
- Residents living with chronic diseases and disabilities
- Residents from specific SJC geographies
- Unhoused residents
- Youth

Figure 4. Focus Group Participant Profile – San Joaquin County



Representatives from community-based organizations (CBOs) and public agencies who were members of the CHNA Steering Committee were trained by Ad Lucem Consulting to conduct focus groups with community residents. This approach allowed for a large number of focus groups to capture the diverse perspectives of many County subpopulations. CBOs/public agencies attending the training received instruction on a 10-step focus group process, including participant recruitment, focus group logistics, focus group facilitation, note taking and summarizing the focus group discussion. The training participants received a toolkit which included a focus group manual describing the 10 steps as well as the focus group guide and instructions on returning the focus group materials. The CBOs/public agencies had the opportunity to apply for funds to support focus group logistics and focus group participants were each provided with a $50 gift card as thanks for their participation.

CBO/public agency staff recruited participants and organized logistics for the focus groups. Each focus group session averaged 60 minutes and was facilitated by a participating CBO/agency. Six out of the 40 focus groups used a virtual format. During the focus group, CBO/public agency staff members took notes (either the focus group facilitator or a co-moderator); CBOs/public agencies were instructed to use the notes to prepare a focus group summary on a template provided in the toolkit. CBOs/public agencies emailed focus group summaries and demographic questionnaires to Ad Lucem Consulting for data entry and analysis.

Focus group question guide: A focus group guide ensured consistency across groups. The focus group questions were developed by Ad Lucem Consulting with input from the Core Team. The questions were translated into Spanish by a native Spanish speaker experienced in translation. For focus groups conducted in Hmong and Cambodian, the focus group facilitator translated the focus group questions themselves. At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses. An overview of the discussion was provided as well as a review of discussion ground rules. For the complete list of focus group questions, see Appendix E. Questions addressed the following topics:

1. What is healthy about the community
2. What makes it difficult to be healthy in the community
3. Top health issues in the community
4. Groups/populations most affected by the top health issues
5. Strategies to address the top health issues

Data Analysis: Summaries of focus group discussions were prepared by the CBOs/agencies who facilitated the focus groups and were submitted to Ad Lucem Consulting. The most prominent themes in the focus group summaries were identified,

and health topics discussed by focus group participants were organized into the health need categories defined by the secondary data. Ad Lucem Consulting used software to code and analyze responses by health need. Health needs were assigned points based on the frequency and importance given to the health need by focus group participants. Points for each health need were tallied across focus groups to develop scores for health need priority, racial/ethnic disparities and geographic or other disparities.

In addition to the community resident focus groups described above, a meeting of the Resilient Community Advisory Committee took place in November 2024, at which a focus group-like discussion was led by San Joaquin County Public Health Service staff. The 39 attendees represented a wide cross-section of community-based organizations and entities serving historically disenfranchised populations within the County. The discussion highlighted issues related to several health needs, including chronic disease/HEAL, community safety, and housing. The Resilient Community Advisory Committee perceived these issues as ripe for policy interventions that could be included in the CHIP.

iii. San Joaquin County Reports and Assessments

A number of San Joaquin County partners have published documents that contribute to the overall understanding of the local social, environmental, and economic conditions that impact residents' health. These documents were reviewed as part of the CHNA assessment to highlight health issues and contributing factors for the County's historically underserved populations. This information can inform intervention strategies to promote health equity. For the complete annotated bibliography, see Appendix F.

C. Written Comments

Each hospital has provided the public an opportunity to submit written comments on the facility's previous CHNA Report through their website. These websites will continue to allow for written community input on each facility's most recent CHNA Report.

As of the time of this CHNA report development, members of the Core Team had not received written comments about the previous CHNA report. Core Team members will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data Limitations and Information Gaps

The CHNA data platform includes over 100 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are limitations with regard to these data, as is true with any secondary data:

- Some data were only available at a county level and did not contribute to the understanding of Priority Neighborhood needs.
- A number of indicators reported rely on the Census/American Communities Survey which may be based on small sample sizes and are estimates rather than actual measures.
- Disaggregated data around ethnicity/race are not available for all data indicators, which limited the ability to examine some health disparities.
- Data are not always collected on a yearly basis, and some data are several years old.

Primary data collection is also subject to limitations:

- Themes identified during interviews and focus groups were likely dependent upon the experiences of individuals selected to provide input; input from a robust and diverse group of stakeholders sought to minimize this bias.

V. Priority Neighborhoods

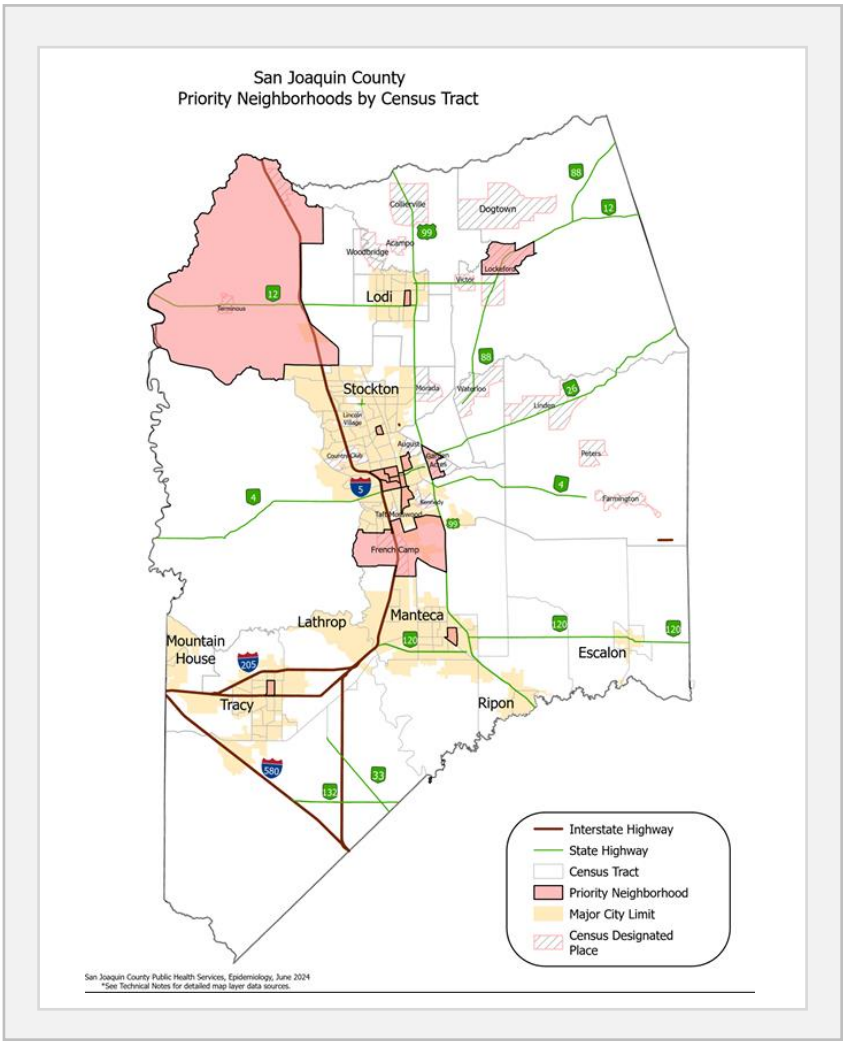
Table 6 lists the 14 San Joaquin County Priority Neighborhoods. The residents of the Priority Neighborhoods are the most impacted by both historic health disparities and lack of infrastructure investment, based on the data analysis described above.

Table 6: San Joaquin County Priority Neighborhoods (Census Tracts)

Census Tract	City	Included in 2022 CHNA
1.01 and 1.02	Stockton	✓ (as CT1)
3	Stockton	✓
6	Stockton	✓
7	Stockton	✓
16	Stockton	✓
22.01	Stockton	✓
27.01	Stockton (Garden Acres)	✓
33.12	Stockton	✓
38.03	French Camp	✓
40.01	Thornton	✓
44.03	Lodi	✓
47.01	Lockeford	✓
51.09	Manteca	✓
53.03	Tracy	✓

The map in Figure 5 below shows where the Priority Neighborhoods are located. The CHNA includes 14 Priority Neighborhoods. Profiles of the Priority Neighborhoods (Census Tracts) are presented in Section VII.A. Each Priority Neighborhood's profile includes the following: map of the census tract, demographic data, root causes of health, and birth and death statistics. For each of the data points, the change since the 2022 CHNA is described.

Figure 5. Map of 14 Priority Neighborhoods



VI. Identification and Prioritization of the Community's Health Needs

A. Identifying Community Health Needs

i. Definition of "Health Need"

Community-wide health needs represent the greatest challenges faced by County residents around maximizing health and well-being. For the purposes of the CHNA, health needs are defined as including requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). Requisites may include addressing financial and other barriers to care as well as preventing illness; ensuring adequate nutrition; or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

The following criteria were used:

- It fits the definition of a "health need" as described above.
- It was confirmed by multiple data sources (i.e., identified in both secondary and primary data).
- Indicator(s) related to the health need performed statistically significantly worse than the state average.
- It was chosen as a community priority based on the frequency with which key informants and focus groups mentioned the need. The final list included only those that informants and focus groups identified as a priority need.

The following methods were used:

- A health needs identification table was developed which included all related indicators that benchmarked statistically significantly worse than the state. Race and ethnicity data were reviewed (when available) to identify all indicators for which disparities existed. The number of groups experiencing disparities for a given indicator was noted and addressed during prioritization. Primary data were reviewed and assessed for overall priority of health issues, racial/ethnic disparities, geographic disparities and disparities affecting other groups.
- While Cancer, Climate and Environment, and Sexual Health each had several indicators that performed poorly against the state average, they were not included as health needs for the CHNA because they were not mentioned with frequency in the primary data collection.

Ten health needs met the above criteria:

Highest Priority
Access to care
Mental health including substance use
Chronic disease/Healthy Eating, Active Living (HEAL)
Medium Priority
Housing
Economics
Social support
Lower Priority
Community safety (tied with Education)
Education
Food security (tied with Transportation)
Transportation

All of these health needs are interrelated and affect each other, and it is often necessary to address lower-priority and additional needs in order to improve the higher-priority needs on an individual and/or community level. This list is useful for revealing the most pressing needs of San Joaquin County residents and framing future investments by health systems and policymakers.

B. Criteria and Process Used for Prioritization of Health Needs

i. Prioritization Criteria

The following criteria were identified to use in prioritizing the list of health needs:

- Health measures: San Joaquin County indicators compare poorly to the California average.
- Clear disparities or inequities: Data show differences by racial/ethnic subgroups.
- Community input: Interviews/focus groups identified important issues related to the health need.

- Prevention: Opportunities exist for health promotion and disease prevention rather than treatment.

ii. Prioritization Process

After points were assigned to each health need for the above criteria, scores were totaled for the health needs (Sections IV.A.ii and IV.B.ii describe the process of assigning points to the secondary data and primary data, respectively). Scores for health need rankings from the 2022 CHNA and CHIP processes were also factored into the overall health need scores. The scores for the 15 health needs were then normalized to a 100 point scale, producing a list of the health needs in rank order.

The CHNA assessment findings and health need prioritization were presented at three community meetings. Meeting attendees provided input and concurred that each of the health needs was important and that these issues are interrelated.

C. Prioritized Description of Health Needs Identified through the CHNA

See Section VII.B. for the ten complete Health Needs Profiles. The paragraphs below summarize their content.

Highest Priority

- **Access to care**: Access to comprehensive, quality healthcare is important for health and for increasing and maintaining a high quality of life. In San Joaquin County, residents have access to significantly fewer health care providers (including mental health providers) than the California average, which contributes long wait time for appointments, limited clinic hours, the need to travel for specialty care, and frustration with and distrust of the medical system. Lack of prenatal care and lower rates of health insurance, especially among women of color, can be linked to the higher percentage of poor outcomes for infants. Key informants and focus group participants emphasized the need for culturally and linguistically competent providers, as well as assistance with insurance applications and other healthcare paperwork. Many key informants and focus group participants noted the success of pop-up and mobile COVID-19 vaccination and testing clinics established in partnership with community-based organizations, which created access points for other health care services in underserved areas; they suggested that this model be maintained and expanded to address a variety of health needs.
- **Mental health including substance use:** Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school, and to participate fully in family and community activities. Residents of San Joaquin County have a higher rate of deaths by suicide, drug overdose, and alcohol poisoning combined than the California average, with significantly fewer

mental health providers available. Participants of almost two-thirds of the focus groups described mental health as the number one health issue within their communities, and, along with key informants, expressed particular concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens. Key informants and focus group participants pointed out the intersection of mental health needs, substance use, and homelessness, and stressed the urgent necessity for diverse providers, timely crisis intervention services, improved access to mental health care in rural areas, and services tailored to the needs of underserved groups.

- **Chronic disease/Healthy Eating, Active Living (HEAL):** Chronic diseases are a primary cause of poor health outcomes and death and a leading driver of health care costs. The rates of diabetes and obesity among adults in San Joaquin County are higher than California overall, as are the rates of heart disease and stroke deaths. Black/African American County residents have the highest rates of diabetes, pediatric asthma prevalence, hospitalizations for cardiovascular disease, and the highest incidence of colorectal and lung cancer among all ethnicities/races. Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare. These are especially present in communities/neighborhoods with a high percentage of low-income residents, people of color, and immigrants.

Medium Priority

- **Housing:** Stable, affordable housing is strongly associated with health, well-being, educational achievement, and economic success. Housing stability and housing cost burden are especially important factors for both health and economic stability. When compared to California overall, indicators of housing instability in San Joaquin County are better than state averages. However, countywide rental and mortgage costs have substantially increased, and secondary data indicates that disparities exist for residents of color and residents of the Priority Neighborhoods related to homeownership and crowded housing. Focus group participants and key informants agreed that the lack of affordable housing in the county is severe, with high housing costs contributing to stress and reducing available financial resources for health needs. They described homelessness as a significant problem in the county, in part because many unhoused individuals require additional services, treatments and/or rehabilitation programming that are not sufficiently available to meet demand. Low- and middle-income residents (especially people of color, immigrants, migrants, older adults, people with special needs, urban residents, and

single parents) are most impacted by rising housing costs, and struggle to obtain housing assistance and services tailored to meet their specific needs.

- **Economics**: People with steady employment are less likely to have an income below the poverty level and more likely to be healthy. San Joaquin County's higher unemployment, lower average income, pervasive poverty, and variable access to high-speed Internet, especially among people of color, may affect opportunities and behaviors that exacerbate chronic disease and disability, reduce food security, limit healthy food and physical activity choices, erode mental health, and impact substance use. Focus group participants and key informants stated that obtaining employment or regaining economic stability has been difficult after pandemic-related job losses, especially for middle-income residents who now find themselves struggling with expenses but not able to qualify for assistance and services. People of color, older adults, and unhoused individuals experience disparities in employment resulting in lower incomes that negatively impact health.
- **Social support:** The presence or absence of a strong social support network affects all aspects of life, including physical and mental well-being. Communities are the context in which families prosper or struggle, highlighting the importance of identifying areas of need and disparity and leveraging community resources to address them. In San Joaquin County, racial/ethnic disparities are present among those with disabilities and many residents have limited English proficiency – both statuses for which social support can be essential for integrating into long-term stability, health, and economic success. Focus group participants and key informants perceived that residents (especially those in rural areas) require more support with caring for children, loved ones with disabilities, and older adults; more opportunities to combat loneliness and isolation; and more assistance for children aging out of foster care.

Lower Priority

- **Community Safety:** Safe communities promote community cohesion and economic development and provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Rates of violent crime, injury, motor vehicle accidents, and premature deaths are all higher in San Joaquin County than statewide. Focus group participants and key informants agreed that residents' perceived lack of community safety in public, outdoor spaces like parks limits the ability to be physically active, especially for children and older adults.
- **Education:** The link between education and health is well known—those with higher levels of education are more likely to be healthier and live longer. Fewer children in San Joaquin County are enrolled in preschool than statewide, which is

associated with academic readiness for kindergarten and long-term success. San Joaquin County students have lower rates of proficiency in math and reading than students across California, with evidence of significant disparities for Hispanic/Latino, Black/African American, and multiethnic students. Adults in the County are less likely to have a high school diploma or have completed a college degree. Focus group participants noted lasting pandemic impacts on education quality and outcomes, especially for students of color and those in underresourced schools, while key informants requested more support for career development and readiness at all educational levels.

- **Food security:** Many individuals and families struggle to consistently access the kinds of foods that support health and wellness. The percentage of San Joaquin County residents relying on SNAP to afford food is almost 50% higher than California overall, and more students qualify for free and reduced-price school lunches than the statewide average. Key informants and focus group participants reported that the need for food assistance is increasing due to post-pandemic economic impacts and resulting inflation.
- **Transportation:** Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing health care, and securing food. Secondary data indicates that County residents are less likely to engage in active transportation, such as biking or walking, and are more likely to commute alone by car. Focus group participants and key informants agreed that San Joaquin County residents experience challenges related to transportation, substantially impacting decisions related to healthcare, housing, and nutrition, and potentially leading to poor physical and mental health.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

San Joaquin County's community-based organizations, public agencies, hospitals and clinics, and other entities are engaged in addressing many of the health needs identified by this assessment. Key resources available to respond to the identified health needs of the County are listed in Appendix G Community Resources.

VII. Profiles

A. Priority Neighborhood Profiles

PRIORITY NEIGHBORHOOD PROFILE

Census Tracts 1.01 and 1.02

Census tract (CT) description:

Since the 2022 community health needs assessment (CHNA), CT 1 has been divided into CTs 1.01 and 1.02. CT 1.01 is bordered by the following streets: Highway 4 in the north, S. El Dorado Street to the west, Hazelton on the south, and Union/Aurora on the east. CT 1.02 is bordered by Highway 4 in the south, Union/Aurora on the east, Park on the north, and Madison/El Dorado on the west. All data presented in this neighborhood profile combines the statistics for CTs 1.01 and 1.02 to attain stable rates and counts. This Priority Neighborhood is home to 3,662 people.

San Joaquin County Public Health Services, Epidemiology. 6/25/2024

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64 years old. Since the 2022 CHNA, CTs 1.01/1.02 experienced demographic changes reflected by a substantial increase in the Asian population and a decrease in the Black/African American population, as well as a decrease in young people below 24 years old (Table 1).

How to read the tables that follow: This profile presents data for the CTs and San Joaquin County (SJC) and explores how these CTs changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CTs 1.01/1.02 vs SJC)

		CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Total Population		3,662	↓	779,445
Race/Ethnicity	Asian	14%	↑↑↑	17%
	Black/African American	11%	↓↓	7%
	Hispanic	60%	↑↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	1%	↑	<1%
	White	10%	↓	29%
	Multiple Races	4%	↑	4%
Gender	Female	45%	↓	50%
	Male	55%	↑	50%
Age Group	0- 5 yrs	8%	↓	8%
	6- 17 yrs	11%	↓	19%
	18- 24 yrs	4%	↓↓	10%
	25- 44 yrs	36%	↑	27%
	45- 64 yrs	28%	↑	23%
	≥65 yrs	12%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to SJC as a whole, CTs 1.01/1.02 measure worse on access to care, economics, social support, education, food security, and housing conditions. The difference is substantial for income, and at least 10 percentage points worse than the County for percent insured, percent living in poverty, employment, two parent households, limited English proficiency, adults with no high school diploma, adults with a bachelor's level or higher education, SNAP enrollment, automobile access, housing habitability, and homeownership. Since the 2022 CHNA, this neighborhood has

improved on income, percent living in poverty, two parent households, preschool enrollment, adult educational attainment, automobile access, and homeownership. Performance has worsened for employment, limited English proficiency, SNAP Enrollment, active commuting, and housing habitability.

Table 2: Root Causes of Health (CTs 1.01/1.02 vs SJC)

Health Topic	Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	81%	↓	91%
	Uninsured children (ages <19 yrs)	4%	↓	3%
Economic	Income	$25,464	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	42%	↓↓	13%
	Employed (ages 20- 64 yrs)	27%	↓↓	70%
Social Support	Two Parent Households	51%	↑↑	77%
	Limited English Proficiency	61%	↑↑↑↑	41%
Education	Preschool Enrollment	38%	↑	38%
	Adults (ages 25+ yrs) with no high school diploma	44%	↓	20%
	Bachelor's Education or Higher	8%	↑↑	20%
Food Security	Low Access to Grocery Stores	35%	—	28%
	SNAP Enrollment	38%	↑↑	15%
Transportation	Automobile Access	54%	↑	95%
	Active Commuting	8%	↓↓	3%
Built Environment	Retail Density	2%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	88%	↓	99%
	Homeownership	2%	↑↑	60%
Climate & Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

Although the % of CTs 1.01/1.02 residents living in poverty has decreased since the 2022 CHNA, the poverty rate is over three times higher than SJC overall.

SNAP (food assistance) enrollment, which has increased since the 2022 CHNA, is over double the SJC average, indicating that CTs 1.01/1.02 residents need financial assistance to meet basic needs, but are receiving support.

Homeownership is one element of housing and economic stability. Despite increasing since the 2022 CHNA, homeownership in CTs 1.0/1.02 remains very low and substantially lower than SJC overall.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with overall County rates, CTs 1.01/1.02 have a higher overall birth rate, and a higher percentage of teen births. There are fewer pregnant persons

receiving early prenatal care in these neighborhoods. Compared to the 2022 CHNA, there has been a decrease in babies born with low birth weights.

Table 3: Birth Outcomes (CTs 1.01/1.02 vs SJC)

Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Pre-term births	10%	↓	9%
Low birth weight	8%	↓↓	8%
Prenatal care in 1st trimester	67%	↓	79%
Teen births (mothers ages 15- 19 yrs)	10%	↑	4%
Birth Rate			
Total	18	↓	13
Asian	9	↓↓	13
Black/African American	5	↓↓↓	12
Hispanic	20	↓	15
White	27	↑↑↑	8

Refer to technical notes for data sources.

In this neighborhood, Hispanic and Black/African American individuals are dying at a younger age than other racial/ethnic groups. The age- adjusted death rate in this neighborhood is well over double the overall County rate. In terms of leading causes of death, this neighborhood's rates of death from heart disease, COVID-19, unintentional injuries, and deaths of despair are more than twice as high as the County rate, and its rate of cancer deaths is also higher than the County average. The average age of death among Asian, Black/African American, and White residents has increased since the 2022 CHNA, while the average age of death among Hispanic residents has decreased.

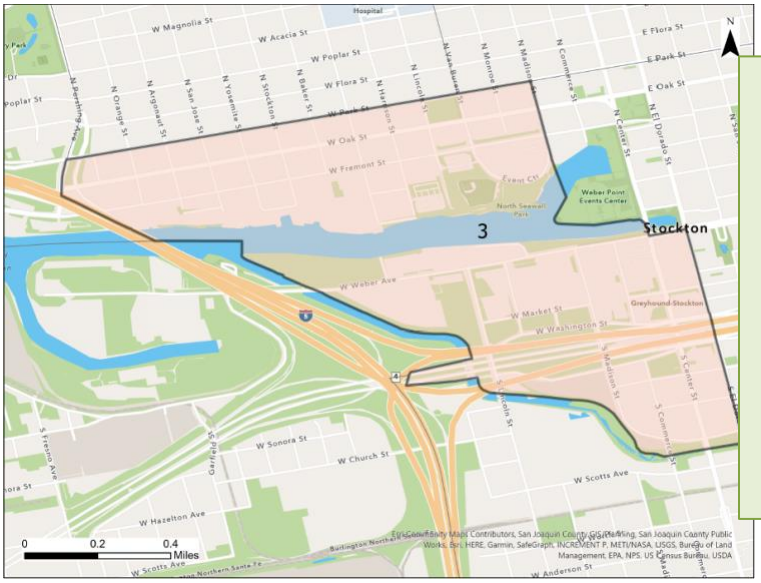
Table 4: Death Statistics (CTs 1.01/1.02 vs SJC)

Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	69		77
Average Age of Death (yrs)			
Total	63	↑	71
Asian	68	↑	72
Black/African American	62	↑	64
Hispanic	62	↓	65
White	65	↑	75
Age-Adjusted Death Rate - Total	2,174	↑↑	832
Top 5 Causes of Death			
Heart disease deaths	493	↑↑↑	148
Cancer deaths	256	↑↑↑	144
COVID-19 deaths	200	↑	61
Unintentional injury deaths	131	↓↓	55
Deaths of despair	130	↓	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 3



San Joaquin County Public Health Services, Epidemiology. 6/25/2024

Census tract (CT) description:

CT 3 in Stockton is bounded by the following streets: Madison/El Dorado on the east, Park on the north, Hazelton/Scotts on the south, and I-5 on the west. This Priority Neighborhood is home to 2,298 people.

Demographics

The most prominent race/ethnicity living in this CT is Hispanic, followed by Black/African American; the CT has a higher percentage of females than males. Since the 2022 community health needs assessment (CHNA), CT 3 experienced an increase in the Black/African American and Multiple Race populations, and an increase in children under age five and between ages 18-24 (Table 1), while the population of adults aged 45-64 years has decreased.

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 3 vs SJC)

		CT 3	Change Since 2022 CHNA	SJC
Total Population		2,298	↑	779,445
Race/Ethnicity	Asian	11%	↓	17%

	Black/African American	25%	↑↑	7%
	Hispanic	44%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	16%	↑	29%
	Multiple Races	5%	↑↑↑↑	4%
Gender	Female	57%	↑	50%
	Male	43%	↓	50%
Age Group	0- 5 yrs	13%	↑↑	8%
	6- 17 yrs	12%	—	19%
	18- 24 yrs	12%	↑↑	10%
	25- 44 yrs	28%	↑	27%
	45- 64 yrs	16%	↓↓	23%
	≥65 yrs	19%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to the County overall, CT 3 performs worse on access to care, economics, social support, education, and food security. Income in CT 3 is less than a third of the County average income and substantial disparities (10 percentage points or worse) between CT 3 and SJC overall exist for: percent living in poverty, employment, two parent households, limited English proficiency, low access to grocery stores, SNAP enrollment, automobile access, and homeownership. This neighborhood performs better than the County on drought risk. Since the 2022 CHNA, this neighborhood has improved on measures of insurance coverage, income, adult educational attainment, automobile access, active commuting, and homeownership. However, percent living in poverty, employment, two parent households, limited English proficiency, preschool enrollment, and SNAP enrollment have worsened.

Table 2: Root Causes of Health (CT 3 vs SJC)

Health Topic	Measure Name	CT 3	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	87%	↑	91%
	Uninsured children (ages <19 yrs)	5%	↓↓	3%
Economic	**Income**	$24,223	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	45%	↑	13%
	Employed (ages 20- 64 yrs)	60%	↓	70%
Social Support	Two Parent Households	33%	↓↓	77%
	Limited English Proficiency	69%	↑↑↑↑↑	41%

Despite an increase in average income since the 2022 CHNA, the Income level in CT 3 is under a third of the SJC average income.

Education	Preschool Enrollment	32%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	20%	↓↓	20%
	Bachelor's Education or Higher	15%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	56%	—	28%
	SNAP Enrollment	43%	↑	15%
Transportation	Automobile Access	70%	↑	95%
	Active Commuting	5%	↑	3%
Built Environment	Retail Density	2%	—	<1%
	Urban Tree Canopy	11%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	12%	↑↑	60%
Climate and Environment	Drought Risk	1	—	52
	Air pollution: PM2.5 concentration	12	—	15

The percentage of adults with higher education has increased substantially since the 2022 CHNA.

Food security in CT 3 is a concern; SNAP (food assistance) enrollment is almost triple the SJC average indicating that CT 3 residents require support to meet food needs.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, this neighborhood has a higher overall birth rate, as well as higher birth rates among Black/African American and Hispanic residents. There are double the percentage of teen births in this neighborhood when compared to the County. Notable changes to birth rates since the 2022 CHNA include an increase for the Asian population and a decrease for the Black/African American and White populations.

Table 3: Birth Outcomes (CT 3 vs SJC)

Measure Name	CT 3	Change Since 2022 CHNA	SJC
Pre-term births	9%	↓	9%
Low birth weight	10%	↑	8%
Prenatal care in 1st trimester	72%	↓	79%
Teen birth rate (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	7	↑↑	13
Black/African American	16	↓↓	12
Hispanic	22	↑	15
White	8	↓↓	8

Refer to technical notes for data sources.

In this neighborhood, White and Black/African American residents are dying at a younger age than the County average, and Black/African American residents are dying at a younger age than other racial/ethnic groups within this CT. The average age of death for all groups except the Asian population has increased since the 2022 CHNA. This neighborhood's rates of deaths due to unintentional injuries, despair, and cancer are at least double the County's rate. Rates for all five leading causes of death have decreased since the 2022 CHNA.

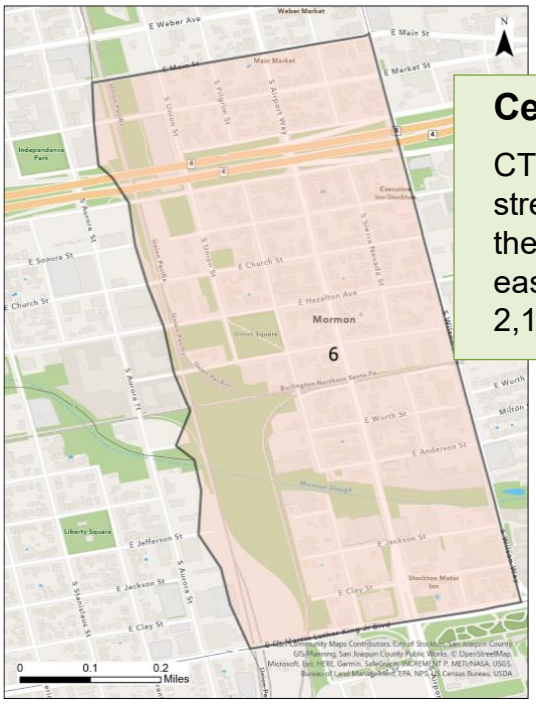
Table 4: Death Statistics (CT 3 vs SJC)

Measure Name	CT 3	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	70	—	77
Average Age of Death (yrs)			
Total	69	↑	71
Asian	84	↓	72
Black/African American	63	↑	64
Hispanic	68	↑	65
White	69	↑	75
Age- Adjusted Death Rate - Total	1,094	↓	832
Top 5 Causes of Death			
COVID-19 deaths	197	↓↓	148
Heart disease deaths	171	↓	144
Unintentional injury deaths	139	↓↓	55
Deaths of despair	111	↓	44
Cancer deaths	93	↓↓	144

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 6



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 6 in Stockton is bounded by the following streets: Union/Aurora on the west, Charter on the south, Main on the north, and Wilson on the east. This Priority Neighborhood is home to 2,171 people.

Demographics

Three-quarters of the neighborhood's residents are Hispanic and between the ages of 25 and 64. Demographic changes in CT 6 include an increase in the Black/African American population and a decrease in the White and Multiple Race populations since the 2022 community health needs assessment (CHNA). There was an increase in young adults aged 18-24 and older adults over 65 years, and a decrease in children under age 5 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 6 vs SJC)

		CT 6	Change Since 2022 CHNA	SJC
Total Population		2,171	↑↑	779,445
Race/Ethnicity	Asian	11%	↓	17%
	Black/African American	9%	↑↑↑↑↑	7%
	Hispanic	75%	—	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	1%	—	<1%
	White	3%	↓↓	29%
	Multiple Races	1%	↓↓↓	4%
Gender	Female	49%	↑	50%
	Male	51%	↓	50%
Age Group	0- 5 yrs	7%	↓↓	8%
	6- 17 yrs	19%	↑	19%
	18- 24 yrs	15%	↑↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	24%	↑	23%
	≥65 yrs	10%	↑↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood has lower measures than the County for access to care, economics, social support, education, transportation, and housing conditions. Income in CT 6 is substantially lower than the County average and disparities (10 percentage points worse) are present in CT 6 for: percent with insurance coverage, percent living in poverty, preschool enrollment, adult educational attainment, SNAP enrollment, and homeownership. CT 6 fares better (10 percentage points or more) than SJC on access to grocery stores. Since the 2022 CHNA, CT 6 has improved on percent with insurance coverage, income, employment, adults without high school diplomas, automobile access, and housing habitability. However, the percent living in poverty, two parent households, limited English proficiency, adults with a bachelor's education or higher, SNAP enrollment, active commuting, and homeownership have worsened.

Table 2: Root Causes of Health (CT 6 vs SJC)

Health Topic	Measure Name	CT 6	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	69%	↑	91%
	Uninsured children (ages <19 yrs)	7%	↓↓	3%
Economic	Income	$31,853	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	36%	↑	13%
	Employed (ages 20- 64 yrs)	64%	↑	70%
Social Support	Two Parent Households	70%	↓	77%
	Limited English Proficiency	43%	↑	41%
Education	Preschool Enrollment	20%	↑↑	38%

Economic stability directly impacts residents' health and well-being. The poverty rate has slightly increased from the 2022 CHNA, and is now almost three times higher than that of SJC.

	Adults (ages 25+ yrs) with no high school diploma	53%	↓	20%
	Bachelor's Education or Higher	2%	↓	20%
Food Security	Low Access to Grocery Stores	12%	—	28%
	SNAP Enrollment	50%	↑↑↑↑	15%
Transportation	Automobile Access	92%	↑	95%
	Active Commuting	<1%	↓↓↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	98%	↑	99%
	Homeownership	14%	↓	60%
Pollution	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Education attainment has a role in economic security long-term. Although there are more adults receiving high school diplomas since the 2022 CHNA, it is still considerably lower than the SJC average.

SNAP (food assistance) enrollment is more than triple the SJC average, indicating that CT 6 residents need financial assistance to meet basic needs, but that they are receiving support.

Birth and Death Statistics

When compared with the County, this neighborhood has higher birth rates across most racial/ethnic groups, with the highest rates seen among Hispanic and Asian residents. There are over double the rate of teen births and fewer pregnant persons receiving early prenatal care in CT 6 than the County overall. Since the 2022 CHNA, this neighborhood performs worse on babies born at low birth weight.

Table 3: Birth Outcomes (CT 6 vs SJC)

Measure Name	CT 6	Change Since 2022 CHNA	SJC
Pre-term births	8%	↓	9%
Low birth weight	6%	↑↑	8%
Prenatal care in 1st trimester	68%	↑	79%
Teen births (mothers ages 15- 19 yrs)	11%	↑	4%
Birth Rate			
Total	16	↓↓	13
Asian	16	↓	13
Black/African American	11	↓↓↓	12
Hispanic	16	↓↓	15
White	15	↑	8

Refer to technical notes for data sources.

In this neighborhood, all racial/ethnic groups have a lower average age of death than the County overall, with the Black/African American population experiencing the lowest average age of death despite improving since the 2022 CHNA. Among the top five causes of death in CT 6, the rate of death due to unintentional injuries is almost twice the County rate, while the rates of death due to COVID-19 and heart disease have decreased substantially since the 2022 CHNA.

Table 4: Death Statistics (CT 6 vs SJC)

Measure Name	CT 6	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	61	↓	71
Asian	64	↓	72
Black/African American	58	↑	64
Hispanic	60	↓	65
White	61	↓	75
Age-Adjusted Death Rate - Total	1,051	↓↓	832
Top 5 Causes of Death			
COVID-19 deaths	157	↓↓↓	61
Cancer deaths	125	↓	144
Unintentional injury deaths	116	↑↑	55
Heart disease deaths	53	↓↓↓	148
Deaths of despair	51	↓	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 7

Census tract (CT) description:

CT 7 in Stockton is bounded by the following streets: I-5 on the west, Charter on the south, Hazelton/Scotts on the north, and Union/Aurora on the east. This Priority Neighborhood is home to 5,284 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64. Since the 2022 community health needs assessment (CHNA), CT 7 has experienced demographic changes, including an increase in the Multiple Races population. The number of children under five has increased substantially since the 2022 CHNA, while the percentage of adults aged 45 and above has decreased in this neighborhood (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 7 vs SJC)

		CT 7	Change Since 2022 CHNA	SJC
Total Population		5,284	↑	779,445
Race/Ethnicity	Asian	13%	↓	17%
	Black/African American	7%	↓	7%
	Hispanic	70%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	7%	↓	29%
	Multiple Races	2%	↑↑	4%
Gender	Female	50%	↓	50%
	Male	50%	↑	50%
Age Group	0- 5 yrs	8%	↑↑↑↑	8%
	6- 17 yrs	18%	↑	19%
	18- 24 yrs	10%	↓	10%
	25- 44 yrs	30%	↑	27%
	45- 64 yrs	25%	↓	23%
	≥65 yrs	7%	↓↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County as a whole on most topics, including access to care, economics, social support, education, and housing conditions. Income in this CT is about half the SJC average income and disparities (at least 10 percentage points worse than the County) are present for percent of insured adults, percent living in poverty, employment, limited English proficiency, adult educational attainment, SNAP enrollment, automobile access, and homeownership. CT 7 performs better (10 percentage points or more) than the County on measures of preschool enrollment and access to grocery stores. Since the 2022 CHNA, there have been improvements in income, employment, two parent households, preschool enrollment, adult educational attainment, SNAP enrollment, housing habitability, and homeownership. However, performance has worsened when it comes to the percentage of adults with insurance coverage, percent living in poverty, limited English proficiency, automobile access, and active commuting.

Table 2: Root Causes of Health (CT 7 vs SJC)

Health Topic	Measure Name	CT 7	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	75%	↓	91%
	Uninsured children (ages <19 yrs)	8%	—	3%
Economic	Income	$41,793	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	39%	↑	13%
	Employed (ages 20- 64 yrs)	55%	↑	70%
Social Support	Two Parent Households	74%	↑	77%
	Limited English Proficiency	53%	↑↑↑	41%
Education	Preschool Enrollment	52%	↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	46%	↓	20%
	Bachelor's Education or Higher	8%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	5%	—	28%
	SNAP Enrollment	27%	↓	15%
Transportation	Automobile Access	84%	↓	95%
	Active Commuting	3%	↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	12%	—	—
Housing	Housing Habitability	100%	↑	99%
	Homeownership	45%	↑↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

Income and poverty directly impact residents' health and well-being; the percent of individuals living in poverty in CT 7 is triple the SJC poverty rate.

Adults pursuing a bachelor's education or higher increased since the 2022 CHNA but is lower than SJC overall.

SNAP (food assistance) enrollment is close to double the SJC average, indicating that CT 7 residents need financial assistance to meet basic needs, but that they are receiving support.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, CT 7 has double the rate of teen births. The rate of pre-term births has decreased in this neighborhood since the 2022 CHNA. While the overall birth rate is higher than the County rate, this neighborhood has lower birth rates among Asian and Black/African American residents when compared to the County.

Table 3: Birth Outcomes (CT 7 vs SJC)

Measure Name	CT 7	Change Since 2022 CHNA	SJC
Pre-term births	10%	↓↓	9%
Low birth weight	10%	↓	8%

Prenatal care in 1st trimester	71%	↓	79%
Teen births (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	8	↓↓	13
Black	10	↓	12
Hispanic	19	↓	15
White	8	↓	8

Refer to technical notes for data sources.

In this neighborhood, Black/African American and Hispanic residents are dying younger than other racial/ethnic groups. Since the 2022 CHNA, the average age of death for all groups, excluding Asian residents, has decreased. This neighborhood's rates of death due to heart disease, cancer, unintentional injuries, despair and COVID-19 are higher than the County rates. There has been a substantial increase in the rate of deaths due to cancer and a decrease in the rate of deaths due to COVID-19 since the 2022 CHNA.

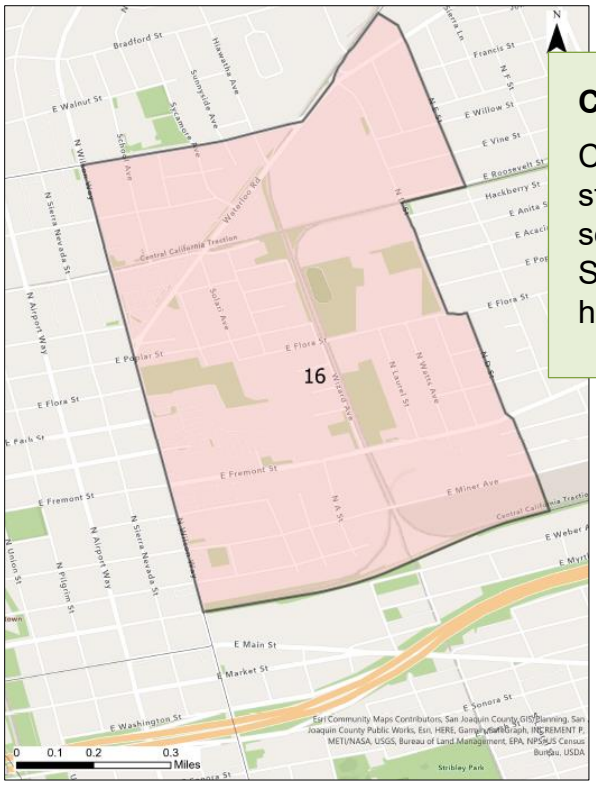
Table 4: Death Statistics (CT 7 vs SJC)

Measure Name	CT 7	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	71	—	77
Average Age of Death (yrs)			
Total	62	↓	71
Asian	79	↑	72
Black	57	↓	64
Hispanic	57	↓	65
White	61	↓	75
Age-Adjusted Death Rate - Total	1,343	↑	832
Top 5 Causes of Death			
Heart disease deaths	218	↑	148
Cancer deaths	182	↑↑↑	144
Unintentional injury deaths	160	↑	55
Deaths of despair	125	↑	44
COVID-19 deaths	103	↓↓	61

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 16



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 16 in Stockton is bounded by the following streets: Wilson on the west, Weber/Miner on the south, Harding/Cherokee on the north, and D/E St. on the east. This Priority Neighborhood is home to 2,494 people.

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 0-24. This neighborhood has seen demographic change since the 2022 community health needs assessment (CHNA), including a decrease in the Asian, Black/African American, and White populations (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 16 vs SJC)

		CT 16	Change Since 2022 CHNA	SJC
Total Population		2,494	↑	779,445
Race/Ethnicity	Asian	2%	↓↓↓	17%
	Black	3%	↓↓	7%
	Hispanic	74%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	15%	↓↓	29%
	Multiple Races	6%	—	4%
Gender	Female	47%	↑	50%
	Male	53%	↓	50%
Age	0- 5	4%	↓↓	8%
	6- 17	33%	↑	19%
	18- 24	14%	↑↑↑↑↑	10%
	25- 44	25%	↓	27%
	45- 64	19%	↓	23%
	≥65	6%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This Priority Neighborhood fares worse than the County overall across economics, education and transportation. Income in this CT is two thirds that of the SJC average income, and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, adults with bachelor's education or higher, SNAP enrollment, and homeownership. In contrast, this neighborhood performs better than the County (10 percentage points or more) on preschool enrollment. Since the 2022 CHNA, this neighborhood performs better on uninsured children, income, employment, preschool enrollment, adult educational attainment, automobile access, housing habitability, and homeownership, but worse on the percent living in poverty, two parent households, limited English proficiency, SNAP enrollment, and active commuting.

Table 2: Root Causes of Health (CT 16 vs SJC)

Health Topic	Measure Name	CT 16	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	89%	—	91%
	Uninsured children (ages <19 yrs)	3%	↓	3%
Economic	Income	$54,653	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	28%	↑	13%
	Employed (ages 20- 64 yrs)	71%	↑↑	70%
Social Support	Two Parent Households	74%	↓	77%
	Limited English Proficiency	39%	↑↑↑↑	41%
Education	**Preschool Enrollment**	66%	↑	38%
	Adults (ages 25+ yrs) with no high school diploma	28%	↓↓	20%
	Bachelor's Education or Higher	5%	↑	20%

Economic stability directly impacts residents' health and well-being. Employment in CT 16 has substantially improved since the 2022 CHNA.

Preschool enrollment has increased since the 2022 CHNA and is substantially greater than the SJC average.

Food Security	Low Access to Grocery Stores	—	—	28%
	SNAP Enrollment	45%	↑↑↑	15%
Transportation	Automobile Access	93%	↑	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	3%	—	<1%
	Urban Tree Canopy	7%	—	—
Housing	Housing Habitability	100%	↑	99%
	Homeownership	38%	↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

Enrollment in SNAP (food assistance) is triple the SJC average and has increased substantially since the 2022 CHNA, indicating that individuals in CT 16 require support to meet basic needs.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared to the County, this neighborhood has higher percentages of pre-term births, babies born at a low birth weight, and teen births, and fewer pregnant persons receiving early prenatal care. The birth rate is also higher in this neighborhood when compared to the County. Since the 2022 CHNA, CT 16 has improved on teen births, pre-term births, and accessing early prenatal care, but low birth weights have increased. The birth rate among Asian and Black/African American residents has substantially increased.

Table 3: Birth Outcomes (CT 16 vs SJC)

Measure Name	CT 16	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓	9%
Low birth weight	11%	↑↑	8%
Prenatal care in 1st trimester	74%	↑	79%
Teen births (mothers ages 15- 19 yrs)	6%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	30	↑↑↑↑↑	13
Black	26	↑↑↑↑↑	12
Hispanic	17	↓	15
White	10	↑	8

Refer to technical notes for data sources.

When compared to SJC overall, Asian, Hispanic, and White CT 16 residents are dying at a younger age, and the total age adjusted death rate is more than twice the County

rate. Compared to the 2022 CHNA, the average age of death for all groups combined has decreased while the average age of death for individual racial/ethnic groups have increased. Among the leading causes of death in this neighborhood, the rates of deaths due to cancer, heart disease, COVID-19, Alzheimer's, and unintentional injuries are higher than the County. While deaths due to COVID-19 have decreased, the rates of death due to cancer and Alzheimer's have more than doubled since the 2022 CHNA.

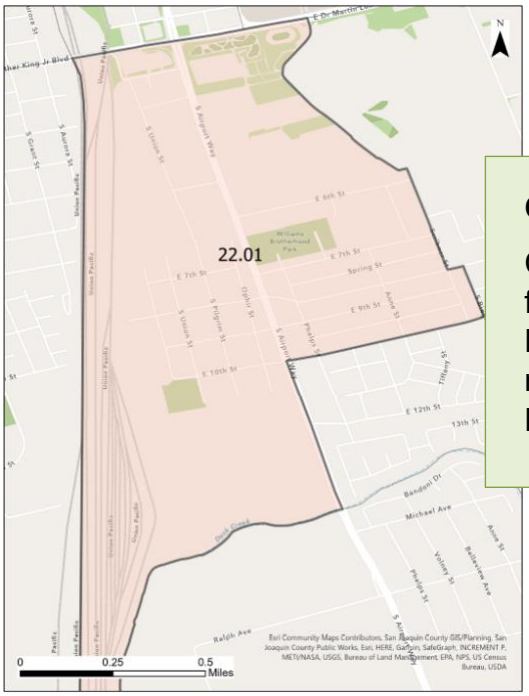
Table 4: Death Statistics (CT 16 vs SJC)

Measure Name	CT 16	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	73	—	77
Average Age of Death (yrs)			
Total	64	↓	71
Asian	59	↑↑	72
Black/African American	73	↑	64
Hispanic	63	↑	65
White	68	↑	75
Age-Adjusted Death Rate - Total	1,942	↑↑	832
Top 5 Causes of Death			
Cancer deaths	264	↑↑↑↑↑	144
Heart disease deaths	253	↑↑↑	148
COVID-19 deaths	172	↓	61
Alzheimer's deaths	155	↑↑↑↑↑	35
Unintentional injury deaths	115	↑	55

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 22.01



Census tract (CT) description:

CT 22.01 in Stockton is bounded by the following streets: Union/Aurora on the west, Duck Creek Levee on the south, Charter on the north, and Scribner/Bieghle on the east. This Priority Neighborhood is home to 3,564 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

The majority of this neighborhood's residents are Hispanic. The neighborhood population is young, with 52% age 24 or younger. The population aged 25-64 has decreased since the 2022 community health needs assessment (CHNA), while all other age groups have increased. Additionally, CT 22.01 experienced demographic changes reflected by a substantial decrease in the Asian and Multiple Race Populations (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 22.01 vs SJC)

		CT 22.01	Change Since 2022 CHNA	SJC
Total Population		3,564	↑	779,445
Race/Ethnicity	Asian	<1%	↓↓↓	17%
	Black/African American	18%	↑	7%
	Hispanic	78%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	2%	↓↓	29%
	Multiple Races	1%	↓↓↓	4%
Gender	Female	52%	↓	50%
	Male	48%	↑	50%
Age Group	0- 5 yrs	13%	↑	8%
	6- 17 yrs	26%	↑	19%
	18- 24 yrs	13%	↑	10%
	25- 44 yrs	27%	↓	27%
	45- 64 yrs	15%	↓	23%
	≥65 yrs	7%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

CT 22.01 fares worse than the County overall on economics, social support, education, and housing conditions. Income in this CT is just over 40% of the average SJC income and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, limited English proficiency, preschool enrollment, adult educational attainment, SNAP enrollment, automobile access, housing habitability, and homeownership. This neighborhood has a lower drought risk than the County overall. Since the 2022 CHNA, CT 22.01 has experienced improvements in percent of insured adults, income, percent living in poverty, employment, two parent households, adults without high school diplomas, active commuting, and homeownership. However, limited English proficiency, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 22.01 vs SJC)

Health Topic	Measure Name	CT 22.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	90%	↑	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%
Economic	Income	$34,588	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	31%	↓	13%
	Employed (ages 20- 64 yrs)	61%	↑	70%
Social Support	Two Parent Households	71%	↑	77%
	Limited English Proficiency	51%	↑↑↑↑	41%
Education	Preschool Enrollment	23%	↓	38%
	Adults (ages 25+ yrs) with no high school diploma	45%	↓	20%
	Bachelor's Education or Higher	4%	↓	20%
Food Security	Low Access to Grocery Stores	27%	—	28%
	SNAP Enrollment	40%	↑	15%
Transportation	Automobile Access	81%	↓	95%
	Active Commuting	8%	↑↑↑	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	8%	—	—
Housing	Housing Habitability	87%	↓	99%
	Homeownership	42%	↑	60%
Climate and Environment	Drought Risk	3	—	52
	Air pollution: PM2.5 concentration	12	—	15

Economic stability directly impacts residents' health and well-being. Although poverty has decreased since the 2022 CHNA, CT 22.01 has a poverty rate more than double the SJC average.

Limited English proficiency can impact ability to access health care and other services. The % of CT 22.01 residents with limited English increased substantially since the 2022 CHNA and is higher than SJC overall.

The % of adults without a high school diploma in CT 22.01 is over double the % for SJC, but has decreased since the 2022 CHNA.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, this neighborhood has higher birth rates for all racial/ethnic groups combined. The birth rate among Asian residents has substantially increased since the 2022 CHNA, while the rate among Black/African American, Hispanic, and White residents has decreased. CT 22.01 performs worse than the County when it comes to pre-term births, babies born at a low birth weight, early prenatal care, and teen births. Since the 2022 CHNA, this neighborhood has seen a

decrease in teen births and pre-term births as well as a decrease in mothers receiving early prenatal care. The percentage of babies born at a low birth rate increased.

Table 3: Birth Outcomes (CT 22.01 vs SJC)

Measure Name	CT 22.01	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓↓	9%
Low birth weight	11%	↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	7%	↓↓	4%
Birth Rate			
Total	16	↓	13
Asian	42	↑↑↑↑↑	13
Black/African American	10	↓↓	12
Hispanic	16	↓	15
White	19	↓	8

Refer to technical notes for data sources.

This neighborhood's average age of death for all racial/ethnic groups except Hispanic is higher than the County average and has increased since the 2022 CHNA. The age adjusted death rate for all groups is 68% higher than the County average. For the top five causes of death, the rates of cancer, COVID-19, heart disease, stroke, and diabetes are considerably higher than the County rates. Compared to the 2022 CHNA, rates of death due to cancer, COVID-19, and heart disease have decreased.

Table 4: Death Statistics (CT 22.01 vs SJC)

Measure Name	CT 22.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	73	—	77
Average Age of Death (yrs)			
Total	67	↑	71
Asian	76	↑↑	72
Black/African American	69	↑	64
Hispanic	66	↑	65
White	71	↑	75
Age-Adjusted Death Rate - Total	1,225	↓↓	832
Top 5 Causes of Death			
Cancer deaths	219	↓	144
COVID-19 deaths	206	↓↓	61
Heart disease deaths	118	↓↓	148
Stroke deaths	96	↑	50
Diabetes deaths	86	↑	30

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 27.01

Census tract (CT) description:

CT 27.01 in Stockton is bounded by the following streets: Highway 99 on the west, Main on the south, Stokes/Cardinal on the north, and Del Mar on the east. This Priority Neighborhood is home to 6,362 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

Over three-quarters of this neighborhood's residents are Hispanic and the majority are between the ages of 25 and 64 years old. Compared to the 2022 community health needs assessment (CHNA), the Asian population has increased and there has been a decrease in individuals between the ages of 18-64 years old (Table 1) and an increase in residents aged 65 years and older.

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 27.01 vs SJC)

		CT 27.01	Change Since 2022 CHNA	SJC
Total Population		6,362	↑	779,445
Race/Ethnicity	Asian	3%	↑↑↑	17%

	Black/African American	2%	↓	7%
	Hispanic	81%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	14%	↓	29%
	Multiple Races	1%	—	4%
Gender	Female	49%	↑	50%
	Male	51%	↓	50%
Age Group	0- 5 yrs	10%	↑	8%
	6- 17 yrs	10%	—	19%
	18- 24 yrs	8%	↓↓	10%
	25- 44 yrs	31%	↓	27%
	45- 64 yrs	22%	↓	23%
	≥65 yrs	10%	↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

In comparison with the County, CT 27.01 fares worse across access to care, economics, education, and housing. Income in this CT is two thirds of the SJC average income and disparities (10 or more percentage points worse than the County) are present for limited English proficiency, adult educational attainment, and SNAP enrollment. In contrast, this neighborhood performs better than the County (10 percentage points or more) on measures of preschool enrollment and drought risk. The percent insured adults, income, the percent living in poverty, employment, two parent households, preschool enrollment, adult educational attainment, automobile access, and homeownership have improved since the 2022 CHNA, while uninsured children, limited English proficiency, SNAP enrollment, active commuting, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 27.01 vs SJC)

Health Topic	Measure Name	CT 27.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	82%	↑	91%
	Uninsured children (ages <19 yrs)	5%	↑	3%
Economic	**Income**	$54,338	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	15%	↓↓	13%
	Employed (ages 20- 64 yrs)	64%	↑	70%
Social Support	Two Parent Households	85%	↑	77%
	Limited English Proficiency	51%	↑↑↑↑	41%

Income directly impacts residents' health and well-being; although it has increased from the 2022 CHNA, the average income in CT 27.01 is still a third less than that of SJC.

Education	Preschool Enrollment	49%	↑↑↑↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	49%	↓	20%
	Bachelor's Education or Higher	5%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	26%	—	28%
	SNAP Enrollment	44%	↑↑	15%
Transportation	Automobile Access	96%	↑	95%
	Active Commuting	1%	↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	92%	↓	99%
	Homeownership	53%	↑	60%
Climate and Environment	Drought Risk	4	—	52
	Air pollution: PM2.5 concentration	11	—	15

The % of adults without a high school diploma in CT 27.01 is over double the % for SJC, but has decreased since the 2022 CHNA

SNAP (food assistance) enrollment is close to triple the SJC average, indicating that CT 27.01 residents need financial assistance to meet basic needs, but that they are receiving support.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, CT 27.01 has a higher overall birth rate across all racial/ethnic groups. There are slightly more pre-term births, fewer pregnant persons receiving prenatal care during the first trimester, and more teen births compared to the County. However, there are fewer babies born with a low birth weight compared to the County.

Table 3: Birth Outcomes (CT 27.01 vs SJC)

Measure Name	CT 27.01	Change Since 2022 CHNA	SJC
Pre-term births	10%	↑	9%
Low birth weight	6%	↑	8%
Prenatal care in 1st trimester	75%	↓	79%
Teen births (mothers ages 15- 19 yrs)	6%	↓↓	4%
Birth Rate			
Total	17	↓	13
Asian	16	↓↓↓	13
Black/African American	18	↑↑↑↑↑	12
Hispanic	17	↓	15
White	9	↓	8

Refer to technical notes for data sources.

In this neighborhood, the average age of death across racial/ethnic groups is lower than the County average, except for the Asian population. The Hispanic population is dying at the youngest age in this neighborhood, followed by the Black/African American population. This neighborhood's rates of death due to heart disease, COVID-19, unintentional injuries, and despair are higher than the County's rates. Since the 2022 CHNA, rates of death due to heart disease, cancer, and COVID-19 have decreased, while the rates of death due to unintentional injuries and despair have increased.

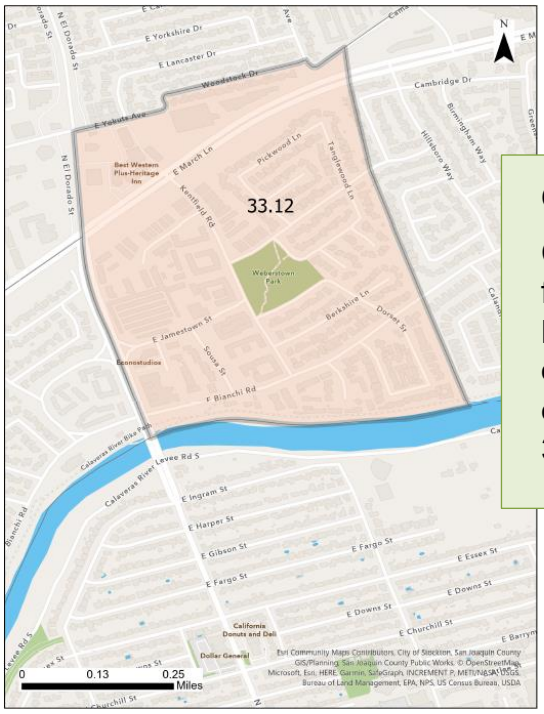
Table 4: Death Statistics (CT 27.01 vs SJC)

Measure Name	CT 27.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	65	↑	71
Asian	76	↑	72
Black/African American	63	↑	64
Hispanic	62	—	65
White	69	↑	75
Age-Adjusted Death Rate - Total	1117	↓	832
Top 5 Causes of Death			
Heart disease deaths	188	↓↓	148
Cancer deaths	138	↓↓	144
COVID-19 deaths	101	↓↓	61
Unintentional injury deaths	81	↑↑	55
Deaths of despair	67	↑↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 33.12



Census tract (CT) description:

CT 33.12 in Stockton is bounded by the following streets: El Dorado on the west, Bianchi on the south, Woodstock/Camanache on the north, and Colebrook/Burnham on the east. This Priority Neighborhood is home to 3,095 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

Just under half of the residents in CT 33.12 are Hispanic and almost one third are Black/African American. The largest portion of residents are between the ages of 25 and 64 years old; there has been an increase in the 18-24 year old population as compared with the 2022 community health needs assessment (CHNA) (Table 1).

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 33.12 vs SJC)

	CT 33.12	Change Since 2022 CHNA	SJC
Total Population	3,095	—	779,445

Race/Ethnicity	Asian	12%	↓	17%
	Black/African American	30%	↑	7%
	Hispanic	43%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	9%	—	29%
	Multiple Races	6%	↑↑↑	4%
Gender	Female	54%	↑	50%
	Male	46%	↓	50%
Age Group	0- 5 yrs	12%	↑	8%
	6- 17 yrs	19%	↓	19%
	18- 24 yrs	14%	↑↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	20%	↑	23%
	≥65 yrs	9%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

CT 33.12 performs worse than the County on economics, social support, and education. Income in this CT is substantially lower than the SJC average and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, employment, two parent households, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, and homeownership. In contrast, this neighborhood performed better (10 percentage points or more) than the County on access to grocery stores. Since the 2022 CHNA, CT 33.12 performance has improved for the percent of insured adults, income, percent living in poverty, adults without high school diplomas, and active commuting. However, it has worsened for employment, two parent households, limited English proficiency, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, housing habitability, and homeownership.

Table 2: Root Causes of Health (CT 33.12 vs SJC)

Health Topic	Measure Name	CT 33.12	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	91%	↑	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%
Economic	**Income**	$32,400	↑	$82,837

Income is a key element of economic stability, which directly impacts well-being. Income in CT 33.12 has increased since the 2022 CHNA but is less than half

	Living in poverty (<100% Federal Poverty Level)	32%	↓	13%
	Employed (ages 20- 64 yrs)	58%	↓	70%
Social Support	Two Parent Households	51%	↓	77%
	Limited English Proficiency	44%	↑↑↑↑	41%
Education	**Preschool Enrollment**	12%	↓↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	29%	↓	20%
	Bachelor's Education or Higher	6%	↓↓	20%
Food Security	Low Access to Grocery Stores	<1%	—	28%
	SNAP Enrollment	51%	↑	15%
Transportation	Automobile Access	79%	↓	95%
	Active Commuting	5%	↑↑↑↑↑	3%
Built Environment	Retail Density	1%	—	<1%
	Urban Tree Canopy	16%	—	—
Housing	Housing Habitability	99%	↓	99%
	Homeownership	10%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Preschool attendance positively impacts children's social and emotional development. Preschool enrollment dropped substantially since the 2022 CHNA and is much lower than SJC overall.

Over half of CT 33.12 residents are enrolled in SNAP (food assistance), pointing to a high level of food insecurity.

Birth and Death Statistics

When compared with the County, CT 33.12 has higher birth rates among Black/African American, Hispanic, and White residents. This neighborhood has more preterm births and teen births, and fewer pregnant persons receiving early prenatal care. In comparison to the 2022 CHNA, this neighborhood has seen a reduction in early prenatal care and teen births, and experienced an increase in pre-term births and babies born with low birth weight.

Table 3: Birth Outcomes (CT 33.12 vs SJC)

Measure Name	CT 33.12	Change Since 2022 CHNA	SJC
Pre-term births	11%	↑	9%
Low birth weight	8%	↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			

Total	20	↑	13
Asian	10	↓	13
Black/African American	15	↓	12
Hispanic	23	↑	15
White	13	↓	8

Refer to technical notes for data sources.

In this neighborhood, the Hispanic population is dying at a younger age than any other racial/ethnic group, followed closely by the Black/African American population. The CT 33.12 average age of death for all groups combined is lower than the County's average and has decreased since the 2022 CHNA, except for the Asian population. The age adjusted death rate is higher in this neighborhood than the overall County rate. The top 5 causes of death for this neighborhood – heart disease, cancer, COVID-19, stroke, and Alzheimer's – are almost all double or more than the County's rates. Compared with the previous CHNA, the rates of death due to COVID-19 and stroke have declined while the rates of death due to cancer and Alzheimer's have increased.

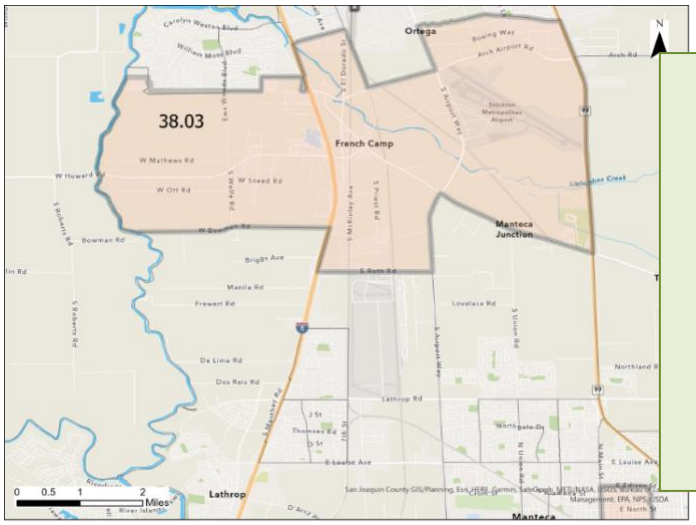
Table 4: Death Statistics (CT 33.12 vs SJC)

Measure Name	CT 33.12	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	66	—	77
Average Age of Death (yrs)			
Total	65	↓	71
Asian	70	↑	72
Black/African American	60	↓	64
Hispanic	58	↓	65
White	70	—	75
Age-Adjusted Death Rate - Total	1,861	↓	832
Top 5 Causes of Death			
Heart disease deaths	421	—	148
Cancer deaths	223	↑↑	144
COVID-19 deaths	167	↓↓↓	61
Stroke deaths	145	↓	50
Alzheimer's deaths	143	↑	35

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 38.03



Census tract (CT) description:

CT 38.03 is in the unincorporated community of French Camp and is bounded by the following streets: San Joaquin River on the west, Bowman and Roth on the south, French Camp on the north, and Highway 99 on the east. This Priority Neighborhood is home to 6,728 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

This Census tract includes more residents than any other Priority Neighborhood, with more than three times the population of CT 6. The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64 years old. There is a higher percentage of males than females in this neighborhood compared to the County overall. Since the 2022 community health needs assessment (CHNA), CT 38.03 has experienced a decrease in a number of racial/ethnic populations, a decrease in residents 18-24 years old and an increase in children aged 6-17 (Table 1).

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash – to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 38.03 vs SJC)

		CT 38.03	Change Since 2022 CHNA	SJC
Total Population		6,728	↑	779,445
Race/Ethnicity	Asian	8%	↓	17%
	Black/African American	9%	↓	7%
	Hispanic	59%	—	43%
	American Indian/Alaska Native	<1%	↓	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	20%	↑	29%
	Multiple Races	3%	↑↑↑	4%
Gender	Female	42%	↑	50%
	Male	58%	↓	50%
Age Group	0- 5 yrs	5%	↑	8%
	6- 17 yrs	14%	↑↑	19%
	18- 24 yrs	10%	↓↓	10%
	25- 44 yrs	36%	↓	27%
	45- 64 yrs	24%	↑	23%
	≥65 yrs	10%	—	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood performs worse than the County overall across economics, education, food security, and transportation. Disparities (at least 10 percentage points worse than the County) are present for the percent of insured adults, employment, limited English proficiency, adult educational attainment, low access to grocery stores, and SNAP enrollment. In contrast, this neighborhood has a higher average income than the County overall and performs better than the County on drought risk. Since the 2022 CHNA, income, employment, two parent households, and homeownership have improved, while the percent of insured adults, living in poverty, limited English proficiency, preschool enrollment, adult educational attainment, SNAP enrollment, active commuting, and housing habitability have all worsened.

Table 2: Root Causes of Health (CT 38.03 vs SJC)

Health Topic	Measure Name	CT 38.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	75%	↓	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%

Economic	**Income**	$88,418	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	14%	↑↑	13%
	Employed (ages 20- 64 yrs)	56%	↑↑	70%
Social Support	Two Parent Households	84%	↑	77%
	Limited English Proficiency	54%	↑↑↑↑	41%
Education	Preschool Enrollment	38%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	38%	↑	20%
	Bachelor's Education or Higher	6%	↓↓	20%
Food Security	Low Access to Grocery Stores	39%	—	28%
	SNAP Enrollment	25%	↑↑↑↑↑	15%
Transportation	Automobile Access	91%	—	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	5%	—	—
Housing	Housing Habitability	95%	↓	99%
	Homeownership	60%	↑	60%
Climate and Environment	Drought Risk	16	—	52
	Air pollution: PM2.5 concentration	11	—	15

Income in CT 38.03 has increased substantially since the 2022 CHNA and is higher than SJC.

Educational attainment plays a critical role in long-term economic security. Compared to SJC, CT 38.03 has a much smaller percentage of adults with education beyond high school.

SNAP enrollment (food assistance) in CT 38.03 has more than doubled since the 2022 CHNA and is substantially higher than SJC, indicating that residents require support to meet basic needs.

** Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

In comparison to the County overall, this neighborhood has lower birth rates across all racial/ethnic groups, more teen births, pre-term births, and babies born at low birth weights, and fewer pregnant persons receiving prenatal care early in their pregnancy.

Table 3: Birth Outcomes (CT 38.03 vs SJC)

Measure Name	CT 38.03	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓	9%

Low birth weight	9%	↑↑	8%
Prenatal care in 1st trimester	74%	↑	79%
Teen births (mothers ages 15- 19 yrs)	6%	↑	4%
Birth Rate			
Total	9	↓	13
Asian	7	↓↓	13
Black/African American	7	↑↑	12
Hispanic	12	↓	15
White	5	↓	8

Refer to technical notes for data sources.

In this neighborhood, the Black/African American population is dying at the youngest age when compared to other racial/ethnic groups, followed by the Hispanic population. The age-adjusted death rate is lower in this CT compared to the County. This neighborhood's rates of death due to heart disease, cancer, COVID-19, and stroke are all lower than the County's rates, but rates of death from diabetes in CT 38.03 are higher than in SJC.

Table 4: Death Statistics (CT 38.03 vs SJC)

Measure Name	CT 38.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	80	—	77
Average Age of Death (yrs)			
Total	71	↑	71
Asian	79	↓	72
Black/African American	63	↓	64
Hispanic	66	↑	65
White	74	↑	75
Age-Adjusted Death Rate - Total	636	↓	832
Top 5 Causes of Death			
Heart disease deaths	141	↑	148
Cancer deaths	103	↑	144
COVID-19 deaths	49	↑	61
Diabetes deaths	44	↑	30
Stroke deaths	40	↑	50

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 40.01

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 40.01 in the unincorporated community of Thornton is bounded by the following streets: Mokelumne River on the west and north, White Slough on the south, and I-5 on the east. This Priority Neighborhood is home to 2,249 people.

Demographics

The majority of this neighborhood's residents are Hispanic, followed by White, and between the ages of 25 and 64 years old. The Asian and Black/African American populations represent a smaller percentage of the total population in CT 40.01 as compared to the County (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last community health needs assessment (CHNA) was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 40.01 vs SJC)

		CT 40.01	Change Since 2022 CHNA	SJC
Total Population		2,249	↑	779,445
Race/Ethnicity	Asian	4%	—	17%
	Black/African American	2%	↑↑↑↑	7%
	Hispanic	52%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	40%	↓	29%
	Multiple Races	2%	↑↑↑	4%
Gender	Female	46%	↓	50%
	Male	55%	↑	50%
Age Group	0- 5 yrs	7%	↑	8%
	6- 17 yrs	16%	↓	19%
	18- 24 yrs	9%	↑	10%
	25- 44 yrs	26%	—	27%
	45- 64 yrs	27%	↑	23%
	≥65 yrs	15%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County across economics, social support, and education; disparities are notable for income and at least 10 percentage points worse than the County for the percent of insured adults, limited English proficiency, and adults with no high school diploma. In contrast, CT 40.01 performs better than the County on access to grocery stores (10 percentage points or more) and on drought risk. Compared to the 2022 CHNA, there have been improvements in income, percent living in poverty, employment, adults with a bachelor's or higher education, and homeownership. However, the percent of insured adults, two parent households, limited English proficiency, preschool enrollment, adults with no high school diploma, SNAP enrollment, automobile access, and active commuting conditions have worsened.

Table 2: Root Causes of Health (CT 40.01 vs SJC)

Health Topic	Measure Name	CT 40.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	80%	↓	91%
	Uninsured children (ages <19 yrs)	1%	—	3%
Economic	**Income**	$49,609	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	22%	↓	13%
	Employed (ages 20- 64 yrs)	69%	↑	70%
Social Support	Two Parent Households	73%	↓	77%
	Limited English Proficiency	52%	↑↑↑	41%
Education	Preschool Enrollment	44%	↓	38%

While income in CT 40.01 has increased since the 2022 CHNA, it is only 60% of the SJC average.

	Adults (ages 25+ yrs) with no high school diploma	32%	↑	20%
	Bachelor's Education or Higher	12%	↑↑↑	20%
Food Security	**Low Access to Grocery Stores**	3%	—	28%
	SNAP Enrollment	20%	↑↑↑	15%
Transportation	Automobile Access	97%	↓	95%
	Active Commuting	3%	↓↓	3%
Built Environment	Retail Density	0%	—	<1%
	Urban Tree Canopy	—	—	—
Housing	Housing Habitability	99%	—	99%
	Homeownership	57%	↑	60%
Climate and Environment	Drought Risk	41	—	52
	Air pollution: PM2.5 concentration	10	—	15

Educational attainment is linked to economic security. In CT 40.01 the % of adults with education beyond high school is substantially lower than SJC overall.

Access to grocery stores impacts ability to buy healthy foods. Residents of CT 40.01 have much better access to grocery stores than SJC overall.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

In comparison with the County overall, this neighborhood has a higher birth rate among Black/African American residents, while all other racial/ethnic groups have lower birth rates. While there are smaller percentages of pre-term births and babies born at a low birth weight than in the County, the rate of low birth weight has greatly increased since the 2022 CHNA, as has births from teen mothers.

Table 3: Birth Outcomes (CT 40.01 vs SJC)

Measure Name	CT 40.01	Change Since 2022 CHNA	SJC
Pre-term births	5%	↓↓	9%
Low birth weight	7%	↑↑↑↑	8%
Prenatal care in 1st trimester	68%	↓	79%
Teen births (mothers ages 15- 19 yrs)	9%	↑↑↑↑	4%
Birth Rate			
Total	9	↓	13
Asian	6	—	13
Black/African American	23	↓	12
Hispanic	11	↑	15
White	6	↓	8

Refer to technical notes for data sources.

In this neighborhood, the age-adjusted death rate is higher than the County's overall rate for all groups combined, and Black/African American residents are dying at a younger age when compared to other racial/ethnic groups, followed by Hispanic residents. For the CT 40.01 top five causes of death, the rates of death due to heart disease, cancer, unintentional injuries, despair, and COVID-19 are higher than in SJC. Compared to the 2022 CHNA, the rate of death due to cancer, unintentional injuries, despair, and COVID-19 has increased while the rate of death due to heart disease has decreased.

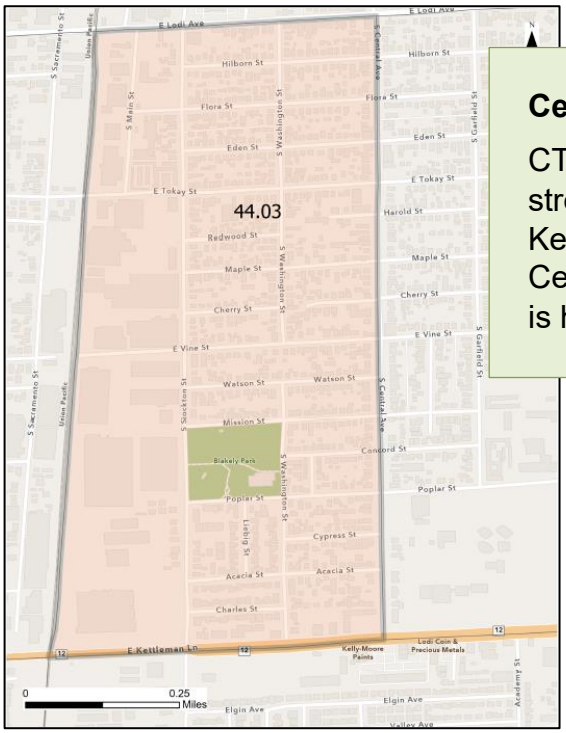
Table 4: Death Statistics (CT 40.01 vs SJC)

Measure Name	CT 40.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	78	—	77
Total	70	↓	71
Asian	85	—	72
Black/African American	45	—	64
Hispanic	59	↑	65
White	72	↓	75
Age-Adjusted Death Rate - Total	882	↑	832
Top 5 Causes of Death			
Heart disease deaths	177	↓↓	148
Cancer deaths	156	↑	144
Unintentional injury deaths	89	↑↑	55
Deaths of despair	55	↑↑	44
COVID-19 deaths	53	↑↑↑↑	61

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 44.03



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 44.03 in Lodi is bounded by the following streets: Sacramento/Stockton on the west, Kettleman on the south, Lodi on the north, and Central on the east. This Priority Neighborhood is home to 3,800 people.

Demographics

The majority of this neighborhood's residents are Hispanic, and about one-third of the population falls between the ages of 25 and 44. Since the 2022 community health needs assessment (CHNA), CT 44.03 experienced increases in the Asian and Multiple Race populations, as well as the percent of the population ages 18-24 and 45-64 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 44.03 vs SJC)

		CT 44.03	Change Since 2022 CHNA	SJC
Total Population		3,800	—	779,445
Race/Ethnicity	Asian	33%	↑↑	17%
	Black/African American	0%	—	7%
	Hispanic	51%	↓	43%

	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	11%	—	29%
	Multiple Races	5%	↑↑↑↑↑	4%
Gender	Female	50%	↑	50%
	Male	50%	↓	50%
Age Group	0- 5 yrs	13%	↑	8%
	6- 17 yrs	22%	↓	19%
	18- 24 yrs	10%	↑↑	10%
	25- 44 yrs	29%	↓	27%
	45- 64 yrs	20%	↑↑	23%
	≥65 yrs	7%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

When looking at the root causes of health, CT 44.03 performs worse than the County on economics and education. Income in this CT is substantially lower than the SJC average and disparities (at least 10 percentage points worse than the County) are present for the percent of insured adults, percent living in poverty, employment, limited English proficiency, preschool enrollment, adult educational attainment, automobile access, and homeownership. This neighborhood performs better (10 percentage points or more) than the County on access to grocery stores. Since the 2022 CHNA, this neighborhood has improved on uninsured children, preschool enrollment, adults with a bachelor's education or higher, and SNAP enrollment. However, the percent of insured adults, income, percent living in poverty, employment, limited English proficiency, adults without a high school diploma, automobile access, active commuting, and homeownership have worsened since the 2022 CHNA.

Table 2: Root Causes of Health (CT 44.03 vs SJC)

Health Topic	Measure Name	CT 44.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	73%	↓	91%
	Uninsured children (ages <19 yrs)	3%	↓↓	3%
Economic	Income	$28,992	↓↓	$82,837
	Living in poverty (<100% Federal Poverty Level)	44%	↑↑	13%

Poverty directly impacts health and well-being. Poverty increased since the 2022 CHNA and is over three times higher than the SJC poverty rate.

	Employed (ages 20- 64 yrs)	56%	↓	70%
Social Support	Two Parent Households	83%	↓	77%
	Limited English Proficiency	54%	↑↑	41%
Education	Preschool Enrollment	19%	↑↑↑↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	49%	↑	20%
	Bachelor's Education or Higher	8%	↑↑↑↑↑	20%
Food Security	Low Access to Grocery Stores	11%	—	28%
	SNAP Enrollment	22%	↓	15%
Transportation	Automobile Access	81%	↓	95%
	Active Commuting	4%	↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	9%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	30%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

The % of adults without a high school diploma in CT 44.03 is more than double SJC overall.

Homeownership is related to housing stability. The CT 44.03 homeownership rate is 50% lower than the SJC rate and has decreased since the 2022 CHNA.

** Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County overall, this neighborhood performs worse on preterm births, early prenatal care, and teen births. This neighborhood's birth rates (across most racial/ethnic groups) are higher than the County. Since the 2022 CHNA, this neighborhood has experienced a substantial increase in pre-term births and babies born at low birth weight.

Table 3: Birth Outcomes (CT 44.03 vs SJC)

Measure Name	CT 44.03	Change Since 2022 CHNA	SJC
Pre-term births	11%	↑↑↑↑	9%
Low birth weight	8%	↑↑↑↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	7%	↓	4%
Birth Rate			

Total	19	↓	13
Asian	14	↓↓	13
Black/African American	—	—	12
Hispanic	25	↑	15
White	12	↓	8

Refer to technical notes for data sources.

In this neighborhood, Asian and Hispanic residents are dying at a younger age than other racial/ethnic groups. Across all racial/ethnic groups the average age of death is lower than County averages. Compared to the 2022 CHNA, the average age of death among Asian and White residents has increased, while the average age among the Hispanic population has decreased. For the top five causes of death, the rates of death due to heart disease, COVID-19, unintentional injuries, and despair are higher in this neighborhood than the County; in contrast, deaths due to cancer are slightly lower in CT 44.03. The rates of death due to unintentional injuries and despair have increased substantially since the 2022 CHNA, while the rate of death due to COVID-19 has decreased.

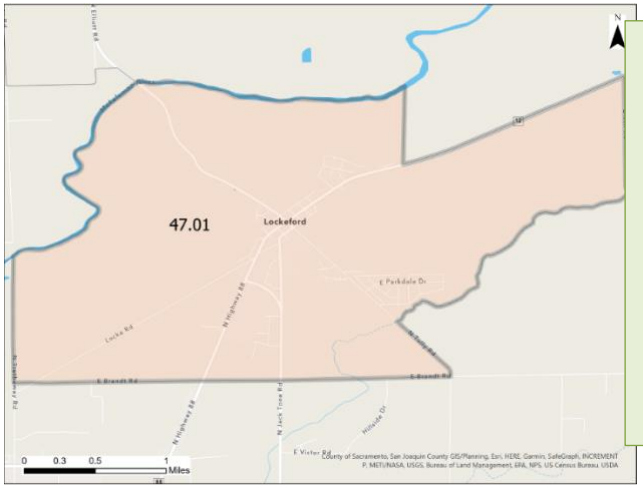
Table 4: Death Statistics (CT 44.03 vs SJC)

Measure Name	CT 44.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	78	—	77
Average Age of Death (yrs)			
Total	64	↓	71
Asian	58	↑	72
Black/African American	—	—	64
Hispanic	58	↓	65
White	72	↑	75
Age-Adjusted Death Rate - Total	983	↑	832
Top 5 Causes of Death			
Heart disease deaths	162	↑	148
Cancer deaths	141	↑	144
COVID-19 deaths	111	↓↓↓	61
Unintentional injury deaths	69	↑↑↑	55
Deaths of Despair	65	↑↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 47.01



Census tract (CT) description:

CT 47.01 in the unincorporated community of Lockeford is bounded by the following streets: Tretheway on the west, Brandt on the south, Mokelumne River on the north, and Disch on the east. This Priority Neighborhood is home to 3,426 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

The majority of this neighborhood's residents are White and above the age of 25 years old. There is a slightly higher percentage of males than females when compared to SJC overall. Since 2022, CT 47.01 experienced an increase in the Asian and Multiple Race populations. The percent of the population age 65 years and older is increasing (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last community health needs assessment (CHNA) was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 47.01 vs SJC)

		CT 47.01	Change Since 2022 CHNA	SJC
Total Population		3,426	↑	779,445
Race/Ethnicity	Asian	1%	↑↑↑↑↑	17%
	Black/African American	<1%	—	7%

	Hispanic	36%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	58%	↓	29%
	Multiple Races	4%	↑↑↑↑	4%
Gender	Female	44%	↑	50%
	Male	56%	↓	50%
Age Group	0- 5 yrs	9%	↓	8%
	6- 17 yrs	16%	↓	19%
	18- 24 yrs	7%	↓	10%
	25- 44 yrs	23%	↑	27%
	45- 64 yrs	22%	↑	23%
	≥65 yrs	24%	↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood performs similar to the County across health topics. CT 47.01 measures at least 10 percentage points worse than the County on two parent households, preschool enrollment, and access to grocery stores. In contrast, this neighborhood has a higher average income than SJC overall and performs better (10 percentage points or more) than the County on measures of homeownership and drought risk. Since the 2022 CHNA, CT 47.01 has improved on the percent of uninsured children, income, percent living in poverty, employment, two parent households, adult educational attainment, SNAP enrollment, and homeownership. However, the percent of insured adults, limited English proficiency, preschool enrollment, automobile access, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 47.01 vs SJC)

Health Topic	Measure Name	CT 47.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	83%	↓	91%
	Uninsured children (ages <19 yrs)	<1%	↓↓↓↓	3%
Economic	Income	$105,870	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	10%	↓↓↓	13%
	Employed (ages 20- 64 yrs)	73%	↑	70%
Social Support	**Two Parent Households**	60%	↑	77%
	Limited English Proficiency	34%	↑↑↑↑↑	41%

CT 47.01 has a smaller percentage of households with 2 parents than the SJC average.

Education	Preschool Enrollment	7%	↓	38%
	Adults (ages 25+ yrs) with no high school diploma	12%	↓↓	20%
	Bachelor's Education or Higher	28%	↑↑	20%
Food Security	**Low Access to Grocery Stores**	47%	—	28%
	SNAP Enrollment	6%	↓	15%
Transportation	Automobile Access	98%	↓	95%
	Active Commuting	2%	—	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	—	—	—
Housing	Housing Habitability	99%	↓	99%
	Homeownership	86%	↑	60%
Climate and Environment	Drought Risk	11	—	52
	Air pollution: PM2.5 concentration	10	—	15

Access to grocery stores is linked to ability to purchase healthy foods. CT 47.01 residents have less access to grocery stores than SJC overall.

Homeownership is an element of economic and housing stability. Residents in CT 47.01 are more likely to own their homes than in SJC overall.

Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, CT 47.01 has lower birth rates across all racial/ethnic groups. There are fewer pre-term births, babies born at low birth weights, and teen births in this neighborhood as compared to the County overall. Compared to the 2022 CHNA, fewer pregnant persons are receiving early prenatal care and there is an increase in pre-term births. However, there is a decrease in babies born at low birth weight and a decrease in teen births.

Table 3: Birth Outcomes (CT 47.01 vs SJC)

	CT 47.01	Change Since 2022 CHNA	SJC
Pre-term births	7%	↑	9%
Low birth weight	5%	↓	8%
Prenatal care in 1st trimester	78%	↓	79%
Teen births (mothers ages 15- 19 yrs)	3%	↓↓	4%
Birth Rate			
Total	7	↓	13

Asian	9	—	13
Black/African American	—	—	12
Hispanic	8	↓↓	15
White	6	↓	8

Refer to technical notes for data sources.

In this neighborhood, the age adjusted death rate is lower for all groups combined than the County overall rate. The Asian population is dying at the youngest age on average when compared with other racial/ethnic groups. Rates for CT 47.01's five top causes of death are lower than the County's. Since the 2022 CHNA, rates of death due to heart disease and lung disease have increased, while the rates of death due to cancer, unintentional injuries, and stroke have decreased.

Table 4: Death Statistics (CT 47.01 vs SJC)

Measure Name	CT 47.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	79	—	77
Average Age of Death (yrs)			
Total	73	↓	71
Asian	59	—	72
Black/African American	—	—	64
Hispanic	66	↓	65
White	75	↓	75
Age-Adjusted Death Rate - Total	697	↓↓	832
Top 5 Causes of Death			
Heart disease deaths	142	↑	148
Cancer deaths	138	↓	144
Unintentional injury deaths	37	↓	55
Lung disease deaths	36	↑	37
Stroke deaths	34	↓	50

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 51.09

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 51.09 in Manteca is bounded by the following streets: Main on the west, Moffat on the south, Edison on the north, and Powers on the east. This Priority Neighborhood is home to 3,493 people.

Demographics

The neighborhood's residents are predominantly Hispanic and White, and almost half are between the ages of 25 and 64. Since the 2022 community health needs assessment (CHNA), demographic changes in CT 51.09 include a decrease in the Asian population, increase in the White population and a decrease in the percent of the population ages 0-5 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 51.09 vs SJC)

		CT 51.09	Change Since 2022 CHNA	SJC
Total Population		3,493	↓	779,445
Race/Ethnicity	Asian	1%	↓↓↓	17%
	Black/African American	2%	↑	7%

	Hispanic	46%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	1%	—	<1%
	White	46%	↑↑	29%
	Multiple Races	4%	↓	4%
Gender	Female	51%	↑	50%
	Male	49%	↓	50%
Age Group	0- 5 yrs	6%	↓↓	8%
	6- 17 yrs	17%	↑	19%
	18- 24 yrs	13%	↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	23%	↑	23%
	≥65 yrs	16%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County overall on access to care, economics, social support, and transportation. Income in this neighborhood is substantially lower than the County average income and disparities (at least 10 percentage points worse than the County) are present for limited English proficiency and homeownership. In contrast, this neighborhood performs better (10 percentage points or more) than the County on preschool enrollment and SNAP enrollment. Since the 2022 CHNA, this neighborhood has improved on income, employment, preschool enrollment, adult educational attainment, SNAP enrollment, automobile access, and homeownership. Adult and child insurance coverage, percent living in poverty, two parent households, limited English proficiency, and active commuting are worse compared to the 2022 CHNA.

Table 2: Root Causes of Health (CT 51.09 vs SJC)

Health Topic	Measure Name	CT 51.09	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	88%	↓	91%
	Uninsured children (ages <19 yrs)	10%	↑	3%
Economic	Income	$53,542	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	21%	↑	13%
	Employed (ages 20- 64 yrs)	68%	↑	70%

Poverty impacts health and well-being. In CT 51.09, the percentage of those living in poverty increased since the 2022 CHNA and is higher than SJC.

Social Support	Two Parent Households	75%	↓	77%
	Limited English Proficiency	52%	↑↑↑↑↑	41%
Education	Preschool Enrollment	63%	↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	13%	↓↓	20%
	Bachelor's Education or Higher	16%	↑↑↑↑↑	20%
Food Security	Low Access to Grocery Stores	—	—	28%
	SNAP Enrollment	5%	↓↓↓	15%
Transportation	Automobile Access	93%	↑	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	1%	—	<1%
	Urban Tree Canopy	8%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	46%	↑↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

Educational attainment plays a role in economic security. In CT 51.09, the percentage of adults with education beyond high school has more than doubled since the 2022 CHNA.

Homeownership is linked with economic and housing stability. Homeownership in CT 51.09 has increased since the 2022 CHNA but remains lower than SJC overall.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County overall, CT 51.09 performs better when it comes to pre-term births, teen births, low birth weight babies, and receiving prenatal care in the first trimester. Compared to the 2022 CHNA, there are more babies born at a low birth weight. This neighborhood has a higher total birth rate among all groups combined than the County overall; birth rates among Asian and Hispanic residents have increased since the 2022 CHNA, while the White birth rate has decreased.

Table 3: Birth Outcomes (CT 51.09 vs SJC)

Measure Name	CT 51.09	Change Since 2022 CHNA	SJC
Pre-term births	8%	↓	9%
Low birth weight	7%	↑↑↑	8%
Prenatal care in 1st trimester	81%	↑	79%
Teen births (mothers ages 15- 19 yrs)	3%	↑	4%
Birth Rate			
Total	14	—	13

Asian	46	↑↑↑↑↑	13
Black/African American	30	↓	12
Hispanic	21	↑↑	15
White	6	↓↓	8

Refer to technical notes for data sources.

In this neighborhood, Asian residents are dying at the youngest age on average compared to all other racial/ethnic groups. The age-adjusted death rate among all groups combined is higher than the County rate. This neighborhood's rates of death due to heart disease, cancer, COVID-19, lung disease, and despair are all higher than the County rates. In comparison to the 2022 CHNA, the average age of death among the Asian, Hispanic, and White populations has increased, while the average age of death has decreased among the Black/African American population. Deaths due to lung disease and despair have increased since the 2022 CHNA, while COVID-19 deaths have decreased.

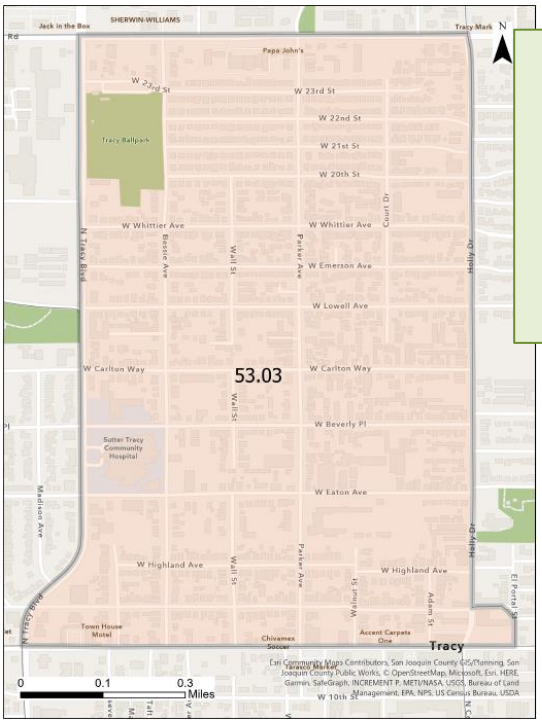
Table 4: Death Statistics (CT 51.09 vs SJC)

Measure Name	CT 51.09	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	72	—	77
Average Age of Death (yrs)			
Total	72	↑	71
Asian	63	↑	72
Black/African American	67	↓	64
Hispanic	65	↑	65
White	76	↑	75
Age-Adjusted Death Rate - Total	1,223	—	832
Top 5 Causes of Death			
Heart disease deaths	257	↑	148
Cancer deaths	146	↓	144
COVID-19 deaths	86	↓↓	61
Lung disease deaths	85	↑↑	37
Deaths of despair	71	↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 53.03



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 53.03 in Tracy is bounded by the following streets: Tracy on the west, 11th on the south, Grant Line on the north, and Holly on the east. This Priority Neighborhood is home to 6,454 people.

Demographics

Just over two-thirds of the neighborhood's residents are Hispanic, and just over one third are between the ages of 25 and 44. Since the 2022 community health needs assessment (CHNA), demographic changes in CT 53.03 include a decrease in the White population and increases in the Asian, Hispanic, and Multiple Races populations. CT 53.03 has a growing young population, with all age groups 44 years and younger experiencing increases since the 2022 CHNA, while ages 45 years and older decreased during this time (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 53.03 vs SJC)

		CT 53.03	Change Since 2022 CHNA	SJC
Total Population		6,454	↑↑	779,445
Race/Ethnicity	Asian	6%	↑↑	17%

	Black/African American	4%	↓	7%
	Hispanic	68%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	18%	↓↓	29%
	Multiple Races	3%	↑↑↑↑	4%
Gender	Female	47%	—	50%
	Male	53%	—	50%
Age Group	0- 5 yrs	16%	↑↑	8%
	6- 17 yrs	21%	↑	19%
	18- 24 yrs	9%	↑	10%
	25- 44 yrs	34%	↑	27%
	45- 64 yrs	14%	↓	23%
	≥65 yrs	7%	↓↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to the County overall, CT 53.03 fares worse on access to care, economics, education, and housing. Disparities (10 or more percentage points worse) compared to the County are present for the percent living in poverty and homeownership. This neighborhood performs better (10 percentage points or more) than the County on grocery store access. Since the 2022 CHNA, this neighborhood has improved on insurance coverage for adults and children, income, employment, SNAP enrollment, and active commuting, while the percent living in poverty, two parent households, limited English proficiency, preschool enrollment, adult educational attainment, housing habitability, and homeownership have worsened.

Table 2: Root Causes of Health (CT 53.03 vs SJC)

Health Topic	Measure Name	CT 53.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	89%	↑	91%
	Uninsured children (ages <19 yrs)	7%	↓↓	3%
Economic	Income	$81,889	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	25%	↑↑	13%

Poverty directly impacts health and well-being. In CT 53.03, the % living in poverty has increased since the 2022 CHNA and is almost double the SJC %.

	Employed (ages 20- 64 yrs)	78%	↑	70%
Social Support	Two Parent Households	73%	↓	77%
	Limited English Proficiency	32%	↑↑	41%
Education	**Preschool Enrollment**	37%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	24%	↑	20%
	Bachelor's Education or Higher	11%	↓	20%
Food Security	Low Access to Grocery Stores	<1%	—	28%
	SNAP Enrollment	12%	↓	15%
Transportation	Automobile Access	96%	—	95%
	Active Commuting	9%	↑↑↑↑↑	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	20%	—	—
Housing	Housing Habitability	97%	↓	99%
	Homeownership	29%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	9	—	15

Preschool is linked to academic achievement. CT 53.03 had a decrease in preschool enrollment since the 2022 CHNA.

Active commuting, which supports physical/mental health and contributes to environmental sustainability, has substantially increased in CT 53.03 since the 2022

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

CT 53.03 fares better than the County on pre-term births and babies born at a low birth weight. In contrast, this neighborhood has lower performance on early prenatal care and teen births. In comparison to the 2022 CHNA, performance has worsened for babies born at a low birth weight and teen births. The birth rate among Asian residents has increased since the 2022 CHNA, while rates for all other racial/ethnic groups have decreased.

Table 3: Birth Outcomes (CT 53.03 vs SJC)

Measure Name	CT 53.03	Change Since 2022 CHNA	SJC
Pre-term births	8%	—	9%
Low birth weight	7%	↑↑↑	8%
Prenatal care in 1st trimester	78%	↑	79%
Teen births (mothers ages 15- 19 yrs)	5%	↑↑	4%
Birth Rate			
Total	10	↓↓	13
Asian	14	↑	13

Black/African American	9	↓	12
Hispanic	10	↓↓	15
White	9	↓↓	8

Refer to technical notes for data sources.

This neighborhood, compared to the County overall, has a higher age adjusted death rate. Hispanic residents have the lowest average age of death in this neighborhood compared to all other racial/ethnic groups. Since the 2022 CHNA, Black/African American residents of CT 53.03 are living longer while the average age of death decreased for all other population groups. For the top five causes of death, CT 53.03 has higher rates of death for heart disease, cancer, COVID-19, stroke, and Alzheimer's compared to the County's rates. Compared to the 2022 CHNA, the rate of death due to COVID-19 has decreased and the rates of death due to heart disease, stroke, and Alzheimer's have increased.

Table 4: Death Statistics (CT 53.03 vs SJC)

Measure Name	CT 53.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	70	↓	71
Asian	84	↓	72
Black/African American	71	↑	64
Hispanic	63	↓	65
White	75	↓	75
Age-Adjusted Death Rate - Total	889	↓	832
Top 5 Causes of Death			
Heart disease deaths	172	↑↑	148
Cancer deaths	145	↑	144
COVID-19 deaths	78	↓↓↓	61
Stroke deaths	73	↑↑	50
Alzheimer's deaths	52	↑↑	35

Refer to technical notes for data sources.

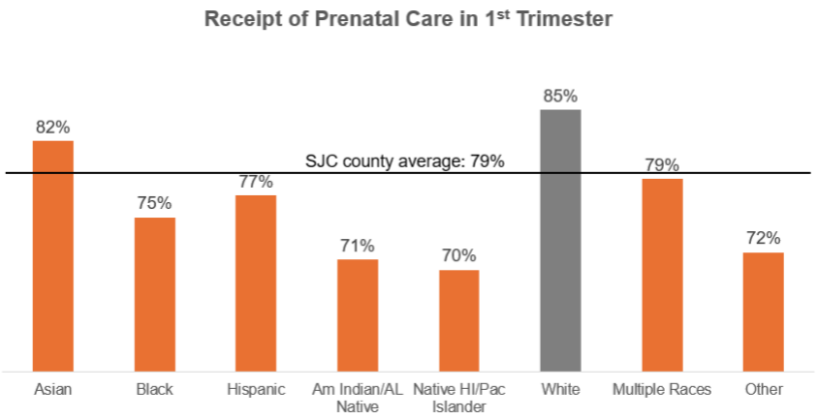
B. Health Need Profiles

Access to Care

Rationale: Why this is a critical health need

Access to comprehensive, quality healthcare is essential for achieving and maintaining health and for increasing quality of life. Components of access to and delivery of care include: insurance coverage; adequate numbers of primary/specialty care providers; health care timeliness, quality, and transparency; and culturally aligned healthcare. Limited access to healthcare and compromised healthcare delivery negatively affect health and quality of life.

Access to care	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Infant deaths (per 1000 live births)	Yes	No	↓
Uninsured children (ages <19 yrs)	No	Yes	↑
Insured (ages 19-64 yrs)	No	Yes	–
Medi-Cal enrollment	No	N/A	↓
Low birth weight	Yes	Yes	↑
Pre-term births	Yes	Yes	↓
Prenatal care in 1st trimester	Yes	Yes	↓
Dentists per 100,000 population	Yes	N/A	↑
Primary care physicians per 100,000 population	Yes	N/A	↓



*--: no change, ↑: 1-25% change, ↑↑: 26-50% change, ↑↑↑: 51-75% change, ↑↑↑↑: 76-100% change, ↑↑↑↑↑: >100% change. Arrow direction does not indicate negative/positive change; orange (↑↓) indicates negative change, green (↑↓) indicates improvement.

Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have access to significantly fewer health care providers than the CA average. SJC has 29% fewer primary care physicians (58 per 100,000 population) and 35% fewer dentists (59 per 100,000 population) than the state benchmarks (82 and 91 per 100,000, respectively).
- Newborn infants in SJC experience significantly worse outcomes compared to CA averages: infant deaths per 1,000 live births in SJC (5) are 20% higher than CA (4) and low birth weight births (8%) are significantly higher than CA (7%).
- The percentage of pregnant persons receiving prenatal care in the first trimester in SJC (79%) is significantly lower than the CA benchmark (86%); pregnant persons of all ethnicities/races have a significantly lower likelihood of receiving prenatal care than White pregnant persons in SJC.

- SJC has a lower percent of uninsured children and adults than CA, but disparities are present; American Indian/Alaskan Native children (4%) are more likely to be uninsured than White children (3%), and significantly fewer Hispanic (90%), American Indian/Alaskan Native (91%), and Multiracial (93%) adults are insured in SJC than White adults (97%).

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Prenatal care in the first trimester of pregnancy is lower in 13 of 14 Priority Neighborhoods as compared to SJC overall.
- 12 of 14 Priority Neighborhoods have higher rates of teen births than SJC.
- Since the 2022 CHNA, CT 40.01 experienced increases in low birth weight rates and teen births and a decrease in the rate of prenatal care during the first trimester.

What community stakeholders say about access to care (based on key informant interviews and focus groups)

Overall

- 48% (19 out of 40) of focus groups and 4 of 10 key informants identified access to care as a top priority health need in SJC.
- Focus group participants described ongoing healthcare and dental provider shortages resulting in frustration about long waits and substantial travel to appointments.
- Key informants noted that many specialty healthcare services are unavailable locally, difficult to access or have long wait times.
- Limited, daytime clinic hours present a healthcare barrier to many community members, particularly for agricultural workers, those without paid time off, or those with long commutes, according to key informants and focus group participants.

> "There's a very big divide [in the ability to access healthcare]...whether it's by provider, whether it's dental services, whether it's emergency services...or products and resources for health care." – *Community Based Organization Leader*

- Telehealth addresses some provider gaps and transportation challenges, but many focus group participants and key informants expressed dissatisfaction with virtual healthcare, especially for residents lacking Internet connectivity or with limited literacy and/or technology skills.
- Focus group participants and key informants reported pervasive distrust of the healthcare system/providers and negative beliefs within communities around accessing healthcare.

Disparities

- Focus group participants noted the lack of healthcare providers who speak residents' languages and understand, represent, or respect their cultures, echoing key informants' reports that healthcare organizations need to employ diverse, representative providers.
- Health insurance applications were viewed by key informants and focus group participants as burdensome and complicated, especially for older adults, non-English speakers, and immigrants.

> "We need health professionals who are as diverse as the population they serve." – *Focus group participant*

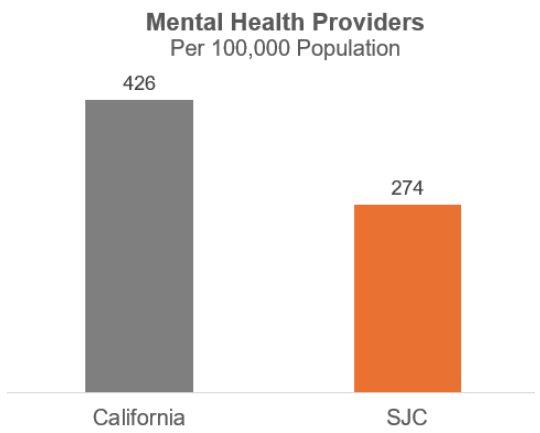
- Several key informants and focus group participants cited the success of pandemic era pop-up/mobile vaccination and testing clinics, which created access points for other healthcare services in underserved communities.

Mental health including substance use

Rationale: Why this is a critical health need

Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school, and to participate fully in family and community activities. Deaths of despair — due to suicide, drug overdose, and alcoholism — are on the rise. Communities are experiencing a critical lack of capacity to meet the increased demand for mental health and substance use treatment services.

Mental health	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Mental health providers per 100,000 pop	Yes	N/A	↑
Deaths of despair per 100,000 pop	Yes	Yes	↑↑
Suicide deaths	No	Yes	↑
Poor mental health (days per month)	No	N/A	↑
Substance use			
Current smokers	Yes	N/A	↓
Alcohol-impaired driving deaths	Yes	N/A	↑
Opioid-related overdose deaths per 100,000 pop	No	Yes	↑↑
Excessive drinking	No	NA	↓



*--: no change, ↑: 1-25% change, ↑↑: 26-50% change, ↑↑↑: 51-75% change, ↑↑↑↑: 76-100% change, ↑↑↑↑↑: >100% change. Arrow direction does not indicate negative/positive change; orange (↑↓) indicates negative change, green (↑↓) indicates improvement

Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have access to significantly fewer mental health care providers; SJC has 36% fewer mental health practitioners than the state.
  - Since 2019, SJC has only added half as many mental health providers per 100,000 residents as CA: 36 versus 73 providers per 100,000 population.
- Deaths of despair (due to suicide, alcohol related disease, and drug overdoses) in SJC have increased 48% over the past three years and are almost 13% higher in SJC (64 per 100,000 population) than in CA overall (56 per 100,000 population).
- Black/African American SJC residents experience significantly more opioid overdose deaths (39 per 100,000 population) than White residents (17 per 100,000 population).
- 13% of SJC adults are current smokers, compared to only 9% of Californians. Both of these rates have decreased since the 2022 CHNA.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Despair is among the top 5 causes of death in 8 of 14 Priority Neighborhoods.
- CT 27.01 and CT 44.03 have experienced substantial increases in deaths of despair since the 2022 CHNA.

What community stakeholders say about mental health and substance use (based on key informant interviews and focus groups)

Overall

- 65% (26 of 40) focus groups and 4/10 key informants identified mental health as a top priority in SJC.
- 53% (21 of 40) focus groups and 5/10 key informants identified substance use as a top priority in SJC.
- Key informants stated that pandemic impacts on mental health are continuing, especially affecting children, young adults, older adults, and health care workers.
- Many focus group participants described mental health as the number one health issue and need within their communities.
- Both key informants and focus group participants highlighted concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens.
- Key informants and many focus group participants pointed out the intersection of mental health needs, substance use, and homelessness and the damage this trifecta has inflicted on the health, safety, and morale of communities.

> "There's just not enough [mental health] support to meet the needs and the type of support is inconsistent and has challenges, being able to be consistent. The type of service base that has been built does not meet the need...we have an old system that is not meeting new needs."
> – *Community Based Organization Leader*

- Available mental health treatment is often not flexible enough to be of use to residents lacking housing stability or consistent sobriety, according to key informants; focus group participants reported that some organizations providing substance use/addiction treatment are inadequately funded/staffed or challenged by politics/red tape.
- Focus group participants expressed frustration with ubiquitous smoke shops, liquor stores, and dispensaries in their communities that normalize/promote substance use, make substances readily available, and contribute to drug related activities in parks, on sidewalks, and near public spaces.

Disparities

- Focus group participants emphasized the importance of receiving mental health services from diverse providers, who reflect the races, cultures, and languages of SJC residents.
- Timely services for mental health crises are limited to nonexistent in some communities, according to focus group participants; key informants specified that farm and migrant workers in rural areas have difficulty accessing mental health preventive services and treatment.

> "Mental health is something that affects the south side [of Stockton] more." – *Public health official*

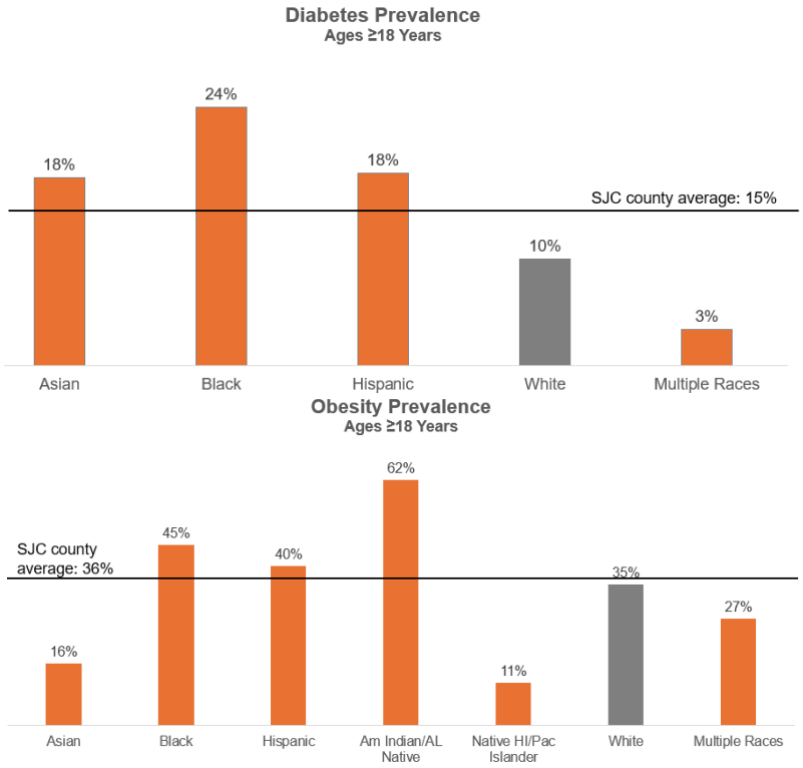
- Key informants observed that SJC is deficient in substance use treatment services tailored to the needs of underserved groups, noting the lack of residential treatment for youth and services for LGBTQIA+ individuals based on harm reduction principles.
- Substance use was perceived by focus group participants as a coping mechanism/self-medication for marginalized, underserved residents.

Chronic Disease/Healthy Eating Active Living (HEAL)

Rationale: Why this is a critical health need

Chronic diseases are primary causes of poor health outcomes and death and a leading driver of health care costs. Residents with limited access to healthy foods have a higher risk of developing a chronic disease, such as obesity, heart disease, diabetes, or asthma. Along with a healthy diet, physical activity is key to preventing and reducing complications from chronic diseases. This exploration of chronic disease focuses on the most common chronic conditions causing illness and death and does not include many other chronic conditions, including autoimmune diseases.

Chronic disease*	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA**
Poor physical health (days per month)	Yes	N/A	↓
Poor or fair health (ages 18+ yrs)	Yes	Yes	↓
Heart disease hospitalizations	Yes	Yes	↓
Heart disease deaths	Yes	No	↓
Stroke hospitalizations	No	Yes	↓
Stroke deaths	Yes	No	↓
Diabetes prevalence (ages 18+ yrs)	Yes	Yes	↑
Asthma prevalence (all ages)	No	Yes	–
Asthma prevalence (ages 0-17 yrs)	Yes	Yes	↑↑
Colorectal cancer incidence	Yes	Yes	↑↑
Lung cancer incidence	Yes	Yes	↓
HEAL opportunities*			
Obesity (ages 18+ years)	Yes	Yes	↑
Physical inactivity (ages 18+ years)	Yes	N/A	↓
Exercise opportunities	Yes	N/A	↑



* Table includes selected indicators that are worse than CA average or illustrate disparities

**--: no change, ↑: 1-25% change, ↑↑: 26-50% change, ↑↑↑: 51-75% change, ↑↑↑↑: 76-100% change, ↑↑↑↑↑: >100% change. Arrow direction does not indicate negative/positive change; orange (↑↓) indicates negative change, green (↑↓) indicates improvement.

Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have significantly (30%) more days per month of poor physical health than the CA average.
- The heart disease death rate in SJC is higher than CA overall (149 versus 142 per 100,000, respectively), and death from stroke (49 per 100,000) is 26% higher in SJC than CA (39 per 100,000).

- Black/African American SJC residents have the highest rates of hospitalization for cardiovascular disease; they are almost 35% more likely to be admitted to the hospital for heart disease and over 35% more likely to be admitted for stroke than White residents.
- Adults in SJC are significantly more likely to have a diabetes diagnosis (15%) than all California adults (11%). White adults are less likely to have diabetes than Black/African American, Hispanic, and Asian SJC residents.
- Pediatric asthma prevalence (24%) in SJC is almost twice that of the CA average (13%), with Black/African American (39%) and Hispanic (34%) children experiencing significantly higher rates than White children (16%).
- Black/African American SJC residents have the highest incidence of colorectal and lung cancer among all ethnicities/races; 19% and 12% higher, respectively, compared to White residents.
- Approximately 36% of adults in SJC experience obesity, compared to 28% across CA; Black/African American (45%), Hispanic (40%), and American Indian/Alaskan Native (62%) SJC adults have significantly higher rates of obesity than White adults (35%).
    - The Black/African American and American Indian/Alaskan Native communities experienced a disproportionate increase (by 28% and 54% respectively) in their rates of obesity since the 2022 CHNA compared to their White neighbors (14% increase).

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have a lower average age of death than SJC overall.
- Heart disease is one of the top 5 causes of death in all Priority Neighborhoods.
- The rates of death due to cancer and Alzheimer's disease have more than doubled in CT 16 since the 2022 CHNA.

What community stakeholders say about chronic disease/HEAL (based on key informant interviews and focus groups)

Overall

- 28% (11 of 40) focus groups and 5 of 10 key informants identified chronic disease as a top priority health need in SJC.
- 50% (20 of 40) focus groups identified HEAL opportunities as a top priority health need in SJC, and 4 of 10 key informants mentioned it.
- Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare.
- Key informants asserted that too few resources are available for chronic disease prevention.
- High cost healthy foods and low cost convenience/fast foods present major barriers to healthy eating, according to focus group participants, who noted that grocery stores offering affordable, appealing produce are not available in all communities.
- Focus group participants identified multiple barriers to outdoor physical activity in parks/public spaces: gun violence, gang activity, drug use/paraphernalia, unhoused camps, hazardous driving, limited lighting, trash, and incomplete bike routes/lanes.

> "We know that it [diabetes prevention] is trigger behavior – if a loved one gets really sick or loses a foot, they all of a sudden pay attention. But otherwise, it's very difficult to get traction for that issue." – *Public health official*

Disparities

- Focus group participants perceived that diabetes, heart disease, obesity and asthma are most common in Black/African American and Hispanic/Latino neighborhoods.
- Key informants highlighted diabetes disparities, noting that certain racial/ethnic groups and low-income communities are disproportionately impacted; effective prevention and treatment services must be affordable, provided in the languages of affected populations, and located in venues/formats that make access easy for busy individuals/families.
- Focus group participants reported that low-income residents, people of color, and immigrants are more likely to live in communities that are food deserts and lack gyms/indoor recreation spaces or parks for regular physical activity.

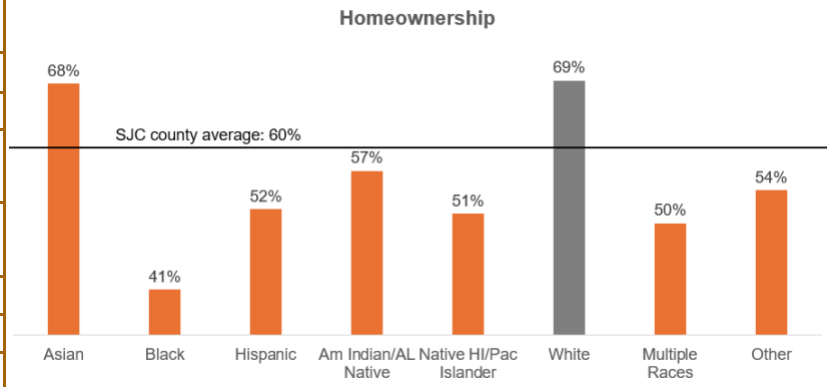
> "In certain neighborhoods, it's not that easy to get good access [to healthy foods] without getting on a bus or in your car. We have some food deserts where there's not great access to fresh food."– *Community based organization leader*

Housing

Rationale: Why this is a critical health need

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. Higher expenditures can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside. Homelessness is correlated with poor health: poor health can lead to homelessness and homelessness is associated with greater rates of preventable diseases, longer hospital stays, and greater risk of premature death. When compared to California overall, measures of housing in SJC fare better than state averages; however, this comparison is distorted due to the overall high cost of housing in California and masks the housing challenges and instability that exist in SJC, especially in the Priority Neighborhoods.

Housing	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Homeownership	No	Yes	↑
Uncrowded housing	No	Yes	↓
Low-income renters (Severe housing cost burden)	No	NA	↓
Low-income Homeowner (Severe housing cost burden)	No	NA	↑
Severe housing cost burden	No	NA	↓
Median rental cost	No	NA	↑
Housing Habitability	No	NA	-
Housing affordability index	No	NA	↓↓
Percent of income for mortgage	No	NA	↑↑



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Key findings and disparities across San Joaquin County (based on health data)

- Median rental costs in SJC remain lower than CA overall, but the median rental cost in SJC has increased by approximately 10% to $1,527 since the 2022 CHNA.
- While the homeownership rate in SJC is better than CA overall, for most SJC residents of color homeownership rates are significantly lower. Residents of all racial/ethnic groups -- except Asian -- are significantly less likely to own their home than their White neighbors.

- Rates of uncrowded housing in SJC are similar to the CA average, but compared to White residents, all other SJC racial/ethnic groups have a higher percentage living in crowded housing.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Half (7) of the Priority Neighborhoods experienced a decrease in housing habitability since the 2022 CHNA.
- 12 of 14 Priority Neighborhoods have lower rates of homeownership compared to SJC.
- CT 22.01 has the lowest rate (87%) of housing habitability among the Priority Neighborhoods.

What community stakeholders say about housing (based on key informant interviews and focus groups)

Overall

- 40% (16/40) of focus groups and 2 of 10 key informants identified housing as a top priority health need in SJC.
- Focus group participants and key informants agreed that the lack of affordable housing in SJC is severe, reporting that most affordable housing options are in unsafe neighborhoods or provide unhealthy living conditions.
- Prohibitively high housing costs contribute to stress and reduce available financial resources for health needs, according to focus group participants and key informants.
- Key informants pointed out that skyrocketing housing costs have increased the number of residents at risk for housing instability or homelessness, and county housing assistance programming/services are not keeping pace with demand to support middle-income families now at risk.
- Focus group participants described homelessness as a significant problem in SJC; state/local governments' efforts to address the county's unhoused population were perceived as ineffective.
- Finding a living space for the unhoused is only part of the solution, according to key informants. Many unhoused individuals require additional supports, services, treatments, and/or rehabilitation to decrease risk of returning to transiency or homelessness.

> "Why isn't the government helping those who are on the street?" – *Focus group participant*

Disparities

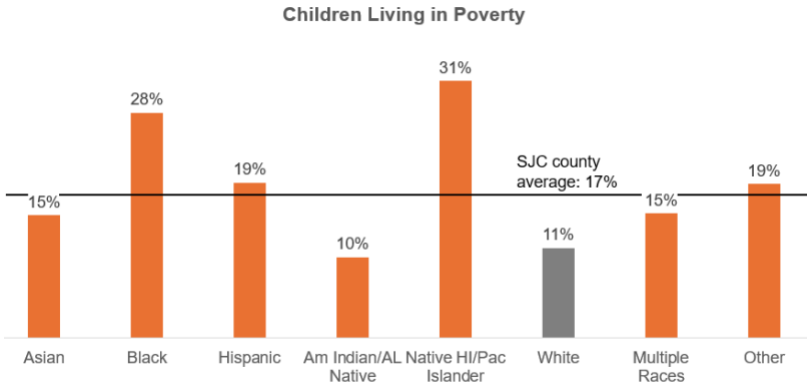
- Focus group participants and key informants stated that low- and middle-income residents (especially people of color, immigrants, migrants, older adults, people with special needs, urban residents, and single parents) are most impacted by rising housing costs, struggle to obtain housing assistance, and require expanded services tailored to meet their specific needs.
- Homelessness in SJC disproportionately affects people of color, those with mental health and substance use challenges, undocumented immigrants, and LGBTQIA+ individuals, according to key informants.

Economics

Rationale: Why this is a critical health need

People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of well-resourced schools and an adequate concentration of well-paying jobs. Childhood poverty has long-term effects; even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The establishment of policies that positively influence economic conditions can create sustainable improvements in the physical and mental health of individuals and communities.

Economic	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Income	Yes	Yes	↑
Employed (ages 16+)	Yes	Yes	↑
Jobs Proximity Index	No	N/A	N/A
Income inequality – Gini Index	No	N/A	N/A
Living in poverty (<100% Fed Poverty Level)	Yes	Yes	↓
Seniors (ages 65+ years) living in poverty	No	Yes	↑
Children living in poverty	Yes	Yes	↓
Young people not in school and not working	Yes	N/A	↑
High speed internet	Yes	Yes	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Among SJC residents, average yearly income ($83,000) is almost 10% less than the CA average ($92,000); average income for White SJC residents is close to the CA average, but Hispanic ($74,000), Black/African American ($65,000), American Indian/Alaskan Native ($77,000), and Multiethnic ($77,000) residents earn significantly less.
    - Average income in SJC has increased by almost $20,000 since the 2022 CHNA, and all racial/ethnic groups' average incomes have increased as well, but not enough to eliminate income disparities.
- 70% of SJC residents aged 16 and older are employed, significantly lower than statewide (73%).

- The poverty rates in SJC for all residents (13%) and for children (17%) are significantly higher than the CA averages (12% and 16%, respectively).
    - All racial/ethnic groups in the county, except for American Indian/Alaska Native residents, have significantly higher poverty rates for all residents/children than White SJC residents.
- SJC older adults (aged 65 and older) who are Black/African American (15%), Hispanic (15%), American Indian/Alaskan Native (14%), and Native Hawaiian/Pacific Islander (47%) are significantly more likely to be impoverished than their White neighbors (9%).
- High-speed Internet access (90%) among SJC residents is significantly lower than the CA average (92%); Black/African American residents have the lowest percentage of Internet connectivity.
    - Internet access has increased in SJC almost 10% since the 2022 CHNA, with all racial/ethnic groups experiencing some increase.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have lower average incomes than SJC overall.
- 13 of 14 Priority Neighborhoods have higher rates of people living in poverty than in SJC.
- CTs 1.01/1.02 have the lowest percentage (27%) of employed adults among the Priority Neighborhoods; adult employment has substantially decreased since the 2022 CHNA.

What community stakeholders say about economics (based on key informant interviews and focus groups)

Overall

- 13% (5/40) of focus groups and 3 of 10 key informants identified economics as a top priority health need in SJC.
- Recent inflation and the high cost of living was perceived by focus group participants and key informants as detrimental to health; focus group participants asserted that working long hours and/or multiple jobs to meet expenses leaves little time/energy to address mental or physical health needs.
- Focus group participants and key informants stated that obtaining employment or regaining economic stability has been difficult after pandemic-related job losses.
- Due to inflation/job loss, focus group participants noted that residents who were recently comfortably middle-income now frequently struggle with expenses but do not qualify for assistance and services.

> "There was always a lot of manual jobs out there. We started as an organization for migrant seasonal farm workers and there were tons of jobs. There are not tons of farm jobs anymore or manual jobs." – *Community Based Organization Leader*

> "There is no opportunity for homeless people who do want to work or do something, but don't know how or can't. I mean, who's gonna give us a shot at it?" – *Focus group participant*

Disparities

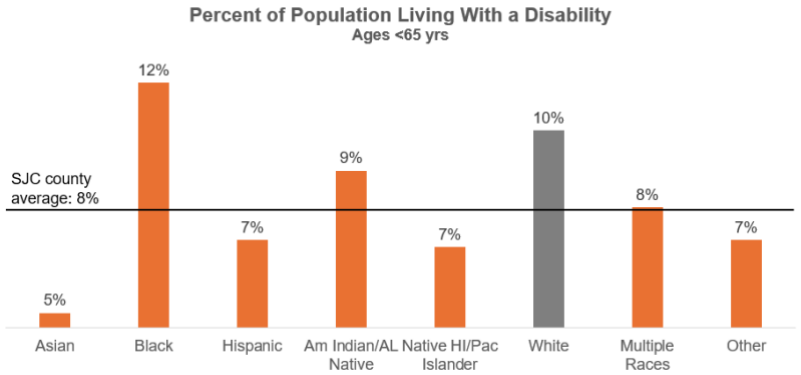
- People of color, older adults, and unhoused individuals experience disparities in employment, according to focus group participants, resulting in lower incomes that negatively impact health.
- Rising health care costs disincentivize individuals and families, especially lower income residents, from seeking preventive health care and/or treatment; key informants reported that residents often seek medical care only when a health problem is exacerbated, resulting in expensive emergency care.

Social Support

Rationale: Why this is a critical health need

The presence or absence of a strong social support network affects all aspects of life, including physical and mental well-being; social connections provide emotional support that assists in responding to life challenges and difficulties. Loneliness has been associated with a wide variety of health problems including heart disease, poor immunity, and cognitive decline. Communities are the context in which individuals and families prosper or struggle, highlighting the importance of leveraging community resources to foster social connections.

Social Support	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Limited English proficiency	Yes	Yes	↑
Disability Population (ages <65 years)	No	Yes	↓
Disability Population (all ages)	No	N/A	↓
Seniors living alone (ages 65+ years)	No	N/A	↓
Two parent households	No	N/A	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Limited English proficiency is higher in SJC (41%) as compared to the CA average (39%).
    - Since the 2022 CHNA, rates of limited English proficiency have increased among almost all racial/ethnic groups in SJC, except for Native Hawaiian/Pacific Islanders.
- Approximately 12% of SJC residents of all ages are living with a disability, including 8% of younger adults. Among residents under age 65, Black/African American SJC residents (12%) have the highest disability rate.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 11 of 14 Priority Neighborhoods have a smaller percentage of two parent households than SJC overall.
- All 14 Priority Neighborhoods experienced an increase in individuals with limited English proficiency since the 2022 CHNA; 9 Priority Neighborhoods experienced a 75% or greater increase.

- CT 3 faces substantial social support challenges with the lowest percentage (33%) of two parent households and the highest rate (69%) of individuals with limited English proficiency among the Priority Neighborhoods.

What community stakeholders say about social support (based on key informant interviews and focus groups)

Overall

- 13% (5 of 40) of focus groups and 1 of 10 key informants identified social support as a top priority health need in SJC.
- Focus group participants and key informants agreed that many SJC families need more support with caring for children, loved ones with disabilities, and older adults.
- Residents (particularly older adults and children) are experiencing increased isolation and loneliness, according to focus group participants, which has persisted post-pandemic. Key informants perceived that there are fewer opportunities for in-person gatherings in the post COVID-19 era.
- Key informants noted that the pandemic caused many children to lose or delay development of age-appropriate social skills, leaving parents and families to grapple with the aftermath.
- Young adults aging out of the foster care system lack appropriate supports; focus group participants perceived that more services are needed to maximize their potential.

> "Families who…take care of their adult children [with disabilities] who have needs, those families struggle...there's no board and care facility or my board and care facility shut down or...the cost is not affordable." – *Community based nonprofit leader*

Disparities

- Key informants reported that obtaining and affording childcare is a significant challenge for many families in rural communities, which limits parents' employment opportunities because they need to stay home to care for their children.

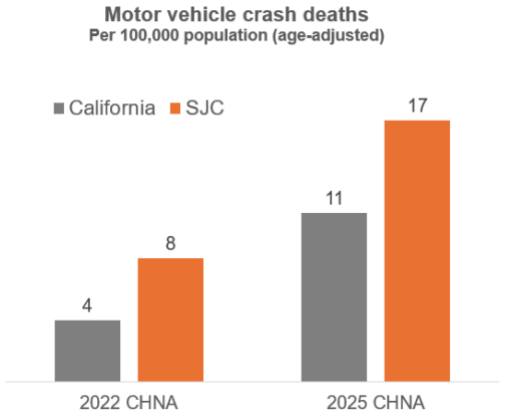
> "Childcare was the biggest barrier to staying/getting back into workforce. They couldn't afford it or it's just not available." – *Healthcare leader*

Community Safety

Rationale: Why this is a critical health need

Safe communities promote social interaction, economic development, and opportunities to be active, while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to worse physical and mental health outcomes for victims, perpetrators, and the community at large. Communities that have been systematically marginalized experience higher rates of violence. Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color—particularly males—is disproportionately affected by juvenile arrests and incarceration related to policing practices. Motor vehicle crashes, pedestrian accidents, and falls are common causes of unintended injuries, lifelong disability, and death.

Community safety	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Premature death (Years of potential life lost before age 75 per 100,000 population)	Yes	N/A	↑
Violent crimes	Yes	N/A	↓
Unintentional injury deaths	Yes	No	↑
Motor vehicle crash deaths	Yes	No	↑↑↑↑
Pedestrian accident deaths	No	No	↑



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Key Findings and Disparities Across San Joaquin County (based on health data)

- SJC residents experience significantly more premature deaths than CA overall, with over 30% more years of potential life lost (YPLL) before age 75 among SJC residents compared to residents statewide.
    - The YPLL in SJC had increase by 14% since the 2022 CHNA, indicating that the number of premature deaths has increased in the county.
- Violent crime is nearly 40% higher in SJC than CA overall; however, the rate of violent crime has decreased in SJC since the 2022 CHNA by about 14%.
- The number of unintentional injury deaths in SJC (69 per 100,000 population) is significantly higher than CA overall (55 per 100,000 population).

- Motor vehicle crash deaths are more than 50% higher in SJC (17 per 100,000 population) than statewide (11 per 100,000 population).
    - The number of motor vehicle crash deaths in SJC has more than doubled since the 2022 CHNA, from 8 per 100,000 population to 17 per 100,000 population.

What community stakeholders say about community safety (based on key informant interviews and focus groups)

Overall

- 30% (12/40) of focus groups and 1 of 10 key informants identified community safety as a top priority health need in SJC.
- Focus group participants and key informants agreed that residents' perceived lack of community safety in public and outdoor spaces, like parks, limits their ability to be physically active.
- Key informants listed the types of violence/criminal activity that are commonly experienced, such as interpersonal aggression, domestic abuse, and illegal substance use, as well as fear of violence.
- Key informants also mentioned how frequent yet seemingly smaller issues, like speeding cars or stray dogs, negatively impact health by discouraging outdoor physical activities.
- Children's safety was a concern voiced by focus group participants; many streets/parks/outdoor recreation areas were deemed unsafe due to gang/criminal activity, substance use, blight, and the presence of unhoused individuals.

> "We've had multiple people sent to the hospital for dog bites. And we've had a lot of people not willing to go outside because of stray dogs." – *Community Based Organization Leader*

- For older adults, safety concerns pose barriers to engaging in the community, according to focus group participants, resulting in isolation and less ability to access necessary services and healthcare.

Disparities

- Focus group participants reported that low income/historically underserved neighborhoods experience reckless driving, deteriorating infrastructure, and gun violence, but often receive fewer community safety resources/investment from government/law enforcement.

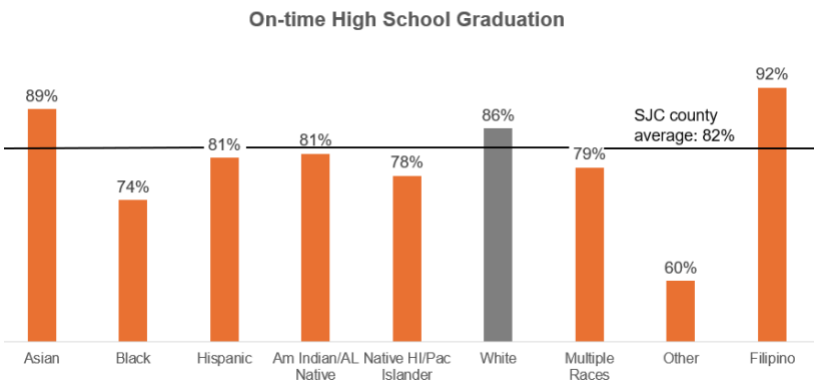
> "Downtown to the south side [of Stockton] I feel is being just left alone [by law enforcement]." – *Focus group participant*

Education

Rationale: Why this is a critical health need

The link between education and health is well known — individuals with higher levels of education are more likely to be healthier and live longer. Pre-school education is positively associated with readiness for and success in school, and has long-term benefits for individuals and society, including greater educational attainment, higher income, and lower engagement in delinquency and crime. Individuals with at least a high school diploma do better on several measures, including income, health outcomes, life satisfaction, and self-esteem. Wealth among families in which the head of household has a high school diploma is 10 times higher than that of families in which the head of household didn't complete high school. Moreover, the majority of jobs in the U.S. require education beyond high school.

Education	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Preschool enrollment	Yes	NA	↓
High school enrollment	No	NA	↓
Students proficient in math	Yes	Yes	↓
Students proficient in reading	Yes	Yes	↓
On-time high school graduation	Yes	Yes	↑
Adults with no high school diploma	Yes	Yes	↓
Adults with some college education	No	Yes	↑
Bachelor's education or higher	Yes	Yes	↑



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Key findings and disparities across San Joaquin County (based on health data)

- The percentage of children enrolled in preschool in SJC (38%) is significantly lower than the CA average (45%).
    - Preschool enrollment in SJC has decreased since the 2022 CHNA by 13%.
- Students in SJC have significantly lower rates of proficiency in math (27%) and reading (40%) than students across CA (35% and 47%, respectively) and SJC Hispanic, Black/African American, and Multiethnic students have significantly lower proficiency in math and reading compared to White SJC students.
- The on-time high school graduation rate for SJC students (82%) is significantly lower than the CA average (86%); Black/African American students (74%) have significantly lower rates of on-time graduation than White students (86%).

- Only 9% of Hispanic adults and 19% of Black/African American adults in SJC have completed a college education, compared to 25% of White adults.
    - The percentage of adults who have completed a college education in SJC has increased since 2022 across all racial/ethnic groups except for Multiracial adults.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have higher percentages of adults without a high school diploma than SJC overall.
- 13 of the 14 Priority Neighborhoods have smaller percentages of individuals with a bachelor's education or higher than SJC.
- CT 47.01 has the lowest rate (7%) of preschool enrollment among the Priority Neighborhoods.

What community stakeholders say about education (based on key informant interviews and focus groups)

Overall

- 13% (5 out of 40) of focus groups and 2 of 10 key informants identified education as a top priority.
- Focus group participants noted that lasting pandemic impacts on education quality have resulted in unmotivated, less educated students who are more prone to behavioral issues, mental health concerns, substance use (especially vaping), and violence.
- Key informants want more support for career development and readiness at all educational levels, beginning in early childhood and continuing through young adulthood.
- Effective health education requires more than passing out information in various languages or pointing out websites, suggested key informants; they recommended aligning health information to community cultural norms and values and discussing health education in person.

> "We are going to have to help education, they can't solve it alone. So many of the things that plague our community - having kids properly cared for in preschool sets them up for success in schools, in their career or college pathway. – *Community Based Organization Leader*

Disparities

- Students from marginalized/low-income neighborhoods are disproportionately impacted by under resourced schools, according to focus group participants.
- Focus group participants emphasized that students of color, especially Black/African American children and teens, face societal and structural challenges in educational environments, are more likely to receive disciplinary action and are less likely to receive academic support.
- Healthcare providers who receive graduate education and training within the SJC communities they serve, or who receive continuing education relevant to their communities, are better positioned to connect with patients and encourage ongoing healthcare, according to key informants, especially within populations that have historically been underserved or even mistreated by the medical system.

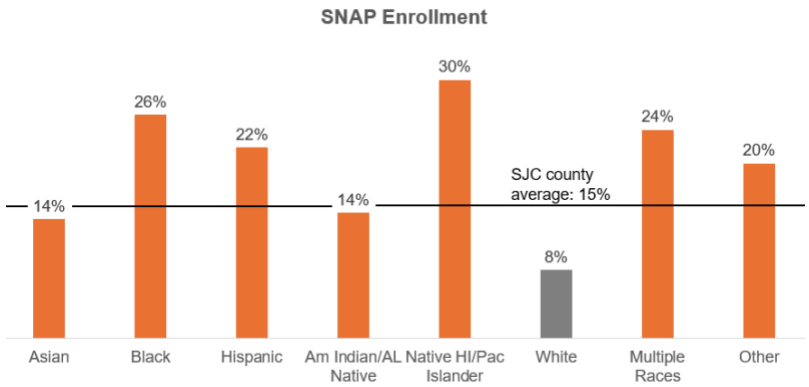
> "We can make beautiful pamphlets with all the information. We meet them where they are, like elementary school, or we can go to the parishes. If you hand out flyers, it's like Charlie Brown's teacher. A lot of them have too much verbiage. So it's just getting out there and educating them one-on-one." – *Community Based Organization Leader*

Food Security

Rationale: Why this is a critical health need

Many individuals and families, especially those with financial or transportation challenges, struggle to consistently access the kinds of foods that support health and wellness. The link between food insecurity and chronic diseases related to diet is well established. Poor diet is a prominent risk factor for chronic health conditions, which are prevalent, deadly, and costly.

Food security	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
SNAP enrollment	Yes	Yes	↑
Free and reduced-price lunch	Yes	N/A	↑
Convenience stores per 1,000 population	No	N/A	N/A
Grocery stores per 1,000 population	No	N/A	N/A
Low access to grocery store	No	N/A	–
Food insecure	No	N/A	↓



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Key findings and disparities across San Joaquin County (based on health data)

- The percentage of SJC residents (15%) relying on SNAP (food assistance) to afford food is almost 50% higher than the statewide rate (10%). County residents of all racial/ethnic groups (except for Asian) have nearly double or even triple the rate of SNAP enrollment compared to white SJC residents.
    - Since the 2022 CHNA, SNAP enrollment has increased in SJC overall and for most racial/ethnic groups. Only American Indian/Alaska Native and White populations have experienced slight decreases.
- A higher percentage of SJC students (66%) qualify for free and reduced-price lunch (FRPL) as compared to California overall (62%).
    - More SJC students (66%) qualify for FRPL currently as compared to the 2022 CHNA (57%) – a 17% increase.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 11 of 14 Priority Neighborhoods have higher rates of SNAP (food assistance) enrollment than SJC.
- SNAP enrollment increased in 9 of 14 Priority Neighborhoods since the 2022 CHNA.
- Over half (51%) of CT 33.12 residents are enrolled in SNAP, more than three times higher than SJC overall.

What community stakeholders say about food security (based on key informant interviews and focus groups)

Overall

- 10% (4 of 40) of focus groups identified food security as a top priority health need in SJC, and 6 of 10 key informants mentioned it as a health need.
- Key informants and focus group participants reported that the need for food assistance is increasing due to post-pandemic economic impacts and resulting inflation.
- Focus group participants and key informants described the difficult choices that many SJC residents frequently encounter buying food or affording bills, healthcare, or other necessities of daily living.
- Focus group participants listed a variety of accessible sources for food assistance, including schools, libraries, churches, government, and community organizations.
- Existing SJC food banks and food distribution programming meet some of the need for food assistance, but key informants stated that these programs should be expanded to better meet the demand.

> "We see our families making choices between prescriptions and food. And we wonder why they don't go for health care appointments. But these are the choices they are making."
>
> *– Community based nonprofit leader*

Disparities

- Key informants pointed out the link between chronic diseases and the inability to access food, especially healthy food, and the disproportionate impact on vulnerable populations, such as older adults or low-income residents without vehicles.

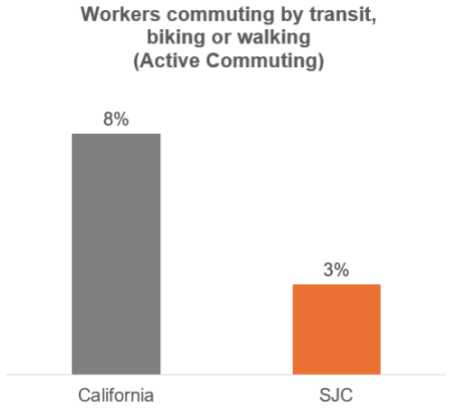
> "Food insecurity ties so closely to diabetes...Through 211 and Door Dash, we have those food boxes delivered to people that don't have transport, like seniors who can't drive. Those kinds of partnerships are important for diabetes and other issues."
> *– Community based nonprofit leader*

Transportation

Rationale: Why this is a critical health need

Without reliable and safe transportation, individuals struggle to meet basic needs, such as earning an income, accessing health care, and securing food. Transportation infrastructure favors automobile use, which is associated with several adverse outcomes, including motor vehicle injuries and deaths, vehicle ownership expenses, and greenhouse gas emissions (which are a risk factor for heart disease, stroke, asthma, and cancer.) For households without a vehicle - including many low-income individuals and people of color - walking, biking, and using public transportation provides a critical link to employment, increases access to essential services, promotes exercise, and supports social cohesion.

Transportation	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Workers driving alone to work	Yes	Yes	↑
Workers driving alone with long commutes	Yes	N/A	↑
Workers commuting by transit, biking or walking (Active Commuting)	Yes	N/A	↓
Retail density	Yes	N/A	N/A
Automobile Access	No	N/A	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Significantly more SJC workers (83%) drive alone to work than in CA overall (79%); workers of most races/ethnicities have lower rates of driving to work alone than their White colleagues.
- Workers in SJC are almost twice as likely to drive alone with long commutes (20%) than statewide (11%).
    - Since the 2022 CHNA, the rate of SJC workers driving alone with long commutes has increased (approximately 9%).
- Far fewer SJC workers actively commute by transit, biking, or walking (3%) than in CA overall (8%).
    - SJC and statewide rates of active commuting have dropped slightly since the 2022 CHNA.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 10 of 14 Priority Neighborhoods have lower rates of automobile access than SJC overall.

- 6 of 14 Priority Neighborhoods have low rates of active commuting compared to SJC.
- The automobile access rate of CTs 1.01/1.02 is approximately half the SJC average (54% vs 95%).

What community stakeholders say about transportation (based on key informant interviews and focus groups)

Overall

- 8% (3/40) of focus groups and 4 of 10 key informants identified transportation as a top priority health need in SJC.
- Focus group participants stated that transportation barriers make meeting basic needs difficult, jeopardizing food security and access to health care.
- Key informants specified that barriers to active transportation include crime and lack of infrastructure that supports biking and walking.

Disparities

- Although focus group participants expressed appreciation for the public transportation that is currently available within the county, key informants noted that, even in urban SJC communities, available public transportation systems are inadequate to meet residents' needs.
- Key informants also pointed out that rural residents have few options for transportation into urban centers.
- Focus group participants suggested providing affordable or free transportation for patients in need of medical services and for low-income residents.

> "Stockton...it's not a walkable city. There are very nice paths in certain areas, but the city has not been planned to encourage walking. And it's sad that it's not a bike city, because it's as flat as can be but there is very minimal biking. Commuting would be dangerous because drivers are crazy, and the streets are dangerous." – *Community Based Organization Leader*

> "We are seeing a big need especially in rural areas; if you live on the outskirts of town, getting to those doctors' appointments can be a challenge." – *Community Based Organization Leader*

VIII. Appendices

A. CHNA Secondary Data Indicator Definitions, Data Sources and Dates
B. San Joaquin County CHNA Secondary Data Table
C. Community Input Tracking Form
D. Key Informant Interview Guide
E. Focus Group Screener and Guide
F. Annotated Bibliography of San Joaquin County Reports and Assessments
G. Community Resources

Appendix A: CHNA Secondary Data Indicator Definitions, Data Sources and Dates

Health Topic	Measure	Definition	Data Source, Year
Access to care	Low Birth Weight Births	Low birth weights are defined as less than 5 pounds, and 8 ounces (2,500 grams).	VRBIS, 2019-2023 (Birth Certificate)
	Prenatal Care in 1st Trimester (per 100 live births)	Trimester means "3 months." A normal pregnancy lasts around 10 months and has 3 trimesters. Prenatal care in the 1st Trimester would be the first 3 months.	VRBIS, 2019-2023 (Birth Certificate)
	Pre-Term Births	Preterm birth is when a baby is born too early, before 37 weeks of pregnancy have been completed.	VRBIS, 2019-2023 (Birth Certificate)
	Dentists per 100,000 population	Number of Dentists per 100,000 population	KP 2025 Community Health Needs Dashboard
	Infant Deaths (per 1000 live births)	(VRBIS Deaths under 1 year of age/5)/(VRBIS live births/5)	VRBIS, 2019-2023 (Birth & Death Certificate)
	Insured (ages 19-64 years)	Percentage of adults ages 19-64 currently insured	US Census, ACS 2022 (5-year Estimates Data Profiles)
	Medicaid/Public Insurance Enrollment	Percentage of the population enrolled in Medicaid or another public health insurance program	US Census, ACS 2022 (5-year Estimates Data Profiles)
	Primary Care Physicians per 100,000 population	Number of Primary care physicians per 100,000 population	KP 2025 Community Health Needs Dashboard
	Uninsured Children	Percent of children under the age of 19 without health insurance coverage	US Census, ACS 2022 5-year Estimates Subject Tables (State/County/Priority Neighborhood Tracts)

Health Topic	Measure	Definition	Data Source, Year
			US Census, ACS 2022 1-year Estimates Subject Tables (Race/Ethnicity)
Cancer	Lung cancer incidence	Lung and Bronchus Cancer, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	All Cancer Sites Combined	All Cancer Sites Combined, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Breast cancer incidence	Breast Cancer, Age-Adjusted Incidence Rates, All Stages, Female, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Colorectal cancer incidence	Colon Cancer, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Prostate cancer incidence	Prostate Cancer, Incidence, County Rates, Compare By Race/Ethnicity, Male, All Ages, Year of Diagnosis: 2017-2021	California Cancer Registry, 2017-2021
	Cancer Deaths (age adjusted per 100,000)	State v County, All Sites age adjusted cancer death rate/100,000 population 2020-2022; Census tract and Race/Ethnicity, All Sites cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Breast cancer deaths	State v County, Female breast cancer age adjusted death rate/100,000 female population 2020-2022; Census tract and Race/Ethnicity, Breast cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Colorectal cancer deaths	State v County, Colorectal cancer age adjusted death rate/100,000 population 2020-2022; Census tract and	CDPH - County Health Status Profiles (2024)

Health Topic	Measure	Definition	Data Source, Year
		Race/Ethnicity, Colorectal cancer death rate/100,000 population 2018-2022	VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Lung cancer deaths	State v County, Lung cancer age adjusted death rate/100,000 population 2020-2022; Census tract and Race/Ethnicity, Lung cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Prostate cancer deaths	State v County, Prostate cancer age adjusted death rate/100,000 male population 2020-2022; Census tract and Race/Ethnicity, Prostate cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
Chronic disease	Asthma prevalence (0-17 years)	Topic: Ever diagnosed with asthma ("Respondents were asked: "Has a doctor ever told you that you have asthma?")	askCHIS, 2018-2022 (pooled)
	Asthma ED Visits (0-17 years)	Asthma ED Visits Rate per 10,000 population, 2019	California Breathing, County Asthma Data Tool
	Asthma ED Visits (all ages)	Asthma ED Visits Rate per 10,000 population, By Race/Ethnicity, 2019	California Breathing, County Asthma Data Tool
	Asthma Hospitalizations (0-17 years)	Asthma Hospitalization Rate per 10,000 population, 2019	California Breathing, County Asthma Data Tool
	Asthma Hospitalizations (all ages)	Asthma Hospitalization Rate per 10,000 population, By Race/Ethnicity, 2019	California Breathing, County Asthma Data Tool

Health Topic	Measure	Definition	Data Source, Year
	Asthma prevalence (all ages)	Topic: Ever diagnosed with asthma ("Respondents were asked: "Has a doctor ever told you that you have asthma?")	askCHIS, 2018-2022 (pooled)
	Diabetes prevalence (ages 18+ years)	Topic: Ever diagnosed with diabetes ("Respondents were asked: "{Other than during pregnancy, had/Has} a doctor ever told you that you have diabetes or sugar diabetes?")	askCHIS, 2018-2022 (pooled)
	Heart Disease Deaths (age adjusted rate per 100,000)	((VRBIS Heart Disease Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023 (Death Certificate)
	Heart Disease Hospitalizations	Heart Disease Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+, All Races/Ethnicities, Both Genders, 2019-2021	Interactive Atlas of Heart Disease and Stroke, 2019-2021
	Heart disease prevalence (ages 18+ years)	Topic: Ever diagnosed with heart disease (Respondents were asked "Has a doctor ever told you that you have any kind of heart disease?")	askCHIS, 2018-2022 (pooled)
	Poor physical health (days per month)	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	County Health Rankings & Roadmaps, 2024 Behavioral Risk Factor Surveillance System (BRFSS), 2021
	Poor or fair health (ages 18+ years)	Topic: Health status (Respondents were asked: "In general, would you say your health is excellent, very good, good, fair or poor?")	askCHIS, 2018-2022 (pooled)
	Stroke Deaths (age adjusted rate per 100,000)	((VRBIS Stroke Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023 (Death Certificate)

Health Topic	Measure	Definition	Data Source, Year
	Stroke Hospitalizations	Stroke Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+, All Races/Ethnicities, Both Genders, 2016-2018 NOTE: California rate was not updated from 2022 CHNA	Interactive Atlas of Heart Disease and Stroke, 2019-2022
	Stroke prevalence	Estimated percent of adults ever diagnosed with a stroke, Aged 18+ yrs, 2021	Interactive Atlas of Heart Disease and Stroke, 2021
Climate and environment	Air Pollution: PM2.5 Concentration	Past: Annual mean concentration of PM 2.5 (weighted average of measured monitor concentrations and satellite observations, µg/m3), over three years (2015-2017). Current: Annual mean concentration of PM 2.5 (weighted average of measured monitor concentrations and satellite observations, µg/m3), over three years (2015-2017).	CalEnviroscreen 4.0 California Air Resources Board (CARB)
	Coastal Flooding Risk	A Coastal Flooding annualized frequency value represents the modeled frequency of Coastal Flooding hazard occurrences (events) per year.	KP 2025 Community Health Needs Dashboard
	Drought Risk	Deficiency of precipitation over an extended period of time resulting in a water shortage	FEMA National Risk index
	Heat Wave Risk	A period of abnormally and uncomfortably hot and unusually humid weather typically lasting two or more days with temperatures outside the historical averages for a given area.	FEMA National Risk index
	River Flooding Risk	A Riverine Flooding annualized frequency value represents the average number of recorded Riverine Flooding hazard occurrences (event-days) per year over the period of record (24 years)	KP 2025 Community Health Needs Dashboard
	Water Contaminants	Past: n/a Current: Drinking water contaminant index for selected contaminants (2011 to 2019)	CalEnviroscreen 4.0

Health Topic	Measure	Definition	Data Source, Year
			Drinking water contaminant index for selected contaminants (2011 to 2019)
	Urban Tree Canopy	Percent canopy 2018 by urban census tracts	USDA Forest Service
	Road Network Density	Number of interconnected roads in a given area.	KP 2025 Community Health Needs Dashboard
Community safety	Unintentional Injuries Deaths (Age adjusted rate per 100,000)	Age adjusted death rate of deaths due to unintentional injuries	VRBIS 2019-2023
	Motor Vehicle Traffic Deaths (Age adjusted rate per 100,000)	Age Adjusted death rate of deaths caused by motor vehicle crashes	VRBIS 2019-2023
	Pedestrian Accident Deaths (Age adjusted rate per 100,000)	Age adjusted death rate of pedestrian accidents	VRBIS 2019-2023
	Premature Death (YPLL)	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	County Health Rankings & Roadmaps, 2024 The 2024 County Health Rankings used data from 2019-2021 for this measure.
	Violent Crimes	Total Number of Violent Crimes reported per 100,000 population, 2019	State of California Department of Justice, 2022
Demographics	% American Indian/Alaska native population	Percent of the total population that identify as American Indian/Alaska native, non-Hispanic	2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	% Asian population	Percent of the total population that identify as Asian, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Black/African American population	Percent of the total population who identify as Black or African American, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Hispanic/Latino population	Percent of the total population that identify as ethnically Hispanic/Latino	2022: ACS 5-year Estimates Data Profiles
	% Multiracial population	Percent of the total population that identify as multiple races, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Native Hawaiian/other Pacific Islander population	Percent of the total population that identify as Native Hawaiian/other Pacific Islander, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Some other race population	Percent of the total population that identify as some other race, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% White population	Percent of the total population that identify as White, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	Life expectancy	The average number of years a person can expect to live at birth	County Health Rankings, 2024
	Average Age of Death	n/a	VRBIS 2019-2023 (Death Certificate)
	Total Population	Total population of San Joaquin County and Priority Neighborhoods	2022: ACS 5-year Estimates Data Profiles
	Age Group	Total population of San Joaquin County and Priority Neighborhoods by age group	2022: ACS 5-year Estimates Data Profiles
	Gender	Total population of San Joaquin County and Priority Neighborhoods by gender	2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
Economics	Children (ages 0-17 years) Living in Poverty	Percent of children 0-17 that live in households with incomes below the federal poverty level	US Census, 2022: ACS 5-year Estimates Data Profiles
	Employed (16+)	Percentage of the population ages 16 years and over who are employed	US Census, 2022: ACS 5-year Estimates Data Profiles
	High Speed Internet	Percent of population with access to high-speed internet	US Census, 2022: ACS 5-year Estimates Data Profiles
	Income Inequality - Gini Index	Ranges from 0, indicating perfect equality (where everyone receives an equal share), to 1, perfect inequality (where only one recipient or group of recipients receives all the income).	KP 2025 Community Health Needs Dashboard
	Jobs Proximity Index	The accessibility and distance to all job locations within its area, with larger employment centers weighted more heavily.	Community Health Needs Dashboard - All Counties in KP States, HUD Policy Development and Research, 2014
	Living in Poverty (<100 Federal Poverty Level)	Percent of population living below the poverty level in the past 12 months	US Census, 2022: ACS 5-year Estimates Data Profiles
	Income	Median household income	US Census, 2022: ACS 5-year Estimates Data Profiles
	Seniors (ages 65+ years) living in poverty	Percent of population ages 65 and older who are living in poverty	US Census, 2022: ACS 5-year Estimates Data Profiles
	Young People Not in School and Not Working	Percent of 16-19-year-olds who are not currently enrolled in school or employed	US Census, 2022: ACS 5-year Estimates Data Profiles
Education	Adults (ages 25+ years) with Some College Education	Percent of the population over age 25 with some college education	2022: ACS 5-year Estimates Data Profiles (State/County/Priority Neighborhoods) 2022: ACS 1-year Estimates Data Profiles (Race/Ethnicity)

Health Topic	Measure	Definition	Data Source, Year
	Adults (ages 25+ years) with No High School Diploma	Percent of the population over age 25 with less than a high school degree	2022: ACS 5-year Estimates Data Profiles
	Bachelors' Education or Higher	Percentage of population over age 25 with a bachelors' education or higher	2022: ACS 5-year Estimates Data Profiles
	High School Enrollment	Percentage of 15-17-year-olds enrolled in school	2022: ACS 5-year Estimates Data Profiles
	On-time high school graduation	Four-Year Adjusted Cohort Graduation Rate, 2019-2020	California Dept of Education, Four-Year Cohort Graduation Rates & Outcomes, 2022-2023
	Preschool Enrollment	Percent of 3 and 4-year-olds enrolled in preschool	2022: ACS 5-year Estimates Data Profiles
	Students proficient in Math	Students Meeting or Exceeding Grade-Level Standard in Mathematics (CAASPP), by Race/Ethnicity, 2022-23. NOTE: The dashboard view will show values for both Reading and Mathematics. See special filters for additional notes	California Assessment of Student Performance and Progress (CAASPP)
	Students proficient in Reading	Students Meeting or Exceeding Grade-Level Standard in Reading (CAASPP), by Race/Ethnicity, 2022-23. NOTE: The dashboard view will show values for both Reading and Mathematics. See special filters for additional notes	California Assessment of Student Performance and Progress (CAASPP)
Food security	Convenience Stores per 1,000 population	Number of Convenience stores per 1,000 population	Community Health Needs Dashboard - All Counties in KP States, USDA Food Environment Atlas, 2016
	Food insecure	Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods.	KP 2025 Community Health Needs Dashboard

Health Topic	Measure	Definition	Data Source, Year
	Grocery Stores per 1,000 population	Number of Grocery stores per 1,000 population	Community Health Needs Dashboard - All Counties in KP States, USDA Food Environment Atlas, 2020
	Low access to grocery store	Percent of individuals with low grocery store access; If a census tract is urban, the percentage of the population that resides more than 0.5 mile from a supermarket. If the census tract is rural, the percentage of the population that resides more than 10 miles from a supermarket. The county total represents the percentage of the population that resides more than .05 mile from a supermarket.	USDA Food Access research Atlas 2019
	SNAP enrollment	Percent of households receiving food stamps/SNAP	US Census, 2022: ACS 5-year Estimates Data Profiles
	Free and Reduced Price Meals	Free and Reduced Price Meals, 2023-24	California Dept of Education, Free and Reduced Price Meals, 2023-24
HEAL opportunities	Exercise opportunities	Percentage of population with adequate access to locations for physical activity	County Health Rankings & Roadmaps, 2024 Data from 2023, 2022 & 2020
	Obesity (ages 18+ years)	Topic: Body Mass Index - 4 level (adult only)	askCHIS, 2018-2022 (pooled)
	Overweight/ Obesity (grades 5,7,9)	Percentage of public-school students in grades 5, 7, and 9 with body composition above the "Healthy Fitness Zone" of the FitnessGram assessment, race/ethnicity and grade level	California Dept of Education, Physical Fitness Test, 2018-2019
	Physical inactivity (ages 18+ years)	Percentage of adults aged 20 and over reporting no leisure-time physical activity.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021

Health Topic	Measure	Definition	Data Source, Year
	Park Access	Percent of residents that live further than a half mile from a park.	Parks for All Californians Park Access Tool, 2020
	Walkability Index	Index scores walkability upon characteristics of the built environment that influence the likelihood of walking being used as a mode of travel	KP 2025 Community Health Needs Dashboard
	Student Participation in California Physical Fitness Test (grades 5, 7, and 9)	Percentage of public school students in grades 5, 7, and 9 participating in the California Physical Fitness Test. There are 5 components to the California Physical Fitness Test: Component 1: Aerobic Capacity, Component 2: Abdominal Strength and Endurance, Component 3: Trunk Extensor and Strength and Flexibility, Component 4: Upper Body Strength and Endurance, and Component 5: Flexibility.	California Department of Education School Accountability Report Card, 2022-23 Reporting year 2024
Housing	Homeownership rate	Percentage of occupied housing units occupied by property owners	US Census, 2022: ACS 5-year Estimates Data Profiles
	Housing Affordability Index	Index of ability of typical resident to purchase an existing home in the area	KP 2025 Community Health Needs Dashboard
	Housing Habitability	Percent of households with kitchen facilities and plumbing.	Comprehensive Housing Affordability Strategy (CHAS) Tables 15A, 15B, 15C, 2016-2020
	Low Income Homeowner (Severe housing cost burden)	Percent of low income owner households with housing costs exceeding 50% of income.	Comprehensive Housing Affordability Strategy (CHAS) Table 8, 2016-2020
	Low Income Renters (Severe housing cost burden)	Percent of low income renter households with housing costs exceeding 50% of income.	Comprehensive Housing Affordability Strategy (CHAS) Table 8, 2016-2020
	Median Rental Cost	Rent per month	KP 2025 Community Health Needs Dashboard

Health Topic	Measure	Definition	Data Source, Year
	Percent of Income for Mortgage	Part of median household income dedicated to monthly payments on a home priced at the median value	KP 2025 Community Health Needs Dashboard
	Severe Housing Cost Burden	Percentage of households with housing costs greater than 50% of income	KP 2025 Community Health Needs Dashboard
	Uncrowded Housing	Percentage of households with less than or equal to 1 occupant per room	US Census, 2022: ACS 5-year Estimates Data Profiles
Mental health	Mental health providers per 100,000 population	Number of Mental health providers per 100,000 population	KP 2025 Community Health Needs Dashboard
	Deaths of despair (age adjusted rate per 100,000)	((VRBIS Deaths of Despair/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023
	Poor mental health (days per month)	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	County Health Rankings & Roadmaps, 2024 Behavioral Risk Factor Surveillance System (BRFSS), 2021
	Suicide deaths (age adjusted rate per 100,000)	((VRBIS Suicide Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023
Other	Social Vulnerability Index (SVI)	The SVI groups sixteen factors into four themes that summarize the extent to which the area is socially vulnerable to natural or human-caused disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.	SVI Interactive Map | Place and Health - Geospatial Research, Analysis, and Services Program (GRASP) | ATSDR, 2022

Health Topic	Measure	Definition	Data Source, Year
Sexual health	Teen birth rate	Teens giving birth between the ages 15 to 19.	VRBIS 2018-2022 (Birth Certificate) & 2022: ACS 5-year Estimates Data Profiles
	Total birth rate (per 1000)	Total live births (for a specific area and timer period) divided by total population (for the same area and time) multiplied by 1,000.	VRBIS 2019-2023 (Birth Certificate) & 2022: ACS 5-year Estimates Data Profiles
	Chlamydia Rate (per 100,000)	((CalREDIE Clamydia Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	Syphilis Rate (per 100,000)	((CalREDIE Syphilis Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	Gonorrhea Rate (per 100,000)	((CalREDIE Gonorrhea Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	HIV deaths (per 100,000)	(deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CDPH HIV data, 2018-2022 (SJC HIV/AIDS DUA file, 2023Q4)
	HIV prevalence in pop over 13 (per 100,000)	(total HIV/AIDS cases)/(2019 ACS 5 year population estimate -San Joaquin County)	CDPH HIV data, 2018-2022 (SJC HIV/AIDS DUA file, Q4 of each year)
Social support	Seniors Living alone (ages 65+ years)	Percent of total households with someone 65 and older living alone	US Census, 2022: ACS 5-year Estimates Data Profiles
	Limited English Proficiency	Percent of the population ages 5 and older that speak a language other than English at home and speak English less than “very well”	US Census, 2022: ACS 5-year Estimates Data Profiles
	Disability Population (ages <65 years)	Population under 65 with a disability	US Census, 2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	Disability Population (all ages)	Population with a disability	US Census, 2022: ACS 5-year Estimates Data Profiles
	Two Parent Households	Percentage of family households with children under 18 with two parents present	US Census, 2022: ACS 5-year Estimates Data Profiles
Substance use	Alcohol-impaired Driving Deaths	Number of people killed in a crash involving a driver or motorcycle rider with a blood alcohol concentration of .08 grams per deciliter or greater / total fatalities	KP 2025 Community Health Needs Dashboard
	Current Smokers	Adult Smoking is the percentage of the adult population in a county who both report that they currently smoke every day or some days and have smoked at least 100 cigarettes in their lifetime.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021
	Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted), Excessive Drinking measures the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021
	Opioid-Related Overdose Deaths (per 100,000)	Age adjusted rate of opioid-related overdose deaths by race/ethnicity	skylab.cdph , 2022
Transportation	Workers commuting by transit, biking or walking (Active Commuting)	Percent of population 16 and older who commute to work by walking, cycling, or public transit (excluding taxicabs)	US Census, 2022: ACS 5-year Estimates Data Profiles
	Automobile Access	Percentage of households with access to an automobile	US Census, 2022: ACS 5-year Estimates Data Profiles
	Workers Driving Alone to Work	Percent of population 16 and older who drive alone to work in a car, truck, or van	US Census, 2022: ACS 5-year Estimates Data Profiles
	Workers Driving Alone with Long Commutes	Percent of population 16 and older who drive alone to work with a commute of 60 minutes or more	US Census, 2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	Retail Density	Gross retail, entertainment, and education employment density (jobs per acre)	U.S EPA Smart Location Database 3.0, 2021

Appendix B: San Joaquin County CHNA Secondary Data Table

Prevalence/incidence rates for indicators of health status, behavior, and risk factors are shown below for San Joaquin County in comparison to statistics for the State of California. Indicators (either percentage of county population or a rate per designated number of residents) are presented across 15 health need categories. Definitions for each indicator and associated data source are provided in Appendix A. Table 1 below notes statistically significant differences for 1) indicators for which the county performs markedly worse than California averages and 2) indicators for which ethnic disparities are present within the county. Ethnic groups examined include Hispanic/Latino, White, Asian, Black/African American, Pacific Islander/Native Hawaiian and American Indian/Alaska Native populations, as well as those who are mixed race or identify with other groups. These differences point to notable health needs across the county and/or for particular ethnic groups, which are discussed in further detail in Section VII.

Table 1: Prevalence/Incidence Rates for Indicators of Health Status, Behavior, and Risk Factors

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
Access to Care	Infant deaths (per 1000 live births)	5.3	4.2	✓	
	Uninsured children (ages <19 yrs)	2.6%	3.4%		✓
	Insured (ages 19-64 yrs)	90.5%	90.0%		✓
	Medicaid/public insurance enrollment	42.5%	38.5%		
	Low birth weight	7.7%	7.4%	✓	✓
	Pre-term births	9.3%	9.1%	✓	✓
	Prenatal care in 1st trimester	79.1%	86.3%	✓	✓
	Dentists per 100,000 population	58.9	91	✓	
	Primary care physicians per 100,000 population	58.0	81.6	✓	
Cancer	Cancer deaths (all sites combined)	138.9	122.0	✓	✓
	Breast cancer deaths	20.1	17.6	✓	

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Colorectal cancer deaths	13.7	11.5	✓	✓
	Lung cancer deaths	25.0	20.6	✓	✓
	Prostate cancer deaths	20.8	18.2	✓	✓
	Breast cancer incidence	113.9	124.1		✓
	Colorectal cancer incidence	36.7	33.5	✓	✓
	Lung cancer incidence	40.9	36.8	✓	✓
	Prostate cancer incidence	90.2	99.0		✓
	Cancer incidence (all sites combined)	397.1	398.3		
Chronic Disease	Poor physical health (days per month)	3.7	3.1	✓	
	Poor or fair health (ages 18+ yrs)	22.2%	17.2%	✓	✓
	Heart disease prevalence (ages 18+ yrs)	7.7%	6.9%		
	Heart disease hospitalizations	33.1	31.2		✓
	Heart disease deaths	148.9	142.2	✓	
	Stroke prevalence	3.1%	2.6%		
	Stroke hospitalizations	9.6	10.4		✓
	Stroke deaths	49.2	39.1	✓	
	Diabetes prevalence (ages 18+ years)	14.9%	10.5%	✓	✓
	Asthma ED visits (all ages)	57.9	42.6		✓
	Asthma Hospitalizations (all ages)	5.0	4.5		✓
	Asthma ED visits (ages 0-17 years)	76.0	63.4		
	Asthma Hospitalizations (ages 0-17 years)	9.5	8.3		
	Asthma prevalence (all ages)	18.4%	15.4%	✓	✓
	Asthma prevalence (ages 0-17 yrs)	23.7%	12.5%	✓	✓

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
Climate and Environment	Urban Tree canopy cover	1.4	4.0		
	Road network density	18.3	20.6		
	Coastal flooding risk	0.0	5.5		
	Drought risk	99.7	2.5	✓	
	Heat wave risk	95.6	8.4	✓	
	Air pollution: PM2.5 concentration	10.54	10.18		
	River flooding risk	57.7	29.3	✓	
	Water Contaminants	661.27	477.98	✓	
Community Safety	Injury deaths	68.9	54.9	✓	
	Motor vehicle crash deaths	16.8	10.8	✓	
	Pedestrian accident deaths	1.5	1.6		
	Violent crimes	681.3	488.2	✓	
	Premature death (YPLL)	8327	6373	✓	
Economics	Income	$82,837	$91,905	✓	✓
	Employed (16+ years old)	56.8%	59.3%	✓	✓
	Jobs Proximity Index	43.5	47.7		
	Income inequality – Gini Index	0.4	0.4		
	Living in poverty (<100% Fed Poverty Level)	12.9%	12.1%	✓	✓
	Seniors (ages 65+ years) living in poverty	11.3%	11.0%		✓
	Children living in poverty	17.4%	15.6%		✓
	Young people not in school and not working	9.3%	6.6%	✓	
	High speed internet	89.6%	91.5%	✓	✓
Education	Preschool enrollment	38.2%	44.7%	✓	

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	High school enrollment	96.7%	97.3%		
	Students proficient in math	27.1%	34.6%	✓	✓
	Students proficient in reading	39.5%	46.7%	✓	✓
	On-time high school graduation	82.3%	86.2%	✓	✓
	Adults with no high school diploma	19.8%	15.6%	✓	✓
	Adults with some college education	22.2%	20.2%		✓
	Bachelor's education or higher	20.3%	35.9%	✓	✓
Food Security	SNAP enrollment	15.3%	10.3%	✓	✓
	Convenience stores per 1,000 population	0.2	0.2		
	Grocery stores per 1,000 population	0.2	0.2		
	Low access to grocery store	28.4%	32.4%		
	Food insecure	10.8%	9.8%		
	Free and reduced-price lunch	66.1%	61.7%	✓	
HEAL Opportunities	Obesity (ages 18+ years)	35.5%	28.1%	✓	✓
	Overweight/obesity (grades 5,7,9)	43.3%	39.7%	✓	✓
	Physical inactivity (ages 18+ years)	24.9%	19.9%	✓	
	Exercise opportunities	89.0%	94.0%	✓	
	Walkability Index	10.3	12.1	✓	
	Park access	27.0	21.0		
Housing	Homeownership	60.0%	55.6%		✓
	Uncrowded housing	91.5%	91.8%		✓
	Low income renters (Severe housing cost burden)	23.7%	25.5%		
	Low income Homeowner (Severe housing cost burden)	11.9%	12.7%		

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Severe housing cost burden	16.9%	19%		
	Median rental cost	$1,527	$1,831		
	Housing Habitability	98.8%	98.7%		
	Housing affordability index	82	72.7		
	Percent of income for mortgage	29.7%	38.3%		
Mental Health	Mental health providers per 100,000 population	273.7	425.5	✓	
	Deaths of despair per 100,000 population	63.5	56.4	✓	✓
	Suicide deaths	10.8	10.5		✓
	Poor mental health (days per month)	4.7	4.7	✓	
Sexual Health	HIV deaths	4.3	5.2		✓
	Total birth rate	12.5	11.2	✓	
	Teen birth rate	14.9	11.1		✓
	Gonorrhea rate	198.6	204.7		✓
	Chlamydia rate	542.8	535.8	✓	✓
	Syphilis rate	62.9	39.7	✓	✓
	HIV prevalence (ages 13+ years)	190.6	354.3		✓
Social Support	Disability Population (all ages)	12.2%	11.0%		
	Disability Population (ages <65 years)	8.3%	7.1%		✓
	Limited English proficiency	41.1%	39.0%	✓	✓
	Seniors living alone (ages 65+ years)	20.9%	22.0%		
	Two parent households	77.4%	77.6%		
Substance Use	Current smokers	13.1%	8.8%	✓	
	Opioid-related overdose deaths per 100,000 population	14.5	18.7		✓

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Alcohol-impaired driving deaths	29.5%	26.6%	✓	
	Excessive drinking	16.5%	17.2%		
Transportation	Workers driving alone to work	82.7%	79.2%	✓	✓
	Workers driving alone with long commutes	19.9%	10.5%	✓	
	Workers commuting by transit, biking or walking (Active Commuting)	3.0%	7.8%	✓	
	Retail density	0.1	n/a	✓	
	Automobile Access	94.8%	93.1%		

Appendix C: Community Input Tracking Form

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
1	Key Informant Interview	Catholic Charities	1	Low income, medically underserved, children, youth and families, seniors, immigrants, veterans, unhoused and at risk for being unhoused	Leader	4/9/24	Administers direct social services and advocacy through a variety of programs for the most vulnerable and underrepresented citizens
2	Key Informant Interview	San Joaquin County Public Health Services	1	Public health	Leader	4/15/24	Responsible for protecting, promoting and improving the health and well-being for all who live, work, and play in San Joaquin County.
3	Key Informant Interview	San Joaquin County Continuum of Care	2	Communities of Color, medically underserved and low income	Leader	4/17/24	Provides information, resources, and leadership on evidence-based methods to end homelessness in San Joaquin County utilizing the “Continuum of Care” model
4	Key Informant Interview	San Joaquin County Behavioral Health Services	1	Communities of Color, medically underserved and low income individuals with mental health and substance use treatment needs	Leader	4/17/24	Provides integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.
5	Key Informant Interview	El Concilio Council for the Spanish Speaking	1	Communities of Color, medically underserved and low income	Leader	4/19/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources
6	Key Informant Interview	Community Medical Centers, Inc.	1	Communities of Color, medically underserved and low income	Leader	4/23/24	System of 11 federally qualified health centers (FQHCs) providing health services to low income, underinsured and high need populations

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
7	Key Informant Interview	Family Resource and Referral Center	1	Communities of Color, medically underserved and low income families	Leader	4/24/24	Provides child care referrals and administers child care and nutritional resources; conducts workshops in effective child rearing, child care, and child safety.
8	Key Informant Interview	San Joaquin County Department of Aging and Community Services	1	Older adults, adults with disabilities, family caregivers, and residents in long-term care facilities	Leader	4/24/24	Helps older adults find employment; supports older and disabled individuals to live as independently as possible; promotes healthy aging and community involvement; and assists family members in their vital care giving role.
9	Key Informant Interview	Central Valley Gender Health and Wellness	2	LGTBQ+ communities including medically underserved, low income, communities of color, unhoused	Leader	5/16/24	Serves the diverse LGBTQ+ community in San Joaquin County by championing equity and well-being for all through a safe and supportive community hub providing access to healthcare, mental health support, educational resources, and housing and legal assistance
10	Key Informant Interview	First 5 of San Joaquin	1	Communities of Color, medically underserved and low income children ages 0-5 and their families	Leader	5/17/24	Provides financial support for health, preschool and literacy programs, and fosters active participation of parents, caregivers, educators and community members in the lives of young children, prenatal to 5 years
11	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Communities of Color, medically-underserved, low income, impacted by gang violence	Member	9/11/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
12	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Parents/guardians of youth, Communities of Color, medically-underserved, low income	Member	9/13/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
13	Focus Group	El Concilio Council for the Spanish Speaking	10	Communities of Color, older adults	Member	9/16/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
14	Focus Group	L.O.V.E.U Foundation	10	Communities of Color, parents, low income	Member	9/20/24	Community church serving youth and families of color
15	Focus Group	Public Health Advocates	8	Youth, BIPOC, low income	Member	9/24/24	Program for low income youth of color learning about public health policy and redlining to create neighborhood change
16	Focus Group (virtual)	San Joaquin County Public Health Services Perinatal Equity Initiative & Black Infant Health Community Advisory Board	7	Communities of color, medically-underserved	Member	9/25/24	Advocates for improved Black/African American birth outcomes. Represents birth workers, hospitals and clinics, and community organizations.
17	Focus Group	L.O.V.E.U Foundation	8	Communities of color, low income	Member	9/27/24	Community church serving youth and families of color
18	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Communities of color, low income, victims of gun violence	Member	9/27/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
19	Focus Group	Public Health Advocates	9	Youth, BIPOC, low income	Member	9/28/24	Program for low income youth of color learning about public health policy and social injustices to create neighborhood change
20	Focus Group	El Concilio Council for the Spanish Speaking	10	Communities of color, undocumented immigrants, Hispanic/Latino population, Spanish-speaking, Indigenous population, medically underserved, low income	Member	9/30/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
21	Focus Group	L.O.V.E.U Foundation	7	Communities of color, low income	Member	10/6/24	Community church serving youth and families of color
22	Focus Group	Mayfair Christian Church	10	Older adults	Member	10/6/24	Christian church serving the Stockton community.
23	Focus Group	Asian Pacific Self-Development and Residential Association	10	Older adults, Cambodian population, Khmer and Lao-speaking, refugees, chronic physical/mental health conditions, medically-underserved, low income	Member	10/8/24	Provides housing and economic support to Khmer refugees who experienced trauma and economic hardship after fleeing the Khmer Rouge.
24	Focus Group	Community Health Leadership Council	10	Communities of Color, Hispanic/Latino population, Spanish-speaking, parents of young children, chronic physical/mental health conditions, low income, medically-underserved	Member	10/9/24	Works with community partners across healthcare, education, and business to identify and address pressing public health issues in San Joaquin County.
25	Focus Group	Community Health Leadership Council	10	Communities of Color, Hispanic/Latino population, Spanish-speaking, chronic physical/mental health conditions, low income, medically-underserved, migrant workers	Member	10/9/24	Works with community partners across healthcare, education, and business to identify and address pressing public health issues in San Joaquin County.
26	Focus Group	Emergency Food Bank of Stockton	10	Older adults, low income, chronic health conditions	Member	10/12/24	Provides nutrition education and distributes food to low income diabetic and pre-diabetic older adult individuals.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
27	Focus Group	Center for Business and Policy Research (CBPR), University of the Pacific	6	Communities of Color, low income, chronic health conditions	Member	10/15/24	Researches public policy issues facing North San Joaquin Valley region.
28	Focus Group (virtual)	Tracy Area Alumnae Chapter of Delta Sigma Theta Sorority Inc.	8	Youth, Communities of Color, Black/African American population	Member	10/16/24	Offers programs in the areas of educational development, economic development, international awareness and involvement, physical and mental health, and political awareness and involvement for members.
29	Focus Group	Housing Authority of San Joaquin	16	Communities of Color, Hispanic/Latino population, Spanish-speaking, low income	Member	10/16/24	Provides affordable housing to older adults, low income individuals, working families, and disabled residents of San Joquin County.
30	Focus Group	Tracy Area Alumnae Chapter of Delta Sigma Theta Sorority Inc.	8	Communities of Color, Black/African American population	Member	10/16/24	Offers programs in the areas of educational development, economic development, international awareness and involvement, physical and mental health, and political awareness and involvement for members.
31	Focus Group	Health Plan of San Joaquin	7	Communities of Color, chronic health conditions	Member	10/17/24	Provides community-led health services to Medi-Cal recipients.
32	Focus Group	Health Plan of San Joaquin	9	Communities of Color, chronic health conditions, low income, medically-underserved, community care providers	Member	10/17/24	Provides community-led health services to Medi-Cal recipients.
33	Focus Group (virtual)	Public Health Advocates	4	Older adults, low income, community leaders in climate and health	Member	10/17/24	Develops community-led solutions to climate change.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
34	Focus Group	San Joaquin County Public Health Services Staff Cohort	13	Staff of Public Health Services	Leader	10/17/24	Protects, promotes, and improves health and the conditions that impact wellbeing for all in San Joaquin County.
35	Focus Group	Reinvent South Stockton Coalition	10	Youth, low income	Member	10/19/24	Advocates for improvements to public health, education, and housing in South Stockon.
36	Focus Group	Amelia Ann Adams Whole Life Center	8	Communities of color, low income, impacted by the Justice System	Member	10/22/24	Serves at-risk, under resourced individuals and focuses on neighborhood change to build thriving communities.
37	Focus Group	Reinvent South Stockton Coalition	8	Communities of Color, Hispanic/Latino population, Spanish-speaking, medically-underserved, low income	Member	10/23/24	Advocates for improvements to public health, education, and housing in South Stockon.
38	Focus Group (virtual)	San Joquin Opioid Safety Coalition	7	Communities of Color	Member	10/23/24	Opioid safety stakeholders working to reduce opioid overdoses and deaths in their communities.
39	Focus Group	Emergency Food Bank Stockton	8	Communities of Color, Hispanic/Latino population, Spanish-speaking, chronic health conditions, low income, medically underserved	Member	10/25/24	Provides nutrition education and distributes food to low income diabetic and pre-diabetic adult individuals.
40	Focus Group	Stanislaus State Stockton Campus	10	Young adults, Communities of Color, low income	Member	10/28/24	Local state college serving community of color and low income populations.
41	Focus Group	Housing Authority of San Joaquin	11	Older adults, low income	Member	10/28/24	Provides affordable housing to older adults, low income individuals, working families, and disabled residents of San Joquin County.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
42	Focus Group	Central Valley Gender Health and Wellness	8	LGBTQ+ community, chronic physical/mental health conditions, medically underserved, low income	Member	10/29/24	Serves the diverse LGBTQ+ community in San Joaquin County by championing equity and well-being for all through a safe and supportive community hub providing access to healthcare, mental health support, educational resources, and housing and legal assistance
43	Focus Group	Dignity Health, St. Joseph's Behavioral Health	7	Behavioral healthcare workers	Member	10/29/24	Provides behavioral health services such as behavioral evaluations, chemical recovery program, inpatient services, and outpatient services, to San Joaquin County community.
44	Focus Group	San Joaquin Health Center	4	Unhoused community, Communities of Color, low income, medically underserved, chronic physical/mental health conditions	Member	10/29/24	Provides mobile health care services to unhoused community.
45	Focus Group	St. Joseph's Medical Center, Doctor Up Your Meals Diabetes Health Group	10	Older adults, chronic physical/mental health conditions, medically underserved	Member	10/30/24	Diabetes health and nutrition education program serving adults over 60 who are medically underserved and diagnosed with diabetes or prediabetes.
46	Focus Group	St. Joseph's Medical Center, Cancer Center	2	Older adults, chronic physical/mental health conditions	Member	10/30/24	Medical facility cancer treatment center serving San Joaquin County.
47	Focus Group	San Joaquin Health Center	6	Unhoused community, Communities of Color, low income, medically underserved, chronic physical/mental health conditions	Member	10/30/24	Provides mobile health care services to unhoused community.
48	Focus Group	Healings in Motion	10	Communities of color, chronic physical/mental health conditions, low income, medically underserved	Member	11/1/24	Organization assists survivors of stroke, traumatic brain injuries, and neurological impairments, and provides support and resources for caregiver.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
49	Focus Group	Little Manila Rising	6	Communities of Color, medically underserved, low income	Member	11/5/24	Serves the South Stockton Filipino community, addressing issues of marginalization through educational, environmental, and public health programs.
50	Focus Group	St. Joseph's Medical Center, Power Hour Diabetes Health Group	10	Communities of Color, chronic physical/mental health conditions	Member	11/6/24	Diabetes health and nutrition education program serving adults who are diagnosed with diabetes or prediabetes.
51	Meeting	Resilient Community Advisory Committee	39	Disenfranchised communities most affected by COVID-19	Member	11/14/24	Brings together those who serve, and have trusting relationships with, the most disenfranchised communities in SJC to engage community partners and residents in the development of messages tailored to resonate with community members, promote community outreach and disease mitigation activities, and gather feedback and guidance on planned activities.
52	Meeting	SJC CHNA Steering Committee	33	Chronic physical/mental health conditions, Communities of Color, medically underserved, and low income	Leader	1/21/25	CBOs/public agencies/health care organizations that work with low income and ethnic populations in SJC work to address health disparities and are a critical voice in determining priority health needs.

CHNA 2025 Key Informant Interview Protocol

INTRODUCTION

Thank you for agreeing to do this interview today. My name is **[NAME]** with **Ad Lucem Consulting**. Kaiser Permanente has partnered with **Ad Lucem Consulting** to conduct the Community Health Needs Assessment, or CHNA, in STANISLAUS COUNTY**.** For your background, we do not play any role in Kaiser Permanente's grant-making.

The CHNA, which is conducted every three years, includes consideration of health outcomes and social and environmental health factors, along with community perspectives, in order to identify key health-related issues and assets in each community Kaiser Permanente serves. This information informs how Kaiser Permanente develops strategies to address selected community health needs. You are an important contributor to this assessment because of your knowledge of the community you serve or represent. We greatly value your input.

CONSENT SCRIPT: By participating in this interview, you agree that Kaiser Permanente (KP) will use the information you provide - including de-identified statements or quotes - in the community health needs assessment. Information will be compiled and reported in a way that is not attributable to you. Additionally, because KP collaborates with hospital partners as part of its community health needs assessment process, you agree that KP may share transcripts or notes from this interview with partner organizations. Do you have any questions before we get started?"

If they continue with the interview, we accept that as passive assent.

- Do we have your permission to record the interview?

➔ **If yes, start the recording. If no permission granted, take verbatim notes.**

HEALTH NEEDS

Great – let's get started!
For individuals/organizations interviewed last cycle: I see that you (or your organization) participated in an interview for the previous CHNA – thank you for your participation last cycle. The questions this time are quite similar, and we are interested to hear how things may or may not have changed.

First, I would like to ask a few questions about health needs and potential strategies to address them in your community. This will be followed by questions about inequities that have an impact on these health needs.

3. What are the 2-3 healthiest assets or characteristics of **San Joaquin County** (e.g., a strong transportation system, an active arts and culture sector, safe and accessible spaces for physical activity, community resilience)?

    a. What are the facilitators in the community that support these healthy characteristics? (e.g., local elected official support, funding, policies, strong community organizations)?

4. What are the 3 biggest health issues and/or conditions your community struggles with? Please briefly describe the issues. [*If unsure what we mean: e.g., a health issue can be a factor that contributes to poor health, like lack of stable housing, or a health outcome like heart disease or cancer.]*

    a. What are the factors that create these health issues and why are they the top needs? *A need can be a top priority because it impacts lots of people in the County, impacts vulnerable populations such as kids or older adults, costs the County lots of money, or impacts County residents' ability to have a high quality of life. Factors that create priority issues can include economics, societal/social factors, environmental factors.*
    b. How have you seen community needs change over the last few years in **San Joaquin County**?
    c. How has COVID pandemic recovery, including expiration of certain benefits, influenced the magnitude of these needs in **San Joaquin County**?

5. You indicated that **[RESTATE THE top 3 health needs mentioned above**] are significant health needs in your community. What are one or two of the biggest challenges to addressing each of these needs in **San Joaquin County?**

6. *If the interviewee did not mention any of the following (list health needs addressed in 2022 Report* Are these health needs still a priority? If no, what changed?

EQUITY

Now I have a few questions to ask you about inequities in **San Joaquin County** that have an impact on the important health needs you mentioned. This could be racial inequity as well as inequities related to gender, age, geography, and other factors. Inequities can also relate to access to services, for instance when lack of culturally and

language appropriate services are not available and prevent community residents from receiving needed services.

REQUIRED: For each question in the equity section, probe for more detail about groups or subgroups:

1. *American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/other Pacific Islander, or Individuals of Hispanic/Latino origin (i.e., if a participant mentions the Asian population, who do they mean specifically? If they bring up Latinx, what ethnicities are they referring to?)*
2. *Socially disadvantaged groups (i.e., if the participant says general terms like "marginalized", "disadvantaged", "underrepresented" or others, who are they referring to in their geographic context?*
3. *If the participant says all subgroups or declines to specify that is ok, just looking for more detail when it's relevant.*

7. Are there certain people or geographic areas in **San Joaquin County** that have been affected by the issues we've been talking about more than others? If so, in what ways? Is this relevant to all the needs we've been talking about or a specific one?
   a. Which specific groups of the population, if any, should Kaiser Permanente focus on to reduce disparities and inequities related to race or other factors?

8. What are effective strategies to reduce health disparities and address structural inequities in **San Joaquin County**?

   a. Is there existing work underway that is promising?
   b. Who are the individuals or organizations in **San Joaquin County** that are important for connecting the groups most affected by disparities to community resources that address [list *most important health need(s)*]?

COMMUNITY RESOURCES and POTENTIAL INVESTMENTS

Finally, I would like to ask about the resources available to address important health needs in the community. This will be followed by a question about potential future investments.

9. What are the key community resources, assets, or partnerships in **San Joaquin County** that can help address the significant health needs we talked about today?

   a. What services does [*your organization*] provide to help meet those needs in **San Joaquin County**?

b. Describe how other organizations or collective efforts, if any, are working to address these needs in **San Joaquin County**?

10. Are there any significant gaps in community resources, assets, or partnerships in **San Joaquin County** to address the significant health needs we talked about today?

a. Who is not yet involved in **San Joaquin County** but needs to be to help address the top health needs we talked about? *Repeat top health needs if needed.*

11. How would you like to see health care organizations in **San Joaquin County** invest in community health programs or strategies to address these needs**?** What would those investments be?

CLOSING

12. Are there any other **thoughts or comments you would like to share that we have not discussed?**

Appendix E: Focus Group Screener and Guide

Focus Group Screener Questions

Thank you for joining our focus group. To learn more about you, we'd like you to fill this survey out. All information is confidential and will be used only for our research.

1. How long have you lived in San Joaquin County? _____ Number of years

2. Race/Ethnicity (check all that apply):

- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Hispanic/Latino
- ☐ White/ Caucasian
- ☐ Different race/ethnicity (please describe):

3. How old are you? _____ Number of years

4. Gender? _____

Thank you!

Grupo de Enfoque Encuesta

Gracias por unirse a nuestro grupo de discusión. Para aprender más sobre usted, nos gustaría que complete esta encuesta. Toda la información es confidencial y se usará sólo para nuestra investigación.

1. **¿Por cuánto tiempo ha vivido usted en el Condado de San Joaquin?**

   _____ Número de años

2. **Raza/grupo étnico** (favor de marcar todo lo que aplique a usted):
   - ☐ Negro/Afro Americano
   - ☐ Indio Americano o nativo de Alaska
   - ☐ Asiático
   - ☐ Nativo de Hawaii/Islas del Pacífico
   - ☐ Hispano/Latino
   - ☐ Blanco/Caucásico
   - ☐ Raza/etnicidad diferente (Por favor describa): _____

3. **¿Qué edad tiene usted?** _____ Número de años

4. **¿Género?** _____

¡Gracias!

Focus Group Guide

Welcome

- Hello everyone, thank you for joining our discussion today.
- My name is (moderator).
- This is (note taker) who will be taking notes during our conversation.
- Our discussion today will take about 1 hour.
- Your participation is voluntary, and you can leave the group at any time, without explanation.

Purpose of Focus Group

Community organizations across the County are conducting focus groups to learn more about what residents feel are our most important health issues. We want to know what you, as a community member, think about what makes it easy or difficult to be healthy and what services and resources are available or needed in your community to improve health. Your opinions will help our county nonprofit hospitals, Public Health Services, community based organizations, insurers and others create a three year plan to work on the major health issues affecting people in the County.

Verbal Consent

By continuing to participate in this focus group, you are indicating your consent to have the information you provide used for the San Joaquin County Community Needs Health Assessment. The information collected during the focus group may be shared with other hospitals in San Joaquin County. Information shared from the focus group will not include your name or identifying information. If you do not consent, please leave the focus group.

Meeting Agreements

There are no right or wrong answers because we're interested in everyone's thoughts and opinions and people often have different opinions.

Please, feel free to share your opinions even though it's not what others have said. If there are topics you don't know about or a question you are not comfortable answering, feel free to not answer. All input will be welcomed and valued.

Next, we want to have a group discussion, but we'd like only one person to talk at a time because we want to make sure everyone has a chance to share their opinion.

The last guideline is about protecting your privacy. Your name will not be used in any reports, and your name will not be linked to comments you make. I'd also like for all of us to agree that what is said in this group stays with the group. Are there other meeting agreements you would like us to add?

Introductory Question

Let's start by introducing ourselves. Tell us your first name.

Community Health

We would like to discuss what is healthy and not so healthy about your community.

1. **Think about your community right now. What is healthy about your community?**

Things that make a community healthy can include the environment (sidewalks, clean streets, parks), social factors (e.g., feeling safe, access to mental health services), opportunities for healthy behaviors (e.g., places to buy healthy food, places to exercise) community services and events (e.g., low cost or free activities for families), and health care (e.g., access to health care services)

2. **What makes it difficult to be healthy in your community, including any lasting impacts from the COVID pandemic?**

For example, lack of access to health services, few grocery stores with healthy, affordable food, unsafe neighborhoods, lack of access to transportation, lots of pollution in the air, no safe places to be active, no affordable dental care

<u>Identifying top health issues/successful strategies to address health issues</u>

3. **Thinking about what does or does not make your community healthy, what do you think is the one top health issue facing your community?**

A health issue can be a disease like heart disease or cancer, or something that causes poor health like unhealthy food or drug abuse, or something that affects overall wellbeing like mental health, violence or access to care. We know you might have ideas about many important health issues, but try to limit your answer to identify the most important health issue.

4. **Thinking about the top health issues you identified, do you think there are certain groups of people that are more affected by these issues than others? For example, racial/ethnic groups, low income groups, specific neighborhoods or areas in San Joaquin County, or other marginalized communities?** *PROMPT:* **Which groups?**

5. **Thinking about the top health issue you identified as most important, what are the top one or two things that could be done to fix this issue?**

Some examples could be improvements to your community (like fixing sidewalks so it is easier to walk or starting farmers markets where you can get fruits and vegetables) or changes to clinic services (like health and mental health services available at places you usually go, services available in your preferred language).

<u>Final Question</u>

6. **We're just about ready to wrap up. Is there anything else you feel is important for us to know about health in your community?**

Thank you for your participation!

Guía Grupos de Discusión

Bienvenida

- Hola a todos y gracias por participar hoy en este grupo de discusión.
- Mi nombre es (moderator).
- El/ella es (Note taker) y se encargará de tomar notas durante nuestra conversación.
- La reunión durará, más o menos una hora.
- La participación es voluntaria y pueden retirarse del grupo cuando quieran, sin tener que dar explicaciones.

Objetivos del grupo de discusión

Organizaciones comunitarias en todo el condado están llevando a cabo grupos de discusión para aprender más sobre lo que los residentes sienten que son nuestros problemas de salud más importantes. Queremos saber lo que usted, como miembro de la comunidad, piensa acerca de lo que hace que sea fácil o difícil estar saludable y qué servicios y recursos hay disponibles o se necesitan en su comunidad para mejorar la salud. Su opinión ayudará a los hospitales sin fines de lucro de nuestro condado, los Servicios de Salud Pública, las aseguradoras y otros a crear juntos un plan de tres años para trabajar en los principales problemas de salud que afectan a las personas en el condado.

Consentimiento Verbal

Al continuar participando en este grupo de discusión, usted está indicando su consentimiento para que la información que proporcione sea utilizada para la Evaluación de las Necesidades de Salud de la Comunidad del Condado de San Joaquín. La información recopilada durante el grupo de discusión puede compartirse con otros hospitales del condado de San Joaquín. La información compartida del grupo de discusión no incluirá su nombre ni otra información que lo identifique. Si no está de acuerdo, por favor abandone el grupo de discusión.

Reglas Básicas

No hay respuestas correctas o incorrectas porque nos interesa conocer las ideas y las opiniones de todos, y las personas, muchas veces, tienen opiniones diferentes.

Por favor, sientan la libertad de decir lo que piensan, aunque no sea lo mismo que dijeron otros.
Si hay temas que no conocen o preguntas con las que no se sienten cómodos, simplemente no las respondan.
Todas las ideas son valiosas y bienvenidas.

Luego, queremos tener una discusión grupal, pero nos gustaría que hable una persona por vez porque queremos estar seguros de que todos tengan la oportunidad de dar su opinión.

La última indicación tiene que ver con la privacidad. Su nombre no va a utilizado en ningún informe y su nombre no se lo va a asociar con los comentarios que hagan aquí. También me gustaría que nos pongamos de acuerdo en que lo que se dice en este grupo, queda en este grupo. ¿Hay alguna otra regla que les gustaría agregar?

Pregunta introductoria

Empecemos por presentarnos. Díganos su nombre.

Salud de la comunidad

Nos gustaría hablar de lo que es saludable y no tan saludable en su comunidad.

1. **Piensen en cómo está la comunidad en este momento. ¿Qué cosas les parecen saludables de su comunidad?**

Cosas que hacen que una comunidad sea saludable puede incluir el entorno (por ejemplo, las aceras, las calles limpias y los parques); los factores sociales (por ejemplo, sentirse seguro, acceso a servicios de salud mental); oportunidades para tener hábitos saludables (por ejemplo, lugares donde comprar alimentos saludables, espacios donde hacer ejercicio); servicios comunitarios y eventos (por ejemplo, actividades de bajo costo o gratis para la familia); y el cuidado médico (por ejemplo, el acceso a los servicios de cuidado médico).

2. **¿Qué dificulta el estar saludable en su comunidad, incluyendo las repercusiones de la pandemia de COVID?**

Por ejemplo: falta de acceso a los servicios de salud, pocos lugares donde encontrar alimentos saludables y económicos, vecindarios poco seguros, falta de acceso al transporte, mucha contaminación en el aire, falta de lugares seguros donde hacer actividad física, falta de cuidado dental accesible.

<u>Identificando los principales problemas de salud/estrategias eficaces para resolverlos</u>

3. **Pensando en las cosas que hacen que la comunidad sea saludable o no, ¿cuál cree que es el principal problema de salud que afecta a su comunidad?**

Un problema de salud puede ser una enfermedad, como una enfermedad del corazón o cáncer; o algo que causa falta de salud, como alimentos no saludables o el abuso de drogas; o algo que afecta el bienestar general, como la salud mental, la violencia o el acceso al cuidado médico. Sabemos que, posiblemente, se les ocurran muchos problemas de salud que son importantes, pero traten de limitar la respuesta al problema de salud que consideran más importante.

4. **Pensando en los principales problemas de salud que identificó, ¿cree que hay ciertos grupos de personas que se ven más afectados por estos problemas que otros? Por ejemplo, ¿grupos raciales/étnicos, grupos de bajos ingresos, vecindarios o áreas específicas en el Condado de San Joaquín u otras comunidades marginadas?** *PISTA*: **¿Qué grupos?**

5. **Pensando en el problema de salud que ha identificado como el más importante, ¿qué es lo que se podría hacer para solucionarlo? Nombre una o dos cosas.**

   Algunos ejemplos podrían ser mejoras en su comunidad (como arreglar las calles para que sea más fácil caminar o poner en marcha mercados donde se pueda comprar fruta y verdura) o cambios en los servicios clínicos (como servicios de salud y de salud mental disponibles en los lugares a los que suele ir, servicios disponibles en su idioma preferido).

<u>Ultima Pregunta</u>

6. **Ya casi estamos listos para terminar. ¿Hay alguna otra cosa que crean que es importante que sepamos sobre la salud en su comunidad?**

¡Muchas gracias por participar!

Appendix F: Annotated Bibliography of SJC Reports and Assessments

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
First 5 San Joaquin – 2022-2027 Strategic Plan	First 5 San Joaquin	First 5 San Joaquin Strategic Plan	Describes First 5's five-year strategic plan (2022-2027). Details their assessment of community needs and their plan to provide programming in response to these needs within four goals: quality early learning, child health and development, resilient families, and strong systems.	• First 5 partnered with community organizations to hold 15 focus groups. Participants included parents and caregivers, service providers, recipients of Temporary Assistance for Needy Families (TANF), and members of the business community. First 5 also administered an online survey which received 189 responses from the community. • Priority needs identified: ○ Expand and enhance the availability of childcare programs ○ Enhance the childcare workforce through more professional development and recruiting a more diverse childcare workforce ○ Provide parenting skill support and more information for parents about child development ○ Ensure easily accessible food and nutrition assistance ○ Enhance access to services for children with special needs: developmental screenings, treatment/interventions and parent support for children with behavioral issues ○ Expand prenatal/perinatal care: free birth services, birth centers, and lactation consultants ○ Expand mental health care for children and caregivers ○ Expand dental health services for children • Challenges to accessing services faced by families with young children included: ○ Affordable housing ○ Financial concerns ○ Limited public transportation • Investments and strategies in the plan address: ○ High-quality childcare and preschools ○ Developmental screening and early intervention services ○ Oral health services coordination ○ Mental health supports for children and parents ○ Safe and affordable housing ○ Early literacy • Culturally and linguistically appropriate outreach strategies to publicize county services

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings

Little Manila Rising California Equitable Recovery Initiative (CERI): South Stockton Community Needs Assessment	Little Manila Rising	Not available	Details the results of Little Manila Rising's community needs assessment of South Stockton residents conducted August to December of 2023. The survey focused on health equity, including asthma mitigation, COVID-19 recovery, and mental health.	• Little Manila Rising received 57 responses to their community survey
				  ○ Racial demographics of population surveyed
				  ▪ 42% Asian
				  ▪ 35% African American/Black
				  ▪ 26% Hispanic/Latinx
				• More than half of respondents had trouble paying for basic necessities; food, utilities, and debt were sources of financial hardship.
				• Behavioral and mental health issues such as substance use and lack of information about mental health services were identified as areas of concern. Youth behavioral health services were identified as a need.
				• Concern expressed about Long COVID and co-infection with asthma
				• Hesitancy to interact with healthcare providers and financial concerns were identified as barriers to accessing health services
				• Green space, opportunities for physical activity, and grief support were recommended to support pandemic recovery in the community.
				• Recommended changes to improve public safety/health in South Stockton:
				  ○ Road and driving infrastructure improvements, such as speed bumps, traffic lights, sidewalks, and lighting
				  ○ Support for children traveling to school alone
				  ○ Increased food access and grocery stores in South Stockton
				  ○ Access to elder care centers
				  ○ Prescription medicine financial assistance
				  ○ Enhanced resources for pet care, and care for abandoned/neglected pets
				• Recommended community improvements:
				  ○ Programs for financial, economic, and civic literacy
				  ○ More community centers in neighborhoods
				  ○ More green space
				  ○ Minimize/eliminate the warehouses built by tech investors in South Stockton, which negatively impact neighborhood quality of life
				  ○ Improve local news coverage
				• Policy directions based on findings:
				  ○ Support investments addressing food insecurity
				  ○ Invest in infrastructure to make utilities more affordable and reliable
				  ○ Sustain and deploy funds from the Mental Health Services Act and other community based efforts to address mental health
				  ○ Provide health education on Long COVID
				  ○ Ensure health services staff receive cultural competency and trauma-informed practices training

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				• Increase funding for community based organizations that provide holistic support services
California Jobs First Part One Baseline Regional Assessment Report North San Joaquin Valley	North Valley Thrive	North Valley Thrive	This document presents North Valley Thrive's research on the public health and economic conditions of the North San Joaquin Valley region. This research will support the planning phase of their partnership with the California Economic Resiliency Fund (CERF) to develop a roadmap to inclusive economic prosperity for the region.	• To develop this report, researchers utilized CalEnviroScreen 4.0, Healthy Places Index, and County Health Rankings. Based on this data, researchers developed five public health "themes" and integrated public health indicators from each data source to evaluate public health conditions in the North San Joaquin Valley Region and compare them to other CERF (Community Economic Resilience Fund) regions • Behavioral and Mental Health, Including Substance Abuse ○ Shortage of mental health providers in North San Joaquin Valley (NSJV) indicates a regional inequity and worsens related inequities such as rates of substance abuse, suicide, and mental illness ○ Elevated mental health indicators for the NSJV likely reflect high levels of mental distress and low availability of mental health care in the region • Environmental ○ CalEnviroScreen ranks NSJV in the 71st percentile for environmental health risks; substantial environmental inequities are experienced in the region. ○ Lower air quality has led to large numbers of cases of asthma and Valley Fever. ○ Agricultural and growing manufacturing/transportation/warehousing industries have led to significant air, land and water pollution. ○ Need for investment in environmental cleanup and strategies to mitigate climate change • Health and Safety ○ NSJV ranks 10th out of 13 regions on the Social Vulnerability Index due to weak ability to respond to disease outbreaks and natural or man-made disasters. ○ The life expectancy inequity in NSJV is likely caused by climate impacts, environmental factors, including environmental injustices, disinvestment in the region and related economic inequalities. ○ Limited outdoor space, extreme heat, and violent crimes are barriers to physical activity for NSJV residents, leading to obesity. ○ Need to invest in green spaces in BIPOC neighborhoods • Healthcare Access and Transportation ○ Residents face barriers accessing health services because of lack of transportation and language barriers.

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				○ Low English proficiency among NSJV residents ○ Low automobile access among NSJV residents • Income, Education, and Employment ○ NSJV has the lowest ranking among the CERF regions for: asthma, cardiovascular disease, low birthweight infants, educational attainment, housing burdened low income households, linguistic isolation, poverty, and unemployment. ○ Concentration of inequities falls along racial lines and disproportionately affects BIPOC communities ○ Lower levels of educational attainment compared to CA contribute to challenges with unemployment, home ownership, and poverty. ○ English proficiency barriers affect educational attainment.
Uniform Data System (UDS) 2023 - Demographics	Community Medical Centers	Not available	This document presents changes in Community Medical Centers' (CMC) patient demographic data for the year 2023.	• Changes in patient demographics ○ Increases in: male patients, female patients, homeless patients, non-English speaking patients ○ Decreases in: migrant patients ○ Increased number of patients across racial categories ○ Increased number of patients at or below the poverty level ○ Decreased number of patients above the poverty level ○ Increased number of patients on Medicaid and Medicare ○ Stockton: patient increases in all zip codes except 95202 and 95203 ○ Lodi: patient increases in all zip codes except 95632 ○ Manteca/Tracy: patient increases in all zip codes except 95336 • Changes in services ○ Increases in patients seen and total visits ○ In person clinic visits increased and virtual visits decreased ○ Increased medical visits, dental visits, behavioral health visits, substance use disorder services, and other health and wellness supportive services ○ Number of patients/number of visits increased for: hypertension, diabetes, overweight/obesity, tuberculosis, abnormal breast findings, eye exams, oral exams, restorative services, childhood lead test screening, rehabilitative services, anxiety disorders, and other mental health disorders ○ Number of patients/number of visits decreased for: novel coronavirus, seasonal flu vaccine, selected immunizations • Quality measures ○ Decrease in occurrences for the following: childhood immunizations, breast cancer screenings, depression screening and follow-up plan,

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				colorectal cancer screenings, IVD, use of Aspirin or antithrombotic therapies, dental sealants, child/adolescent weight assessment and counseling, tobacco assessment, statin therapy, HIV linkage to care ○ Increase in occurrences for the following: Cervical cancer screenings, depression remission at 12 months, HIV screenings, uncontrolled diabetes, adult weight screening and follow-up, hypertension control

Appendix G: Community Resources

The Community Resources are organized by health need and represent a sampling of organizations addressing these health needs. The list is not exhaustive; there are many other organizations in San Joaquin County providing a variety of services and programs to address the health needs.

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Public Agencies											
San Joaquin County and City Parks and Recreation Departments	Parks and Recreation Departments develop and maintain parks/open spaces, operate facilities including aquatic centers, playgrounds, athletic fields, camps, and community centers, and provide programming that supports physical activity, youth development, relaxation and social interaction.		X	X				X			
San Joaquin County Behavioral Health Services	Provides integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of SJC residents.	X	X			X					
San Joaquin County Council of Governments	Joint-powers authority comprised of San Joaquin County and the cities of Stockton, Lodi, Manteca, Tracy, Ripon, Escalon, and Lathrop. Fosters intergovernmental coordination with local/regional jurisdictions, State and Federal agencies, the private				X	X					X

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	sector, and community groups. Facilitates and administers regional programs, and advocates for regional/inter-regional strategies. Committees include transit, coordinated transportation and land use, climate, housing and economic security.										
San Joaquin County Human Services Agency	Provides State and federally-mandated public assistance and a variety of social service programs for SJC residents. Programs include: California Work Opportunity and Responsibility to Kids (CalWORKs), Foster Care, CalFresh, General Assistance, Medi-Cal, Adoptions, Child Protective Services, Adult Protective Services, In-Home Supportive Services (IHSS), Refugee Assistance, and the Mary Graham Children's Shelter.	X	X	X		X	X	X		X	
San Joaquin County Public Health Services	In partnership with the community, protects, promotes and improves health and well-being for all who live, work, and play in San Joaquin County. Programs and services include chronic disease prevention, nutrition and physical activity, family health, tobacco control, and environmental health.	X		X			X	X		X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Mental/Behavioral Health/Substance Abuse Recovery											
Aegis Medical Systems, Inc.	Offers outpatient substance abuse treatment including detoxification, methadone maintenance, and methadone detoxification.		X								
Community Medical Centers --Recovery Center	Provides medical and behavioral assessment, case management, sobering and treatment to individuals struggling with mental health and substance use issues.		X		X						
National Alliance on Mental Illness, San Joaquin County	Raises community awareness of mental illness and provides support groups and a HelpLine to persons with mental illness and their families and friends, education and training, and advocacy.		X								
St. Joseph's Behavioral Health Center	Provides behavioral evaluations, mental/behavioral health screening, inpatient and day treatment programs, outpatient services, chemical recovery programs and referrals to community resources.	X	X								
The Wellness Center of San Joaquin County	Peer support program for people with or without a mental health diagnosis run by and for individuals with mental health challenges. Offers support groups, classes, meditation classes, one-on-one peer coaching, and substance abuse recovery groups.		X								

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Housing and Homelessness											
Affordable Housing Programs (e.g., Mercy Housing, Eden Housing, Valle Del Sol, Housing Authority County of San Joaquin, STAND, Visionary Homebuilders, Central Valley Low Income Housing Corp.)	Provide housing for low income residents through subsidized housing and rental assistance, or affordable housing units.				X	X	X			X	
Grace and Mercy, Lodi Area	Offers a safety net to persons in need and the homeless by providing dry goods, refrigerated storage, clothing for job seekers, haircuts, a soup kitchen, and shelter from severe weather.			X		X				X	
Homeless Services (e.g., St. Mary's Dining Room, St. Anne's Place, Women's Center Youth and Family Services, Stockton Shelter for the Homeless, Hope Harbor Shelter, Coalition of Tracy Citizens to Assist the Homeless, Gospel Center Rescue Mission, McHenry House Tracy Family Shelter, Tracy Community Connections Center, Tracy Interfaith Ministries)	Provide meals, health care, clothing, hygiene services, shelter and social services to homeless and working poor individuals and families.	X	X	X	X	X	X			X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
San Joaquin Continuum of Care	Provides information, resources, and leadership on evidence-based methods to end homelessness in San Joaquin County utilizing the "Continuum of Care" program developed by U.S. HUD.		X		X						
Health Care											
Federally Qualified Health Centers (e.g., Community Medical Centers, Inc., San Joaquin Community Clinics, Golden Valley Health Centers)	Outpatient clinics providing health services to low income, underinsured and high need populations.	X	X	X				X			
Hospitals/medical centers (e.g., San Joaquin General, Sutter Tracy Community Hospital, Kaiser Permanente Manteca, Adventist Health Lodi Memorial and Dameron Hospital, Dignity Health St. Joseph's Medical Center)	Multiple facilities dedicated to comprehensive outpatient and inpatient services including primary care and specialty care.	X	X	X							
MediCal Managed Care Plans (MCPs), e.g., Health Plan of San Joaquin, Health Net Community Solutions, Inc., Kaiser Permanente	MCPs work toward a more equitable health system that will result in better health outcomes for Californians by providing high-quality, equitable and comprehensive health insurance coverage.	X	X	X							

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Education											
Higher Education (San Joaquin Delta College, University of the Pacific, Humphries University, Cal State University Stanislaus)	Provide post-secondary educational opportunities and student services to build skills and enhance economic security.					X			X		
Manteca Give Every Child a Chance	Provides tutoring/homework assistance, science and technology programs, and healthy eating/active living opportunities for low income students.			X					X		
San Joaquin County School Districts (Fourteen including Lodi Unified School District, Manteca Unified School District, Stockton Unified School District, and Tracy Unified School District)	The County's 14 school districts promote a well-rounded education and ensure students have the knowledge/skills necessary for future success. The school districts set policy and performance standards, ensure compliance with laws/regulations, monitor finances, select curricula, and oversee intervention and support services (such as counseling and free and reduced price meals) for students and families.	X	X	X			X		X	X	
San Joaquin County Office of Education and Healthy Kids Resource Center	Supports education of more than 145,000 students enrolled in 14 school districts in the county. The HKRC provides access to educational resources, including health promotion resources, that can be borrowed at no cost.	X	X	X			X		X	X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Community, Families, and Children's Supports											
Amelia Ann Adams Whole Life Center	Empowers women, men and children by providing supportive services, resources, and other tools that create opportunities for individuals and families to overcome their current obstacles.		X	X		X	X	X		X	
Catholic Charities of the Diocese of Stockton	Provides direct social services and advocacy for adults, families and children including: programs for the elderly; a food bank in Stockton; supports for immigrants including family reunification, citizenship application and education; health insurance enrollment, short-term counseling services; youth engagement; Cal Fresh application assistance and environmental justice promotion.	X	X	X		X	X		X	X	
Child Abuse Prevention Council of San Joaquin County	Protects children and strengthens families through awareness and outcome driven programs including childcare, family supports and clinical services, delivered with compassion.	X	X				X				
Community Partnership for Families of San Joaquin	Provides tools, resources, and connections to help families improve their quality of life. Operates Family Resource Centers to build strong, resourceful and financially sufficient families.		X			X	X				

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Family Resource and Referral Center	Clearinghouse for information on child care services, parenting, nutrition, and child safety. Provides child care referrals and administers child care and nutritional resources. Conducts workshops on effective practices of child rearing, child care, and child safety.	X	X	X			X	X		X	
First 5 San Joaquin County	Provides financial support for health, preschool and literacy programs, and fosters the active participation of parents, caregivers, educators and community members in the lives of young children, prenatal to five years old.	X	X	X			X		X	X	
Cultural/Ethnic/LGBTQI Communities											
Asian Pacific Self Development and Residential Association	Provides a residential facility to over 200 Cambodian families as well as social services (including nutrition education, after school, mercury reduction, and recreational programs among others.)	X	X	X	X		X				
El Concilio	Empowers diverse communities to realize their greatest potential through comprehensive and compassionate programs and services that provide outreach, education, counseling, job training, classes, and awareness building of community resources and personal strengths and abilities.	X	X			X	X		X	X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Lao Family Community Empowerment Center	Provides direct service and advocacy programs to support individuals and families, and community engagement and outreach services on behalf of other agencies wanting to reach the Southeast Asian community. Preserves cultural traditions.		X			X	X				
Little Manila Rising	Provides education and leadership development opportunities to preserve and revitalize the Filipino American community. Offers holistic, culturally rooted community healing and after school, environmental justice, martial arts, dance and other programming. Conducts social justice advocacy.		X	X		X	X	X	X		
San Joaquin Pride Center	Serves the LGBTQ community by creating a safe and welcoming space, providing resources that enrich body, mind and spirit, and by educating the public on tolerance and respect for all people within the LGBTQ community.	X	X					X			
Youth Services											
The One-Eighty	Safe place for teens for mentoring, relationship building, and support systems that promote positive youth development through meaningful activities, adolescent		X	X		X	X	X	X		

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	counseling, gang prevention, and life skills programs.										
Boys and Girls Clubs (Tracy, Manteca, Lodi, Stockton)	Enable young people, especially those with high needs, to reach their full potential as productive, caring, responsible community members. Provide afterschool, academic and health programs, and character and leadership development opportunities for youth.		X	X		X	X	X			
Lord's Gym City Center	Provides a safe and fun environment for youth to build their confidence, form friendships, engage in physical activity and games, and further their educations.		X	X			X	X	X		
Women's Center - Youth and Family Services	Offers a safe haven and place of healing for vulnerable populations in the community. Provides free, confidential services and shelters designed to meet the needs of homeless and runaway youth and victims of domestic violence, sexual assault and human trafficking.	X	X		X		X	X			

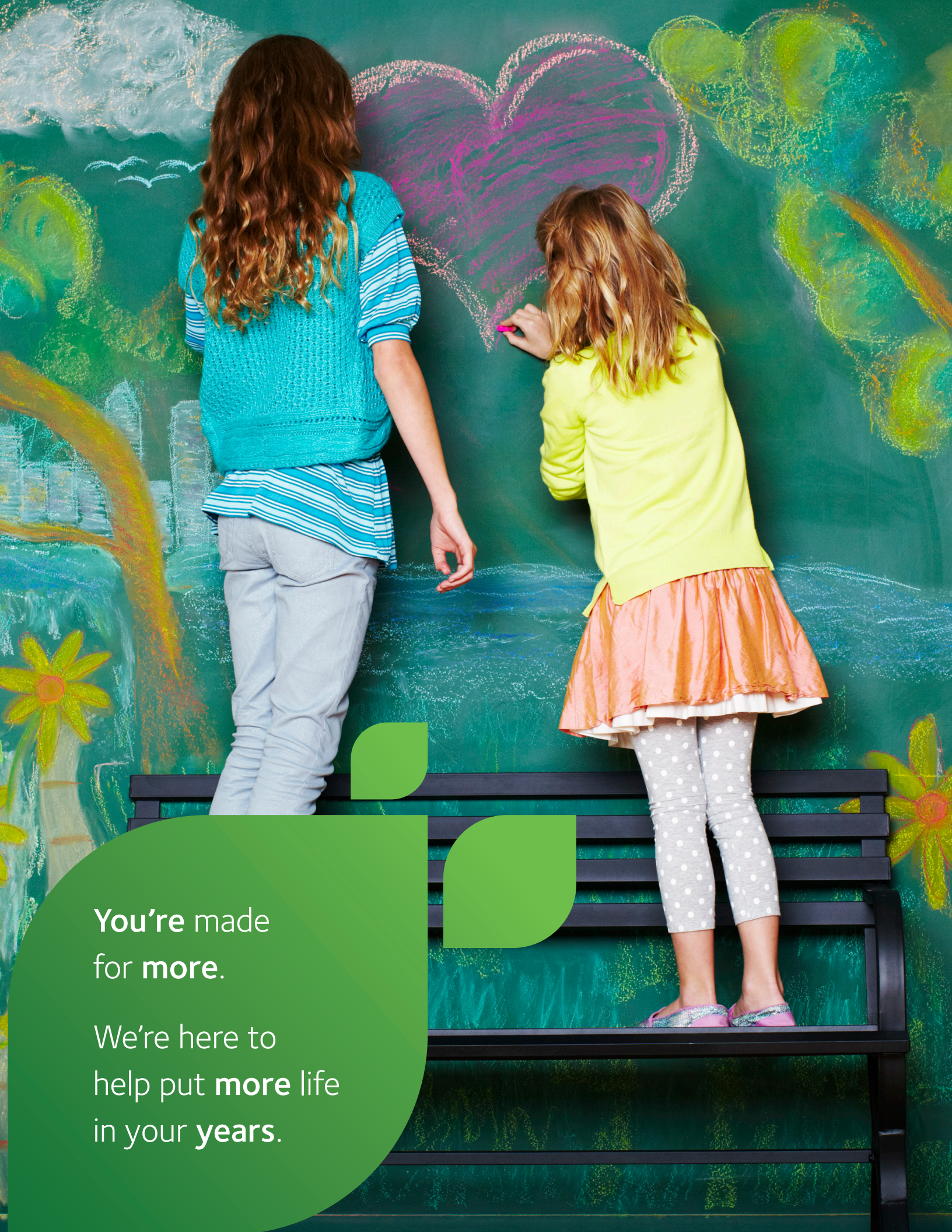
Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
YMCA of San Joaquin County	Builds youth social skills and relationships and improves health and educational achievement through programs such as youth sports, camp, aquatics, and high school enrichment.		X	X				X	X		
Food Security											
Emergency Food Bank of Stockton/San Joaquin	Families and individuals in need of emergency food assistance can visit the Emergency Food Bank's on-site food pantry. Other programs include: Mobile Farmer's Market, Nutrition on the Move Education Classes, CalFresh outreach, Partner Pantries, and job training.			X		X			X	X	
Women, Infant and Children's Program (WIC), Supplemental Nutrition Program, Tracy, Stockton, Lodi, Manteca	Offers food vouchers, nutrition education and counseling, and health care referrals to low income pregnant or postpartum women, infants and children up to age 5.	X		X					X	X	
Older Adult Services											
Senior Centers in San Joaquin County, e.g., LOEL Senior Center (Lodi), Lolly Hansen Senior Center (Tracy), Manteca Senior Center, Oak Park Senior Citizens Center (Stockton), Stockton PACE Center, City Parks and Recreation Departments	Multi-purpose senior centers serve adults aged 50 and above with a variety of programs to encourage social interaction, promote healthy eating and physical activity, and contribute to overall healthy aging.		X	X			X			X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Employment and Economic Assistance											
Energy Assistance Programs (e.g., HEAP, REACH, PG & E)	Assist low income residents with paying utility bills.					X					
San Joaquin County WorkNet	Offers programs specifically designed for individuals seeking employment. At the Lodi and Stockton WorkNet Centers, orientations provide information about training, EDD services, and re-employment supports.					X					
Oral Health											
San Joaquin Treatment & Education for Everyone on Teeth & Health (SJ TEETH) Collaborative	Coalition composed of First 5 San Joaquin, San Joaquin County Public Health Services, dentists, nonprofit organizations, and other partners working together to prevent and treat oral diseases in children, increase awareness of the importance of dental health to overall health, and increase access to dental services.	X		X							
St. Raphael's Free Dental Clinic	Community based dental center that provides free dental services and information/education on dental health and prevention for low income people.	X									
Stockton Unified School-based Dental Program	Provides dental clinics at numerous school sites to students with or without insurance.	X									

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Active Transportation											
San Joaquin Bike Coalition	Advocates for bicycle safety, holds bicycle related events and serves as a hub for the advancement of bicycles in the community. Works with local government to implement bicycle lanes and provides resources for motorists and cyclists.			X				X			X
UC Cooperative Extension of San Joaquin County	Bridges local issues and UC research. Campus-based specialists and county-based farm, home and youth advisors work as teams to bring practical, unbiased, science-based answers to problems. Advocates for healthy communities, promotes nutritious foods and exercise for better health, and provides the 4-H Youth Development Program.		X	X							
Other											
2-1-1 San Joaquin	An online and phone database for referrals to health and social services. Available 24 hours a day, 7 days a week with assistance provided in over 200 languages.	X	X	X	X	X	X	X	X	X	X
California Human Development, San Joaquin Country	Provides job training, affordable housing support, disabilities services, substance abuse treatment/sober living, and immigration	X	X	X	X	X	X				

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	and citizenship resources. The headquarters are located in Lodi.										
Disability Resource Agency for Independent Living (DRAIL)	Increases the independence of persons with disabilities through services such as housing and personal assistant referral, peer counseling, benefits advising, independent living skills training, and advocacy.	X	X	X	X	X	X				
LOVE, Inc. Manteca	Provides social services through faith-based organizations/churches. Supports ministries to respond to communities' unmet needs including food, clothing, furniture, bicycles, transportation to medical appointments, and prescription assistance.	X	X	X		X	X			X	X
Public Health Advocates, Stockton Office	Helps neighborhoods and schools become places that nurture wellness by creating equitable physical, social, and economic conditions for health. The REACH project promotes healthy eating/physical activity and expanded access to healthy foods in neighborhoods and organizations serving Stockton's African American residents. Engages residents in working with city leaders.		X	X							

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Restore the Delta	Provides public education and outreach to raise awareness of the Sacramento-San Joaquin Delta as a valuable part of the natural environment. Fights for fishable, farmable, swimmable, and drinkable Delta waters. Advocates for water sustainability policies.			X							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APPROVAL PAGE

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

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

Brook McCollough
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