Sutter Health

NOVATO COMMUNITY HOSPITAL

2019 Community Health Needs Assessment

Novato Region Community Benefit

CHNA Report for NCH

Contents

I. Introduction/background

A. About Novato Community Hospital

Novato Community Hospital (NCH) was founded in 1961 by a group of local physicians to serve what was then the unincorporated area of North Marin County. In 1984 the hospital affiliated with Sutter Health, a not-for-profit network of hospitals and other health care service providers sharing resources and expertise to advance health care quality and access to patients and their families in more than 100 Northern California cities and towns.

In 2001, with Sutter Health and the generosity of Marin donors, a new 47-bed facility was constructed to replace the original hospital. The newer hospital is more centrally located with easy access from the region's major freeway, Highway 101. In addition to its inpatient services, the hospital operates a 24- hour emergency department; a same-day and general surgery department; advanced outpatient diagnostic services including a recently updated 3-D Mammography also known as Digital Breast Tomosynthesis.

NCH outpatient services are located adjacent to the main hospital campus with easy access from Hwy 101. An outpatient laboratory, X-ray, and outpatient physical therapy program are housed at the site. In 2010 a Marin branch of the Kalmanovitz Child Development Center opened. The Center provides comprehensive developmental assessment and treatment programs for infants, preschoolers, school-age children, and families on a sliding-fee scale. February 1, 2016 Novato Community Hospital became part of Sutter Health Bay Area Operations, which includes hospitals and medical groups in Alameda, Contra Costa, Marin, Santa Clara, San Francisco, San Mateo, Santa Cruz, Sonoma, and Lake Counties.

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B. About Community Health

Sutter Health is a not-for-profit network of physicians, employees, and volunteers who care for more than 100 Northern California towns and cities. Together, they are creating a more integrated, seamless, and affordable approach to caring for patients. At Sutter Health, we believe there should be no barriers to receiving top-quality medical care. Everyone deserves access to excellent health care services, regardless of insurance or ability to pay. As part of their not-for-profit mission, Sutter Health invests millions of dollars back into the communities they serve–and beyond. Through these investments and their partnerships within local communities, they are adding and preserving vital programs and services. This improves the health and well-being of their neighbors.

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

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

D. Marin County's approach to Community Health Needs Assessment

The Marin County CHNA Collaborative, as contributing members of the HMP, has conducted CHNAs since 1996. The new federal CHNA requirements have provided an opportunity to revisit the needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency, and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification and prioritization of needs to the development of an implementation strategy, the intent was to develop a process that would yield meaningful results.

Marin County CHNA Collaborative's approach to the assessment process includes the use of Kaiser Permanente's free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 130 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing secondary data available through the CHNA data platform and other sources of secondary data, the Marin County CHNA Collaborative collected primary data through key informant interviews and focus groups. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of some existing community assets and resources to address the health needs.

The Marin County CHNA Collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were prioritized based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report. In conjunction with this report, Sutter Novato Community Hospital will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Novato Community Hospital's assets and resources, as well as on evidence-based strategies, wherever possible. The IS will be filed with the IRS using Form 990 Schedule H. Both the CHNA and the IS, will be posted publicly on http://www.novatocommunity.org/about/community_benefits.html

II. Community served

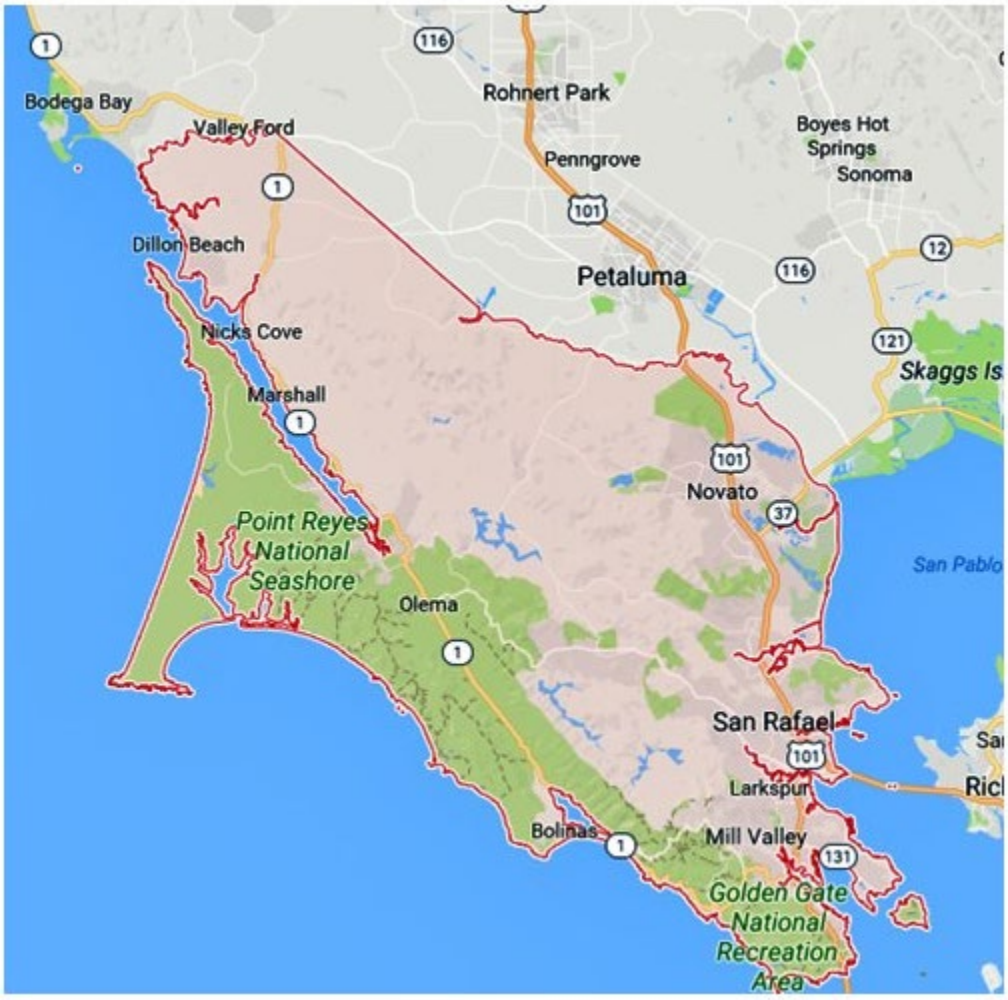
A. Marin County's definition of community served

In order to determine the health needs of the Marin County CHNA Collaborative member hospital service areas, it is first important to understand the communities of interest. The following section describes the service area community by geography, demographics, and socioeconomic indicators, as well as by indicators of overall health, and climate and the physical environment.

B. Map and description of community served

i. Map

The map below depicts Marin County, the geographic region assessed in this CHNA.



Marin County

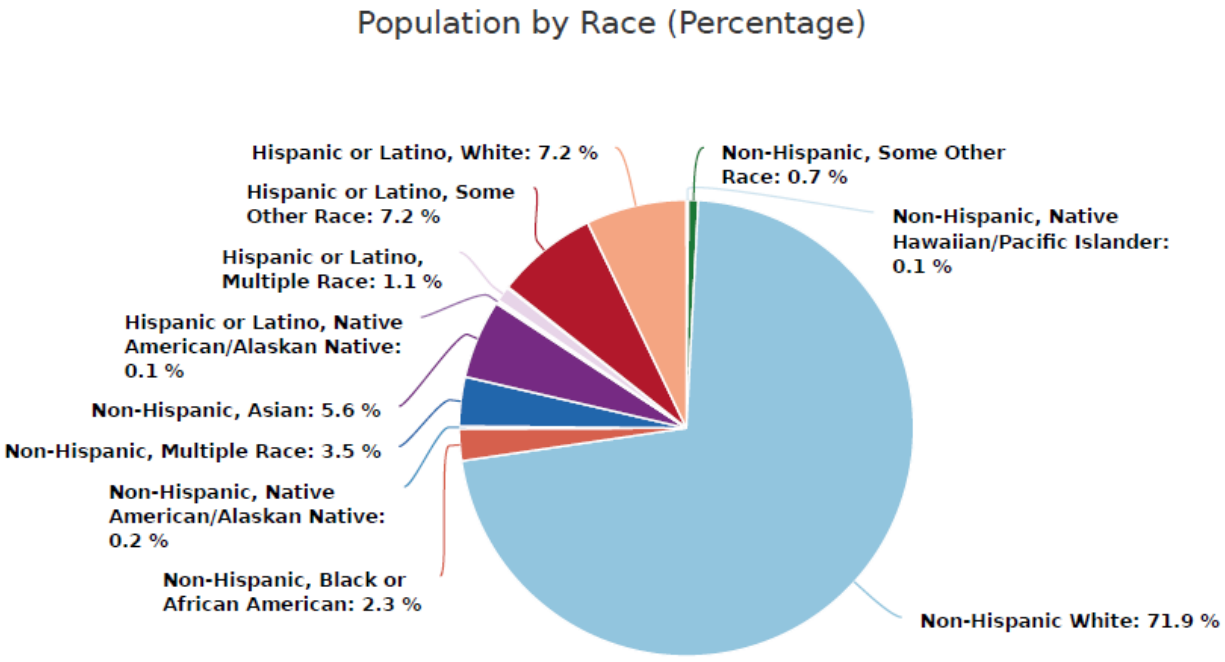
ii. Geographic description of the community served

Novato Community Hospital service area comprises Marin County unincorporated areas and cities including Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San

Anselmo, San Rafael, Sausalito, and Tiburon, and the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales.

iii. Demographic profile of the community served

Demographic profile:



Socioeconomic Data[1]	
Living in poverty (<100% federal poverty level)	8.08%
Children in poverty	9.89%
Unemployment	2.20%
Uninsured population	6.38%
Adults with no high school diploma	6.89%

[1] Data drawn from the CHNA data platform. See Appendix A.

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

NCH connected with both hospital and other partner organizations with similar service areas in Marin County to support the CHNA. In Marin County, many of these partners were already engaged in a collaborative, the Healthy Marin Partnership (HMP), which was formed in 1995 as a result of working together on prior CHNAs. This group developed a coordinated approach to primary data collection, and then determined the list of significant health needs based on both primary and secondary data. NCH then organized with these partners to engage a broader group of community stakeholders to prioritize the identified health needs (described in Section VI-B).

Collaborative hospital partners:

1. Kaiser Foundation Hospital – San Rafael
2. Marin General Hospital
3. Sutter Health – Novato Community Hospital

Additional partners:

1. Marin County Health and Human Services
2. Healthy Marin Partnership
    a. Hospital Council of Northern and Central California
    b. Northbay Leadership Council
    c. Marin County Office of Education
    d. Marin Community Foundation
    e. San Rafael Chamber of Commerce

B. Identity and qualifications of consultants used to conduct the assessment

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts—including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other

hospital service areas in Roseville, Sacramento, San Bernardino, Santa Rosa, South Sacramento, Vacaville, and Vallejo.

IV. Process and methods used to conduct the CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

The Novato Community Hospital service area largely overlaps with the Kaiser Permanente-San Rafael service area, so for the purpose of this CHNA collaboration, data were used from both the county and the Kaiser Permanente CHNA Data Platform (CHNA Data Platform).

Harder+Company used the CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources.

Harder+Company also used additional data sources beyond those included in the CHNA Data Platform (e.g., California Healthy Kids Survey, Marin County Point in Time Homeless Count and Survey, and Commission on Aging: Housing Report).

For details on specific sources and dates of the data used, please see Appendix A. Secondary data sources and dates.

ii. Methodology for collection, interpretation, and analysis of secondary data

The CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, Harder+Company also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners (e.g., county health departments, service providers, and other stakeholders) provided additional data (e.g., frequency tables, reports, etc.) to inform both the identification and prioritization of health needs across the service area (see Appendix A. Secondary data sources and dates for a list of additional data sources). This data provided additional context and, in some cases, more up-to-date statistics to the indicators included in the CHNA Data Platform. The Harder+Company team did not conduct additional analysis on secondary data shared by CHNA partners as the data was already disaggregated across several variables including region, race/ethnicity, and age. Each health need profile includes a reference section with a detailed list of all secondary data sources used in that profile to inform the prioritization of health needs (see Appendix C. Health Need Profiles).

B. Community input

i. Description of who was consulted

Community input was provided by a broad range of community members through key informant interviews, group interviews, and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations as well as community leaders, clients of local service providers, and other individuals representing medically underserved, low-income, and sub-populations that face unique barriers to health (e.g., race/ethnic minority populations, individuals experiencing homelessness). For a complete list of communities and organizations who provided input, see Appendix B. Community input tracking form.

ii. Methodology for collection and interpretation

In an effort to include a wide range of community voices from individuals with diverse perspectives and experiences and those who work with or represent underserved populations and geographic communities within the NCH service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries. (For a complete list of participating organizations, see Appendix B. Community input tracking form).

The consulting team developed interview and focus group protocols, which the CHNA Collaborative reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. Participants were also asked to describe any new or emerging health issues and to prioritize the top health concerns in their community. For more information about data collection protocols, see Appendix E. Focus Group Protocol and Appendix F. Key Informant Interview and Group Interview Protocol.

Harder+Company conducted key informant interviews over the phone by a single interviewer, while provider group interviews and community focus groups were in person and completed by both a facilitator and notetaker. When respondents granted permission, we recorded and transcribed all interviews.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations

or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended healthcare solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the codebook was finalized to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

In comparison to secondary (i.e., quantitative) data sources, primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

Appendix G. Focus Group Optional Participant Survey Results and Appendix H. Group Interview Optional Participant Survey Results detail survey responses for focus group and group interview participants who completed an optional survey. This data provides information on key demographics and health-related experiences of participants.

C. Written comments

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment and Implementation Strategy were available to the public on the website https://www.sutterhealth.org/community-benefit. To date, no comments have been received.

D. Data limitations and information gaps

The CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the

unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that perform poorly compared to the state flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to the identification of overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, Harder+Company made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, focus groups were conducted focus groups in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, Sutter Health defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

Extensive secondary quantitative data (from the CHNA Data Platform and other publicly available data), as well as primary qualitative data collected from key informant interviews, provider focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or

similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews, see Section IV B ii for details). Part of the analysis included grouping individual qualitative themes (e.g., green spaces, safe spaces, food security, obesity, diabetes) into health need categories (e.g., healthy eating and active living) similar to those identified in the CHNA Data Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as **high need based on secondary data** from the CHNA Data Platform if it met *any* of the following conditions:
    - *Overall severity:* at least one indicator Z-score within the health need was much worse or worse than benchmark.
    - *Disparities:* at least one indicator Z-score within the health need was much worse or worse than benchmark for any defined racial/ethnic group.
    - *External benchmark:* indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020).
2. A health need category was identified as **high need based on primary data** if it was identified as a theme in a majority of key informant interviews, group interview, *and* focus groups.
3. Classification of primary and secondary data was combined into the final health need category using the following criteria:
    - **Yes**: high need indicated in *both* secondary and across *all types* of primary data. CHNA partners then confirmed these health needs.
    - **Maybe**: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with CHNA partners to determine final status.
        - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
        - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
    - **No**: high need indicated in only one or fewer sources.

B. Process and criteria used for prioritization of health needs

For each identified community health need, Harder+Company developed a three- to four-page written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers, residents, and others) to prioritize the health needs. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity:** Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.
- **Clear Disparities or Inequities:** Health need disproportionately impacts specific subpopulations based on geography, age, gender, race/ethnicity, or sexual orientation.
- **Impact:** The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

Compared to other counties in California, Marin remains a relatively healthy county in which to live, work, play, raise a family, and grow older. However, many individuals and communities in Marin do not have access to resources and good health. During the small-group discussions, meeting participants considered county-wide needs as well as ways in which specific health issues may disproportionately impact some populations or communities more than others. They referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-10 (*1=lowest priority*; *10=highest priority*). Ranking required that no two health needs were scored the same within each criterion. Appendix D. Prioritization Scoring provides the specific breakdown of scores used for ranking and any weighting considerations across the three criteria. Harder+Company tallied the votes after the prioritization meeting and shared the final ranked list of health needs with participants via email.

C. Prioritized description of all the community needs identified through the CHNA

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to Appendix C. Health Need Profiles. Health needs were identified using local county-level data sources provided by the CHNA collaborative partners in addition to data drawn from the CHNA data platform, which provides population averages for the Kaiser Foundation Hospital San Rafael service area. Since there is a large overlap between county boundaries, the NCH service area, and the Kaiser service area, these data were considered sufficient proxy indicators for identifying the health needs of the county.

1. **Economic Security:** Economic security means having the financial resources, public supports, and career and educational opportunities that are necessary to live your fullest life. As such, this health need touches upon every other health-related issue in the San Rafael community, from mental health to housing. While Marin County ranks among the top in the country in terms of economic wealth and community resources, 50 percent of residents spend 30 percent or more of household income on rent.[2] Importantly, many residents expressed that the County's riches are unevenly distributed and not available to all. These divides are particularly stark along lines of race/ethnicity and citizenship status. For example, roughly, 60 percent of both the Black and Hispanic populations in Marin County are living below the 250 percent federal poverty line compared to 21 percent of the White population; in the state overall, the average is 35 percent.[3] Further, U.S. born residents in Marin County have an average annual wage of $75,493 compared to only $23,742 for undocumented immigrants.[4] Geographically, outcomes related to education, employment, and wage demonstrate a glaringly uneven distribution, with the Canal region and West Marin facing the greatest barriers to economic security. Relatedly, **t**he percentage of businesses owned by minorities is roughly 15 percent in Marin County compared to nearly 46 percent across the state of California.[5] In focus groups, participants connected economics and health by reporting how the economic necessity of working multiple jobs and the long commutes needed to get from where they can afford to live to where jobs are available, lead to mental and physical health issues.

2. **Education:** Educational attainment is a primary factor that influences individual health. It can both shape the economic opportunities that impact health outcomes, as indicated in the Economic Security section, above as well as inform people about how to live a healthy lifestyle. While some education outcomes are higher for Marin County than the rest of California, disparities—particularly among English language learners, African

[2] American Community Survey. (2012-16).
[3] Ibid.
[4] USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
[5] Healthy People 2020; US Census Bureau – Economic Census 2012

Americans, and Latino students—indicate that educational equality is a high concern in the county. Among White third graders, 76 percent demonstrate English and language arts proficiency compared to just 32 percent of Latino students and 27 percent of African Americans.[6] In mathematics, 73 percent of White third graders are proficient compared to 28 percent of Latino student and 31 percent of African Americans.[7] These disparities are present both among achievement (e.g., reading/math proficiency) outcomes and educational attainment (e.g., college attendance). For example, 85 percent of White 3- and 4-year olds attend preschool compared to only 35 percent of Latinos.[8] Among 16-24 year olds, college attendance among Whites is 80 percent compared to only 47 percent for Black/African Americans and 37 percent for Hispanic/Latinos.[9] These racial disparities also extend to a sense of belonging at school, with only 23 percent of African American 7th graders reporting a high level of school connectedness compared to 75 percent of Whites.[10] Many community members signaled educational equity and increased health awareness as strategies necessary to advancing health goals.

3. **Mental Health/Substance Use:** Marin County residents demonstrate high need in addressing mental health issues, indicated by rates of suicide, medication for mental health issues, and substance abuse treatment. In the San Rafael service area, 20 percent of adults report needing help with mental, emotional, or substance use issues compared to only 15 percent of adults in California.[11] Relatedly, 15 percent of Marin County adults take daily prescriptions for mental health issues, which is higher than the California rate of 11 percent.[12] In general as well as in Marin County specifically, mental health issues frequently coexist with substance abuse. In the San Rafael service area, 21 percent of adults report excessive drinking, higher than the California average of 18 percent.[13] The suicide rate is particularly high among non-Hispanic White and non-Hispanic Black residents, at 13 per 100,000 and 12 per 100,000 respectively; this is roughly twice the rate of suicide among Hispanic/Latinos in the region.[14] In focus groups, community members discussed the stigma around mental illness, a lack of access to mental health providers, and few treatment options for people who are homeless as major concerns.

4. **Access to Care:** Access to health care includes insurance coverage, physician access, and availability and affordability of emergency and specialty health services. Access to quality health care is important to overall health, disease prevention, and reducing unnecessary disability and premature death. Importantly, it is also one of the key drivers

[6] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020
[7] Ibid.
[8] http://www.marinkids.org/wp-content/uploads/2015/02/Education-Data-20141.pdf
[9] American Community Survey. (2012-16).
[10] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020.
[11] Healthy People 2020. California Health Interview Survey. (2014-15).
[12] Ibid.
[13] Behavioral Risk Surveillance Task Force. (2017).
[14] CDPH. (2010-12). (Death Master Files, pulled from 2015 Pathways to Progress)

in achieving health equity. While Marin County scores better than the California state average on many indicators measuring health care access, the county has not yet met the Healthy People 2020 benchmark for insurance coverage. In particular, almost half of undocumented immigrants (48 percent) lack insurance coverage compared to just 6 percent without insurance among U.S. born citizens.[15] Group interview participants were aware of the disparity and reported that the county continues to work toward providing affordable and culturally competent care for all residents, especially community members who are undocumented. Racial minority groups and lower income individuals also face great challenges in obtaining affordable care. For example, in the San Rafael service area, roughly 20 percent of both Hispanic/Latino and non-Hispanic Pacific Islander populations are without health insurance.[16] There are also important disparities by income, with fewer women on Medi-Cal receiving prenatal care during their first trimester (89 percent) compared to 94 percent of all pregnant women in Marin.[17] Additionally, focus group participants expressed that, as Marin's population ages, innovative options for those who wish to age in place or who are unable to travel to receive health care services will be important. The elderly are less physically mobile, experience more frequent health issues, and often survive on fixed incomes.

5. **Housing/Homelessness:** Marin County's high cost of housing exacerbates issues related to health care access and affordability, which in turn has a negative impact on health outcomes in the area. More than half of renters pay 30 percent or more of their income on rent.[18] Focus group participants shared that, in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. These circumstances are exacerbated by racial inequities since only a quarter of Black or Latino residents in Marin own homes compared to two thirds of White residents.[19] Further, housing costs present unique challenges for older adults who wish to age in place but who often live on a fixed income and may require additional services and supports as their needs change. Additionally, homelessness exposes individuals to increased health risks, especially as 63 percent of Marin's homeless population is unsheltered,[20] and service providers have difficulty linking persons who are experiencing homelessness to supportive housing and health care services. Racial minorities are disproportionately represented among persons experiencing homelessness,[21] and the portion of youth experiencing homelessness has increased in recent years. Twenty-nine percent of those experiencing homelessness are between 18-24 years old, an increase from 6 percent in 2013.[22]

[15] USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
[16] American Community Survey. (2012-16).
[17] Family Health Outcomes Project, California Maternal Child and Adolescent Health 2012.
[18] American Community Survey. (2012-16).
[19] Ibid.
[20] Point in Time Homeless Count. (2015). Marin Homeless Census and Survey.
[21] Ibid.
[22] Point in Time Homeless Count. (2015). Marin Homeless Census and Survey.

6. **Healthy Eating and Active Living (HEAL):** HEAL relates to Marin residents' ability to shape health outcomes through a focus on nutrition and physical activity. Rates of obesity and diabetes are lower in Marin County compared to California as a whole. However, there is a high prevalence of youth in the San Rafael service area who are overweight or obese, especially among Black (18 percent), Hispanic (20 percent), and Native American/Alaska Native populations (24 percent).[23] Disparities also exist in rates of cancer; it is 483/100,000 persons among Whites, compared to only 326/100,000 among Asian and Pacific Islanders.[24] Black Marin residents have the highest rate of cardiovascular disease, at 174/100,000 persons, compared to 112/100,000 among Whites.[25] This is also true for strokes, for which Blacks have a rate of 53/100,000 persons compared to 23/100,000 among Whites.[26] Related to all of these disparities, healthy lifestyle choices greatly affect the rates of chronic conditions like cardiovascular disease, stroke, and cancer. For example, focus group participants bemoaned the lack of resources for education around diabetes management. They also expressed that access to healthy food is a top concern. This is particularly true in the "food deserts" of Lynwood, Hamilton, and the Canal area of San Rafael.[27]

7. **Maternal and Infant Health:** Maternal and infant health describes the health concerns of mothers and their newborn children, and many of the indicators in this category are predictive of health outcomes over the life course. The San Rafael service area has a lower infant mortality rate than California,[28] and the county has a lower maternal mortality rate, but still struggles with many issues relating to child health and development. For example, of the 750 children on Marin Childcare Council's waiting list, 288 are infants.[29] In interviews, service providers highlighted the racially concentrated nature of maternal and infant health concerns: only 83 percent of African American mothers and 88 percent of Latina mothers receive first trimester prenatal care compared to 94 percent of Whites.[30] Further, African Americans have higher rates of pregnancy-related death and lower rates of pre-natal care than other ethnicities.[31] Additionally, the Marin Hispanic/Latino population has a teen birthrate 20 times higher than their White counterparts.[32] Relating this to the health need of Economic Security, described above, focus group participants expressed the need for improved childcare and better educational options.

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[23] FITNESSGRAM® Physical Fitness Testing (2016-17)
[24] CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress)
[25] Ibid.
[26] Ibid.
[27] Burd-Sharps, S. & Lewis, K. (2012). *A Portrait of Marin: Marin County Human Development Report 2012*
[28] Area Health Resource File (Health Resources & Services Administration)
[29] *Marin Independent Journal.* Retrieved from http://www.marinij.com/article/NO/20150617/NEWS/150619808
[30] Centers for Disease Control and Prevention, Birth Certificate Data 2008-17
[31] The California Pregnancy Associated Mortality Review. Retrieved from https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/PAMR/CA-PAMR-Report-1.pdf
[32] Family Health Outcomes Project, California Maternal Child and Adolescent Health

8. **Violence/Injury Prevention:** Violence and Injury prevention is a broad category of health related indicators that captures things as distinct as physical abuse and accidental poisoning. These health-related events are concentrated among certain parts of the population, indicating they may have important social determinants. The San Rafael service area has a much lower rate of violent crime (237/100,000) than California overall (403/100,000).[33] However, Marin does have several issues related to violence and injury that present distinct challenges. Due to heavy manual labor, many work-related injuries affect day laborers, particularly community members who are undocumented — 20 percent of day laborers report being injured on the job.[34] Crime rates are unevenly distributed, across racial groups and neighborhoods. For example, juvenile felony arrests are occurring at a rate of 43/100,000 among the Black/African American population compared to 10/100,000 among Hispanic/Latinos, and 2/100,000 among Whites.[35] Conditions that increase the likelihood of involvement with the juvenile justice system include family poverty, separation from family members including parental incarceration, a history of maltreatment, exposure to violence, and discrimination by law enforcement. Further, the city of San Rafael has a violent crime rate nearly twice as high as Novato.[36] Community residents expressed concern that crime reporting had decreased as a result of recent Immigration and Customs Enforcement (ICE) raids and that some youth in the Canal Area cities feel pressured to join gangs. Finally, older adults face unique challenges related to physical accidents, as falls are the leading cause of fatal injuries; 20 percent of seniors reporting a fall in the past year[37] and most homes are not designed for aging in place and universal accessibility.

9. **Oral Health:** Oral health is a key indicator of overall health; however, it is often treated as separate due to the professional separation of dentistry work from other medical fields. The impact of untreated oral health conditions disproportionally affects the most vulnerable populations and contributes to such conditions as cardiovascular disease, and poor pregnancy and birth outcomes. Although tooth decay and gum disease are preventable, inadequate access to dental insurance and dental providers, and underutilization of dental care, are affecting the oral health of Marin County residents. For example, 43 percent of adults in Marin County do not have dental insurance compared to the state average of 39 percent.[38] The incidence rate of oral cavity and pharynx cancer is 14/100,000 persons, which is higher than the California average of 10/100,000.[39] Marin has not yet reached its Healthy People 2020 goal for children's dental health provision,[40] and Denti-Cal reimbursement rates are low, indicating an opportunity for improving utilization. Key informant and focus group participants report

[33] FBI Uniform Crime Report 2017.
[34] *UCLA Newsroom,* http://newsroom.ucla.edu/releases/First-Nationwide-Study-of-Day-Laborers-6774.
[35] Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center. 2016.
[36] Data from Uniform Crime Reporting Statistics (2012), US Department of Justice.
[37] California Health Interview Survey (2011-12).
[38] California Health Interview Survey (2014-15).
[39] National Cancer Institute (2011-15).
[40] Healthy People 2020; California Oral Health Reporting 2008-10.

that dental insurance is difficult to obtain, and specialty care, like oral surgery, is not affordable.

10. **Social Connection:** Social connections can directly impact mental health and their influence on lifestyle have important consequences for physical health. The San Rafael service area boasts many social associations, and residents generally feel they know where to go for emotional and social support. Only 18 percent of residents feel they have insufficient social and emotional support compared to the California average of 25 percent.[41] However, economic inequality and the county's rapidly aging population increase the risk of social isolation. For example, 54 percent of individuals over 65 years of age reported eating alone, and 44 percent reported living alone.[42] Further, the lack of alternative forms of transportation in rural towns, and racial segregation in parts of Marin, create barriers to community cohesion. According to the residential segregation dissimilarity index, Whites and Hispanics in the San Rafael area in particular, experience a high degree of census tract separation.[43] Racial and ethnic minority students report bullying and a lack of connection to their schools; White 7th graders are three times more likely to feel connected to their schools than African Americans, and 50 percent more likely than Latinos.[44] Key informants reported that language barriers lead to further isolation among immigrant communities. Populations such as the LGBTQ community and people experiencing homelessness report a lack of safe and welcoming social spaces. Finally, at both ends of the age spectrum, youth and older adults desire social connection; youth want opportunities for positive mentorship and older adults desire more community events.

D. Community resources potentially available to respond to the identified health needs

The service area for NCH contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

Examples of community resources available to respond to each community-identified health need, as identified in qualitative data, are indicated in each health need brief found in Appendix C. Health Need Profiles. In addition, a list of community-based organizations and agencies that participated in the CHNA process can be found in Appendix B. Community input tracking form. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference https://www.211ca.org/ and enter the topic and/or city of interest.

[41] Behavioral Risk Factor Surveillance System.
[42] American Community Survey. (2011-14).
[43] Brown University US2010 Project, 2010 data available from: http://www.s4.brown.edu/us2010/index.htm6. Centers for Disease Control and Prevention, Birth Certificate Data 2008-17.
[44] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020

VI. NCH 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

The implementation strategy describes how Novato Community Hospital, a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016 - 2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

B. 2016 Implementation Strategy evaluation of impact overview

The table below reflects the framework of the 2016 Implementation Strategy Plan that described how Novato Community Hospital planned to address each identified significant health need, and lists the impacts achieved for each of the programs where NCH provided services and/or resources in 2016, 2017, and/or 2018.

C. 2016 Implementation Strategy evaluation of impact by health need

Sutter Novato Community Hospital Priority Health Need: Access to Health Care

Although access to healthcare as measured by health insurance is relatively high in Marin, there are significant geographies where residents lack insurance and lack obtaining timely and effective screening and treatment. Limitations on access affect participation in screenings and treatment of early diagnosis of disease and illness such as, cancer, heart disease, asthma, mental health, substance abuse, and diabetes. Sutter Health's impact on Access to Care is listed below along followed by the impact by health need.

Sutter Bay Hospitals Access to Care Program Highlights		
Program Name	**Description**	**Results**
Services for the Poor and Underserved	Services for the poor and underserved include traditional charity care which covers health care services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Services for the poor and underserved also include the cost of other services provided to persons who cannot afford health	• **2016: $150,735,540** • **2017: $126,280,914** • **2018: $303,971,053**

	care because of inadequate resources and are uninsured or underinsured, and cash donations on behalf of the poor and needy.	
Benefits for the Broader Community	Benefits for the broader community includes costs of providing the following services: health screenings and other non-related services, training health professionals, educating the community with various seminars and classes, the cost of performing medical research and the costs associated with providing free clinics and community services. Benefits for the broader community also include contributions Sutter Health makes to community agencies to fund charitable activities	• **2016: $80,575,269** • **2017: $77,088,321** • **2018: $70,222,413**

Access to Care Grant Making Highlights and Collaboration Partnerships		
Summary of Impact: During 2016-2018, Novato Community Hospital provided grants that reached over 10,000 patients and residents addressing Access to Care in the Sutter Novato Community Hospital, Marin County service area. In addition, a portion of money managed by a donor advised fund at Sutter Novato Community Hospital Foundation was used to award grants to Novato Unified School District in service of Sutter Novato Community Hospital's 2016 Access to Care implementation strategies. These programs are denoted by an asterisks (*) in the table below.		
Grantee/Partner	**Project Description**	**Results to Funding**
Novato Unified School District*	Three components: • A fund for uninsured and underserved students to access specialty care, such as dental, eye exams, prescription glasses, health screenings. • Hire and manage a team of RNs to provide daily support to students with acute health needs such as type 1 diabetes, spina bifida, and epilepsy. • Hire and manage two high school athletic trainers to provide consultation to coaches, perform baseline concussion testing of all student athletes, attend games	6,094 students served

	and facilitate injury management.	
Kalmanovitz Child Development Center (Terra Linda)	KCDC is a special clinic operated under the NCH license that provides evaluation and services to developmentally delayed and special needs children ages 0-21. For those who are unable to pay, services are provided on a sliding fee scale. KCDC is the largest multi-disciplinary clinic of its kind in Northern California, and accepts most insurance.	370 patients served
RotaCare	Provide a grant to the RotaCare clinic of San Rafael that provides services free of charge to the underinsured/uninsured residents of Marin County. In addition to the grant, Sutter Health labs provide, in-kind diagnostic laboratory services for all patients of the RotaCare free clinic.	3,362 patients served
Homeward Bound	Transition to Wellness Program provides beds for homeless acute care patients discharged from hospitals that require a safe, supervised environment to heal.	285 patients served

VII. Appendices

Appendix A. Secondary data sources and dates

i. Secondary sources from the CHNA Data Platform

ii. Additional sources

Appendix B. Community input tracking form

Appendix C. Health Need Profiles

Appendix D. Prioritization Scoring

Appendix E. Focus Group Protocol

Appendix F. Key Informant Interview/Group Interview Protocol

Appendix G. Focus Group Optional Participant Survey Results

Appendix H. Group Interview Optional Participant Survey Results

Appendix A. Secondary data sources and dates

i. Secondary sources from the CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1.	American Association of Retired Persons	2012
2.	Area Agency on Aging Marin County Plan	2016-2020
3.	Behavioral Risk Surveillance Task Force	2017
4.	Brown University, Diversity and Disparities Project	2010
5.	California Department of Education, California Physical Fitness Report	2014-2015
6.	California Department of Education, School Level Data Files	2014-2015
7.	California Department of Public Health	2010-2012
8.	California Department of Public Health, Kindergarten Assessment Results	2013-15
9.	California Health Interview Survey	2014-2015
10.	California Healthy Kids Survey	2017-2018
11.	California Office of Traffic Safety (OTS)	2016
12.	California Oral Health Reporting	2008-2010
13.	Centers for Disease Control	2013
14.	Centers for Disease Control and Prevention	2008-2017
15.	Commission on Aging, Housing Report	2018
16.	County Business Patterns	2015
17.	Insight Center	2012
18.	Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center	2016
19.	Marin Community Clinic	2013-2015
20.	Marin County Human Development Report	2012
21.	Marin County Oral Health Report	2014
22.	Marin County Point in Time Homeless Count and Survey	2015
23.	Marin Independent Journal	2015
24.	MarinKids	2015
25.	Maternal and Infant Health Assessments, California Department of Public Health	2013-2015
26.	National Cancer Institute	2011-2015
27.	National Survey of Children's Exposure to Violence	2015
28.	National Vital Statistics System	2016
29.	Same as above	
30.	The California Pregnancy-Associated Mortality Review, California Department of Public Health	2002-2007
31.	U.S. Census Bureau (Economic Census)	2012
32.	UCLA Newsroom	2006
33.	Uniform Crime Reporting Statistics, U.S. Department of Justice	2012
34.	USC Dornsife, Center for the Study Immigrant Integration	2016

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Marin Food Policy Council (Program Manager)	1	a) health department representative b) minority c) medically underserved d) low income	Service provider	10/3/18
2	Key Informant Interview	Canal Alliance (Family Resource Manager)	1	b) minority c) medically underserved d) low income	Service provider	8/30/18
3	Key Informant Interview	City of San Rafael (Chief of Police)	1	b) minority c) medically underserved d) low income	Service provider	9/5/18
4	Key Informant Interview	Marin Transit (Director of Policy and Legislative Programs)	1	b) minority c) medically underserved d) low income	Service provider	9/18/18
5	Key Informant Interview	Marin County Dept. of Health & Human Services, Behavioral Health and Recovery Services (Director)	1	a) health department representative b) minority c) medically underserved d) low income	Service provider	8/28/18
6	Group Interview	Substance Use/Behavioral Health: RxSafe Marin (Coordinator), National Alliance of Mental Illness Marin (executive Director), North Marin Community Services (Director of Mental Health Programs)	3	a) health department representative, b) minority, c) medically underserved d) low income	Service providers	10/8/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
7	Group Interview	Healthcare Delivery/Access: Coastal Health Alliance (CEO), Marin City Health and Wellness Center (CEO), Marin Community Clinics (CEO), RotaCare Clinic of San Rafael (Medical Director)	4	a) health department representative, b) minority c) medically underserved d) low income	Service providers	10/11/18
8	Group Interview	Economic Development: Marin Economic Forum (Board member), San Rafael Chamber of Commerce (President and CEO), Novato Chamber of Commerce (CEO), Latino Council of Marin (Executive Director), North Bay Leadership Council (President and CEO)	5	a) health department representative, b) minority, d) low income	Service providers	10/15/19
9	Group Interview	Disabilities: Marin Center for Independent Living (Executive Director), Buckelew Programs (CEO), Whistlestop (Healthcare Market Strategist), Casa Allegra (Executive Director), Marin Ventures (Executive Director), Marin IHSS Public Authority (Executive Director)	6	a) health department representative b) minority c) medically underserved d) low income	Service providers	9/21/18
10	Group Interview	Housing/Safety Net: Ritter Center (Executive Director), Homeward Bound (Executive Director and	8	a) health department representative b) minority c) medically	Service providers	9/19/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
		Chief Provider of Homeless Services), St. Vincent de Paul Society (Executive Director), Marin Housing Authority (Executive Director), Whole Person Care Marin County (Director), Downtown Streets Team (Program Director)		underserved d) low income		
Community residents						
	Focus Group	Youth: Youth served by the Marin County Youth Court program located in San Rafael	6	b) minority d) low income	Community members	9/5/18
	Focus Group	LGBT: LGBT community members served by the Spahr Center located in San Rafael	7	d) low income	Community members	9/21/18
	Focus Group	ESL: Parent members of the District English Language Learners Advisory Council of San Rafael City Schools	9	b) minority c) medically underserved d) low income	Community members	10/2/18

*Focus Group and Group Interview participants completed an optional survey. These data were used to inform representation of the four target groups during data collection events.

Medically underserved
Focus Groups: One or more participant indicated they have “No Insurance”

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.

Low-income

Focus Groups: One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.

Minority

Focus Groups: One or more participant indicated their race/ethnicity as non-White.

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the minority community.

Health department representative

Focus Groups: N/A

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.

Appendix C. Health Need Profiles

Health need profiles include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics), and were developed prior to the prioritization meeting. The profiles do not reflect additional knowledge shared by individual stakeholders during that meeting. Additionally, statistics presented in the health need profiles were not analyzed for statistical significance and should be interpreted in conjunction with qualitative findings.

Appendix D. Prioritization Scoring

2019 HEALTH NEEDS PRIORITIZATION SCORES: BREAKDOWN BY CRITERIA

Health Need	Rank 1= Highest Priority	Composite Weighted Score
Economic Security	1	887.5
Education	2	854.5
Mental Health/Substance Use	3	842.5
Access to Care	4	800
Housing & Homelessness	5	767.5
Healthy Eating & Active Living (HEAL)	6	682.5
Maternal & Infant Health	7	546
Violence/Injury Prevention	8	454
Oral Health	9	432.5
Social Connection	10	388.5

Prioritization Criteria Definitions

Criteria	Definition	Weight used for scoring
Disparities	Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.	1.5
Severity	Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. *(Also considers the magnitude/scale of the need. The magnitude refers to the number of people affected by the health need.)*	1
Impact	The ability to create positive change around this issue including – potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.	1

Appendix E. Focus Group Protocol

San Rafael Service Area

Note to facilitator: Text in red should be updated prior to the start of the focus group.

Introduction + Getting Settled (15 minutes)

Hello, my name is _____ from Harder+Company Community Research and I will be leading today's discussion. This is _____ and he/she will be taking notes and tracking time. He/she may jump in with any additional questions as we go along. We want to thank you for agreeing to be a part of this discussion, which will last about an hour and a half.

We are working with the Healthy Marin Partnership to help understand the health needs in this area. We will be using the information we collect during discussions like this and data from the health department and census to write our report.

The goal is to understand the health needs of your community. We will talk today about "health", including diseases like asthma and heart diseases, and also things that can influence health, like social, political and environmental situations. These are sometimes called "social determinants of health" and can include thing like how easy it is to get medical care, the economy, safety, and housing. We will also talk about "health equity" in your community, which means how easy or hard it is for everyone to be as healthy as they can be, with no one at a disadvantage because of their position in society.

Before we start, I want to share some guidelines for our discussion:

- We want everyone to have an equal chance to speak.
- There are no right or wrong answers, and we hope that you will be as honest as possible.
- What you say will be confidential, which means that we will not use your name when talking about what we learn from our discussion.
- Please respect everyone's opinions. It is fine to have a different opinion, and we hope that you will feel comfortable sharing your opinion even if it is different from what others have said.
- Please ask questions if you are not sure what something means.
- Because we have a short time together and a lot to talk about, I may interrupt you so that we can hear what everyone has to say about all my questions.

[FACILITATOR ADJUST AS NECESSARY, DEPENDING ON # OF SURVEYS FILLED AT ONSET]
I also have a short survey for you to fill out if you would like to. This will help us learn more about who is joining these conversations. The survey is anonymous, so you do not need to put your name on it and we will only use it in our report all together with everyone else's answers. If you have not filled the survey out and would like to, please do so after we finish the discussion.

If everyone is okay with it, we want to record our discussion. We will only use the recording to make sure we remember what we talked about as we write our report. Again, we will never use your name in anything we write. Is it okay with everyone if I record?

Does anyone have any questions before we start?

[turn on recorder]

Background - 20 minutes (75 minutes left at the *start* of this section)

1. Let's start by introducing ourselves.

    a. Residents: Please tell us your name, the town you live in, and one thing that you are proud of about your community.

    b. Service Providers: Please tell us your name, your current position, and role within your organization.

2. We would like to hear about the community where you live/that you serve.

    a. Residents: Tell us in a few words what you think of as "your community". What it is like to live in your community?

    b. Service Providers: How would you define the communities and populations you serve?

3. Next, we would like to do a short activity.

    Note to facilitator: After participants have answered Question #2, hand out the ladders to everyone.

    Step 1

    We are handing out pieces of paper with ladders on them. On the ladder, you will see numbers. Circle the number that you think best stands for the community that you just described, *in comparison to other communities*. A lower number represents worse off than other communities and a higher number represents better off than other communities. You will not have to share the number you select. It may be helpful to think about how your community compares to other communities by: geographic region, racial or ethnic makeup, or the physical environment.

    Step 2

    Next, please take a minute to write or think about what experiences your community has had that contribute to the number you circled on the ladder. You can write in the box next to the ladder if you would like. For example, how does the description you gave of your community a minute ago relate to the number you chose on the ladder?

    Step 3
    Finally, how do these experiences relate to health in your community?

    Note to facilitator: Remind participants that we define health broadly, including health outcomes such as asthma and heart diseases, as well as all factors that influence health, such as social, political, and environmental surroundings (social determinants of health). These can include access to medical services, economic conditions, safety in your community, and housing, factors influencing health that we refer to as social determinants of health.

Health Issues - 15 Minutes (55 minutes left)

Next, I would like you to think about what a "healthy environment" is, keeping in mind the broad definition of health discussed earlier which includes social, political, environmental, and equity factors.

4. What do you think that a "healthy environment" is?

5. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?

    a. PROMPT: Are needs more prevalent in a certain geographic area, or within a certain group of the community?

6. What issues are coming up lately in the community that may influence health needs?

Challenges and Barriers - 10 Minutes (40 minutes left)

We have talked about what a healthy community looks like and what needs exist in the community. Now I would like to talk about challenges and barriers to healthy living and a healthy community.

7. What are the challenges or barriers to being healthy in your community?

    a. PROMPT: I know [insert from above conversation if applicable] has already been mentioned, what are some other things that act as barriers or challenges?

    Note to Facilitator: Reflect on what you have heard so far, ask about other types of barriers that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land).

8. From your perspective, what health services are difficult to access for you and the people you know in your community?

    a. PROMPT: What challenges keep individuals from seeking help?

Solutions - 10 Minutes (30 minutes left)

Now that we have identified barriers and challenges that exist in the community that make health hard to attain, I would like to talk about solutions.

9. What are some solutions that can help solve the barriers and challenges you talked about?

    *Note to Facilitator**:** Reflect on what you have heard so far, ask about other types of barriers that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land)*

    ** These solutions should not be focused just on Kaiser, or clinical care, but about the factors that holistically impact the community. It is important to note for example that community investment guidance arises from CHNAs.*

Priorities - 15 minutes (25 minutes left)

Now that we have had a chance to discuss the community's health needs from a number of perspectives, I would like to ask you to identify the top needs.

10. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address to improve the health of the community? [*Note to Facilitator: Go around and have everyone share their top 3 health issues; probe those who don't respond or allow folks to add only 1 or 2 that haven't been mentioned. The group does NOT need to agree on a final top 3.*]

    a. PROMPT: These are health issues or challenges you identify in your community and they may be the same or very different from others, we'd like to hear all of your perspectives.

11. Are these needs that have recently come up or have they been around for a long time?

    a. PROMPT: What historical/societal events have occurred since the last assessment (2015) that should be taken into consideration regarding any changes in health needs and inequities?

12. **[TIME PERMITTING]** During the last Community Health Needs Assessment (in 2015), obesity, education, housing, and healthcare access were identified as key needs in this region. What do you think has changed/stayed the same in the community since 2015 that makes these priorities less/more/equally pressing?

2016 CHNA Priorities

1. Obesity and Diabetes
2. Education
3. Economic and Housing Insecurity
4. Access to Healthcare
5. Mental Health
6. Substance Use
7. Oral Health
8. Violence and Injury

Resources - 10 Minutes (10 minutes left)

13. What are resources that exist in the community that help your community live healthy lives and address the health issues and inequity we have discussed?

    a. PROMPT:
        i. Barriers to accessing these resources.
        ii. New resources that have been created since 2016
        iii. New partnerships/projects/funding

14. **[TIME PERMITTING: prioritize for initial focus groups]** Are there certain groups or individuals that you think would be helpful to speak with as we go forward with our Community Health Needs Assessment?

    a. PROMPT:
        i. Service providers
        ii. Community leaders
        iii. Community groups

15. Is there anything else you would like to share with our team about the health of the community?

Thank you for your time and sharing these insights with us!

Community Ladder – Background and Directions

Question #3

Purpose

This activity builds on the MacArthur Scale of Subjective Social Status Ladder (https://macses.ucsf.edu/research/psychosocial/subjective.php). The goal is to help focus group participants think about social determinants of health as they discuss health needs, priorities, and challenges.

As part of the materials for the focus group, bring enough copies of the ladder for everyone in the focus group.

Directions below can be read to participants unless indicated as a note to the facilitator.

Directions (Note: these directions are also included above in the FG Script)

Step 1

Note to facilitator: After participants have answered Question #2 and a chance to describe how they describe the community in which they live/or serve, hand out the ladders to everyone.

We are handing out pieces of paper with ladders on them. On the ladder, you will see numbers. Circle the number that you think best represents your community that you just described, in *comparison* to other communities. A lower number represents worse off than other communities and a higher number represents better off than other communities. You can also hold the number in your head. You will not have to share the number you select. It may be helpful to think about the following: specific geographic regions, the racial or ethnic makeup of the community or the physical environment.

Step 2

Next, please take a minute to write or think about what experiences your community has had that contribute to the number you circled on the ladder. You can write in the box next to the ladder if you would like. For example, how does the description you gave of your community a minute ago relate to the number you chose on the ladder?

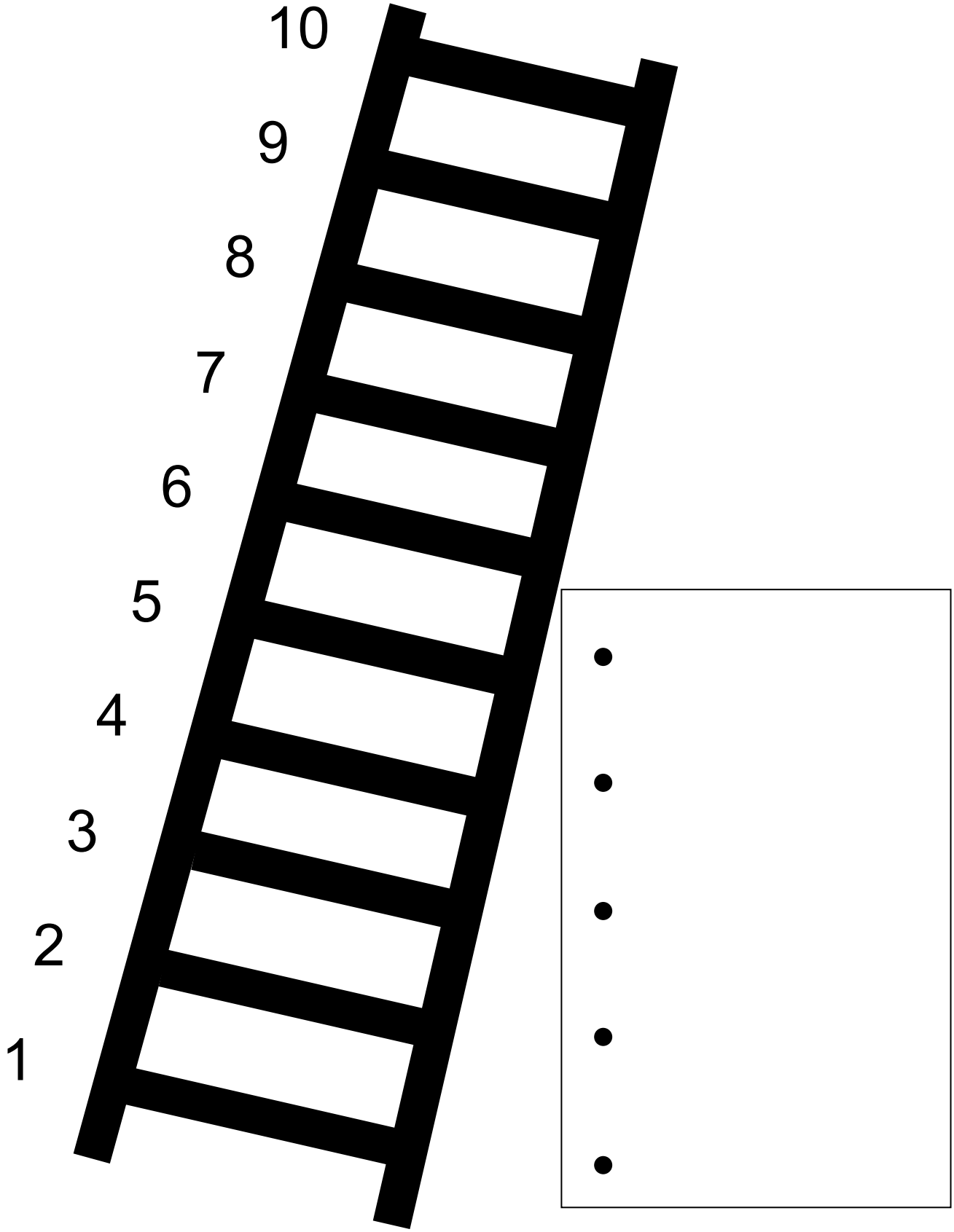
Step 3

Finally, how do these experiences relate to health in your community?

Note to facilitator: Remind participants that we are defining health broadly, including health outcomes such as asthma and heart diseases, as well as all factors that influence health, such as one's social, political, and environmental surroundings, referred to as social determinants of health. These can include access to medical services, economic conditions, safety in your community, and housing, factors influencing health that we refer to as social determinants of health.

Return to protocol

Note to facilitator: Return to the protocol and refer to the concepts discussed throughout the focus group as they relate to subsequent conversations.


10
9
8
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1

Appendix F. Key Informant Interview/Group Interview Protocol

San Rafael Service Area

Introduction (10 minutes)

Hello my name is _____ from Harder+Company Community Research. This is _____, my colleague, who will be taking notes today and jumping in as needed to clarify what was said or keep me on track with time. We are working with the Healthy Marin Partnership, Kaiser Permanente, Marin General and Sutter Health to complete their 2019 Community Health Needs Assessment to better understand the health needs in this region.

The goal of this interview is to understand the priority health needs of the community that you serve. *Health* is to be defined broadly, including health outcomes such as asthma and heart diseases, as well as all factors that influence health such as social, political, and environmental surroundings, referred to as social determinants of health.

We are also interested in understanding health equity and inequity in the community. To make sure we are all on the same page, *health equity* is defined as the opportunity for everyone to attain full health potential where no one is disadvantaged in achieving this potential based on social position or other socially defined circumstances.

Before we begin, I would like you to know that your responses will be confidential, which means that we will not connect your name with anything you say when we report our findings. There are no right or wrong answers, and we encourage you to be as candid as possible.

I also have a voluntary questionnaire for you to fill out that will help us understand your role in your organization and the community you serve. You do not need to fill it out if you do not want to.

[Group Interviews only, when applicable] For this interview, two members of the Kaiser leadership is/are present. I will give them a chance to introduce themselves in a minute. They are here to listen to your perspectives on your community health needs and will not be active participants in this interview. As I mentioned before, we encourage you to be honest and candid so we can truly understand the health needs of the community you serve.

Lastly, if no one objects, we would like to record this conversation. The recording will only be used to ensure that we accurately capture the conversation today. Everything we write in the reports will be about all our interviews together, and not use your name. Is it okay if I record?

Do you have any questions for me before we start?

{turn on recorder}

Background - 10 minutes (50 minutes left)

16. Briefly, what is your current position and role within your organization?

17. How would you define the communities you serve and live in, as well as the population you serve?

    a. It may be helpful to think about the following: specific geographic regions, the racial or ethnic makeup of the community or the physical environment

Health Issues – 10 Minutes (40 minutes left)

Next, I would like you to think about what a *healthy environment* is, keeping in mind the broad definition of health discussed earlier, which includes social, political, environmental, and equity factors.

18. What does a healthy environment look like?

19. When thinking about your community in the context of the healthy community you just described, what are the biggest health needs in the community?

    a. PROBE: Are needs more prevalent in a certain geographic area, or within a certain group of the community?

20. What have been some emerging issues in the community that may influence health needs?

Challenges/Barriers - 10 Minutes (30 minutes left)

We have talked about what a healthy community looks like and what needs exist in the community. Now I would like to talk about challenges and barriers to healthy living and a healthy community.

21. What challenges or barriers exist in the community to being healthy?

    a. PROMPT: I know *[insert from above conversation if applicable]* has already been mentioned, what are some other things that act as barriers or challenges?

    b. PROMPT: *Reflect on what you have heard so far, ask about other types of barriers that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land)*

       Barriers should not just focus on clinical care, but also on factors that holistically impact the community.

Solutions - 10 Minutes (20 minutes left)

Now that we have identified barriers and challenges that exist in the community that make health hard to attain, I would like to talk about solutions.

22. What are some solutions that can address the barriers and challenges that you have identified?

    a. PROMPT: *Reflect on what you have heard so far, ask about other types of solutions that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land)*

       As with the barriers, solutions should not just focus on clinical care, but also on factors that holistically impact the community. It is important to note for example that community investment guidance arises from CHNAs.

Priorities - 5 minutes (10 minutes left)

Now that we have had a chance to discuss the community's health needs, I would like to ask you to identify the top needs.

23. Based on what we have discussed so far, what are currently the *most important* or urgent top 3 health issues or challenges to address to improve the health of the community?

24. Are these needs that have recently emerged recently or are they long-standing?

    a. PROBE: What historical/societal influences have occurred since the last assessment (in 2015) that should be taken into consideration regarding any changes in around health needs and inequities?

Resources - 5 Minutes (5 minutes left)

25. What are resources that help your community live healthy lives and address the health issues and inequity we have discussed?

    a. PROBE:

        - Barriers to accessing these resources.
        - New resources that have been created since 2016
        - New partnerships/projects/funding

26. {IF EARLY IN THE PROCESS AND THIS IS NEEDED} Are there certain groups or individuals that you think would be helpful to speak with as we go forward with our Community Health Needs Assessment?

    a. PROMPT:

        - Service providers
        - Community leaders
        - Community groups

27. Is there anything else you would like to share with our team about the health of the community?

Thank you for your time and sharing these insights with us!

Appendix G. Focus Group Optional Participant Survey Results

Respondent Demographics

Exhibit 1. What is your zip code?*

	N	%
94901	2	22%
94925	1	11%
94941	1	11%
94945	1	11%
94947	2	22%
94964	1	11%
94965	1	11%
Total	9	100

* The sum of percentages in this table and those hereafter may not equal 100 percent due to rounding.

Exhibit 2. What is your race/ethnicity?

	N	%
White	6	86%
Multiple races	1	14%
Total	7	100%

Exhibit 3. What would you say is your gender identity?

	N	%
Female/Woman	2	29%
Male/Man	4	57%
Non-Binary/ Gender Non-conforming	1	14%
Total	7	100%

Other options included but not reported: Non-Binary/Gender non-conforming, Transgender, and Other.

Exhibit 4. How would you describe your employment status?*

	N	%
Self-employed	2	25%
Employed part-time	2	25%
Retired	2	25%
Full-time student	1	13%
Other	1	13%
Total	8	100%

* The sum of percentages in this table and those hereafter may not equal 100 percent due to rounding.

Exhibit 5. Do you or your family get any government assistance programs (like WIC, Head Start, Medi-Cal, Cal-fresh, etc.)?

	N	%
No	4	50%
Yes	4	50%
Total	8	100%

Exhibit 6. How much money per year does everyone in your family make all together? Your best guess is fine.*

	N	%
0-10,000	1	17%
10,001-20,000	1	17%
20,001-30,000	2	33%
30,001-40,000	1	17%
75,001-100,000	1	17%
Total	6	100%

Exhibit 7. How many people (including you) does the money that everyone in your family makes take care of?*

	N	%
1	5	63%
2	2	25%
6+	1	13%
Total	8	100%

Exhibit 8. What is your current marital status?

	N	%
Single	6	86%
Married	1	14%
Total	7	100%

Exhibit 9. What is the highest level of education you have?

	N	%
High school diploma or GED	1	14%
Some college	2	29%
Associate or technical degree	1	14%
College degree	1	14%
Graduate or professional degree	2	29%
Total	7	100%

Exhibit 10. What kind of health insurance do you have?*

	N	%
Medi-Cal	3	38%
Covered California	1	13%
Insurance bought directly by me or my partner	1	13%
Other	2	25%
Don't know	1	13%
Total	8	100%

Social Support

Exhibit 11. Some people consider social support as a resource to support health. When you need to talk to someone about something personal or private – for instance, if you had something on your mind that was worrying you or making you feel down – are there enough people you can count on, too few people, or no one you can count on?

	N	%
Enough people	3	43%
Too few people	4	57%
Total	7	100%

Exhibit 12. Do you think the number of people you can turn to or support is similar to others in your community, more than most people have, or less than most people have? *

	N	%
Similar to other people	2	33%
More than most people	2	33%
Less than most people	2	33%
Total	6	100%

Appendix H. Group Interview Optional Participant Survey Results

Exhibit 13. What is your position in the organization?

	N	%
Executive Director	12	50%
Program Manager/Coordinator/Supervisor	5	21%
Other	7	29%
Total	24	100%

Exhibit 14. How long have you been with the organization?

	N
Mean = 10 years	24

Exhibit 15. Do you identify as a leader, representative, or member of any of the following communities?* (*Mark all that apply*)

	N	%
Health Department or Health Care Sector	10	40%
Non-Health Care Sector (e.g., law enforcement, religion, education)	5	20%
Individuals with chronic conditions (e.g., diabetes, obesity, heart disease)	6	24%
Minority population	9	36%
Medically underserved	10	40%
Low-income	13	52%

*Total does not equal 100% as respondents selected multiple responses. N = 25

Exhibit 16. What topic area(s) does your organization support?* (*Mark all that apply*)

	N	%
Health	22	88%
Education	14	56%
Employment	17	68%
Housing	20	80%
Faith-Based	3	12%
Neighborhood/community well-being	14	56%
Poverty	14	56%
Criminal/juvenile justice	3	12%
Other	12	48%

*Total does not equal 100% as respondents selected multiple responses. N = 25

Exhibit 17. What age range do you primarily serve?* (*Mark all that apply*)

	N	%
1-10 years old	10	40%
11-20 years old	12	48%
21-30 years old	16	64%
31-40 years old	18	72%
41-50 years old	21	84%
51-60 years old	19	76%
61-70 years old	19	76%
71+ years old	16	64%

*Total does not equal 100% as respondents selected multiple responses. N = 25

Exhibit 18. What areas/neighborhood/cities does your organization serve primarily?

	N	%
All County	1	5%
All Marin	1	5%
All of Marin	1	5%
Canal San Rafael	1	5%
County - Wide and Bay Area	1	5%
Entire County of Marin	1	5%
Marin	1	5%
Marin City / Marin County and Southern Sector of SF / Bayview Hunters Point Community	1	5%
Marin County	4	19%
Marin County (S. B, Novato)	1	5%
Marin County-Wide	1	5%
Marin, Sonoma and Napa Counties	1	5%
Novato and Surrounding Communities	1	5%
Novato, CA	1	5%
People w/all types of disabilities / older adults	1	5%
San Rafael / Novato	1	5%
San Rafael and Marin County	1	5%
San Rafael, Novato, Mill Valley, Marin City	1	5%
Total	21	5%

Exhibit 19. What is your race/ethnicity?

	N	%
Black/African American	1	5%
Hispanic/Latino/a	1	5%
White	17	85%
Multiple races	1	5%
Total	20	100%