

**COMMUNITY HEALTH NEEDS ASSESSMENT
2020**

Sonoma County Service Area

**Santa Rosa Memorial Hospital,
Petaluma Valley Hospital**



To provide feedback about this CHNA or obtain a printed copy free of charge, please email:

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St. Joseph Health 
Santa Rosa Memorial • Petaluma Valley

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MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

It is with great joy and pride that we present Santa Rosa Memorial and Petaluma Valley Hospitals' 2020 Community Health Needs Assessment to our community – both our collaborative partners as well as the communities we serve.

For the past several months we have worked diligently to gather the appropriate and most complete data on the health-related needs of our service area. This will enable us to make informed and thoughtful decisions about how best to serve and provide resources to areas with highest needs and to the most vulnerable populations in our community.

This Community Health Needs Assessment builds upon the 2020 Sonoma County Collaborative CHNA, conducted in partnership with Sonoma County's Public Health Division, Kaiser Permanente, and Sutter Health. The process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted field surveying and community listening sessions.

Despite the challenges presented by a global pandemic, we held steadfast to our guiding principles of including the voice of the community in this report. We spoke with several key stakeholders about what they felt were the biggest needs in our community and incorporated findings from the 2020 collaborative CHNA that we participated in with our other local hospital system partners.

We've also analyzed and examined data that demonstrates how social determinants and health disparities affect communities and neighborhoods. The data overwhelmingly validates the gaps and inspire us to continue our work towards addressing the social determinants of health and their influence on the health and wellbeing of our communities without distinction.

We could not have done this work alone and would like to thank our partners who brought diverse skills and expertise to this process.

We invite you to study the findings and most importantly to join us in our efforts to restore health and improve quality of life to our *Dear Neighbors* and the communities in which they live throughout Sonoma County.

With deep gratitude,

Tyler Hedden
Chief Executive Officer, St. Joseph Health, Sonoma County

Debbie Meekins
Chair, St. Joseph Health, Sonoma County, Community Benefit Committee

RESPONDING TO THE COVID-19 PANDEMIC

The Community Health Needs Assessment and Improvement Planning process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted field surveys and community listening sessions. Additionally, the impacts of COVID-19 are likely to effect community health and well-being beyond what is currently captured in secondary and publicly available data. We seek to engage the community as directly as possible in prioritizing needs and throughout the community health improvement process.

We recognize that in these unprecedented times, COVID-19 is likely to exacerbate existing community needs and may bring others to the forefront. Our commitment first and foremost is to respond to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. While this is a dynamic situation, we recognize the greatest needs of our communities will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our communities in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities.

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across Sonoma County, information collected includes public health data regarding health behaviors, morbidity and mortality, and hospital-level data. In 2019, St. Joseph Health Sonoma partnered with Sutter Health and Kaiser Permanente to gather data from listening sessions and interviews with diverse, low-income and medically underserved communities in Sonoma County. In 2020, individual stakeholder interviews were conducted with representatives from organizations that serve these populations to better understand the impacts of COVID-19 in our communities. Some key findings include the following:

- Housing affordability and instability continue to be serious issues, a situation exacerbated by recent fires and by the pandemic. This contributes to a growing homelessness problem, challenging our community to respond to the need for shelter and care in a humane way, but also challenging and stressing families who are struggling with housing security.
 - Stakeholders shared the cost of living in Sonoma County outpaces the income for many people in the community, making it challenging for families to meet their basic needs.
 - The median income in the high need service area is about \$14,000 lower than Sonoma County and \$26,000 lower than the broader service area. These areas with lower median incomes are more likely to experience severe housing cost burden (households spending 50% or more of income on housing costs), with 28% of renter households in the high need service area being severely housing cost burdened compared to 25% in the broader service area.
- There is a growing prevalence of mental health and substance use disorder challenges in our community, and ongoing challenges to provide adequate, coordinated and efficient access to services.
 - The percentages of 7th, 9th, and 11th grade students who reported alcohol and/or drug use in the past month was higher for Sonoma County than California overall.

- Stakeholders shared there is a need for mild to moderate mental health services, as well as more wraparound case management for families to address mental health needs, especially due to compounding trauma from recent fires and the COVID-19 pandemic.
- There persists an equity challenge in our community as communities of color are disproportionately affected by COVID-19, have limited access to services, and are victimized by wage and housing discrimination.
 - The Hispanic population is disproportionately represented in the high need service area compared to Sonoma County overall.
 - Stakeholders and caregivers spoke to the Latino/a community being disproportionately affected by housing instability, food insecurity and economic insecurity due to systemic inequities and racism.
- Despite our best efforts in recent years, we continue to experience barriers to access to health and health-related services and resources for our most vulnerable and low-income communities. Among these barriers are those presented by geographic isolation, lack of transportation, racial discrimination, complexity of system navigation, and affordability.

Identifying Top Health Priorities, Together

Through a collaborative process engaging St. Joseph Health Sonoma’s Community Benefit Committee, the following priority areas were agreed upon:

PRIORITY 1: HOUSING INSTABILITY & HOMELESSNESS

The cost of living in Sonoma County outpaces the income for many people in the community, making it challenging for families to meet their basic needs. Housing is foundational to one’s health: people who are stably housed are better able to care for their physical and mental health. Those most impacted by housing stability and affordability are the Latino/a community due to income inequities; youth experiencing homelessness, especially those identifying as LGBTQ+; and older adults whose fixed income limits their ability to afford local housing prices. There is also need for supportive housing, using a Housing First approach, for people with mental health challenges, substance use disorders, and other special needs. There are especially few resources for people who are undocumented.

PRIORITY 2: MENTAL HEALTH & SUBSTANCE USE SERVICES

Accessing quality mental health and substance use services can be a challenge for many. Trauma from the recent fires, COVID-19, and the current political climate contribute to the community mental health needs. There is a particular need for mild to moderate mental health services, perinatal mental health services, more wraparound case management for families to address mental health, and more substance use disorder treatment services. There is further need for more bilingual and bicultural mental health professionals to serve the Latino/a community, including those that are undocumented. School-age children and older adults are two additional groups with unmet mental health needs. Major barriers to accessing mental health services include insurance coverage limitations, cost of care, and shortage of providers resulting in long wait times for appointments.

PRIORITY 3: HEALTH EQUITY: RACISM AND DISCRIMINATION

Stakeholders described being at an “inflection point” in acknowledging and addressing racism in the community, with more people talking about the issue. They shared racism keeps people in poverty by limiting education and job opportunities, leading to more Black, Indigenous, and people of color (BIPOC) working in lower-wage jobs, with particular emphasis on the Latino/a community in Sonoma County. Housing discrimination prevents the Latino/a community from accessing good-quality, affordable housing. Racism contributes to inequities in the ways different schools are funded, contributing to the opportunity gap. Stakeholders shared particular concern for the ways in which xenophobia and racist policies negatively affect the mental health and economic security of the Latino/a community.

PRIORITY 4: ACCESS TO HEALTH CARE

Stakeholders discussed the need for more affordable health care, as well as challenges accessing primary and specialty care. They noted a particular need for more case management and navigation resources, especially for Spanish-speaking patients and new parents. Transportation to care is a consistent barrier for many, but especially older adults. Fears of immigration enforcement and changes in public charge rules may prevent mixed status households from applying for Medi-Cal. A lack of culturally responsive and linguistically appropriate health care services and documentation status may prevent the Latino/a community from receiving the care they need.

Community Health Improvement Plan

Santa Rosa Memorial Hospital and Petaluma Valley Hospital will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners in early 2021 considering resources, community capacity, and core competencies.

INTRODUCTION

Mission, Vision, and Values

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Who We Are

Part of a larger healthcare system known as Providence St. Joseph Health (PSJH), Santa Rosa Memorial Hospital (SRMH) and Petaluma Valley Hospital (PVH) are part of a countywide ministry, St. Joseph Health-Sonoma County (SJH-SC) that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region.

SRMH is an acute-care hospital founded in 1950 and located in Santa Rosa, CA. The hospital has 338 licensed beds, and a campus that is approximately 5 acres in size with additional off-site facilities throughout Sonoma County. SRMH has a staff of more than 2,000 caregivers (employees) and professional relationships with more than 430 local physicians. As the designated Level II Regional Trauma Center for Sonoma, Mendocino, Napa and Lake counties, Santa Rosa Memorial Hospital provides a wide range of specialty services including critical care, cardiovascular care, stroke care, women’s and children’s services, cancer care and orthopedics. The hospital is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

PVH is a community hospital founded in 1980 by the Petaluma Healthcare District, and is located in Petaluma, CA. St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds and a campus that is 14.63 acres in size. PVH has a staff of 501 employees and professional relations with more than 260 local physicians. PVH is a Leapfrog A-rated facility, a Joint Commission Stroke-Ready certified hospital, has been designated as a Baby-Friendly® Hospital by Baby-Friendly USA, and as a Blue Distinction® specialty care facility by Blue Cross Blue Shield for maternity services. Major programs and services also include emergency care, outpatient surgery, obstetrical services, and pulmonary rehabilitation.

In addition, both SRMH and PVH offer a variety of community-based programs such as: a free Mobile Health Clinic, Mobile Dental Clinic, fixed-site Dental Clinic, health promotions, school-based behavioral

health, and Care Network. These programs and services offered to the community are designed to meet the needs of vulnerable populations and focus on health equity, primary prevention, health promotion and community building.

Our Commitment to Community

St. Joseph Health Sonoma dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, SRM and PVH provided \$63,346,330 in community benefit¹ in response to unmet needs and improve the health and well-being of those we serve in Sonoma County. Our service area also includes St. Joseph Health Medical Group, St. Joseph Health Home and Community Care, and multiple urgent care facilities

SRMH and PVH further demonstrate organizational commitment to the CHNA through the allocation of staff time, financial resources, and participation and collaboration to address community identified needs. The Sonoma County Community Health Investment Manager, Dan Schurman, is responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

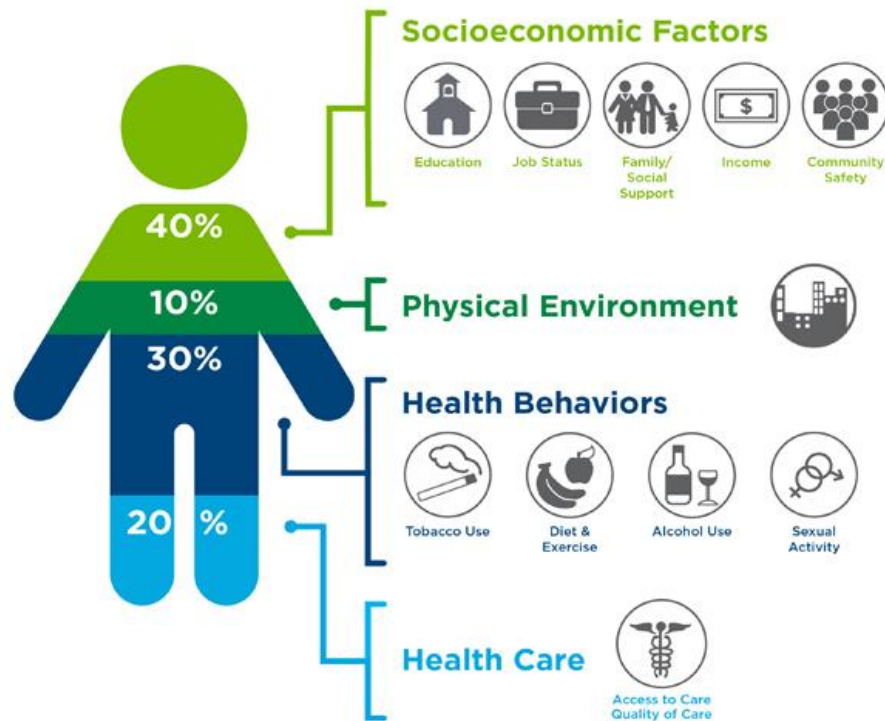
Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1²).

¹ A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

² Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

What Goes Into Your Health?



Source: Institute for Clinical Systems Improvement, *Going Beyond Clinical Walls: Solving Complex Problems* (October 2014)

The Bridgespan Group

Figure 1. Factors contributing to overall health and well-being

The Community Health Needs Assessment (CHNA) is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms³). Across our organizational footprint, we consistently heard from our community partners that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

³ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

Health Equity

A principle meaning that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.” (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

Figure 2. Definitions of key terms

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:



Approach

- Explicitly name our commitment to equity
- Take an asset-based approach, highlighting community strengths
- Use people first and non-stigmatizing language



Community Engagement

- Actively seek input from the communities we serve using multiple methods
- Implement equitable practices for community participation
- Report findings back to communities



Quantitative Data

- Report data at the block group level to address masking of needs at county level
- Disaggregate data when responsible and appropriate
- Acknowledge inherent bias in data and screening tools

OUR COMMUNITY

Description of Community Served

SRMH and PVH provide Sonoma County communities with access to advanced care and advanced caring. The hospitals' community extends from Cloverdale and Gualala in the north, Petaluma in the south, Sonoma Valley in the east and Sebastopol and the Pacific Coast in the west. This includes a population of approximately 495,000 people.

Hospital Service Area

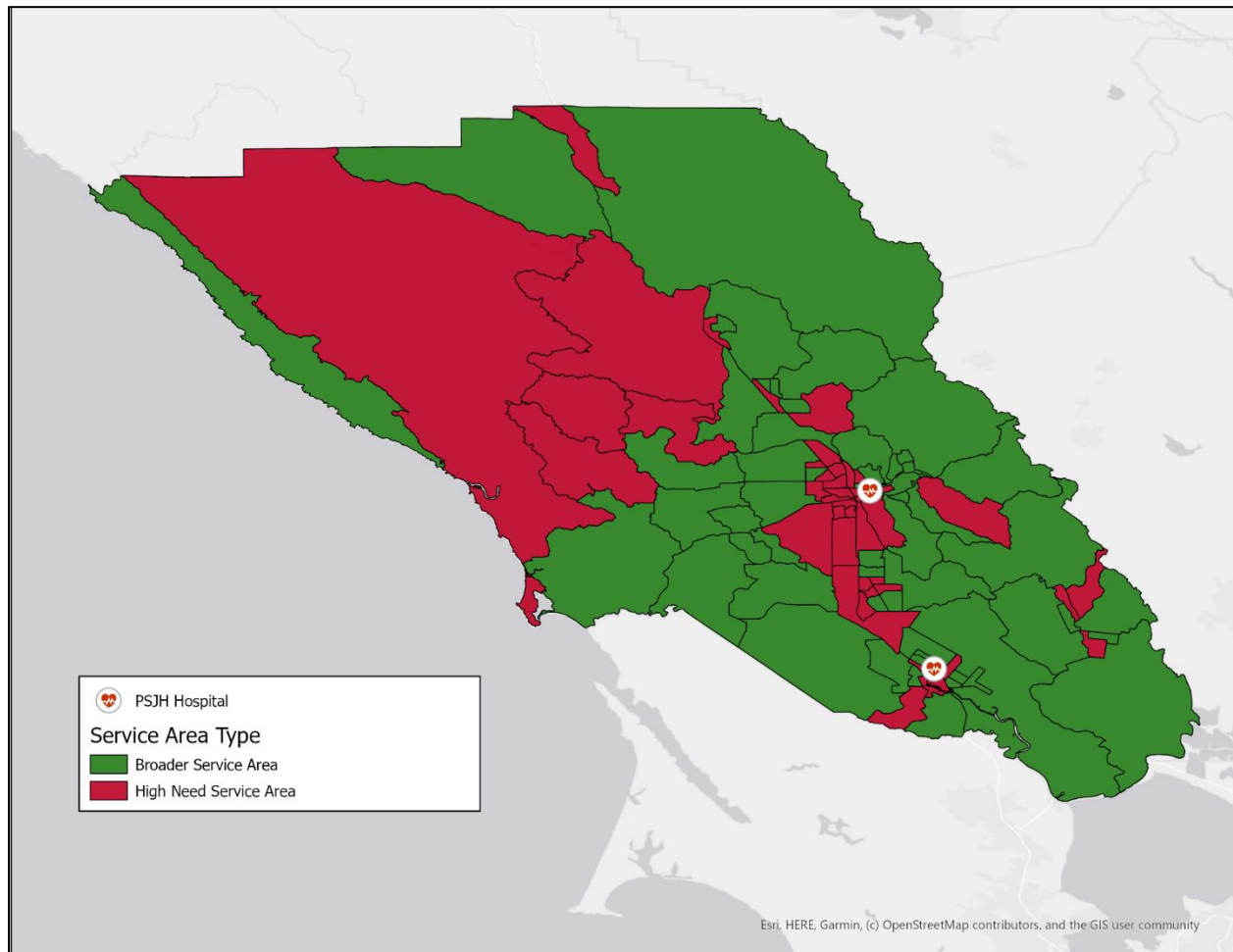
Santa Rosa Memorial Hospital and Petaluma Valley Hospital serve all of Sonoma County. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, Sonoma County serves as the boundary for the hospital service areas. See map below for further detail, including communities identified as higher needs.

Table 1. Cities and ZIP Codes Included in Total Service Area

Cities/Communities	ZIP Codes
Santa Rosa	95403, 95404, 95407, 95409, 95401, 95405, 95402, 95406
Rohnert Park	94928, 94927
Windsor	95492
Sebastopol	95472, 95473
Healdsburg	95448
Fulton	95439
Graton	95444
Petaluma	94954, 94952, 94975, 94953, 94955
Sonoma	95476
Cloverdale	95452
Cotati	94931
Forestville	95436
Guerneville	95446, 95471
Gualala	95445
Penngrove	94951
Kenwood	95452
Glen Ellen	95442
Geyserville	95441
Monte Rio	95462, 95486
Bodega Bay	94923
Cazadero	95421
The Sea Ranch	95497
Bodega	94922

Occidental	95465
Duncan Mills	95430
Timber Cove/Fort Ross	95450
Valley Ford	94972

Figure 3. Santa Rosa Memorial Hospital and Petaluma Valley Hospital Service Area



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the Sonoma Service Area and how the high need area compares to the broader service area. The Service Area (SA) of Sonoma includes approximately 495,000 people and encompasses the entire county of Sonoma. The high need area includes census tracts identified based upon lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of \$51,500 or less for family of 4.

POPULATION AND AGE DEMOGRAPHICS

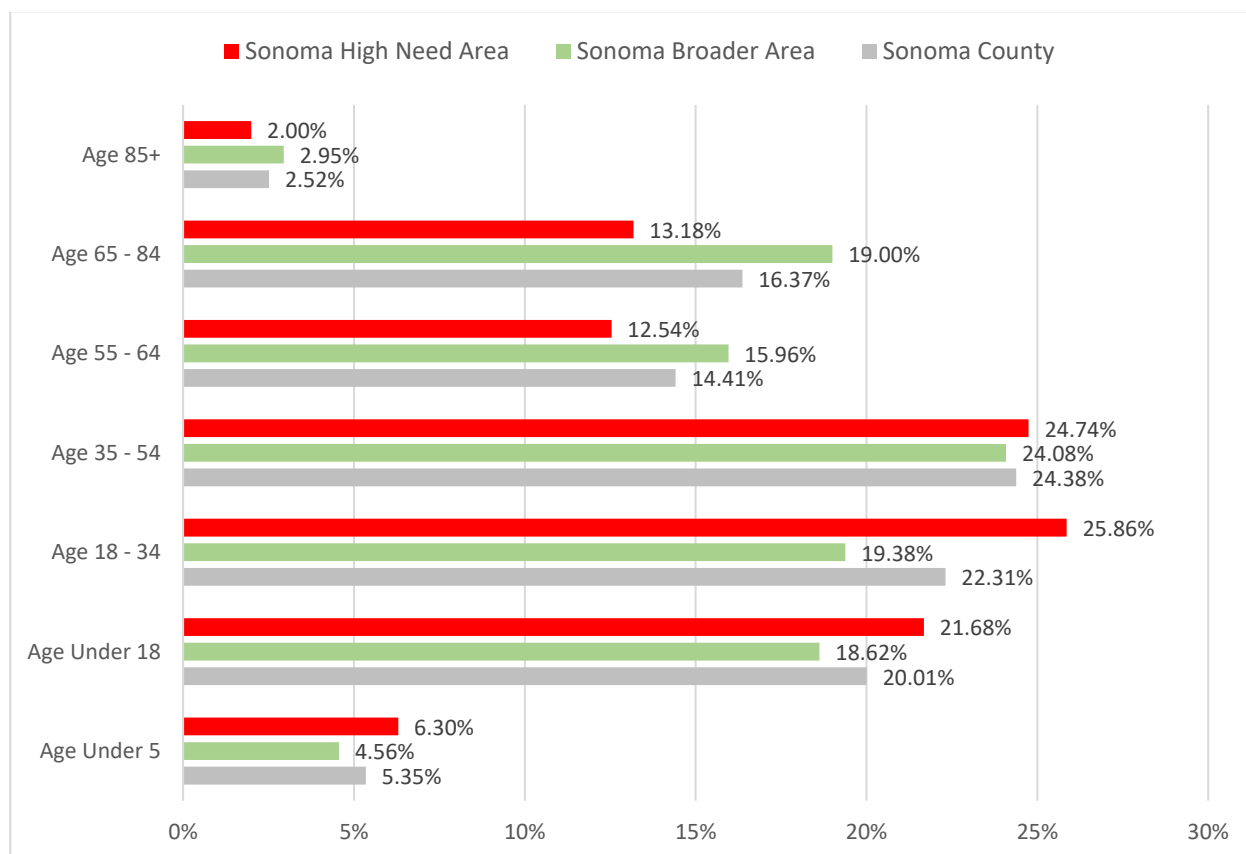
Table 2. Population Demographics for Sonoma County Service Areas

Indicator	Sonoma County	Sonoma Broader Area	Sonoma High Need Area
2019 Total Population	495,319	271,307	224,012
Female Population	50.75%	51.28%	50.11%
Male Population	49.25%	48.72%	49.89%

For the most part, the age distribution is roughly proportional across Sonoma County geographies, with those between 18 and 34 slightly more likely to live in a high need area, likely young families and those in and around college towns. Those ages 65 to 84 are less likely to live in a high need area, perhaps due in part to secondary and/or vacation homes.

The male-to-female ratio is approximately equal across geographies.

Figure 4. Age Group by Geography in Sonoma County



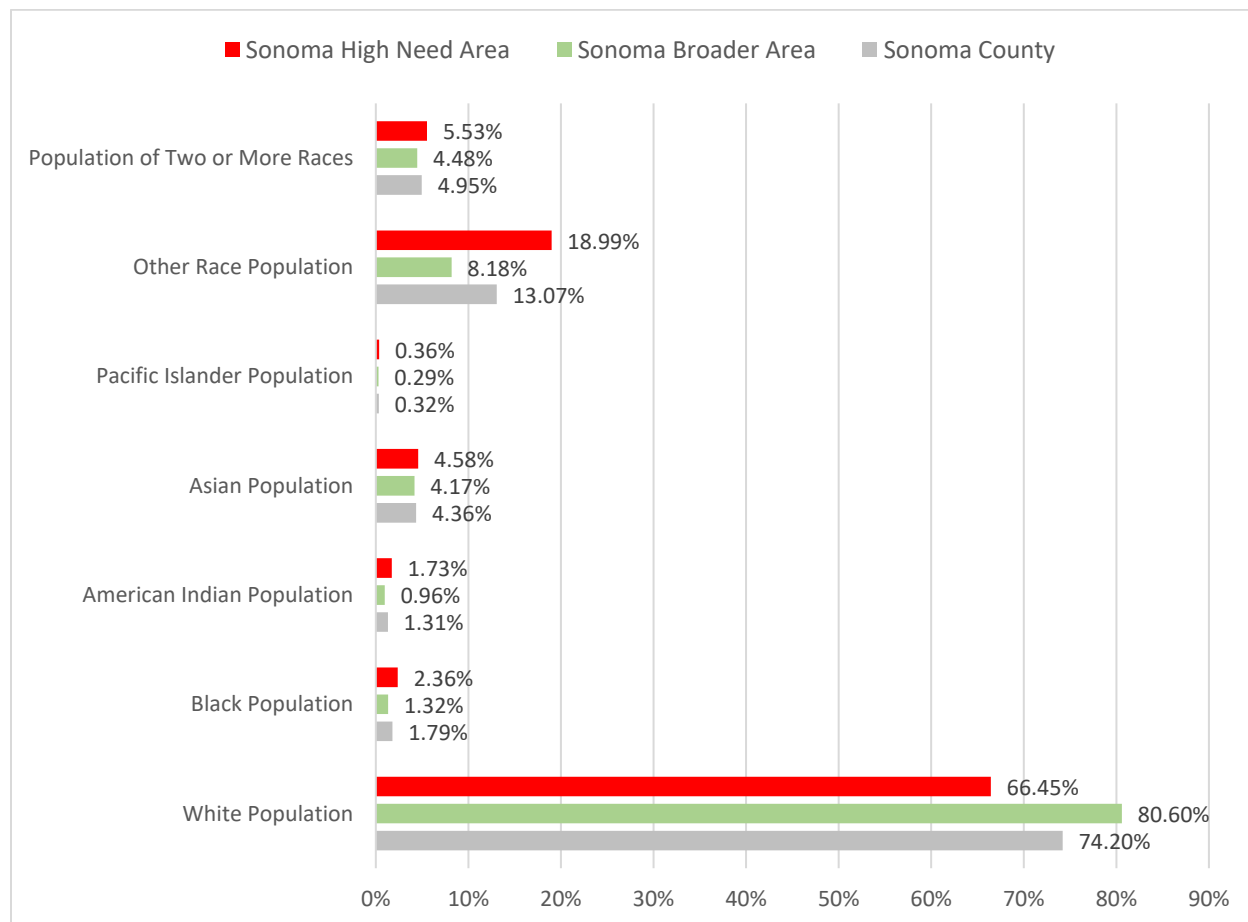
In Sonoma County, approximately 6% of the population are veterans, roughly in line with the 5% in the state of California.

POPULATION BY RACE AND ETHNICITY

Table 3. Ethnicity for Sonoma County Service Areas

Indicator	Sonoma County	Sonoma Broader Area	Sonoma High Need Area
Hispanic Population	27.63%	19.61%	37.36%

Figure 5. Race by Geography in Sonoma County



The “other race” population is over-represented in the high need census tracts compared to the county population, whereas those who identify as white are less likely to live in high needs communities. Individuals who identify as Hispanic are also over-represented in high need communities, representing nearly 38% of the population in those areas, compared to just under 20% in the broader service area.

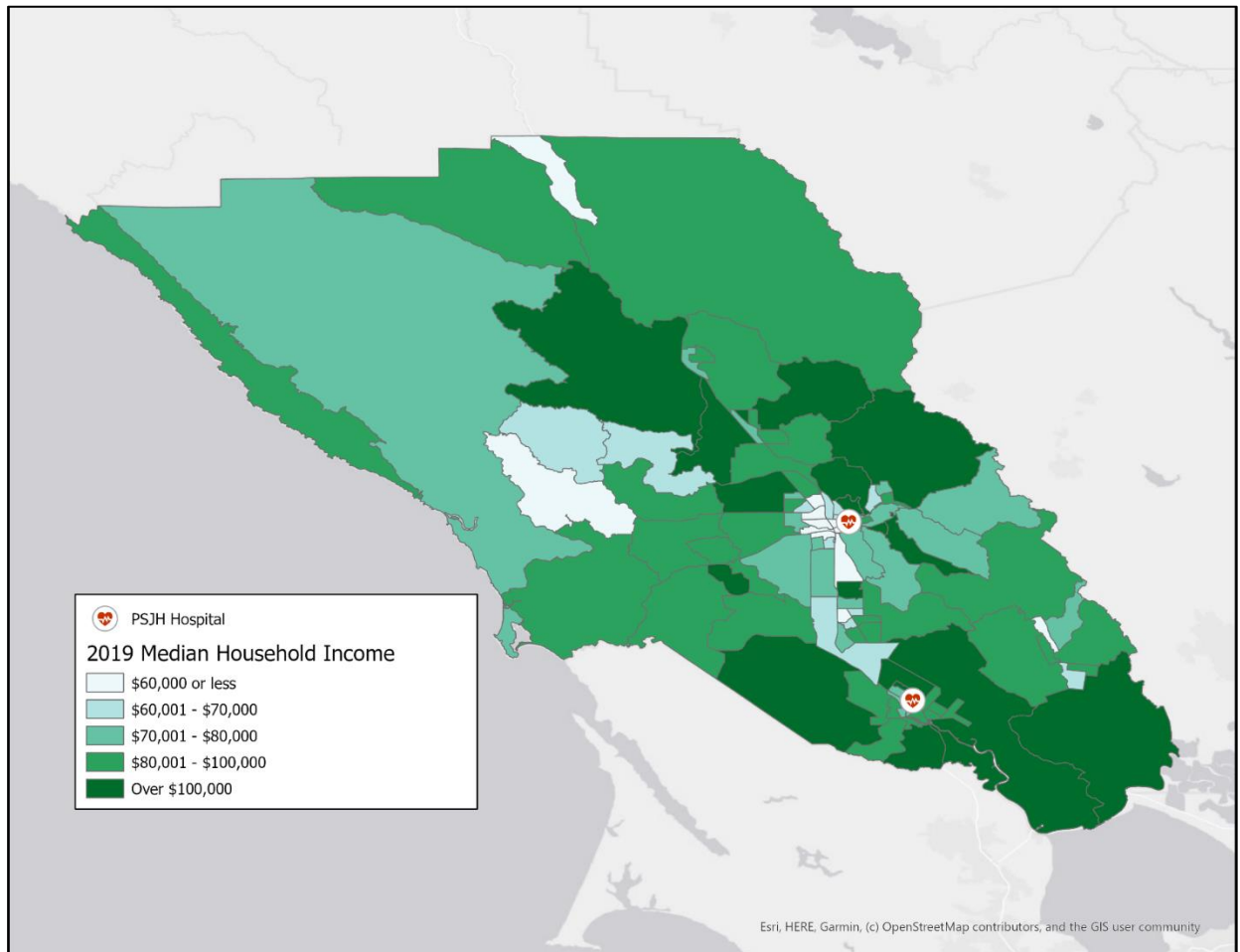
INCOME INDICATORS

Table 4. Income Indicators for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Median Income	\$93,090	\$67,310	\$81,477
Data Source: American Community Survey Year: 2019			

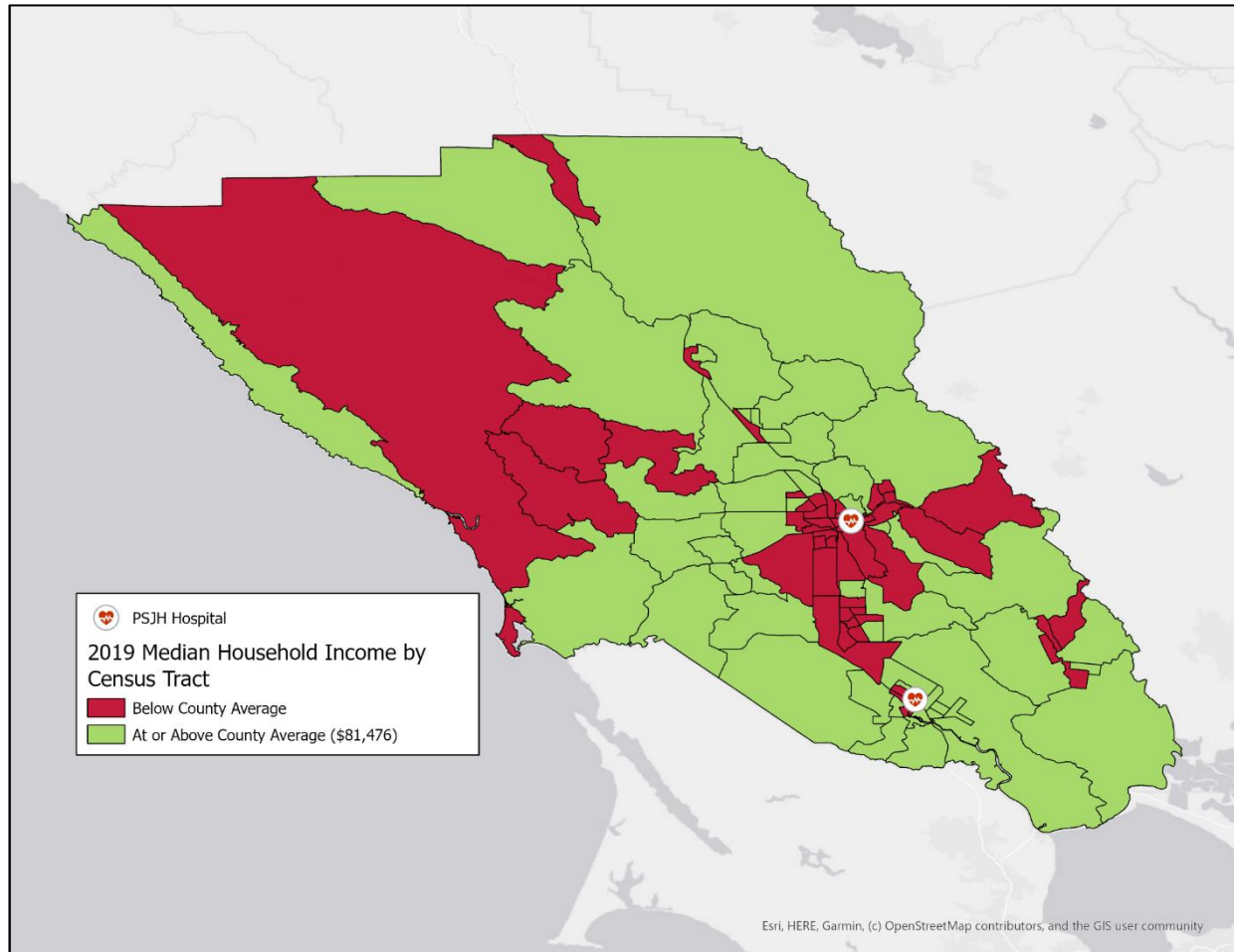
- The median income in the high need service area is about \$14,000 lower than Sonoma County.
- There is about a \$26,000 difference in median income between the broader service area and the high need service area.

Figure 6. 2019 Median Household Income by Census Tract in Sonoma County



In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

Figure 7. Comparison of Median Household Income by Census Tract to County Average



SEVERE HOUSING COST BURDEN

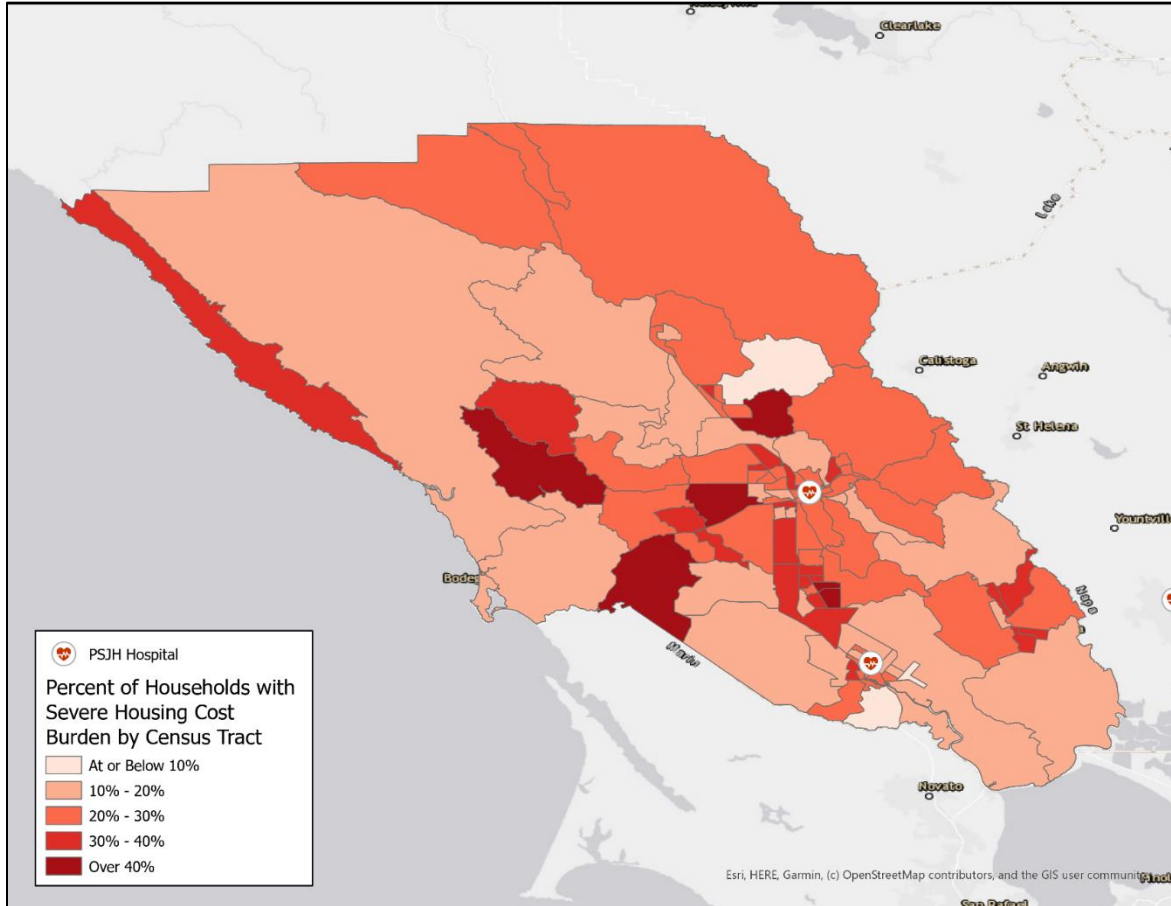
Table 5. Severe Housing Cost Burden for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	25.3%	28.3%	26.9%

Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average about 27% of households in Sonoma County are severely housing cost burdened.

In the high need service area 28% of renter households are severely housing cost burdened. Within Sonoma County there are census tracts in which over 40% of households are experiencing severe housing cost burden.

Figure 8. Percent of Households with Severe Housing Cost Burden by Census Tract in Sonoma County



OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by SRMH and PVH, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. We also invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address health disparities within and across communities.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance abuse.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Information gathered during stakeholder interviews and caregiver listening sessions is dependent on who was invited and who participated. Efforts were made to include people who

could represent the broad interests of the community and/or were representative of communities of greatest need.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners.

No comments or questions were received.

HEALTH INDICATORS

The following indicators compare Sonoma County to the state of California and the other PSJH service areas in Northern California. Red indicates a measure “worse than” that of the state, green indicates a measure “better than” the state, and yellow indicates a measure equal to that of the state.

Socioeconomic Indicators

Table 6. Socioeconomic Indicators Comparing Northern CA Counties to the State

Indicator	California	Humboldt County	Napa County	Sonoma County
Median Household Income	\$75,300	\$49,500	\$85,600	\$81,000
Children eligible for free or reduced lunch (enrolled in public schools)	60%	61%	51%	48%
Children in poverty	17%	23%	9%	12%

Sonoma County’s median household income is higher than California’s average and a smaller percentage of children are in poverty. Additionally, 48% of children enrolled in public schools are eligible for free or reduced lunch, which is lower than the state percentage and other PSJH service areas in Northern California.

Physical Environment

Table 7. Physical Environment Indicators Comparing Northern CA Counties to the State

Indicator	California	Humboldt County	Napa County	Sonoma County
More than 1 occupant per room	8%	4%	8%	5%
Severe housing problems	27%	25%	22%	23%
Pollution Burden	25	13	18	15
Air pollution- particulate matter	10	9	11	10
Violent crimes (rate per 100,000 inhabitants)	421	432	398	368

Sonoma County performs well on physical environment indicators. Sonoma County has a lower rate of violence crimes than the state and other PSJH service areas in Northern California.

Health Outcomes

Table 8. Health Outcome Indicators Comparing Northern CA Counties to the State

Indicator	California	Humboldt County	Napa County	Sonoma County
Self-reports of fair or poor health (age-adjusted)	17%	16%	14%	14%
Self-reports of fair or poor health (ages 65+)	29%	27%	24%	24%
Asthma in children (ages 1-17)	15%	10%	24%	16%
Asthma in adults (ages 18+)	15%	18%	18%	18%
Diabetes in adults (ages 18+)	10%	7%	9%	8%
Heart disease (ages 18+)	6%	7%	7%	6%
Serious psychological distress (ages 18+)	8%	10%	6%	10%

Based on surveillance data, Sonoma County performs better than or similarly to the state average. Children and adults are slightly more likely to have asthma and adults are slightly less likely to have diabetes. There is a higher prevalence of serious psychological distress.

Health Behaviors

Table 9. Health Behavior Indicators Comparing Northern CA Counties to the State

Indicator	California	Humboldt County	Napa County	Sonoma County
Overweight (ages 2-11)	15%	N/A	6%	16%
Overweight or obese (ages 12-17)	38%	17%	47%	17%
Obese (ages 18+)	28%	31%	29%	24%

Sugary drink consumption (ages 18+)	11%	13%	9%	9%
Regular physical activity (ages 5-17)	17%	48%	6%	27%
Youth alcohol/drug use in the past month (7 th grade)	7%	10%	7%	9%
Youth alcohol/drug use in the past month (9 th grade)	20%	27%	15%	22%
Youth alcohol/drug use in the past month (11 th grade)	29%	45%	30%	40%
Current smoker (ages 18+)	11%	14%	10%	10%

Youth in Sonoma County are slightly more likely than their peers elsewhere in the state to report alcohol or drug use in the past month (at 7th, 9th, and 11th grades). A substantially smaller percentage of youth ages 12 to 17 are overweight or obese in Sonoma County compared to California. Likewise, a substantially greater percentage of youth ages 5 to 17 report regular physical activity in Sonoma County compared to California.

Clinical Care

Table 10. Clinical Care Indicators Comparing Northern CA Counties to the State

Indicator	California	Humboldt County	Napa County	Sonoma County
Uninsured (ages 0-17)	3%	4%	4%	3%
Uninsured (ages 18-64)	10%	11%	10%	9%
First trimester prenatal care	84%	80%	89%	88%
# of people per primary care physician	1,260	1,440	1,040	980
# of people per non-physician primary care provider	1,590	928	1,765	1,428
# of people per dentist	1,180	1,270	1,120	1,090
# of people per mental health provider	280	220	180	220

Sonoma County performs well on clinical care indicators in comparison to the state of California. Percentages of children and adults are relatively similar to the state. Ratios of providers to people are better for primary care and mental health providers and dentists compared to California.

See Appendix 5: Quantitative Data

Hospital Utilization Data

In addition to this public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Sonoma County. We were particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) is reported as a percentage of all Emergency Department visits over a given time period and are identified based on an algorithm developed by PSJH’s Population Health Care Management team based on NYU and MediCal’s definitions.

The Prevention Quality Indicators (PQIs) are similar, although they are based on in-patient admissions. Both PQIs and AED serve as proxies for inadequate access to, or engagement in, primary care. As possible, we look at the data for total utilization, frequency of diagnoses, demographics, and payer to identify disparities.

Table 11. Avoidable Emergency Department Visits for PSJH Northern California Ministries

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
Queen of The Valley Medical Center	16,902	8,188	25,090	32.6%
Redwood Memorial Hospital	7,458	4,307	11,765	36.6%
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
St. Joseph Hospital Eureka	16,880	11,307	28,187	40.1%
Grand Total	76,903	41,512	118,415	35.1%

Across PSJH’s northern California service areas, Petaluma Valley and Santa Rosa Memorial have below average percentages of potentially avoidable ED utilization in 2019. At Santa Rosa Memorial Hospital, individuals identifying as Pacific Islander/ Native Hawaiian had the highest percentage of avoidable ED visits. At Petaluma Valley Hospital, individuals identifying as Black/ African American had the highest percentage of avoidable ED visits.

At Santa Rosa Memorial Hospital, age groups 18-44 and 45-65 years had slightly above average percentages of avoidable ED visits, with ZIP Codes 95408, 95401, and 95404 producing the greatest number of potentially avoidable ED visits. These three ZIP Codes were responsible for approximately 37% (4,675) of all potentially avoidable visits in. There were nearly 1,5000 additional visits from patients identified as experiencing homelessness, with 51% of visits by this population being categorized as avoidable.

At Petaluma Valley Hospital, age group 18-44 years had a slightly above average percentage of avoidable ED visits, with ZIP Codes 94954 and 94952 producing the greatest number of potentially avoidable visits. These two ZIP Codes were responsible for approximately 55% (2,818) of all potentially avoidable visits in 2019. There were over 300 additional visits from patients identified as experiencing homelessness, with 50% of visits by this population being categorized as avoidable.

Table 12. Avoidable Emergency Department Visits by Ministry and Patient Zip Code

Encounters by Patient Zip Code	Non-AED Visits	AED Visit	Total ED Visits	AED %
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
95407	3,505	2,006	5,511	36.4%
95401	2,579	1,339	3,918	34.2%
95404	2,582	1,330	3,912	34.0%
ZZZZZ	1,377	1,458	2,835	51.4%
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
94954	3,934	1,649	5,583	29.5%
94952	3,077	1,169	4,246	27.5%
ZZZZZ	312	306	618	49.5%

See Appendix 5: Quantitative Data

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Santa Rosa Memorial and Petaluma Valley Hospitals conducted 11 stakeholder interviews with representatives from community-based organizations, including 12 participants from June to July 2020. During these interviews, nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 2.

These 2020 qualitative findings supplement the qualitative data from the 2019 Sonoma County Collaborative CHNA collected from August to November 2018 and summarized in Appendix 6. Overlaps and differences between the 2020 and 2018 main themes are summarized in the following findings. The following findings represent the **high priority health-related needs** from the 2020 stakeholder interviews, based on community input:

Homelessness/ lack of safe, affordable housing

In the 2020 stakeholder interviews, stakeholders shared the cost of living in Sonoma County outpaces the **income** for many people in the community, making it challenging for families to meet their basic needs. Stakeholders spoke to housing as being **foundational**: people who are stably housed are better able to care for their physical and mental health. They were particularly concerned about housing stability and affordability for the **Latino/a community** due to income inequities; **youth experiencing homelessness**, especially those identifying as LGBTQ+; and **older adults** whose fixed income prices them out of the area. They also noted the importance of **supportive housing**, using a Housing First approach, for people with substance use disorders.

Stakeholders identified a lack of safe, **affordable housing**, leading to overcrowding and poor living conditions. To address housing instability, they shared a need for more **rental assistance**, particularly in times of disaster. There are especially few resources **for mixed status families**. Stakeholders shared a need for more resources to address homelessness at the community level rather than through **law enforcement** and more **political will** to create sustainable solutions to homelessness.

In 2018, stakeholders and community members spoke to the high cost of housing as outpacing the income for many people, making living in Sonoma County unsustainable for families with low incomes. The 2017 fires exacerbated people's housing instability. They spoke to housing as being important for physical and mental health, noting that experiencing homelessness or housing instability can lead to a lot of stress and anxiety. The 2018 participants suggested the following: develop more affordable housing units for all income levels, ensure new housing is accessible for people with disabilities, increase homelessness services, and ensure medical respite is available for people experiencing homelessness.

Racism and discrimination

In the 2020 stakeholder interviews, stakeholders described being at an “inflection point” in acknowledging and addressing racism in the community, with more people talking about the issue. They shared racism keeps people in **poverty** by limiting education and job opportunities, leading to more Black, Brown, Indigenous, and People of Color (BBIPOC) working in **lower-wage jobs**, with particular emphasis on the Latino/a community in Sonoma County.

Housing discrimination prevents the Latino/a community from accessing good-quality, affordable housing. Racism contributes to inequities in the ways different **schools** are funded, contributing to the opportunity gap. Stakeholders shared particular concern for the ways in which xenophobia and racist policies negatively affect the **mental health and economic security** of the Latino/a community.

In 2018, stakeholders and community members also shared that BBIPOC communities are limited in their education and job opportunities due to inequitable access to high-quality schools and career and technical education. They shared concerns about the Latino/a community, noting that they often lack workplace protections and experience poor treatment due to racism, negatively affecting their mental health and economic security.

Food insecurity

In the 2020 stakeholder interviews, stakeholders were concerned about families’ abilities to access good-quality, nutritious food, even with a working adult in the home. They identified **Latino/a households** and **households with a single mother** as disproportionately affected by food insecurity. They shared the following barriers to accessing good-quality, nutritious food: **transportation**, **cost of fresh food**, and a **lack of grocery stores** but an over-abundance of fast food restaurants in under-resourced communities. They discussed the need for more upstream solutions to addressing food insecurity, identifying food banks as a downstream strategy.

In 2018, stakeholders and community members spoke to food insecurity as being an emerging issue exacerbated by the 2017 fires. They identified the high cost of healthy food and a lack of time to prepare nutritious meals as the biggest barriers for families. They also shared a need to improve nutritional options in the school lunch programs and to provide culturally appropriate healthy eating classes.

The following findings represent **medium-priority health-related needs** based on community input:

Access to health care services

In the 2020 stakeholder interview, stakeholders discussed the need for more affordable health care, as well as challenges accessing primary and specialty care. They noted a particular need for more **case management** and **navigation resources**, especially for Spanish-speaking patients and new parents.

Transportation to care is a consistent barrier for many, but especially older adults. Public charge rules may prevent mixed status households from applying for MediCal. A lack of **culturally responsive** and **linguistically appropriate** health care services and documentation status may prevent the Latino/a community from receiving the care they need.

The qualitative themes from 2018 were very similar to those in 2020. Stakeholders and community members spoke to long wait times for appointments, cost of care, and transportation as major barriers to accessing health care. They were also concerned about a lack of culturally responsive and linguistically appropriate services, advocating for more support with system navigation. They emphasized the importance of co-locating services or bringing services to people when possible and shared that mixed status families may forgo seeking services due to immigration-related fear.

Behavioral health challenges and access to care (includes both mental health and substance use disorder)

In the 2020 stakeholder interviews, stakeholders shared accessing quality mental health and substance use services can be a challenge for many. They named behavioral health services as a basic need, linked to overall stability and ability to remain employed. Not addressing behavioral health challenges can contribute to Adverse Childhood Experiences (ACEs). They shared trauma from the recent fires, COVID-19, and the current political climate contribute to the community mental health needs. They shared there is a particular need **for mild to moderate mental health services**, as well as more **wraparound case management** for families to address mental health. They identified a need for more **substance use disorder treatment services**, as well as more **perinatal mental health services**.

Stakeholders named **racism** and **xenophobia** as contributors to increased anxiety and despair for many in the Latino/a community, noting a specific lack of mental health supports for mixed status families. They discussed a need for more **bilingual and bicultural mental health professionals** to serve the Latino/a community. They also identified school-age children and older adults as two groups with unmet mental health needs. Major barriers to accessing mental health services include **cost of care** and **long wait times** for appointments.

In 2018, stakeholders and community members also spoke to the barriers that prevent people from receiving needed behavioral health services, including long wait times, transportation, and a lack of bilingual and bicultural mental health providers, echoing the themes shared in 2020. Participants also noted stigma and a lack of understanding around what depression or anxiety are prevent people from getting care. They shared a need for more behavioral health services for people experiencing homelessness, foster and transitional-age youth, veterans, and immigrants. They also shared they are seeing increased vaping among young people.

Unemployment and lack of living wage jobs

In 2020 stakeholder interviews, stakeholders described **economic inequality** in the county due to a divided economy: one for higher paying jobs and one for lower paying jobs. They identified **Latino/a community members**, particularly mixed status families, as experiencing inequities in income and being more likely to work in lower wage jobs in the retail, tourism, and hospitality industries. Stakeholders identified a need to address **opportunity gaps** by providing job skill training and education opportunities, as well as more **financial literacy education**. Stakeholders were also concerned about **older adults** whose fixed incomes may not be sufficient to meet their basic needs.

In 2018, stakeholders and community members were primarily concerned about the economic inequity that exists in Sonoma County, echoing the 2020 stakeholders who shared there is a gap between those who have higher paying jobs and those in lower paying jobs. They noted that this gap and economic insecurity in the community had been exacerbated by the 2017 fires and that families were not being paid a living wage. They shared a need for more education and skill-development opportunities.

Stakeholders discussed the **effects of the COVID-19 pandemic** on the communities they serve:

Effects of COVID-19

Many stakeholders expressed concern for **students**, noting the pandemic has highlighted the opportunity gap as some students have more support and resources to effectively learn from home. Lack of **broadband** and technology is a barrier for remote learning and telehealth visits. The **Latino/a community** has been disproportionately affected by the economic impacts of the pandemic. Stakeholders are seeing people **delay health care** and expressed concerns that **COVID-19 related information** has not been adequately shared in Spanish. They also shared they are seeing increased **isolation, anxiety, and despair**, compounded by the trauma related to the previous fires. Stakeholders noted concern for increased **domestic violence** and **child abuse/neglect** due to increased isolation. Stakeholders noted the number one need is **emergency financial assistance** to pay for housing, food, and other basics. They shared concern for the non-profit sector and the need for more funding to ensure community organizations can provide needed services.

See Appendix 2: Community Input: Qualitative Data

Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Santa Rosa Memorial and Petaluma Valley Hospitals from completing any in-person conversations. While stakeholder interviews were easily adapted to a virtual setting through a video conferencing platform, it was not feasible to host listening sessions comprised of community members in this same way. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

The Community Benefit Committee served as the oversight committee to identify and prioritize the top health-related needs in Sonoma County based upon the findings of the CHNA. Committee members reviewed and analyzed the aggregated quantitative and qualitative data in the CHNA, as well as the needs prioritized by the community stakeholders and caregivers. The Providence St. Joseph Health Data Integration Team presented an in-depth review of publicly available data, internal utilization data, and findings from the stakeholder interviews and results from the 2019 Sonoma County Collaborative CHNA. The Community Benefit Committee identified the following list of significant health needs based on the data presentation. Each member then completed an online prioritization survey identifying the top three health-related needs from the following list of significant health needs:

- Access to health care
- Health equity: racism and discrimination
- Education
- Housing instability and homelessness
- Mental health and substance use
- Economic insecurity
- Food insecurity

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- PSJH service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

The Community Benefit Committee members discussed their ranking choices and refined the language and scope of the health-related needs. The results of the online criteria-based ranking and the subsequent discussion determined the priority health needs.

2020 Priority Needs

The list below summarizes the rank ordered significant health needs identified through the 2020 Community Health Needs Assessment process:

PRIORITY 1: HOUSING INSTABILITY & HOMELESSNESS

The cost of living in Sonoma County outpaces the income for many people in the community, making it challenging for families to meet their basic needs. Housing is foundational to one’s health: people who are stably housed are better able to care for their physical and mental health. Those most impacted by housing instability and affordability are the Latino/a community due to income inequities; youth experiencing homelessness, especially those identifying as LGBTQ+; and older adults whose fixed income limits their ability to afford local housing prices. There is also need for supportive housing, using a Housing First approach, for people with mental health challenges, substance use disorders, and other special needs. There are especially few resources for people who are undocumented.

PRIORITY 2: MENTAL HEALTH & SUBSTANCE USE SERVICES

Accessing quality mental health and substance use services can be a challenge for many. Trauma from the recent fires, COVID-19, and the current political climate contribute to the community mental health needs. There is a particular need for mild to moderate mental health services, perinatal mental health services, more wraparound case management for families to address mental health, and more substance use disorder treatment services. There is further need for more bilingual and bicultural mental health professionals to serve the Latino/a community, including those that are undocumented. School-age children and older adults are two additional groups with unmet mental health needs. Major barriers to accessing mental health services include insurance coverage limitations, cost of care, and shortage of providers resulting in long wait times for appointments.

PRIORITY 3: HEALTH EQUITY: RACISM AND DISCRIMINATION

Stakeholders described being at an “inflection point” in acknowledging and addressing racism in the community, with more people talking about the issue. They shared racism keeps people in poverty by limiting education and job opportunities, leading to more Black, Indigenous, and people of color (BIPOC) working in lower-wage jobs, with particular emphasis on the Latino/a community in Sonoma County. Housing discrimination prevents the Latino/a community from accessing good-quality, affordable housing. Racism contributes to inequities in the ways different schools are funded, contributing to the opportunity gap. Stakeholders shared particular concern for the ways in which xenophobia and racist policies negatively affect the mental health and economic security of the Latino/a community.

PRIORITY 4: ACCESS TO HEALTH CARE

Stakeholders discussed the need for more affordable health care, as well as challenges accessing primary and specialty care. They noted a particular need for more case management and navigation resources, especially for Spanish-speaking patients and new parents. Transportation to care is a consistent barrier for many, but especially older adults. Fears of immigration enforcement and changes in public charge rules may prevent mixed status households from applying for Medi-Cal. A lack of culturally responsive and linguistically appropriate health care services and documentation status may prevent the Latino/a community from receiving the care they need.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current-state capacity and gaps. The organized health care delivery systems include the Sonoma County Department of Health Services, the Sonoma County Human Services Department, Kaiser Permanente, Sutter Health, four special-district hospitals, and seven Federally Qualified Health Centers (FQHCs). In addition, there are numerous social service nonprofit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 3.

Appendix 3: Resources potentially available to address the significant health needs identified through the CHNA

EVALUATION OF 2018-2020 CHIP IMPACT

This report evaluates the impact of the 2018-2020 Community Health Improvement Plan (CHIP). SRMH and PVH responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 13. Outcomes from 2018-2020 CHIP

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
Access to Resources	St. Joseph Health Community Dental Clinic Programs (mobile and fixed-site clinics)	20,279 patients served in 47,700 encounters	All operating costs covered by SJH as a direct service clinical program
Access to Resources	St. Joseph Health Mobile Health Clinic	10,097 patients served in 19,195 encounters	All operating costs covered by SJH as a direct service clinical program
Access to Resources	St. Joseph Health CARE Network Program	9,698 patients served in 15,879 encounters (team-based wrap-around intensive case management for complex care patients)	All operating costs covered by SJH as a direct service clinical program
Access to Resources	St. Joseph Health House Calls Program	1,286 patients served in 17,095 encounters (free in-home health and palliative care for home-bound patients)	All operating costs covered by SJH as a direct service clinical program
Access to Resources	St. Joseph Health Open Access to Community Care Program	8,047 persons served (community health navigator service connecting patients without a medical home to a primary care provider)	All operating costs covered by SJH as a direct service clinical program
Access to Resources	St. Joseph Health Promotoras de Salud Program	3,004 persons served in 3,054 encounters (cardiovascular disease prevention)	All operating costs covered by SJH as a direct service program
Homelessness and Housing Concerns	Sonoma Intersections Coalition	Monthly meetings of housing advocates and providers to develop housing policy advocacy strategies aimed at increasing housing equity; to organize a Sonoma County Tenants Union to educate and advocate for tenants' rights; and to design and	SJH's Community Partnership Fund granted \$450,000 over 3 years to pay for staffing and related costs to convene, facilitate and lead this coalition.

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
		implement trainings on trauma-informed practice for homeless service providers.	
Homelessness and Housing Concerns	Santa Rosa Community Health Homeless Care Transitions Program	316 patients served (team-based wrap-around intensive case management for complex care homeless FQHC patients)	SJH has contributed \$504,000 during the past 3 years towards this program.
Homelessness and Housing Concerns	Committee on the Shelterless (COTS) Permanent Supportive Housing (PSH)	11 new PSH units (13 beds) were built, with accompanying Case Manager social work supports	Annual \$175,000 grant from SJH to COTS to cover the Case Manager costs
Homelessness and Housing Concerns	COTS' Recuperative Care	6 new recuperative beds were created in December 2019	Annual \$200,000 budget for recuperative services shared equally between SJH and Kaiser Permanente
Homelessness and Housing Concerns	Catholic Charities' Caritas Village Project	Capital campaign nearly completed to build new homeless services center, family shelter, and medical clinic. Construction to begin in late 2020.	\$2 million in pledges from SJH to the capital campaign
Homelessness and Housing Concerns	St. Vincent Commons Permanent Supportive Housing	56-unit motel conversion to PSH. Acquisition completed; renovations begun in late 2020.	\$500,000 contribution from SJH towards the acquisition
Homelessness and Housing Concerns	PEP Housing's Linda Tunis Senior Supportive Housing Project	29-unit senior PSH conversion of a former Masonic temple. Acquisition completed; renovations begun in 2020.	\$250,000 contribution from SJH towards the acquisition
Homelessness and Housing Concerns	Health Care for the Homeless Collaborative (HCHC)	Monthly meetings of homeless health care and service providers to coordinate services, share resources, and develop new programs, e.g., Project Nightingale and Petaluma Sober Circle both originated in the HCHC	SJH offers meeting space and staffing on an in-kind basis to convene, facilitate and lead this coalition.
Homelessness and Housing Concerns	Project Nightingale	More than 1,000 patients served (recuperative care program for discharged homeless patients)	SJH contributes \$250,000 annually to a \$675,000 budget (remaining budget covered by contributions from

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
			other local hospitals and Partnership HealthPlan of California)
Behavioral Health	Regional Behavioral Health Integration Project	Comprehensive collaborative project of SJH with all local FQHCs and Sonoma County Behavioral Health Division to address barriers to access in the local behavioral health system of care, including improving systems of care coordination between providers, enhancing psychiatric skills and knowledge of primary care providers, implementing social determinants of health screening in primary care, implementing a health information exchange and closed-loop resource referral system in FQHCs, and examining feasibility of expanding intensive outpatient behavioral health treatment options.	Providence SJH's Well Being Trust funded this 18-month project with a \$800,000 grant to the Redwood Community Health Coalition. Local SJH community benefit staff led the project.
Behavioral Health	Petaluma Sober Circle Project	216 individuals have entered this Serial Inebriate Program (SIP) over the past 3 years.	SJH has contributed \$225,000 over the past three years
Behavioral Health	St. Joseph Health Healthy for Life Program	16,008 persons served in 84,954 encounters	All operating costs covered by SJH as a direct service program

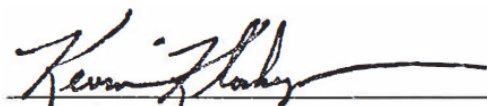
Addressing Identified Needs

The Community Health Improvement Plan developed for the Sonoma County service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how SRMH and PVH plan to address the health needs. If the hospitals do not intend to address a need or plan to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions SRMH and PVH intend to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between SRMH and PVH and community-based organizations in addressing the health need.

2020 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted on by the Community Benefit Committee of the Santa Rosa Memorial and Petaluma Valley Hospitals' Boards of Trustees on Tuesday, February 23, 2021.



Kevin Klockenga
Region Chief Executive, Northern California

2-25-21

Date



Debbie Meekins
Chair, Community Benefit Committee, Sonoma County

2/23/2021

Date



Justin Crowe
Senior Vice President, Community Partnerships
Providence St. Joseph Health

6/29/2021

Date

CHNA/CHIP Contact:

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

APPENDICES

Appendix 1: Definition of Terms Related to Community Input

Access to health care services: The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Access to oral health care services: The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

Accessibility for people with disabilities: The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

Affordable daycare and preschools: All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

Aging problems: The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

Air quality: The degree to which the air is pollution and smoke-free.

Avoidable Emergency Department Utilization (AED): Based on algorithms by MediCal and NYU, PSJH Healthcare Intelligence developed an “AED” flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

Behavioral health challenges and access to care: Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Bullying and verbal abuse: Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism, yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

Child abuse and neglect: “Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child’s health, welfare, and safety is harmed.”⁴

Discrimination: Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.⁵

Domestic violence: Also called intimate partner violence, “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner.”⁶

Economic Insecurity: Lacking stable income or other resources to support a standard of living now and in the foreseeable future.

Few arts and cultural events: A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

Firearm-related injuries: Gun-related deaths and injuries.

Food insecurity: A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

Gang activity/ violence: Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

Health Equity: A principle meaning that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.”⁷

⁴ <https://www.dcyf.wa.gov/safety/what-is-abuse>

⁵ <https://www.eoc.org.uk/what-is-discrimination/>

⁶ <https://www.thehotline.org/is-this-abuse/abuse-defined/>

⁷ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

HIV/AIDS: Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

Homelessness/ lack of safe, affordable housing: Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

Job skills training: Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

Lack of community involvement: Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

Poor quality of schools: Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that “provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students.”⁸

Racism: “Prejudice against someone based on race, when those prejudices are reinforced by systems of power.”⁹

Safe and accessible parks/recreation: Issues around a shortage of parks or green spaces, or existing parks/green spaces being poorly maintained, inaccessible, or unsafe.

Safe streets for all users: People walking, biking, driving, and using public transportation can generally trust that they are safe on the road. Includes safety features such as crosswalks, bike lanes, lighting, and speed limits.

Social Determinants of Health: Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Unemployment/ lack of living wage jobs: Not having employment or lacking a job that pays the minimum income necessary for a worker to meet their basic needs.

⁸ <http://www.ascd.org/ASCD/pdf/siteASCD/policy/ASCD-EI-Quality-Education-Statement.pdf>

⁹ Oluo, Ijeoma. *So You Want to Talk About Race*.

Appendix 2: Community Input

INTRODUCTION

Santa Rosa Memorial and Petaluma Valley Hospitals conducted stakeholder interviews, recognizing the importance of including the voices of community leaders who help make Sonoma County healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder interviews are particularly important this CHNA cycle as the COVID-19 pandemic has prevented us from facilitating listening sessions with community members. We relied on community stakeholders to represent the broad needs of the communities they serve.

Santa Rosa Memorial and Petaluma Valley Hospitals included 11 interviews from 12 stakeholders, people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. The goal of the interviews was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

A total of 11 stakeholder interviews were completed by representatives from Santa Rosa Memorial and Petaluma Valley Hospitals. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Santa Rosa Memorial and Petaluma Valley Hospitals aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a representative from the Sonoma County Human Services Department.

Apx 2_ Table 1. Community Stakeholder Interview Participants

Organization	Name	Title	Sector
Community Foundation Sonoma County	Elizabeth Brown	President & CEO	Philanthropy, community-based organization
First 5 Sonoma County	Angie Dillon-Shore	Executive Director	Public health, early childhood development, quasi-government agency
John Jordan Foundation	Lisa Wittke-Schafner	Executive Director	Education-focused philanthropy, community-based organization

Organization	Name	Title	Sector
La Luz Center	Veronica Vences	Director of Development	Social services, community-based organization
Northern California Center for Well-Being	Karissa Moreno	Executive Director	CVD and heart health, community-based organization
Petaluma Health Care District	Elece Hempel	President (Executive Director of Petaluma People Services Center)	Social services, community-based organization
	Ramona Faith	Executive Director	
Redwood Community Health Coalition	Karen Milman	Chief Executive Officer	Healthcare, coalition of community-based health clinics (FQHCs)
Sonoma County Human Services Department	Oscar Chavez	Assistant Director	Social services, County government agency
United Way of the Wine Country	Jennifer O’Donnell	Executive Vice President	Social services and public health, community-based organization
West County Community Services	Tim Miller	Executive Director	Social services, community-based organization
YWCA Sonoma County	Cindy Berrios	Therapy Program Manager	Behavioral health, community-based organization

Facilitation Guide

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completing their CHNAs (see “Stakeholder Interview Questions” at the end of Appendix 2 for full questions):

- The role of the stakeholder’s organization and community served
- Prioritization of unmet health related needs in the community, including social determinants of health

- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

Training

The facilitation guide provided instructions on how to conduct a stakeholder interview, including basic language on framing the purpose of the interview. Each facilitator was provided a list of questions to ask the stakeholder.

Data Collection

The facilitator conducted all of the interviews using the Microsoft Teams platforms and recorded the interviews with participants' permission.

Analysis

Qualitative data analysis of stakeholder interviews was conducted by Providence St. Joseph Health using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) role of organization, 2) population served by organization, 3) unmet health-related needs, 4) disproportionately affected population, 5) gaps in services, 6) barriers to services, 7) community assets, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "mental health" can occur often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need

and the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Stakeholders were asked to identify their top five health-related needs in the community. Three needs were mentioned in most interviews and were categorized as high priority. Three additional needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

High Priority Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs (in order of priority):

1. Homelessness/ lack of safe, affordable housing
2. Racism and discrimination
3. Food insecurity

Homelessness/ lack of safe, affordable housing

Stakeholders spoke to housing as being connected to many other needs, such as the following:

- **Income and a living wage:** They shared the cost of living in Sonoma County is high and not everyone makes a living wage, particularly the Latino/a community. Even with a working adult in the household, families cannot meet their basic needs.

“I think housing is one of the biggest. Cost of living, just being able to make a living wage is really challenging, especially, in this county.”—Community Stakeholder

- **Health:** Stakeholders spoke to housing as being foundational; people who are stably housed are better able to care for their physical and mental health. People who are stably housed are able to “think clearly” and better able to navigate services.

“I would take on the position that everything is health in some ways, and so then I would really connect it to these issues around equity, in that a healthy community means not just physical health and not just mental health too, but having what you need in your life and your family to thrive. That also means an education, a home, access to wages, access to parks and open space and so a very broad definition of health.”—Community Stakeholder

“Housing, huge determinant of health that if we could do something about that, we would go a long way addressing a broad range of actual health issues”—Community Stakeholder

- **Domestic violence:** Without support networks, people leaving domestic violence situations may enter homelessness. This emphasizes the importance of having safe houses for people seeking to leave unsafe situations.

“Well, shelter is a big one. Often, domestic violence leads to homelessness, and that’s why we have the safe house. Those families that leave a violent or dangerous situation become automatically homeless once they leave, and they lose that resource. Housing insecurity, and it’s beyond just our safe house clients.”—Community Stakeholder

- **Education:** Educational opportunity is connected to job opportunity, which often correlates to income. Therefore, addressing educational opportunity gaps can help create more economic security and housing stability.
- **Family stability and reunification:** Having stable housing is crucial for reunification of parents and their children. Stable housing is also important for the health and development of children and sense of safety.

Stakeholders were particularly concerned about housing stability and affordability for the following populations:

- **Latino/a community:** Income inequities driven by racism contribute to this population being disproportionately housing cost burdened.
- **Youth experiencing homelessness,** especially those identifying as LGBTQ+: This population experiences multiple barriers and is more likely to be kicked out of their homes and lack family support. Stakeholders shared around 50% of youth experiencing street homelessness identify as LGBTQ+.
- **Older adults:** People living on fixed incomes are getting prices out of their homes.
- **People with a substance use disorder:** Stakeholders spoke to the importance of getting people into supportive housing first to be able to address behavioral health needs.

Stakeholders identified a lack of safe, **affordable housing**, leading to overcrowding and poor living conditions. To address housing instability, they shared a need for more **rental assistance**, particularly in times of disaster, such as after fires. Stakeholders shared that after the Kincade Fire, the number one need was financial assistance to pay rent or mortgages, buy food, fix their cars or homes, etc. The current programs run out of money quickly and there are especially few economic support resources for **mixed status families** (families with a variety of documentation statuses).

Stakeholders shared a need for more resources to address homelessness at the community level rather than through **law enforcement**, noting they are not equipped to address behavioral health needs. They also noted a need for more **political will** to create sustainable solutions to homelessness.

“I would also throw in political will. With housing, there are policies that we know have worked in other areas of the country, but it has that political will there to talk about rent stabilization or those type of things.”—Community Stakeholder

The **COVID-19 pandemic** has created more housing instability associated with job loss and economic insecurity. People living in high-density housing have had more challenges socially distancing and quarantining, contributing to easier spread of COVID-19 within households. Additionally, stakeholders noted concern for people experiencing homelessness who have not been able to adequately shelter in place.

Racism and discrimination

Stakeholders described being at an **“inflection point”** in acknowledging and addressing racism in the community, with more people talking about the issue.

“Racism/discrimination is big in this community, and it’s under reported and not discussed enough, I would say. I think this round of protests have really shined a light on it, and it’s been around for a while. It’s not new. We’re just talking about it more, and I hope we continue to talk about it because there are some health outcomes. There’s research out there about living with racism and discrimination, and that impacts all of these other things.” – Community Stakeholder

“Well, I think one of the things that has really kind of awakened our community and I think for us here there’s, it’s nothing new, this issue of structural racism and discrimination. While it is not a new issue, and while we have raised it, and while we have seen it manifest in many different terrible ways, I think for the first time, there’s an opportunity to really lift this up as a primary community-wide concern and use it to help address some of these other challenges like housing, and housing discrimination, and geographic discrimination.” – Community Stakeholder

They shared that we can use the current energy around racial justice as an opportunity to have meaningful **conversations** and see **change** happen in our communities.

“Maybe that’s something that now it-- Change will happen fast. I mean change did happen very, very slow for hundreds of years but maybe we’re at some kind of inflection point, like with gay marriage. Things are very slow and then you have moments where you can have change happen.” – Community Stakeholder

They also noted a need for more **shared language** within the community to ensure that people can engage in these discussions with some foundational knowledge and common understanding.

“The discord that we’re seeing right now in the communities with racial matters and there’s just a lot of lack of knowledge and understanding of what it is that we’re talking about. People don’t think they’re discriminating, but they are. This is lack of understanding, or the empowerment of those who are not educated on the fact to speak out and speak out in a way that’s hurtful to those around them.” – Community Stakeholder

Stakeholders shared racism is connected to and negatively affects the following:

- **Health outcomes:** Racism has long-term effects on the physical and mental health of Black, Brown, Indigenous, and People of Color (BBIPOC).
- **Unemployment and lack of living wages:** Racism keeps people in poverty by limiting education and job opportunities, leading to more BBIPOC working in lower-wage jobs, with particular emphasis on the Latino/a community in Sonoma County. Stakeholders shared these lower-wage jobs typically include retail, tourism, and hospitality in Sonoma.

“Unemployment and lack of living wage. This one's interesting, racism and discrimination, because I don't think that many, if any, of our families come here saying that that's what they're seeking help with, but ultimately, we know that it's... a reaction to that. A sense of discrimination.” – Community Stakeholder

- **Housing:** Racism prevents the Latino/a community from accessing good-quality, affordable housing.
- **Education:** Racism contributes to inequities in the ways different schools are funded, contributing to the opportunity gap.

“I have a great video that talks about structural racism and it looks at if there is one thing that we can change and all schools were funded equally, but every single child in this country received the same education, what a huge upstream impact that would have.” – Community Stakeholder

Stakeholders shared particular concern for the ways in which xenophobia and racist policies negatively affect the **mental health and economic security** of the Latino/a community. Concerns related to public charge prevent the Latino/a community from wanting to apply for public benefits, such as MediCal, further contributing to this population not being able to access the resources they need to be healthy.

“I really do strongly believe that if we were to be able to address institutionalized racism and inequity and all those structures that underlie economic disparities, we would not need... many other systems that support vulnerable people. I truly believe that those are the underpinnings of the disparities across our community. Economic disparities, particularly rural Latino population and structural racism, I would say that's the issue and you can also point to that as far as the access pieces around the mental health stuff. They're connected there.” – Community Stakeholder

The **COVID-19 pandemic** has highlighted disparities by race and ethnicity. Stakeholders spoke to more BBIPOC community members working in essential roles during the pandemic, meaning they are unable to work from home and face greater risk of exposure. This also highlights inequities in remote learning, with some parents able to be at home while their children are learning and others needing to be at work.

Food insecurity

Stakeholders were concerned about families' abilities to access good-quality, nutritious food, even with a working adult in the home. They identified **Latino/a households** and **households with a single mother** as disproportionately affected by food insecurity. Even with working adults in a household, families still have challenges meeting their basic needs. They discussed the need for more **upstream solutions** to addressing food insecurity, identifying food banks as a downstream strategy. These upstream strategies may include addressing lack of living wages and inequitable access to opportunities.

"I think definitely on the food insecurity, that generally we think of the food banks, but I think in our strategies, we think about that as a little downstream in some ways, but thinking about food insecurity, both the food banks and then what do we need to do? What does upstream look like for food insecurity?"—Community Stakeholder

They shared the following barriers to accessing good-quality, nutritious food: **transportation**, **cost of fresh food**, and a **lack of grocery stores** but an over-abundance of fast-food restaurants in under-resourced communities.

"We would just go back to where is food accessible and how expensive it is: good, fresh food. I don't know that years ago I would have ever noticed when you go into some neighborhoods and there's only fast food, you don't see a big grocery store. We're not taught anything like that until we get into some of this work, and that education alone would be good for the community, I think." – Community Stakeholder

Stakeholders shared they are seeing more people experiencing food insecurity during the **COVID-19 pandemic**, noting food resources are one of the first things people ask for.

"When we're serving our patients, what you need is food access, like the things people are saying help find us resource first, it's food, it's rental assistance, and help in staying in their homes."—Community Stakeholder

They were particularly concerned about **older adults**, especially those with low incomes, who may be staying home more due to concerns about COVID-19 or lack of transportation.

"Again, talking about low-income seniors, it's interesting because we have lots of food and meals that we're preparing for seniors. A lot of it is available at our senior center outside for pick up, but those without transportation, at least initially were unable to pick it up. Now, we're having it transported to them." – Community Stakeholder

Organizations have stepped up to address food needs during the pandemic. For example, the You're Not Alone program from Petaluma People Services Center, checked on over 1,000 older adults to see how they are doing and what they need. They are providing many older adults meal deliveries to address the need, but this level of support is not financially feasible long term.

"Everybody's got different needs and they have to all be addressed in how we communicate with our community. Our biggest concern is all of these people are getting this great meal every day of the week now. What's going to happen?... If we don't go back down to a number that's manageable in the number of people who need meals, we're not going to be

able to keep pace... There is this huge gap in what people think is happening and what is really happening.”—Community Stakeholder

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by stakeholders, although with less frequency than the high priority needs (in order of priority):

4. Access to health care services
5. Behavioral health challenges and access to care (includes both mental health and substance use disorder)
6. Unemployment and lack of living wage jobs

Access to health care

Stakeholders discussed the need for more affordable health care, as well as challenges accessing primary and specialty care. Their primary concern was a need for more services to help people get the care they need, including **case management** and **navigation resources** for the following populations:

- **Spanish-speaking community members:** Stakeholders spoke to a need for more bilingual, bicultural public health nurses and community health workers who can help the Latino/a community navigate the health care system. These supports should be culturally responsive and available in Spanish.
- **New parents:** Stakeholders spoke to needing more support systems for new parents to assist in ensuring they get the appropriate care for their children and know how to access health insurance.

Stakeholders also shared **fear** related to immigration and public charge may prevent mixed status families from applying for MediCal. They noted the people they serve are afraid of entering their information into a government database. For some families, they have no affordable insurance options.

*“One of the other challenges that we face that in a lot ways we're not in a position to support, and that is our undocumented community because all of our-- the majority of our programs require that people have permanent legal status to access those services. We see that as a huge gap, and while we may serve children that are born here of undocumented parents, the household still needs some support. To me, there's a need and an opportunity to think about how we can work better together as government where we can support families and other providers to fill in the gap where we can't provide those supports.” –
Community Stakeholder*

A lack of **culturally responsive** and **linguistically appropriate** health care services may also prevent the Latino/a community from receiving high-quality and responsive care in their native language.

Transportation to care is a consistent barrier for many, but especially older adults. Stakeholders described getting patients to health care appointments outside of their community as “almost impossible.”

“When we start to think about healthcare, transportation is so important. We have the I Ride program in Marin, in Petaluma and we have to beg our drivers to drive people to Kaiser. If they are Kaiser patients and they're here getting services in Petaluma, they can ride the bus but if they have to go to Kaiser in Santa Rosa or Marin County it's a big issue. We all know that St. Joseph health has some great heart programs and some amazing programs for people who are aging, but those programs are in Santa Rosa. Getting those seniors to there is almost impossible.” – Community Stakeholder

They noted that mobile health care has been a great way to bring services to people, particularly those experiencing homelessness.

The **COVID-19 pandemic** has created additional barriers to care, leading some people to delay needed care or opt out of preventive care. They may be afraid to seek care in person, meaning that when they do seek care, they are typically much sicker.

“I mean, from what I'm hearing from the hospitals, the people who are in for non-COVID related reasons are much sicker than previously because you're delaying care. They're saying, ‘well, maybe I don't need my preventative screening’ and ‘maybe this can wait’ and then, or because whatever other reason you're home, you're stressed, you're eating out of control, your diabetes is now out of control.” – Community Stakeholder

Telehealth has been a positive change for some people. Using telehealth, providers can see into people’s living rooms and patients may be more comfortable in their own home. Although, for people who lack broadband or technology, they may not be able to engage successfully in telehealth services. Some people may not be comfortable or experienced using technology, particularly older adults.

“One the many inequities that have come to light during this time has been the lack of access to internet services, and to devices that facilitate healthcare... [Technology] is a lifeline for many of us right now. If we don't have that, how can we get seen by a doctor? How can we get seen by a therapist? How do I talk to the person at the food bank? I think it's an equity issue. At this point I think it's getting up to a need. People need Internet. We need to have forums and we need the tech. We need the smartphone or the laptop or the iPad, whatever it is. We need the equipment and we need the Wi-Fi.” – Community Stakeholder

“A lot of our population, either it doesn't have the technology, they don't have the internet connectivity, resources that were previously available such as maybe a computer and a library are no longer accessible. We're unable to reach a lot of folks.”—Community Stakeholder

Some people have had challenges applying and qualifying for **MediCal** because their previous taxes or W2s do not reflect their current income. People may also be delaying applying for benefits, hoping their jobs might return soon. Overall, stakeholders spoke to having a “long road ahead,” knowing that there is and will continue to be a lot of community need as a result of the pandemic.

Behavioral health challenges and access to care (includes both mental health and substance use disorder)

Stakeholders shared accessing quality mental health and substance use services can be a challenge for many. They named behavioral health services as a **basic need**, linked to overall stability and ability to remain employed. Not addressing behavioral health challenges can contribute to **Adverse Childhood Experiences (ACEs)**.

Stakeholders emphasized that community members in Sonoma County are experiencing **compounded trauma** from the recent fires, COVID-19, and the current political climate contribute to the community mental health needs. Because of the fires and COVID-19, families have lost income, they cannot find stable housing, and schooling is interrupted. These overlapping events have caused **stress** and **despair**.

“We're hearing more than seeing. We're hearing despair in the phone calls that we get, frustration, stress. Not only is it this time in of itself, but it's three or four incidents that are overlapping on top of each other. I would say yes, mental health is a huge need out there.”—Community Stakeholder

They shared the following community needs:

- **Mild to moderate mental health and substance use services:** It can be easier to qualify for services if the need is very severe or someone meets the county definition of severe and persistent mental health challenge, but people who do not meet that criteria need support as well.
- **Wraparound case management:** They noted a need for wraparound case management for families to address both mental health challenges and basic needs, including employment, education, and housing.
- **Substance use disorder treatment services:** There is a need for more affordable and easier to access services to address substance use disorders (SUD). There is also a need for supportive housing for people with a SUD.
- **Perinatal mental health services:** Stakeholders spoke to a need for more services not only for folks with a diagnosis, but those with milder symptoms who need support. They spoke to the importance of providing social and emotional support for families and children.

“I think there is a real need for better coordinated and more accessible systems around perinatal mental health. Not just folks that might meet the criteria for diagnosis, for perinatal mental health disorder, but we know that even mild symptoms of depression and anxiety can be disruptive for early development and be part of a complex of conditions that

cause Adverse Childhood Experiences. The wellness of particularly mothers, but all parents is something that we need to put more attention to in our county. Then the social-emotional development of young children under five is-- I think there's a lot of awareness. There's a burgeoning awareness particularly within systems that serve children, but I don't think that there's a broad awareness of how critical that is and how young children have been impacted by all the things that have happened in the last three or four years, the fires, immigration, issues. All of these things have impacted young children just as much as they have adults.” – Community Stakeholder

Stakeholders were particularly concerned about the mental health needs of the following populations:

- Latino/a community: Stakeholders named **racism** and **xenophobia** as contributors to increased anxiety and despair for many in the Latino/a community, noting a specific lack of mental health supports for mixed status families. They discussed a need for more **bilingual and bicultural mental health professionals** to serve the Latino/a community.
- **Older adults**: Stakeholders shared older adults are more socially isolated with limited access to support resources.
- **School-age children**: There is a need for more focus on social and emotional learning in schools and a need to address bullying.

Major barriers to accessing mental health services include **cost of care** and **long wait times** for appointments.

“Mental health as well. It's really hard to access quality mental services. We actually have grown our program in the past couple of years. I know that once these restrictions are lifted, there will be an explosion of need for services across the county. I think CBOs are really encumbered by it that provide therapy services, but also in the private practice field. I think if you talk to anyone who's trying to get a therapist right now, who's willing to pay \$150, \$200, there's still a waitlist. You know a system is encumbered when money can't buy you out of it. If you're willing to drop \$200 and that's still not enough to get you to the top of the list, then, we know that's a bigger systemic problem.” – Community Stakeholder

“I would say the biggest one is affordability. That was one of the biggest lessons that we learned. Because before this, we would say that it's the stigma with mental health, yet once we started offering [mental health services for free], people signed up for it” – Community Stakeholder

Stakeholders shared they have seen increased anxiety and despair related to **COVID-19** and the economic effects. They also noted people are feeling more isolated, which can be exacerbated for people without access to technology or Wi-Fi. They were particularly concerned about **older adults** being isolated without access to support and technology. They were also concerned about the mental health and well-being of **children**, particularly those in unsafe or unhappy homes.

“I think it is going to be huge to come up with a way to address mental health and future thinking for kids through this pandemic and the repercussions... I think we're about to have a huge wave of physical and mental health problems coming from that of all ages, the adults who've given up, and the kids who just can't even think their way forward.” – Community Stakeholder

Families are experiencing new stresses and tensions without their usual outlets for decompressing. Stakeholders also noted there may be increased **substance use** during the pandemic, although the full effects of the pandemic on both mental health and substance use will probably not be fully seen or understood for years.

Unemployment and lack of living wage jobs

Stakeholders described **economic inequality** in the county due to a divided economy: one for higher paying jobs and one for lower wage jobs. These lower wage jobs often do not offer a living wage and disproportionately employ BBIPOC communities.

“We're still very much in a bifurcated economy that we have one economy for the educated higher wage earners. Then in our community where we have a high number of retail tourism and hospitality occupations, we have an economy for our low-wage worker, and that gap is creating such turmoil and destruction in our community that we have to address it. Addressing it through a racial equity lens, I think could help to lift up a lot of other challenges that we're dealing with, whether it's the achievement gap, the income gap, the service gap.” – Community Stakeholder

In Sonoma County, they identified **Latino/a community members**, particularly mixed status families, as experiencing inequities in income and being more likely to work in lower wage jobs in the retail, tourism, and hospitality industries. Additionally, they are less likely to have safety net supports if they do not qualify for or are afraid to apply for public benefits, such as unemployment, CalFresh, and MediCal.

“Lack of living wage, again, we have huge disparities in what people are making in Sonoma County” – Community Stakeholder

“[Latino/a community members] have no safety net, nothing to fall back on, they have to be out there every day doing what they do [in essential jobs]. I don't know about if they got sick or not. Many of them are health center patients. Many of them do have access to healthcare in that regard.” – Community Stakeholder

Stakeholders were also concerned about the economic security of older adults, especially those on fixed incomes that may not be sufficient to meet their basic needs. They noted this population also lacks a safety net.

“We have a lot of vulnerable seniors that are getting priced out because their fixed incomes cannot support their housing.” – Community Stakeholder

Stakeholders connected the lack of living wage jobs to other community needs:

- **Housing:** Many families are housing cost burdened, meaning they spend more than 30% of their income on rent. Low wages, coupled with high cost of housing, leads to overcrowding and poor-quality housing.

“I think housing is one of the biggest. Cost of living, just being able to make a living wage is really challenging, especially, in this county.” – Community Stakeholder

“Think low wages compared to the cost of housing. I don't know if it's that the wages are too low or the housing is too high, but either way they're both a problem. Then you can't help but call out institutionalized racism when you look at those numbers between Latino and white [people].” – Community Stakeholder

- **Ability to meet basic needs:** Because of economic insecurity, some families cannot meet their basic needs, including stable housing, childcare, and healthy food.

“We look at something called the Real Cost Measure that United Way of California, it's an analysis they do. Where they build sample budgets based on a household size and look at things like housing, childcare, food, most of your basic needs. This is just saying just to survive, not even to thrive, what do you need? I would say I guess then, right now we feel like the unmet needs are really around basic needs.” – Community Stakeholder

- **Health:** Stakeholders acknowledged that for people to be healthy, they need to have access to livable wages, which are connected to all other social determinants of health.

“Yes. I would take on the position that everything is health in some ways, and so then I would really connect it to these issues around equity, in that a healthy community means not just physical health and not just mental health too, but having what you need in your life and your family to thrive. That also means an education, a home, access to wages, access to parks and open space and so a very broad definition of health.” – Community Stakeholder

Stakeholders identified a need to address **opportunity gaps** by providing job skill training, employment services, and education opportunities, as well as more **financial literacy education**. These employment services could include resume building and support connecting to potential employers. They were also clear that **racism** contributes to economic inequities and the wealth disparity.

“I really do strongly believe that if we were to be able to address institutionalized racism and inequity and all those structures that underlie economic disparities, we would not need... many other systems that support vulnerable people.” – Community Stakeholder

The **COVID-19 pandemic** has contributed to increased job loss and financial insecurity. When families lose their income, they may need to move, compounding the instability caused by Sonoma County fires. This has a negative effect on mental health.

Stakeholders also shared the Latino/a community has been economically disproportionately impacted by the pandemic. Hospitality and retail workers have been especially affected.

“There's just so many of them that if we don't think about how to support them, we're going to start to see a lot of those workers not being able to have jobs. Already the restaurants for example, when you're only able to operate at 25% capacity just because of the square footage that you have, you don't need a larger workforce. Already, we're going to see that for the next couple of months that that sector of employment has significantly decreased, and people are now trying to figure out other ways in which they can earn a living and/or have to work three or four jobs.” – Community Stakeholder

Effects of COVID-19

Many stakeholders expressed concern for **students**, noting the pandemic has highlighted the opportunity gap as some students have more support and resources to effectively learn from home. Some parent may not be able to work from home and support their children with online learning.

“I think one that would not have been on my radar six months ago is what is the longer-term or even shorter-term impact going to be on the learning from home and the loss of learning and how that falls because of the difference between parents who have the capacity and knowledge and money to act as homeschooler and those kids that are left behind. I think that's a newer gap as well.” – Community Stakeholder

Lack of **broadband** and technology is a barrier for remote learning and telehealth visits. Older adults in particular may not be comfortable with connecting with their providers virtually.

Stakeholders are seeing people **delay health care**, meaning when they do seek care, they are much sicker. They also noted people are having challenges qualifying for MediCal because their previous year's taxes do not reflect their current financial situations.

Stakeholders described the COVID-19 pandemic as exacerbating community inequities by race and ethnicity. It has also highlighted some of these disparities, leading stakeholders to call for more focus on health equity. The **Latino/a community** has been disproportionately affected by the economic impacts of the pandemic and stakeholders expressed concerns that **COVID-19 related information** has not been adequately shared in Spanish.

They shared they are seeing increased **isolation, anxiety, and despair**, compounded by the trauma related to the previous fires. They noted we will not know the long-term effects of these compounding traumas for years.

Stakeholders noted the number one need is **emergency financial assistance** to pay for housing, food, and other basics. Stakeholders shared they are seeing more housing instability associated with job loss and economic insecurity. They expressed concern that people experiencing homelessness are not able to adequately shelter in place. Additionally, they noted concern for increased **domestic violence** and

child abuse/neglect due to increased isolation. Children are not having as much interaction with mandated reporters, meaning understanding the full extent of current abuse is challenging.

“In particular because of the isolation, the shelter-in-place, and that we know-- we do have evidence that domestic violence has spiked and children witnessing domestic violence, that's why the commission just funded our bilingual, bicultural counselor for the Y for their program, but we don't have data yet that substantiated child abuse has actually increased because we don't have the mandated reporters that have eyes on the kids.”—Community Stakeholder

“I think that looking ahead, I'm very concerned about child abuse and adult abuse because of the shelter in place. The mandated reporters don't have their eyes on those individuals and I'm very, very concerned as we come out of the shelter in place, the number of calls that we're going to get. We see all the children that are abused in Southern Sonoma County and I think we have right now six clients that we're seeing. We know the abuse doesn't stop, it's just that the teachers and the person in the recess duty person, they're not seeing the signs of abuse and so they're not getting reported.”—Community Stakeholder

They shared concern for the non-profit sector and the need for more funding to ensure community organizations can provide needed services, especially because community need has and will continue to increase.

Community Stakeholder Identified Assets

The following table lists all of the community organizations, programs, or services that were named by community stakeholders during the interviews.

Apx 2_ Table 2. Community Stakeholder Identified Assets

Health-related need	Community program, organization, or services (number of times mentioned if more than 1)
Behavioral Health	Petaluma Sober Circle Regional Behavioral Health Integration Project
Collaboratives	Family Justice Center Family Youth and Children’s Services First 5 Sonoma County Home Visiting Advisory Collaborative
Community Capacity Building	Community Organizations Active in Disaster Sonoma Community Resilience Collaborative
Domestic Violence and Child Abuse	YWCA Sonoma County
Family and Child Support	First 5 Sonoma Redwood Children’s Center Social Advocates for Youth Sonoma County ACEs Connection TLC Child and Family Services
Food Security	Ceres Community Project

	Food for Thought Food Bank Redwood Empire Food Bank
Health Care	Community Health Initiative of the Petaluma Area Health Action Committee for Healthcare Improvement Redwood Community Health Coalition (2) Sonoma Valley Community Health Center St. Joseph Mobile Health Clinic West County Health Centers
Housing and Homelessness	Community Support Network West County Community Services (Temporary Housing Assistance Program)
Resources and Social Services	Catholic Charities of Santa Rosa Community Action Partnership Sonoma County Corazon Healdsburg La Luz (2) Petaluma People Services Center The Rock Resource Center Via Esperanza
Services for the Aging Population	Council on Aging
Services for the Latino/a Community	La Luz (2) Via Esperanza

Opportunities to Work Together

Participants were asked, “What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?” They spoke to Sonoma County generally being a collaborative place, although all agreed there are opportunities to improve collaboration and communication.

Stakeholders saw the primary benefit of collaboration as being able to better serve the community and meet community needs long-term. They saw communication between organizations as creating more seamless referrals and linkage between providers.

They shared that collaborating allows organizations to “**extend their reach,**” noting that no one organization can meet every need.

“I think collaborations are really great in general. I'm a social worker by training, so I believe in systems. I think that it's very-- I don't think there's an organization or a body that can do everything. That can provide every single service for clients. I think that's very rare to see that. Collaboration is really key. It's been really nice to see partnerships around the community.” – Community Stakeholder

They noted that bringing the right people to the table to collaborate is important, recommending that **direct service providers** be involved in collaborations and not just executives who may not work as closely with the community. These collaborations should focus on **relationship building**, which will promote trust. Collaborations developed simply for the financial incentives can lack trust and relationships.

“That’s always been something that foundations want to do, really encourage collaboration. I’ve actually seen the times that it works best is actually not when you-- I mean you can encourage it with money for sure. That will make that happen, but you can’t buy trust. When I’ve actually seen the true kind of mergers happen, I feel like the funding interventions have been around cohorts coming together. Thing’s that you’re building trust among or between organizations and you’re not saying you must collaborate, but the collaboration comes as an outcome of the trust.” – Community Stakeholder

While small-scale collaborations are easier to do, they recommended thinking about more **formal collaborations** through merging organizations or leadership. This is where large scale changes can happen.

“I think on the smaller ways we do that, generally, we’re a collaborative culture in Sonoma County but you can only do so much through meetings and convenings, which it’s really different than becoming one organization which I feel like that’s when the true difference can happen is if you can actually formally collaborate.” – Community Stakeholder

Collaborations should consider happening **across sectors**, recognizing that most community needs are intersectional. For example, the economy, housing, and health are all interconnected. To encourage these collaborations, there needs to be more **communication**. Through communication, organizations can get out of their “bubble” and break down silos that easily form. Additionally, communication builds relationships, which promotes helping one another and moves away from simply **competing for funding**.

“I think that organizations continue to go back to the same well, and we just need to communicate better about what our intentions are. I think part of it might be that there’s just inherent competition around funding. I think the competition is part of the challenge. If we could move beyond the financial aspect of it, even though there tends to be a financial benefit if you collaborate funders like that, so that’s a nice secondary gain, but we’re doing this in service of the clients. For community-based organizations, social service entities. We have to be mission-driven.” – Community Stakeholder

Collaborations need to be **mission-driven** instead of focused on self-interest. By aligning with other organizations with similar missions and staying focused on the community-based goals, organizations can move away from simply competing for funds or trying to better their organization.

“It takes a collective reframing of what it is that we’re here to do. That we have to be mission-driven. That we’re here in service of the clients and keeping that at the forefront of everything that we do, and of the decisions that we make. The policy decisions that we

make, how we go about our procedures. I think that can get lost in the day to day, especially, with nonprofits that are struggling for finances, when we're all competing for the same grant.” – Community Stakeholder

Other recommendations included having clear, **measurable outcomes** and leveraging evidence-based practices. Stakeholders emphasized a need to hold one another **accountable** and really ensure organizations are having the effect on community needs they are hoping for.

“I just think it's important that we recognize that we can throw a lot of money at a lot of great sounding programs, but if they don't have these proven outcomes, I think that there is a need to really understand the goal and hold the nonprofits and our funders accountable to meeting those goals.” – Community Stakeholder

Stakeholders shared the following barriers to working together:

- **A lack of trust:** Organizations that collaborate simply for the financial incentives without first building relationships and trust often will not be as successful.
- **Competition for funding:** With limited funding options, organizations are sometimes forced to compete against one another, making communication and relationship-building more difficult.
- **Lack of workforce capacity and no paid staff on collaboratives:** Stakeholders spoke to the challenges of completing the administrative tasks of a collaborative, such as sending meeting invitations, when organizational staff are already stretched to their limits and no one is formally assigned to that work.
- **Barriers to data sharing:** Different organizations use different technology and have different data sharing policies. They described sharing data and ensuring their clients’ privacy as another logistical barrier to effective collaboration.

Stakeholders described the following opportunities for collaboration in Sonoma County:

- **Large scale community challenges, such as health equity, antiracism, and behavioral health:** Stakeholders shared they see a need for many organizations to work together to address these community needs, with the goal of pooling resources and leveraging the expertise of different partners. They shared examples such as the Latino Scorecard, the Regional Behavioral Health Integration Project, and the Sonoma County Resilience Collaborative.
- **Schools and health care:** Stakeholders saw a need for more collaboration between local schools and health care organizations. Specifically, they would like to see resource centers and health care services located on campuses, even if just for pop-up dental cleanings or clinics.
- **Holistic case managers:** Stakeholders noted the importance of having case managers in health care settings who can support clients with food assistance, income, etc. They saw this role as really linking community resources and providing support to the family as a whole instead of just addressing one issue.

“To me, this is really the kind of case management that we always wanted to have, where you're addressing the concern of the whole family and not just the singular issue that is presented at that time for that individual regardless of what is going on in the family. To me, I see that as not only the appropriate kind of case management and support, but I think where the future needs to go. Where we're really taking a holistic approach and linking a support system.” – Community Stakeholder

- **Structural and upstream changes.** Stakeholders emphasized a need to invest resources in “upstream” solutions and really start to think about making systems more self-sustainable. They noted community capacity building is one way to do this. While they acknowledged it is easier to focus on immediate needs, focusing on prevention will have long-term benefits. Organizations need to hold themselves accountable to investing in prevention and not cut those services as soon as other needs arise.

I think we've got to look at the institution level, and then at the organizational level. I actually, I see a lot more coordination and that's where I think we can reimagine a new kind of community supports both at the individual family and community level... We've talked a number of years ago about what would it look like if we were to promote a self-healing community where we're actually investing in families using their own power to build community, to access resources, to have a strong social network, to build social capital and not be dependent on the institutions that are brokers of that goodwill? We have to invest in community, and not necessarily in the institutions that profit from serving the community.” – Community Stakeholder

I think the biggest barrier just as an overarching system's piece is that we don't truly walk our talk as a community around prevention and around really investing upstream. We are so consumed-- rightly so, of course, with addressing our serious safety net issues, our homelessness issue, our chronic and persistent mental illness, that's the unmet need, that we aren't shifting investments to prevention. I think that's just an overriding barrier because if we're the ones that are supposed to be building this system and investing in the system and prioritizing prevention, and we've got upstream investments, that's what that was supposed to be all about and yet when we have a disaster, when we have a pandemic, when we've got economic downturn, all resources flow to addressing safety net.” – Community Stakeholder

- **First responders and social service agencies:** Stakeholders shared first responders often have insight into people’s homes and needs and the ability to connect them to social service providers. They noted a need for better relationships and more collaboration between first responders and social service agencies.

“If we disband and tear apart our first responders, we are going to be in big trouble. To me, there's this, A, a need to figure out how we work better, and the police department now, if they get called to a house and there's what could be a domestic disturbance, they go and

they knock on the door and they find out that maybe, yes, there's some needs that aren't being met. If nobody's going to get arrested, what they do is they hand the recipient a card that says, 'Call PPSC, here's a list of all the services, but you just need to talk to the receptionist and she can figure out what it is you need, whether you need family counseling or your son needs a job,' all of those things. That's as close to emergency services outside of anything that happens in our community." – Community Stakeholder

Stakeholders shared that while the **COVID-19 pandemic** has brought organizations together and encourage collaboration, there is still room for improvement. Specifically, they saw a need to better integrate efforts to address health care needs and the economic impacts of the pandemic collectively.

"Again, our vulnerable populations have just been so incredibly impacted. This was true before COVID, but it's even more so now. Again, I'm inspired by the collaboration. I'm inspired by really looking to work together in an incredibly intentional way. I do think that there is a silver lining, an upside to this that we're starting to work more effectively and collaboratively as a community to address some these issues." – Community Stakeholder

"For example, the health piece needs to be better integrated with the economic piece, so that we have to both address the immediate healthcare needs, and understand how to best roll out and support the economic segments of our community, and thinking about how best to support the individuals in accessing services." – Community Stakeholder

LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. All sessions were conducted virtually which has its limitations in fostering group conversation.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you describe your organization's role within the community?
2. How would you describe the community your organization serves? Please include the geographic area.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Can you prioritize these issues? What are your top concerns?

5. Using the table, please identify the five most important “issues” that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?
8. Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.
9. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.
10. What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health-related needs you identified earlier? Can you rank them in terms of effectiveness?
11. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
12. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important “issues” that need to be addressed to make your community healthy (1 being most important).

	Aging problems (e.g. memory/ hearing/ vision loss)		Access to oral health care
	Air quality (e.g. pollution, smoke)		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/ verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/ neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/ recreation

	Gang activity/violence		Behavioral health challenges and access to care (includes both mental health and substance use disorders)
	HIV/ AIDS		Poor quality of schools
	Homelessness/ lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to health care services		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other:

Appendix 3: Community Resources Available to Address Significant Health Needs

Santa Rosa Memorial Hospital and Petaluma Valley Hospital cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Apx 3_ Table 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Hospital	Sutter Santa Rosa Regional Hospital	Primary medical care services	30 Mark West Springs Road, Santa Rosa, CA 95403	Access to Care Health Care
Hospital	Kaiser Permanente	Primary medical care services	401 Bicentennial Way, Santa Rosa, CA 95403	Access to Care Health Care
Federally Qualified Health Center	Santa Rosa Community Health	Primary medical care services	3569 Round Barn Circle, Santa Rosa, CA 95403	Access to Care Health Care
Community-based, faith-based nonprofit organization	Catholic Charities of the Diocese of Santa Rosa	Shelter, housing, and homeless services	987 Airway Court, Santa Rosa, CA 95403	Housing Instability and Homelessness
Community-based nonprofit organization	The Committee on the Shelterless (COTS)	Shelter, housing, and homeless services	900 Hopper St, Petaluma, CA 94952	Housing Instability and Homelessness

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Community-based, faith-based nonprofit organization	The Society of St. Vincent de Paul, District Council of Sonoma County	Shelter, housing, and homeless services	5671 Redwood Drive, Rohnert Park, CA 94928	Housing Instability and Homelessness
Community-based nonprofit organization	Buckelew Programs	Counseling, therapy, case management, and service navigation services	2300 Northpoint Pkwy, Santa Rosa, CA 95407	Mental Health & Substance Use Disorders
Community-based nonprofit organization	West County Community Services	Counseling, therapy, case management, and service navigation services	16390 Main St, Guerneville, CA 95446	Mental Health & Substance Use Disorders
Community-based nonprofit organization	Petaluma People Services Center	Counseling, therapy, case management, and service navigation services	1500 Petaluma Blvd S, Petaluma, CA 94952	Mental Health & Substance Use Disorders
Community-based nonprofit organization	La Luz Center	Multiple social services targeting the Latino/a communities in the Sonoma Valley	17560 Greger St, Sonoma, CA 95476	Health Equity
Community-based nonprofit organization	Community Action Partnership of Sonoma County	Multiple social services targeting the Latino/a communities	141 Stony Circle, #210, Santa Rosa, CA 95401	Health Equity

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
		throughout Sonoma County		
Community-based nonprofit organization	Nuestra Cultura Cura Initiative “La Plaza”	Multiple services aimed at raising awareness and reducing mental health stigma by implementing innovative culturally defined practices to address mental health needs in the Latino/a community.	850 W 9 th Street, Santa Rosa, CA 95401	Health Equity

Appendix 4: St. Joseph Health, Sonoma County, Community Benefit Committee

Apx 4_Table 1. Community Benefit Committee Members

Name	Title	Organization	Sector
Debbie Meekins		Board Member, SRMH	
Jim Carr		Board Member, PVH	
Efren Carillo	Director of Government & Community Relations	Burbank Housing	Affordable Housing
Sister Karen Clock	Sister, Sisters of St. Joseph of Orange	Board Member, SRMH	
Jeannette Currie, MD	President	St. Joseph Health Medical Group	Healthcare
Karin Demarest	Vice President for Programs	Community Foundation of Sonoma County	Philanthropy
Jeff Kolin		Board Member, SRMH	
Angie Dillon-Shore	Executive Director	First 5 Sonoma County	Public Health
Jason Cunningham, DO	Chief Executive Officer	West County Health Centers	Healthcare
Bruce Okrepkie		Board Member, SRMH	
Joanne Ferris		Board Member, PVH	
Tyler Hedden	CEO, President	Santa Rosa Memorial Hospital	Healthcare

Appendix 5: Quantitative Data

HEALTH INDICATOR SOURCES

Apx 5_ Table 1. Data Sources for Health Indicators

Indicator	Data Source
Socioeconomic Indicators	
Median Household Income	County Health Rankings, 2018
Children eligible for free or reduced lunch (enrolled in public schools)	County Health Rankings, 2017-2018
Children in poverty	County Health Rankings, 2018
Veteran status	American Community Survey, 2018
Physical Environment	
More than 1 occupant per room	American Community Survey, 2018
Severe housing problems	County Health Rankings, 2012-2016
Pollution Burden	California Health Interview Survey, 2008-2012
Air pollution- particulate matter	County Health Rankings, 2014
Violent crimes (rate per 100,000 inhabitants)	County Health Rankings, 2014 and 2016
Health Outcomes	
Self-reports of fair or poor health (age-adjusted)	County Health Rankings, 2017
Self-reports of fair or poor health (ages 65+)	California Health Interview Survey, 2016
Asthma in children (ages 1-17)	California Health Interview Survey, 2016
Asthma in adults (ages 18+)	California Health Interview Survey, 2016
Diabetes in adults (ages 18+)	California Health Interview Survey, 2016
Heart disease (ages 18+)	California Health Interview Survey, 2016
Serious psychological distress (ages 18+)	California Health Interview Survey, 2016
Health Behaviors	
Overweight (ages 2-11)	California Health Interview Survey, 2016
Overweight or obese (ages 12-17)	California Health Interview Survey, 2016
Obese (ages 18+)	California Health Interview Survey, 2016
Sugary drink consumption (ages 18+)	California Health Interview Survey, 2016
Regular physical activity (ages 5-17)	California Health Interview Survey, 2016
Youth alcohol/drug use in the past month (7 th grade)	California Health Kids Survey and California Student Survey, 2011-2013
Youth alcohol/drug use in the past month (9 th grade)	California Health Kids Survey and California Student Survey, 2011-2013
Youth alcohol/drug use in the past month (11 th grade)	California Health Kids Survey and California Student Survey, 2011-2013
Current smoker (ages 18+)	County Health Rankings, 2017
Clinical Care	
Uninsured (ages 0-17)	County Health Rankings, 2017
Uninsured (ages 18-64)	County Health Rankings, 2017
First trimester prenatal care	California Department of Public Health, 2012

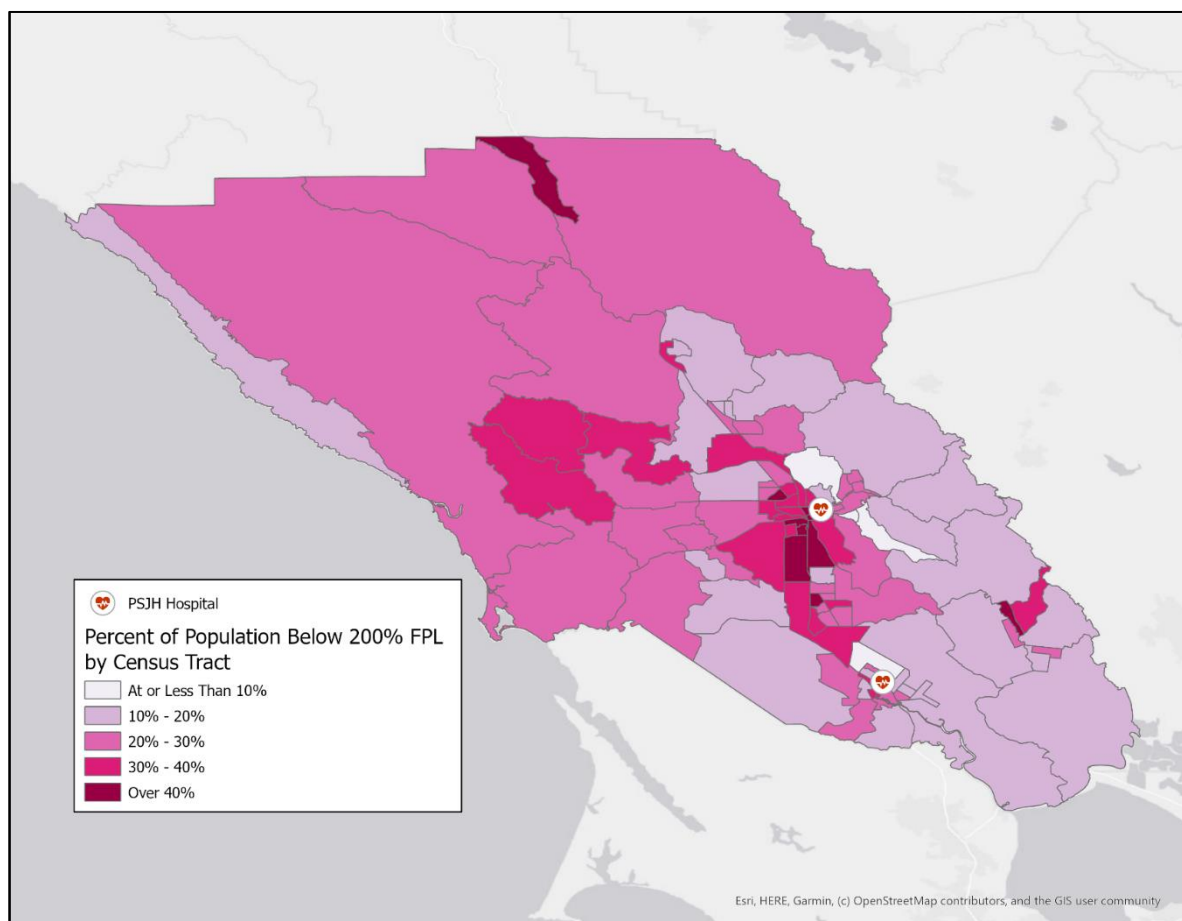
# of people per primary care physician	County Health Rankings, 2017
# of people per non-physician primary care provider	County Health Rankings, 2019
# of people per dentist	County Health Rankings, 2018
# of people per mental health provider	County Health Rankings, 2019

POPULATION LEVEL DATA

Apx 5_Table 2. Population Below 200% FPL for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population Below 200% Federal Poverty Level	19.5%	34.7%	26.3%
Data Source: American Community Survey			
Year: 2019			

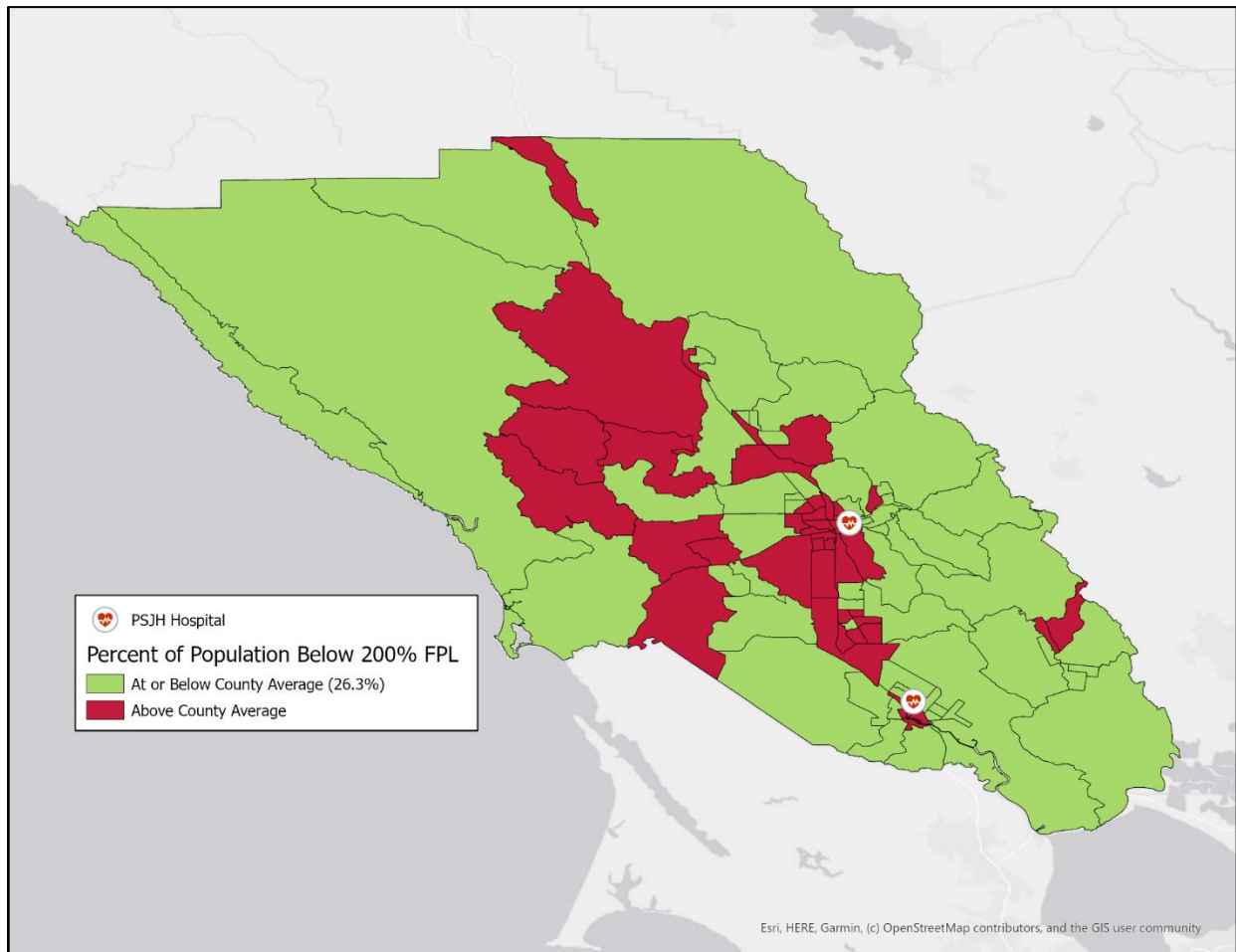
Apx 5_Figure 1. Percent of Population Below 200% FPL by Census Tract



- The high need service area has a substantially larger proportion of population living below 200% FPL, 35%, compared to Sonoma County, 26%.
- The gap is even wider between the high need service area, 35%, and the broader service area, 20%, when comparing percent of population living below 200% FPL.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

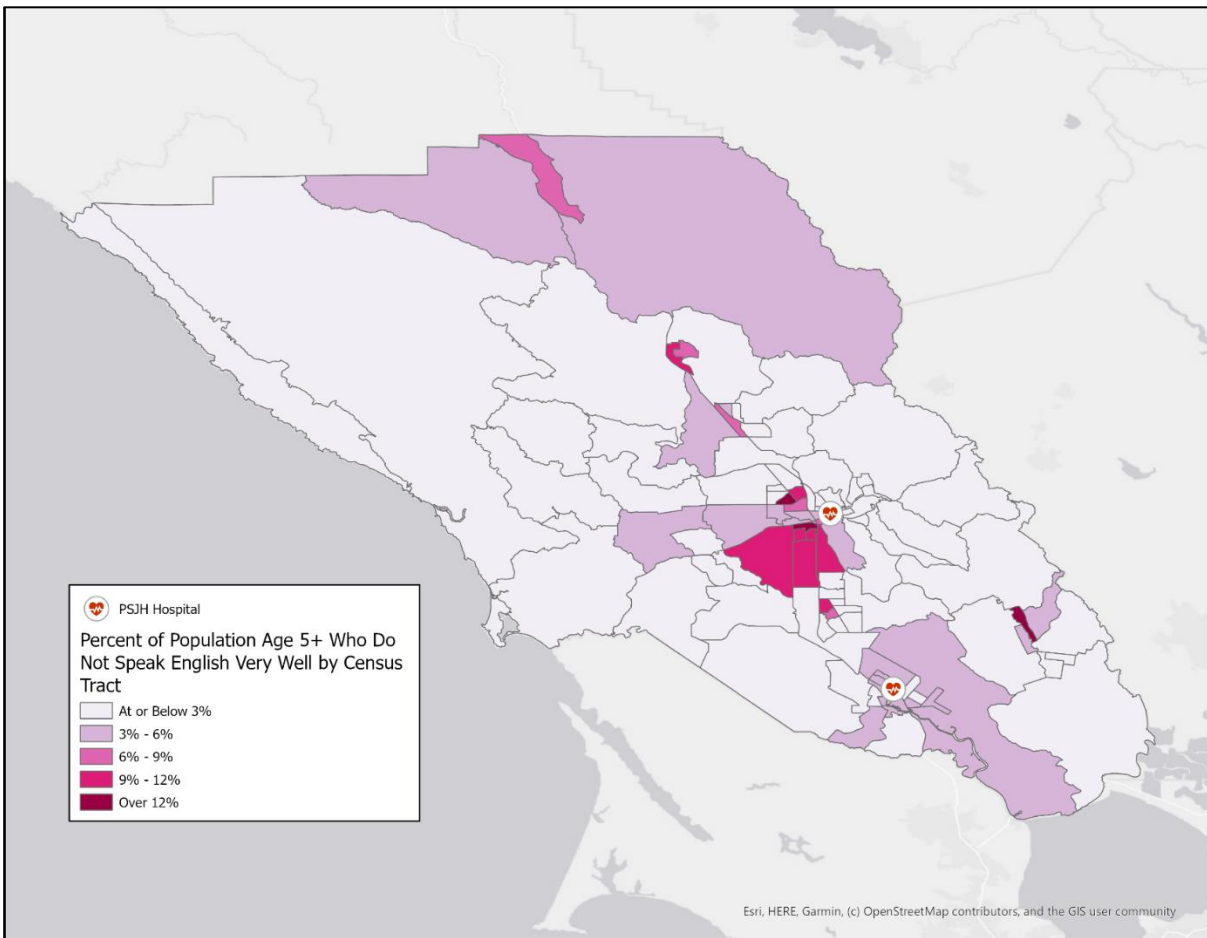
Apx 5_Figure 2. Comparison of Census Tracts to County Average Based on Percent of Population Below 200% FPL



Apx 5_Table 3. Population Age 5 and Older That Does Not Speak English Very Well for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population Age 5+ Who Do Not Speak English Very Well	2.2%	6.0%	3.9%
Data Source: American Community Survey			
Year: 2019			

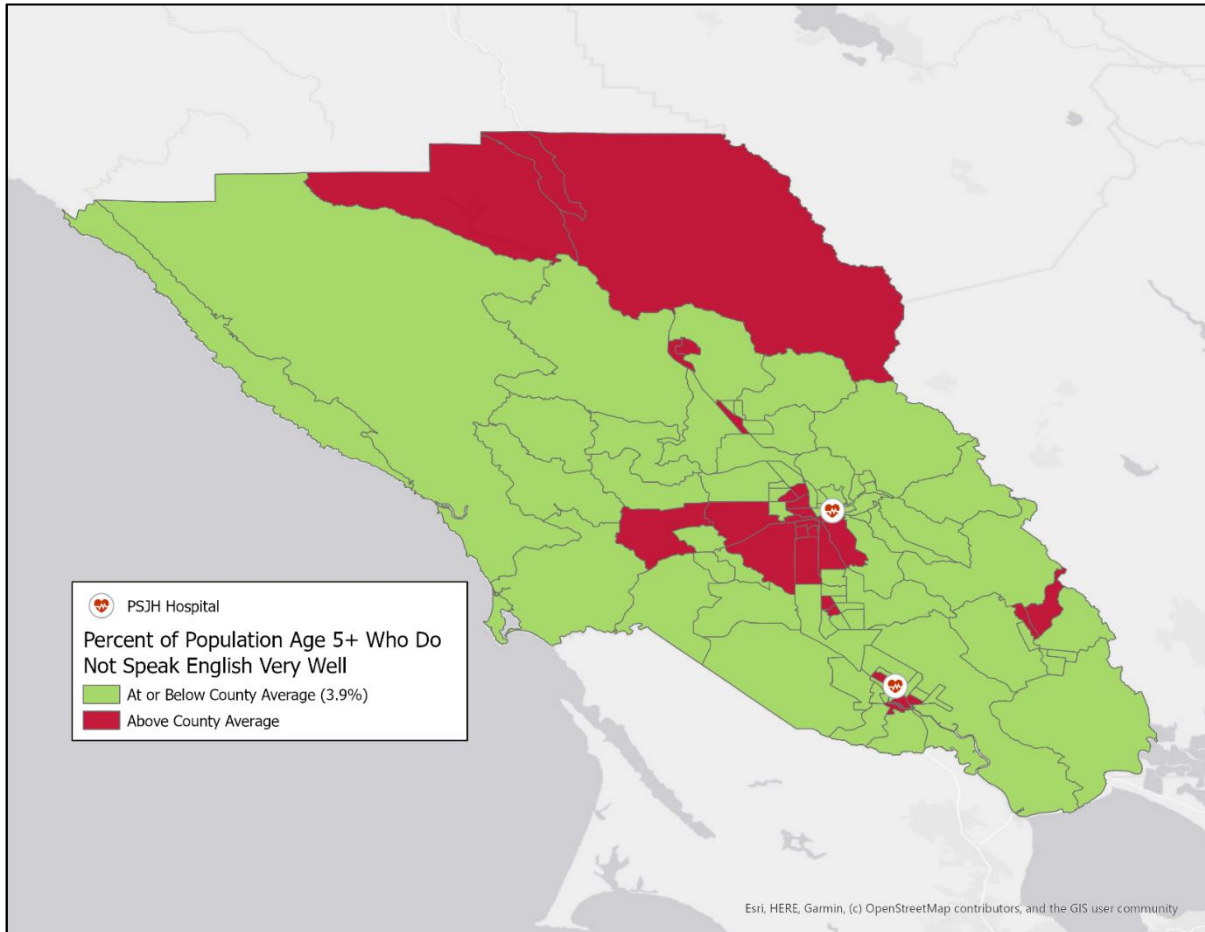
Apx 5_Figure 3. Percent of Population Age 5+ Who Do Not Speak English Very Well by Census Tract



Within Sonoma County there are three census tracts that have a percent of population who does not speak English very well that is over twice the benchmark for the high need service area. Those census tracts are indicated in dark pink in the map above. The dark pink census tract below Santa Rosa

Memorial Hospital has 20% of its population who do not speak English very well. In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

Apx 5_Figure 4. Comparison of Census Tracts to County Average Based on Percent of Population Age 5+ Who Do Not Speak English Very Well

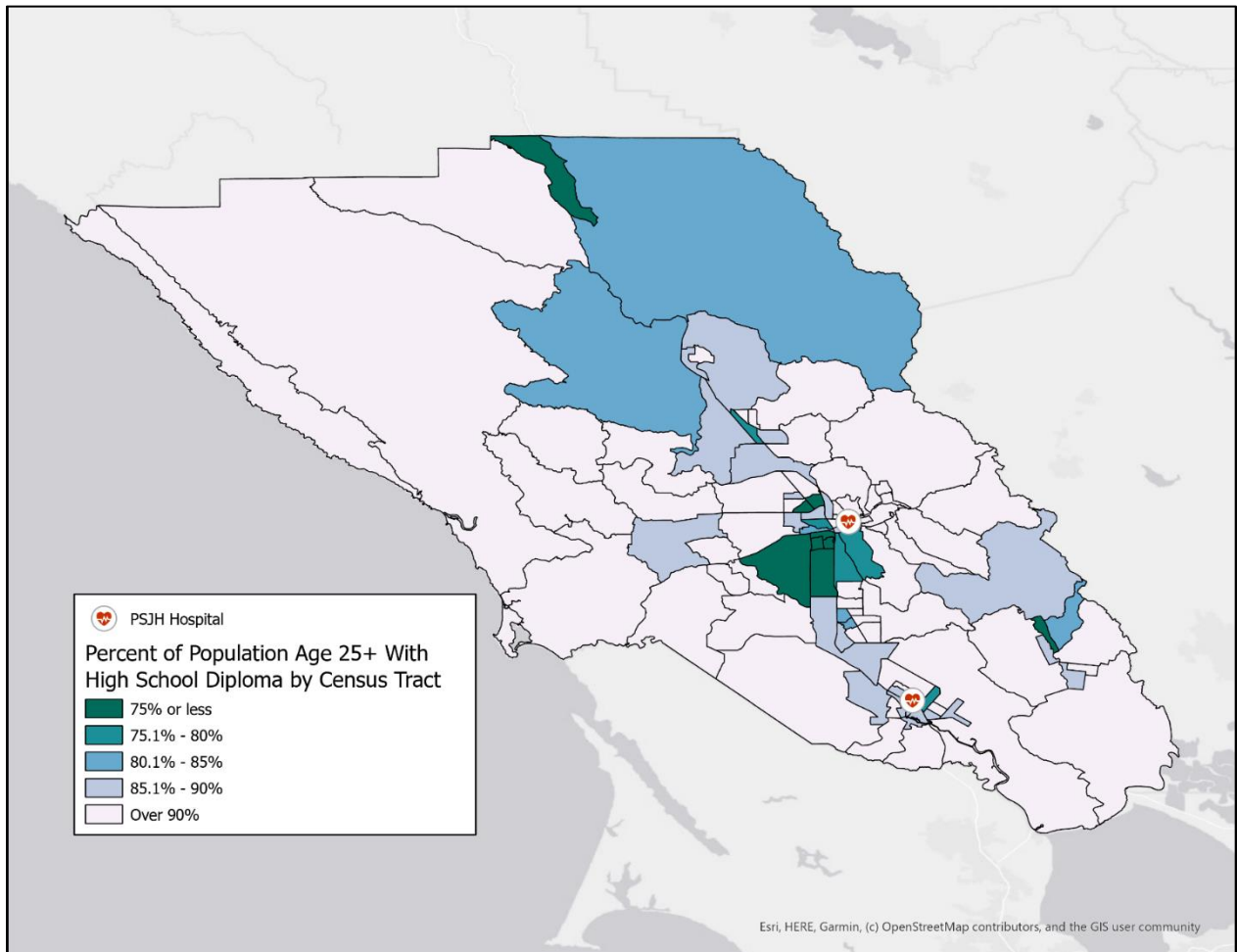


Apx 5_Table 4. Population with A High School Education for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population Age 25+ With A High School Diploma	93.2%	82.6%	88.7%
Data Source: American Community Survey			
Year: 2019			

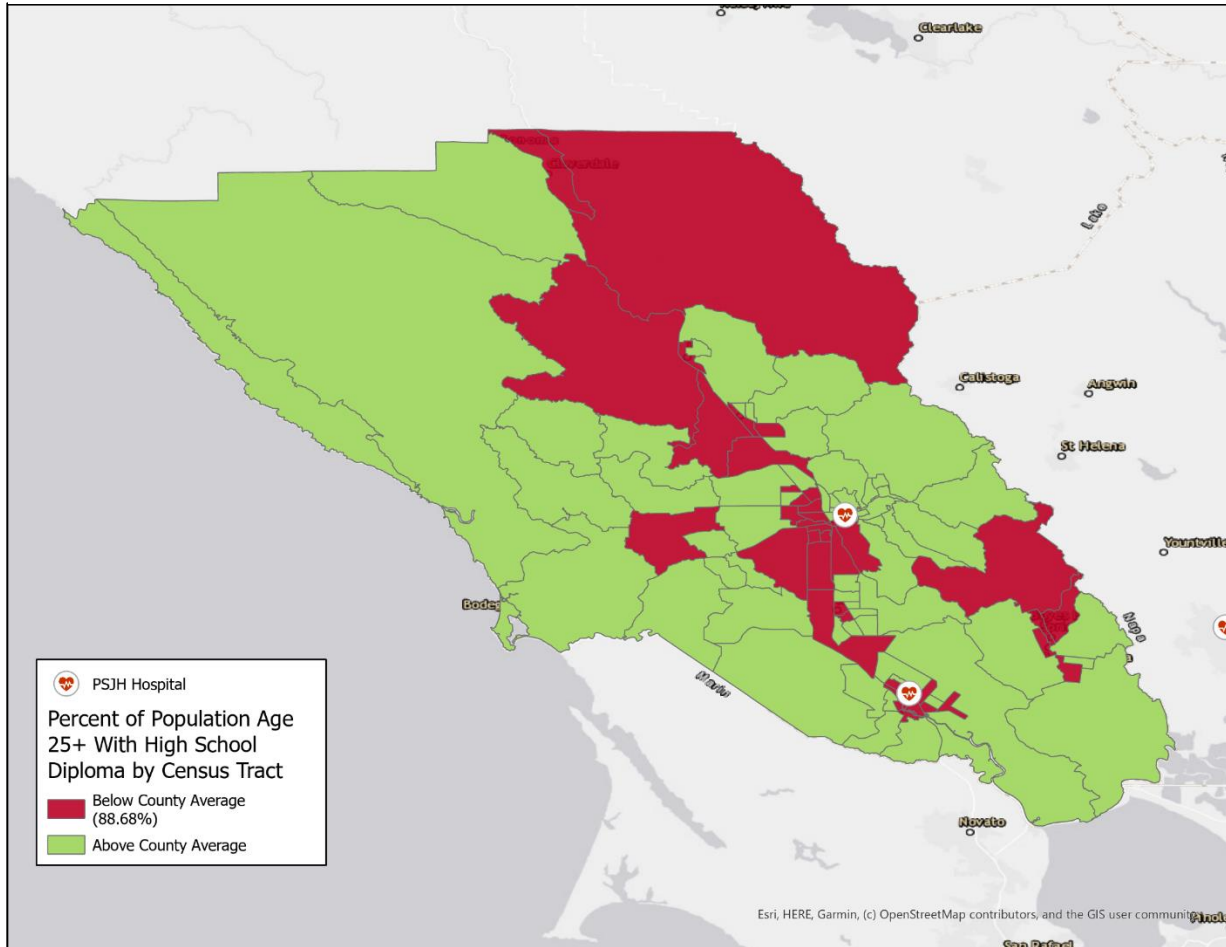
- About 83% of people living in the high need service area who are over 25 years have a high school diploma compared to 93% in the broader service area.
- In some census tracts within Sonoma County less than 75% of people over 25 years have a high school diploma.

Apx 5_Figure 5. Percent of Population Age 25+ with a High School Diploma by Census Tract



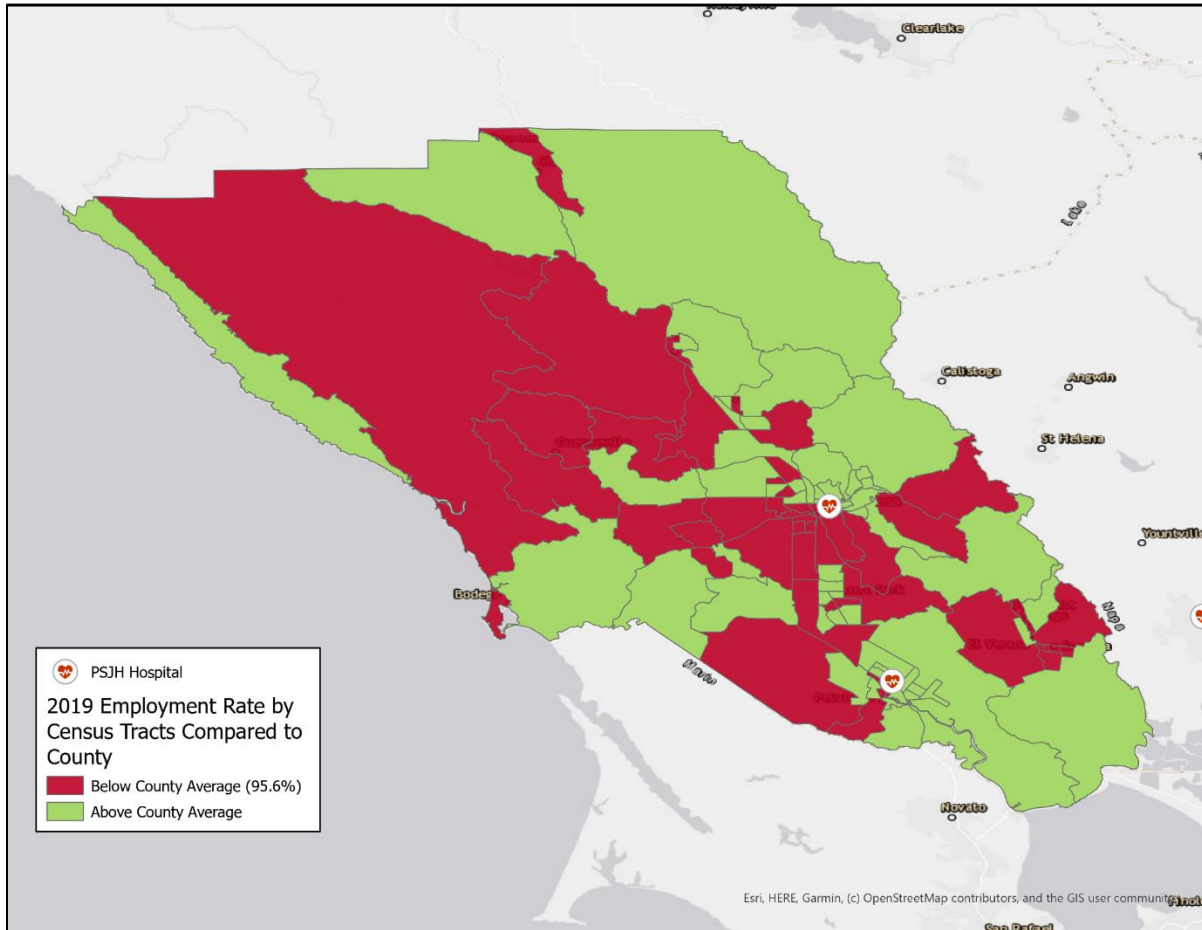
In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

Apx 5_Figure 6. Comparison of Census Tracts to County Average Based on Percent of Population Age 25+ with a High School Diploma



In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red

ApX 5_Figure 8. Comparison of Census Tracts to County Average Based on Percent of Population Age 16+ Employed in 2019

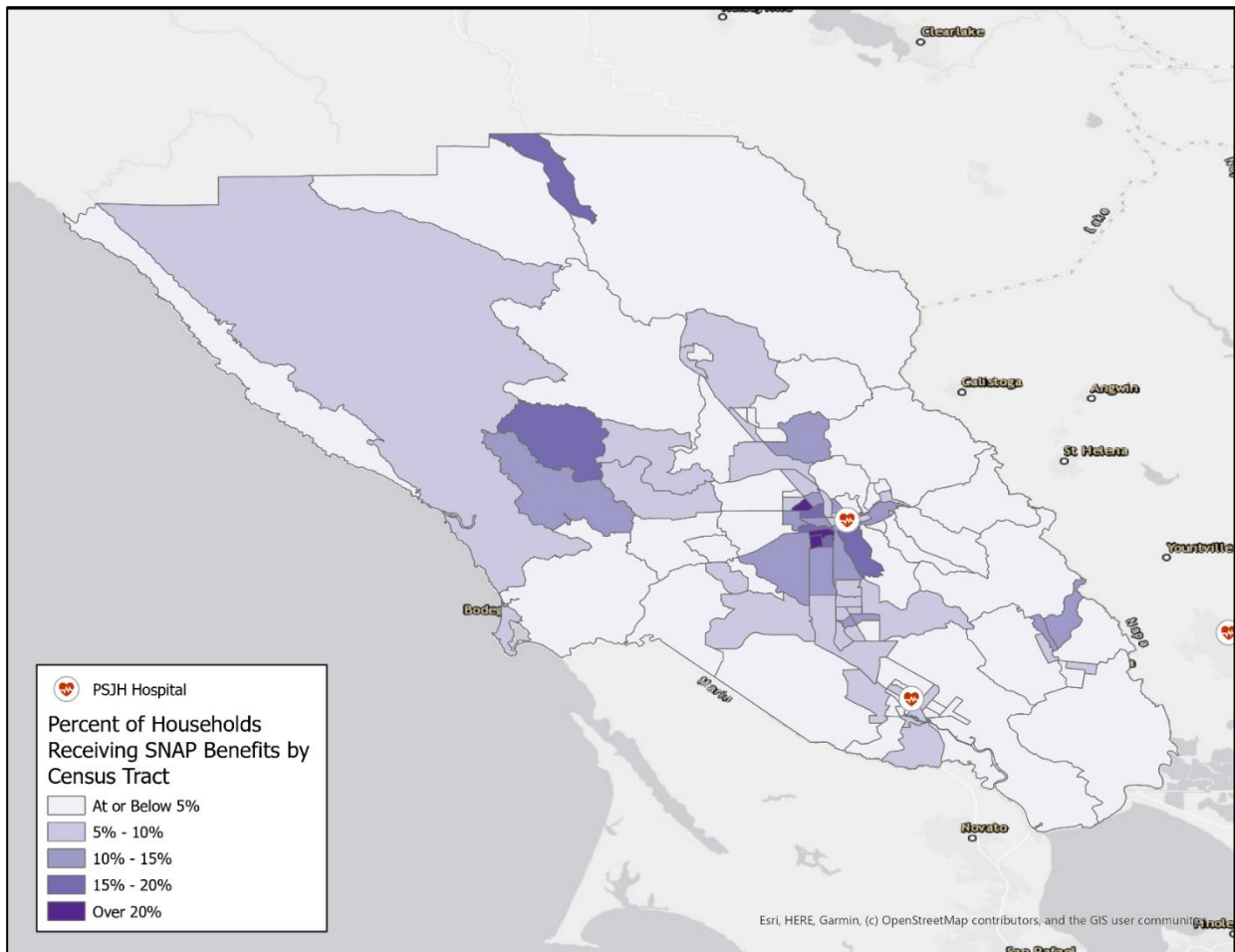


Apx 5_Table 6. Percent of Households Receiving SNAP Benefits for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Households Receiving SNAP Benefits	4.0%	10.8%	6.9%
Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data			

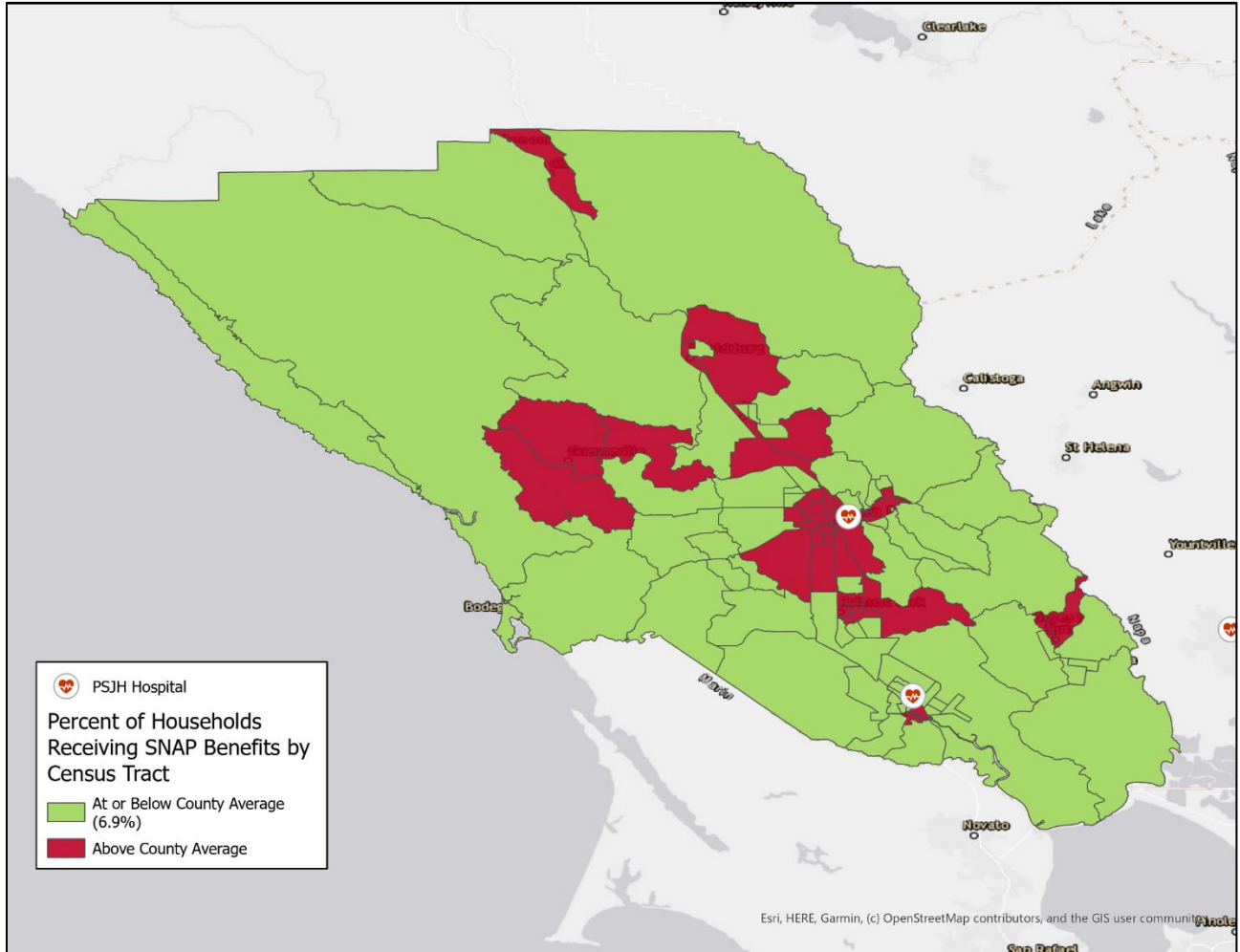
- The high need service has more than twice the percent of households receiving SNAP benefits as the broader service area.
- Three out of the ninety-nine census tracts in Sonoma County have more than 20% of households receiving SNAP benefits. One census tract has 27% of households enrolled in SNAP, the highest percentage in Sonoma County.

Apx 5_Figure 9. Percent of Households Receiving SNAP Benefits by Census Tract



In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

Apx 5_Figure 10. Comparison of Census Tracts to County Average Based on Percent of Households Receiving SNAP Benefits



HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Emergency department discharges for the year 2019 were coded as “avoidable” per the Providence St. Joseph Health definition for Santa Rosa Memorial Hospital, Petaluma Valley Hospital and nearby PSJH hospitals. Avoidable emergency department (AED) are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Apx 5_ Table 7. Avoidable Emergency Department Visits by Northern California Ministry

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
Queen ff The Valley Medical Center	16,902	8,188	25,090	32.6%
Redwood Memorial Hospital	7,458	4,307	11,765	36.6%
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
St. Joseph Hospital Eureka	16,880	11,307	28,187	40.1%
Grand Total	76,903	41,512	118,415	35.1%

Apx 5_ Table 8. Avoidable Emergency Department Visits by Facility and Race

Facility and Race	Non-AED Visits	AED Visits	Total ED Visits	AED %
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
Asian	432	219	651	33.6%
Black/African American	882	597	1,479	40.4%
Nat American/Eskimo/Aleutian	99	68	167	40.7%
Other	81	47	128	36.7%
Pacific Islander/Nat Hawaiian	88	67	155	43.2%
Unknown	48	18	66	27.3%
White	22,260	11,592	33,852	34.2%
(blank)	*	*	*	*
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
Asian	232	115	347	33.1%
Black/African American	251	180	431	41.8%
Nat American/Eskimo/Aleutian	14	7	21	33.3%
Other	323	164	487	33.7%
Pacific Islander/Nat Hawaiian	38	10	48	20.8%
Unknown	27	7	34	20.6%
White	10,876	4,615	15,491	29.8%
(blank)	*	*	*	*
Grand Total	35,663	17,710	53,373	33.2%

*Data suppressed if <10.

Apx 5_ Table 9. Avoidable Emergency Department Visits by Facility and Age Group

Facility and Age Group	Non-AED Visits	AED Visits	Total ED Visits	AED %
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
Under 18	3,762	1,919	5,681	33.8%
18 - 44	8,187	4,650	12,837	36.2%
45 - 64	6,156	3,741	9,897	37.8%
65+	5,793	2,300	8,093	28.4%
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
Under 18	2,080	953	3,033	31.4%
18 - 44	3,810	1,877	5,687	33.0%
45 - 64	2,838	1,230	4,068	30.2%
65+	3,037	1,040	4,077	25.5%
Grand Total	35,663	17,710	53,373	33.2%

Apx 5_ Table 11. Top 10 Zip Codes for Avoidable Emergency Department Visits at Santa Rosa Memorial Hospital

Facility and Top 10 Zip Codes	Non-AED Visits	AED Visits	Total ED Visits	AED %
Santa Rosa Memorial Hospital	23,898	12,610	36,508	34.5%
95407	3,505	2,006	5,511	36.4%
95401	2,579	1,339	3,918	34.2%
95404	2,582	1,330	3,912	34.0%
ZZZZZ	1,377	1,458	2,835	51.4%
95403	1,800	938	2,738	34.3%
95409	1,851	802	2,653	30.2%
94928	1,583	809	2,392	33.8%
95405	1,571	763	2,334	32.7%
95472	1,003	409	1,412	29.0%
95492	601	258	859	30.0%

- These top 10 patient zip codes made up 78.2% of all emergency department visits in 2019 for Santa Rosa Memorial Hospital and 80.2% of all AED visits.
- Patients with a zip code of 'ZZZZZ' are typically patients who are experiencing homelessness. Of the 2,835 ED encounters with a zip code of 'ZZZZZ', 1,377 of these encounters were classified as an avoidable visit. This population has the highest avoidable visit rate compared to all other zip codes, age groups and races.

Apx 5_Table 12. Top 10 Zip Codes for Avoidable Emergency Department Visits at Petaluma Valley Hospital

Facility and Top 10 Zip Codes	Non-AED Visits	AED Visits	Total ED Visits	AED %
Petaluma Valley Hospital	11,765	5,100	16,865	30.2%
94954	3,934	1,649	5,583	29.5%
94952	3,077	1,169	4,246	27.5%
94928	1,231	543	1,774	30.6%
ZZZZZ	312	306	618	49.5%
94931	349	171	520	32.9%
95407	245	110	355	31.0%
94951	217	103	320	32.2%
95476	200	70	270	25.9%
95472	140	65	205	31.7%
95404	123	56	179	31.3%

- These top 10 patient zip codes made up 83.4% of all emergency department visits in 2019 for Petaluma Valley Hospital and 83.2% of all AED visits.
- Patients with a zip code of 'ZZZZZ' are typically patients who are experiencing homelessness. Of the 2,835 ED encounters with a zip code of 'ZZZZZ', 1,377 of these encounters were classified as an avoidable visit. This population has the highest avoidable visit rate compared to all other zip codes, age groups and races.

Prevention Quality Indicators

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.

More info on PQIs can be found on the following links:

https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

Petaluma Valley Hospital had the highest rate of potentially avoidable hospitalizations in the PSJH Northern California service areas (207.06 per 1,000 visits). The top three PQIs for Petaluma Valley Hospital were the following:

1. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults: 44.41 per 1,000 visits
2. Heart Failure: 43.63 per 1,000 visits per 1,000 visits
3. Dehydration: 43.63 per 1,000 visits

Santa Rosa Memorial Hospital had a below average rate of potentially avoidable hospitalizations when compared to other PSJH Northern California service areas (148.65 per 1,000 visits compared to an average of 160.05). The top three PQIs for Santa Rosa Memorial Hospital were the following:

1. Heart Failure: 43.45 per 1,000 visits
2. Dehydration: 30.70 per 1,000 visits
3. Diabetes Composite (includes uncontrolled diabetes, diabetes short-term complications, and diabetes long-term complications): 24.58 per 1,000 visits

Apx 5_Figure 12. Map of Mental Health HPSA



Apx 5_Figure 13. Map of Dental HPSA



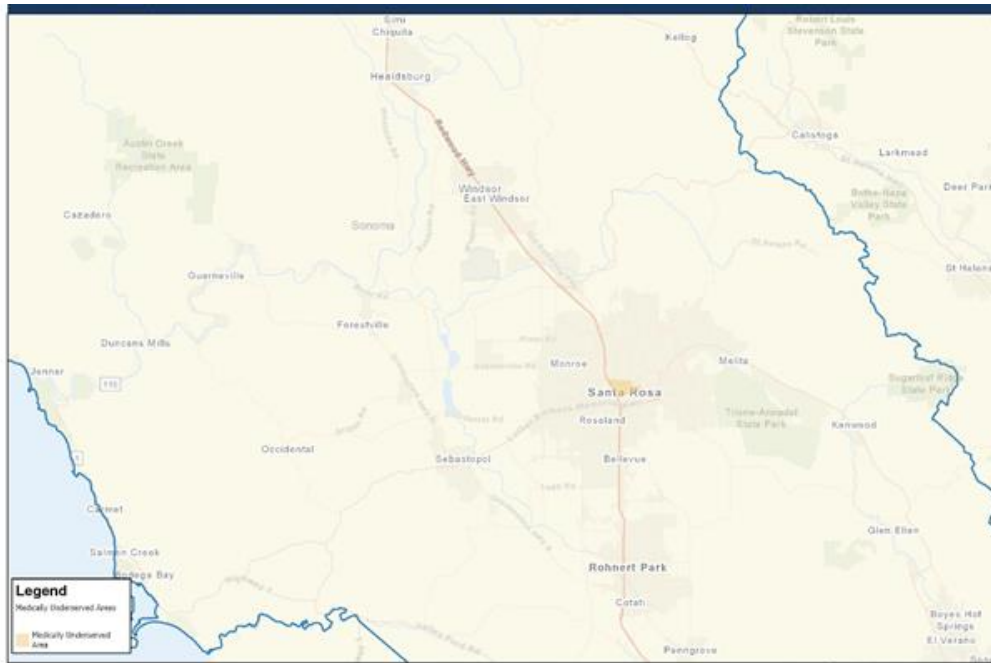
Apx 5_Figure 14. Map of HPSA Facilities



MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area’s level of medical “under service.” MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. Sonoma County has one MUA that does not include but is very close to Santa Rosa Memorial Hospital (Figure 5). There are five service areas in Sonoma County that are designated as MUP for low income populations that do not include the hospitals but are very close (Figure 6).

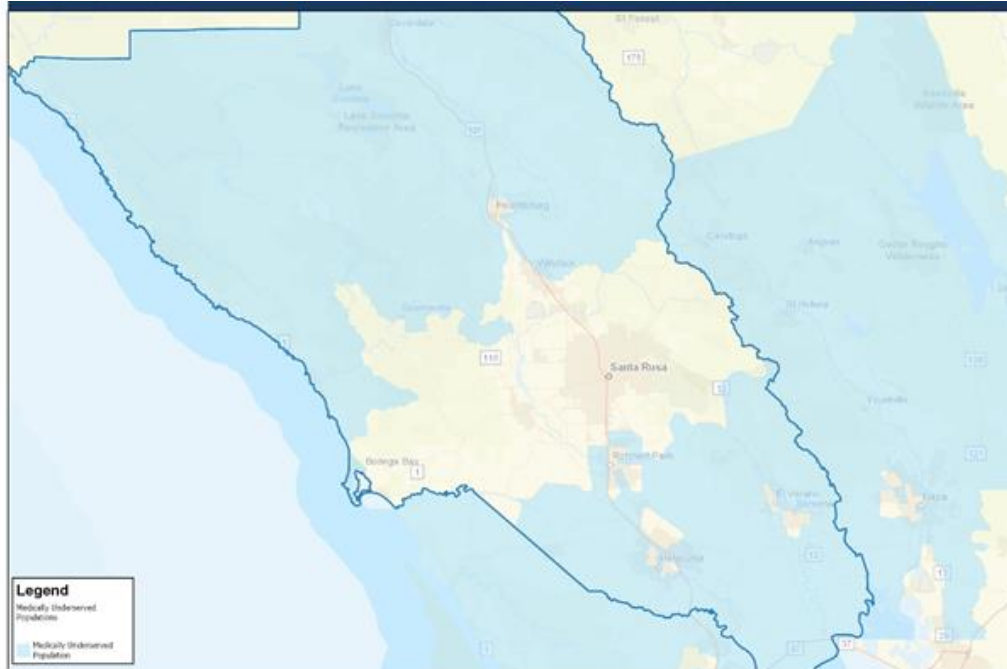
Apx 5_Figure 15. Map of Medically Underserved Areas



data.HRSA.gov

Prepared by:
Division of Data and Information Services
Office of Information Technology
Health Resources and Services Administration
Created on: 04/30/2020

Apx 5_Figure 16. Map of Medically Underserved Populations



data.HRSA.gov

Prepared by:
Division of Data and Information Services
Office of Information Technology
Health Resources and Services Administration
Created on: 04/30/2020

Appendix 6: 2019 Sonoma County Collaborative CHNA Fact Sheets

Sonoma County Community Health Needs Assessment

Access to Care

Access to quality health care is important for maintaining health, preventing disease, and reducing avoidable disability and premature death. Importantly, it is also one of the key drivers in 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 and a higher rate of federally qualified health centers, racial minorities and lower income individuals specifically face great challenges in obtaining affordable care. The county continues to work towards 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.

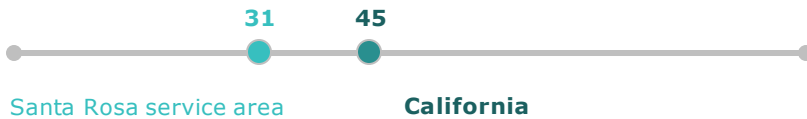
Key Data

Indicators

Uninsured population (under age 65)¹



Preventable hospital stays, Medicare enrollees (rate per 1,000)²



Primary care visits in the past year, Medicare beneficiaries³



Federally Qualified Health Centers (rate per 100,000)⁴



One issue for Sonoma County is, since the fires, it's very difficult to get medical appointments of any kind. They're overloaded.



- Key Informant

“The fear of accessing services has definitely been exacerbated in the last two years. Specifically since the new [presidential] administration.”

- Key Informant

Qualitative Themes



Physical Access/ Transportation

- Long wait times, higher demand post-2017 fires
- Long distances to travel for specialty care (e.g., mental health care)
- Long wait times to access a medical translator



System Navigation

- Language/cultural barriers (e.g., fear of deportation for accessing services)
- Lack of broadband access affects use of telemedicine for rural residents

Populations Disproportionately Affected

Populations with Greatest Risk

70% of Black Santa Rosa service area Medicare enrollees visited a primary care clinician at least once in the past year

77% of White Santa Rosa service area Medicare enrollees visited a primary care clinician at least once in the past year⁵

1/5

of Sonoma third graders have currently untreated cavities



Latino/a children have **3x** the rate of untreated cavities compared to non-Hispanic white counterparts.⁶

30%



of farmworkers have US-based health insurance

86%



of Sonoma County adults have US-based health insurance⁷

Geographic Areas with Greatest Risk

Many coastal communities have a lack of broadband connectivity. What that does is create challenges as far as telemedicine. Folks can't access medical services by internet if they don't have connectivity.

- Key Informant



Life Expectancy⁸

(Highest and lowest census tracts)

85 Years

- Central Bennet Valley
- Sea Ranch/Timber Cove

75 Years

- Downtown Santa Rosa
- Kenwood/Glen Ellen

Emerging Needs

Of the 10% of household that indicated difficulty accessing services during the October 2017 fires:

63% Had difficulties accessing medication

53% Had difficulties accessing medical services⁹

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season "fuel aridity" (i.e., drying flammable natural materials). In the western US, this has led to **9 additional days** per year of high fire potential.¹⁰

Affluent White Americans are more likely to live in fire-prone areas, but non-White communities are less able to adapt to a wildfire event. Communities that are majority Black, Hispanic or Native American are over **50%** more vulnerable to wildfires.¹¹

Examples of Existing Community Assets



Low cost or free community clinics



Public assistance programs (such as Medi-Cal)



Mobile health clinics that reach vulnerable/high-risk populations



Strong sense of community

Ideas from Focus Groups and Interview Participants

- Increase number of bicultural, bilingual service providers across services, especially mental health and other specialized services
- Expand existing peer mentorship and community health worker programs and resources that support system navigation
- Bring services directly to vulnerable/high-risk populations whenever possible, including mobile health clinics, information fairs, etc.
- Increase mental health professionals/counselors within schools
- Make clinics safer and more comfortable spaces for teens to access care on their own



1. Small Area Health Insurance Estimates. (2015).
2. Dartmouth Atlas of Health Care. (2012).
3. Same as above.
4. Small Area Health Insurance Estimates (2015).
5. Dartmouth Atlas of Health Care. (2012).
6. Sonoma County Dental Health Network | Strategic Plan 2017-2020
7. Sonoma County Farmworker Health Survey (FHS) 2013-14, CDC 2014
8. "A Portrait of Sonoma." (2014). Sonoma County Human Development Report.
9. Sonoma County Rapid Health Needs Assessment (CASPER). (2018).
10. "Impact of anthropogenic climate change on wildfire across western US forests." PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
11. Davies et al. (2018). "The unequal vulnerability of communities of color to wildfire." *Public Library of Science*.

Sonoma County Community Health Needs Assessment

Cardiovascular Disease, Stroke, and Tobacco Use

Cardiovascular disease (CVD) is the leading cause of death in the United States, and one of the top five causes of premature years of life lost across the regions of 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. It is the fourth leading cause of death both nationally and in Sonoma. The CDC estimates that 90% of CVD related conditions are preventable; in Sonoma, a greater focus on prevention could address the high disparities that exist in the region by race/ethnicity as well as regional patterns of inequity. Incorporating social determinants of health in prevention efforts is essential.

Key Data

Indicators

Ever diagnosed with heart disease¹



Percentage of adult population that smokes every day²



Ischemic stroke hospitalization rate, Medicare enrollees (rate per 1,000)³



Qualitative Themes



Complexities of cardiovascular health

- Stress and trauma related to high blood pressure and heart attacks
- Wildfire smoke increased risk of cardiovascular complications in general population



Evolving tobacco-related risks

- Concern over the changing tobacco industry and emerging threats (e-cigarettes)
- Changing technology makes identifying tobacco use more difficult for parents



For me, one of the biggest health priorities in the community is heart problems.

- Focus Group Participant [original in Spanish]

Sonoma County is starting to think more holistically about health...Really looking at how the stress of not having housing or, living in an environment where it's so expensive, how that affects things like cardiovascular health.

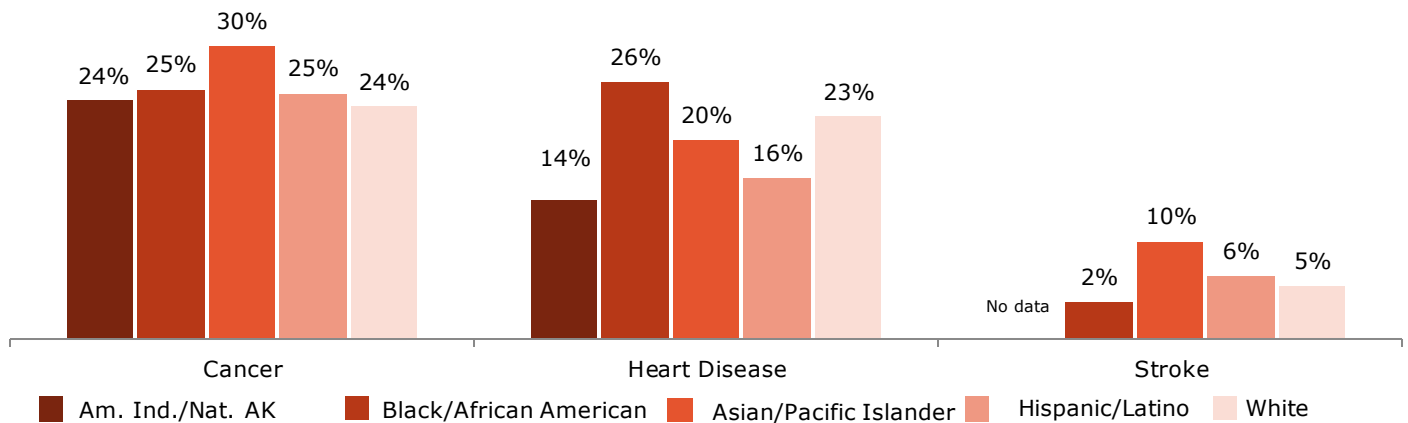
- Key Informant



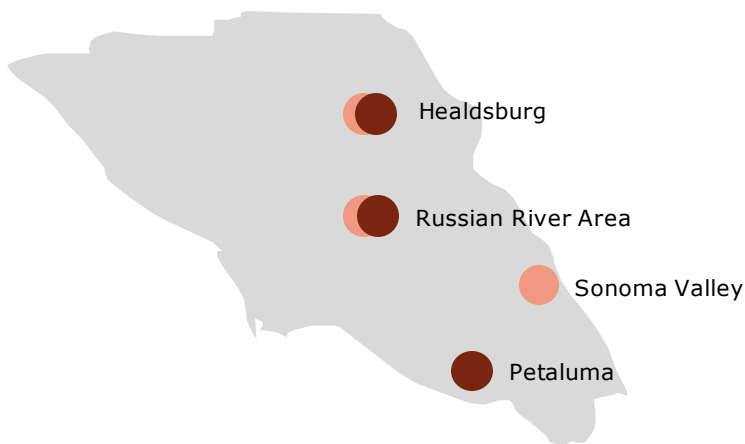
Populations Disproportionately Affected

Populations with Greatest Risk

Leading causes of death (**Cancer, Heart Disease, Stroke**) by race/ethnicity for 2013-15⁴



Geographic Areas with Greatest Risk



Mortality, percent of total deaths⁵

Cancer Deaths

(Highest and lowest areas)

- Russian River Area (**26%**)
- Sonoma Valley (**23%**)

Heart Disease Deaths

(Highest and lowest areas)

- Petaluma (**25%**)
- Healdsburg (**19%**)

Stroke Deaths

(Highest and lowest areas)

- Healdsburg (**8%**)
- Russian River Area (**4%**)

It is based on zip code, where you live, which neighborhoods are at greatest risk for cardiac disease. Low-income, rural and minority populations, primarily Latino communities are at greatest risk for cardiac disease.

- Key Informant

Emerging Needs

“E-cigarettes are an issue. It's just a new form that tobacco's taking hold, and more youth are using. Physicians need to adapt because the tobacco industry is changing so quickly. They often just ask, 'Do you use tobacco?', they don't ask if you vape.”
- Key Informant

Marketing towards children?

- Innocuous, bright and youthful packaging
- Flavors include:
 - Gummy Bear
 - Cotton Candy
 - Bubble Gum⁶



Between 2000-2015, vape usage rose from **1.5%** to **20.8%** among U.S. high school students and from **.6%** to **4.9%** among middle school students. This is sobering because the earlier you get people hooked on nicotine, the higher the likelihood they will be lifelong users.⁷

Examples of Existing Community Assets



Pop-up/mobile clinics to identify needs in hard-to-reach communities



Culturally appropriate cardiovascular health campaigns



Community centers that offer exercise classes



Public policy advocacy to limit sale of tobacco in all forms

Ideas from Focus Groups and Interview Participants

- Increase mobile health clinics that measure basic indicators of cardiovascular health (blood pressure, cholesterol, etc.)
- Mobilize community health workers/peer health network to help educate people to “know their numbers”
- Strengthen parent-child relationships to educate children about the risks of e-cigarettes



1. California Health Interview Survey (2015-17)
2. 2018 County Rankings (2016 BRFSS Data)
3. Interactive Atlas of Heart Disease and Stroke (2015)
4. California Department of Public Health, VRBIS Death Data 2013-2015
5. 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
6. “Teen Vaping on the Rise” Kaiser Permanente Look Inside (2018)
7. 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>.

Sonoma County Community Health Needs Assessment

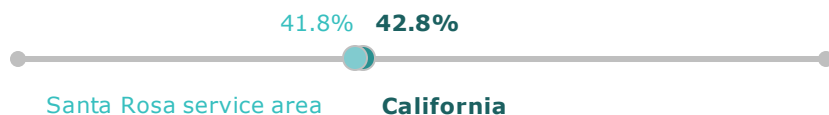
Economic Security

Economic security means having the financial resources, public supports, career and educational opportunities necessary to be able to live your fullest life. As such, this health need touches upon every other health-related issue in the Sonoma community from mental health to housing. While Sonoma has slightly less economic inequality than California as a whole, there is significant racial and regional variation along economic measures. Child poverty is especially high among Hispanic/Latino, Black, and Native American community members in the Santa Rosa service area. Non-Hispanic Whites in the county have higher wages and rates of business ownership. The October 2017 wildfires contributed to economic divergence between demographic groups, as the most vulnerable residents work in occupations (e.g., grape picking) affected by the fires.

Key Data

Indicators

Percent of households with costs exceeding 30% of income¹



Opportunity index (Measure of economic well-being, 100=max)²



Income inequality (Ratio of 80% income to 20%)³



Through work, I have the rock bottom health plan. And if something happens to you, you're on your own. We're not getting paid enough to make ends meet. My credit cards are just going up and up and up with healthcare costs. I don't know when I'm gonna be able to pay them off.

- Focus Group Participant

I hear people say depression is a luxury. We cannot get depressed. We have to keep working.

- Key Informant



Qualitative Themes



Income Inequality and Segregation

- Inequity between low and high-income areas affects cohesion of the community
- Lack of opportunity for children in low-income neighborhoods
- Sentiments of under-representation in politics



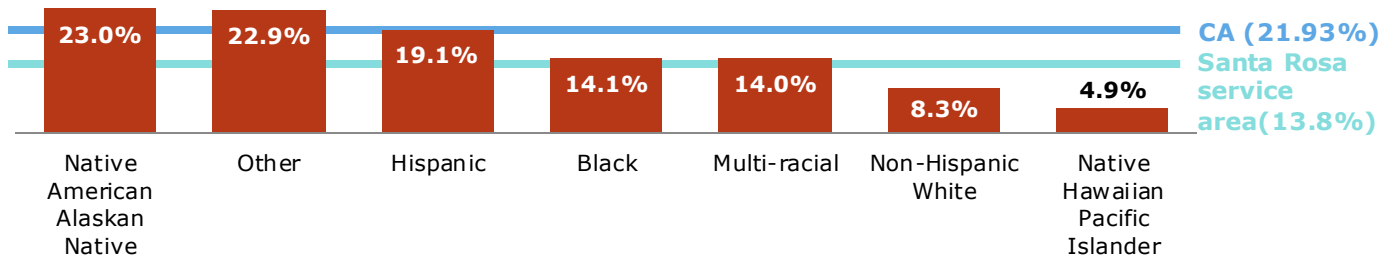
Financial and Social Barriers

- 2017 fires exacerbated financial struggles for already vulnerable populations
- Cost of housing, medical expenses are major stressors
- Fear of accessing social services among undocumented community members

Populations Disproportionately Affected

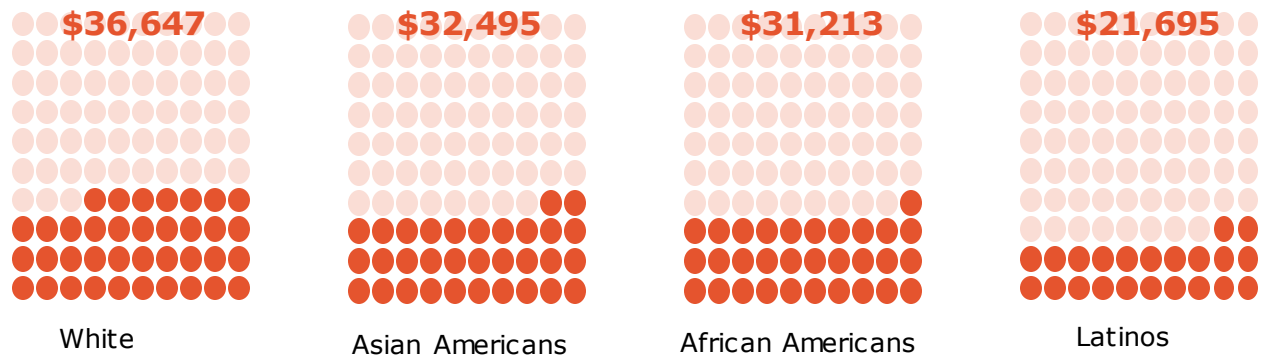
Populations with Greatest Risk

Children living below 100% of the federal poverty level⁴

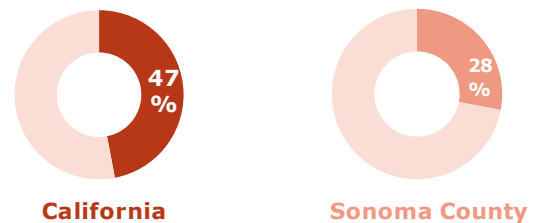


Median personal earning of households across Sonoma County⁵

In Sonoma County, Whites earn the most money, \$36,647 annually, followed by Asian Americans (\$32,495), African Americans (\$31,213), and Latinos (\$21,695).



In Sonoma County, **28%** of businesses are minority owned, compared to **47%** across the state.⁶



“ There are two very different communities in this county that people don't talk about. We see it, because we work in it. But I think that a lot of people who are not social service providers might not acknowledge that **there is a major gap between communities here.**

- Key Informant

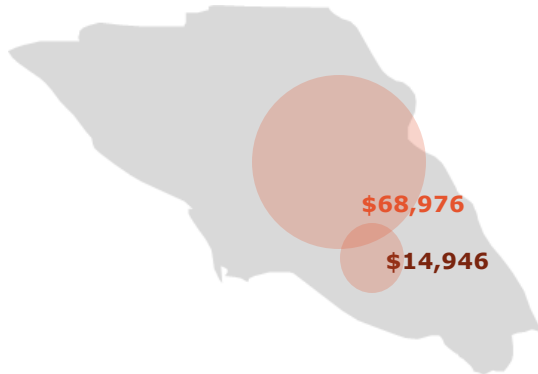
If you look where the rich people live, you don't see the same parks as what we have here in Roseland. There they have nicer parks, more after school programs for kids like painting, violin, dance, and here, we don't have that. We all pay taxes, we all work, we all deserve to have a good life.

- Focus Group Participant [original in Spanish]

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Annual earnings by census tract



Significant disparities in earnings separate census tracts within Sonoma County.

Annual earnings range from **\$14,946 in Rohnert Park B/C/R Section**, which is below the federal poverty line for a two-person household, to **\$68,967 in East Bennett Valley**, more than double the county median. ⁷

Emerging Needs

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season “fuel aridity” (i.e., drying flammable natural materials). In the western US, this has led to **9 additional days** per year of high fire potential. ⁸

Of the roughly **28,000 undocumented community members** who live and work in Sonoma County, some laborers who worked at affected vineyards after the fires **had fewer or no grapes to pick**; others **picked what was left in the vineyards without masks**, prompting an advisory from the state Occupational Safety and Health Administration. ⁹

“There's quite a few individuals and families that are still really, really struggling financially. The impacts of the fire on their jobs, their income, their rent was so much so that it's really put them in a more vulnerable position to stay here and survive economically.

- Key Informant

Other emerging needs relate to demographic change. **22%** of Sonoma County seniors age 65 and older **have incomes less than 200%** of the Federal Poverty Level. ¹⁰



Examples of Existing Community Assets



Low cost or free community clinics



Public assistance programs (such as Medi-Cal)



Partnerships among nonprofits to address complex issues related to economic insecurity



Community food banks/ pantries

Ideas from Focus Groups and Interview Participants

- Implement programs to help community members navigate complex social services and medical system
- Co-locate service providers to ease system navigation
- Increase broadband connectivity in rural areas
- Organize work/volunteering programs for youth
- Implement culturally appropriate peer counseling programs for vulnerable populations to address anxiety, trauma, and general mental health
- Increase reach of mobile medical clinics to meet high-risk populations directly
- Expand low-cost/free clinic services



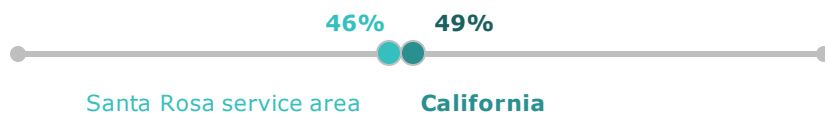
1. American Community Survey (2012-16)
2. Opportunity Nation (2017)
3. American Community Survey, five year estimates (2012-16)
4. US Census Bureau, American Community Survey, 1 Year Estimates, 2014 and ZTCA, 5 Year Estimates 2011-2015 Tables S1701, and S1501, C1501B-H
5. "A Portrait of Sonoma" Sonoma County Human Development Report 2014
6. US Census Quick Facts, <https://www.census.gov/quickfacts/fact/table/ca,sonomacitycalifornia,sonomacountycalifornia/SBO030212>
7. "A Portrait of Sonoma" Sonoma County Human Development Report 2014
8. "Impact of anthropogenic climate change on wildfire across western US forests." PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
9. *Northbay Business Journal*. <https://www.northbaybusinessjournal.com/industrynews/bankingandfinance/7520230-181/sonoma-napa-mendocino-fires-economic-impact>
10. Aging and Living Well in Sonoma County A Community Report from the Sonoma County Area Agency on Aging, 2012

Education has consequences for public 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 higher for Sonoma than the rest of California, in the Santa Rosa service area, only half of children attend preschool and two-in-five adults lack college education. In addition to the need for progress on these standard benchmarks, strong racial inequities persist in the school system. Racial minorities in the service area have lower rates of high school completion. Further, the proficiency gaps seen between Hispanic/Latino and non-Hispanic White students in early education persist throughout secondary school.

Key Data

Indicators

Preschool enrollment¹



Adults with some post-secondary education²



High school graduation rate³



I went to public school here and I had to transfer to a private school just to be able to have a chance at going to college.

- Key Informant

Programs must provide education to these individuals so they don't end up back in the cycle [of homelessness] again.

- Key Informant



Qualitative Themes



Educational inequity

- Unequal access to high quality early childhood programs, schools, and extracurricular enrichment

Need for career & technical education

- Would address local workforce needs and boost economic opportunity

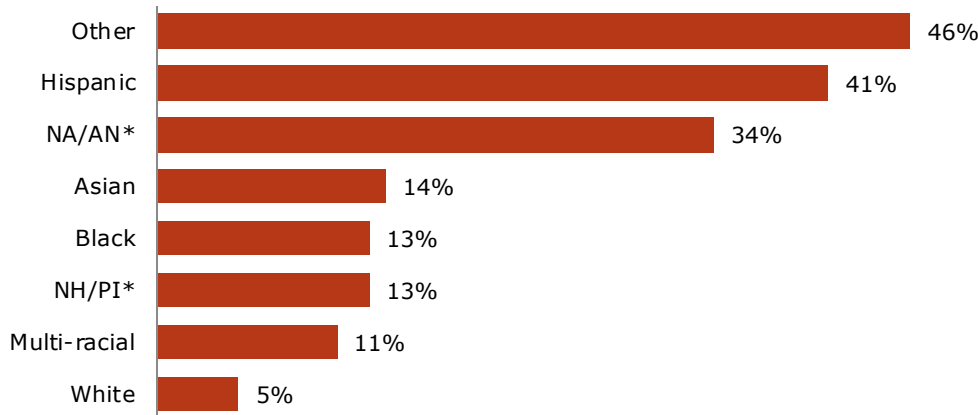
Need for community-based life-skills education

- Topics to cover include financial literacy, soft skills, ESL, parenting, and physical and sexual health

Populations Disproportionately Affected

Populations with Greatest Risk

Proportion of adults in the Santa Rosa service area with no high-school diploma⁴

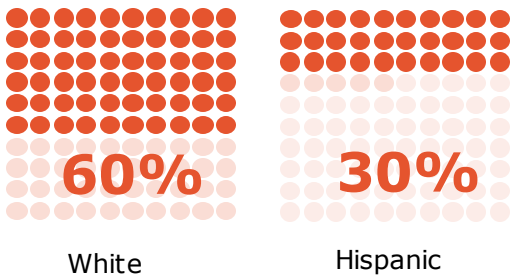


“The need for culturally competent education staff is a big issue. When all of your teachers are White, they don’t understand your culture, they don’t understand your language.”

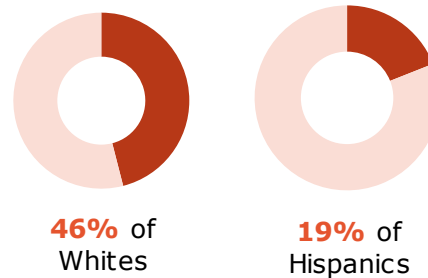
- Key Informant

* NA/AN refers to Native American and Alaskan Natives, and NH/PI refers to Native Hawaiian and Pacific Islanders.

Proportion earning proficient scores on 3rd grade literacy tests⁵

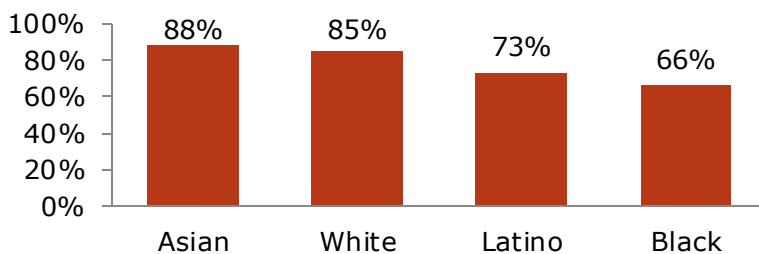


Proportion meeting or exceeding 11th grade math standards⁶

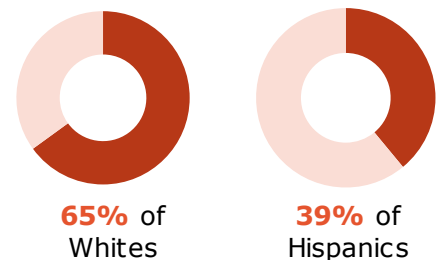


Of the **71,000** students enrolled in K-12 public schools, the majority are Hispanic/Latino (**45%**) or White (**43%**)⁷

Proportion of students to graduate on time by race/ethnicity⁸

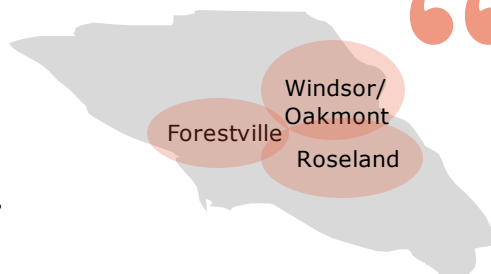


Proportion enrolled in pre-school⁹



Geographic Areas with Greatest Risk

Only **0.4%** of adults lack a high school diploma in **North Oakmont**, compared to **46%** in **Roseland**. **Forestville** has **54%** school enrollment, whereas **Windsor** has **100%**.¹⁰



“If you look where the rich people live, you don’t see the same parks as what we have here in Roseland. There they have nicer parks, more after school programs for kids like painting, violin, dance, and here, we don’t have that. We all pay taxes, we all work, we all deserve to have a good life.”
- Focus Group Participant [original in Spanish]

Examples of Existing Community Assets



Increased awareness of the importance of early childhood



Community-based education programs and partnerships



Financial and political capital that can be channeled to promote equity

Ideas from Focus Groups and Interview Participants

- Provide community and school-based education on life skills, health, and ESL, particularly for youth, immigrant communities, and people experiencing homelessness
- Increase mental health supports within schools, including evidence-based professional development for staff on behavioral health and trauma, school clinics, and community school models
- Pursue greater integration of diverse populations in schools and classrooms
- Ensure quality across schools by equitably distributing investment
- Increase access to culturally competent, bilingual educators
- Improve access to high-speed internet for youth in rural areas



1. American Community Survey (2012-16)
2. American Community Survey (2013-17)
3. EDfacts(2011-12)
4. American Community Survey (2012-16)
5. Educational and Workforce Development Report (2018)
6. Same as above.
7. Same as above.
8. Measure of America analysis of California Department of Education, DataQuest, 2011-12 school year
9. U.S. Census Bureau, American Community Survey, 2012, 5-year estimates.
10. "A Portrait of Sonoma" Sonoma County Human Development Report 2014

Healthy Eating, Active Living: Obesity and Diabetes

Nutritious food and an active lifestyle impacts 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. Although the 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. 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 fires in concurrence with increased economic and housing insecurity.

Key Data

Indicators

Diabetes prevalence¹

8.5% of total population in the Santa Rosa service area

8.37% in the state of California

Proximity to walkable destinations²

18.5% of total population in the Santa Rosa service area

29.03% in the state of California

Children living in food insecure households³

16.1% of total population in Sonoma County

19.1% in the state of California

Hunger and poor nutrition have all sorts of links to cognitive impairments, diabetes, obesity, depression, violence. There's no point in treating somebody for diabetes if they can't afford healthy food because that's just going to worsen their diabetic situation. And what could be more depressing than not being able to feed yourself or your family?

- Key Informant

Qualitative Themes



Barriers to active living

- Community members fear for their safety going to parks alone and with their children
- Interconnectedness of healthy lifestyle and mental health



Food insecurity and hunger

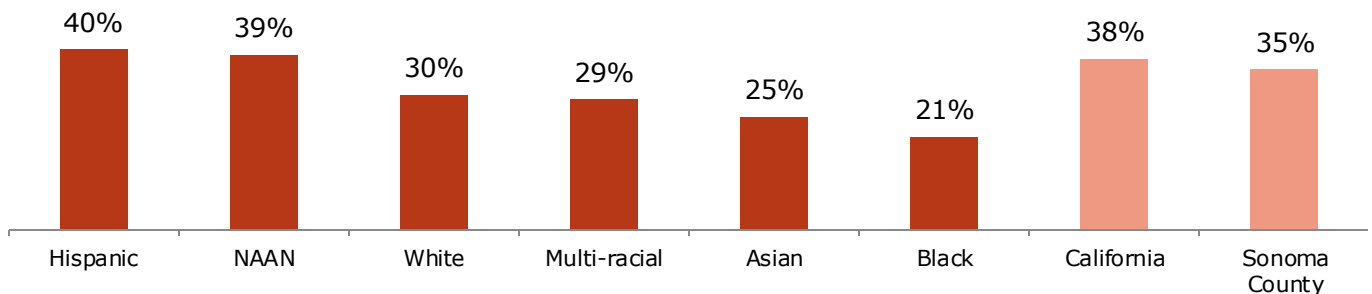
- Hunger is an emerging issue exacerbated by the 2017 fires
- Parents concerned over the quality of food given at schools
- Healthy foods are more costly and time-consuming to prepare

Populations Disproportionately Affected

Populations with Greatest Risk

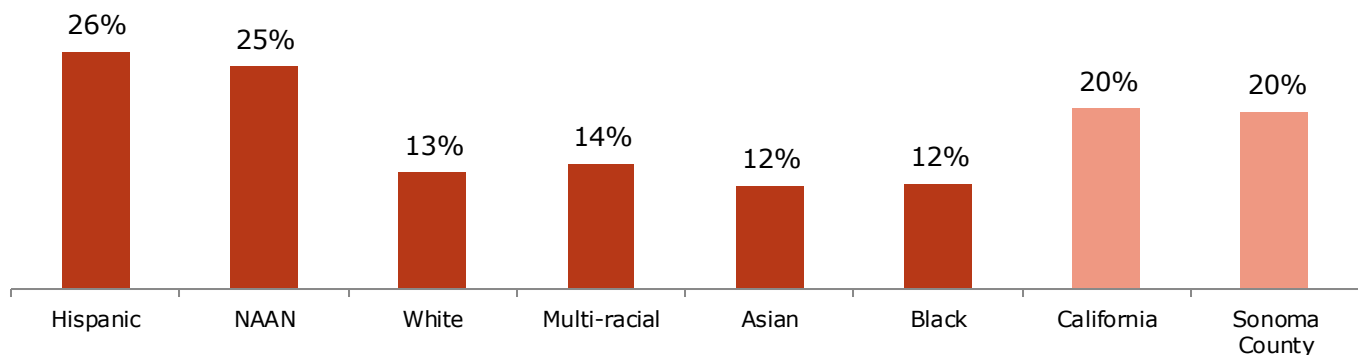
Physical inactivity rates among youth in the Santa Rosa service area

Percentage of children in grades 5, 7, and 9 ranking within the "High Risk" or 'Needs Improvement' zones for aerobic capacity on the Fitnessgram physical⁴



Obesity rates among youth in the Santa Rosa service area

Percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category for body composition on the Fitnessgram physical fitness test⁵



15% of farmworkers reported ever being diagnosed with **diabetes** after adjusting for age as compared with **5%** of all adults in Sonoma County.⁶

“Sometimes you bring your kids to the park, it doesn't feel safe. For example one park – it feels more like a bar than a park sometimes, everyone is smoking marijuana, drinking, playing cards. The police don't do anything about it.

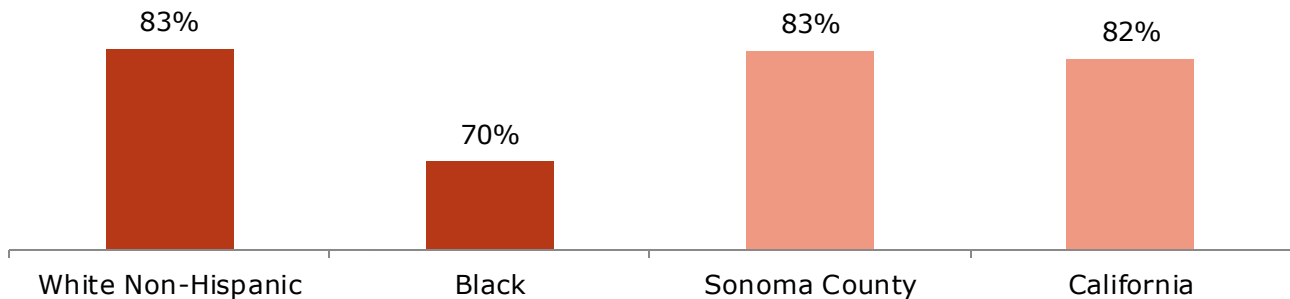
- Focus Group Participant [original in Spanish]

Populations Disproportionately Affected

Populations with Greatest Risk

Diabetes management

Percentage of diabetic Medicare patients in the Santa Rosa service area who have had a hemoglobin A1c (hA1c) test of blood sugar levels administered by a health care professional in the past year⁷



Geographic Areas with the Greatest Risk



In 2013-2015, **Rohnert Park and Santa Rosa** had **significantly higher rates of YPLL-75** (years of potential life lost before the age of 75) **due to diabetes** compared to the overall county. Sonoma Valley, Windsor, and Petaluma had significantly lower rates of YPLL-75 due to diabetes compared to the overall county⁸

14.2% of the population in Sonoma County does not live in close proximity to a large grocery store or supermarket, compared to **13.4%** of all Californians. ⁹

We still have a rising rate of diabetes, overweight, and obesity rates. With diabetes, you also have to consider access to health education and preventive services before heart disease gets more progressive. When we talk about self-management, that goes back to who has access to these kinds of services? Who has the ability to make healthy lifestyle changes, and access to healthy foods, too?

”

- Key Informant

Examples of Existing Community Assets



Exercise, dancing classes for older adults



Community centers with sports programs and social gatherings for all ages



Diabetes management educational resources



Food banks/pantries

Ideas from Focus Groups and Interview Participants

- Provide healthy eating educational programs at the school level as a natural community center for children and parents
- Increase culturally appropriate nutrition/healthy-eating classes and chronic disease management classes
- Improve safety and quality of resources in parks to increase use
- Improve nutritional options in school lunch program
- Increase use of peer health navigators/community health worker model to educate about healthy lifestyle choices, disease management, and physical activity



1. California Health Interview Survey (2014-15)
2. USDA Food Access Research Atlas
3. Gundersen, C., et al. (2016). Map the Meal Gap 2016: Food insecurity and child food insecurity estimates at the county level. Feeding America.
4. Fitnessgram Physical Fitness Testing (2017)
5. Same as above.
6. Disparities in Health Insurance Coverage and Health Status Among Farmworkers, Sonoma County, California, 2013-2014
7. Dartmouth Atlas of Healthcare (2012)
8. 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
9. Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America) (2014).

Sonoma County Community Health Needs Assessment

Housing and Homelessness

Sonoma County's high cost of living exacerbates issues related to health care access and affordability. More than half of renters pay 30% or more of their income on rent. A quarter of households in the service area face poor conditions such as inadequate plumbing or kitchen facilities. There is strong regional variation in home prices; and in unaffordable areas, many are constrained in their renting and shared-housing options. 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. Individuals experiencing homelessness identify across several race/ethnicities, with the majority identifying as White, followed by Hispanic/Latino, and Multi-racial. These issues were exacerbated by the October 2017 wildfires which both destroyed homes, and increased unemployment among the most disadvantaged.

Key Data

Indicators

Households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities¹

25% 27%

Santa Rosa service area California

Renters spending 30% or more of household income on rent²

56% 56.1%

Sonoma County California

Proportion of individuals experiencing homelessness who are sheltered and unsheltered

36% 64%

Sheltered

Unsheltered

“

Each municipality has to submit to the state their plan for affordable housing every year...They submit it... and then they sometimes attempt to implement it.

- Key Informant

It's almost impossible to be healthy unless you can stay warm, dry, and clean at night.

- Key Informant

”

Qualitative Themes



Increasing population experiencing homelessness

- Housing is essential to health
- Homelessness crisis has steepened post-2017 fires
- Behavioral health, poverty, and substance abuse must be addressed concurrently



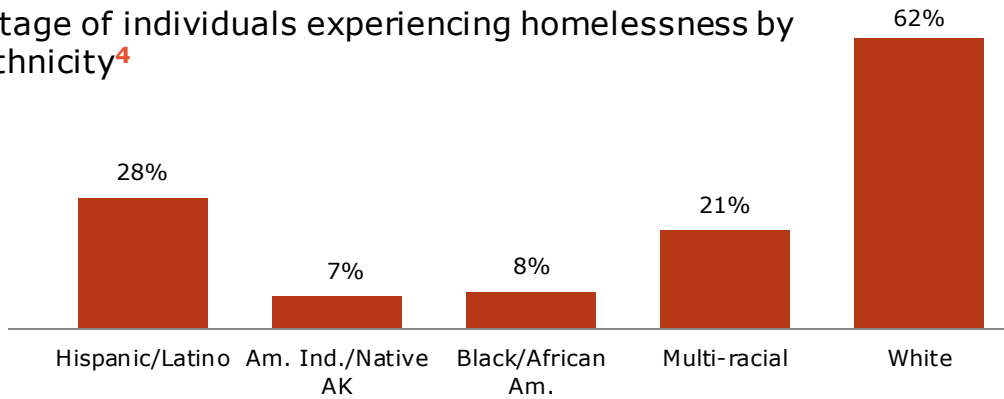
Unsustainably rising rent

- Rents are unaffordable across income levels; the 2017 fires have magnified this issue tremendously
- Money spent on rent takes away from preventive and urgent medical care
- Housing instability creates anxiety in community

Populations Disproportionately Affected

Populations with Greatest Risk

Percentage of individuals experiencing homelessness by race/ethnicity⁴



If my landlord decided to sell, I probably wouldn't be able to stay here [North Sonoma]. It's like you build relationships, you get invested in a community, and then it can all be gone in a second.

- Focus Group Participant

Characteristics of those who are [experiencing homelessness]⁵

35% Have psychiatric or emotional conditions



27% Have chronic health problems (three percent have HIV/AIDS)



33% Experience drug or alcohol abuse



27% Have a physical disability



28% Have a post-traumatic stress disorder



14% Have a traumatic brain injury



Populations Disproportionately Affected

Populations with Greatest Risk

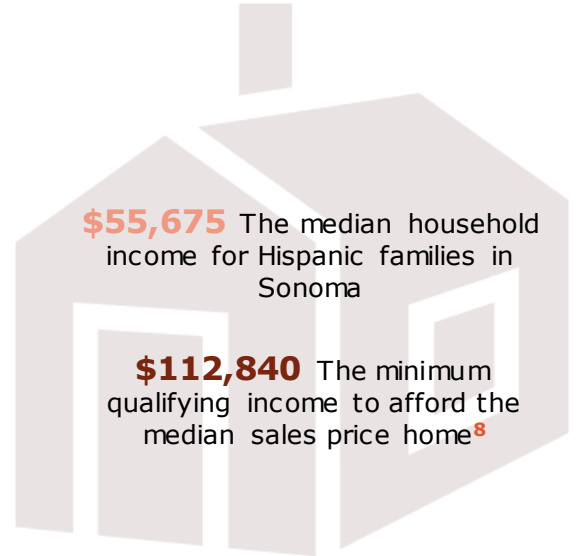
Racial Segregation Index (1 = maximum segregation) ⁶



Santa Rosa service area California

Home prices are out of reach for many community members across race and ethnicity, and are particularly unaffordable for Hispanic/Latino families which make up 25% of the population of Sonoma County.

The median sales price of a home in Sonoma County between 2015-16 increased by **13%** from \$512,100 to \$580,500. ⁷

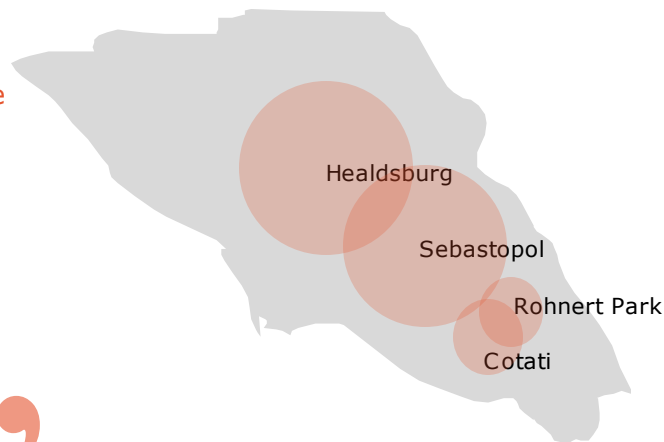


Geographic Areas with Greatest Risk

A lot of these folks [manual laborers] before could rent a room at 600 bucks, or maybe 800. That's not the case, anymore. Most people sadly are in conditions where they'll rent the living room, and then they'll partition it with curtains.



- Key Informant



Home Owner's Market⁹

(Median Home Sales Price)

Least Affordable

- Healdsburg \$804,000
- Sebastopol \$800,000

Most Affordable

- Cotati \$479,500
- Rohnert Park \$479,500

Emerging Needs

Of the 40% of households with a member who reported experiencing traumatic events during the October 2017 wildfires:

9.8%

said that their home was not livable during the fires¹⁰

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season "fuel aridity" (i.e., drying flammable natural materials).

In the western US, this has led to **9 additional days** per year of high fire potential. ¹¹



Many people who were living at the edge, the waiters and the bus boys, the gardeners and the house cleaners, lost their jobs because their jobs burned up. A fair number of people lost their housing and are now homeless, living in cars and in tents, or camped out under bridges.

- Key Informant

Examples of Existing Community Assets



Mobile health clinics



Programs that connect residents in affordable housing to other social/medical services



Nonprofits and community organizations working to address housing crisis



Available shelters and affordable housing

Ideas from Focus Groups and Interview Participants

- Build more affordable housing units at all income levels
- Ensure new housing is accessible for people with disabilities
- Increase livability of communities for people experiencing homelessness (e.g., free public restrooms and showers)
- Ensure shelter upon discharging people experiencing homelessness from emergency room/hospital; sustain partnerships between hospitals and organizations linking people with housing or shelter
- Continue to build partnerships among case managers, housing developers, and organizations connecting people who are experiencing homelessness to housing
- Increase co-location of services, to aid people experiencing homelessness, such as medical care, behavioral health treatment, food provision, and shelter
- Increase mobile health clinics to directly reach vulnerable populations



1. American Community Survey. (2012-16)
2. American Community Survey. (2013-17)
3. Point in Time Count, Sonoma County, Homeless Census and Survey (2018)
4. Same as above
5. Same as above
6. Decennial Census (2010). Segregation Index Score – A measure of the spatial distribution of population demographic groups.
7. "Hispanic Demographic Trends." Economic Development Board (2017)
8. Same as above
9. Bay Area Real Estate Information Services (2017)
10. Rapid Health Needs Assessment (CASPER) 2018
11. "Impact of anthropogenic climate change on wildfire across western US forests." PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>

Sonoma County Community Health Needs Assessment

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 which 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 and children born with low birth weight. Additionally, Hispanic/Latino populations have higher teen birthrates. Interviewees expressed frustration with a lack of childcare options and culturally competent educational resources related to sexual education. Further, maternal asthma is associated with a number of negative outcomes including premature birth, low birthweight, and neonatal death. Asthma during pregnancy disproportionately affects women in Sonoma when compared to the state average.

Key Data

Indicators

Births where the infant weighed less than 2,500 grams (low birth weight)¹

6% 7%



Sonoma County California

Women who reported having asthma before pregnancy²

8% 11%



California Sonoma County

Women who reported excessive weight gain during pregnancy³

41% 50%



California Sonoma County

“A lot of our families are working two, three, four jobs. No childcare is available for overnights, weekends, in our county. So, where are our children during those times?”

- Key Informant

There's a gap between early care and the system of identifying special needs...they're in kindergarten before we finally recognize these problems, and then it's so much harder to intervene.

- Key Informant

Qualitative Themes



Unequal access to high quality child care

- Family child care providers need better training & pay
- Lack of early identification systems and HEAL practices in child care

Teenage pregnancy

- Culturally competent sexual health education needed

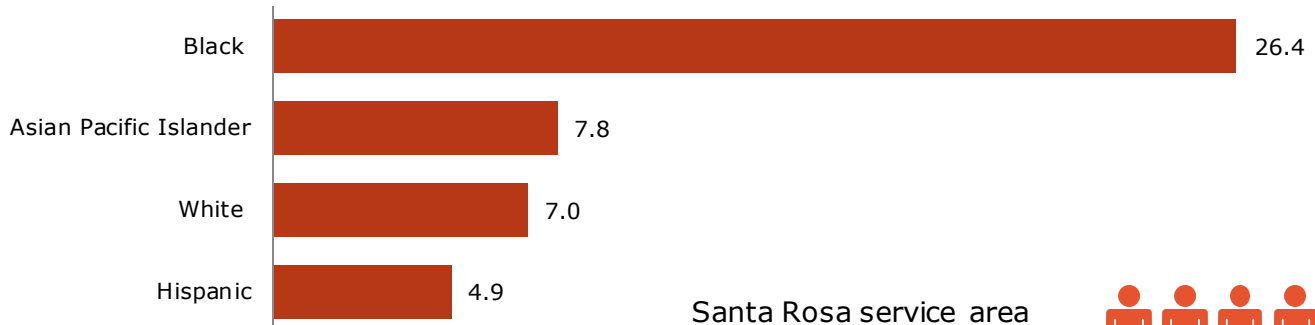
Unsafe conditions for immigrant mothers & children

- Overcrowded living situations and discrimination
- Domestic workers face sexual abuse, and exposure to hazardous chemicals and ergonomics, which impact their fertility

Populations Disproportionately Affected

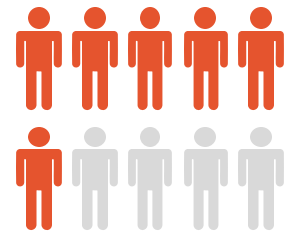
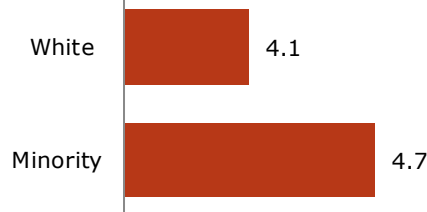
Populations with Greatest Risk

Pregnancy-related mortality rates in California during 2011-2013 per 100,000 population⁴



- **31%** of Sonoma County's demand for care for children aged 0-12 is unmet.
- There is a shortage of **7,923** child care spaces in Sonoma County, particularly for infants and school-aged youth.⁵

Santa Rosa service area infant mortality rate per 1,000 population⁶



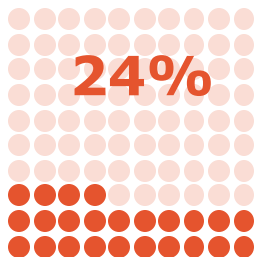
62% of teen births in the Santa Rosa service area are to Hispanic mothers⁷

“ Working with our home-based providers we see a discrepancy in the quality of their programs, from nutrition to the environment. Most of our bilingual providers maybe didn't finish high school...so we're helping them get their child development knowledge so when they're working with infants and toddlers they're getting well-rounded support.

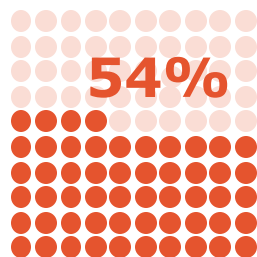
- Key Informant

Emerging Needs

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season “fuel aridity” (i.e., drying flammable natural materials). In the western US, this has led to **9 additional days** per year of high fire potential.⁸



Proportion of households reporting ever being diagnosed with asthma prior to 2017



Proportion of these households that reported worsened asthma symptoms following the fires⁹

- Phthalates found in the fragrances of cleaning products are associated with **increased risk of poor pregnancy and birth outcomes**. Domestic workers are at increased risk of exposure.¹⁰
- Restrictive immigration law and the accompanying stress is associated with **low birth weight among the infants of Hispanic/Latina women**. A body of research also shows that chronic stress and discrimination in general are associated with poor birth outcomes among women of color.¹¹

Examples of Existing Community Assets



Increased awareness of importance of early childhood



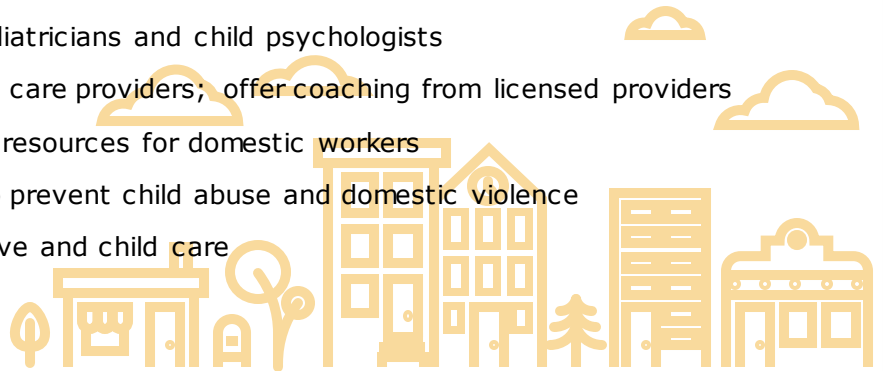
Early childhood organizations and resources



Play groups and parenting classes

Ideas from Focus Groups and Interview Participants

- Increase access to high quality, affordable child care, including on evenings and weekends
- Increase access to prenatal and perinatal care, including home-based services
- Enhance access to bilingual doctors, pediatricians and child psychologists
- Improve training options for family child care providers; offer coaching from licensed providers
- Increase occupational health and safety resources for domestic workers
- Address economic security of families to prevent child abuse and domestic violence
- Offer employee-supported maternity leave and child care



1. National Center for Health Statistics – Natality Files (2006-12)
2. MIHA Data snapshot, Sonoma County 2013-14
3. Same as above.
4. California Health Care Foundation Report 2016
<http://www.calhealthreport.org/2016/06/30/maternal-mortality-has-declined-in-california-but-disparities-persist/>
5. Sonoma County Childcare Needs Assessment Update 2014
6. Area Health Resource File (Health Resources and Services Administration) 2015
7. California Department of Public Health, Birth Statistical Master Files, 2006-2012 (pulled from Sonoma County MCAH Annual Report 2013)
8. “Impact of anthropogenic climate change on wildfire across western US forests.” PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
9. Rapid Health Needs Assessment (CASPER) 2018
10. International Journal of Occupational Medicine and Environmental Health”
https://www.researchgate.net/publication/304027669_Effect_of_environmental_phthalate_exposure_on_pregnancy_duration_and_birth_outcomes
11. American Journal of Epidemiology, 2018
<https://academic.oup.com/aje/advance-article-abstract/doi/10.1093/aje/kwy218/5144386?redirectedFrom=fulltext>

Sonoma County Community Health Needs Assessment

Mental Health & Substance Use

Residents in Sonoma County display significant needs related to mental health. Compared to the state, residents reported similar rates of ever seriously considering suicide and excessive drinking, in the county and service area respectively. Sonoma County had significantly higher rates of hospital visits due to opiate overdoses. Community stakeholders expressed a desire to increase accessibility of mental health services, erase stigma, and develop a language to discuss mental health issues. Interviewees also identified concerns with the prevalence of vaping and marijuana, especially among youth. Furthermore, feelings of depression, hopelessness, and anxiety or fear nearly doubled among at least one member of households in the year following 2017 wildfires.

Key Data

Indicators

Adults that seriously considered suicide¹



Adults reporting excessive drinking²



Emergency department visits for unintentional opiate poisoning per 100,000 (rate)³



Qualitative Themes



Need for mental health & substance use services

- Mental health care is inaccessible for many
- Lack of culturally competent options and services for seniors with dementia
- Increased vaping among youth
- Service providers experiencing high stress

Barriers to services

- Long wait times for appointments and long travel distances
- Current political climate and the 2017 fires heighten both the need and the barriers
- Stigma



In the community in general, there's a lack of mental health services and programming available, despite how great the need is.

- Key Informant

You get to know folks a little bit and you come to understand why it is that they are engaging in that intoxication. There's a lot of mental health issues, there's a lot of trauma.

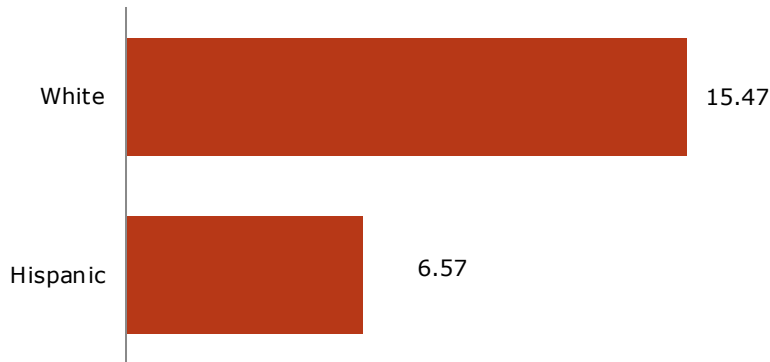
- Key Informant



Populations Disproportionately Affected

Populations with Greatest Risk

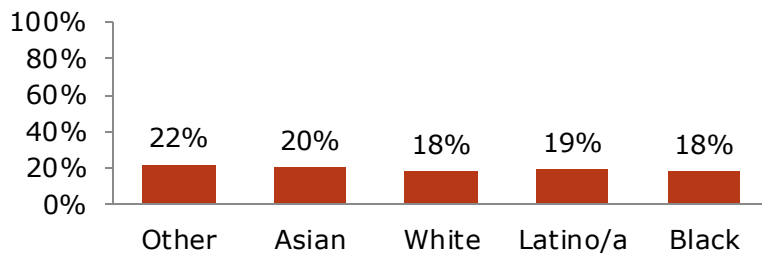
Age-adjusted rate of deaths by suicide per 100,000 population⁴



“ Sometimes our children have problems in school and they don't talk to their families. Or they have problems and the parents don't take them to the doctor to see if they're depressed. And what happens? They commit suicide. This needs to be discussed at home to prevent it from happening.

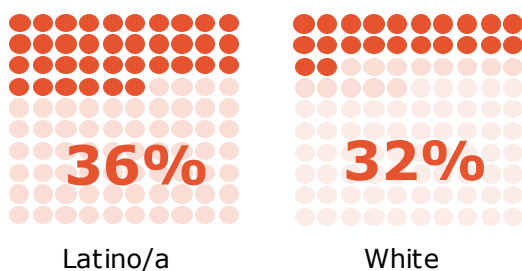
- Focus group participant
[original in Spanish]

Proportion of 9th grade students in Sonoma County who reported seriously considering suicide in the past 12 months⁵



30% of **White** students and **15%** of **Latino/a** students at non-traditional schools (alternative settings) in Santa Rosa School District reported seriously considering suicide.⁷

Proportion of 9th grade students in Sonoma County who reported chronic sadness/hopelessness⁶



“ [Referring to migrant laborers]: They say, depression is a luxurious matter. We can not get depressed. We can not get sad. We have to keep working. Or sometimes, like when you ask, 'Oh, are you depressed?' Some folks I've spoken to, they don't know what 'depression' is.

- Focus group participant

Age-adjusted Drug poisoning deaths per 100,000

-This rate is similar in Sonoma County than in California, but higher among males than females in Sonoma County.⁸

California	11.3	Sonoma	12.8
Females (Sonoma)	8.1	Males (Sonoma)	17.4

Males had over **three times** the number of years of potential life lost before the age of 75 due to suicide (**3,383**) compared to females (**1,043**) in Sonoma.⁹

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Years of Potential Life Lost Before Age 75 (YPLL 75) ¹⁰



The YPLL (75) indicates the years of potential life lost by the age of 75. This measure is also broken down to show the **leading causes of premature death as a proportion of the total YPLL (75)**. In **Windsor**, the percentage of YPLL (75) lost due to suicide is **10.5%**, compared to **7%** in the **Russian River area**, and **4.7%** in **Rohnert Park**.

Emerging Needs

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season “fuel aridity” (i.e., drying flammable natural materials). In the western US, this has led to **9 additional days** per year of high fire potential. ¹¹

1 in 6 households had at least one member who reported **depression or hopelessness**. Percent of households with at least one member reporting depression/hopelessness and anxiety/fear **nearly doubled** in the year following the October 2017 fires, according to the Rapid Health Needs Assessment. ¹²

“So many people that we work with may not have been immediately touched by the fires, meaning they weren't burned out of their homes, but this whole county has been so affected that the anxiety that we come across seems to be county wide.

- Key Informant

59%

of households had at least one member who **reported anxiety or fear** in the year following the October 2017 wildfires compared to

30%

before the fire¹³

It is stressful because a lot of the stuff they end up talking to us about, you carry, and you're like oh my God. You start going through your own mental health stuff.

- Key Informant, Service Provider

Examples of Existing Community Assets



Community organizations, committees, and support groups



Coordinated entry among service providers



School-based therapists

Ideas from Focus Groups and Interview Participants

- Increase number of bilingual and bicultural service providers and ensure educational resources are translated and written at an appropriate reading level
- Create “community health navigator” programs to aid in system navigation
- Offer more school-based counseling services and peer support groups for youth
- Increase access across the whole range of mental health needs, from minor to acute, and bring services directly to hard-to-reach groups
- Integrate currently fragmented channels of care (hospital/ER, primary, dental, mental health, substance abuse, social services)
- Confront stigma around accessing mental health care services; educate community about the many manifestations of mental health
- Expand services for vulnerable populations: people experiencing homelessness, foster and transitional-aged youth, veterans, immigrants

1. California Health Interview Survey (2009-17)
2. Behavioral Risk Factor Surveillance System
3. CDPH Opioid Dashboard 2015-17
4. Sonoma County Suicide and Self-harm Data from 2017 (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services. (2018)
5. Sonoma County California Healthy Kids Survey Analysis (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services. (2018)
6. Same as above
7. Same as above.
8. 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
9. Same as above.
10. “Impact of anthropogenic climate change on wildfire across western US forests.” PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
11. Rapid Health Needs Assessment (CASPER) 2018
12. Same as above.

Sonoma County Community Health Needs Assessment

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. Work-related falls and other injuries disproportionately affect day laborers in the county. Sonoma County also has the second worst rate of vehicle collision deaths involving underage drinking and driving. Women of color experience higher rates of intimate partner violence, which is interlaced with issues of economic security and the risk of homelessness. Finally, the impact of the 2017 fires caused an increase in disaster-related injuries. Community stakeholders expressed concern with personal safety while walking, and fear for undocumented community members who are vulnerable to injury.

Key Data

Indicators

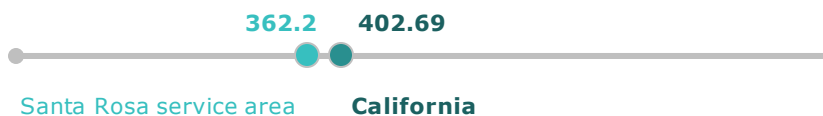
Injury deaths (rate per 100,000)¹



Traffic Safety²

Sonoma ranks **2nd worst** out of CA 58 counties for collision deaths involving underage drinking drivers and **9th worst** for collision deaths of pedestrians below age 15.

Violent crimes (rate per 100,000)³



“If you are undocumented ... you will be deported if you report these crimes that are happening in your household. You will be the one deported.

- Key Informant

Under the bridge [there are] gangs smoking, they followed me. I was horrified...I'm not going to walk around anymore, there's no safety on the streets.

- Focus Group Participant
[original in Spanish]

Qualitative Themes



Vulnerability of undocumented community and foster youth

- Reluctance to report violence and crimes due to fear of deportation or other negative consequences
- Lack of workplace protections and occupational safety and health for day laborers and domestic workers



Violence (youth & family)

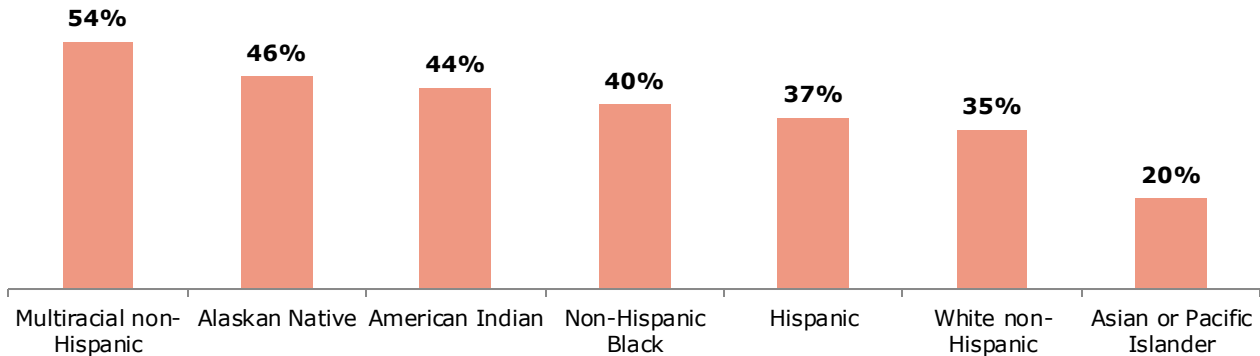
- Connection between violence and economic security, and substance use (circumstances exacerbated by the fires)
- Bullying, violence, and gang presence in schools and among youth

Populations Disproportionately Affected

Populations with Greatest Risk

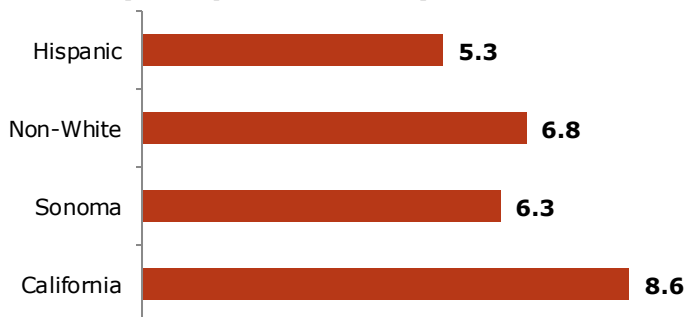
National prevalence of intimate partner violence⁴

Percent of women who reported that they have been the victim of rape, physical violence, and/or stalking by an intimate partner in their lifetime.



Many of our clients ...their options are be on the wait list for several months to get into a shelter. So it's: do I live in my car until I'm in that shelter? And so they end up returning to their abuser because they literally have no place else to go and they can rationalize that their children have a roof over their heads, and they have food in their stomach, and can just endure. – Key Informant

Santa Rosa service area Motor Vehicle Crash Deaths (rate per 100,000)⁵



The damaging effects of high rates of crime and violence on health include causing chronic stress, discouraging outdoor exercise, and, at worst, resulting in injury or death.

Sonoma County's rate of **412 violent crimes per 100,000 residents** is roughly double Marin's rate and far higher than those of Ventura and San Luis Obispo Counties, **but it is below the rates in Napa and Monterey**, which have nearly 500 violent crimes per 100,000 residents.⁶

In 2013-2015 **unintentional injuries were the second leading cause of premature death and 6th leading cause of death in Sonoma County.**

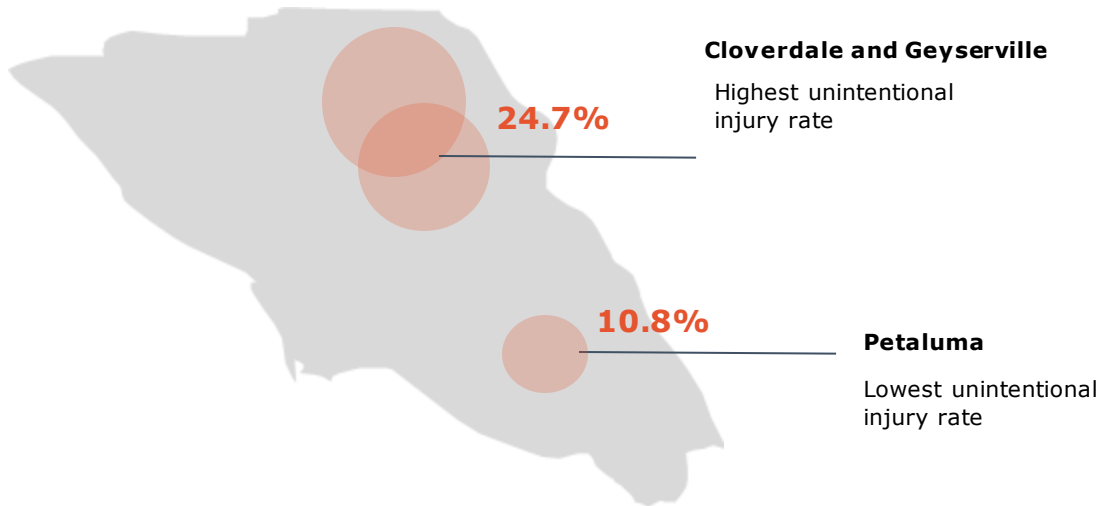
Drug poisonings, falls, and motor vehicle collisions—were responsible for **77%** of all premature deaths and **74%** of all deaths from unintentional injury among Sonoma County residents.⁷



Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Years of potential life lost before age 75 due to unintentional injuries⁸



Emerging Needs

Between 2000-2015, **human-caused climate change** contributed to **75% more** forested areas experiencing fire-season “fuel aridity” (i.e., drying flammable natural materials). In the western US, this has led to **9 additional days** per year of high fire potential.⁹

Of the 40% of households with a member that experienced traumatic events during the October 2017 wildfires¹⁰:

12.5%

Reported having been trapped or delayed in an evacuation

7.3%

Saw a serious injury of non-family member

7.9%

Suffered a significant disaster related illness or injury to self or family member



Assets and Ideas

Examples of Existing Community Assets



Community groups and initiatives against violence (e.g., legal advocacy resources)



Law enforcement; especially bilingual/bicultural officers



Housing and economic support resources for victims

Ideas from Focus Groups and Interview Participants

- Provide financial/workforce training and housing/economic supports
- Expand community and school-based education on healthy relationships, sexual health, and sexual assault prevention
- Implement anti-bullying/harassment initiatives and violence prevention programs in schools
- Offer culturally competent counseling and support for victims
- Educate community on legal and social resources for victims to reduce barriers to seeking help
- Provide targeted support for high-risk youth, including career training, to reduce involvement with gangs



1. National Vital Statistics System (2016)
2. California Office of Traffic Safety, https://www.ots.ca.gov/Media_and_Research/Rankings/default.asp#what
3. FBI Uniform Crime Report 2017
4. National Intimate Partner Violence Survey. Note: National data, not Sonoma specific
5. National Vital Statistics System (2016)
6. "A Portrait of Sonoma" Sonoma County Human Development Report 2014
7. 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
8. Same as above.
9. "Impact of anthropogenic climate change on wildfire across western US forests." PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
10. Rapid Health Assessment (CASPER) 2018