



SUTTER SANTA ROSA REGIONAL HOSPITAL

2019 Community Health Needs Assessment

Sutter Santa Rosa Regional Hospital Region Community Benefit
CHNA Report for Sutter Santa Rosa Regional Hospital

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I. Introduction/background

A. About Sutter Santa Rosa Regional Hospital

The legacy of Sutter Santa Rosa Regional Hospital started in 1867, as a small community hospital on the corner of Humboldt and Cherry streets in Santa Rosa. Heeding cries to move the facility outside of city limits, the County of Sonoma purchased land just north of town and built a hospital on Chanate Road in 1936. A new wing was added to modernize the facility in 1956 and further expansion included a four-story wing, increasing the hospital's capacity. In 1996, Sutter Health agreed to improve the aging County medical center, expand services and ultimately build a modern replacement hospital that met new earthquake safety standards.

Sutter Santa Rosa Regional Hospital fulfills that promise and provides state-of-the-art health care for the region. The new facility—which opened in fall of 2014—is located at 30 Mark West Springs Road and is accredited by the Joint Commission and consistently ranks among the top hospitals in the region according to independent quality rating organizations. Sutter Santa Rosa Regional Hospital is part of Sutter Health, a not-for-profit network of hospitals, doctors and nurses who share expertise and resources to advance health care quality. Other Sutter affiliates in Sonoma County include Sutter Pacific Medical Foundation, Sutter Care At Home, and Sutter Health Plus (Sutter Health's new insurance plan), all working together to ensure a high quality, patient centered continuum of care.

Sutter Santa Rosa Regional Hospital is licensed by the State of California Department of Health Services to operate 84 acute care beds and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the California Medical Association. Sutter Health is committed to giving back to the community in response to identified health priorities.

The most significant community benefit program is their Family Medicine Residency Training Program. This three year program graduates twelve primary care physicians each year, about half of whom stay and practice in their community. Also, about 75% of the local Federally Qualified Health Centers are staffed by graduates of the program.

B. About Sutter Santa Rosa Regional Hospital 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. Sutter Santa Rosa Regional Hospital's approach to Community Health Needs Assessment

The new federal CHNA requirements have provided an opportunity to revisit our 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 rigorous, collaborative approach to understanding the needs and assets in our communities.

The SC CHNA Collaborative's approach to the needs assessment 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 150 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 the secondary data available through the Kaiser Permanente CHNA data platform, and other sources of secondary data, the SC CHNA Collaborative collected primary data through key informant interviews and focus groups. Primary data collection consisted of reaching out to local 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 existing community assets and resources to address the health needs.

The SC 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 all 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, each hospital will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on the hospital's assets and resources, as well as on evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once finalized, will be posted publicly on all hospital websites. In alignment with the hospital implementation plans, Health Action will use this report for strategic planning and developing cross-sector approaches to address key health needs.

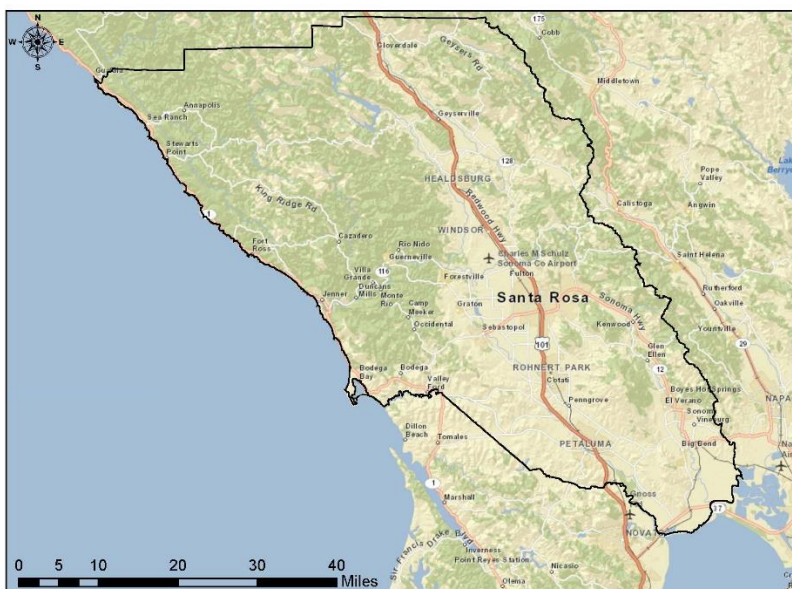
II. Community served

A. Sutter Santa Rosa Regional Hospital's definition of community served

Each primary hospital in the SC CHNA Collaborative defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and description of community served

i. Map



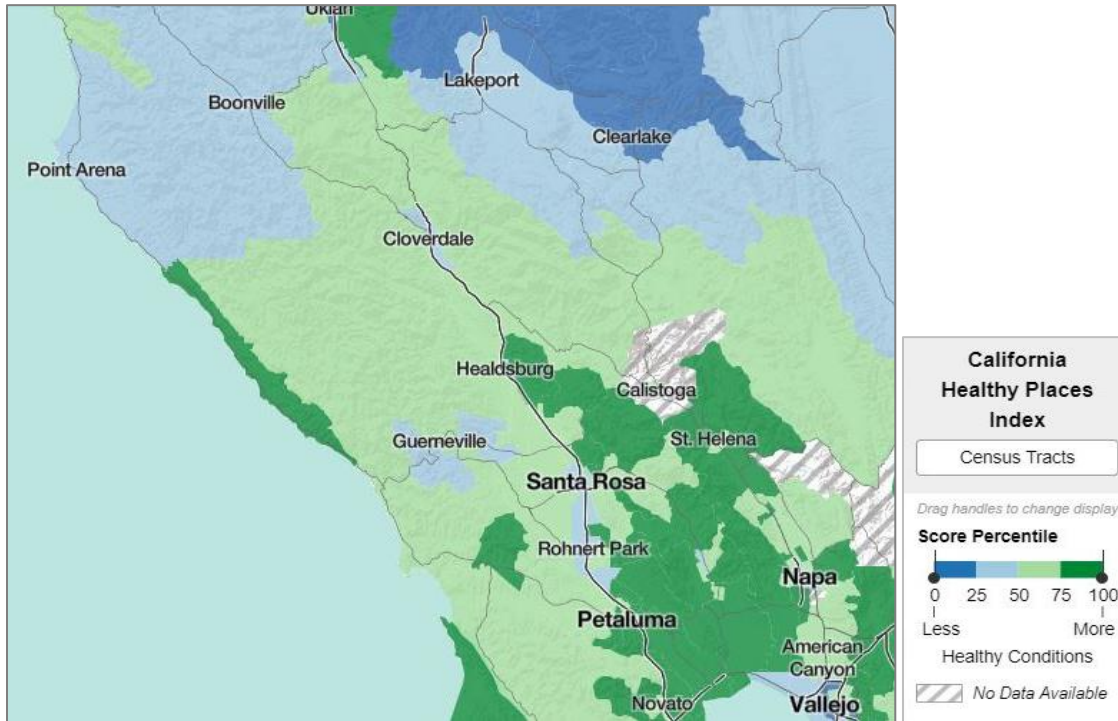
Sonoma County

ii. Geographic description of the community served

The Sutter Health – Santa Rosa Regional service area includes Sonoma County. Care centers located throughout various cities include Healdsburg, Santa Rosa, Rohnert Park, Sebastopol and Petaluma serve residents from all over Sonoma County.

The health of Sonoma County residents is shaped by policies and community characteristics, not traditionally viewed as related to health, such as housing, education, economic, and social factors. The map below presents those community conditions, or social determinants of health, as an aggregate score within the SRRH service area and surrounding geographic areas. Each score represents how well each geography compares to other similar geographies in the state on specific social determinants with higher scores indicating healthier conditions. Healthy conditions represented in this index include factors related to economic, social, and

neighborhood resources, as well as a clean environment, education, transportation, housing, and health care, as measured in the California Healthy Places Index (<https://map.healthyplacesindex.org/>). Higher scores on this index are correlated with greater access to health care, and improved mental and physical health outcomes.



Medical Service Study Area (MSSA) – Santa Rosa

The overall index score for the Santa Rosa MSSA is 69.3 percent, or this MSSA has healthier community conditions than 69.3 percent of other California MSSAs. The following illustrates a breakdown of the scores in the Santa Rosa MSSA for each of the eight policy action domains.

MSSA: Santa Rosa x

HPI Score: 69.3 Percentile



This MSSA has healthier community conditions than **69.3%** of other California medical service study areas.

MSSA information

Population: 192,802

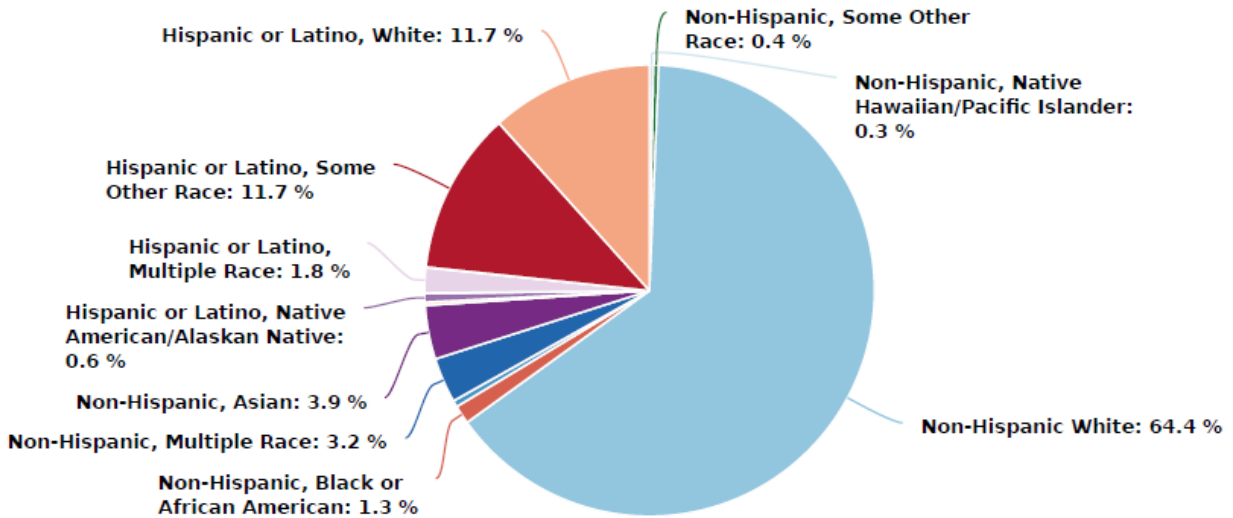
Policy Action Areas are ordered by their contribution to the overall HPI Score.

- Economic v
- Education v
- Transportation v
- Social v
- Neighborhood v
- Housing v
- Clean Environment v
- Healthcare Access v

iii. Demographic profile of the community served

Demographic profile: Sutter Santa Rosa Regional Hospital service area

Population by Race (Percentage)



Socioeconomic Data ¹	
Living in poverty (<100% federal poverty level)	11.22%
Children in poverty	13.58%
Unemployment	2.80%
Uninsured population	10.11%
Adults with no high school diploma	12.77%

III. Who was involved in the assessment?

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

Sutter Santa Rosa Regional Hospital worked with both hospital and other partner organizations with similar service areas in Sonoma County to form the Sonoma County CHNA Collaborative to support the 2018/19 CHNA. 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 analysis. Sutter Santa Rosa Regional Hospital then coordinated with these

¹ Population by Race and Socioeconomic data are drawn from the CHNA Data Platform. See Appendix A for sources.

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 – Santa Rosa
2. St. Joseph Health – Santa Rosa Memorial Hospital
3. Sutter Health – Santa Rosa Regional Hospital

Additional partners:

1. Sonoma County Department of Health Services

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 Kaiser Foundation Hospital service areas in Roseville, Sacramento, San Bernardino, San Rafael, 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 Sutter Santa Rosa Regional Hospital service area largely overlaps with the Kaiser Permanente-Santa Rosa service area, so for the purpose of this CHNA collaboration, data were used from both the county and the Kaiser Permanente CHNA Data Platform (hereafter: CHNA Data Platform).

Sutter Santa Rosa Regional Hospital used the CHNA Data Platform (<http://www.chna.org/kp>) to review approximately 120 indicators from publicly available data sources.

Sutter Santa Rosa Regional Hospital also used additional data sources beyond those included in the CHNA Data Platform (e.g., California Healthy Kids Survey, Rapid Health Needs Assessment (CASPER), and the Sonoma County Farmworker Health Survey).

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, Sutter Santa Rosa Regional Hospital also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners 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 health needs across the service area. 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

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 SRRH service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities in both English and Spanish. 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/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.

Primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA, since in order to be identified as a potential “health need” an issue had to be mentioned in at least half of the qualitative data collection activities. 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. 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 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). 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 Santa Rosa Regional Hospital 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 publically 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 (number of standard deviations from the mean) 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 interviews, *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. CHNA hospital partners and representatives from the Sonoma Department of Health Services attended the meeting to observe and help facilitate, but did not vote. 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 geographic, age, or racial/ethnic subpopulations.
- **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.

During the small-group discussions, meeting participants 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 1-9 (*1=lowest priority; 9=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 Santa Rosa service area. Since there is a large overlap between county boundaries, the SRRH service area, and the Kaiser service area, these data were considered sufficient proxy indicators for identifying the health needs of the county.

In October 2017, wildfires colloquially known as the Sonoma Complex Fires, Tubbs Fires, or the October Fires ravaged over 5,000 homes in Santa Rosa. This tragic event was declared a national disaster and significantly impacted the health of many Sonoma County community members. The following health needs descriptions present data relating to these fires (hereafter “Sonoma Complex Fires”) to highlight their significance for each identified health need.

1. **Housing and Homelessness:** Sonoma County’s high cost of living exacerbates issues

related to health care access and affordability. More than half of renters in the county spend 30 percent or more of their income on rent. A quarter of households in the Santa Rosa service area face poor conditions such as inadequate plumbing or kitchen facilities. There is also strong regional variation in home prices: Rohnert Park is the most affordable area with a median home selling for \$479,500, compared to Healdsburg, which is least affordable with a median home price of \$804,000.² The burden of housing costs exacerbates disparities; for example, Latino families in Sonoma (with median household incomes of \$55,675) fall below the minimum qualifying income for a median price home in the county (\$112,840).³ Additionally, homelessness exposes individuals to increased health risks on a variety of measures, and service providers have difficulty getting those experiencing chronic homelessness both off the street and into a continued care arrangement. 35 percent of those who are experiencing homelessness have psychiatric or emotional conditions, 33 percent experience drug or alcohol abuse, and 27 percent have chronic health problems.⁴ Individuals experiencing homelessness in Sonoma County identify across several race/ethnicities, with the majority identifying as White (62 percent) followed by Hispanic/Latino (28 percent) and multi-racial (21 percent). Focus group respondents reported that money spent on rent impedes their ability to afford preventative and urgent medical care. These issues were exacerbated by the October 2017 Sonoma Complex Fires, which both destroyed homes, and increased unemployment among the most disadvantaged.

2. **Education:** Education directly impacts a person's ability to live a long and healthy life. Education has consequences for health because it shapes professional advancement and the pursuit of a stable life. Additionally, education provides the knowledge and cultural capital necessary for navigating complicated health systems and sorting through available resources to seek help. While some education outcomes are better for Sonoma County than the rest of California, only half of children in the Santa Rosa service area attend preschool and two-in-five adults in the county lack a college education.⁵ In addition to the need for progress on these standard benchmarks, strong racial inequities persist in the educational system. For example, racial minorities have lower rates of high school completion. In the Santa Rosa service area, the highest proportions of adults without a high school diploma are Hispanic at 41 percent and Native American/Alaska Native at 34 percent, compared to the White population at 5 percent.⁶ The proficiency gaps for literacy and math seen between Hispanic/Latino and non-Hispanic White students in the early grades persist throughout secondary school. For example, 60 percent of White 3rd graders earn proficient scores on literacy tests compared to only 30 percent of Hispanics.⁷ Similarly, 46 percent of Whites meet 11th grade math standards compared to only 19 percent of Hispanics.⁸ Focus group

² Bay Area Real Estate Information Services (2017).

³ "Hispanic Demographic Trends." Economic Development Board (2017).

⁴ Point in Time Count, Sonoma County, Homeless Census and Survey. (2018).

⁵ American Community Survey (2013-17).

⁶ American Community Survey. (2012-16).

⁷ Educational and Workforce Development Report (2018).

⁸ Ibid.

participants also expressed a desire for career and technical training to meet workforce needs, and felt classes on financial literacy and sexual health would particularly benefit the most disadvantaged residents.

- 3. Economic Security:** Economic security means having the financial resources, public supports, career, and educational opportunities necessary to be able to live one’s life to the fullest. As such, this health need touches on every other health-related issue in the Santa Rosa community, from mental health to housing. While Sonoma County has slightly less economic inequality than California as a whole, there is significant racial and regional variation along economic measures. Child poverty (children living 100 percent below the federal poverty level) is especially high among Native American/Alaska Native (23 percent), Hispanic/Latino (19 percent) and Black (14 percent) community members in the Santa Rosa service area.⁹ Non-Hispanic Whites in the county have higher wages and rates of business ownership. For example, Whites have the highest average annual income of \$36,647, followed by Asian Americans (\$32,495), African Americans (\$31,213), and Latinos (\$21,695).¹⁰ Additionally, 22 percent of seniors have incomes less than 200 percent of the federal poverty level.¹¹ The October 2017 Sonoma Complex Fires contributed to even greater economic inequality between racial and ethnic groups, as the most vulnerable residents work in occupations (e.g., agricultural work) affected by the fires. Community members voiced in focus groups that inequity between high- and low-income areas impacts community cohesion and leads some to feel underrepresented in political discussions, which can impact economic and health policy.
- 4. Access to Care:** Access to quality health care is important for maintaining health, preventing disease, and reducing avoidable disability and premature death. In terms of preventative investments, improving healthcare access is one of the key strategies to achieving health equity. While Sonoma County scores better than the California state average on many indicators measuring health care access, including a low uninsured rate (9 percent)¹² and a higher proportion of federally qualified health centers per the population, racial minorities and lower income individuals specifically face great challenges in obtaining affordable care. Only 70 percent of Black Medicare enrollees in the Santa Rosa Service area visited a primary care physician in the past year compared to 77 percent of Whites.¹³ Additionally, Latino children have three times the rate of untreated dental cavities compared to their non-Hispanic White counterparts.¹⁴ Fewer Medicare beneficiaries in the Santa Rosa service area had a primary care visit in the past year (61 percent) compared to the state average of 72 percent.¹⁵ Additionally, 30

⁹ US Census Bureau, American Community Survey, 1 Year Estimates, 2014 and ZTCA, 5 Year Estimates 2011-2015.

¹⁰ “A Portrait of Sonoma” Sonoma County Human Development Report 2014.

¹¹ Aging and Living Well in Sonoma County A Community Report from the Sonoma County Area Agency on Aging, 2012

¹² Small Area Health Insurance Estimates. (2015).

¹³ Dartmouth Atlas of Health Care. (2012).

¹⁴ . Sonoma County Dental Health Network | Strategic Plan 2017-2020.

¹⁵ Dartmouth Atlas of Health Care. (2012).

percent of farmworkers in the region have U.S.-based health insurance compared to 86 percent of Sonoma County adults overall.¹⁶ The county continues to work toward providing affordable and culturally competent care for all residents, especially its large Hispanic/Latino population. At the same time, focus group and interview respondents indicated several additional ways leaders can expand these supports to address disparities across the community, including increasing the number of bilingual service providers and expanding peer mentorship and resources that aid in health systems navigation.

- 5. Mental Health and Substance Use:** Residents in Sonoma County showed significant needs related to behavioral health. Compared to the state, residents of Sonoma County reported similar rates of contemplating suicide (10 percent and 13 percent, respectively).¹⁷ However, there are also racial differences. For example, 36 percent of Latino 9th graders in Sonoma County reported chronic sadness/hopelessness compared to 32 percent of White 9th graders.¹⁸ With respect to gender, men in Sonoma County have over three times the number of years of potential life lost before the age of 75 due to suicide compared to women.¹⁹ Community stakeholders expressed a desire to increase accessibility to mental health services, erase stigma, and develop a language to discuss mental health issues. Furthermore, feelings of depression, hopelessness, and anxiety or fear nearly doubled among at least one member of households in the year following 2017 Sonoma Complex Fires. In terms of substance use, residents of the Santa Rosa service area reported similar rates of excessive drinking compared to the state (20 percent and 18 percent, respectively).²⁰ However, Sonoma County has higher rates of hospital visits due to opiate overdoses, with 18/100,000 residents experiencing emergency department visits related to opiate overdoses compared to 10/100,000 of California residents.²¹ Interviewees also identified concerns with the prevalence of vaping and marijuana, especially among youth.
- 6. Maternal and Child Health:** Mothers and infants in Sonoma County face a range of barriers to health, from excessive weight gain during pregnancy to factors that impact economic security and general well-being. These issues are further magnified by racial disparities. Minorities in the Santa Rosa service area experience higher rates of infant mortality with 5/1,000 persons compared to a rate of 4/1,000 for Whites.²² Additionally, Hispanic/Latino populations have higher teen birth rates; 62 percent of teen births in the

¹⁶ Sonoma County Farmworker Health Survey (FHS) 2013-14, CDC 2014

¹⁷ California Health Interview Survey (2009-17)

¹⁸ Sonoma County California Healthy Kids Survey Analysis (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services. (2018)

¹⁹ CDPH Vital Statistics Multiple Cause of Death Files & California Department of Public Health - Safe and Active Communities Branch (2015-17) Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015

²⁰ Behavioral Risk Factor Surveillance System.

²¹ CDPH Opioid Dashboard 2015-17

²² Area Health Resource File (Health Resources and Services Administration) 2015.

Santa Rosa service area are to Hispanic mothers.²³ Interviewees expressed frustration with a lack of childcare options and culturally competent educational resources related to sexual education. For example, 31 percent of Sonoma County's demand for care for children ages zero to twelve is unmet.²⁴ Further, maternal asthma is associated with a number of negative outcomes including premature birth, low birth weight, and neonatal death. Asthma during pregnancy disproportionately affects women in Sonoma (11 percent reported asthma during pregnancy) when compared to the state average (8 percent reported asthma before pregnancy).²⁵ Group interview participants highlighted how domestic workers in particular face sexual abuse and exposure to hazardous chemicals, which impact maternal and child health.

7. Healthy Eating & Active Living (includes obesity and diabetes): Nutritious food and an active lifestyle impact community members' well-being in a variety of ways, from mental health to the risk of developing obesity and diabetes. Many factors such as economic security, transportation, and access to safe parks and grocery stores contribute to peoples' ability to lead a healthy lifestyle. For example, proximity to walkable destinations in the Santa Rosa service area is at 19 percent compared to the state average of 29 percent.²⁶ Although prevalence of diabetes in the region is similar to the state's, significant racial disparities exist, especially among youth and other vulnerable populations such as farmworkers. 40 percent of Hispanic children in grades 5, 7, and 9 rank within the *high risk*, or *needs improvement* zones for aerobic capacity compared with 39 percent of Native American/American Natives, 30 percent of Whites, 25 percent of Asians, and 21 percent of Blacks.²⁷ 15 percent of farmworkers reported ever being diagnosed with diabetes compared with 5 percent of adults in Sonoma County overall.²⁸ There is also a higher proportion of the population that does not live in close proximity to a large grocery store or supermarket in Sonoma County (14 percent) compared to the California average (13 percent). Further, looking across geographic regions, residents in Santa Rosa and Rohnert Park see more years of potential life lost before age 75 due to diabetes compared to the County overall.²⁹ Residents and stakeholders named access to educational resources for diabetes management, as well as access to healthy, affordable food as vital issues for their community's overall wellness. Additionally, stakeholders emphasized that hunger and food insecurity have worsened since the 2017 Sonoma Complex Fires in concurrence with increased economic and housing insecurity.

8. CVD/Stroke and Tobacco Use: Cardiovascular disease (CVD) is a leading cause of

²³ California Department of Public Health, Birth Statistical Master Files, 2006-2012 (pulled from Sonoma County MCAH Annual Report 2013).

²⁴ Sonoma County Childcare Needs Assessment Update. (2014).

²⁵ MIHA Data snapshot, Sonoma County 2013-14.

²⁶ USDA Food Access Research Atlas.

²⁷ Fitnessgram Physical Fitness Testing (2017).

²⁸ Disparities in Health Insurance Coverage and Health Status among Farmworkers, Sonoma County, California, 2013–2014.

²⁹ Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015.

death in Sonoma County. There is a strong causal link between tobacco use and CVD, with more people dying from tobacco-caused CVD than lung cancer. Stroke is both a risk factor for CVD and increases in likelihood among those who have had a heart attack. Sonoma has a higher percentage of adults who smoke everyday (11 percent) than California (12 percent),³⁰ but a lower ischemic stroke hospitalization rate (8/1,000 compared to 9/1,000, respectively).³¹ In terms of leading causes of death, Asian/Pacific Islanders have the highest rate of cancer deaths (30 percent) and stroke deaths (10 percent) across all race/ethnicities, and Blacks/African Americans have the highest rate of heart disease deaths (26 percent).³² In terms of geographic diversity, Healdsburg has the highest rates of cancer deaths (26 percent) and stroke deaths (8 percent), and Petaluma has the highest rate of heart disease deaths (25 percent).³³ Key informants identified vaping as an emerging issue of concern (U.S. vape usage rose from 2 percent in 2000 to 21 percent in 2015³⁴) and expressed that physicians do not yet inquire about vaping along with tobacco use.

- 9. Violence and Injury Prevention:** The Santa Rosa service area has a significantly lower rate of violent crime than California overall and a similar rate of deaths due to accidental injury. However, Sonoma County faces a number of serious violence and injury trends. Work-related falls and other injuries disproportionately affect day laborers in the county. Sonoma County's rate of violent crime (412/100,000 persons) is roughly double neighboring Marin County's rate.³⁵ Sonoma County also has the second worst rate of vehicle collision deaths involving underage drinking and driving among all of California's 58 counties. Sonoma County ranks 9th worst for collision deaths of pedestrians below age 15.³⁶ Women of color experience higher rates of intimate partner violence, which is related to their higher rates of economic insecurity and increased risk of experiencing homelessness. 54 percent of multiracial women reported intimate partner violence compared to 44 percent of American Indians, 40 percent of Blacks, and 35 percent of Whites.³⁷ In terms of geographic disparities, Petaluma has the lowest rate of unintentional injury (11 percent of years of potential life lost before age 75) compared to Cloverdale and Geyserville with the highest rates (25 percent YPLL-75 each).³⁸ Finally, the impact of the 2017 Sonoma Complex Fires caused an increase in disaster-related injuries. Of the 40 percent of households with a member who experienced traumatic

³⁰ 2018 County Rankings (2016 BRFSS Data).

³¹ Interactive Atlas of Heart Disease and Stroke (2015).

³² Interactive Atlas of Heart Disease and Stroke. (2015).

³³ Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015

³⁴ Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product among Middle and High School Students — United States, 2011–2018. *MMWR Morb Mortal Wkly Rep* 2018;67:1276–1277. DOI: <http://dx.doi.org/10.15585/mmwr.mm6745a5>

³⁵ "A Portrait of Sonoma" Sonoma County Human Development Report 2014.

³⁶ FBI Uniform Crime Report. (2017).

³⁷ National Intimate Partner Violence Survey.

³⁸ Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015

events during those fires, 8 percent suffered a significant disaster-related illness or injury to self or a family member.³⁹ Community stakeholders also expressed concern with personal safety while walking, and fear for undocumented community members who are vulnerable to injury.

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

The service area for Sutter Santa Rosa Regional Hospital 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.

VI. Sutter Santa Rosa Regional Hospital 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

The implementation strategy describes how Sutter Santa Rosa Regional 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

³⁹ Rapid Health Assessment (CASPER). (2018).

2016 Implementation Strategy Evaluation of Impact by Health Need

Although access to healthcare as measured by health insurance is relatively high in Sonoma County, 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 Santa Rosa Regional Hospital Priority Health Needs are listed below:

- Access to Health Care
- Economic & Housing Insecurity
- Obesity & Diabetes
- Oral Health
- Access to Education

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 care because of inadequate resources and are uninsured or underinsured, and cash donations on behalf of the poor and needy.	<ul style="list-style-type: none"> • 2016:\$150,735,540 • 2017:\$126,280,914 • 2018:\$303,971,053
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	<ul style="list-style-type: none"> • 2016: \$80,575,269 • 2017: \$77,088,321 • 2018: \$70,222,413

Grant Making Highlights and Collaboration Partnerships by Priority

Summary of Impact: During 2016-2018, Sutter Santa Rosa Regional Hospital provided grants that reached over 69,000 patients and residents addressing health care priorities listed in the Sutter Santa Rosa Regional Hospital, Implementation Strategy.

Grantee/Partner		Project Description	Results to Date
Catholic Charities Nightingale Project	Economic and Housing Insecurity	The Project Nightingale – Respite Care Program provides post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital or skilled-nursing facility (SNF). Medical respite is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services.	635 individuals served
Social Advocates for Youth – Dream Center	Economic and Housing Insecurity	Social Advocates For Youth (SAY) is a community based organization that serves teens and transition-age young adults by providing housing, counseling and career services. SAY’s Housing Continuum program empowers youth on the pathway to being stable and able to rise to life's challenges and opportunities.	303 individuals served
Santa Rosa Family Residency	Access to Health Care	The Santa Rosa Family Medicine Residency Program has been the sole local contributor to the primary care provider pipeline in Sonoma County for more than 45 years	Graduates of the program represent about 50% of the current practicing family doctors in Sonoma County and about 2/3 of the medical staff at our local FQHC’s are graduates. FQHC’s care for about 25% our county’s population. Resident physicians serve patients at the FQHC

			along with patients seen during hospital rotations are estimated to be over 20,000 annually.
Operation Access	Access to Health Care	Operation Access recruits volunteer medical facilities and physicians to provide free non-emergent surgeries for uninsured patients. Just in Sonoma County more than \$4.5 million in charity care surgeries were provided with OA.	129 patients served
Northern California Center for Well-Being	Obesity & Diabetes	The Northern California Center for Well-Being (NCCWB) is a not-for-profit community –based organization with a mission to improve the health of the community through prevention-oriented education and intervention to address obesity, diabetes and heart disease. They offer a myriad of classes and health education materials that are free or sliding-scale fee-based for low-income families.	985 patients served
Community Soil Foundation	Obesity & Diabetes	Community Soil Foundation exists to cultivate the wellness of Sonoma County communities by offering land-based education, creating access to organic produce and regenerating habitat and natural resources. The demonstration project of the foundation is the Larkfield Community Garden, co-located near the campus of an elementary school in Santa Rosa, nearby the hospital. The garden provides an outdoor learning lab for the students on healthy eating,	834 students served

		the food cycle, sustainable farming and the economics of food/food scarcity.	
Pediatric Dental Initiative	Oral Health	<p>Pediatric Dental Initiative (PDI) has existed to provide safe, child-friendly surgical intervention to treat severe dental caries in children</p> <p>and to provide effective and culturally appropriate health education to families of patients to reduce the risk of recurrence with the patient or younger siblings. The goal of the program is to educate itself out of business by increasing dental health and reducing the need for surgical intervention</p>	6,184 patients served
Social Advocates for Youth (SAY) College and Career Readiness Program	Access to Education	SAY's College and Career Readiness program offers work-based learning programs at high schools in the Santa Rosa City Schools District. Work-based learning is an educational approach that, by design, links learning in the workplace to learning in the classroom to engage students more fully and to intentionally promote their exposure and access to future educational and career opportunities.	160 individuals 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/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. A Report of the Surgeon General	2017
2. Alcohol and Other Drug Prevention Strategic Plan, County of Sonoma	2015-2020
3. American Journal of Epidemiology	2018
4. Bay Area Real Estate Information Services	2017
5. California Department of Public Health	2013-2015
6. CDPH Opioid Dashboard	2015-17
7. CDPH Vital Statistics Multiple Cause of Death Files & California Department of Public Health - Safe and Active Communities Branch	2015-17
8. California Health Care Foundation	2016
9. California Health Report	2016
10. California Healthy Kids Survey	2015-2016
11. California Office of Traffic Safety (OTS)	2016
12. County Rankings (BRFSS Data)	2016
13. Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018.	2018
14. Economic Development Board	2017
15. Educational and Workforce Development Report	2018
16. Feeding America	2016
17. International Journal of Occupational Medicine and Environmental Health	2016
18. Kaiser Permanente Look Inside	2018
19. Maternal and Infant Health Assessment (MIHA)	2013-2014
20. Measure of America analysis of California Department of Education data (DataQuest)	2011-2012
21. National Center for Health Statistics	2006-2012
22. National Intimate Partner Violence Survey	2015
23. North Bay Business Journal	2017
24. Proceedings of the National Academy of Sciences of the United States of America	2016
25. Public Library of Science	2018
26. Rapid Health Needs Assessment (CASPER)	2018
27. Small Area Health Insurance Estimates	2012
28. Sonoma County Area Agency on Aging	2012
29. Sonoma County Childcare Needs Assessment Update	2014
30. Sonoma County Dental Health Network Strategic Plan	2017-2020
31. Sonoma County Farmworker Health Survey	2013-2014
32. Sonoma County Human Development Report	2014
33. Sonoma County Maternal, Child and Adolescent Health (MCAH) Annual Report for the California Department of Public Health	2013
34. Sonoma County Point-in-Time Homeless Count and Survey	2018
35. Sonoma County Suicide and Self-harm Data from 2017 (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services.	(2017) 2018
36. Sonoma County Summary Measures of Health	2005-2015
37. U.S. Department of Education, EDfacts	2011-2012
38. US Census Quick Facts	2018

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	United Way (Director of Community Benefits)	1	Low-income, Medically underserved, Minority	Service provider	8/17/18
2	Key Informant Interview	Community Foundation Sonoma County (Executive Director)	1	Low-income, Medically underserved, Minority	Foundation/Philanthropy	8/29/18
3	Key Informant Interview	John Jordan Foundation (Executive Director)	1	Low-income, Medically underserved, Minority	Foundation/Philanthropy	8/22/18
4	Key Informant Interview	Northern California Center for Well-Being (Director of Special Projects)	1	Low-income, Medically underserved, Minority	Service provider	9/17/18
5	Key Informant Interview	Redwood Food Bank (Executive Director)	1	Low-income, Minority	Service provider	9/10/18
6	Key Informant Interview	Sonoma County Department of Behavioral Health (Medical Director for the Division of Behavioral Health); Sonoma County Department of Health Services (Healthy Communities Section Manager)	2	Healthy systems representative, Low-income, Medically underserved, Minority	Government	10/8/18
7	Key Informant Interview	Sonoma County Family Justice Center (Executive Director)	1	Low-income, Medically underserved, Minority	Service provider	8/29/18
8	Key Informant Interview	West County Community Services (Executive Director)	1	Low-income, Medically underserved, Minority	Service provider	8/27/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
9	Key Informant Interview	YWCA of Sonoma County (Director of Program Services and Chief Executive Officer)	1	Low-income, Medically underserved, Minority	Service provider	10/16/18
10	Group Interview	Service providers for day laborers and domestic workers: Graton Day Labor Center	3	Low-income, Medically underserved, Minority	Service providers	9/13/18
12	Group Interview	Service providers for children and youth (education) : -Sonoma County Office of Education (Director, CTE Partnerships) -Santa Rosa City Schools (Superintendent, Assistant Superintendent Student and Family Services) -First 5 (Executive Director) -Family, Youth, and Children's Services (Coordinators) -Community Child Care Council of Sonoma County (Executive Director)	6	Health Systems Representative, Low-income, Medically underserved, Minority	Service providers	9/5/18
13	Group Interview	Service providers for community advocacy: -Community Action Partnership of Sonoma (Various representatives)	6	Low-income, Medically underserved, Minority	Service providers	9/26/18
14	Group Interview	Service providers for mental / behavioral health and substance use: -Redwood Health Coalition (Project Directors)	7	Health systems representative, Low-income, Medically underserved, Minority	Service providers	9/5/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		<ul style="list-style-type: none"> - Opioid Safety Coalition (Representatives) -Voices Youth Center (Representatives) -The Hanna Center (Co-Director) 				
15	Group Interview	<p>Service providers for housing and safety net services:</p> <ul style="list-style-type: none"> -Burbank Development (Director/Coordinator(s) of Resident Services)- Catholic Charities (Director of Shelter & Housing) - Sonoma County Community Development Commission (Senior Community Development Specialist) - Pepp Housing (Resident Services Manager) -COTS (Senior Development Officer) - Social Advocates for Youth (Development Associate) West County Health Center (Director of Community Programs) 	8	Low-income, Medically underserved, Minority	Service providers	8/31/18
16	Group Interview	<p>Service providers for health services (Federally Qualified Health Centers – FQHC):</p> <p>RCHC Coalition Leaders, FQHC CEO</p>	10	Low-income, Medically underserved, Minority	Service providers	9/11/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
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Community residents

17	Focus Group	Northern region (Windsor), convened in collaboration with Windsor Wellness Partnership	3	N/A	Community members	10/16/18
18	Focus Group	Sonoma Springs region convened in collaboration with La Luz	6	Low-income, Medically underserved, Minority	Community Members	11/1/18
19	Focus Group	Population of Older Adults, convened in collaboration with the Cloverdale Multipurpose Senior center	8	Low-income	Community Members	10/19/18
20	Focus Group	South County region(Rohnert Park, Cotati, Petaluma), convened in collaboration with the Petaluma People's Services	8	Low-income, Minority	Community Members	9/19/18
21	Focus Group	Spanish speaking residents of Northern Region (Healdsburg, Windsor, Cloverdale), convened in collaboration with Corazon Healdsburg	11	Low-income, Medically underserved, Minority	Community Members	10/18/18
22	Focus Group	Spanish speaking residents of Santa Rosa/Roseland region, convened in collaboration with Community Action Partnership of Sonoma County	11	Low-income, Medically underserved, Minority	Community Members	10/11/18
23	Focus Group	West County region, convened in collaboration with West County Community Services	15	Low-income, Medically underserved, Minority	Community Members	10/3/18

*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 systems representative

Focus Groups: N/A

Group Interviews: One or more participant indicated they identify as a leader, representative, or member 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

Sonoma Prioritization Event Attendees

December 13th, 2018

1. Sonoma County Department of Health Services
2. Community Child Care Council (4C's) of Sonoma County
3. Cloverdale Unified School District
4. First Five Sonoma County
5. Burbank Housing
6. Cloverdale Health Action
7. West County Health Center
8. Sonoma County Regional Parks
9. Petaluma Health Care District
10. Center for Well-Being
11. Corazon Healdsburg
12. Hanna Institute
13. United Way Wine Country
14. Community Foundation Sonoma County

2019 HEALTH NEEDS PRIORITIZATION SCORES

Health Need	Rank	Composite Weighted Score
	1= Highest Priority	
Housing and Homelessness	1	325.5
	2	299.5
Education		
Economic Security	3	294
Access to care	4	293
Mental Health and Substance Use	5	271
Maternal and Child health	6	241.5
Healthy Eating & Active Living (HEAL): Obesity and Diabetes	7	177.5
CVD/Stroke and Tobacco Use	8	131.5
Violence and Injury Prevention	9	115

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. <i>(Also considers the magnitude/scale of the need. The magnitude refers to the number of people affected by the health need.)</i>	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

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

The Facilitator should, prior to the day of the Focus Group, identify and be familiar with the priority needs assessed in the 2016 CHNA for the site, as well as recent secondary data identifying current health needs in the community. Please refer to the Focus Group Daily Procedures for more detail.

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 for Kaiser Permanente, St. Joseph Health, and Sutter Health 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 the community **that you serve [FOR SERVICE PROVIDERS]/where you live [FOR COMMUNITY MEMBERS]**. 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 things 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.

We would also like to take a moment to acknowledge a catastrophe that likely affected all of you and your communities significantly – the 2017 Sonoma Complex Fires (often referred to as the October Wildfires or Tubbs Fire). During this discussion, we invite you to reflect on your community's *broad* health needs: while the community faces new challenges after the fires, we also would like to hear about the many other issues that have persisted since before these tragic events and continue to affect your community today.

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 haven't 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?

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 does a healthy environment look like?
5. When thinking about your community in the context of the healthy environment you just described, what are the biggest health needs in the community? Which health conditions do you see as impacting your community most often?

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

6. What have been some emerging issues 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.

b. [*Note to Facilitator: modify this prompt based on the health needs identified above. If chronic diseases have not been mentioned, utilize this prompt.*]

PROMPT: Do you see diseases such as diabetes, obesity, cancer, heart disease, or other illnesses that last for several months, as a prominent issue in your community?

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 (conducted in 2015), [*insert top 2-3 key priority needs from 2016 CHNA here*] were all 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?

Example for Santa Rosa:

- access to affordable, high quality early childhood education
- Improved equity in K-12 educational outcomes
- affordable housing

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?

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?

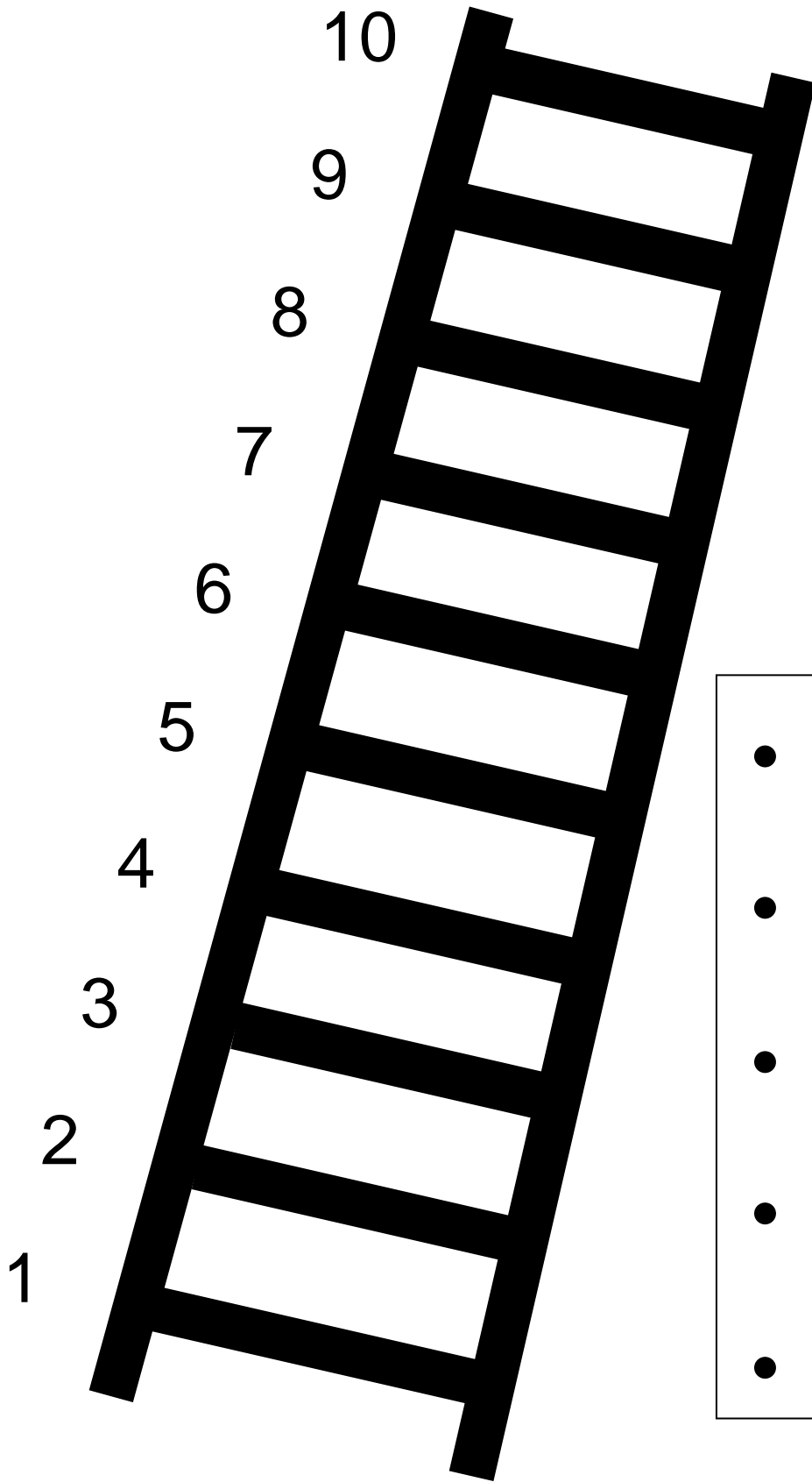
Step 3

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.



A vertical rectangular box with a thin black border. Inside the box, there are five solid black dots arranged in a vertical line, corresponding to the rungs of the ladder.

Appendix F. Key Informant Interview/Group Interview Protocol

Santa Rosa Service Area

Introduction + Getting Settled 10 minutes

Hello my name is _____ from Harder+Company Community Research. We have been hired by Kaiser Permanente, St. Joseph Health and Sutter Health to complete their 2019 Community Health Needs Assessment to better understand the health needs in this region. We will be using the data collected during interviews as well as quantitative data to inform the report. We are also working closely with Sonoma Department of Health Services.

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 one's 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'd 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.

[When applicable, and for group interviews only] For this interview [one, two, several] members of Kaiser leadership is/are present. I will give her/him/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.

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. They will be shared with CHI and only reviewed by Harder+Company and CHI staff. Is it okay with everyone if I record?

Do you have any questions for me before we start?

Background- 10 minutes (50 minutes left)

1. Briefly, what is your current position and role within your organization?
2. 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'd like you all 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.

3. What does a healthy environment look like?
4. 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?
5. What have been some emerging issues in the community that may influence health needs?

Challenges/Barriers- 10 Minutes (30 minutes left)

We've 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.

6. 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)*

Solutions -10 Minutes (20 minutes left)

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

7. 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 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 CHNA's.*

Priorities- 5 minutes (10 minutes left)

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

8. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address in order to improve the health of the community?
9. Are these needs that have recently emerged or are long-standing?
 - a. PROBE: What historical/societal influences have occurred since the last assessment (2015) that should be taken into consideration regarding any changes in around health needs and inequities?

Resources- 5 Minutes (5 minutes left)

10. 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. PROBE:
 - i. Barriers to accessing these resources.
 - ii. New resources that have been created since 2016
 - iii. New partnerships/projects/funding
11. 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
12. Is there anything else you would like to share with our team about the health of the community?

Appendix G. Focus Group Optional Participant Survey Results

Respondent Demographics

Exhibit 1. What is your zip code?

	N	%
94923	2	4%
94947	1	2%
94952	3	6%
94954	1	2%
95401	3	6%
95404	4	8%
95407	5	10%
95412	1	2%
95421	2	4%
95425	11	22%
95436	1	2%
95441	1	2%
95446	5	10%
95448	2	4%
95472	1	2%
95476	6	12%
95492	2	4%
Total	51	100%

Exhibit 2. What is your race/ethnicity?

	N	%
Hispanic/Latino/a	22	46%
White	21	44%
Multiple races	1	2%
Another race	4	8%
Total	48	100%

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

	N	%
Female/Woman	38	76%
Male/Man	11	22%
Non-Binary/ Gender Non-conforming	1	2%
Total	50	100%

Other options included but not reported: Transgender and Other.

Exhibit 4. How would you describe your employment status?

	N	%
Not employed, looking for work	7	15%
Not employed, choose not to work	5	11%
Self-employed	7	15%
Employed part-time	5	11%
Employed full-time	9	20%
Retired	9	20%
Full-time student	1	2%
Cannot work due to disability	2	4%
Other	1	2%
Total	46	100%

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

	N	%
No	21	42%
Yes	28	56%
Don't Know	1	2%
Total	50	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	6	15%
10,001-20,000	3	8%
20,001-30,000	8	21%
30,001-40,000	9	23%
40,001-50,000	2	5%
50,001-75,000	5	13%
75,001-100,000	2	5%
100,001+	4	10%
Total	39	100%

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

	N	%
1	8	16%
2	15	31%
3	9	18%
4	2	4%
5	9	18%
6+	6	12%
Total	49	100%

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

Exhibit 8. What is your current marital status?*

	N	%
Single	8	18%
Not married, but living with partner	7	16%
Married	21	47%
Divorced	5	11%
Widowed	4	9%
Total	45	100%

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

	N	%
Less than high school	14	33%
High school diploma or GED	6	14%
Some college	3	7%
Associate or technical degree	3	7%
College degree	11	26%
Graduate or professional degree	6	14%
Total	43	100%

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

	N	%
No Insurance	7	17%
Medi-Cal	16	38%
Covered California	2	5%
Insurance bought directly by me or my partner	5	12%
Insurance provided by my job or my partner's job	6	14%
Other	6	14%
Total	42	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	25	60%
Too few people	14	33%
No one	3	7%
Total	42	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	16	42%
More than most people	14	37%
Less than most people	8	21%
Total	38	100%

Appendix H. Group Interview Optional Participant Survey Results

Exhibit 13. What is your position in the organization?

	N	%
Executive Director	8	20%
Direct Service Provider	1	3%
Program Manager/Coordinator/Supervisor	13	33%
Other	18	45%
Total	40	100%

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

	N
Mean = 7 years	37

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	14	38%
Non-Health Care Sector (e.g., law enforcement, religion, education)	12	32%
Individuals with chronic conditions (e.g., diabetes, obesity, heart disease)	10	27%
Minority population	21	57%
Medically underserved	15	41%
Low-income	25	68%

*Total does not equal 100% as respondents selected multiple responses. N = 37

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

	N	%
Health	29	73%
Education	20	50%
Employment	10	25%
Housing	20	50%
Faith-Based	3	8%
Neighborhood/community well-being	25	63%
Poverty	22	55%
Criminal/juvenile justice	7	18%
Other	15	38%

*Total does not equal 100% as respondents selected multiple responses. N = 40

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

	N	%
1-10 years old	20	56%
11-20 years old	23	64%
21-30 years old	23	64%
31-40 years old	20	56%
41-50 years old	19	53%
51-60 years old	17	47%
61-70 years old	18	50%
71+ years old	17	47%

*Total does not equal 100% as respondents selected multiple responses. N = 40

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

	N	%
"West" County (Sonoma), Santa Rosa, Sepastopol, Windsor Rohnert Park	1	3%
All of Sonoma County - Santa Rosa Largely	1	3%
All Sonoma County	1	3%
County of Sonoma	1	3%
County wide	1	3%
County-wide	1	3%
Geyserville - Healdsburg -	1	3%
Geyserville, Cloverdale, Hopland	1	3%
Petaluma / Sonoma	1	3%
Santa Rosa	2	6%
Santa Rosa / Southwest	1	3%
Santa Rosa mainly (Sonoma County)	1	3%
Santa Rosa, Outlying areas that are a part of the school district boundaries	1	3%
Scheville to kenwood	1	3%
Sonoma Co	1	3%
Sonoma County	5	16%
Sonoma County Wide	1	3%
Sonoma Valley	1	3%
Sonoma, Napa, Marin, Yolo Counties	2	6%
Sonoma, Napa, Yolo counties	1	3%
Sonoma, Napa, Yolo, and Marin Counties	1	3%
The Entire County	1	3%
West County Sonoma	1	3%

Exhibit 19. What is your race/ethnicity?

	N	%
Asian	1	4%
Black/African American	2	7%
Hispanic/Latino/a	6	21%
White	18	64%
Multiple races	1	4%
Total	28	100%

