Community Health Improvement Plan for San Joaquin County

2026 - 2028

PREPARED FOR:

The Healthier San Joaquin Collaborative

JULY 2025

PREPARED BY:

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Letter from the Healthier San Joaquin Collaborative CHNA/CHIP Core Team

This Community Health Improvement Plan (CHIP) guides collective efforts to address health throughout San Joaquin County, particularly in communities experiencing the greatest health disparities. The approach laid out in this plan builds on the priority health needs identified in the 2025 Community Health Needs Assessment (CHNA).

The CHNA and this CHIP are the products of a collaborative effort that engaged nearly 2000 individuals throughout San Joaquin County who provided diverse perspectives on opportunities for and challenges to health and wellness. County residents were essential to the process; they shared their knowledge and life experience to inform the selection of priority health needs and strategies. Agency and organizational partners were critical to data collection, prioritization of health needs and building the CHIP strategies.

The aim is for this CHIP to guide local decision makers, key stakeholders, and the community-at-large to work together to improve health and address disparities. The CHIP defines a path forward while accounting for the changing funding, policy and health landscape.

We are grateful to all who contributed to this CHIP and look forward to ongoing partnership which strengthens existing efforts, leverages the power of collaboration to achieve collective impact, and ultimately builds a healthier community moving forward.

This CHIP report, as well as the 2025 CHNA are available online at https://www.healthiersanjoaquin.org/.

We look forward to working with you.

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Executive Summary

As the northernmost county in the Central Valley, San Joaquin bridges northern and central California and is among the fastest growing counties in the state. San Joaquin is home to eight cities, many small towns, and a number of rural farm and ranching communities. County residents are diverse, including Hispanic/Latino, Black/African American, Caucasian and Asian/Pacific Islander populations. San Joaquin's geographic position makes it well situated for business and industry, and the County has many growth opportunities and a variety of assets and resources to support health. At the same time, health disparities are present among San Joaquin's racial/ethnic groups and many residents face significant challenges in terms of economic security, educational inequities, and poor health outcomes when compared to California overall.

From March 2024 through April 2025, the San Joaquin County 2025 Community Health Needs Assessment (CHNA) was conducted to present a comprehensive picture of community health, encompassing the conditions that impact health in the County. The CHNA was designed to inform and engage local decision makers, key stakeholders, and community members in a collaborative effort to identify local needs and improve the health and wellbeing of all San Joaquin County residents. The process in 2025 was inclusive and comprehensive, guided by a Core Team planning group (San Joaquin County Public Health Services, San Joaquin County Behavioral Health Services, San Joaquin County's nonprofit hospitals, Medi-Cal managed care plans, federally qualified health centers as well as representatives from the philanthropic and education sectors, Reinvent South Stockton Coalition and First 5 San Joaquin) and broadly representative Steering Committee, with input from County residents. The 2025 CHNA included interviews with 12 key informants, 40 focus group discussions with 350 community residents, and data analyses for over 100 indicators, creating a robust picture of the issues affecting residents' health.

The 2025 CHNA report placed particular emphasis on the health issues and contributing factors that impact historically marginalized populations that disproportionately have poor health outcomes across multiple health needs. It 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 were helpful for identifying interventions that promote health equity.

Building on the 2025 CHNA, San Joaquin County created its Community Health Improvement Plan (CHIP) with an approach aimed at achieving maximum collective impact. Like the 2025 CHNA, the 2025 CHIP process was a function of the Healthier San Joaquin Collaborative, guided by the Core Team, who engaged the Steering Committee. The Core Team was responsible for planning and key decision making, including providing review and input into the CHIP report. The broadly representative Steering Committee assisted with collecting survey data, selecting priorities, and building out the CHIP.

The CHIP focuses on three prioritized health needs and presents a select list of key strategies. CHIP strategies will be implemented jointly by multiple collaborators. Public agencies, managed care plans, hospital/health care systems, and community organizations will be encouraged to coordinate and target resources, particularly in the Priority Neighborhoods identified in the CHNA, to address disparities.

The CHIP process identified **three priority health needs and corresponding goals** for strategic attention.

Mental health/substance use (MH/SU)
Goal: All community members have access to high quality Mental health/substance use education, prevention, and programming.

Access to care
Goal: All community members have access to comprehensive, quality healthcare to achieve and maintain health and increase quality of life.

Chronic disease/healthy eating, active living (HEAL)
Goal: Help community members prevent/manage chronic disease, with emphasis on reducing risk factors associated with access to healthy food and physical activity.

To address the selected health needs, the Core Team and Steering Committee identified objectives, strategies/activities, measures and potential leads/partners, which are included in this CHIP report. A Year 1 action plan was also developed and is included. It is important to note that the CHIP is a living document; work has already begun to add specificity to the strategies and action steps, and to determine how best to monitor progress. As a result, it is anticipated that plans will be adjusted as San Joaquin County moves forward in implementing the CHIP through 2028 and beyond.

The CHIP is an inclusive, county-wide effort. The Core Team and Steering Committee encourage community members and community organizations to participate in implementing the strategies. There are a variety of opportunities for collaboration, including outreach to and engagement of community members, implementing specific interventions, or collecting feedback and data to support tracking and evaluation of CHIP progress. If the selected strategies and activities are not part of an organization's/agency's core mission, it is hoped they can find ways to complement CHIP efforts.

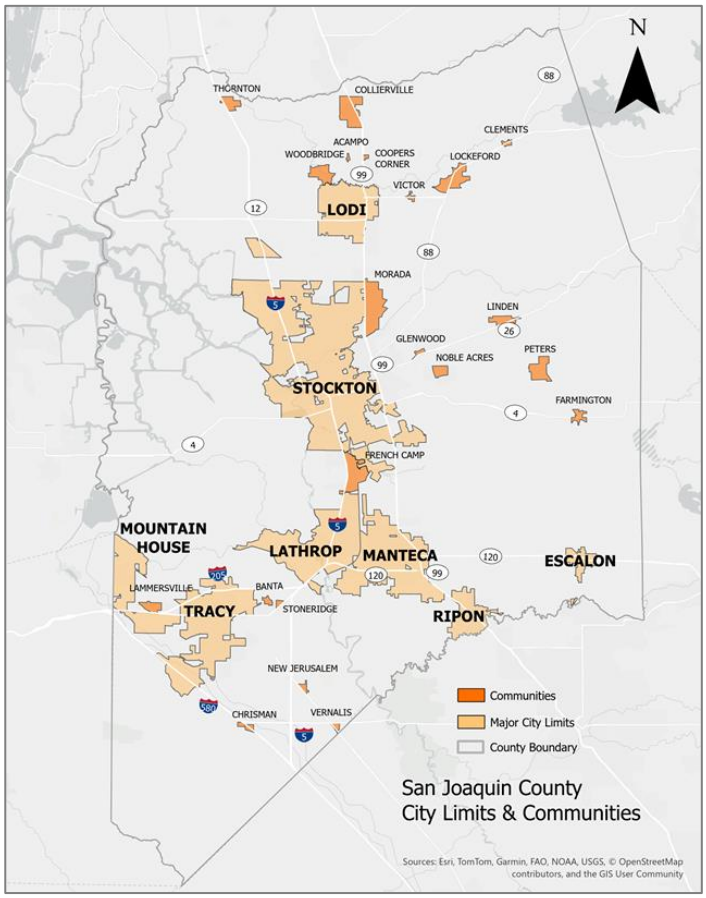
Organizations, public agencies, or San Joaquin County community members seeking to contribute to the CHIP activities should contact the San Joaquin County Public Health Director/Director of Nursing Renee Sunseri, DNP, MS, RN, PHN, NEA-BC (rsunseri@sjcphs.org) or any other Core Team member for more information.

Community Health Improvement Plan

I. Background: San Joaquin County

San Joaquin County is the northernmost county in the Central Valley; its geographic position places the County within a dynamic growth corridor for business and industry, and San Joaquin County has a history as and continues to be a highly productive agricultural center. The County, roughly 60 miles east of San Francisco and 35 miles south of Sacramento, has a total population of 779,445 (US Census, 2022) and encompasses an area of 1,426 square miles, with 35 square miles of water and waterways. Stockton is the County's large urban core, and there are several smaller cities (Escalon, Lathrop, Lodi, Manteca, Mountain House, Ripon, and Tracy) and many ranching and farming communities (Figure 1). Communities and cities maintain their unique geographic identities, separated by agriculture and open space lands.

Figure 1: San Joaquin County map



San Joaquin County is one of California's fastest growing counties, home to diverse racial and ethnic populations; over 40% of residents are Hispanic/Latino, 29% are White, 17% are Asian and 7% are Black/African American (US Census, 2022). Almost half of the population speaks a language other than English at home (U.S. Census Bureau, 2023 American Community Survey 1–Year Estimates, Table B16001).

San Joaquin is a county of contrasts; there are 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. Some neighborhoods have links to well-paying jobs in nearby counties, while residents in other neighborhoods struggle to find local living wage jobs and cope with high crime rates. Many San Joaquin County residents face challenges around economic security which impact physical and mental health. Compared to California overall, San Joaquin County has higher unemployment and lower average income, especially among people of color;

this limits access to health promoting community assets and exacerbates chronic disease and disability while also eroding mental health. Health care provider shortages within the County can lead to poor health outcomes and residents experience a number of disease related challenges and health disparities. Obesity rates and diabetes prevalence were higher in San Joaquin County as compared to California overall, with adults of color having significantly higher rates of obesity than their White neighbors. County residents experience significant disparities related to the prevalence of and hospitalization for cardiovascular diseases and asthma. A number of mental health and substance use indicators compare poorly to California; County residents have access to significantly fewer mental health care providers than the state average; deaths of despair (due to suicide, alcohol related disease, and drug overdoses) have increased in the County over the past three years and are higher than California overall, with Black/African American residents experiencing significantly more opioid overdose deaths than White residents; there are also more smokers among the County population than the state average.

II. Overview of the San Joaquin County Community Health Needs Assessment (CHNA)

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 health for San Joaquin County residents, especially in diverse, low-income communities. The 2025 CHNA report is available at www.healthiersanjoaquin.org.

The 2025 CHNA meets federal requirements and fulfills one of San Joaquin County Public Health Service's requirements for national Public Health Accreditation. From data collection and analysis to the identification of prioritized needs and implementation strategies, the development of the 2025 CHNA report was an inclusive and comprehensive process guided by a Core Team planning group and a broadly representative Steering Committee (See Appendix A). As many community members as possible were engaged in the process; opinions were sought from decision makers and key stakeholders and—more importantly—from hundreds of community members whose voices are not often heard.

A social determinants of health framework was employed for the CHNA and guided examination of 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 disease and death rates and contributing factors, exploring disparities for populations experiencing poor health outcomes across multiple health needs including populations residing in specific geographies referred to as "Priority Neighborhoods" and among the County's diverse ethnic populations.

A. Priority Neighborhoods: Focus on disparities

The 14 Priority Neighborhoods encompass specific geographies (Figure 2) located throughout San Joaquin County; implementing CHIP activities in these neighborhoods will serve the populations experiencing the greatest physical and mental health disparities as well as an historic lack of infrastructure investment. Demographic data, root causes of health indicators, and birth and death statistics for each Priority Neighborhood can be found in the 2025 CHNA.[1]

Figure 2: Priority Neighborhoods

Census Tract	City	Neighborhood Street Boundaries
1.01 and 1.02	Stockton	Union/Aurora on the east, Park on the north, Hazelton on the south, and Madison/El Dorado on the west.
3	Stockton	Madison/El Dorado on the east, Park on the north, Hazelton/Scotts on the south, and I-5 on the west.
6	Stockton	Union/Aurora on the west, Charter on the south, Main on the north, and Wilson on the east.
7	Stockton	I-5 on the west, Charter on the south, Hazelton/Scotts on the north, and Union/Aurora on the east.
16	Stockton	Wilson on the west, Weber/Miner on the south, Harding/Cherokee on the north, and D/E St. on the east.
22.01	Stockton	Union/Aurora on the west, Duck Creek Levee on the south, Charter on the north, and Scribner/Bieghle on the east.
27.01	Stockton (Garden Acres)	Highway 99 on the west, Main on the south, Stokes/Cardinal on the north, and Del Mar on the east.
33.12	Stockton	El Dorado on the west, Bianchi on the south, Woodstock/Camanche on the north, and Colebrook/Burnham on the east.
38.03	French Camp	San Joaquin River on the west, Bowman and Roth on the south, French Camp on the north, and Highway 99 on the east.
40.01	Thornton	Mokelumne River on the west and north, White Slough on the south, and I-5 on the east.
44.03	Lodi	Sacramento/Stockton on the west, Kettleman on the south, Lodi on the north, and Central on the east.
47.01	Lockeford	Tretheway on the west, Brandt on the south, Mokelumne River on the north, and Disch on the east.
51.09	Manteca	Main on the west, Moffat on the south, Edison on the north, and Powers on the east.
53.03	Tracy	Tracy on the west, 11th on the south, Grant Line on the north, and Holly on the east.

[1] San Joaquin County 2025 Community Health Needs Assessment, May 2025.

B. Mixed-methods approach for 2025 CHNA

Secondary/Quantitative Data: A review and analysis of community health indicators provided understanding of the drivers of health outcomes in San Joaquin County, including understanding racial/ethnic disparities and comparing local indicators with state benchmarks. The 2025 CHNA data was compiled by San Joaquin County Public Health Services (PHS) and generally follows the health needs and indicators found in the Kaiser Permanente (KP) Community Health Data Platform (KP Platform)[2]. 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.

Primary/Qualitative Data: Key informant interviews and focus groups were conducted to gather a wide range of opinions on health needs with greatest impact on community members, examples of existing resources that address those health needs, and suggestions for continued progress in addressing the needs.

C. CHNA health need prioritization

The analyzed quantitative and qualitative data were triangulated to identify the top health needs in the County and summary health need profiles were created. The following criteria were used to prioritize the 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.

After points were assigned to each health need for the above criteria, scores were totaled for the health needs. The CHNA report describes the process of assigning points to the secondary data and primary data.[3] Scores for health need rankings from the 2022 CHNA and CHIP processes were also factored into the overall health need scores. Scores for health needs were then normalized to a 100 point scale, producing a list of the health needs in rank order as shown in Figure 3.

At the January 2025 Steering Committee meeting, the health need profiles containing secondary and primary data were presented and discussed during small group breakouts. In addition, the CHNA findings and the health need prioritization were presented at four community meetings where attendees provided input and concurred that each of the health needs was important and that the health needs are interrelated.

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

[3] San Joaquin County 2025 Community Health Needs Assessment, May 2025.

Figure 3: 2025 CHNA Prioritized Health Needs

Highest Priority
Access to care
Mental health/substance use (MH/SU)
Chronic disease/healthy eating, active living (HEAL)
Medium Priority
Housing
Economics
Social support
Lower Priority
Community safety
Education
Food security
Transportation

San Joaquin County used the results of the 2025 CHNA to drive the development of this CHIP. In addition, each of the County's nonprofit hospitals will develop an individualized implementation plan for their service area, with strategies tailored to build on a hospital's individual assets and resources. Their Implementation Strategies will be filed with the Internal Revenue Service.

III. Purpose of the CHIP

The CHIP is a systematic plan to address the health needs emerging from the CHNA process.[4] It serves as a guide for collaborators county-wide to align efforts, coordinating and focusing resources on agreed upon intervention objectives and strategies. The aim of the CHIP is to have a collective impact, improving the health and wellness of County residents.

Like the San Joaquin County CHNA, this CHIP takes a holistic view of health, in line with the World Health Organization definition which states that health is complete physical, mental and social wellbeing and not the mere absence of infirmity.[5] The CHIP

[4] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment

[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

embodies a public health framework that defines the goal of health promotion as a combination of approaches for addressing the social determinants of health with the commitment to facilitate and encourage individuals and communities to take an active approach to achieving health.[6,7]

Ultimately, this CHIP is intended to focus on health disparities and to promote equal opportunities for all community members to be healthy and to seek the highest level of health possible.[8]

IV. CHIP Process

The CHIP process was a function of the Healthier San Joaquin Collaborative and was guided by the Core Team, which engaged the Steering Committee (Appendix A). The Core Team included San Joaquin County Public Health Services, San Joaquin County Behavioral Health Services, San Joaquin County's nonprofit hospitals, Medi-Cal managed care plans, federally qualified health centers as well as representatives from the philanthropic and education sectors, the Reinvent South Stockton Coalition and First 5 San Joaquin.

The Core Team was responsible for planning and key decision making, including providing review and input into this CHIP report. The broadly representative Steering Committee (which included public agencies, community organizations, organizations representing County residents disproportionately impacted by conditions leading to poor health outcomes, educational institutions and local leaders) assisted with collecting survey data to inform strategy development, identifying and prioritizing strategies and activities, and building out the CHIP (Figure 4).

Figure 4: CHIP Process Steps

Developing the CHIP was a systematic process that involved input from community members, the Core Team and the Steering Committee.

Step 1: With Core Team guidance, a survey was developed to identify County residents' top priority interventions to address the needs selected for the CHIP (Access to care, Mental health/substance use, and Chronic disease/HEAL). Steering Committee members conducted the survey with County residents.

Step 2: The Steering Committee convened to identify strategies and activities to address the needs, including identifying lead and partner organizations as well as a timeline.

Step 3: A draft CHIP was developed, including objectives, strategies/activities, measures, and lead and partner organizations. The Core Team reviewed and further refined the CHIP. A Year 1 Action Plan was developed as a companion to the CHIP to facilitate the initiation of CHIP activities.

Step 4: The CHIP was sent out for comment.

Step 5: The CHIP was revised based on input and finalized.

[6] World Health Organization. Global conferences on health promotion – charters, declarations and other documents: Available at: https://www.who.int/health-topics/health-promotion#tab=tab_1
[7] Tulchinski T, Varavikova EA. The new public health. 3rd ed. San Diego: Elsevier Academic Press; 2014. p. 884.
[8] https://healthequity.sfsu.edu/health-equity-resources

In April 2025, following the completion of the CHNA, the Core Team initiated the CHIP process. The methods for the 2025 CHIP were aligned with the Mobilizing for Action through Planning and Partnerships (MAPP)[9] process and focused on:

- Garnering County resident input into the CHIP via a survey.
- Achieving maximum impact through leveraging efforts already underway and sustaining momentum through partnership among Steering Committee members to conduct asset and gap analyses and promote funding and policy solutions that lead to systems level change.
- Planning for CHIP implementation to improve health and reduce health disparities experienced by community members.
- Creating a plan to align funders, public agencies and community organizations to have a collective impact on a defined set of interventions, working county-wide with emphasis in the Priority Neighborhoods.

V. CHIP Community Resident Survey

A. Methods

The purpose of the ten-item multiple-choice CHIP Community Resident Survey was to capture residents' opinions on the most important strategies to address each of the health needs selected for the CHIP (Mental health/substance use, Access to care, and Chronic disease/HEAL); in addition, the survey gathered demographics (age, race/ethnicity, language, gender and sexual identity, and location of residence) and health status. See Appendix B for detailed findings on respondent demographics.

Community organizations that participate in the CHNA/CHIP Steering Committee conducted the survey with County residents. Surveys were completed via paper and pencil (n=135) and online (n=1394) in English and Spanish for a total of 1529 respondents. Nine percent of surveys were completed in Spanish.

B. Limitations

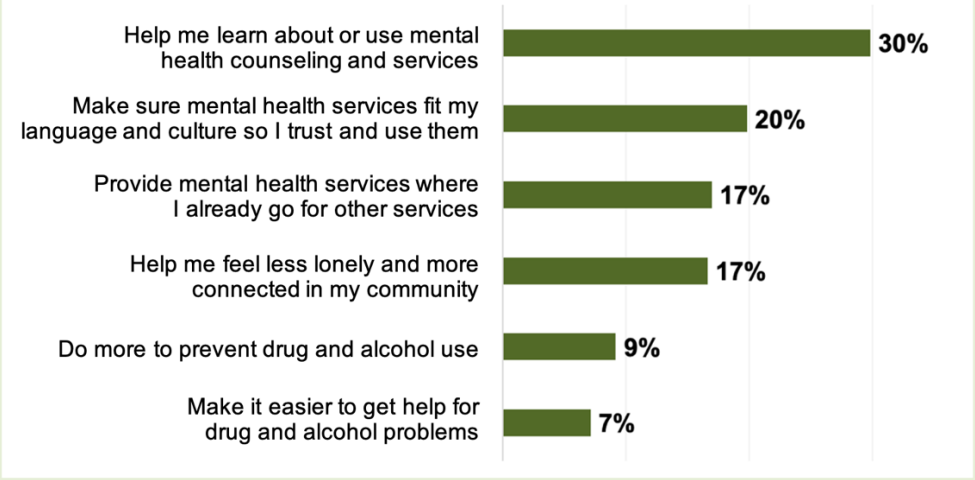
While the survey was successful in reaching a large number of County residents, a few limitations can be noted. The survey was offered in English and Spanish only. Residents not served by community organizations/public agencies as well as Hispanic/Latino and Asian residents were underrepresented among survey respondents. The survey employed only a small number of multiple-choice questions for ease of completion; a more in-depth survey may have gleaned additional findings.

[9] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

C. Survey Results

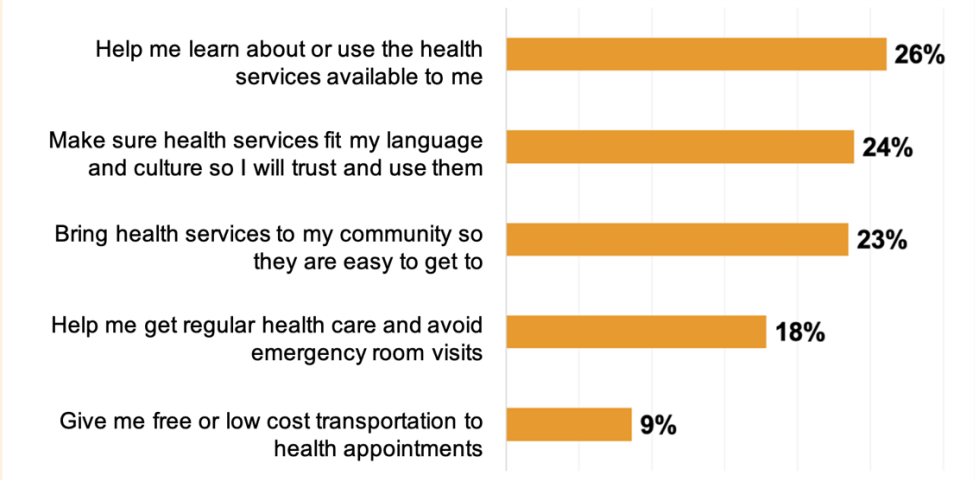
Mental health/substance use: ***Help me learn about or use mental health counseling and services*** emerged as the preferred strategy (30%).

Figure 5: Mental health/substance use priority strategies



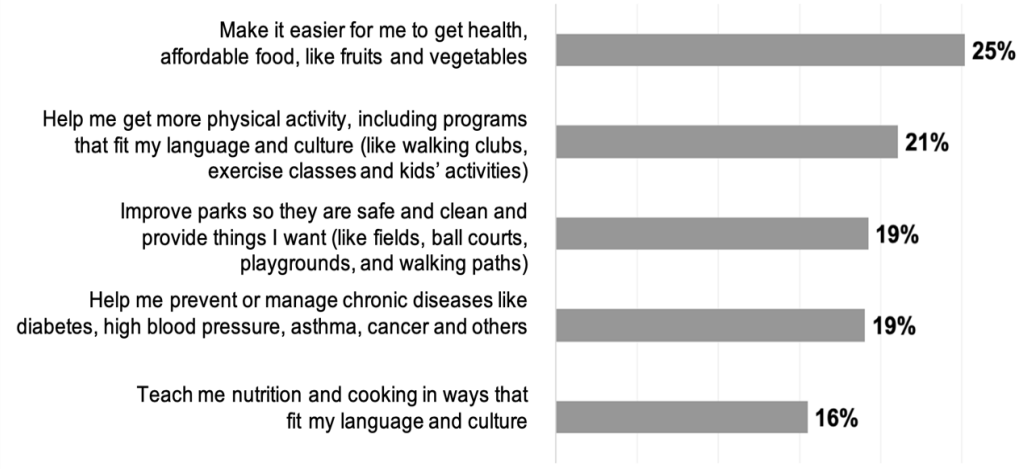
Access to care: The largest percentage of respondents (26%) chose ***Help me learn about or use the health services available to me*** as the most important strategy.

Figure 6: Access to care priority strategies



Chronic disease/HEAL: The largest percentage of respondents (25%) selected ***Make it easier to get healthy affordable food, like fruits and vegetables*** as their priority strategy.

Figure 7: Chronic disease/HEAL priority strategies



VI. Building Out the CHIP

The highest scoring health needs from the 2025 CHNA were selected as the CHIP needs to address (Figure 8). The Core Team identified Mental health/substance use as the highest priority need to build out first during the CHIP planning process.

Figure 8: CHIP Health Needs and Goals

	Health need	Goal
	Mental health/substance use	All community members have access to high quality Mental health/substance use education, prevention, and programming.
	Access to care	All community members have access to comprehensive, quality healthcare to achieve and maintain health and increase quality of life.
	Chronic disease/ HEAL	Help community members prevent/manage chronic disease, with emphasis on reducing risk factors associated with access to healthy food and physical activity.

At the April 2025 Steering Committee meeting, approximately 47 attendees completed worksheets on and discussed current efforts and partnership and policy opportunities related to Mental health/substance use. After the meeting, the information provided by Steering Committee members was analyzed and synthesized, resulting in a list of 11 potential CHIP strategies to address Mental health/substance use.

Guided by the criteria in Figure 9, the Core Team voted to select 2 strategies as the focus for Mental health/substance use action. Measures for the selected strategies were gleaned from Core Team and Steering Committee discussions. The Core Team also provided guidance on the development of the goal and objectives for Mental health/substance use.

At the second CHIP meeting (May 2025), 30 Steering Committee members broke into small groups to review and refine activities needed to implement each Mental health/substance use key strategy. Participant discussion focused on:

1. Refining strategies/activities to ensure feasibility.
2. Adding missing strategies/activities
3. Strengthening policy strategies/activities
4. Identifying potential lead and partner organizations
5. Assigning the CHIP year (1, 2, or 3) in which each strategy/activity will be initiated.

Following the meeting, the key themes from the Steering Committee discussion were integrated into the CHIP matrix and formed the basis of a draft Year 1 Action Plan.

Figure 9: Criteria Guiding CHIP Strategy Prioritization

- Greatest potential for collective impact
- Builds on ongoing work
- Feasible to accomplish in 3 years
- Resources (cash or in kind) currently available or easy to obtain for the strategy
- There is a clear owner/lead for the strategy (Core Team or Steering Committee member)

Between the second and third Steering Committee meetings, San Joaquin County Public Health Services refined and built out the CHIP Matrix for Access to care and Chronic disease/HEAL, identifying objectives, strategies and measures. Work will continue to further build out and add specificity to these sections of the CHIP Matrix.

At a third Steering Committee meeting (June 2025), 29 attendees developed a Year 1 Action Plan for the Mental health/substance use, specifying the initial action steps needed to implement the CHIP strategies/activities, the Year 1 timeline for implementation, and the composition of workgroups (public agencies and community organizations) who will lead implementation. In addition, the Steering Committee reviewed the Access to care and Chronic disease/HEAL sections of the matrix, provided

feedback and discussed plans for continuing to build out strategies to address these needs as well as the Year 1 Action Plan.

VII. CHIP Implementation

CHIP implementation partners will work throughout the County with concerted efforts in the Priority Neighborhoods, where resources can be aligned across organizations and agencies to address the greatest disparities and needs. The CHIP aims to guide development or enhancement and implementation of policies, systems, and programs that achieve measurable changes to promote good mental health and decrease substance use, improve access to health care and prevent chronic disease and enhance healthy eating and active living for San Joaquin residents. This CHIP is inclusive and provides a broad spectrum of roles for all community partners from implementing specific CHIP strategies to outreach and engagement of San Joaquin's diverse community members.

Appendix E lists potential assets that can be mobilized for CHIP implementation.

VIII. Policies to Support Successful CHIP Implementation

For San Joaquin County to achieve the CHIP objectives and successfully address disparities, there is a need to develop and promote policies that drive systems change. The CHIP matrix (Appendix C) includes policy strategies that are aimed at improving organizational and public structures, programs, and practices to make progress towards the CHIP goals.

The CHIP policy strategies include:

Mental health/substance use	• Identify or create model policies to institutionalize CHW staff positions in public agencies, health care, and community organizations, including policies that:
	  ○ Formalize CHW career paths
	  ○ Provide a living wage for CHWs
	• Support ongoing adoption of trauma informed policies (by health care and other county organizations and agencies) related to Mental health/substance use

Access to care	• Research and elevate policy strategies to address funding cut impact on access to care and health insurance.
Chronic disease/HEAL	• Research and elevate policy strategies to address healthy eating and active living.

San Joaquin County Public Health Services will support policy strategy implementation through the following actions:

- Convene stakeholders to:
  - Further define policy strategies
  - Identify specific, effective mechanisms for policy improvement
- Facilitate change to policies that are within the PHS purview
- Employ technical evaluation to inform policy advocacy with data and lessons learned

IX. SJC CHIP Alignment with Other Health Improvement Initiatives

The CHIP priority health needs and strategies align with and complement a number of California and Federal initiatives (Figure 10).

Figure 10: Aligned San Joaquin County, State and Federal Priority Placed on Mental health/substance use, Access to care, and Chronic disease/HEAL

San Joaquin County Priority Health Need		
Mental health/substance use	STATE	**CalAIM Behavioral Health Initiative:** https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx The behavioral health components of CalAIM support whole-person, integrated care; move the administration of Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform. **CA Behavioral Health Services Act (BHSA) (Proposition 1):** https://www.dhcs.ca.gov/BHT/Pages/FAQ-BHS-Act.aspx The BHSA (aka Prop. 1), passed in March 2024, aims to strengthen California's behavioral health system by funding mental health treatment, substance use disorder services, and supportive housing for veterans and individuals facing homelessness. Ensuring equitable access to these essential services is critical as the state works to address both housing insecurity and behavioral health needs across diverse populations. **Children and Youth Behavioral Health Initiative (CYBHI):** https://cybhi.chhs.ca.gov CYBHI reimagines and transforms the way California supports children, youth and families, seeking to ensure kids and families can find support for their emotional, mental and behavioral health needs, when, where and in the way they need it most.
	FEDERAL	**Healthy People 2030 Overarching Goals:** https://odphp.health.gov/healthypeople/about/healthy-people-2030-framework Promote healthy development, healthy behaviors, and well-being across all life stages. **Healthy People 2030 Mental Health Objectives:** https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders Increase the proportion of adults with depression who get treatment Increase the proportion of children and adolescents who get preventive mental health care in school
Access to care	STATE	**Providing Access and Transforming Health (PATH):** https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM-PATH.aspx PATH, a 5-year, $1.85 billion initiative, addresses gaps in local CA organizational capacity and infrastructure, enabling local partners to scale services they provide to Medi-Cal beneficiaries. With resources funded by PATH—such as additional staff, billing systems, and data exchange capabilities—community partners will successfully contract with managed care organizations, bringing their wealth of expertise in community needs to the Medi-Cal delivery system.
	FEDERAL	**Healthy People 2030 Overarching Goals:** https://odphp.health.gov/healthypeople/about/healthy-people-2030-framework Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all. **Healthy People 2030 Health Care Access and Quality Objectives:** https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality Increase the proportion of adults who get recommended evidence-based preventive health care
Chronic disease/HEAL	STATE	**CalFresh Healthy Living Program:** https://calfresh.dss.ca.gov/healthyliving/home CalFresh Healthy Living (SNAP-Ed) supports healthy, active and nourished lifestyles by teaching Californians about good nutrition and how to stretch their food dollars, while also building partnerships in communities to make the healthy choice, the easy choice.
	FEDERAL	**Healthy People 2030 Overarching Goals:** https://odphp.health.gov/healthypeople/about/healthy-people-2030-framework Promote healthy development, healthy behaviors, and well-being across all life stages. **Healthy People 2030 Nutrition and Healthy Eating Objectives:** https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating Reduce household food insecurity and hunger

X. Statement of Need

For each of the three CHIP health needs selected to address, health data and community leader and resident perspectives are described to illustrate the importance of the need in San Joaquin County.

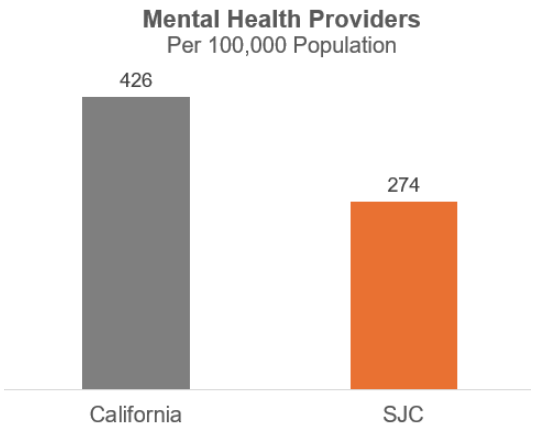
Mental health including substance use

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*

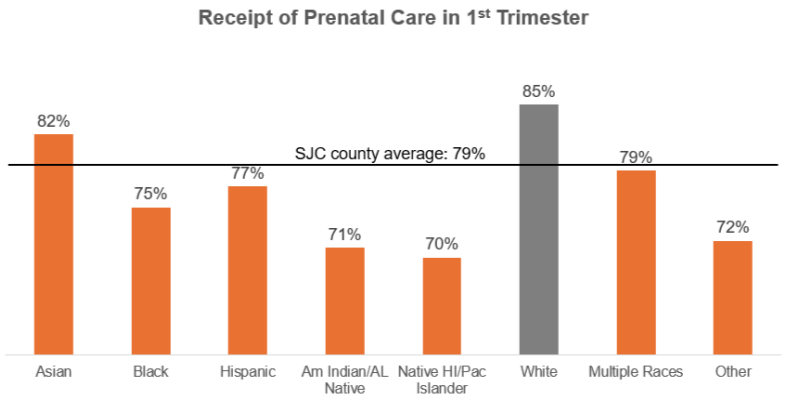
- Key informants observed that SJC is deficient in substance use treatment services tailored to the needs of underserved groups, noting the lack of residential treatment for youth and services for LGBTQIA+ individuals based on harm reduction principles.
- Substance use was perceived by focus group participants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

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.

> "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*

- 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.
- 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.
- 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.

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

Chronic Disease/Healthy Eating Active Living (HEAL)

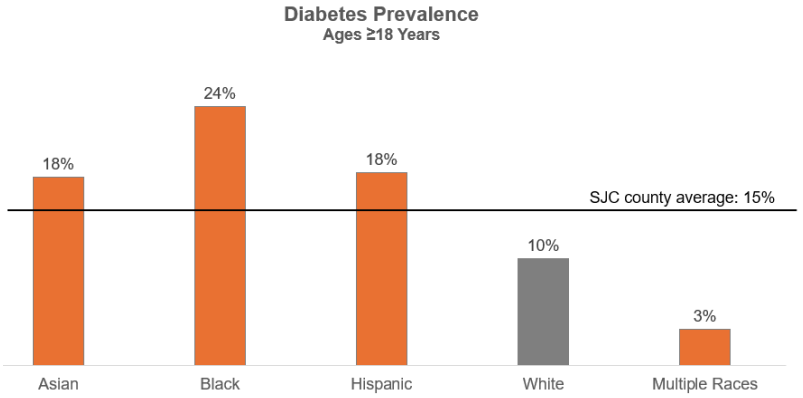
Rationale: Why this is a critical health need

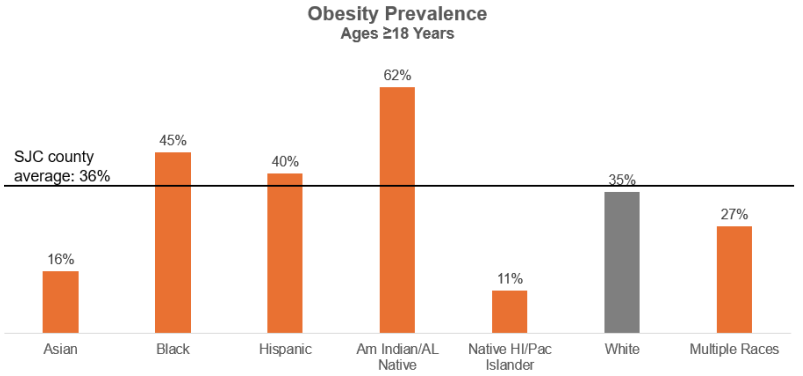
Chronic diseases are primary causes of poor health outcomes and death and a leading driver of health care costs. Residents with limited access to healthy foods have a higher risk of developing a chronic disease, such as obesity, heart disease, diabetes, or asthma. Along with a healthy diet, physical 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*

XI. Evaluation: Tracking CHIP Progress

Ongoing evaluation and monitoring of the CHIP will be the responsibility of the Healthier San Joaquin Collaborative. The CHIP includes measures for each objective, and a number of actions will be undertaken to assure progress on the CHIP. While specific tracking mechanisms are to be developed, the following items outline the plan for progress tracking:

- Lead organizations/workgroups responsible for specific CHIP activities will track their implementation progress and impact of their efforts according to the CHIP measures associated with their activities.
  - The Core Team will develop an online progress tracking survey for completion by the lead organizations and partners. The survey will be in an easy to complete, checklist or multiple-choice format to enhance response rates.
- At quarterly Steering Committee meetings, the Core Team and lead organizations/workgroups will report progress on the CHIP measures and solicit input on the activities implemented and progress towards objectives.
- The scope of work in grant proposals to fund CHIP strategies will include tracking activities in an effort to ensure that resources are available for progress tracking.
- San Joaquin County Public Health Services will prepare CHIP progress reports as required for public health accreditation.

XII. Next Steps: From Planning to Action

The implementation of the CHIP will be driven by the Healthier San Joaquin Collaborative, a group representative of the many agencies and organizations that contribute to health and wellness within the County. The Collaborative will institute the structure needed to implement the CHIP, formalizing a governance structure for leadership and decision-making processes, establishing CHIP workgroups, and defining operations such as meeting format, frequency and agenda items.

The CHIP will guide community health improvements from 2026–2028. As a living document, the CHIP will evolve as the funding, policy, and health context changes over the next three years; CHIP efforts will be revisited and refined at least annually to address emerging opportunities and challenges. Next steps include:

- Further build out the CHIP Matrix and Year 1 Action Plan for Access to care and Chronic disease/HEAL, adding specificity and responding to the changing economic and policy landscape.
- Develop a funding plan for the CHIP activities and align funder investments around specific activities, with emphasis on the Priority Neighborhoods.
- Engage County residents, including Priority Neighborhood community members, in implementing Year 1 activities in their neighborhoods.
- Identify specific contributions from Steering Committee organizations/agencies. There are a variety of opportunities for collaboration, including community member

engagement, implementation of specific interventions, and feedback and data collection to support CHIP progress tracking and evaluation.

- Convene the Core Team and Steering Committee on a regular basis to review accomplishments, develop solutions to challenges and review and revise timelines and workplans.
- Put in place an ongoing process to ensure efforts are aligned and progress is tracked.

XIII. Working Together to Improve Community Health in San Joaquin County

The CHIP belongs to all of San Joaquin County; the more public agencies, community organizations and community members engaged in CHIP implementation, the more likely it is that CHIP objectives and concrete improvements will be achieved.

Organizations, public agencies or San Joaquin County residents seeking to contribute to the CHIP activities should contact Public Health Director/Director of Nursing Renee Sunseri ,DNP, MS, RN, PHN, NEA-BC at rsunseri@sjcphs.org or any other Core Team member for more information.

Appendix A. Steering Committee, Core Team

The Steering Committee member organizations are listed below. Organizations that are also part of the Core Team, which guided the CHIP process, are indicated with an asterisk.

- 211 San Joaquin
- Adventist Health Lodi Memorial*
- Amelia Adams Whole Life Center
- Asian Pacific Self-Development and Residential Association (APSARA)
- Boys and Girls Club
- Catholic Charities Diocese of Stockton
- Child Abuse Prevention Council
- City of Stockton
    - Office of the Mayor
    - Office of Violence Prevention
- San Joaquin Community Foundation*
- Community Medical Centers*
- Dameron Hospital*
- 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
- 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
- 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
- Trust for Public Land
- University of the Pacific, School of Health Sciences*
- Visionary Home Builders
- Women's Center and Youth Services Agency

Appendix B. 2025 CHIP Community Survey and Results

San Joaquin County Community Health Survey

Make your voice heard! We want to hear what **you think** is most important to make your community healthy!

Please fill out this survey to tell us your thoughts. The survey does not ask for your name and your answers cannot be linked to you. If you have already filled out this survey, please don't fill out another.

1) What is the most important thing that makes it easier for you to get **HEALTH CARE**? **All the answers below are important, but please check only 1 box.**

a) ☐ Make sure health services fit my language and culture so I will trust and use them
b) ☐ Help me learn about or use the health services available to me
c) ☐ Bring health services to my community so they are easy to get to
d) ☐ Help me get regular health care and avoid emergency room visits
e) ☐ Give me free or low cost transportation to health appointments

2) What is the most important thing that makes it easier for you to have good **MENTAL HEALTH? MENTAL HEALTH** can include but is not limited to stress, anxiety, depression, trauma, loneliness and problems with drug and alcohol use. **All the answers below are important, but please check only 1 box.**

a) ☐ Provide mental health services where I already go for other services
b) ☐ Help me learn about or use mental health counseling and services
c) ☐ Make sure mental health services fit my language and culture so I trust and use them
d) ☐ Help me feel less lonely and more connected in my community
e) ☐ Do more to prevent drug and alcohol use
f) ☐ Make it easier to get help for drug and alcohol problems

3) What is the most important thing that makes it easier for you to prevent or manage **CHRONIC DISEASE** (like asthma, diabetes, etc.) and be healthier through **eating healthy food** and **staying active**. **All the answers below are important, but please check only 1 box.**

a) ☐ Make it easier for me to get healthy, affordable food, like fruits and vegetables
b) ☐ Teach me nutrition and cooking in ways that fit my language and culture
c) ☐ Help me get more physical activity, including programs that fit my language and culture (like walking clubs, exercise classes and kids' activities)
d) ☐ Improve parks so they are safe and clean and provide things I want (like fields, ball courts, playgrounds, and walking paths)
e) ☐ Help me prevent or manage chronic diseases like diabetes, high blood pressure, asthma, cancer and others

PLEASE TELL US ABOUT YOU

4) How would you describe your health? **Check only one.**

☐ Excellent ☐ Fair
☐ Good ☐ Poor

Go to page 2 to finish the survey!

5) Race/Ethnicity? **Check all that apply.**

☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ White/Caucasian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Different race/ethnicity (description optional):_____
☐ Prefer not to answer

6) What language do you most often speak at home? **Check only one.**

☐ English
☐ Spanish
☐ Chinese
☐ Cambodian/Khmer
☐ Filipino/Tagalog
☐ Punjabi
☐ Different language (description optional):_____
☐ Prefer not to answer

7) Your age? **Check only one.**

☐ 18-24 ☐ 25-44 ☐ 45-64 ☐ 65-80 ☐ Over 80 ☐ Prefer not to answer

8) Your gender identity? **Check only one.**

☐ Woman
☐ Man
☐ Identify in another way (description optional): _____
☐ Prefer not to answer

9) Which of the following best represents how you think of yourself?

☐ Straight/Heterosexual
☐ Lesbian, Gay, or Bisexual
☐ Identify in another way (description optional): _____
☐ Prefer not to answer

10)Where do you live? **Check only one**.

☐ Escalon ☐ Lodi ☐ Ripon ☐ Stockton
☐ Lathrop ☐ Manteca ☐ Tracy ☐ Not in a city or in County unincorporated area:
(description optional):_____

THANK YOU FOR FILLING OUT THIS SURVEY!

OPTIONAL: Enter your email address below for a chance to **win a $100 gift card**! Your answers to the survey will never be linked to you.

Email: _____

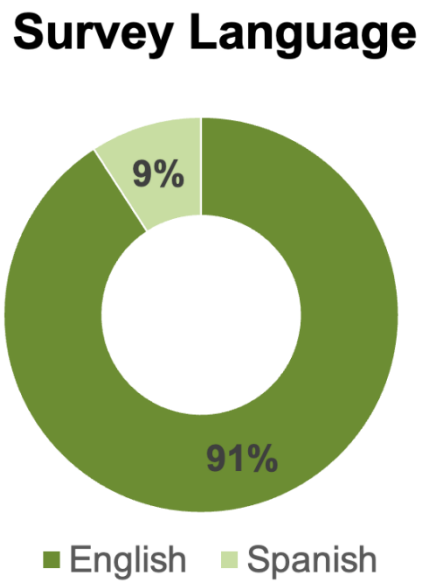
If you win, you'll get an email from sjmcommunityhealth@commonspirit.org.

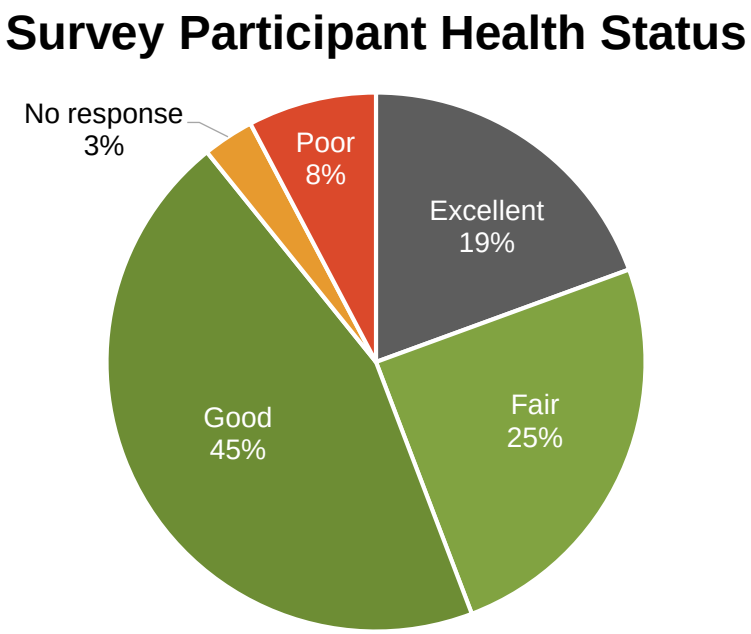
SURVEY RESPONSE:

Surveys received:

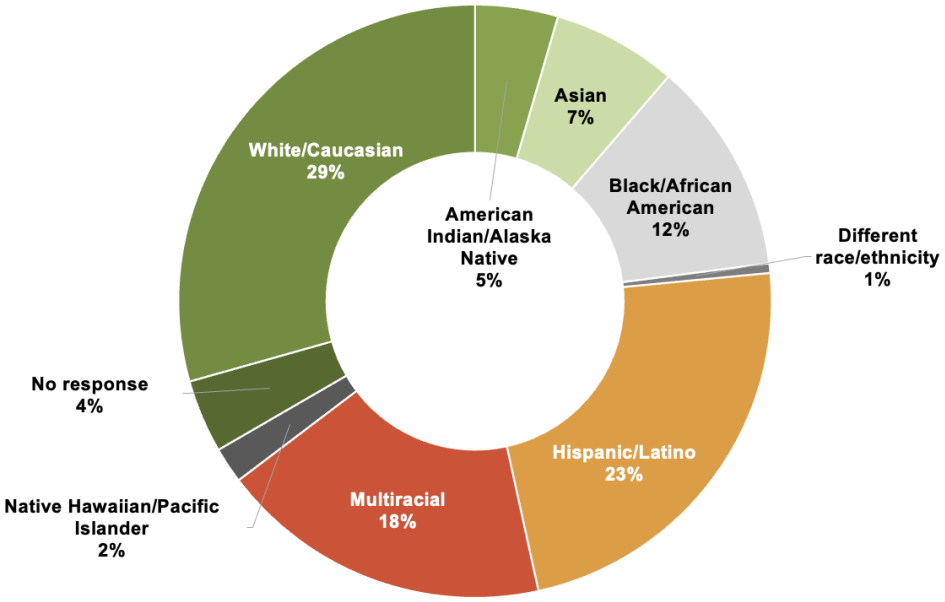
1529

Paper: 135
Online: 1394

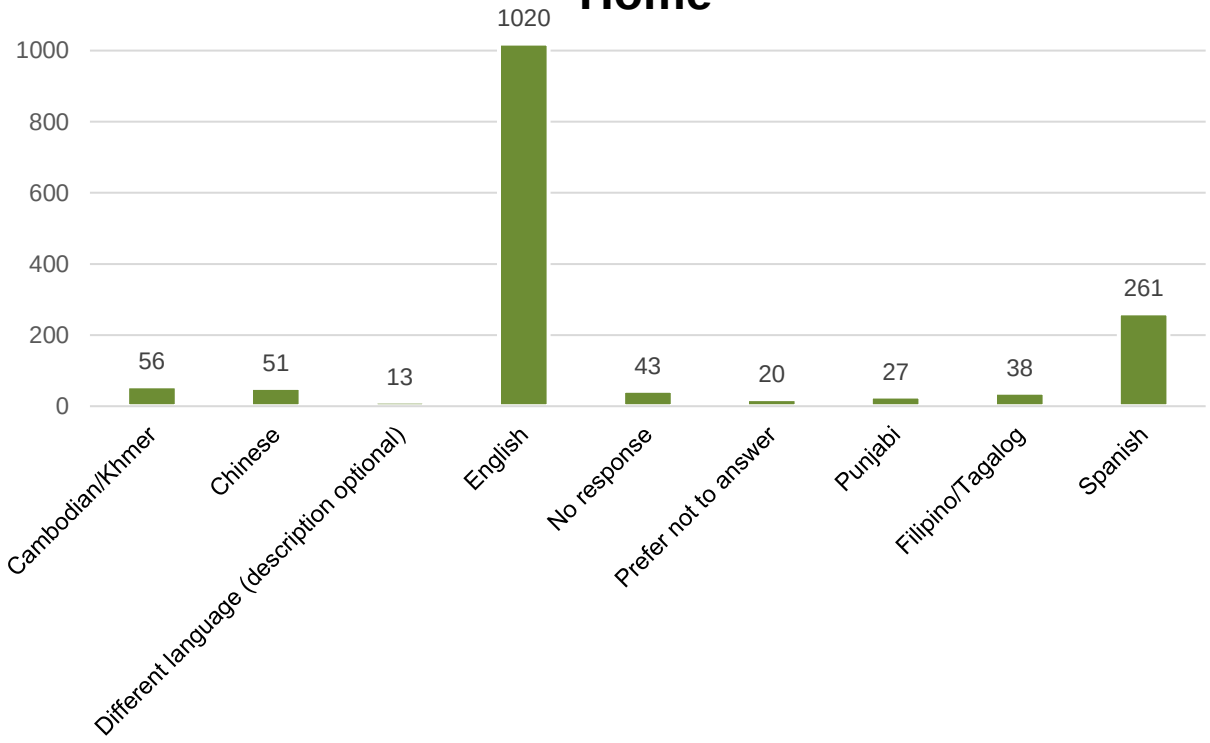




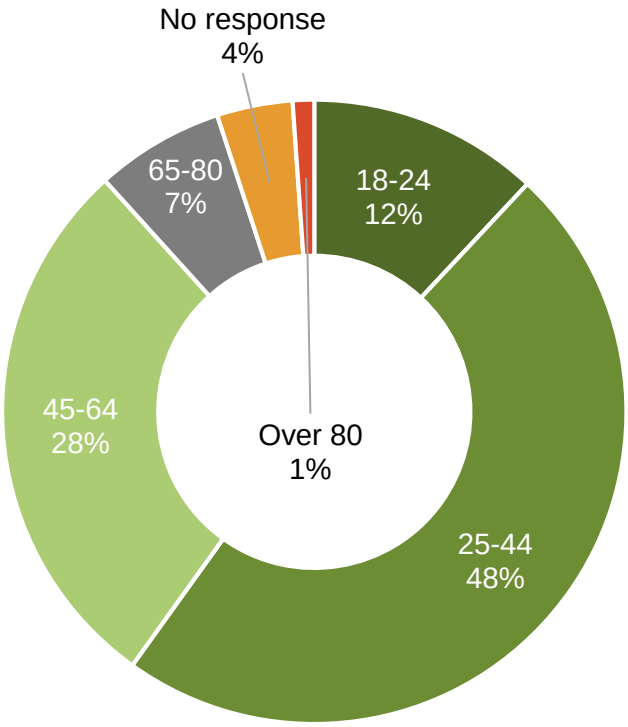
Survey Participant Race/Ethnicity



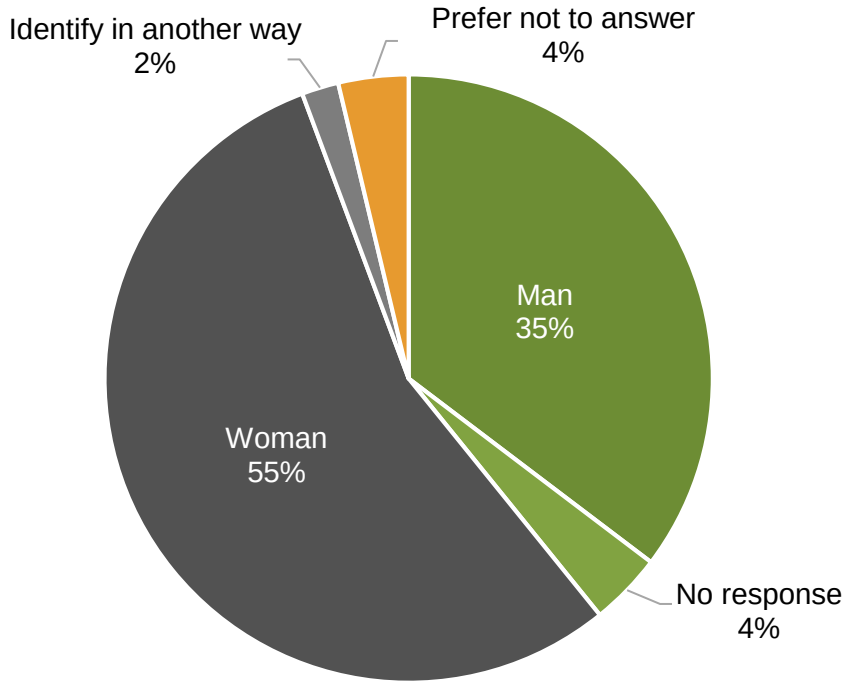
Survey Participant Language Spoken at Home



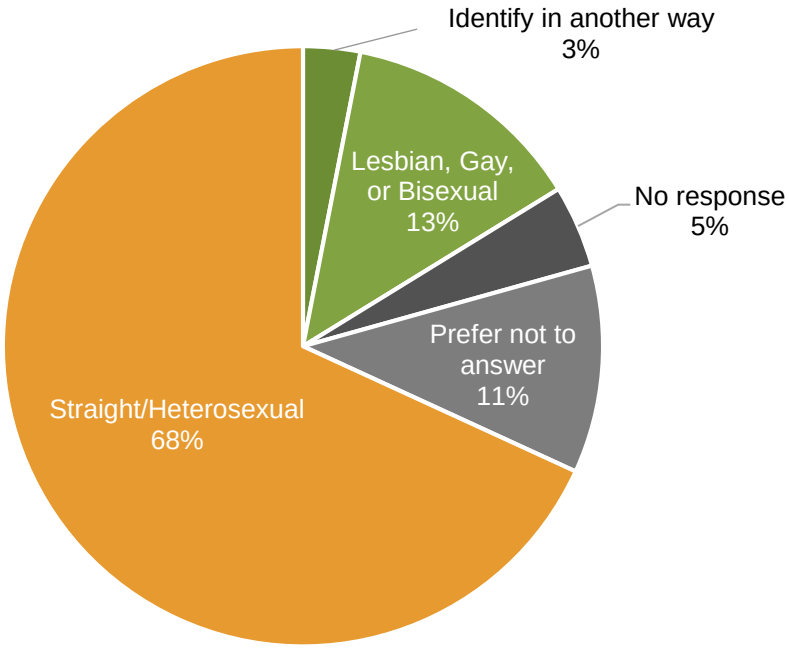
Survey Participant Age



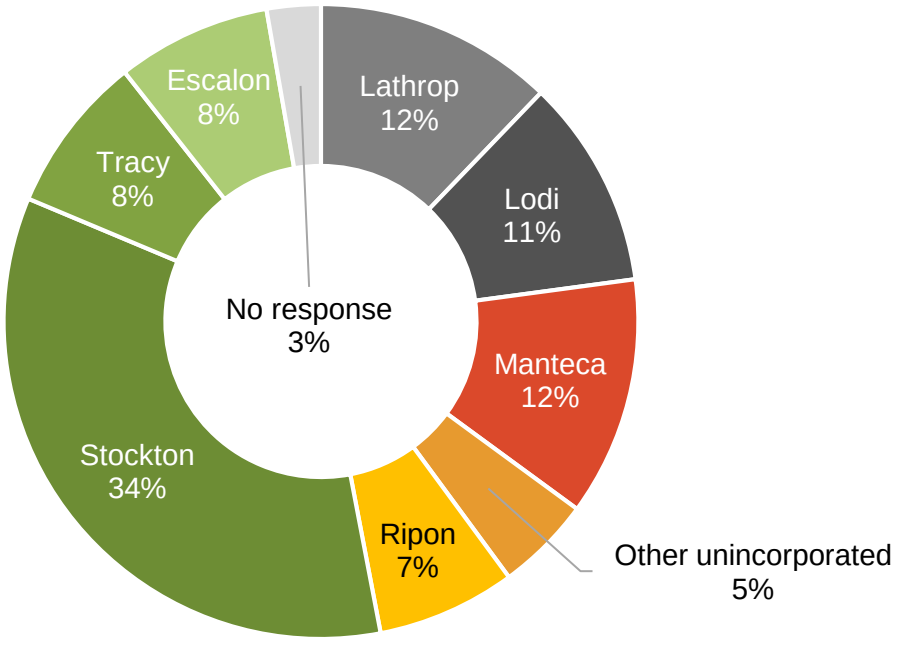
Survey Participant Gender Identity



Survey Participant Sexual Orientation



Survey Participant City of Residence



Appendix C. 2025–2028 CHIP Matrix

MENTAL HEALTH/SUBSTANCE USE (MH/SU) OVERALL GOAL: All community members have access to high quality mental health/substance use education, prevention, and programming.				
Timeline	**Strategies/activities**	**Measures**	**Potential Lead Organizations**	**Partners**
Objective A: Deploy and fund Community Health Workers (CHWs) to address disparities and support access to MH/SU services, including education and prevention, for at least two topics/issues and in a minimum of two Priority Neighborhoods by December 2028				
	A1. Sustain CHW funding for MH/SU:	A1: Produce ecomap/gap analysis produced and disseminated to SJC leaders A1: Steering Committee members secure at least 1 additional funding stream to sustain community-based CHWs A1: Increased billing for CalAIM reimbursement by organizations employing CHW MH/SU to provide services A1: # of CHW MH/SU trainings provided A2: Connected Community Network (CCN) indicators identified and tracked to measure # CHWs working on MH/SU in inpatient, housing, and other community settings A3: At least 1 policy strategy to support CHW work on MH/SU identified and promoted	• Adventist Health Lodi Memorial • APSARA • CSU Stanislaus Stockton Campus (Stan State) • Dameron Health • HealthNet • Health Plan of San Joaquin (HPSJ)	• Children and Youth Behavioral Health Initiative • CHWs • City leaders • Community Medical Centers (CMC) • County leaders • Kaiser Permanente, Sutter Health, Dignity Health, and other hospitals • Medi-Cal Managed Care Plans (MCPs) • Schools • SJ Health • SJC Public Health Services (PHS) • SJC Behavioral Health Services • United Way of San Joaquin
Year 1	a. Develop CHW MH/SU systems ecomap* and gap analysis			
Year 2	b. Seek funding to support community-based CHWs who provide MH/SU services beyond those billable under CalAIM			
Year 2	c. Support county organizations to maximize Medi-Cal reimbursement for CHW MH/substance use services			
Year 2	d. Seek funding to provide existing CHW training curricula and certification on MH/SU and trauma-informed approaches			
	A2: Support integrating CHWs into a variety of settings including supportive housing, inpatient settings, and high need geographies to increase residents' knowledge of MH/SU, decrease stigma, and increase awareness of treatment options.			
Year 2 + ongoing	a. Continue utilizing and explore expanding CHWs (or care navigators) in health care settings to facilitate care navigation, MH/SU screenings, and referral to substance use treatment			
Year 2	b. Support expansion of CHW/navigator services to low-income and supportive housing organizations to address MH/SU			
	A3: Identify or create model policies to institutionalize CHW staff positions in public agencies, health care and community organizations.			
Year 3	a. Formalize CHW career paths, including career development with promotion opportunities and long term employment with benefits			
Year 3	b. Advocate for policy strategies that support a living wage for CHWs			

* A systems ecomap illustrates organizational and systems relationships and connections related to a specific community/geography and topic area. It is a tool used to understand context and identify needs and assets for the topic being studied.

Timeline	Strategies/activities	Measures	Potential Lead Organizations	Partners
Objective B: By December 2028, partner with organizations serving cultural/linguistic groups to improve 4-6 MH/SU programs and/or services to meet the needs of residents, particularly in Priority Neighborhoods, more effectively				
Year 1	**B1: Expand access to and promote culturally/linguistically congruent and trauma-informed MH/SU programs and services** a. Conduct asset map/gap analysis of culturally/linguistically congruent and trauma-informed MH/SU programs, services, existing provider/CBO trainings, and related policies	B1: At least one change made to 4-6 MH/SU programs/services to culturally /linguistically align with Priority Neighborhood residents' needs B1: # of trauma informed trainings conducted B1: # CHWs engaged in MH/SU B1: At least 1 new culturally congruent, trauma-informed care policy adopted by at least 1 SJC health system B2: # of youth participating in MH/SU career exposure	• Amelia Ann Adams Whole Life Center • CMC • CommonSpirit • First 5 • Health Force Partners • MCPs • NAACP • PHS • PREVAIL • Reinvent South Stockton Coalition • SJ Pride Center • SJC Behavioral Health • SJC Human Services Agency training and community services • SJC Office of Education (SJCOE) • Stan State • Tracy Area Alumnae Chapter (TAAC) of Delta Sigma Theta Sorority	• CBOs serving specific cultural and language groups (Little Manila Rising, APSARA, El Concilio, others) • Chambers of Commerce • Child Abuse Prevention Council (CAP) • Children's Services/SJC Human Services Agency • City leaders • Community centers • Community Health Leadership Council • County leaders • Faith-based organizations • Health systems • Law enforcement • League of United Latin American Citizens • Legal Services • Mental Health professional associations • Parent Cafes • Program of All-inclusive Care for the Elderly (PACE) • School districts • SJ Delta college • SJ Medical Society • SJC Youth Wellness Alliance • Sow a Seed Community Foundation
Year 2	b. Promote trainings for providers (including students/interns/residents), CBOs and CHWs to 1) improve access to/provide culturally/ linguistically congruent MH/SU services/programming and 2) destigmatize accessing MH/SU services/programs			
Year 3	c. Connect MH/SU providers with CBOs serving specific cultural and language groups to tailor education, prevention and care to meet residents' needs			
Year 2 + ongoing	d. Support ongoing adoption of trauma informed approaches/policies to MH/SU			
Year 2 + ongoing	e. Engage CHWs and CBOs in promoting, screening for, and making referrals to available culturally/linguistically congruent and trauma-informed MH/SU services for residents in Priority Neighborhoods			
Year 2	f. Continue and expand school-based MH/SU screening and referrals			
Year 2 + ongoing	**B2: Expose diverse, local youth to a variety of mental health career paths to build their interest in pursuing these professions.** a. Continue to provide and support mentorship programs that orient youth to MH/SU careers in middle and high schools			
Year 3	b. Provide Mental Health First Aid training for youth in middle and high schools			
Year 3	c. Define and promote MH/SU career pathways that don't require lengthy education			

The Access to care section of the CHIP Matrix will be further developed to include the specific and feasible CHIP strategies/activities needed to respond to the changing political and economic landscape.

ACCESS TO CARE **OVERALL GOAL: All community members have access to comprehensive, quality healthcare to achieve and maintain health and increase quality of life.**				
Timeline	**Strategies/activities**	**Measures**	**Potential Lead Organizations**	**Partners**
Objective A: Asset Map / Resource List				
TBD	**A1: Create linkages to the Community Connections website on the PHS Priority Neighborhood Profiles Data Dashboard, that include resources for accessing care in San Joaquin County.** **A2: Maintain an immunization safety net that includes any LHD resource and referral lists to other programs that connect patients to services.**	A1: PHS will have created at least one linkage within a publicly available data dashboard A2: Referral list completed and updated on an annual basis.	• PHS	• TBD
Objective B: Community Partner/Stakeholder Engagement				
TBD	**B1: Identify opportunities for community-based organizations and service providers in SJC to partner with large health providers to improve equitable and inclusive services and access.** **B2: Ensure that the local PEI CAB members participate in training or educational opportunities designed to enhance cultural sensitivity to advocate for efforts to address racial health disparities.**	B1: # community events held in which partners hosted or participated, focused on access to care B2: # of trainings, activities, and conferences attended by CAB members and role/affiliated agency during each FY according to the reporting schedule	• PHS	• TBD
Objective C: Outreach Education				
TBD	**C1: Train dental providers on best practices for serving vulnerable and underserved communities through providing training on cultural competence and support for participation in the Medi-Cal Dental program.** **C2: Develop and deliver culturally appropriate education and outreach for African American/Black communities that addresses stigma and medical mistrust.**	C1: Train at least 50 dental providers, including dentists, RDAs, and RDHAPs, per year on best practices for serving Medi-Cal patients C2: At least # flyers distributed	• PHS	• TBD

Objective D: Improve Access				
TBD	**D1: Train # CHWs/navigators located within health care systems and community settings and provide ongoing support to promote MAT services to residents experiencing substance use disorder (SUD) in San Joaquin County, with a focus on culturally competent outreach and support.** **D2: Expand community outreach efforts to increase enrollment rates for health insurance and MediCal coverage in SJC.** **D3: Implement and expand school-based and school-linked (SBSL) dental programs with an effective care coordination component and ensure compliance with the Kindergarten Oral Health Assessment (KOHA) mandate.** **D4: Expand the San Joaquin County Medi-Cal dental provider workforce.**	D1: # trained CHWs/navigators D2: # enrolled among community members attending presentations and/or educational events held on the Medi-Cal program options D3: Increase the number of eligible schools participating in SBSL dental programs to 10 D3: Provide at least 2,000 free dental screenings annually for children in K-6th grade at five priority schools D4: Increase the number of dental providers who accept Medi-Cal from 81 to 91	• PHS	• TBD
Objective E: Policy				
TBD	**E1: Research and elevate policy strategies to address funding cut impact on access to care/health insurance.**	TBD	• PHS	• TBD

The Chronic disease/HEAL section of the CHIP Matrix will be further developed to include the specific and feasible CHIP strategies/activities needed to respond to the changing political and economic landscape.

CHRONIC DISEASE/HEALTHY EATING, ACTIVE LIVING (HEAL) **OVERALL GOAL: Help community members prevent/manage chronic disease, with emphasis on reducing risk factors associated with access to healthy food and physical activity.**				
Timeline	**Strategies/activities**	**Measures**	**Potential Lead Organizations**	**Partners**
Objective A: Increase community partner collaboration to address food insecurity				
TBD	**A1: Ensure partners who provide food, supportive services, and resources to people experiencing food insecurity are engaged in the Work Group by XXXX.** **A2: Connect communities to 211.** **A3: Update a repository of local food resources (making sure the list is sent to 211 and CCN).** **A4: Promote farmer's markets that accept CalFresh.**	A1: Two additional organizations join the Work Group. A2: # referrals from 211 to local food resources A3: One directory of organizations providing food resources/assistance created A4: A minimum of 2 farmer's markets, that accept CalFresh, are identified, promoted, and supported in ###.	• PHS	• TBD
Objective B: Increase the availability of and community access to healthy food within San Joaquin County				
TBD	**B1: Identify 2-4 opportunities in priority neighborhoods—to increase access to healthy food (community gardens, community food grant programs, existing food resource programs, food sheds, food preparation education).**	B1: Two additional organizations participate in efforts to increase availability of, and access to, healthy food	• PHS	• TBD
Objective C: Increase community partner collaboration to increase awareness and prevention of HEAL issues				
TBD	**C1: Increase information and resource sharing between organizations and community members.** **C2: Ensure partners who address HEAL are engaged in the Work Group by XXXX.**	C1: # community events held in which partners hosted or participated, focused on HEAL C1: # pamphlets about HEAL distributed to residents C2: Two additional organizations join the Work Group	• PHS	• TBD
Objective D: Policy				
TBD	**D1: Research and elevate policy strategies that align with the CHIP HEAL objectives**	TBD	• PHS	• TBD

Appendix D. Year 1 Action Plan

Mental Health/Substance Use (MH/SU)

Objective A: Deploy and fund Community Health Workers (CHWs) to address disparities and support access to MH/SU services, including education and prevention, for at least two topics/issues and in a minimum of two Priority Neighborhoods.			
CHIP Activities Initiated Year 1	**Action Steps**	**Timeline (2026)**	**Workgroup members (* = potential leads)**
A1 Sustain CHW funding for MH/SU a. Develop CHW MH/SU systems ecomap and gap analysis i. Develop and utilize a CHW case-making document that conveys the value of CHWs to potential funders	• Convene a CHW workgroup to implement activities and be accountable for progress ○ Identify members, set meeting schedule, plan meeting agendas	Q1	• Adventist Health Lodi Memorial • Amelia Ann Adams Whole Life Center • APSARA • El Concilio • Emergency Foodbank Stockton • Full Circle Solutions-Community Health Leadership Council • Little Manilla Rising • Reinvent South Stockton Coalition* • San Joaquin County Public Health Services • Sutter Health • United Way*
	• Conduct ecomap/gap analysis, including: ○ Define what is included as CHW MH/SU services ○ Gather and review SJC assessments conducted recently exploring related topics to avoid duplication of efforts, identify service gaps, and understand overarching findings ○ Conduct data collection ○ Conduct analysis to describe: ▪ Who employs CHWs ▪ CHW funding streams ▪ Where CHWs are working ▪ Organizational, regulatory and legislative policies related to CHW funding ○ Identify at least 2 topics/issues to work on ○ Identify a minimum of 2 Priority Neighborhoods with highest needs for the selected topics ○ Develop and disseminate a CHW case-making document conveying the value of CHWs and their role in addressing MH/SU disparities	Q1-Q3 (Q1collect/ review reports & data, Q2 analysis & identify topics and Priority Neighborhoods, Q3 develop/ disseminate case making document)	
	• Identify appropriate Connected Community Network (CCN) indicators to track CHW MH/SU services ○ Assign a lead to collect and report data ○ Develop and implement a standard reporting format to annually report on CHW MH/SU services	Q1	

Objective B: Partner with organizations serving cultural/linguistic groups to improve 4-6 MH/SU programs and/or services to meet the needs of residents in Priority Neighborhoods more effectively.			
CHIP Activities Initiated Year 1	**Action Steps**	**Timeline (2026)**	**Workgroup members (* = potential leads)**
B1: Expand access to and promote culturally/linguistically congruent and trauma-informed MH/SU programs and services a. Conduct asset map/gap analysis of culturally/linguistically congruent and trauma-informed MH/SU programs, services, existing provider/CBO trainings, and related policies ○ Create, resource and implement a plan for filling gaps identified	• Convene a workgroup to plan and conduct the asset map/gap analysis, identify policy strategies to pursue ○ Identify members (ensure representation from diverse cultural groups/sectors), set meeting schedule, plan meeting agendas ○ Form subgroups as needed to address specific topics (e.g., mental health, alcohol, cannabis, opioids, tobacco, stimulants) ○ Identify resources to conduct asset map/gap analysis • Plan and conduct asset mapping/gap analysis, including: ○ Define specific mental health and/or substance use topics for analysis focus ○ Define and identify priority cultural groups, which may include race/ethnicity, age, income, identity ○ Review SJC assessments conducted recently exploring related topics to understand findings and avoid duplication of efforts ○ Conduct data collection and analysis to describe: ▪ Existing culturally/linguistically congruent and trauma informed MH/SU services ▪ Cultural/linguistic groups with the greatest need for congruent services ▪ Providers and CBOs ready for cultural congruence/trauma informed and MH/SU trainings ▪ Existing trainings addressing cultural/linguistic congruence and MH/SU ▪ Programmatic/policy approaches to improve MH/SU services/programming access, including through mobile services ▪ Funding streams that could be tapped to support this work (private philanthropy, public funding) ○ Gather input from residents directly to understand what needs to change/be in place to facilitate their use of MH/SU services • Develop a plan for addressing service and training gaps: ○ Review and leverage BHS framework for culturally aligned care to provide structure for CHIP MH/SU efforts ○ Identify existing funds/resources that can be leveraged to enhance cultural/linguistic congruence and reduce stigma for MH/SU programs/services (e.g., Housing Assistance Program (HAP), domestic violence funding) ○ Leverage existing training opportunities and promote participation: ▪ Create a directory of existing trainings ▪ Engage KP to provide cultural trainings to providers/CBOs outside their system ▪ Explore available online trainings ▪ Develop training marketing plan ▪ Explore funding stipends for CBOs/residents to engage in trainings • Initiate implementation of plan to address service and training gaps	Q1 Q2 Q2-Q3 Q4	• Amelia Ann Adams Whole Life Center • APSARA • Business Council San Joaquin County • Common Spirit* • Community Medical Centers • Delta Health Care • El Concilio • First 5 Commission • Full Circle Solutions-Community Health Leadership Council • Helping Hands of San Joaquin County • Kaiser Permanente • Little Manila Rising • Opioid Safety Coalition • Public Health Advocates • Reinvent South Stockton Coalition • San Joaquin County Behavioral Health Services* • San Joaquin County Office of Education • San Joaquin County Public Health Services • San Joaquin Pride Center • Tracy Area Alumnae Chapter (TAAC) of Delta Sigma Theta Sorority • Vietnamese Voluntary Foundation

The Access to care section of the Year 1 Action Plan will be built out to include the specific and feasible CHIP action steps needed to respond to the changing political and economic landscape.

Access to Care

CHIP Activities Initiated Year 1	Action Steps	Timeline (2026 calendar year)	Workgroup members (* = potential leads)
Objective A: Asset Map / Resource List			
TBD	• TBD		PHS*
Objective B: Community Partner/Stakeholder Engagement			
TBD	• TBD		PHS*
Objective C: Outreach Education			
TBD	• TBD		PHS*
Objective D: Improve Access			
TBD	• TBD		PHS*
Objective E: Policy			
TBD	• TBD		PHS*

The Chronic disease/HEAL section of the Year 1 Action Plan will be built out to include the specific and feasible CHIP action steps needed to respond to the changing political and economic landscape.

Chronic disease/HEAL

CHIP Activities Initiated Year 1	Action Steps	Timeline (2026 calendar year)	Workgroup members (* = potential leads)
Objective A: Increase community partner collaboration to address food insecurity			
TBD	• TBD		PHS*
Objective B: Increase the availability of and community access to healthy food within San Joaquin County			
TBD	• TBD		PHS*
Objective C: Increase community partner collaboration to increase awareness and prevention of HEAL issues			
TBD	• TBD		PHS*
Objective D: Policy			
TBD	• TBD		PHS*

Appendix E. Assets for CHIP Implementation

The Community Resources represent a sampling of organizations addressing the CHIP 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	Mental health/ substance use	Access to care	Chronic disease/HEAL
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
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	
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
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
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		
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		

Assets/Resources	Description	Mental health/ substance use	Access to care	Chronic disease/HEAL
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		
Housing and Homelessness				
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
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
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		
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
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

Assets/Resources	Description	Mental health/ substance use	Access to care	Chronic disease/HEAL
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
Education				
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
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
San Joaquin County Office of Education and the California Healthy Kids Resource Center	Supports education of more than 145,000 students enrolled in 14 school districts in the county. The CHKRC provides access to educational resources, including health promotion resources, that can be borrowed at no cost.	X	X	X
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
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
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	
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		
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
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

Assets/Resources	Description	Mental health/ substance use	Access to care	Chronic disease/HEAL
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
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	
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		
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
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	
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 counseling, gang prevention, and life skills programs.	X		X
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
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
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	
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

Assets/Resources	Description	Mental health/ substance use	Access to care	Chronic disease/HEAL
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
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
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
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	
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

Assets/Resources	Description	Mental health/ substance use	Access to care	Chronic disease/HEAL
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
California Human Development, San Joaquin Country	Provides job training, affordable housing support, disabilities services, substance abuse treatment/sober living, and immigration and citizenship resources. The headquarters are located in Lodi.	X	X	X
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
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
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
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
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