2026 County of Del Norte Community Health Improvement Plan

Prepared by:
County of Del Norte Department of Health and Human Services Public Health Branch
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Acknowledgements

The 2026-2028 Del Norte County Community Health Improvement Plan (CHIP) reflects contributions from many partners across the community. The CHIP Core Team would like to thank the partners listed below.

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- California Center for Rural Policy (CCRP)
- Janel Obenchain, Deputy Director of Public Health, DHHS
- Ranell Brown, Director of DHHS
- CHIP Subcommittee Chairs: Shiann Hogan (Deputy Director, Behavioral Health Branch, DHHS), Pamela Wilder (Director, Foster & Homeless Youth Service Program, Del Norte Unified School District), Ellie Popadic (Sr. Director of Operations, Sutter Coast Hospital)
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Thank you to the people of the following organizations, initiatives, and projects who participated in the CHIP stakeholders engagement and the CHIP cross-sector subcommittee meetings to address the CHIP priority areas.

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- First 5 Del Norte Oral Health Program/Healthy Families of America
- Rx Safe Del Norte Coalition
- Tobacco Free Del Norte Coalition
- Open Door Clinic
- Tri-County Independent Living
- Sutter Coast Hospital
- Del Norte County Healthcare District
- Stallant Health and Wellness
- Area 1 Agency on Aging
- Del Norte and Tribal Lands Community Food Council
- DNUSD (Del Norte County Unified School District)-EPIC Student Support Services
- DNUSD- Health Services, Mental Health
- North Coast Rape Crisis Team
- Del Norte Child Care Council
- Resilient DNATL (Del Norte and Tribal Lands)
- NorCal 4 Health
- United Indian Health Services (UIHS)
- Trillium Teen Center
- Child Abuse Prevention Council (CAPC)
- California Health Collaborative
- True North
- Independent Community Builder-citizen activist

Del Norte County Community Health Fair 2025

Table of Contents

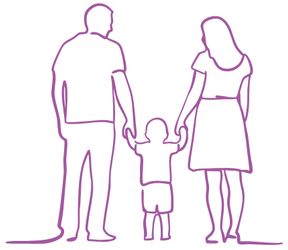
Executive Summary

The Community Health Improvement Plan (CHIP) is a collaborative, data-driven roadmap designed to improve the health and well-being of residents across Del Norte County. Developed through partnerships among public health, healthcare providers, community-based organizations, local government, and residents, the CHIP identifies priority health issues and outlines strategic actions to be addressed over the next 3 years.

Using findings from the Community Health Assessment (CHA), stakeholder input, and community engagement activities, three priority areas were identified:

Access to Healthcare Services

Behavioral Health



Child Abuse and Adverse Childhood Experiences (ACEs)

These priorities reflect both the greatest health needs and opportunities for collective impact within the community.

The CHIP emphasizes health equity by prioritizing populations disproportionately impacted by health disparities, addressing the social determinants of health and the root causes of inequities. Cross-sector subcommittees were established for each priority area to guide the CHIP development and implementation, set measurable goals, and monitor progress.

Key strategies outlined in the CHIP include strengthening community partnerships, improving service coordination, increasing access to prevention and early intervention services, and promoting policies that support healthy environments. Each strategy includes clear objectives, performance measures, and identified leads to ensure accountability and transparency.

Implementation of the CHIP will be ongoing and adaptive, with regular progress reviews and opportunities for community feedback. Through sustained collaboration and shared responsibility, this CHIP serves as a living document that guides collective action toward a healthier, more equitable future for all residents of Del Norte County.

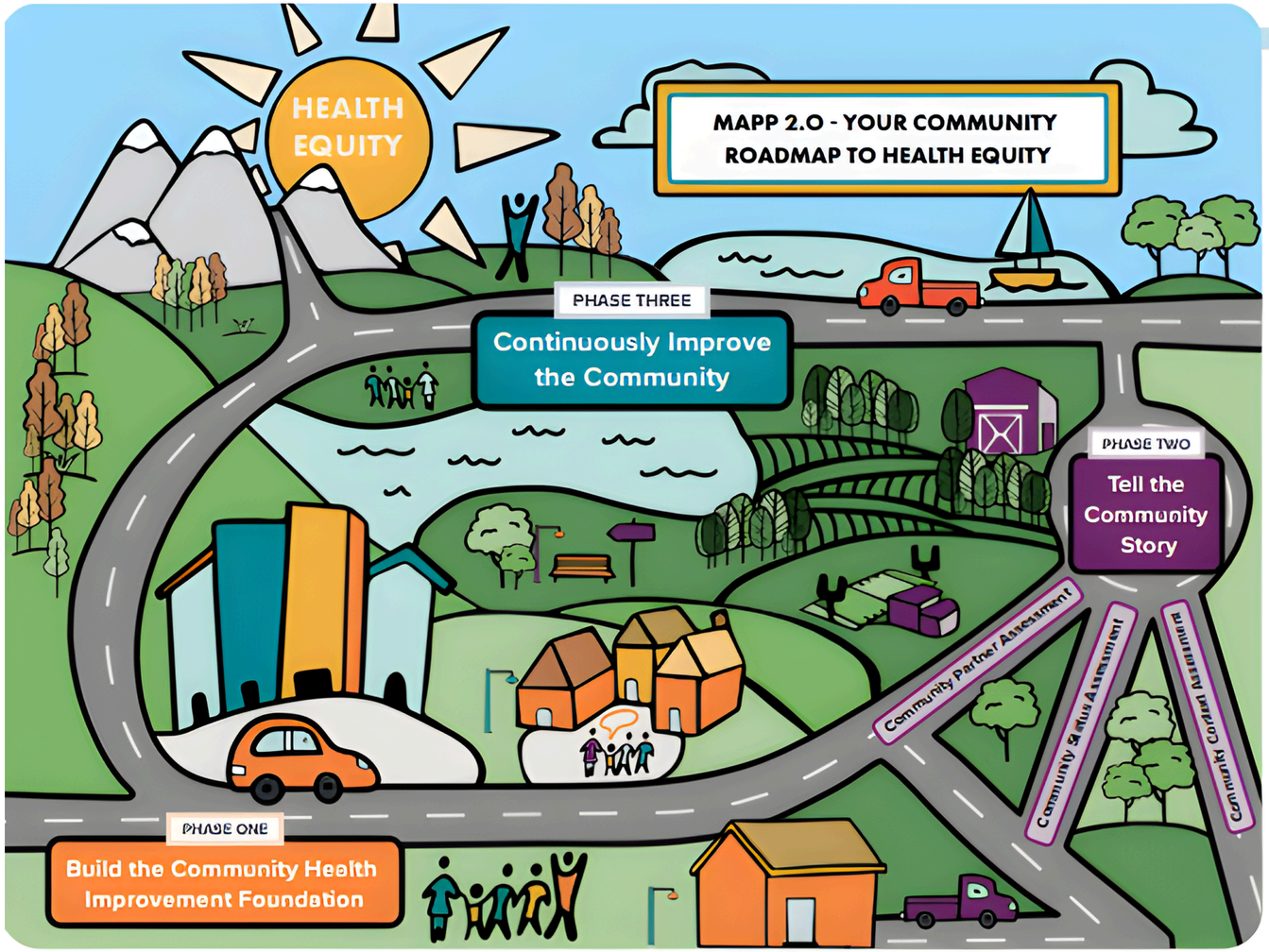
Introduction and Background

What is a Community Health Improvement Plan (CHIP)?

Completed in September 2024, the Community Health Assessment (CHA) provided a comprehensive analysis of community health status, disparities, and social determinants of health, serving as the foundation for the Community Health Improvement Plan(CHIP) development process.

The CHIP builds on these findings to guide collaborative action aimed at improving community health and advancing health equity across Del Norte County. The CHIP outlines long-term strategic efforts to enhance the health and well-being of the residents in Del Norte County.

The CHIP is guided by the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework developed by the National Association of County and City Health Officials (NACCHO). MAPP framework is a community-driven collaborative planning process designed to advance health equity by identifying urgent health issues and aligning community resources to address them.



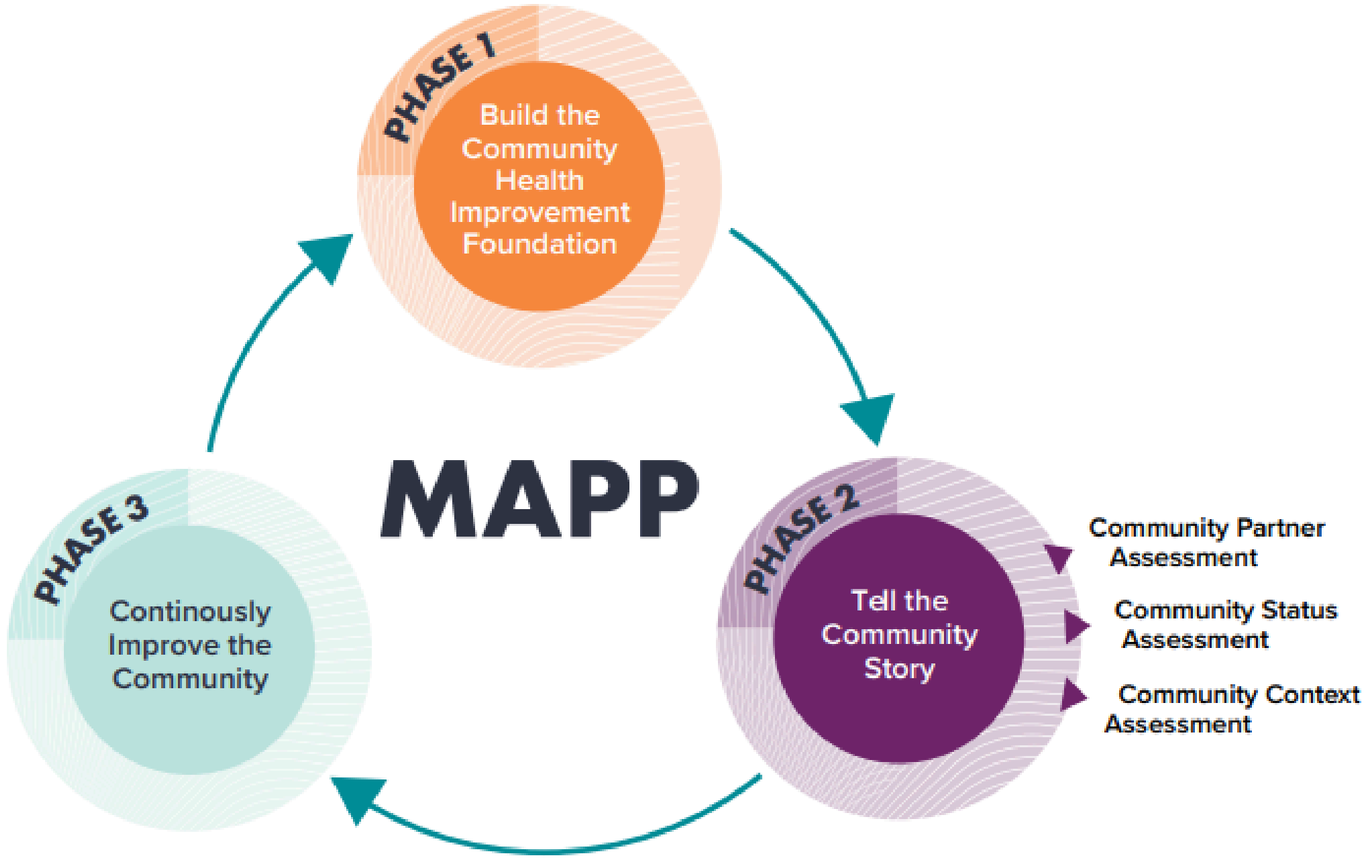
Reference: MAPP 2.0 Handbook pg 9

Overview of the MAPP 2.0 Framework

MAPP framework provides a structured approach for communities to assess population health needs, prioritize key issues, and coordinate action across sectors. The framework emphasizes meaningful community engagement, cross-sector collaboration, and policy, systems, and environmental change to address both health outcomes and the root causes of health inequities.

The MAPP process consists of three phases to be completed over a three- to five-year cycle:

- **Phase I**: Build the Community Health Improvement Foundation, which focuses on establishing partnerships, shared vision, and commitment among diverse stakeholders to support the planning process.
- **Phase II:** Tell the Community Story centers on conducting a comprehensive Community Health Assessment (CHA) to understand health status, disparities, social determinants of health, and root causes affecting all populations within the community.
- **Phase III:** Continuously Improve the Community involves developing and implementing the Community Health Improvement Plan (CHIP), a three- to five-year action plan that sets priorities, coordinates strategies, and targets resources based on CHA findings.



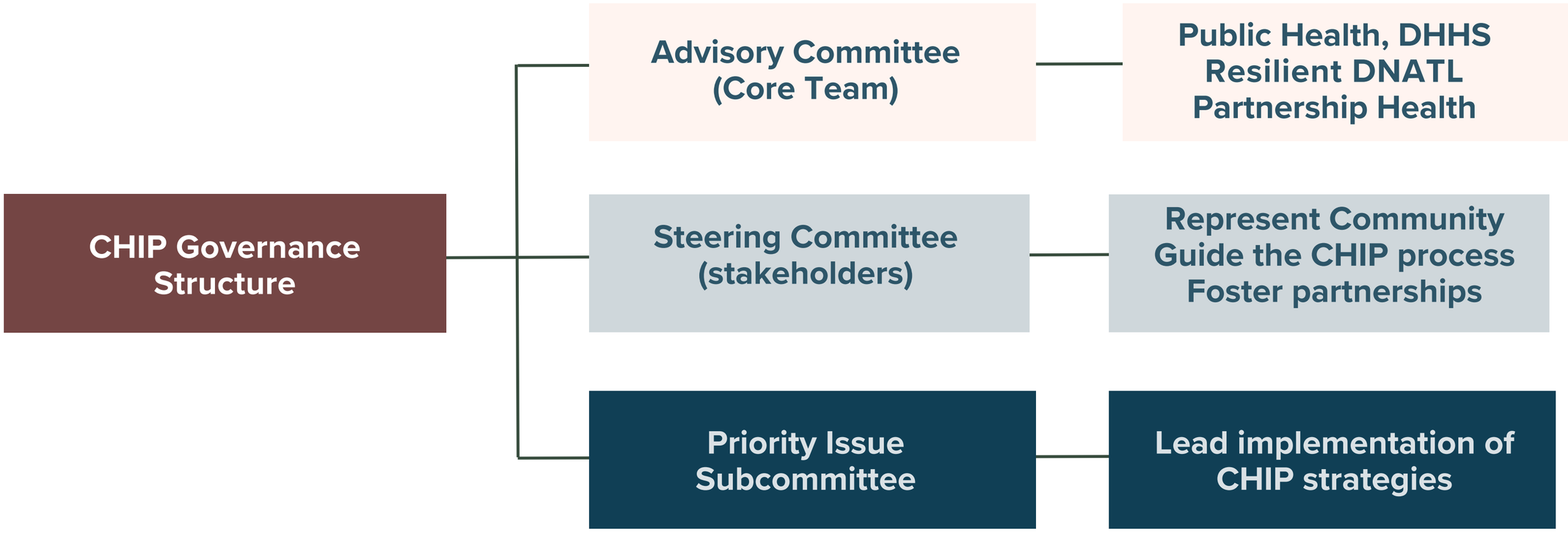
Reference: MAPP 2.0 Handbook pg 8

Ongoing Engagement

The DHHS Public Health Branch engaged the Core Team, Steering Committee, and Priority Issue Subcommittees throughout the CHIP development period from January 2025 through December 2025, ensuring sustained collaboration, shared ownership, and progress toward implementation.

DEL NORTE COUNTY CHIP INFRASTRUCTURE

The participants who foster collaboration, steer decision-making, and make sure efforts remain aligned.



The development of the Community Health Improvement Plan (CHIP) was a collaborative, community-led effort involving Del Norte County Department of Health and Human Services (DHHS), local partners, and community stakeholders.

CHIP Leadership and Facilitation

Following completion of the CHA, the DHHS Public Health Branch initiated and led the CHIP development process. The Public Health Branch facilitated a community-based planning process guided by CHA findings and lessons learned from community engagement. DHHS provided overall leadership, coordination, and communication support to ensure the CHIP remained community-driven while maintaining responsibility and accountability for both CHIP development and implementation.

CHIP Governance and Structure

To support the CHIP process, DHHS engaged community stakeholders to establish the following CHIP structures:

CHIP Core Team

The CHIP Core Team was formed with representatives from DHHS Public Health, Resilient DNATL (Del Norte and Tribal Lands), and Partnership HealthPlan of CA. The Core Team met regularly to guide the MAPP process, design the overall CHIP steps and timeline, and provide technical expertise, resources, and strategic advice throughout the planning process.

Steering Committee

The Steering Committee was composed of diverse community stakeholders who participated in CHIP development activities, particularly Steps 1–4 of the MAPP process. The Steering Committee played a crucial role in developing a shared community vision and identifying priority health issues, informed by CHA findings and community input.

Priority Issue Subcommittees

Following the selection of priority issues by the Steering Committee, Priority Issue Subcommittees were established to lead implementation planning. The identified priority areas include: Access to Healthcare Services, Behavioral Health (Substance Use, Mental Health, Tobacco Use), and Child Abuse and Adverse Childhood Experiences (ACEs).
Each subcommittee is chaired by a subject matter expert, with a Core Team member serving as co-chair to provide alignment, support, and accountability. These subcommittees focused on Steps 5–7 of the CHIP process, developing goals, objectives, and action plans for their respective priority areas.

CHIP Community Stakeholder Vision Statement

A resilient, diverse, and thriving community where everyone has equitable access to quality healthcare, supportive networks, and collaborative resources to achieve optimal health and well-being.

Values Statement

- **Community-Led Empowerment** – We recognize that those closest to the challenges hold the power to drive meaningful change and must be at the center of decision-making.
- **Respectful & Inclusive Communication** – We foster open, honest, and respectful conversations that create a safe space for all voices to be heard and valued.
- **Transparency & Trust –** We are committed to clear and open processes, ensuring that our work remains community-driven, ethical, and accessible.
- **Collaborative Action –** We work together across communities, organizations, and sectors to create sustainable, collective impact.
- **Integrity & Accountability –** We hold ourselves responsible for making meaningful, lasting health improvements, recognizing that change takes time and collaborative effort.

Development of the Community Health Improvement Plan (CHIP) centers through prioritization of health issues and the selection, implementation, and evaluation of strategies led by community partners. This phase consists of eight structured steps designed to translate assessment findings into action.

Issue Prioritization and Review of Existing Assessments (Steps 1–2: March-July, 2025)

Step 1- Prioritize issues for the CHIP:

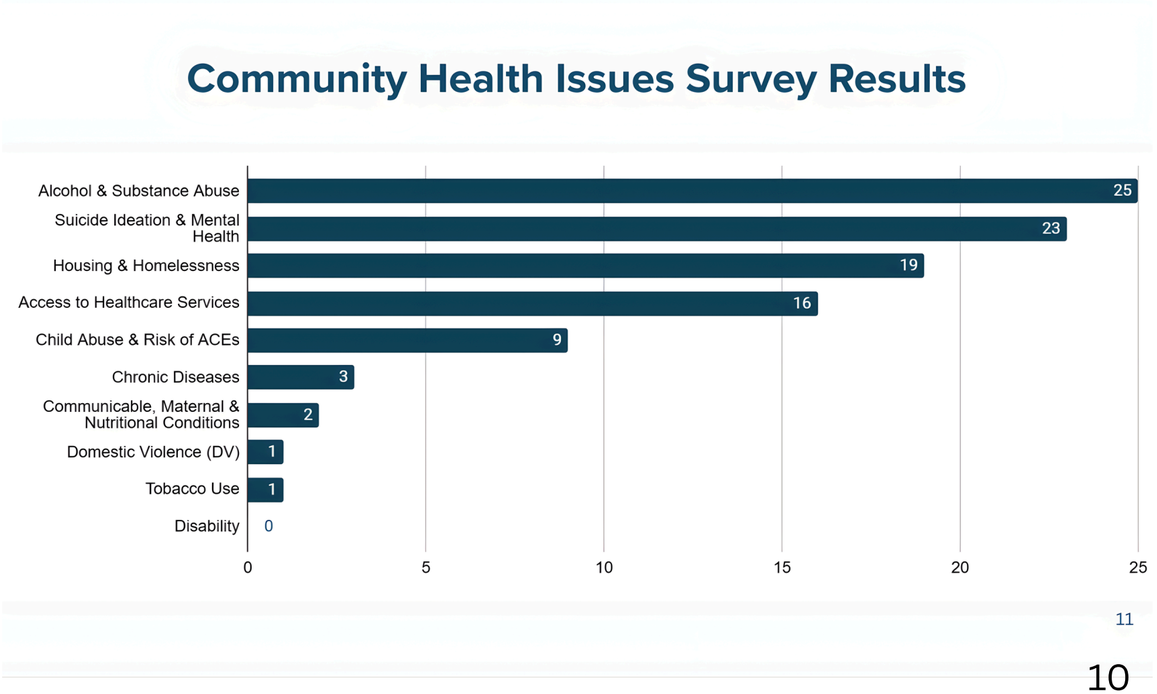
From March through July 2025, the Steering Committee engaged in a structured prioritization process through meetings, email communication, and formal voting. The CHIP Core Team assessed the 2019 CHIP outcome and impact by conducting key informant interviews with the partner organizations listed in the previous plan. This outreach gathered information on progress achieved, community impact, gaps, and recommendations to inform prioritization and strategy development for the 2025 CHIP. Findings from the 2019 CHIP review, along with data from the 2024 Community Health Assessment (CHA), guided the prioritization of health issues and informed the development of health issue profiles.

The CHIP Core identified 10 health issues from the 2024 CHA report, and the CHIP stakeholders participated in voting in May 2025 to prioritize the top 3-5 health issues. A standardized prioritization rubric listed below was used for stakeholder discussions to help with decision-making for prioritization.

- Magnitude and severity of the issue
- Urgency of addressing the issue
- Impact on communities and populations experiencing disparities
- Relevance to community members
- Availability and practicality of effective solutions and strategies

The result of the voting is attached to the right. The top 5 priority health issues were:

- Alcohol & Substance Abuse
- Suicide Ideation & Mental Health
- Housing & Homelessness
- Child Abuse & Risk of ACEs
- Chronic DIseases



CHIP Development Process

Step 1: Issue Prioritization

Combining the Community Health Issue Prioritization Survey results, the 2019 CHIP progress report, and community feedback, the CHIP Core Team selected 7 health issues and developed the health issue profiles. Del Norte County CHA 2024 Health Issue Profiles are included in Appendix E. The 7 health issues include:

- Access to Healthcare Services
- Behavioral Health
- Child Abuse & Adverse Childhood Experiences
- Chronic Diseases
- Domestic Violence
- Disability
- Homeless and Housing

The CHIP stakeholders participated in the 2nd survey for prioritization in July 2025.

Based on this process, the Steering Committee selected three priority health issues for the 2025 CHIP:

Access to Healthcare Services

Behavioral Health

Child Abuse and Adverse Childhood Experiences (ACEs)

Survey Results:

Rank	Opinion	Score
1st	Access to Healthcare Services (2019 goals: access to oral healthcare)	62
2nd	Behavioral Health* - Mental Health, Tobacco Use, Substance Use	51
3rd	Child Abuse and Adverse Childhood Experiences (2019 goals: maternal and child health)	41
4th	Homelessness and Housing* (2019 goals: transportation)	33
5th	Chronic Diseases (2019 goals: food access)	29
6th	Domestic Violence (2019 goals: violence & preventable injuries)	23
7th	Disability	21

Step 2 - Do a Power Analysis of Each Issue: April, 2025

CHIP stakeholders participated in a power mapping activity and engagement strategies exercise for the identified priority issues. This involves identifying the systems, organizations, and individuals that can either positively or negatively impact progress on the issue. Based on this information, appropriate potential partners were identified for each priority subcommittee to develop interventions to address the issues.

The goals of the power analysis are to do the following:

- Assess the systems, organizations, and people who have an impact on the priority issue
- Identify who the issue affects the most and where there is an opportunity to build their influence
- Identify factors and people perpetuating the problems

This power analysis involves the following steps:

- Identify potential partners and opponents of addressing the priority issue
- Determine who is aligned to the issue and who has the power to influence it
- Consider how to engage each partner and manage opponents

Power influences health equity and policy decisions by:

- Building collective and community power
- Creating shared decision-making processes
- Uniting community partners on equitable terms
- Focusing on uplifting community voices
- Ensuring inclusive participation

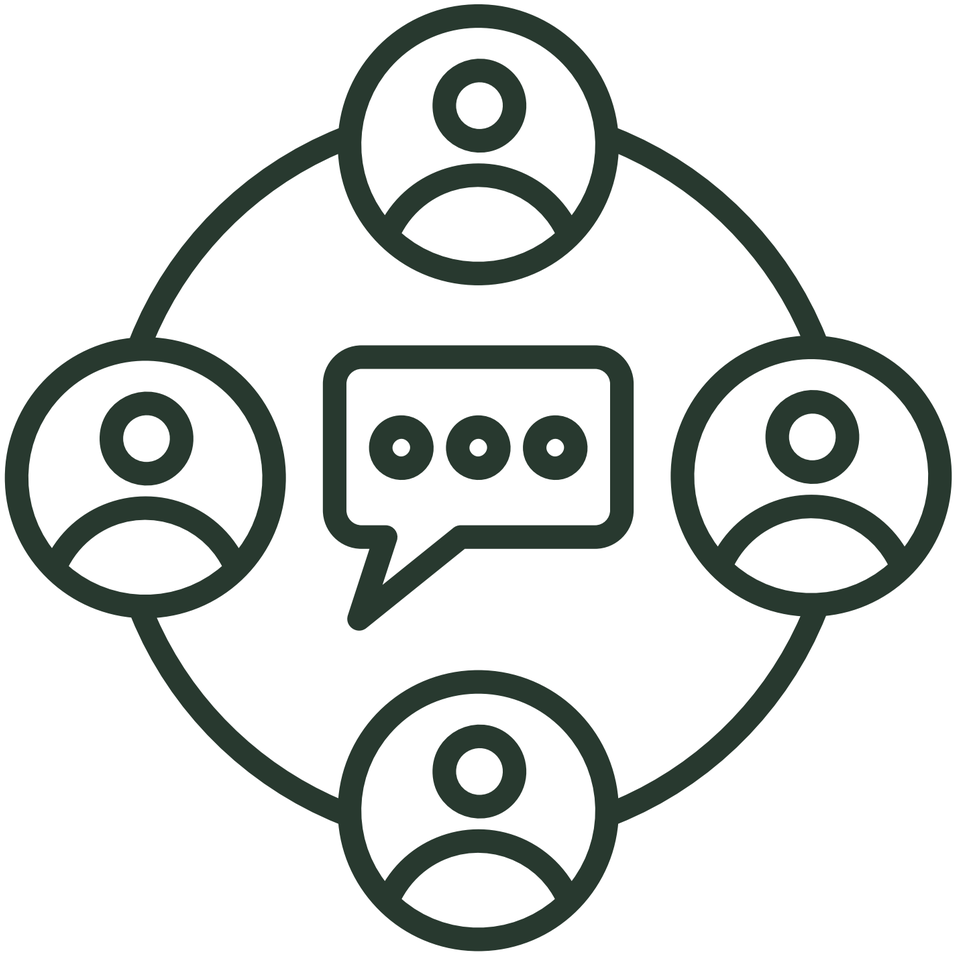
Reference: Power Analysis diagram MAPP 2.0 page 142

"Power properly understood is nothing but the ability to achieve purpose. It is the strength required to bring about social, political, and economic change."

- DR. MARTIN LUTHER KING JR

Step 3 - Set up Priority Issue Subcommittees: July 2025

A CHIP Priority Issue Subcommittee was established for each priority area to develop action plans and define implementation processes for selected strategies. CHIP stakeholders were invited to self-nominate for subcommittee participation based on their capacity, expertise, and available resources aligned with each priority issue area. The CHIP Core Team identified targeted recruitment strategies for subcommittee members, informed by power mapping activity and stakeholder engagement, to ensure diverse representation and strategic engagement.



Development of Goals, Strategies, and Action Plans (Steps 4–7): August - December 2025

From August through December 2025, the Priority Issue Subcommittees convened to advance the CHIP development process. Each subcommittee was led by a subject matter expert serving as Chair, with a Core Team member designated as Co-Chair to provide facilitation support, ensure alignment with the MAPP framework, and maintain progress toward established timelines and accountability.

Each subcommittee determined its own communication and engagement methods, which included email, Zoom, Google Meet, shared Google Drive folders, and in-person meetings, as well as meeting frequency and format. Most subcommittees adopted a bimonthly meeting schedule, meeting either in person or virtually via Zoom, with meetings typically lasting 1.5 hours.

Subcommittee members committed approximately 6–8 hours per month to engagement and planning activities. Responsibilities included identifying opportunities for collaboration, contributing subject matter expertise, sharing and reviewing local data, and supporting the development of goals, strategies, and action steps plans.

Access to Healthcare Services
Chair Ellie Popadic,
Sutter Coat Hospital

Behavioral Health
Chair Shiann Hogan
DHHS Behavioral Health Branch

Child Abuse and ACEs
Chair Pamela Wllder
EPIC Center DNUSD

Step 4 – Create Community Partner Profiles: August, 2025

Partner profile worksheets were distributed and collected using Google Forms. The CHIP Core Team analyzed the profiles to better understand participating organizations' missions, values, resources, and existing efforts related to each priority issue. The partner profiles for the three health priority areas are included in the appendix.

Partner Profile collects the following information;

- Organizational mission, goals, and values
- Available assets and resources to assist with the action plan
- Access to and knowledge of appropriate data and metrics
- Alignment of current interventions, programs, and activities
- Engagement and involvement with priority sub-populations experiencing inequities related to the priority issue

The purpose of the partner profile is to help the CHIP Core Team engage partners effectively by understanding how their organization's work aligns with the priority issue. Partnerships are critical for the CHIP implementation.

Access to Health Care Services - Initial Insight from Partner Profiles:

- Recruit and retain providers; *" Collaborate and get services that help our community."*
- Promote Preventative Services: "*Empower with Health System Literacy."*
- Improve Experience: *"Coordination of care among healthcare services."*
- Reduce need*: " Access issue is largely due to staffing shortage and transportation gaps..Root cause focus (population-level education on unhealthy habits) will create health."*

Behavioral Health - Initial Insights from Partner Profiles:

- Leverage existing resources and interventions
- Proactive and integrated approach for families
- Access to care and support
- Community engagement and awareness
- Data-driven and policy-informed strategies

Child Abuse/ACEs - Initial Insights from Partner Profiles:

- Strong emphasis on upstream strategies (parenting education, stress management, home visiting, early screening)
- Proactive rather than reactive- aiming to prevent ACEs before they occur
- Calls for stronger partnerships with child welfare, healthcare, education, and safety net services
- Acknowledgement that interventions need to be tailored to local community contexts, including rural and tribal communities
- Clear recognition that stigma prevents families from accessing supports

Step 5 – Develop Shared Goals and Long-Term Measures

Each subcommittee established shared goal statements and identified measures to track progress for its priority issue. Goals represent broad, long-term outcomes that set the overall direction for addressing each priority area. Long-term measures are evidence-based and quantifiable indicators used to assess progress toward and achievement of these goals.

Subcommittees reviewed key data findings and engaged in structured goal-development brainstorming using the MAPP Goal Development Worksheet*. This process was guided by transformational approaches that address root causes and align with existing community assets and resources. A SWOT analysis was then applied to prioritize and refine the goals, resulting in the identification of three to five goals per priority issue.

SWOT Analysis- Strengths, Weaknesses, Opportunities, Threats:

- What internal strengths can support each goal?
- What weaknesses or capacity gaps exist?
- What opportunities or capacity gaps exist?
- What threats might limit success?

Example of SWOT taken from Behavioral Health Subcomittee

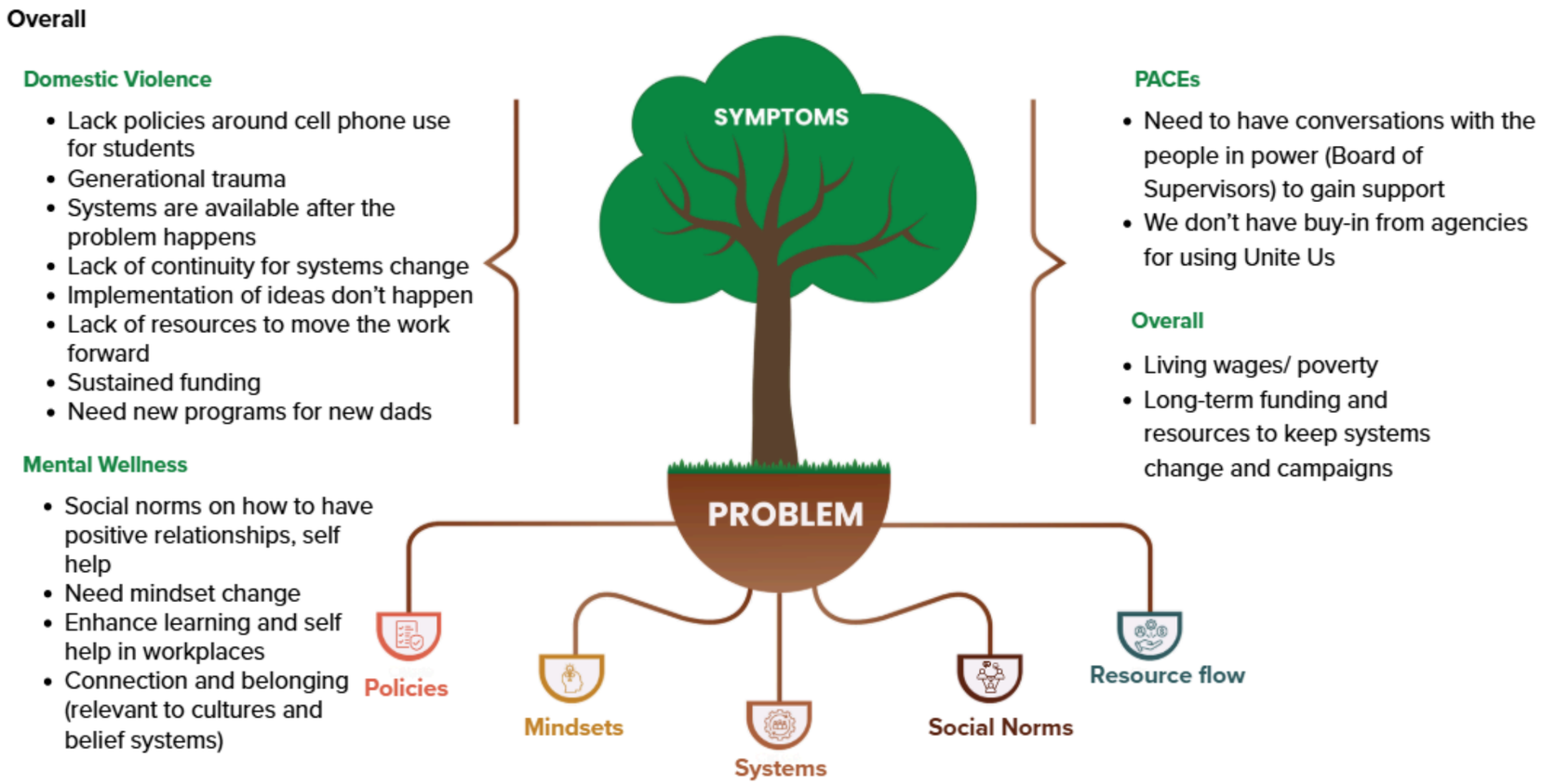
*MAPP Goal Development Worksheet can be found on pages 152 -153 of the MAPP 2.0 Handbook
SWOT Analyis can be found on page 157

Step 6 – Select CHIP Strategies: August-December 2025

Strategies were selected across the health equity action spectrum to address root causes and achieve desired outcomes. Three subcommittees used SWOT analysis for strategic planning, while the Child Abuse/ACEs Prevention subcommittee also used a fishbone* analysis to identify root causes. The findings from these analyses are included in the appendix.

Step 7 – Develop a Continuous Quality Improvement Action Planning Cycle: August-December 2025

Each subcommittee developed an action plan that includes objectives, performance measures, timelines, assigned responsibilities, and a Plan-Do-Study-Act (PDSA) cycle to support continuous improvement.



Root Cause Analysis from Step 7 Child Abuse and ACEs Subcommittee Meeting 11/17/2025

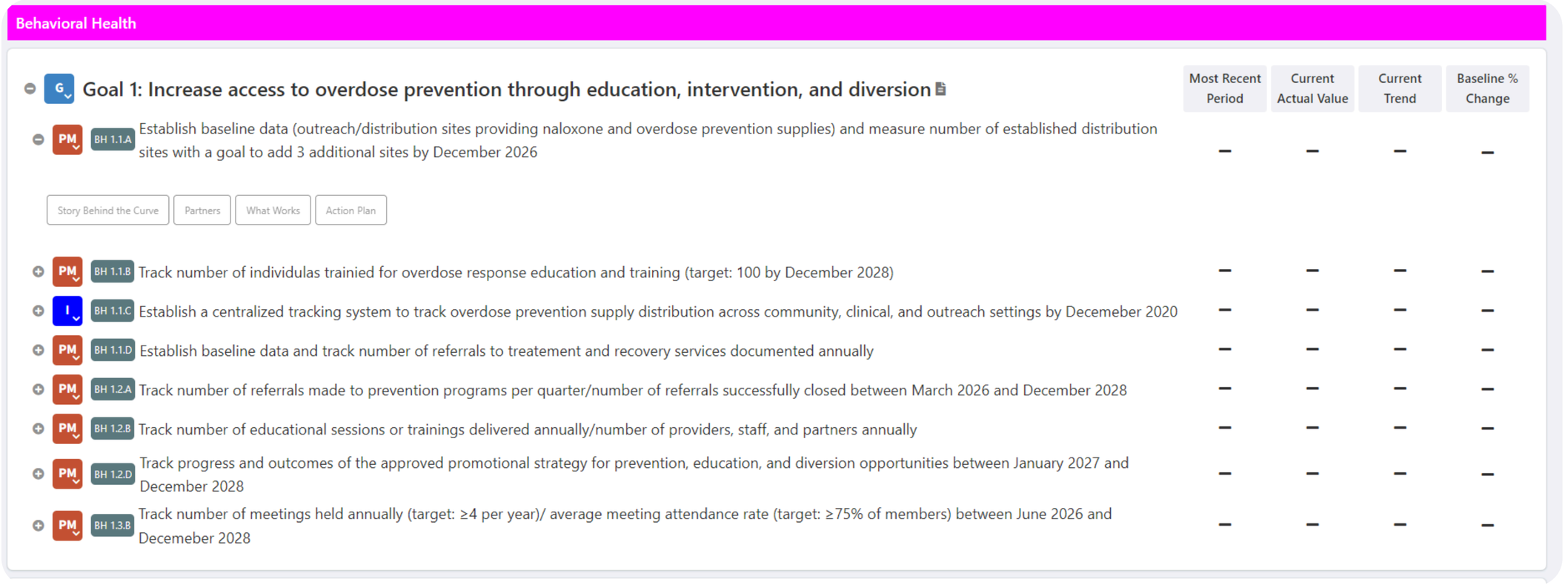
*MAPP 2.0 Fishbone Analysis found on page 120 of Handbook

Step 8- Monitor and Evaluate the CHIP: January 2026-December 2028

Ongoing data collection and performance tracking will occur from January 2026 through December 2028 to assess progress toward goals, evaluate the effectiveness of strategies, and inform timely adjustments.

Clear Impact Scorecards will be used to track work plan objectives, action step implementation, and overall impact. Evaluation efforts will be guided by the Results-Based Accountability (RBA) framework and the Plan-Do-Study-Act (PDSA) model to support continuous quality improvement and promote CHIP team values of accountability and transparency.

Resilient DNATL received funding from the Klamath Promise Neighborhood (KPN) initiative in Del Norte County to develop a centralized data dashboard. The dashboard will regularly post local data and CHIP progress reports, ensuring timely public access and transparency in tracking progress.



Example of Clear Impact RBA Scorecard for Behavioral Health

Priority Area: Access to Healthcare Services

Many residents in Del Norte County face significant barriers to healthcare, including provider shortages, high out-of-pocket costs, limited availability of dental services, and long travel distances often requiring costly transportation. Community members consistently identified improved access to medical care as the priority with the greatest potential health impact. Del Norte County is designated as a Health Professional Shortage Area (HPSA), reflecting insufficient availability of primary care, mental health, and dental providers to meet community needs.

Magnitude of the Issue and Community Perspectives

Residents experience multiple, compounding barriers to healthcare access, These barriers contribute to delayed or forgone care, increasing the risk of preventable and chronic conditions such as diabetes, hypertension, and cancer. Limited access to primary and preventive care also results in higher use of emergency departments for non-urgent needs, placing strain on local hospitals and driving up healthcare costs. Financial burden is significant; a Del Norte County family with two full-time working parents and two children spends approximately 23% of household income on healthcare, nearly double the California state average. Additionally, 43% of community members identified dental care as one of the most important health challenges facing the county.

MAGNITUDE OF ISSUE

Skipping or delaying medical care can lead to the progression of preventable diseases, including:

- **Diabetes**
- **Hypertension**
- **Cancer**

Without primary and preventive care, many people turn to emergency rooms for non-urgent needs, which **strains hospitals and raises healthcare costs.**

A Del Norte family with two full-time working parents and two kids spends about 23% of their income on healthcare, nearly double the state average.

VOICES FROM THE COMMUNITY

#1 Ranked
Community reports that improved access to medical care would have the greatest impact on health

Healthcare access is limited with additional barriers like **provider shortages and travel time.**

43%
said dental care is one of the most important health challenges.

Action Plan: Access to Healthcare Services

Goal #1) Strengthen recruitment and retention of healthcare professionals

1.1) By December 2026, develop a comprehensive Community Connection Program available for all newly recruited providers of all levels. By December 2027, ensure 90% of incoming providers are offered the program during onboarding, with at least 80% participating in at least one community-engagement activity within their first 12 months.

Strategy: Strengthen recruitment and retention of healthcare professionals

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.1.A) Connect with Humboldt County Chamber to understand their program as well as other similar programs in California.	Receive at least one program outline	March 2026	Deputy Director Department of Health and Human Services, County of Del Norte
1.1.B) Engage Del Norte Chamber of Commerce	Meet at least once with Del Norte Chamber of Commerce	March 2026	COO Sutter Hospital
1.1.C) Establish partnerships with community organizations	10 community partners formally committed	May 2026	Executive Director Chamber of Commerce Del Norte
1.1.D) Establish Community Connection Program Design committee with volunteers from committed community partners.	3- 5 community partners on CCPD committee, with 1 community partner desginated as Chair	June 2026	Executive Director Chamber of Commerce Del Norte
1.1.E) Support integration of program into provider onboarding workflows at participating local entities' hiring providers.	Added to onboarding checklists. (base target is 80% and full performance 100%)	February 2027	Committee Chair >> provider champions
1.1.F) Launch the Community Connection Program.	Program fully available to all new providers	February 2027	Committee Chair >> provider champions
1.1.G) Monitor Participation	80% participate in one activity for new provider engagement, annual report will be provided	December 2027	Provider champions >> committee

Collaborators/Partners:	Strategy Details:
College of the Redwoods- Career Pathways, Chamber of Commerce (Del Norte & Humboldt), Open Door, Stallant, UIHS, Sutter,	Strategy will pivot if needed around Chamber of Commerce engagement, DHHS in supporting role

Action Plan: Access to Healthcare Services

Goal #1) Strengthen recruitment and retention of healthcare professionals

1.2) Establish a Recruitment Collaboration Workgroup with key community stakeholders by March 2026. The workgroup will focus on supporting the recruitment of 10 new healthcare providers across all levels by December 2028.

Strategy: Strengthen recruitment and retention of healthcare professionals

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.2.A) Identify and invite key community stakeholders.	Invitations sent to ≥5 organizations/entities.	January 2026	COO Sutter Coast Hospital
1.2.B) Convene first meeting Provider Recruitment Workgroup	Minimum 5 stakeholders attend and workgroup chair selected.	March 2026	COO Sutter Coast Hospital/Deputy Director Department of Health and Human Services, County of Del Norte
1.2.C) Develop shared committee recruitment strategy inclusive of sign on and retention incentives for providers	Strategy completed and signed off by participating stakeholders	June 2026	Workgroup Chair
1.2.D) Support provider implemention of shared strategy regarding sign on and retention incentives for providers.	Implementation strategy inclusive of community sign on bonus included in provider postings.	September 2026	Hiring entities/ Workgroup Chair
1.2.E) Track recruitment progress.	10 net providers recruited and retained by 2028	Quarterly through 2028	Workgroup Chair

Collaborators/Partners:	Strategy Details:
College of the Redwoods- Career Pathways, Chamber of Commerce (Del Norte & Humboldt), Open Door, Stallant, UIHS, Sutter, HealthCare District	Develop community-available incentive (i.e. for all providers) HealthCare District key partner DHHS in supporting role

Action Plan: Access to Healthcare Services

Goal #2) Enhance communication and coordination of care.

2.1) Launch a local Healthcare Navigation Coalition by June 2026, engaging at least 75% of invited healthcare entities. The coalition will convene monthly beginning in Q3 2026, maintain an average attendance of 70%, and complete a shared plan to strengthen navigation services by March 2027.

Strategy: Enhance communication and coordination of care

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
2.1.A) Identify healthcare/community entities.	List of ≥10 entities created (5 minimum)	April 2026	Member Services Manager, Open Door
2.1.B) Send invitations and outreach	≥75% confirm participation.	May 2026	Member Services Manager, Open Door
2.1.C) Identify Coalition Chair	Chair established for coalition	May 2026	Participating entities
2.1.D) Hold coalition kickoff	Charter developed and coalition launched	June 2026	Coalition Chair
2.1.E) Convene monthly meetings	≥75% confirm participation.	Begin July 2026	Coalition Chair
2.1.F) Develop shared navigation plan	Plan approved	May 2027	Coalition workgoup

Collaborators/Partners:	Strategy Details:
Sutter, Open Door, Stallant, UIHS, Area One on Aging, Addie Meedom, DHHS	DHHS in participatory role.

Action Plan: Access to Healthcare Services

Goal #3) Expand access to telehealth and mobile services

3.1) Identify high-need areas/populations that would benefit from expanded telehealth access and/or mobile services and leverage existing stakeholder expertise to create action plan.

Strategy: Expand access to telehealth and mobile services

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
3.1.A) Initiate program exploration by establishing working group	Identify stakeholders necessary to spearhead program exploration	April 2026	COO Sutter Coast Hospital/Deputy Director Department of Health and Human Services, County of Del Norte
3.1.B) Working group to identify high-need areas/populations; corresponding potential access sites/solutions, and point person for documenting Action Plan	≥3 high-need zones/solution sites identified	December 2026	Working group
3.1.C) Initiate Development of Action Plan that includes feasibility assessment	Feasibility assessments completed for all identified sites	March 2027	Identified point person
3.1.D) Draft and Share Proposed Action Plan	Action plan shared with larger stakeholder group.	December 2027	Identified point person

Collaborators/Partners:	Strategy Details:
Open Door, Stallant, UIHS, Sutter, Del Norte County Department of Education, Area 1 Agency on Aging	This strategy relies on leveraging the operational subject matter expertise held by workgroup invitees.

Action Plan: Access to Healthcare Services

Goal #4) Create a culture of wellness

Objective 4.1) Identify/develop a culturally relevant health literacy curriculum by April 2027 to support community wellness. Train at least 10 people as Health Literacy Community Champions facilitators by December 2027. Facilitators begin leading ongoing community education sessions in 2028.

Strategy: Create a culture of wellness

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
4.1.A) Initiate program exploration by establishing working group	Identify stakeholders necessary to spearhead program exploration	April 2026	COO Sutter Coast Hospital/Deputy Director Department of Health and Human Services, County of Del Norte
4.1.B) Connect with Lake and Mendocino connections from Partnership and Sutter to understand hub model & feasibility	Acquire information from Partnership and Sutter and meet to review	July 2026	Deputy Director DHHS, County of Del Norte/COO SCH/ Community Health Needs Liaison Partnership Health
4.1.C) Assess free/low cost training opportunities/certification for community members who want to lead health literacy initiatives	Identify selected opportunities/curriculum and identify how to share information and designate Community Champions.	April 2027	Stakeholder working group
4.1.D) Health Literacy Community Champion Program trained members start a network of Community health literacy/health promotion events.	Trained community members self-launch health literacy events, at least 1 per quarter (4 per year) by December 2028.	December 2028	Trained Community Champions

Collaborators/Partners:	Strategy Details:
Sutter, DHHS, Partnership Health and other local community partners to be determined	This strategy does not directly connect with the educational opportunities sponsored by career pathways, but may identify/provide opportunities of connection that support those goals. This strategy is meant to engage and empower the community to take action in areas deemed relevant by community members.

Priority Area: Behavioral Health (including tobacco use, substance use, and mental health)

The 2024 CHA identified Behavioral Health as a priority issue due to its significant and growing impact on community health and safety. Behavioral health challenges in the county encompass mental health conditions, substance use, and tobacco use, all of which contribute to preventable illness, injury, and premature death.

Magnitude of the Issue and Community Perspectives

Based on the 2024 Del Norte Community Health Assessment (CHA), Del Norte County experiences mental health–related death rates that are significantly higher than the California average, with trends indicating worsening outcomes over time. The age-adjusted mortality rate for suicide in Del Norte County is approximately 2.5 times higher than the state average.

Substance use has emerged as a critical driver of preventable deaths. Drug overdose deaths increased by 167% between 2021 and 2022, reflecting the ongoing opioid crisis and the increasing presence of synthetic opioids such as fentanyl. Substance use is also a contributing factor in other leading causes of death, including motor vehicle crashes and accidental injuries. In addition, Del Norte County reports the highest rates of newly diagnosed Hepatitis C cases in California, a condition strongly associated with intravenous drug use and co-occurring mental health challenges.

Tobacco and nicotine use remain a major public health concern. Mortality rates from smoking-related illnesses—such as lung cancer and chronic lower respiratory diseases—exceed state averages.

Community input collected through the CHA underscores the urgency of addressing behavioral health needs. Seventy-seven percent (77%) of respondents identified drug and alcohol use as a leading health concern, while 56% reported emotional and mental health as one of the most significant health struggles in the community. Tobacco and nicotine use is also prevalent, with one in three respondents reporting current use of a tobacco or nicotine product.

MAGNITUDE OF ISSUE

Drug overdose deaths rose **167%** from 2021 to 2022. This is likely due to the area's opioid crisis and synthetic opioids like fentanyl.

Substance use is linked to the county's high number of **car crashes, drug deaths, and accidental deaths.**

Rates of newly diagnosed cases of Hepatitis C are the **highest in the state.** Hepatitis C is strongly associated with intravenous drug use and mental health issues.

VOICES FROM THE COMMUNITY

77% said that drug and alcohol use was a leading health concern.

1 in 3 said they use some form of nicotine or tobacco product.

56% said emotional and mental health is one of the biggest health struggles.

Action Plan: Behavior Health (Substance Use)

Goal #1) Increase access to overdose prevention through education, intervention, and diversion.

Objective 1.1) By December 2028, increase community-wide access to overdose prevention supplies and information by establishing naloxone distribution and overdose prevention education.

Strategy: Create a culture of wellness

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.1.A) Expand the number of community, clinical, and outreach distribution sites providing naloxone and overdose prevention supplies from baseline to 3 additional sites.	• Establish baseline data • Number of established distribution sites	December 2026	Behavioral Health Opioid Litigation Workgroup Consultant
1.1.B) Provide overdose response education and training to at least 50 individuals by conducting a minimum of 6 training sessions annually across community, clinical, and outreach settings between January 2027 and December 2028.	Number of individuals trained (target: 100 by December 2028)	January 2027-December 2028	Behavioral Health Opioid Litigation Workgroup Consultant
1.1.C) Establish a centralized system to track overdose prevention supply distribution across community, clinical, and outreach settings by December 2026, and use the system for ongoing monitoring and annual reporting through December 2028.	Centralized tracking system	December 2026	Behavioral Health Opioid Litigation Workgroup Consultant
1.1.D) Strengthen referral pathways to treatment and recovery services with providers to increase the number of documented referrals from community, clinical, and outreach settings by 25% from baseline.	• Establish baseline data • Number of referrals to treatment and recovery services documented annually	December 2028	Behavioral Health

Collaborators/Partners:	Strategy Details:
Rx Safe Del Norte, Resilient DNATL, NorCal 4 Health, Aegis/Pinnacle Treatment Centers, Public Health, Data Team, Live Well Del Norte, Partnership HealthPlan of California, Del Norte Community Health Center, Stallant Health & Wellness, Sutter Coast (SUN), United Indian Health Services Opioid Awareness Coalition (UIHS OAC), Yurok Tribe Wellness Coalition, Tolowa Dee-ni' Nation	• Use SAMHSA-allowable language: life-saving overdose prevention and response • Align supplies and services with federal funding guidance • Prioritize equitable access in rural and tribal communities • Funding available for overdose prevention supply distribution through Opioid Litigation Funds.

Action Plan: Behavior Health (Substance Use)

Goal #1) Increase access to overdose prevention through education, intervention, and diversion.

Objective 1.2) By December 2028, increase participation in substance use and overdose prevention activities by 30% from baseline by strengthening engagement in prevention and diversion through coordinated referrals and data-informed improvement.

Strategy: Strengthen engagement in prevention, early intervention, and diversion through coordinated referral pathways and data-informed improvement.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.2.A) Gather baseline data and enhance referrals to prevention programs by expanding warm handoffs, implementing closed-loop referral systems, and tracking referrals and outcomes.	• Baseline data established • Number of referrals made to prevention programs per quarter • Number of referrals successfully closed	March 2026-December 2028	Behavioral Health
1.2.B) Provide at least 2 educational trainings annually to healthcare providers, first responders, and community partners to reduce stigma and bias toward evidence-based treatments, including Medication-Assisted Treatment (MAT).	• Number of educational sessions or trainings delivered annually • Number of providers, staff, and partners trained	Annually December 2026 December 2027 December 2028	Behavioral Health Opioid Litigation Workgroup Consultant
1.2.C) Create a promotional strategy of prevention, education, treatment, and diversion opportunities available to the community by December 2026.	Promotional strategy created and approved	December 2026	Behavioral Health
1.2.D) Implement the approved promotional strategy for prevention, education, treatment and diversion opportunities available to the community between January 2027 and December 2028, and track progress and outcomes	Social media analytics, surveys from local providers and community partners to measure impact	January 2027-December 2028	Behavioral Health

Collaborators/Partners:	Strategy Details:
Del Norte Unified School District (DNUSD), Trillium Teen Center, Family Resource Center of the Redwoods, Coastal Connections, Rx Safe Del Norte, Resilient DNATL, NorCal 4 Health, United Indian Health Services Opioid Awareness Coalition (UIHS OAC), Yurok Tribe Wellness Coalition, Tolowa Dee-ni' Nation, Open Door Teen Clinic, National California Indian Development Council (NCIDC), Aegis / Pinnacle Treatment, Care Court, Public Defender, Juvenile Justice.	• Address declining leverage of punitive systems by emphasizing voluntary engagement (diversion) • Focus on prevention and treatment linkage • Diversion through justice system e.g. Care Court, Teen Court • 1.2.C.- Strategy details to include flyers, brochures, media platforms

Action Plan: Behavior Health (Substance Use)

Goal #1) Increase access to overdose prevention through education, intervention, and diversion.

Objective 1.3) By June 2026, establish a Substance Use Prevention and Education Group to support information sharing and coordination, and maintain regular meetings with participation from cross-sector partners through December 2028.

Strategy: Create a standing cross-sector group to align prevention, education, and diversion efforts.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.3.A) Convene cross-sector partners to establish the Substance Use Prevention and Education Group and formally define its purpose, scope, membership, and roles.	• Partners list with roles outlined • Written purpose, scope, and membership document completed and approved	June 2026	Behavioral Health
1.3.B) Establish a facilitation structure and meeting schedule by June 2026 and facilitate the meetings with the group meeting at least quarterly through December 2028.	• Number of meetings held annually (target: ≥4 per year) • Average meeting attendance rate (target: ≥75% of members)	June 2026-December 2028	Behavioral Health
1.3.C) Annual report on data trends, best practices, and recommendations and publish to the Behavioral Health Webpage.	• Annual report published to Behavioral Health Webpage	Annually December 2027 December 2028	Behavioral Health
1.3.D) Implement the approved promotional strategy for prevention, education, treatment and diversion opportunities available to the community between January 2027 and December 2028, and track progress and outcomes	Social media analytics, surveys from local providers and community partners to measure impact	January 2027-December 2028	Behavioral Health

Collaborators/Partners:	Strategy Details:
Del Norte County Unified School District (DNUSD), Juvenile Justice, Care Court, Healthcare Providers, Rx Safe Del Norte, United Indian Health Services Opioid Awareness Coalition (UIHS OAC), United Indian Health Services (UIHS), NorCal 4 Health, Resilient DNATL, Stallant Health and Wellness, Del Norte Community Health Center, Aegis / Pinnacle Treatment, Public Health, Trillium Teen Center, Coastal Connections, Partnership HealthPlan of California, North Coast Indian Development Council (NCIDC), Yurok Tribe, Tolowa Dee-ni' Nation, Del Norte Reads	• Avoid duplication of existing coalitions • Align with data dashboard reporting • Document outputs and recommendations • A strategy is needed for sharing the annual report with stakeholders.

Action Plan: Behavior Health (Mental Health)

Goal 2) Improve the mental health of Del Norte County community members.

Objective 2.1) By December 2028, increase the number of individuals completing mental health support and suicide prevention trainings by 25% from baseline.

Strategy: Expand evidence based mental health literacy, prevention, and early identification training.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
2.1.A) Asset map all mental health support and suicide prevention trainings to establish baseline training availability and participation data.	• List of mental health supports • Establish baseline data	June 2026	Behavioral Health
2.1.B) Expand Mental Health First Aid and similar evidence-based trainings to increase the number of individuals who enroll and complete mental health support and suicide prevention education.	• Number trainings delivered annually • Number of trainings completed by individuals	January 2026-December 2028	Behavioral Health
2.1.C) Increase trainings to trainers to facilitate mental health support and suicide trainings prioritizing youth, teens, veterans, seniors, and organizations that serve these populations.	• Number of staff who become certified trainers • Number of youth, teens, veterans, senior, and related organizations completing trainings	January 2026-December 2028	Behavioral Health

Collaborators/Partners:	Strategy Details:
Del Norte County Unified School District, Trillium Teen Center, Coastal Connections, Resilient DNATL, NorCal 4 Health, Behavioral Health, Del Norte Reads, Mission Possible, Area 1 Agency on Aging, Senior Center, Open Door, UIHS, Senior Lunch Programs, UIHS Community Outreach Resources and Education Coalition (CORE), National Alliance on Mental Illness, In Home Health Services, Yurok Tribe, Tolowa Dee-ni' Nation, Elk Valley Rancheria, Pulikla Tribe of Yurok People, United Indian Health Services.	• Ensure training reaches rural and senior populations. • Mental Health First Aid (MHFA) • 2.1.B- Individuals need to complete pre-coursework to attend training. • 2.1.C- Enhancement certificates available to trainers to expand more catered trainings

Action Plan: Behavior Health (Mental Health)

Goal 2) Improve the mental health of Del Norte County community members.

2.2) Reduce stigma by implementing a community-wide mental health awareness and recovery campaign.

Strategy: Implement coordinated stigma-reduction and awareness efforts.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
2.2.A) Develop and implement annual mental health awareness and recovery campaign themes and materials.	• Annual campaign theme developed and approved	Annually December 2026, 2027, 2028	Behavioral Health
2.2.B) Engage community partners to support outreach, messaging, and mental health awareness and recovery events.	• Number of outreach events and partner-led activities conducted annually	Annually Annually by December 2026, 2027, 2028	Behavioral Health
2.2.C) Increase awareness by promoting mental health and recovery resources through enhancing referral pathways through campaign messaging.	• Number of mental health resources and referral pathways promoted annually	Annually December 2026, 2027, 2028	Behavioral Health
2.2.D) Track engagement outcomes and relevant materials distributed	• Number of individuals reached through campaigns (events, social media, partners)	Annually	Behavioral Health

Collaborators/Partners:	Strategy Details:
Del Norte Unified School District (DNUSD), Community Based Organizations, Resilient DNATL, Child Abuse Prevention Council (CAPC), Rx Safe Del Norte, Local Media / Marketing partners, Behavioral Health, Public Health, Coastal Connections, Private Sector, local tribes, United Indian Health Services (UIHS), Open Door Community Health Center, Local Influencers, Family Resource Center of the Redwoods, Del Norte County Library, Sutter Coast, Stallant Health & Wellness, Senior programs, MCAH (Maternal Child Adolescent Health)	2.2.A) Campaign materials include flyers, social media graphics, and toolkits 2.2.B) Mental Health Awareness in May (proclamation and walk) using culturally responsive messaging that is youth and family-friendly, and substance use and recovery awareness month in September 2.2.C) The resources are services that are provided (e.g., PATH Mobile Crisis. Our BHSA survey asks about people's awareness of certain programs)

Action Plan: Behavior Health (Mental Health)

Goal 2) Improve the mental health of Del Norte County community members.

Objective 2.3) By December 2028, expand the use of standardized mental health assessment tools in Del Norte County to support tracking outcomes and trends.

Strategy: Conduct a data-informed assessment to guide system improvements.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
2.3.A) Compile and analyze existing mental health assessment tools and service utilization data to establish a baseline.	Data report of analyzed data of Behavioral Health Branch services	December 2026	Behavioral Health
2.3.B) Increase the number of clients receiving a standardized mental health assessment tool through Behavioral Health Branch services.	Number of clients receiving the standardized mental health assessment tool	December 2028	Behavioral Health
2.3.C) Develop and maintain a dashboard to track mental health assessment outcomes and trends.	• Dashboard developed • Quarterly report	December 2026- December 2028	Behavioral Health

Collaborators/Partners:	Strategy Details:
Kings View Electronic Health Records (EHR Consultant), Behavioral Health, Live Well Del Norte Data Dashboard	• HIPAA standards in data collection • 2.3.B- Preference of Milestone of Recovery Scale (MORS)

Action Plan: Behavior Health (Tobacco Use)

Goal 3) Decrease nicotine use and addiction in the community.

Objective 3.1) By December 2028, establish a cross-sector collaborative to implement a coordinated, comprehensive prevention plan through evidence-based prevention, education, and youth leadership projects to reduce youth nicotine use and addiction.

Strategy: Cross-sectoral collaboration through evidence-based prevention, education, and youth leadership projects.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
3.1.A) List and connect with at least 5 youth-serving organizations to establish partnerships.	List of collaborative partners	June 2026	TUPP/Tobacco Free Del Norte Coalition
3.1.B) Asset map existing capacity to identify programs, curricula, resources, school prevention efforts, and gaps.	Comprehensive asset map	August 2026	TUPP/Tobacco Free Del Norte Coalition
3.1.C) Establish shared priorities and design a coordinated prevention plan.	A list of shared priorities and coordinated prevention plan	December 2026	TUPP/Tobacco Free Del Norte Coalition
3.1.D) Implement coordinated prevention plan, monitor progress, and adjust as needed.	Quarterly partner check-ins to measure progress and revise the plan as needed	January 2027-Decemeber 2028	TUPP/Tobacco Free Del Norte Coalition
3.1.E) Analyze and compare youth nicotine use trends from 2025 to 2028 using availbale data sources.	Data analytic reports	December 2028	TUPP/Tobacco Free Del Norte Coalition

Collaborators/Partners:	Strategy Details:
Tobacco Use Prevention Program (TUPP), Tobacco Free Del Norte Coalition (TFDN), Trillium Teen Center, Coastal Connections, Tobacco Use Prevention Education (TUPE), United Indian Health Services (UIHS) ,Northern California Indian Development Council (NCIDC), NorCal 4 Health, Teen Clinic, Resilient DNATL, youth champions, parents, Youth Opportunity Center (YOC), Del Norte Community Health Center, Youth Groups, Teen Advisory Group (TAG), local church youth groups	• 3.1.A) Coastal Connections, Trillium, TUPE, TUPP, Youth Groups, STORM • 3.1.B) MAPP 2.0 toolkit, Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven, strategic planning framework • 3.1.C) Plan outline • 3.1.E) California Healthy Kids Survey (CHKS) biennial data releases to see trends in tobacco and vaping across grades 7th, 9th, and 11th.

Action Plan: Behavior Health (Tobacco Use)

Goal 3) Decrease nicotine use and addiction in the community.

Objective 3.2) By December 2028, Increase awareness of community resources to local providers and community partners to promote tailored supportive services including cessation, social connection, and healthy coping strategies

Strategy: Coordinated, evidence-based cessation awareness promotion.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
3.2.A) Form a collaborative work group to develop tailored cessation strategies.	List of community resources provided to local providers and community partners	June 2026	TUPP/Tobacco Free Del Norte Coalition
3.2.B) Administer surveys to local providers and community partners to understand their awareness of supportive community services available.	Survey analytics and established baseline data	October 2026	TUPP/Tobacco Free Del Norte Coalition
3.2.C) Develop an outreach strategy for local providers and community partners to increase their awareness of resources available and ability to track resource distribution.	Strategy outline developed and approved	November 2026-February 2027	TUPP/Tobacco Free Del Norte Coalition
3.2.D) Implement the approved outreach strategy, including launching a multi-channel awareness campaign to promote tobacco cessation resources and services.	• Social media analytics • Surveys from local providers and community partners	March 2027-September 2028	TUPP/Tobacco Free Del Norte Coalition
3.2.E) Administer a post-survey to local providers and community partners to measure outcomes.	Survey analytics compared to baseline data, with a target of 50% increase comparted to baseline date	October 2027-December 2027	TUPP/Tobacco Free Del Norte Coalition

Collaborators/Partners:	Strategy Details:
Tobacco Use Prevention Program (TUPP), Tobacco Free Del Norte Coalition, United Indian Health Services (UIHS), Northern California Indian Development Council, NorCal 4 Health, Teen Clinic, Resilient DNATL, local health care providers, Tribal organizations, Family Resource Center of the Redwoods, Del Norte County Library, community champions, Senior Center, Partnership HealthPlan of California, Local Media (Redwood Voice, Health Matter), College of the Redwoods, Mission Possible	3.2.C) including cessation programs, behavioral health referral options, mindfulness, mental health support, posters for treatment rooms

Action Plan: Behavior Health (Tobacco Use)

Goal 3) Decrease nicotine use and addiction in the community.

Objective 3.3) By December 2028, research and identify new policy opportunities while strengthening existing nicotine policies by utilizing a multi-sector policy workgroup to increase support and awareness.

Strategy: Establish multi-sector policy working group.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
3.3.A) Establish a multi-sector policy workgroup.	List of workgroup members	June 2026	TUPP/Tobacco Free Del Norte Coalition
3.3.B) Research and evaluate existing and new tobacco and nicotine policies that have been effective in other counties.	Number of policy briefs or fact sheets developed annually	Annually December 2026-December 2028	TUPP/Tobacco Free Del Norte Coalition
3.3.C) Strengthen enforcement and support of existing tobacco and nicotine policies among local authorities and affected populations through training, education, and outreach with a minimum of three presentations per year.	Number of trainings conducted and participants at community outreach sessions about current and new policies annually.	Annually December 2026-December 2028	TUPP/Tobacco Free Del Norte Coalition
3.3.D) Draft new policy recommendation(s) that are feasible, evidence-based, and align with community needs for reducing nicotine use and addiction in the community.	Policy recommendation report ready for next CHIP cycle.	December 2028	TUPP/Tobacco Free Del Norte Coalition

Collaborators/Partners:	Strategy Details:
Tobacco Use Prevention Program (TUPP), NorCal 4 Health, Resilient DNATL, healthcare district, local businesses and retail stores, Chamber of Commerce, multi-unit housing managers, City and County Leaders, Policy chief, Environmental Health, Family Resource Center of the Redwoods, Community Based Organizations, local enforcement agencies, Del Norte Unified School District (DNUSD)	3.3.B) Smoke free zones (parks, places of work, Arcata model) 3.3.C) Provide presentations with workgroup to local authorities, townhall meetings, rallies, social media messages, media events (KFUG, KCRE/KPOD) 3.3.C) Existing tobacco and nicotine policies include Tobacco Retail License (TRL) and Smoke-Free Multi-Unit House (SFMUH) ordinances in Crescent City and Del Norte County

Priority Area: Child Abuse and Adverse Childhood Experiences (ACEs)

The 2024 CHA identified Child Abuse and Adverse Childhood Experiences (ACEs) as a critical priority due to their profound and lasting impact on health, well-being, and community safety. ACEs include experiences such as abuse, neglect, household substance use, exposure to domestic violence, and other forms of childhood trauma. These experiences are strongly associated with negative health behaviors, chronic disease, mental health challenges, and premature mortality across the lifespan.

Magnitude of the Issue and Community Perspectives

Children in Del Norte County face a disproportionately high risk of experiencing abuse and neglect. Local data indicates that children in the county are approximately twice as likely to experience abuse or neglect compared to the California state average. These early adverse experiences increase the likelihood of long-term physical, behavioral, and mental health challenges.

ACEs are widespread among adults in Del Norte County, highlighting the intergenerational nature of trauma experienced locally. Sixty-nine percent (69%) of adults reported experiencing at least one ACE. Specific experiences include emotional neglect (32%) and exposure to mental illness within the household (28%). These findings underscore the cumulative impact of childhood trauma and its continued influence on adult health and lasting impact on behaviors and outcomes throughout their lives.

Exposure to substance use during childhood can normalize addictive behaviors and contribute to intergenerational cycles of addiction and trauma. Research shows that individuals with even one ACE are more likely to have engaged in injection drug use compared to those with none, and the risk increases dramatically—up to ten times higher—for individuals with four or more ACEs. These connections reinforce the need for prevention and early intervention strategies that address root causes of trauma.

Action Plan: Action Plan: Child Abuse and ACEs

Goal 1) Increase positive childhood experience and reduce Adverse Childhood Experiences (ACEs) in Del Norte County.

Objective 1.1) By December 2028, increase the number of resilience screenings for Adverse Childhood Experiences (ACES) conducted across community and healthcare partners and identify the most prevalent ACEs in Del Norte County.

Strategy: Increase the number of ACES And Resilience screenings.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.1.A) Collaborate with community and healthcare partners to collect and analyze ACEs screening data to identify most common ACEs and baseline annual screening rates in Del Norte County.	Number of annual screenings Analyzed data report	December 2026	Resilient DNTAL
1.1.B) Work with at least 5 community and healthcare partners to promote and increase ACEs and Resilience screenings.	List of community and healthcare partners	December 2028	Resilient DNTAL
1.1.C) Establish an MOU to collect ACEs data from screenings under the jurisdiction of the courts and create a report of the top 4 ACEs.	MOU established and report complete		Public Health and Tribal Courts

Collaborators/Partners:	Strategy Details:
Public Health, United Indian Health Services (UIHS), Del Norte Community Health Center, Stallant Health & Wellness, Sutter Coast Community Clinic, Redwood Medical Center, Tribal Courts (Tolowa and Yurok) , CAPC-Ed (Child Abuse Prevention Council- Education Committee), Partnership HealthPlan of California	• Establish contact for Tolowa and Yurok courts *don't collect duplicate scores* • Resilience Screenings- find more information- Youth Wellness Checks (YWC) • Data source: ACEs Aware Medi-Cal dashboard https://data.acesaware.org/medi-cal-aces-children/ • see ACES aware link http://www.traumainformedcareproject.org/resources/resilience_questionnaire.pdf

Action Plan: Action Plan: Child Abuse and ACEs

Goal 1) Increase positive childhood experience and reduce Adverse Childhood Experiences (ACEs) in Del Norte County.

Objective 1.2) By December 2028, increase participation of parenting supports and community programming through collaboration with at least (3) additional Community Based Organizations from the baseline.

Strategy: Establishment of workgroup to increase participation of parenting supports and community programming available to community members.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
1.2.A) Establish a strategic workgroup of community based organizations that offer parenting supports and community programs.	Workgroup member list	June 2026	Resilient DNATL
1.2.B) Workgroup to complete asset map and baseline data of program participation.	Asset map completed and approved	December 2026	Resilient DNATL CAPC-Ed
1.2.C) Workgroup analyzes findings from the asset mapping and develops a strategic plan to increase participation of parenting supports and community programming.	Strategic plan	June 2027	Resilient DNATL CAPC-Ed FRC
1.2.D) Implement the strategic plan and monitor progress of impact and outcomes.	Compared baseline data with new participation rates	December 2028	Resilient DNATL Child Abuse Prevention Council

Collaborators/Partners:	Strategy Details:
Public Health, United Indian Health Services (UIHS), Del Norte Community Health Center, Stallant Health & Wellness, Sutter Coast Community Clinic, Redwood Medical Center, Family Resource Center of the Redwoods (FRC), Child Abuse Prevention Council- Education Committee (CAPC-Ed), Del Norte Unified School District (DNUSD), Community Health Workers, Trillium Teen Center, Del Norte Child Care Council	• 1.2.A Establish connection and build relationships with the tribal programs, CAPC-Ed, Healthy Families of America, Community Health Workers (CHW) at FRC, Resilient DNATL, Del Norte Community Health Center, DNUSD programs working with parents. • 1.2.C- Social media outreach, bring a friend, help participants feel safe and welcome. • Youth Wellness Checks (YWC) for data collection and “Shared Sense Making” for strategy

Action Plan: Action Plan: Child Abuse and ACEs

Goal 2) Increase connection and belonging within the community.

Objective 2.1) By December 2028, build and launch a framework for increasing intergenerational social connections with mentoring programs that foster connection and belonging for community members.

Strategy: Create a cross-sector workgroup to build and implement framework to increase connection and belonging in the community.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
2.1.A) Establish a cross-sector workgroup to build a framework that will teach organizations and community members how to create intergenerational social connections and belonging.	List of workgroup members	June 2026	Resilient DNATL
2.1.B) Workgroup builds a framework and strategy to increase intergenerational social connections and belonging.	Framework and strategy completed and approved	June 2027	Resilient DNATL
2.1.C) Implement and track framework and strategy	Social media analytics, number of flyers/posters, number of presentations	December 2028	Resilient DNATL

Collaborators/Partners:	Strategy Details:
Trillium Teen Center, Resilient DNATL, Public Health (Healthy Families Healthy Baby Coalition), Indigenous Rise, Child Abuse Prevention Council, Family Resource Center of the Redwoods, Behavioral Health (Coastal Connections), DNATL Community Food Council, Senior Center, Area 1 Agency on Aging (AAA), Del Norte Unified School District (DNUSD- EPICenter, Wellness committee), True North Organizing Network	• Community programming to support the ideals of creating connections and belonging (neighborhood BBQs, mentoring programs (peer, intergenerational) • Embed shared voice of people and experiences into framework • Implement promotional plan utilizing partner websites, social media platforms, flyers/posters, and community coalitions. • Reliant on secured and continued funding

Action Plan: Action Plan: Child Abuse and ACEs

Goal 3) Decrease interpersonal violence (IPV) in Del Norte County.

3.1) By December 2028, achieve a 15% reduction in interpersonal violence, as measured by annual call data, through the implementation of evidence-informed prevention strategies that strengthen coping skills and promote healthy communication.

Strategy: Create a cross-sector workgroup to build and implement framework to increase connection and belonging in the community.

Implementation Steps:	Performance Indicator	Target Date	Lead Partner(s)
3.1.A) Establish a cross-sector workgroup to complete an asset map to identify existing programs and resources and evaluate the trends and target populations.	List of workgroup members	June 2026	Resilient DNATL, CAPC, North Coast Rape Crisis Center, Behavioral Health
3.1.B) Workgroup to complete asset map and establish baseline indicators.	Asset map and baseline indicators	December 2026	Resilient DNATL, CAPC, Northcoast Rape Crisis Center, Behavioral Health
3.1.C) Workgroup analyzes findings from asset mapping and develops a strategic plan to decrease interpersonal violence.	Strategic plan	June 2027	Resilient DNATL, CAPC, Northcoast Rape Crisis Center, Behavioral Health
3.1.D) Implement the strategic plan and monitor progress of impact and outcomes.	Compare baseline data from previous year	December 2028	Resilient DNATL, CAPC, Northcoast Rape Crisis Center, Behavioral Health

Collaborators/Partners:	Strategy Details:
Resilient DNATL, Child Abuse Prevention Council (CAPC), Community Champions, Tribal representatives (Yurok & Tolowa), North Coast Rape Crisis Team, Behavioral Health (One Love, Providing Access to Hope-PATH), Harrington House, Faith Based Organizations, Public Health (WIC), Law Enforcement, Trillium Teen Center	• Available programs and resources: One Love, Safe Talk, PATH, North Coast Rape Crisis Team, Harrington House, Tribal resources- https://tolowa.gov/271/Shu-aa-xuu-dvn-Victim-Services-Division • Data collection from: Domestic Violence Calls for Assistance- https://www.kidsdata.org/topic/12/domestic-violence-calls/trend#fmt=940&loc=321&tf=1,164

Resources

Community Health Assessment / Community Health Improvement Plan:

- Community Health Assessment 2024
- Del Norte 2019 Community Health Improvement Plan
- 2019 CHIP Progress Report
- Live Well DNTAL Dashboard

Access to Healthcare Services:

- 2025 CHIP Action Plan - Access to Healthcare Services
- CCRP - Del Norte County Health Care Provider Recruiting and Retention Plan
- Redwood Region RISE - Health & Caregiving Activation Plan
- Partnership HealthPlan - 2025 Annual Data Report for Del Norte County

Behavioral Health:

- 2025 CHIP Action Plan - Behavioral Health
- RxSafe Del Norte
- North Coast Resource Hub
- Northcoast Lifeline Empowering North Coast with vital health resources and support
- Del Norte County Behavioral Health

Child Abuse/ ACEs:

- 2025 CHIP Action Plan - Child Abuse / ACEs
- ACEs Aware - Medi-Cal Members Ages 0-20 Screened with an ACE Score of 4 or More
- ACE & Resilience Questionnaire
- Documentary Draws Connection Between ACEs & Addiction
- CalSCHLS Public Dashboard for Elementary and Secondary schools
- California Healthy Kids Survey - Del Norte County Secondary 2021-2023 Main Report

*If links don't work please contact us.

Appendix A: Glossary

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. ACEs can include violence, abuse and growing up in a family with mental health or substance use problems, instability due to parental separation and household members being in jail or prison. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness and substance misuse in adulthood. About Adverse Childhood Experiences

Community Health Assessment (CHA)

The Public Health Accreditation Board defines community health assessment (CHA) as a comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health. Community Health Assessment (CHA)

Community Health Improvement Plan (CHIP)

A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years. Community Health Improvement Plan (CHIP)

Health Equity

Health Equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities. About Health Equity

Social Determinants of Health

Social determinants of health (SODH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains; Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. Social Determinants of Health

Access to Healthcare Services

ACCESS TO HEALTHCARE SERVICES

Many residents in Del Norte County face significant barriers to healthcare, including provider shortages, high costs, a lack of dental care, and long travel times with expensive transportation. **The county is designated as a Health Provider Shortage Area (HPSA), meaning it lacks adequate primary care, mental health, and dental health providers to meet the needs of the population.**

MAGNITUDE OF ISSUE

Skipping or delaying medical care can lead to the progression of preventable diseases, including:

- **Diabetes**
- **Hypertension**
- **Cancer**

Without primary and preventive care, many people turn to emergency rooms for non-urgent needs, which **strains hospitals and raises healthcare costs.**

A Del Norte family with two full-time working parents and two kids spends about **23%** of their income on healthcare, nearly double the state average.

VOICES FROM THE COMMUNITY

Healthcare access is limited with additional barriers like **provider shortages and travel time.**

#1 Ranked
Community reports that improved access to medical care would have the greatest impact on health.

43%
said dental care is one of the most important health challenges.

ABILITY TO IMPACT

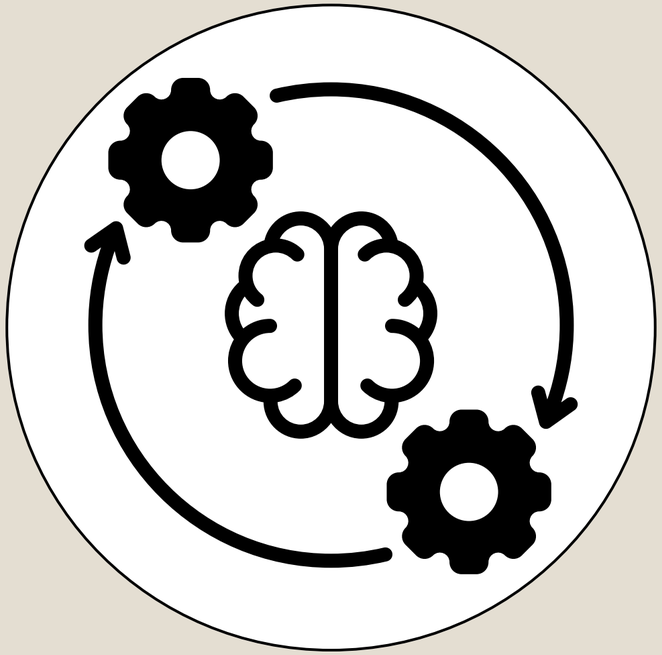
STRATEGIES

Telehealth is Growing: 49% of specialty visits among Del Norte Medi-Cal patients in 2024 were delivered via telehealth (up from 22% in 2021). Telehealth can bridge access gaps.

RESOURCES

Mobile & Community-Based Health Services: Open Door Clinic's Mobile Services, Behavioral Health's Mobile Crisis Team: PATH (Providing Access to Hope), First 5's Local Oral Health Program, Sutter Coast Hospital, United Indian Health Services, Stallant Health, Partnership Health, Public Health

Behavioral Health

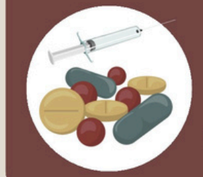


BEHAVIORAL HEALTH

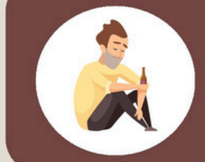
MENTAL HEALTH, TOBACCO USE, SUBSTANCE USE

Del Norte County faces significantly higher mental health-related death rates than the state average, and the situation is worsening. Deaths from smoking-related illnesses, including lung cancer and chronic lower respiratory disease, also exceed state levels. Additionally, drug overdoses are the leading cause of premature death in the county.

MAGNITUDE OF ISSUE



Drug overdose deaths rose **167%** from 2021 to 2022. This is likely due to the area's opioid crisis and synthetic opioids like fentanyl.



Substance use is linked to the county's high number of **car crashes, drug deaths, and accidental deaths.**

Rates of newly diagnosed cases of Hepatitis C are the **highest in the state.** Hepatitis C is strongly associated with intravenous drug use and mental health issues.

VOICES FROM THE COMMUNITY

77% said that drug and alcohol use was a leading health concern.

1 in 3 said they use some form of nicotine or tobacco product.

56% said emotional and mental health is one of the biggest health struggles.

ABILITY TO IMPACT

STRATEGIES

Rx Safe Del Norte Coalition, Behavioral Health's Mobile Crisis Team: PATH (Providing Access to Hope), school district mental health and counseling services, Tobacco Free Del Norte Coalition, STORM youth coalition, Behavioral Health: mental health treatment, counseling, and prevention programs including Service Center and Coastal Connections, mental health support groups, peer support groups, Medical/Partnership Health counseling and managed care services

RESOURCES

Behavioral Health's AOD Program; United Indian Health Service's suicide prevention program, tobacco use prevention, and cessation programs; Opioid Settlement funds; Public Health's Tobacco Use Prevention Program

Child Abuse & Adverse Childhood Experiences

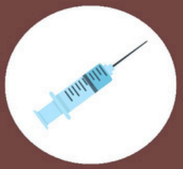
CHILD ABUSE & ADVERSE CHILDHOOD EXPERIENCES

Children in Del Norte County are at significant risk of experiencing Adverse Childhood Experiences (ACES), including abuse, neglect, and witnessing domestic violence. In addition to these, they face increased exposure to a wider range of ACES. These childhood experiences can have profound and lasting effects on healthbehaviors and outcomes throughout their lives.

MAGNITUDE OF ISSUE

Children in Del Norte are about **2x** as likely to face abuse or neglect compared to the state average.

Growing up around substance abuse can make addictive behaviors seem normal, leading to **intergenerational cycles of addiction.**



People with one ACE are more likely to have used injection drugs than those with none. For those with four or more ACEs, the risk jumps to **10x** higher.

VOICES FROM THE COMMUNITY

69%
of adults said they have experienced ACEs.

32%
of adults reported emotional neglect.

28%
reported exposure to mental illness in the household.

ABILITY TO IMPACT

STRATEGIES

Resilient Del Norte and Tribal Lands, Child Abuse Prevention Council, CASA Del Norte

RESOURCES

DHHS Social Services Program, Child Protective Services, DHHS Family Connections, Public Health

CHRONIC DISEASES

Chronic illnesses like diabetes and breathing problems have become the leading cause of death in Del Norte County since 2014, overtaking heart disease. These conditions need long-term care, regular doctor visits, and ongoing medication, which can be costly for both patients and the healthcare system. Chronic diseases often cause pain, tiredness, trouble moving, and make daily tasks harder, which lowers people's quality of life.

MAGNITUDE OF ISSUE

40% of households include at least one person aged 65 years or older.

In rural areas, **diabetes** is especially common because of higher obesity rates, limited access to healthcare services, and healthy food.

The rate of chronic obstructive pulmonary disease (COPD) is **1.6x** higher in Del Norte County compared to the statewide rate.

VOICES FROM THE COMMUNITY

30% said they eat three or more servings of fruits and vegetables each day - well below the recommended five servings.

10% said physical activity and fitness resources had the biggest positive impact on their health.

58% feel Del Norte is a healthy community.

ABILITY TO IMPACT

STRATEGIES

Public Health's CalFresh Healthy Living program, Tobacco Use Prevention Program, United Indian Health Service's Diabetes Prevention Program, Area 1 Aging Senior Center's Meal On Wheels Program,

RESOURCES

Community Food Council programs, Social Service's public assistance (SNAP, CalFresh) Program, Family Resource Center's Mobile Pantry, Rural Human Services' Food Bank, United Indian Health Services' nutrition and garden program, Yurok Tribal food assistance program

DOMESTIC VIOLENCE

Domestic violence remains a serious and ongoing public health issue in the county, affecting individuals and families across all backgrounds. Domestic violence is closely linked to higher rates of depression, anxiety, substance use, and chronic health conditions. In rural areas like Del Norte County, barriers such as geographic isolation, limited access to services, and stigma can make it even harder to seek help.

MAGNITUDE OF ISSUE

The county's domestic violence rate is nearly **12x** the state average. That is over **4x** that of rural California.

Domestic violence is **a leading cause of homelessness** among women and children.

The impact of domestic violence is **equally harmful** across gender, age, and racial groups

VOICES FROM THE COMMUNITY

50% have experienced domestic violence.

Survivors often face **long-term mental health challenges**, including depression, anxiety, PTSD, and suicidal thoughts.

Children exposed to domestic violence face higher risks of **emotional trauma, developmental delays, and future relationship abuse**.

ABILITY TO IMPACT

STRATEGIES

Addressing domestic violence requires a coordinated community response that includes prevention, crisis support, and long-term recovery services.
Del Norte Rape Crisis

RESOURCES

Rural Human Services' Harrington House, Adult Protective Services, Del Norte Senior Center, Area 1 Aging, United Indian Health Services

HOMELESSNESS AND HOUSING

Homelessness is a critical public health issue in Del Norte County. People experiencing homelessness face a significantly higher risk of premature death, chronic disease, depression, and substance use. Our community identified affordable, safe housing the fourth most important factor for better health and stability.

MAGNITUDE OF ISSUE

Disrupted housing affects children's learning, nutrition, and mental health— putting them at risk for **long-term challenges.**

Del Norte County has a homelessness rate **5x** higher than the state.

Homelessness is linked to **shorter life expectancy** due to harsh weather, violence, untreated illness, and overdose.

Substance use and untreated mental health challenges are also key factors that can lead to housing loss.

12% of the homeless population is **under 18 years old.**

Family breakup, domestic violence, child abuse, job loss, reduced income, and eviction all contribute to **housing instability.**

ABILITY TO IMPACT

STRATEGIES

DHHS Behavioral Health and Social Services provide supportive housing programs to help individuals experiencing homelessness access stable housing and essential services. Several affordable housing developments are also underway. These include 26 senior units on H Street and 40 senior units near Joe Hamilton, both opening in October/November 2025. An additional 120 family units are planned for Fall 2026 near Joe Hamilton, with all units designated as low-income and a portion supported by Section 8 vouchers through the Crescent City Housing Authority. At Roosevelt Estates off Washington Boulevard, 56 units have been built over the past two years, with the final phase expected to be completed by Fall 2025.

RESOURCES

County Housing Authority, Encampment Resolution Funding (ERF) Shelter, and Micro Village Project are working to expand safe, affordable housing options.

Access to Healthcare Services

Recruitment Retention

Strengths

- Very involved hospital, clinics, tribal clinics all working on recruitment retention (tuition reimbursement, job placement, residency programs)
- Organizations do Outreach to medical teaching centers
- Loan Forgiveness Program (2 years retention)
- Partnership sign on bonus and retention bonus
- Good at leveraging resources
- Able to connect providers with what their interests are to keep them here
- Healthcare classes

Weaknesses

- 2 year retention (what about after 2 years?)
- Lack of social scene - difficulty building long-term relationships from the beginning
- Lack of specialty care - providers have to take on a lot, patients are having to wait longer to be seen
- Lack of partnering network
- Providers who come in are not knowledgeable on the strains of rural medicine
- Infrastructure - quality in schools for offspring, lack of greenspace/playspace
- We are 20-27 providers short in our area

Opportunities

- Building connections for social interactions
- Chamber of Commerce program in Humboldt helping to connecting providers with interests
- Other community agencies willing to partner and help with sign on bonuses/housing
- easier to get to for traveling (airlines)
- rural residency programs specifically focused on people that want to work with in rural populations

Threats

- Fair market value of employee salary varies in different areas - some areas can offer more than above
- Losing providers to other more appealing locations
- Geographical barriers

Access to Healthcare Services

Communication/Coordination of Care

Strengths

- Open Door and Sutter Coast using EPIC
- Large number of Partnership members in Del Norte, care management services (Care Coordination unit) available in Del Norte
- Open Door has case managers (in Humboldt) and navigators
- UIHS also has Community Health Workers (CHW)
- Strong Family Resources Center
- Coordination with Open Door and school district for pediatric services (mobile van)

Weaknesses

- Difficult to navigate healthcare system by yourself (going from system to system)
- Difficulty with navigation for senior care
- Transportation
- Addressing coordination of care as a community
- Training locally for CHW (patients that don't live here)

Opportunities

- Improve navigation for senior care
- CHW Benefits to work with seniors.
- Bring everyone together in addressing coordination.
- Offering training between care management systems (train the trainer) - Care Coalition
- Unite Us

Threats

- Loss of funding
- Not enough buy-in for Unite Us among organizations
- Sustainable funding for Unite Us may not be available
- Lack of health literacy
- Lack of trust from the community in organizations

Access to Healthcare Services

Expanding Access/Telehealth/Mobile

Strengths

- Partnership HealthPlan has a large platform to refer patients to specialty care
- School district/county office has mental health for any students in need
- Family wellness centers are assigned in schools where coaches and social workers are available
- Open Door mobile van

Weaknesses

- Don’t have reliable, good hubs for people who don’t have devices or know how to access.
- Hubs are not set up in a way that is connected to specialty

Opportunities

- Telehealth private pods that people can reserve for use at different locations
- Internet broadband
- Reaching the low-income population.

Threats

- Changes in Medicare funding for providers for virtual care.

Access to Healthcare Services

Culture of Wellness

Strengths

- Natural resources are available
- State and national parks systems + their programs
- Family Resource Center
- Hike It Baby
- Park and Recs offers youth and adult sports

Weaknesses

- Lack of health literacy
- Convenience of healthy choices/food desert
- isolation from using phone apps.

Opportunities

- Beautiful natural areas
- Getting information out about what healthy options are available at different stores
- Community health worker benefits
- Belonging and connection
- Social norm change
- Healthy check out aisle for children

Threats

- End to funding for SNAP (access to food vs access to healthy food)
- Climate

Behavioral Health

Tobacco Use

Strengths

- Del Norte County operates a tobacco retailer licensing program, including compliance checks and youth/adult coalitions.
- Cross collaboration between Megan and Thelma
- Groundwork has been laid (Policies, education)
- Tobacco retailer licensing in place including compliance checks and youth / adult coalitons
- Strong UIHS Youth group (TAG)
- Prop 64 - include vaping marijuana overlap
- People are wanting to quit
- Youth coalition/Adult coalition

Weaknesses

- TUPE funding being reduced
- Political Climate
- Misinformation and social norms around vaping (less harmful) - Public perception
- SDOH as root causes for tobacco use
- Efforts need to be better coordinated and materials need to be up to date. Providers and educators learning together and sharing info

Opportunities

- Strengthen system-level collaboration between schools, retailers, and public health.
- Install vape detection systems in schools (e.g., Crescent Elk Middle and local high schools).
- Develop educational diversion programs for youth caught vaping (non-punitive).
- Launch “Take Back Parks” environmental prevention campaigns to reduce tobacco waste at public spaces such as Kids Town and local beaches.
- Explore “smoke-free zones” similar to Arcata’s model, beginning with smaller community spaces.
- Engage local businesses in youth prevention messaging and smoke-free policies.
- Education around vaping use and harms
- Battery Point Apts - listening sessions around smoking in new apartments. Alternatives in that space
- Teen Clinics - high vape numbers
- Providers need updated information, willing to do screening and education.
- UIHS - Sadie Sparker and team
- Native Youth education about cultural tobacco
- Culture as Prevention Education

Threats

- Youth smoking among 11th graders in Del Norte County far exceeds the statewide average.
- Nearly 30% of adults use nicotine products
- Funding reduction across board
- Shifting priorities at higher levels
- Economic/social stressors.
- Vaping

Relevant

- Nearly 30% use nicotine products
- Youth smoking among 11th graders in Del Norte County far exceeds the statewide average.

Behavioral Health

Substance use prevention

Strengths

- OLW has been doing a lot of work
- OLF set aside of harm reduction veding and overdose prevention
- TACO CAT! Rx Safe DN
- Sober Living units
- Funding to send people to improve wellness courts
- Prevention $ for substance use should stay the same over the next few years

Weaknesses

- How do we funnel people to intervention/diversion like Teen Court
- Pipeline to diversion and early interventions
- Provider bias around MAT programs
- Community Bias
- Misunderstanding MisInformation
- Government bias
- Changing priorities in funding streams and priority areas
- Prevention $ for substance use should stay the same over the next few years
- N02 ban
- Funding Steams
- Current opiate subsciption policies
- Religious based recovery options are less

Opportunities

- Good start up and maint funds for vending for up to 3-5 yrs.
- Teen Court is starting
- Prop 64 use towards Teen Court
- Education is already happening
- Zoom supports
- Prop 36- mandated treatment
- Parent support or other support groups
- Friday Night Live
- Trillium
- Coastal Connections
- Family Center
- Mobile Crisis Unit-SU calls
- Mobile Crisis Narcan leave behind.
- No2 ban county
- increase in sober living sites
- Opiate subscription policies?
- Parent support or other support groups
- Prop 64 funds around education, mental health with substance misuse, trauma informed care.
- CWS 4E community prevention plan foster care
- Juvenile Justice (probation, law enforcement collaboration, youth opportunity center)
- Naloxone Distribution Tracking
- Collaboration with health class - how to access data and assignments to engage (gamify #'s)
- Alternative to 12-step training that is not religious
- Live Well data dashboard

Threats

- Truancy is no longer prosceutable so referrals don't have as much "teeth"
- SARB changes
- Drug court is a dying system due to changes to laws and punishments
- Incentive for diversion has decreased overall
- High use numbers
- substances danger levels for addiction and overdose-changes in drug landscape
- Syringe Exchange is hugely stigmatized
- Increase in youth substance use
- Increase in alcohol use leading to liver disease
- Federal changes in overdose prevention

Relevant

- Overdose deaths due to fentanyl

Behavioral Health

Mental Health

Strengths

- Over 100 trained adult advisors for 6-12th grade sources
- will have 5 cert trainers
- Mental Health First Aid program going strong
- Teen Clinic-MH component
- School Districts have wellness coaches-certified
- a lot of new programing - things are growing.
- Project Avery fully implemented for incarceration impacted youth
- PATH Mobile Crisis Unit
- ALL the programs at Coastal Connections
- Daybreak - DN County Office of Education
- Sources of Strength (K–5 trained staff, community group, Trillium)
- SARB connection (school connection coming up)

Weaknesses

- stigma misinformation
- high rates with youth and elder populations
- Power and Housing - people with mental health issues often struggle with basic needs at the same time.
- Not maximizing Unite Us
- Geographic isolation/Phycological isolation
- 2023 survey - low engagement in social gatherings i.e. dinner parties
- Depression scale screening for elders. Just doing cognitive screens.
- Warm hand offs (referral programs)
- Service awareness in the area
- Mental health rates in Del Norte (27%) vs. state (20%)
- Suicide ideation and risk rates increased → very high (age groups: very young, up to 34 yrs old)
- Increase in percentage of seniors (⅓) - older population 65+ yrs old very astronomical
- Parents w/ kids 51/50 trending up (self harm 10-14 yrs old, children have to go out of county for services)
- Re-entry
- Many residents travel out of county for care
- Telehealth access limited by state lines

Opportunities

- Prop 64 funds around - education, mental health with substance misuse, trauma informed care
- High rates of removals due to substances use/neglect in removals and removal at birth
- Teen Clinic-MH component
- Area 1 on Aging
- Coastal Connections
- Trillium
- Health Families America home visiting for maternal/prenatal
- Youth Opportunity Center through Probation
- New facilities opening in the coming years; EmPATH unit, Sorreal Leaf, etc
- Family Engagement Liaisons connecting w/ families (Home Visits)
- Unite Us
- Community Connection and Resiliency - Community BBQs
- Engaging DADS - Resilient DNATL
- Social norms around belonging and connection
- Resilient DNATL
- Blue Dot Project
- Screenings-senior population
- Roots of wellness summit in October
- Creating space to learn and share with each other.
- MH 360 website
- Closed loop referral - parents also need to be connected

Threats

- MH prevention money moviing from local to state level
- All funding is temporary
- Unite Us funding leaving and $10K a year
- Rural divides
- Social engagement norms are changing
- Technology divides
- Internet access (telehealth)

Relevant

- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)
- CalAIM - wraparound services for mothers and services
- CYBHI
- CalMAP

Child Abuse and ACEs

Positive and Adverse Childhood Experiences (PACEs)

Strengths

- Dropping silos/awareness of silos between organizations
- Increased commitment from school district (family engagement liaisons)
- Resiliency
- Medical is gathering screenings for the first time
- Small community creates relationships and more opportunities to work together
- Classes available from the FRC around ACEs
- Neighborhood BBQs/increased community events geared towards community building and ACEs
- Healthy Families America program (Public Health) supporting families/peer-child relationships and building awareness about PACEs within the community
- Increase in funding to support the work (mental health in schools)

Weaknesses

- Losing funding for existing programs
- Underfunded programs
- County statistics vs. state statistics
- Lack of access to quality and consistent resources (substance use treatment)
- Not having a centralized resource list
- Lack of participation from families (services and resources are offered, but low participation)
- Stigma
- Lack of understanding from general public about mental health issues, how ACEs impact poverty
- Misunderstanding about what organizations actually do
- Harsh winters (families are stuck indoors, seasonal depression, lack of opportunities for entertainment/healthy connections, transportation)
- Struggle for families to find their community
- Lack of housing (affordable housing)
- How we are communicating/in relationships with each other - leading to substance use
- Drug and alcohol abuse

Opportunities

- Substance use treatment
- Lack of indulging in our natural resources (beaches, rivers, hiking trails)
- Lending library
- Increasing ACEs screenings (how we can provide provider offices/staffing available/ knowledgeable) and resilience screenings - doing the full screenings
- Conversation with local medical providers to support each other
- Increase use of Unite Us
- Setting up a path for help after ACEs/resiliency screenings are done
- Supporting and promoting existing programs, such as those that support belonging and community building
- Warm referrals/warm handoffs for resources
- Board of Supervisors support
- Taking advantage of mild climate conditions

Threats

- Stability of funding
- Basic infrastructure (food - don’t have proper storage, power is sourced from Oregon, affordable housing, economy and living wages)
- Severe weather
- Lack of coordinated programs to help children and families enjoy natural resources/no community center to support children
- Social norm around “severe climate”
- Cost of energy is a threat
- Political landscape is contributing to barriers to building relationships
- Intergenerational trauma/stigma

Child Abuse and ACEs

Violence Prevention

Strengths

- Coastal Connections programs partnering with schools
- Sources of Strengths program - create youth leaders within schools to support wellness campaigns/encourages adults to mentor youth
- Family First Preservation Act - funding available to help identify secondary pathways to offer prevention
- Trillium Youth Center (10-18 yrs old)
- Youth Opportunity Centers offers programming for at-risk youth (runaway, at-risk of homelessness)
- Dad groups through FRC and churches

Weaknesses

- Del Norte county has highest per capita rates vs. state for domestic violence
- No funding for prevention programs of DV in schools
- Children have multiple ways to access internet/cell phone texts (in classrooms)
- Lack of quality local medical providers/specialists
- Lack of staffing to implement programs/services
- Lack of pediatricians
- Low participation for evidence-based parenting programs

Opportunities

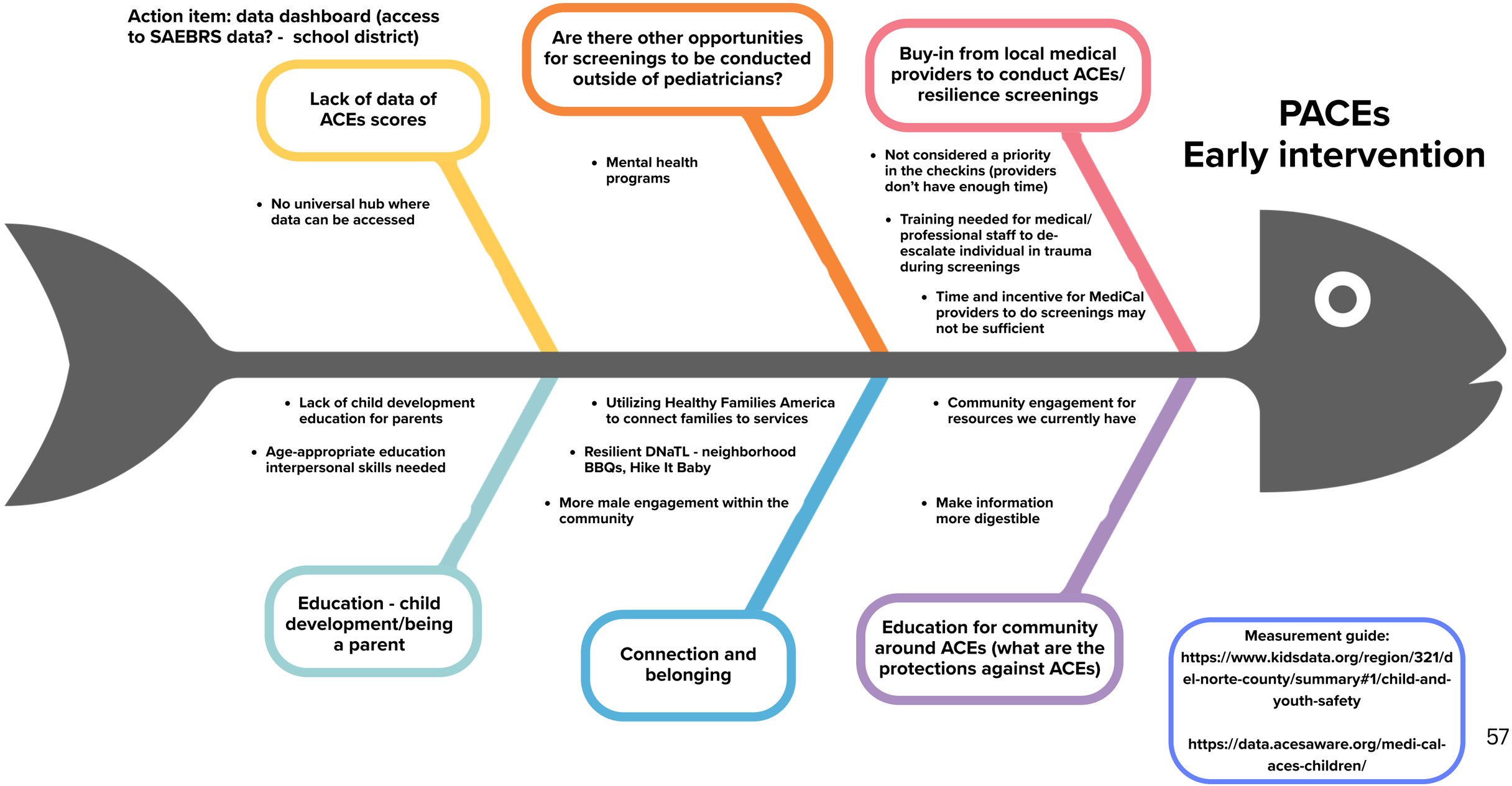
- Law enforcement integrating education in their programs that focuses on DV
- Work on social norm prevention campaigns for kids and cell phones
- Sources of Strength - needs more adoption to be more successful/needs more support from teachers and school districts
- Trillium Youth Center is still fairly new
- Children's Museum currently being built
- NCRC having more access to birthing moms
- Healthy Families of America to support with educations about healthy relationships
- CalAIM - community health workers for wraparound services for moms and seniors

Threats

- Children having access to Internet
- Social norm - Violence has been popularized
- Birth rate in Del Norte county is declining - decline in school enrollment affecting funding
- Stigma around poor quality with local medical providers/ specialists
- Inconsistency with services may affect relationships between organizations
- Parenting classes do not resonate with the attendees - leading to discontinued attendence

Appendix D: Fishbone Analysis

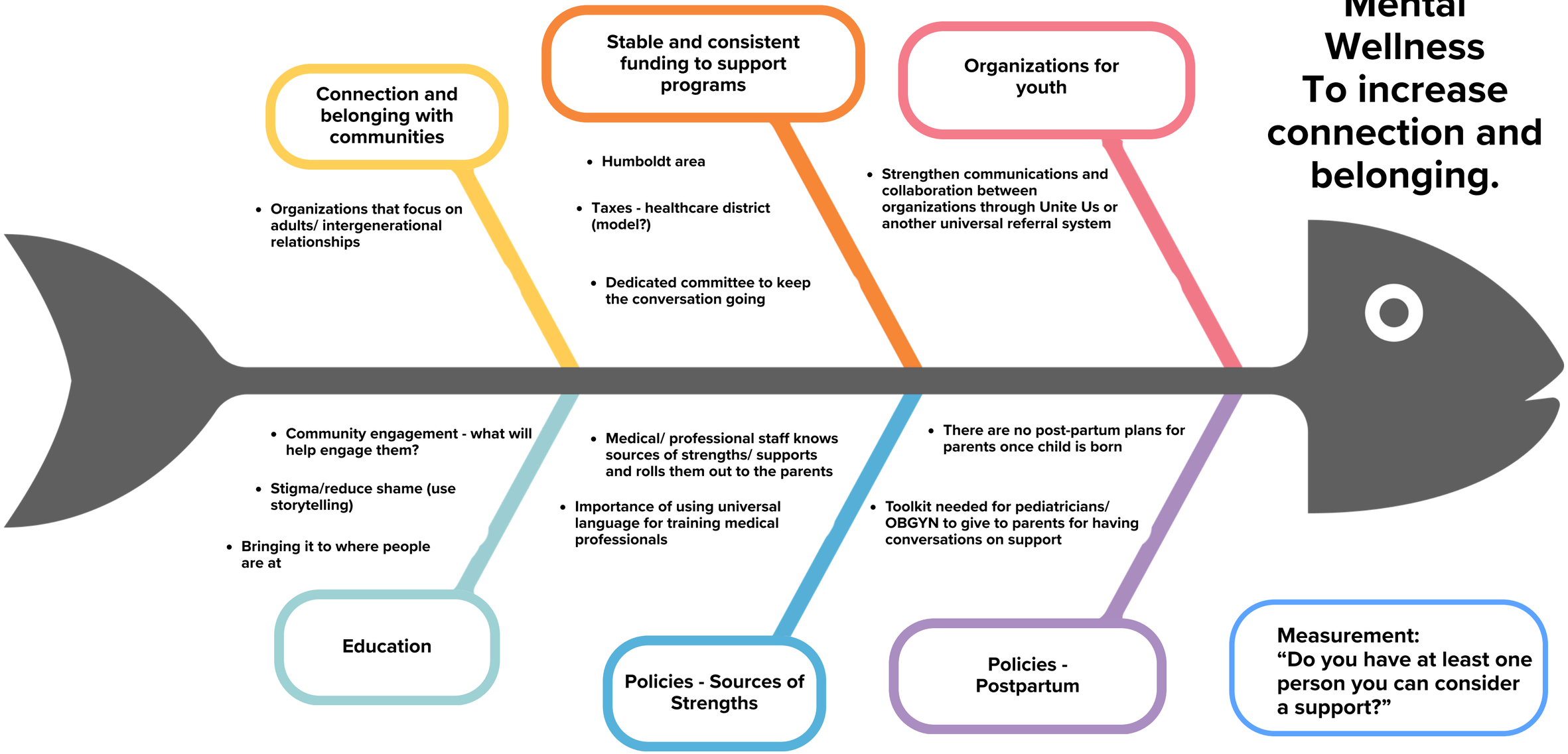
Child Abuse and ACEs



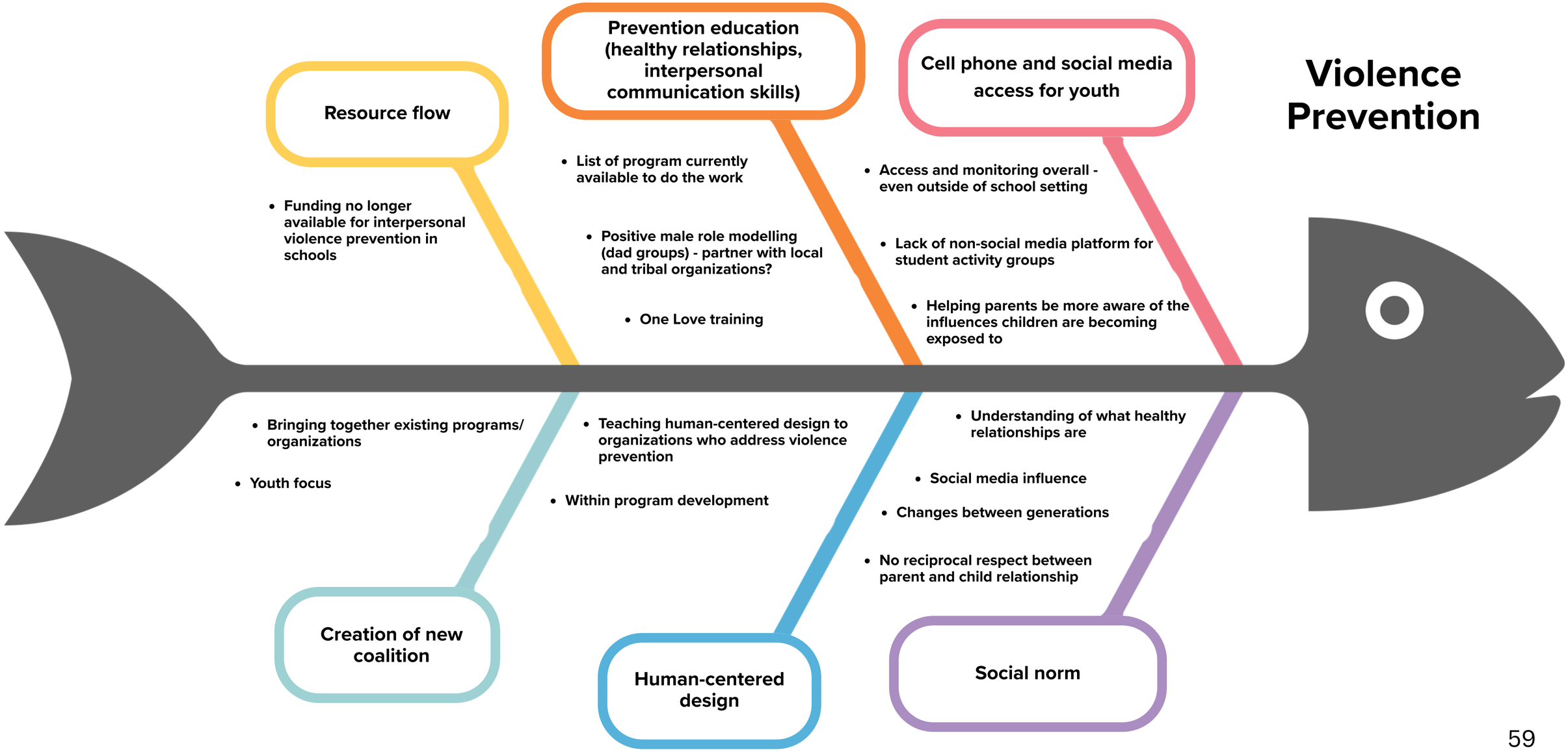
Measurement guide:
https://www.kidsdata.org/region/321/del-norte-county/summary#1/child-and-youth-safety

https://data.acesaware.org/medi-cal-aces-children/

Child Abuse and ACEs



Child Abuse and ACEs



Access to Healthcare Services

Organization Name:	Sector:	Communities Served:	Mission Statement	Current Programs, Services, or Interventions
Tri-County Independent Living	social services	we help independents with a disability with services to live independently on their own.	The Mission of Tri-County Independent Living is "to promote the philosophy of independent living, to connect individuals with service, and work to create an accessible community, so that people with disabilities can have control over their lives and full access to the communities in which they live."	Independent Living Plan, ramps, and assist with services with in the community on referrals
Independent Community Builder - citizen activist	Community-wide (health, education, economy, environment, government)	Focus on oppressed and marginalized groups, disadvantaged, working poor, voiceless groups such as explioted people and animals	Solutions facilitation for better outcomes. (Using local resiliency and tight-knit community models & approaches. Connecting existing resources, creating efficiency and function where it is lacking.)	My role is to advocate multiple viewpoints depending on those not already represented to create greater understanding. Research on proven effective solutions as well as firsthand experience on what works for desired outcomes to be achieved. Understanding policies and the power of incentives and deterrents to direct behavior. Importance of culture, communication and values. Breaking through mindsets that prevent success.
Del Norte County DHHS Public Health Branch - PHN	Healthcare	Del Norte County	To respectfully promote the health, safety, self-sufficiency and well-being of children, families and individuals, creating hope for the future.	Clinic Services, Immunization Program, Communicable Disease Program, TB Program, Maternal Child Adolescent Health (MCAH) Program, Home Visiting Program, CA Children’s Services, Healthcare Program for Children in Foster Care
Partnership HealthPlan of California	0	Partnership serves 24 counties across Northern California	To help our members, and the communities we serve, be healthy.	MediCal Managed Care Plan
Area 1 Agency on Aging	social services	Seniors 60+	To lead and provide services that support people in ways that promote healthy aging .	Information and assistance, Technology assistance, Medicare (HICAP)
Stallant Health and Wellness	Healthcare/Rural Health Clinic	Rural Healthcare Primary Care Provider	To restore physical, mental and spiritual health.	Participation in the Equity Practice Transformation program, expanding care within the Del Norte community by continual growth of our services offered to patients, improved patient outreach and engagement, community events, etc.
Del Norte County Healthcare District	Retired Registered Nurse of 35 years	Del Norte County	The mission of the Del Norte Healthcare District is to promote a collaborative approach to personal and community health through education, prevention, and healthcare services to residents of Del Norte County.	Provide a range of health-related services and programs that benefit communities and their residents.
Sutter Coast Hospital	Hospital	Del Norte County and surrounding areas	Patients first, People always	Inpatient, outpatient, and emergency services.

Appendix E: Partner Profiles

Behavioral Health

Organization Name:	Sector:	Communities Served:	Mission Statement	Current Programs, Services, or Interventions
DHHS Behavioral Health Branch	Behavioral Health	Medi-Cal population, justice involved, Medi-Cal, underserved, homeless and at risk of homeless, justice involved, children and adults	The mission of the Department of Health and Human Services is to respectfully promote the health, safety, self-sufficiency and well-being of children, families and individuals, creating hope for the future. Respectfully promote the health, safety, self-sufficiency and well being of children, families and individuals creating hope for the future.	Prevention, early intervention, and treatment. Substance use prevention, early intervention, and treatment.
First 5 Del Norte	government	children under the age of 5	First 5 Del Norte will promote and enhance the health, development, and wellness of children ages 0 to 5 and their families by utilizing, increasing, and sustaining resources to support innovative, integrated, family-centered, culturally appropriate programs and services.	The Oral Health program provides tobacco-related information to the community.
Open Door	Healthcare	low-income, limited English proficiency, youth, disabled, >65, uninsured/underinsured, minorities and underserved, unhoused, migrant/farm workers, LGBTQIA+	Open Door Community Health Centers promotes social justice and human dignity through exceptional patient-centered care that improves the health and well-being of our patients, community, and staff.	Primary care and behavioral health services for established Open Door Patients. We also have a MAT program that is open to community members regardless of where they receive their primary care.
Tri-County Independent Living	Non Profit organization	Adults and Youth with a disability	The Mission of Tri-County Independent Living is " To promote the philosophy of independent living, to connect individuals with services, and work to create an accessible community, so that people with disabilities can have control over their lives and full access to the communities in which they live".	Community Organizations Assistive Technology Living Skill Training IL Service Plan
Del Norte DHHS - Public Health	Healthy Communities (CAL-EIS)	Del Norte County	The mission of the Department of Health and Human Services is to respectfully promote the health, safety, self-sufficiency and well-being of children, families and individuals, creating hope for the future.	Health care facilities, Crisis Textline, CA Overdose Surveillance Dashboard, MCAH Dashboard
	Nursing	Entire community.		Maternal Child Adolescent Health (MCAH)- Maternal Mental Health- Assisting families in connecting to services, care coordination. Screening for perinatal mood disorders. Care coordination with primary care, specialty services, and partnership. Data collection. HCPCFC (Health Care Program for Children in Foster Care)- Psychotropic medication monitoring and oversight (PMM&O) of children in foster care.
	Tobacco Use Prevention Program	General public, youth, young adults		1. reduce the availability of tobacco. 2. reduce exposure to secondhand smoke, tobacco smoke residue, tobacco waste, and other tobacco products.
Rx Safe Del Norte	Public Health, System Change, Substance Use	Other organizations who work with substance use, people who use drugs, families, youth, schools, businesses, Tribes, government, law enforcement and first responders.	Mission: To engage the community in the prevention of Opioid Use Disorders (OUD), the reduction of stigma, and the promotion of treatment, recovery, and wellness.	Data collection on opioids, naloxone and harm reduction supplies in the region; Naloxone Sticker Project; North Coast Life LIne, North Coat Resource Hub, Opioid Litigation Workgroup, Fentanyl Education Workgroup, Coalition activities, Youth Opioid Overdose Prevention Toolkit, TACO CAT. Partner with Humboldt County organizations and Del Norte County organizations.

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Del Norte Child Care Council	Childcare-Social Services	Families with kids 0-13	The Mission of the Del Norte Child Care Council (DNCCC) is to promote and encourage the healthy growth, education, care, and development of children through increased community and family awareness of children's needs.	Child Care Resource & Referral Services, Subsidized Child Care Program, Trustline and Licensing Support for Child Care Providers
DNUSD - EPIC Student Support Services	Education & Social Services	Our programming support students who are court involved through dependency or delinquency courts (CWS, Probation, or Tribal Court) as well as students experiencing homelessness or housing insecurity	Providing educational, behavioral, and mental well-being advocacy through collaborative efforts with our staff, community partners, students, and families.	many of the students we serve have a history of abuse or neglect and/or have high ACEs scores. We work to ensure our students have what they need to be successful in school and in life by identifying barriers and then helping to eliminate or at least diminishing those barriers
Del Norte and Tribal Lands Community Food Council	food systems non profit	All of Del Norte County	Strengthening our local food system to support and healthy and resilient North Coast community	Certified farmers' market, School Garden program
Resilient DNATL	Non-Profit	Residents of Del Norte and Tribal lands . We are prioritizing parents at this moment and reaching out through universalism approach to all ethnicities.	Resilient DNATL strengthens the health and resilience of Del Norte County and Tribal Land communities through advancing systems change for parental resilience, and building powerful community connections that ensure every child and parent can thrive.	Maternal and paternal mental health (structural and relational systems change work)parental resilience (connection and belonging system change) , and youth mental health podcasts (social norm change)
North Coast Rape Crisis Team	non-profit	Humboldt and Del Norte Counties	To create a culture of safety, solidarity, and support for all who are affected by sexualized violence by empowering survivors through advocacy and education services, in partnership with our communities.	NCRCT is the only non profit organization in Del Norte County that has a 24-hour in person response to child sexual abuse and trafficking of children.
DHHS- Public Health Branch	Public Health - Healthy Communities	People residing in Del Norte County	The mission of the Del Norte County Public Health, Healthy Communities division is to respectfully promote health, safety, well-being, and flourishing communities. Applying evidence-based, upstream and innovative public health strategies to create hope and a healthier future for all in Del Norte County. The mission of the Department of Health and Human Services is to respectfully promote the health, safety, self-sufficiency and well-being of children, families and individuals, creating hope for the future.	CalFresh Healthy Living, CASPHI
	Public Health - Nursing	Families, children		Healthy Families America, Cribs4Kids, VFC (Vaccines for Children)
	Public Health-WIC	Del Norte County		Screening, education and skill building, referrals, and more.