



2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Roseville

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Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

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Kaiser Permanente Northern California Region Community Benefit
CHNA Report for KFH-Roseville

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I. Introduction/background

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Health

For more than 70 years, Kaiser Permanente has been dedicated to providing high quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente’s workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

For many years, we’ve worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we’ve conducted Community Health Needs Assessments to better understand each community’s unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

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

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (<http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at <https://www.kp.org/chna>.

D. Kaiser Permanente’s approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente’s innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of 130 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through group interviews with providers and focus groups with community members. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-Roseville will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, <https://www.kp.org/chna>.

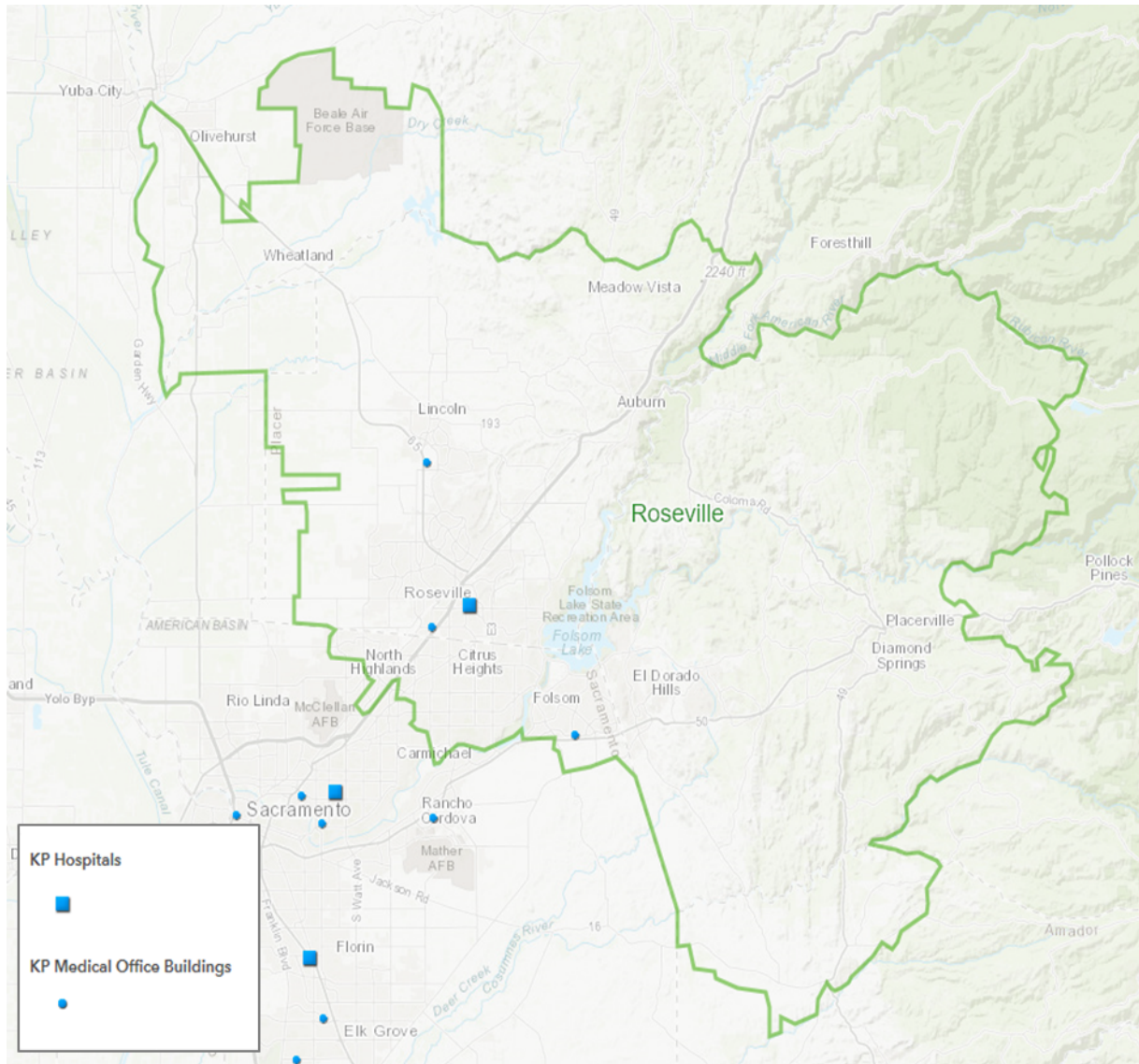
II. Community served

A. Kaiser Permanente's definition of community served

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

B. Map and description of community served

i. Map



KFH-Roseville Service Area

ii. Geographic description of the community served

The KFH-Roseville service area extends into parts of seven counties: Amador, El Dorado, Nevada, Placer, Sacramento, Sutter, and Yuba. The highest concentration of the population resides in the Sacramento Valley. Geographically, the service area principally includes Placer and El Dorado counties. It has a very diverse geography including urban cities (e.g., North Highlands/Foothill Farms and Citrus Heights), suburban cities (e.g., El Dorado Hills, Roseville, Lincoln, and Auburn) and more rural cities and towns (e.g., Placerville and Olivehurst). The service area also encompasses numerous small communities throughout the Sierra Foothills.

iii. Demographic profile of the community served

Demographic profile: KFH-Roseville

Race/ethnicity		Socioeconomic Data	
Total Population	827,023	Living in poverty (<100% federal poverty level)	10.4%
Asian	7.1%	Children in poverty	12.9%
Black	2.6%	Unemployment	3.5%
Native American/Alaska Native	0.7%	Uninsured population	8.1%
Pacific Islander/Native Hawaiian	0.3%	Adults with no high school diploma	7.6%
Some other race	3.6%		
Multiple races	5.3%		
White	80.4%		
Hispanic/Latino	14.3%		

III. Who was involved in the assessment?

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

KFH-Roseville did not collaborate with any other hospitals on this CHNA. Appendix B. Community Input Tracking Form contains a list of community partners and demographic data of participants engaged in the CHNA process.

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

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

IV. Process and methods used to conduct the CHNA

A. Secondary data

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

KFH-Roseville used the Kaiser Permanente CHNA Data Platform (<http://www.chna.org/kp>) to review 130 indicators from publicly available data sources. KFH-Roseville also used additional data sources beyond those included in the CHNA Data Platform. For details on specific sources and dates of the data used, please see Appendix A.

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

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

As described in section IV.A.i above, KFH-Roseville also leveraged additional data sources beyond those included in the CHNA Data Platform.

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

B. Community input

i. Description of who was consulted

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

ii. Methodology for collection and interpretation

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

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

Harder+Company conducted the group interviews and focus groups in-person. When respondents granted permission, data collection activities were recorded and transcribed for all interviews.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended healthcare solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the codebook was finalized to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

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

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were

then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH-Roseville had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

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

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that fall below the state average were flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that

make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, Harder+Company made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, focus groups were conducted focus groups in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.

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

A. Identifying community health needs

i. Definition of "health need"

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

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

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

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

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

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

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

B. Process and criteria used for prioritization of health needs

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

Appendix C. Health Need Profiles.

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

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

During the small-group discussions, meeting participants referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-5 (*1=lowest priority; 5=highest priority*). Ranking required that no two health needs were scored the same within each criterion. Appendix D. Prioritization Scoring provides the specific breakdown of scores used for ranking and any weighting considerations across the three criteria. Harder+Company tallied the votes after the prioritization meeting.

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

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see Section V. B. Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to Appendix C. Health Need Profiles.

1. **Access to Care:** Access to quality health care includes affordable health insurance and utilization of preventive care, with the ultimate goal of reducing the risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The Roseville service area scores better than the California state average on many of the indicators measuring health access, such as a lower percentage of

uninsured individuals, a higher percentage of women receiving breast cancer screenings, and a higher percentage of Medicare recipients reporting recent primary care visits. However, there are higher rates of breast, lung, and prostate cancer in the area, and significant disparities remain. People of color are at greater risk of being uninsured, not receiving preventive care, and dying from cancer. For example, only 71 percent of Black/African American individuals with Medicare insurance reported a recent primary care visit, compared to 80 percent of White individuals covered by Medicare.¹ Similarly, although on average Roseville exceeds the state average for rates of breast cancer screenings, Black/African American women are less likely than White women to receive breast cancer screenings (rates of 57 and 68 per 100,000 women, respectively).² In addition, local stakeholders identified lack of knowledge, affordable insurance, available providers, and transportation as barriers to accessing and navigating existing systems of care, and that these barriers disproportionately affect low-income individuals and people of color. High rates of uninsured populations¹⁰ were found along the I-80 corridor from Sacramento to Loomis, as well as portions Lincoln, Yuba City, and areas surrounding Placerville.

- 2. Mental and Behavioral Health:** Mental and behavioral health are foundations for healthy living and encompass indicators such as rates of mental illness, access to social and emotional support, and access to providers for services related to preventive care and treatment for mental health and substance abuse. In extreme cases, mental health is associated with homelessness. The Roseville service area scores on par with the California state average on many indicators related to mental and behavioral health, including substance use (e.g., lower rates of excessive drinking, current smokers, and opioid prescription drug claims) and access to mental health providers. However, the Roseville service area has slightly higher rates of suicide deaths than the state (13 and 10 deaths per 100,000 population, respectively),³ and fewer mental health providers per capita than the Northern California region (276 and 353 providers per 100,000 population).⁴ In addition, racial and geographic disparities exist related to these indicators. For example, White individuals were at higher risk for suicide-related deaths (16 per 100,000 population) compared to Hispanic/Latino/a, Asian, and Black/African American individuals (rates of 7, 7, and 6 per 100,000 population, respectively).⁵ The numbers of poor mental health days and mental health providers varied by geography. For example, portions of the service area in Sacramento, Sutter, and Yuba counties had a greater number of poor mental health days (compared to Amador, El Dorado, and Placer counties),⁶ and the number of mental health providers was particularly low in the Yuba County portion of the service area, including Yuba City and areas surrounding the Beale Air Force Base.⁷ Local stakeholders identified several challenges to meeting their mental and behavioral health needs: existing trauma among community residents, lack

¹ Dartmouth Atlas of Health Care. (2014). Retrieved from <http://www.dartmouthatlas.org/>

² Ibid.

³ National Vital Statistics System. (2011-2015). Retrieved from <https://www.cdc.gov/nchs/nvss/index.htm>

⁴ Area Health Resource File. (2016). Retrieved from <https://data.hrsa.gov/>

⁵ National Vital Statistics System. (2011-2015). Retrieved from <https://www.cdc.gov/nchs/nvss/index.htm>

⁶ Area Health Resource File. (2016). Retrieved from <https://data.hrsa.gov/>

⁷ Area Health Resource File. (2016). Retrieved from <https://data.hrsa.gov/>

of trust and knowledge to navigate health systems, experiences of stigma from providers, and financial constraints.

- 3. Economic Security:** Economic security means having the financial resources, public supports, career and educational opportunities, and housing accommodations necessary to live one's fullest life. The Roseville service area scores better than the California state average on many of the indicators measuring economic security. The service area has a lower percentage of adults without a high school diploma, fewer children and adults living below the federal poverty line, and fewer residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. However, significant disparities remain across the region by race, ethnicity, and geography. People of color are less likely to surpass the state average on each of these indicators. For example, Hispanic/Latino/a (22 percent) and Black/African American (14 percent) adults are less likely than White adults (5 percent) to have a high school diploma.⁸ Further, economic insecurity varies by geographic area. High rates of housing problems,¹⁰ which include lacking complete kitchens and plumbing facilities, as well as overcrowding, or severe cost burden (all housing costs represent over >30 percent of monthly income), were present in parts of Citrus Heights, Folsom, North Auburn, Roseville, Yuba City, and areas surrounding the Beale Air Force Base. Unemployment rates were higher in Amador, Sutter, and Yuba counties compared to other portions of the service area.⁹ In addition, local stakeholders identified the following barriers to economic security: a lack of awareness of local systems and supports, affordable housing and food, job retention, and experiences of stigma. These barriers disproportionately affected low-income individuals and people of color.
- 4. Women and Children's Well-Being:** Women and children's well-being reflects not only health outcomes, but also access to services, such as reproductive health, pre- and post-natal medical care, childcare, and education. On average, within the Roseville service area, women and children are faring relatively well compared to the state averages. For example, women receiving Medicare are more likely to report having breast cancer screenings and fewer children are eligible for free or reduced lunch. However, disparities within these indicators exist. Black/African American women (57 percent) receive fewer breast cancer screenings than White women (68 percent),¹⁰ and infants of color are at greater risk of mortality than White infants (5.5 versus 4.5 infants per 1,000 births).¹¹ Further, the service area had very low rates of preschool enrollment in Amador County, Sutter, and Yuba Counties, as well as pockets of Placer (e.g., Auburn, Folsom, Lincoln, Roseville), and El Dorado (Placerville) Counties.¹² Local stakeholders identified costly childcare, lack of specialists, and knowledge of systems as barriers to women and children's well-being.

⁸ American Community Survey. (2012-2016). Retrieved from <https://www.census.gov/programs-surveys/acs/>

⁹ Bureau of Labor Statistics. (2017). Retrieved from <https://www.bls.gov/>

¹⁰ Dartmouth Atlas of Health Care. (2014). Retrieved from <http://www.dartmouthatlas.org/>

¹¹ Area Health Resource File. (2006-2010). Retrieved from <https://data.hrsa.gov/>

¹² American Community Survey. (2012-2016). Retrieved from <https://www.census.gov/programs-surveys/acs/>

5. Healthy Eating and Active Living (HEAL): Healthy eating and active living (HEAL) relate to the ability of residents to positively shape their health outcomes through a focus on nutrition and exercise. Many factors outside of individuals' control also shape these behaviors, such as access to safe parks and affordable vegetables. HEAL also impacts the rates of many chronic conditions like cardiovascular disease (CVD), stroke, and cancer. The Roseville service area scores better than the California state average on many of the indicators measuring HEAL. For example, youth in the Roseville service area are less likely than their peers in California to experience obesity (14 percent versus 20 percent)¹³ and physical inactivity (29 percent versus 38 percent).¹⁴ However, significant disparities exist by race and ethnicity, specifically related to obesity, physical inactivity, receipt of SNAP benefits, and stroke deaths. For instance, 26 percent of Native Hawaiian and Pacific Islander, 21 percent of Hispanic/Latino/a, 20 percent of Black/African American youth experience obesity, in contrast to 11 percent of White and 9 percent of Asian youth.¹⁵ Additionally, residents in Yuba County, including Yuba City and areas surrounding the Beale Air Force Base experienced limited access to grocery stores and produce vendors.¹⁶ However, only the Amador County portion of the service area exceeded the state average. Local stakeholders identified access to green, safe, walkable spaces; affordable and healthy food options; and nutritional information as barriers to HEAL.

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

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

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

VI. KFH-Roseville 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Roseville's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Roseville's

¹³ FITNESSGRAM® Physical Fitness Testing. (2016-2017). Retrieved from <https://www.cde.ca.gov/ta/tq/pf/>

¹⁴ Ibid.

¹⁵ American Community Survey. (2012-2016). Retrieved from <https://www.census.gov/programs-surveys/acs/>

¹⁶ County Business Patterns. (2015). Retrieved from <https://www.census.gov/programs-surveys/cbp.html>

Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit (<https://www.kp.org/chna>). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Roseville in the 2016 Implementation Strategy Report:

1. Access to Care
2. Healthy Eating and Active Living (HEAL)
3. Behavioral Health
4. Community and Family Safety

KFH-Roseville is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-Roseville tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-Roseville had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-Roseville will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care

services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- **Medicaid:** Medicaid is a federal and state health coverage program for families and individuals with low-incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- **Medical Financial Assistance:** The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- **Charitable Health Coverage:** Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- **Workforce Training:** Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
- **Research:** Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-Roseville awarded 269 grants amounting to a total of \$5,987,500.24 in service of 2016 health needs. Additionally, KFH Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Roseville service area. During 2017-2018, a portion of money managed by this foundation was used to award 3 grants totaling \$376,116.07 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities, and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-Roseville leveraged significant organizational

assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report below.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFHRoseville engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Examples of collaborations and partnerships are included in the section of the report below.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-Roseville Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care	<p><i>During 2017 and 2018, KFHRoseville awarded 81 grants totaling \$4,295,289.94 that address Access to Care in the KFHRoseville service area</i></p>	<p><u>KP Medicaid and Charity Care:</u> In 2017 and 2018 KP served 22,780 and 23,790 Medi-Cal members respectively totaling \$55,269,702.66 worth of care. KP also provided a total of \$11,033,041.99 of Medical Financial Assistance (MFA) to 11,553 individuals in 2017 and 7,284 individuals in 2018.</p> <hr/> <p><u>Access to primary and specialty care:</u> Latino Leadership Council's CREER En Tu Salud (Believe in your Health) project received \$80,000 (split between KFHRoseville and KFHSacramento) to provide access to health, mental health, dental, and vision services to 533 people from unserved and underserved adult Latino populations in Placer and Sacramento counties. Of these, 215 got flu shots and 338 received connections for primary care (117), mental health (37), dental (35), vision (26), and insurance (78) services. Health promotoras teach patients how to make appointments, and prepare them to ask questions, take notes, and comply with medical orders to improve their health.</p> <hr/> <p><u>PHASE:</u> Over the course of three years (2017-2019), Chapa-De Indian Health Program, Inc. (CDIHP) is the recipient of a \$150K grant (evenly split between KFHRoseville and KFHSacramento) to support the successful use of PHASE among clinic sites. Strategies include building a robust system for alternative visits (nurse and pharmacist) to help increase patient access and integrating their diabetes and primary care teams. CDIHP is reaching just over 2,000 patients through PHASE. 74% of their patients with diabetes and 76% of those with hypertension have their blood pressure controlled</p> <hr/> <p><u>211:</u> Yolo County Health Department received a \$50,000 grant (evenly split between 4 KFHRoseville hospital service areas) to support 211's efforts to connect community members with County services, community based resources and information through a 24 hour call center, web lookup and text alerts. To date, 211 has received 2,432 calls, with the majority related to emergency shelter and housing assistance. Callers were connected to resources and 546 direct referrals were made to service providers across the region.</p>

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		<p><u>Community clinic</u>: St. Vincent de Paul Society's free urgent care community clinic was awarded \$30,000 to provide medical evaluation and prescription medications for urgent medical problems for uninsured and low-income Roseville residents, including the homeless and undocumented immigrants. Care is provided at The Gathering Inn and the St. Vincent de Paul Society office; 434 patients received care and health-care providers issued 161 prescription medications.</p>
Healthy Eating, Active Living	<p><i>During 2017 and 2018, KFH-Roseville awarded 40 grants totaling \$504,063.14 that address Healthy Eating Active Living in the KFH-Roseville service area</i></p>	<p><u>CalFresh</u>: Placer Food Bank received a \$95,000 grant to strengthen its CalFresh program infrastructure and provide targeted outreach to enroll immigrants, seniors, college students, and low-income families in CalFresh. To date, the CalFresh outreach team has prescreened 206 individuals, assisted 37 seniors, families, college students, rural residents, and immigrant families complete applications. Approval rating is at 65%.</p> <p><u>Parks</u>: Health Education Council received a \$75,000 grant to create the vision for Weber Park that was developed by residents engaged in the Invest Health Roseville Initiative. Residents have had conversations with the City about how to prioritize resources and park improvements linked to improving social connection, engagement, health, and economic outcomes. The City of Roseville hosted a neighborhood 'reimagination day' attracting 200 residents to the park and provided an opportunity to obtain input about classroom and outdoor learning space renovations.</p> <p><u>After school program</u>: City of Folsom Parks & Recreation was awarded \$10,000 for Folsom STARS, its partnership with Folsom Cordova Unified School District that provides a safe, secure place for 55 vulnerable, at-risk students to go upon school dismissal. A community-based program for students at Theodore Judah and Blanche Sprentz elementary schools, Folsom STARS offers a place to go during afterschool hours, where children can develop and connect through relationships, focus on academics and life skills, and increase their health, fitness, and family resilience.</p>
		<p><u>Nutrition education and physical activity program</u>: Folsom Cordova Unified School District received \$30,000 (evenly split between KFH-Roseville and KFH-Sacramento) for Growing Together, a program that promotes healthy eating and active living among students and their families. Through a collaboration with Soil Born Farms allowed 206 students from six schools to explore local sources of nutritious food, learn healthy menu planning, and build a commitment to healthy eating at school campuses and beyond. And 120 students, 33 counselors in training, and 118 adults learned where food comes from and how to prepare nutritious meals through the Family Summer Academy. In addition, 3372 students from nine schools participated in the mileage walking clubs and more than 20,000 miles were recorded districtwide.</p>
Mental & Behavioral Health	<p><i>During 2017 and 2018, KFH-Roseville awarded 40 grants totaling \$553,972.33 that address Mental and Behavioral Health in the</i></p>	<p><u>Mental health support</u>: Lighthouse Counseling & Family Resource Center was awarded \$25,000 for its Family Wellness Initiative, which helped more than 3,000 people in Placer County establish self-sufficiency and positive health outcomes through an inclusive approach utilizing case management, evidence-based counseling, therapeutic support groups, education, and in-home visitations at no cost. Of the 136 clients who received therapy, 85% reported positive results. And of the 138 clients who received educational classes and/or therapeutic group support, 90% reported significant positive results. Lighthouse also assists in obtaining vital community resources when it's not able to provide clients with direct services.</p>

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
	<p><i>KFH-Roseville service area</i></p>	<p><u>Stigma</u>: Health Education Council received a \$90,000 grant to work with 1,300 students, parents and staff from five Roseville schools to stimulate discussions about mental health stigma and increase coordination and collaboration between agencies working on mental health issues. The project intends to increase understanding about mental health, its associated stigma and its connection with overall health.</p> <hr/> <p><u>Mental health services for homeless</u>: The Gathering Inn (TGI) received a \$40,000 grant for an onsite mental health clinician (MHC) who works eight hours/week with a caseload of at least 10 homeless guests/patients. Transportation challenges and TGI's high case manager to guest ratio makes travel to community-based mental health appointments difficult, so having an onsite MHC addresses access issues, provides consistency in therapeutic relationships, and leads to better treatment outcomes. During the reporting period, the MHC provided 556 hours of clinical time, averaged more than 100 client encounters quarterly and interacted with 205 guests. Nearly 40% of TGI guests self-report mental health issues, so having an onsite MHC is invaluable to maintaining their treatment and counseling protocols. The MHC has treated mental health issues such as PTSD, depression, anxiety, bipolar disorder, and postpartum depression and has assisted with medical issues such as burns, cuts, bronchitis, and allergies.</p>
<p>Community & Family Safety</p>	<p><i>During 2017 and 2018, KFH-Roseville awarded 17 grants totaling \$159,767.00 that address Community and Family Safety in the KFH-Roseville service area</i></p>	<p><u>Sexual violence</u>: Stand Up Placer was awarded \$25,000 for its Victims' Services Program, which helps survivors of domestic/sexual violence and human trafficking and their children address their trauma and begin the healing process. The program serves clients in Roseville and Auburn. It provides access to the social services safety net, assists clients in obtaining legal remedies to their situations, and helps them reduce the risk of future violence in their lives. During the last year, 1,285 victims received services through the program. Because of the MeToo movement and increased publicity around sexual assault, the number of sexual assault victims seeking assistance skyrocketed. In all, 494 clients received 1,689 legal advocacy services, including court accompaniments; 163 clients received assistance with protection and custody order services; 54 clients received 75 custody order services; and 131 clients sought help with 161 protective order services.</p> <hr/> <p><u>Patient navigation</u>: Community Recovery Resources (CoRR) received \$20,000 for its Culturally Competent Navigation to Wellness program wherein patient navigators support individuals in South Placer County with substance use disorders and/or mental health needs to access behavioral health services, health coverage, primary care, and essential social services to improve child, individual, and family health outcomes. This population is at high risk of criminal justice involvement, inappropriate ER use, involvement with the child welfare system, and homelessness. A total of 193 individuals were reached. Of those, 89% (171) enrolled in coverage, 79% (153) obtained a primary care physician and all know how to access/enroll in coverage and where to find a primary care physician and/or access mental health care. All clients served were connected to social supports relevant to their case and know where to find necessary support. And 54 of the 193 clients (28%) are employed or enrolled in a vocational/educational program and all know where to access education and employment resources.</p>

VII. Appendices

- A. Secondary Data Sources and Dates
 - i. Secondary sources from the KP CHNA Data Platform
 - ii. Additional sources
- B. Community Input Tracking Form
- C. Health Need Profiles
- D. Prioritization Scoring
- E. Focus Group Protocol
- F. Group Interview Protocol

Appendix A. Secondary Data Sources and Dates

i. Secondary sources from the KP CHNA Data Platform

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

ii. Additional sources

Source	Dates
1. Roseville Homeless Response Team, Point-in time homeless count	2017

Appendix B. Community Input Tracking Form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	WellSpace Health (CEO)	1	Low-income; medically underserved; racial or ethnic minorities	Service Provider	6/18/18
2	Group Interview	Latino Leadership Council (Executive Director; Program Manager) Lighthouse Family Resource Center (Executive Director)	3	Low-income; racial or ethnic minorities	Service Providers	7/06/18
3	Group Interview	Adventist Health (Community Impact Specialist) & Bayside Church (Volunteer Outreach Coordinator) County Highway Police (Sargent) Health Education Council (Associate Director) Insights Counseling Group (Therapist) KidsFirst (Grant Specialist) Roseville Police Activities League (Executive Director) Wellness Within (Chair, Board of Directors) Woodbridge Elementary School (Community Liaison)	8	Health department representative; low-income; medically underserved; racial or ethnic minorities	Service Providers	7/10/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
4	Group Interview	Learn for Life Marconi Learning Academy (Counselor; Student Relations and Site Utility) Sacramento City Unified School District (Director of Student Support and Health Services) San Juan Unified School District (Program Manager; Student Support Services; and Program Specialist Health Care Services)	7	Low-income; racial or ethnic minorities	Service Providers	7/12/18
5	Group Interview	City of Sacramento (Program Manager) Downtown Sacramento Partnership (Executive Director) Franklin Property-Based Business Improvement District (Executive Director) Midtown Associates (Executive Director) Roseville area Chamber of Commerce (Executive Director) Sacramento Hispanic Chamber (Executive Director)	6	Low-income; medically underserved; racial or ethnic minorities	Service Providers	7/16/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
6	Group Interview	Placer County Health and Human Services (Executive Director) Placer Rescue Mission (Board of Directors, President) Roseville Police Department (Police Officer and Social Services Administrator) Stand Up Placer (Project Manager) The Gathering Inn (Executive Director)	9	Health department representative; low-income; medically underserved; racial or ethnic minorities	Service Providers	8/17/18
7	Group Interview	Anti-Recidivism Coalition (Director; Administrator; Program Manager; and Member) ¹⁷	4	Low-income; medically underserved; racial or ethnic minorities	3 Service Providers and 1 Community Member	7/19/19

Community residents

8	Focus group	Roseville Coalition of Neighborhood Association (Residents of various Roseville neighborhoods)	15	Low-income; racial or ethnic minorities	Community Member	9/5/18
9	Focus group	Saint Anna Greek Orthodox Church (Roseville faith community leaders and advocates)	6	Low-income	Community Member	9/6/18
10	Focus group	Mexican Consulate and Health Education Council (Latino/a community residents in Roseville)	2	Racial or ethnic minorities	Community Member	9/11/18
11	Focus group	Woodbridge Elementary School (Roseville city parents)	8	Low-income; racial or ethnic minorities	Community Member	9/13/18

¹⁷ Although not located in the KFH-Roseville service area, the Anti-Recidivism Coalition serves individuals across the greater Sacramento region.

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
12	Focus group	Chapa De Indian Health (Native American community in Western Placer)	12	Low-income; racial or ethnic minorities	Community Member	9/25/18
13	Focus group	Western Placer Unified School District (Lincoln Sheridan area parents)	12	Low-income; medically underserved; racial or ethnic minorities	Community Member	10/11/18
14	Focus group	Sacramento LGBT Community Center (LGBT community members) ¹⁸	9	Medically underserved; racial or ethnic minorities	Community Member	11/8/18

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

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

Low-income: One or more participant indicated they received government assistance and/or their family earned less than \$30,000, or worked with a low-income community

Medically underserved: One or more participants indicated they either had “No Insurance” or identified as from traditionally medically underserved communities (e.g., LGBTQ, homeless), or worked with a medically underserved community

Minority: One or more participant indicated their race/ethnicity as non-White, or that they worked with a minority community

¹⁸ Although not located in the KFH-Roseville service area, the Sacramento LGBT Center serves individuals across the greater Sacramento region.

Appendix C. Health Need Profiles

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

Kaiser Foundation Hospital – Roseville Service Area Community Health Needs Assessment

Access to Care

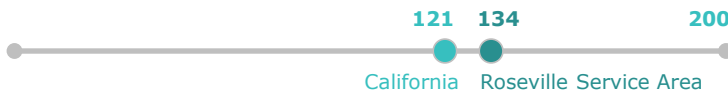
Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The Kaiser Permanente Roseville service area scores better than the California state average on many of the indicators measuring health access, such as a lower percentage of uninsured individuals, a higher percentage of women receiving breast cancer screenings, and a higher percentage of Medicare recipients reporting recent primary care visits. However, there are higher rates of breast and lung cancer in the area, and significant disparities remain within indicators in which the area exceeded state averages. For example, people of color are at greater risk of being uninsured, not receiving preventive care, and dying from cancer. In addition, lack of knowledge, affordable insurance, available providers, and transportation inhibit the ability of individuals to navigate existing systems of care, and these barriers disproportionately affect low-income individuals and people of color.

Key Data

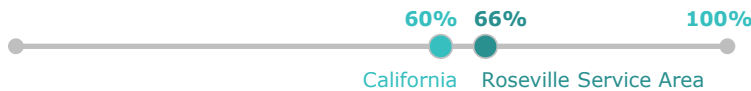
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Breast cancer incidence (rate is per 100,000 females)¹



Breast cancer screening of female Medicare recipients²



Lung cancer incidence (rate is per 100,000 population)³



Recent primary care visit for those with Medicare insurance⁴



Community Identified Barriers



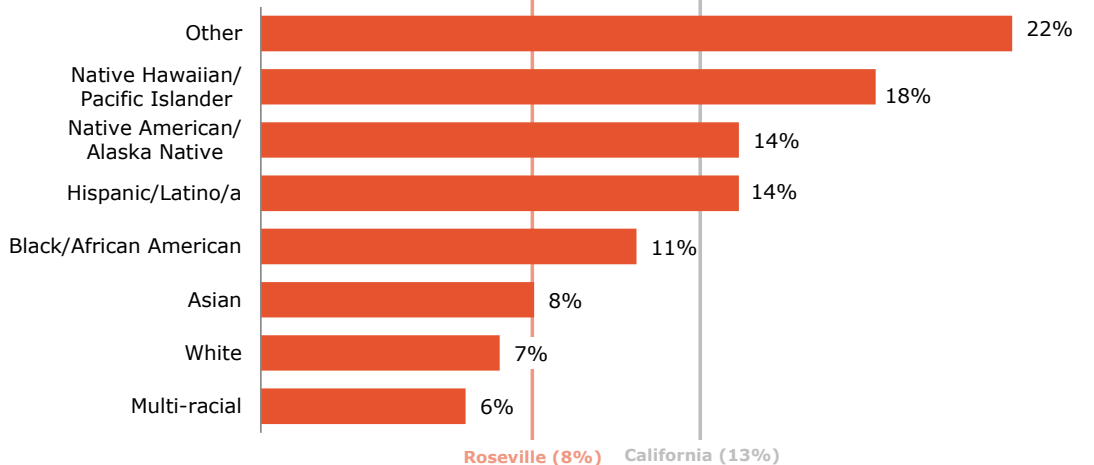
- Lack of financially affordable services
- Lack of insurance coverage
- Lack of knowledge of systems
- Long waiting times for time-sensitive health needs
- Stigma in accessing resources
- Lack of transportation

“It’s just having medical insurance that’s affordable, because you have an ACA approved medical insurance that’s a high deductible, and you’re paying the first \$10,000 of all medical care. For most of us, for me, that’s a quarter of my income, and it just doesn’t work.”
- Focus Group participant

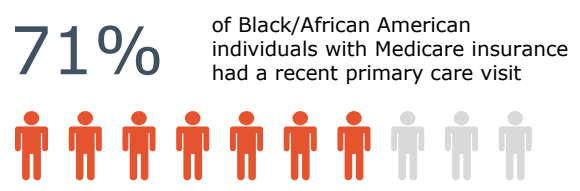
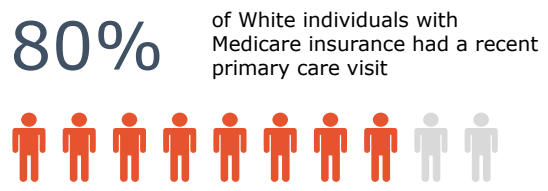
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Uninsured population⁵

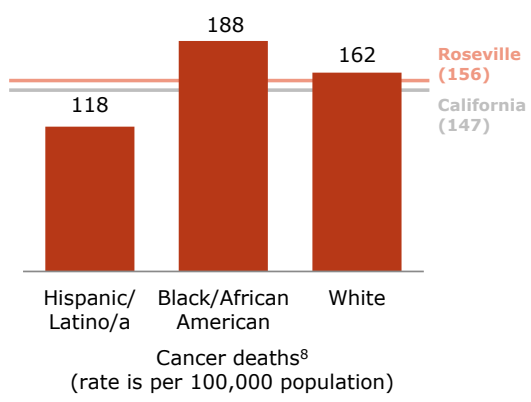
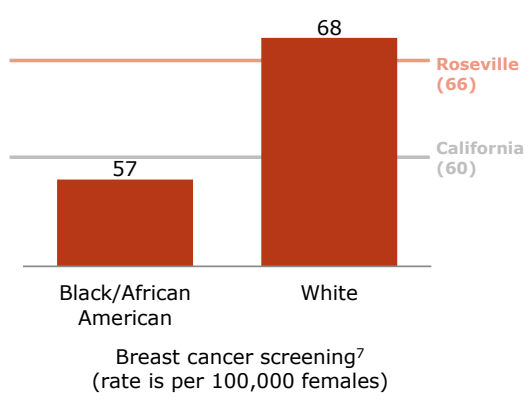


Recent primary care visits of Medicare recipients⁶



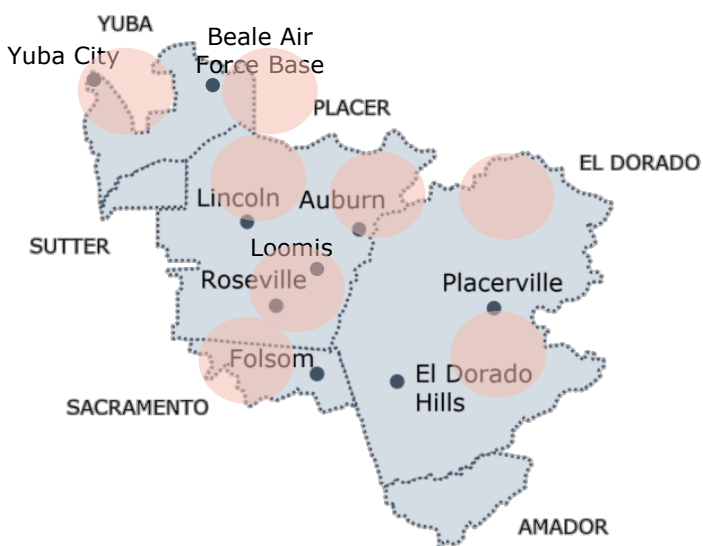
“I've heard stories of people where they try to take their child in, because they do have insurance, but no one's taking their insurance, they're like 'Oh sorry, we're full.'...And so somebody I knew had to drive to Auburn just to go to the doctor.”
 - Focus Group participant

Rates of breast cancer screening and cancer-related deaths



Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers for accessing care varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area.

High rates of uninsured populations⁹ were found along the I-80 corridor from Sacramento to Loomis, as well as portions Lincoln, Yuba City, and areas surrounding Placerville.

Emerging Needs

Roseville residents and providers reported the following emerging community needs:

- Options for affordable health care and medical services
- Services to improve mental health and decrease stigma around mental health in the community
- A need to build trust in the community, especially amongst families with mixed migratory statuses, to increase use of services



“So now it's not just a cultural stigma to reach out for mental health services. There's also fear, and the undocumented ones are afraid to reach out. You know, obviously fear of deportation.”
- Service provider

Because everything is so interconnected between the government and other agencies, like Child Protective Services and the sheriff,...I feel like a lot of people just don't have enough trust or faith to even seek mental help, physical help.”
- Service provider

Assets and Ideas

Examples of Existing Community Assets

Roseville has many strengths. The following are assets identified by residents and providers.



Strong school partnerships with outside community resources



Access to bilingual service providers

Ideas from Focus Groups and Interview Participants

Roseville residents and providers shared their ideas for how best to meet the needs in the community.

- Humanize the health care system by employing health care providers with diverse experiences and perspectives
- Increase partnerships within existing organizations in the community to increase referrals and access
- Provide access to alternative treatment options outside of the realm of western medicine practices
- Increase knowledge of different health care systems in the county
- Continue to use schools as centers that enable access to needed services
- Create more programs and resources for the elderly population



References

- ¹ State Cancer Profiles. (2010-2014). Retrieved from <http://statecancerprofiles.cancer.gov/>
- ² Dartmouth Atlas of Health Care. (2014). Retrieved from <http://www.dartmouthatlas.org/>
- ³ State Cancer Profiles. (2010-2014). Retrieved from <https://statecancerprofiles.cancer.gov/>
- ⁴ Dartmouth Atlas of Health Care. (2014). Retrieved from <http://www.dartmouthatlas.org/>
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Kaiser Foundation Hospital – Roseville Service Area Community Health Needs Assessment

Economic Security

Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. The Kaiser Permanente Roseville service area scores better than the California state average on many of the indicators measuring economic security, including a lower percentage of adults without a high school diploma, fewer children and adults living below the federal poverty line, and fewer residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. However, significant disparities remain across the region both by race/ethnicity and geographically. For example, people of color are less likely to surpass the state average on each of these indicators, and the extent to which food insecurity, unemployment, and housing problems are prevalent varies by geographic region. In addition, through interviews and focus groups with local stakeholders, a lack of awareness of local systems and supports, affordable housing, food, job retention, and experiences of stigma all emerged as common barriers to economic security—and these barriers disproportionately affect low-income individuals and people of color.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adults with no high school diploma¹



Children below 100% Federal Poverty Line (FPL)²



Population below 100% FPL³



Supplemental Nutrition Assistance Program (SNAP) benefits⁴



Community Identified Barriers



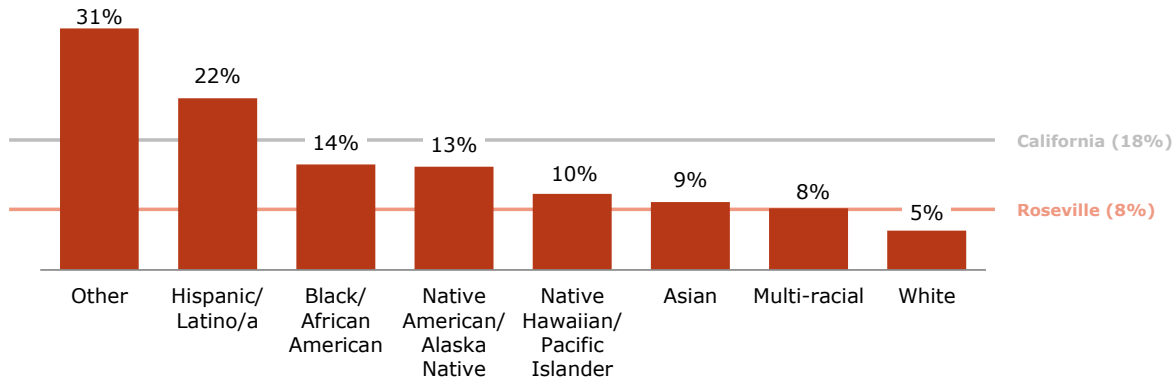
- Job retention issues
- Lack of affordable food options
- Lack of affordable housing
- Lack of knowledge of systems
- Long waitlists for services
- Stigma for vulnerable populations (i.e., the formerly incarcerated)

“And although I qualify for health care, some of that funding is going away because of our administration. And that's going to cause health issues because my bills are going to continue to go up. Either I'm not going to be able to afford to pay for basic necessities or we're just going have to be extremely uncomfortable.”
- Focus Group participant

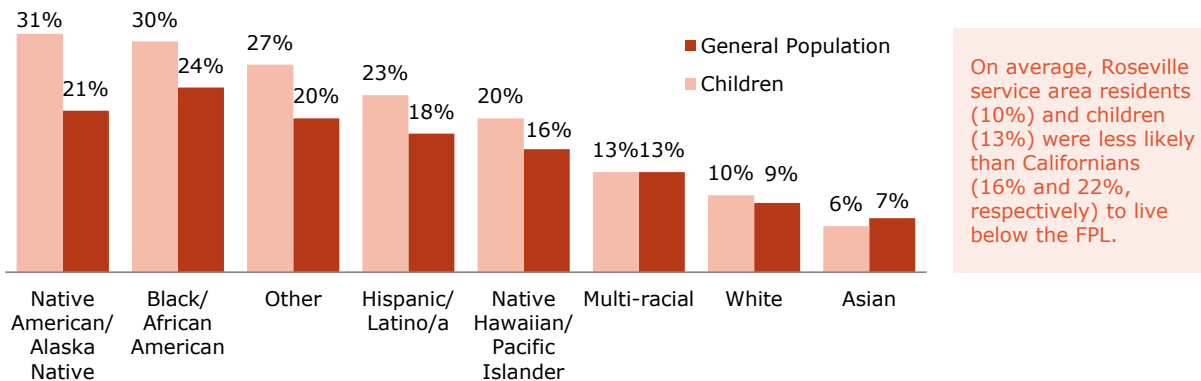
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

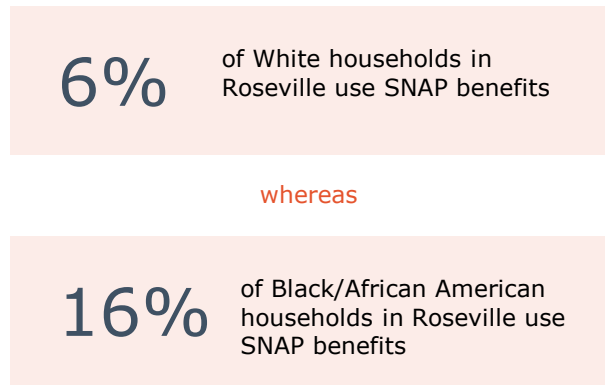
Adults with no high school diploma⁵



Population and children living below the Federal Poverty Line (FPL)⁶



Receipt of Supplemental Nutrition Assistance Program (SNAP) benefits⁷



“We see some of our highest poverty in the city of Roseville. They tend to be our undocumented individuals. A lot of larger families. Unemployment's a little bit higher in these areas...If you go to West Roseville on either end we don't see much of that at all, right? So I think, in this county in particular, we have to talk about the gap because the gap is there.”

- Focus Group participant

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers related to economic security varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

High rates of housing problems,⁸ which include lacking complete kitchens and plumbing facilities, as well as overcrowding, or severe cost burden (all housing costs represent over >30% of monthly income), were present in parts of Citrus Heights, Folsom, North Auburn, Roseville, Yuba City, and areas surrounding the Beale Air Force Base.

**Not shown on map*
Portions of the HSA located in Yuba, Sutter, and Amador Counties had **high unemployment rates.⁹**

Emerging Needs

Roseville residents and providers reported the following emerging community needs:

- Homelessness has increased in the area, especially amongst the formerly incarcerated population
- Access to affordable housing options is limited
- Roseville area is growing at a faster pace than resources are built in the community



“You look at the homeless population, [which] has increased so much....A lot of that has to do with folks coming home from prison, and not being able to have a place to stay.”
- Service provider

Now that we have more homeless who are in some areas being prioritized which is adversely impacting others that may be on lists so we do have a shortage of affordable housing.”
- Service provider

In 2018, 584 homeless individuals were identified in the Placer County annual point-in-time count, of which 39 percent were chronically homeless.¹⁰

Assets and Ideas

Examples of Existing Community Assets

Roseville has many strengths. The following are assets identified by residents and providers.



Summer meal programs for children



Afterschool programs for young kids and teens



Housing assistance programs



Local food banks

Ideas from Focus Groups and Interview Participants

Roseville residents and providers shared their ideas for how best to meet the needs in the community.

- Provide wellness programs in the community, including yoga and meditation, to encourage active living and help reduce stress
- Create affordable housing options including campus-style housing with consolidated centers for resources and supportive services
- Provide affordable child care options for working parents
- Provide incentives for property managers to retain existing tenants
- Centralize access to multiple services



References

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Kaiser Foundation Hospital – Roseville Service Area Community Health Needs Assessment

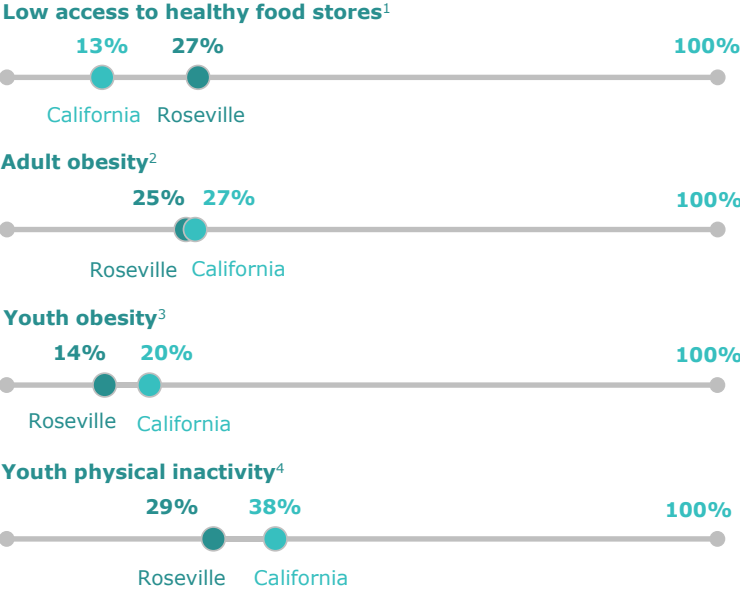
Healthy Eating and Active Living

Healthy eating and active living (HEAL) relate to the ability of residents to positively shape their health outcomes through a focus on nutrition and exercise. These behaviors, however, are impacted by many factors that are outside of individuals’ control, such as access to safe parks and affordable vegetables. Further, HEAL impacts the rates of many chronic conditions like cardiovascular disease (CVD) and stroke. The Kaiser Permanente Roseville service area scores better than the California state average on many of the indicators measuring HEAL, such that children and adults are less likely to experience obesity and physical inactivity. However, significant disparities exist by race and ethnicity, specifically related to obesity, inactivity, receipt of Supplemental Nutrition Assistance Program (SNAP) benefits, and stroke deaths. On average, residents in the Roseville service area are also less likely to have access to healthy food stores, and disparities related to geographic location increase challenges to accessing healthy food. Local stakeholders identified access to green, safe, walkable spaces; affordable and healthy food options; and nutritional information as barriers to HEAL.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.



Community Identified Barriers



- Lack of access to clean green spaces
- Lack of access to safe walkable spaces
- Lack of affordable and healthy food options
- Lack of nutritional education
- Lack of transportation to resources

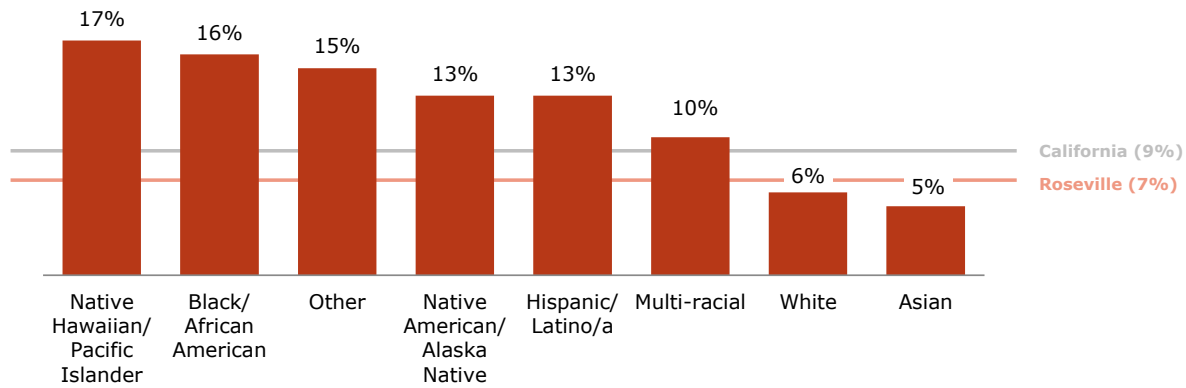
“I mean, to be honest, healthy foods are expensive. Kids can go to McDonald's and get a dollar burger, or pay \$5 for a pound of grapes. And what are they going to choose?”
- Service provider

The lack of nutritional education, where people maybe just don't even know the impact – especially children's health, with eating so much processed food, and things like that.”
- Service provider

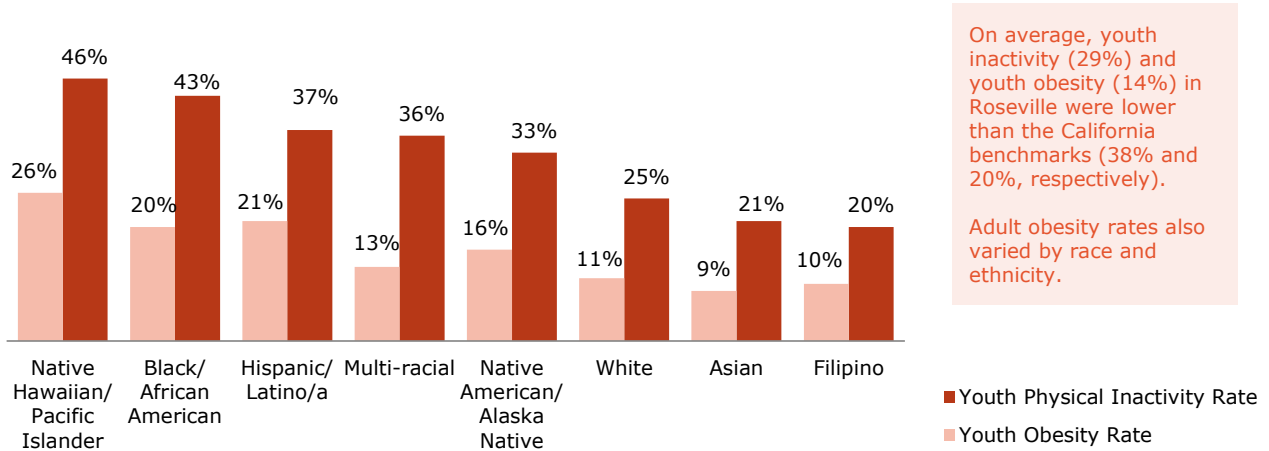
Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

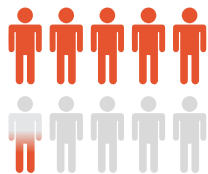
Receipt of Supplemental Nutrition Assistance (SNAP) benefits⁵



Youth obesity and inactivity rates⁶

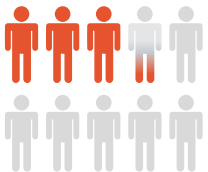


Stroke deaths (rate is per 100,000 population)⁷



54 out of 100,000 Black/African American individuals died of a stroke

whereas



33 out of 100,000 White individuals died of a stroke

“No one's walking to dinner, or to the grocery store, or anything like that. Everyone's driving. So that has an effect on health in that you're not getting physical activity doing that, and then you're dealing with the stress of traffic, and then all the traffic contributes to air quality as well. They all tie in together and have an effect on health.”
- Focus Group participant

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers related to healthy eating and active living varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Limited access to grocery stores and produce vendors⁸ was most prevalent in Yuba County, including Yuba City and areas surrounding the Beale Air Force Base. Only the Amador County portion of the HSA had better access than the state average.

**Not shown on map*
Walkable destinations⁹, including parks and playgrounds, were least available in Yuba, Sutter, and El Dorado Counties. However, the entire HSA has less access than the state average.

Emerging Needs

Roseville residents and providers reported the following emerging community needs:

- Obesity prevalence in the community
- Social media influence on mental health and physical health
- Lack of community trust and fear of reaching out for needed services (e.g., SNAP benefits) amongst the undocumented population



“ I think our needs, most of the ones I listed have been around a long time. I think obesity has become more of an issue in the past 10 years, because food has really gone through quite a lot of changes and it's such a profitable [market].

-Focus Group participant

They [the undocumented community] have always been a little bit resistant, and now...it seems like they won't take advantage of any [services], because of the fear of people coming through the community to deport them.

- Service provider ”

Assets and Ideas

Examples of Existing Community Assets

Roseville has many strengths. The following are assets identified by residents and providers.



Summer meal programs for children



Local food banks



Community education on healthy eating through schools

Ideas from Focus Groups and Interview Participants

Roseville residents and providers shared their ideas for how best to meet the needs in the community.

- Provide wellness programs in the community, including yoga and meditation, to encourage active living and help reduce stress
- Create walking clubs and other related wellness clubs that enable active living as well as socialization
- Provide food bank programs located in school sites to increase accessibility
- Ensure food banks with options for fresh and healthy foods
- Create community gardens
- Provide more affordable grocery store options
- Provide more affordable and efficient transportation options



References

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Kaiser Foundation Hospital – Roseville Service Area Community Health Needs Assessment

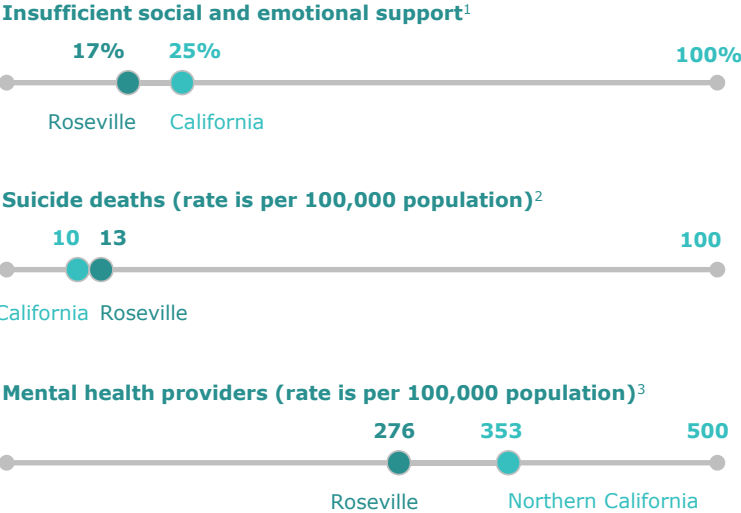
Mental and Behavioral Health

Mental and behavioral health are foundations for healthy living, and encompass rates of mental illness, access to social and emotional support, and access to service providers for preventive care and treatment for mental health and substance abuse. In extreme cases, mental health is associated with homelessness. The Kaiser Permanente Roseville service area scores on par with the California state average on many indicators related to mental and behavioral health, including substance use – excessive drinking, current smokers, and opioid prescription drug claims. However, the region also has higher rates of suicide deaths and reduced access to mental health providers compared to the state and region, respectively. In addition, racial and geographic disparities exist related to these indicators. Local stakeholders also identified existing trauma among community residents; lack of trust and knowledge to navigate health systems; experiences of stigma from providers; and financial challenges to meeting their mental and behavioral health needs.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.



Community Identified Barriers



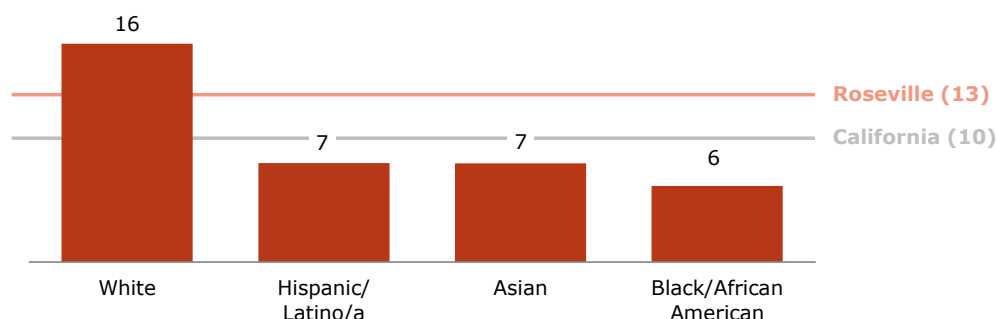
- Existing trauma
- Lack of financially affordable providers
- Lack of providers
- Lack of knowledge of systems
- Lack of trust and stigma
- Long waitlists for services

“The resources are there, but you're dealing with people with mental health issues who already have difficulty even just coming in the door to see us, but also insurance companies make it so difficult to get reimbursed as a therapist or even to get on their panel to be an in-network provider.”
- Focus Group participant

Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Suicide deaths (rate is per 100,000 population)⁴



Geographic Areas with Greatest Risk



Common barriers related to mental and behavioral health varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Low numbers of mental health providers⁵ were present in the Yuba County area. However, only the Sacramento County portion of the HSA exceeded the state average.

**Not shown on map:*
A higher number of poor mental health days⁶ were reported in Yuba, Sutter, and Sacramento Counties.

Emerging Needs

Roseville residents and providers reported the following emerging community needs:

- Increase in mental health issues in the community
- Lack of trust in the health care system, resulting in lack of access to mental health care services
- Influence of social media on mental health issues
- Political rhetoric impacting well-being

“It feels like all of these stressors are sort of ramped up, and a lot of political rhetoric that's ramped up, which impacts our communities without a match in resources and coping skills. I can teach you all the coping skills in the world. If you don't have resources...there's only so much deep breathing is going to do for you, right?”
 - Service provider

In 2018, 584 homeless individuals were identified in the Placer County annual point-in-time count, of which 39 percent were chronically homeless.⁷

Assets and Ideas

Examples of Existing Community Assets

Roseville has many strengths. The following are assets identified by residents and providers.



School-based services for students and their families



Organizations offering free counseling and case management services



Access to on-call nurses that are often coaching people through crises

Ideas from Focus Groups and Interview Participants

Roseville residents and providers shared their ideas for how best to meet the needs in the community.

- Provide information and resources to increase knowledge of how to navigate different health systems, including mental health systems
- Humanized health care systems that have diverse perspectives and present the ability to understand people of diverse backgrounds and complicated social situations
- Provide mentorship programs that connect folks with similar life experiences to support one another
- Provide suicide prevention trainings in school districts and other parts of the community
- Create specialized referrals between systems of care



References

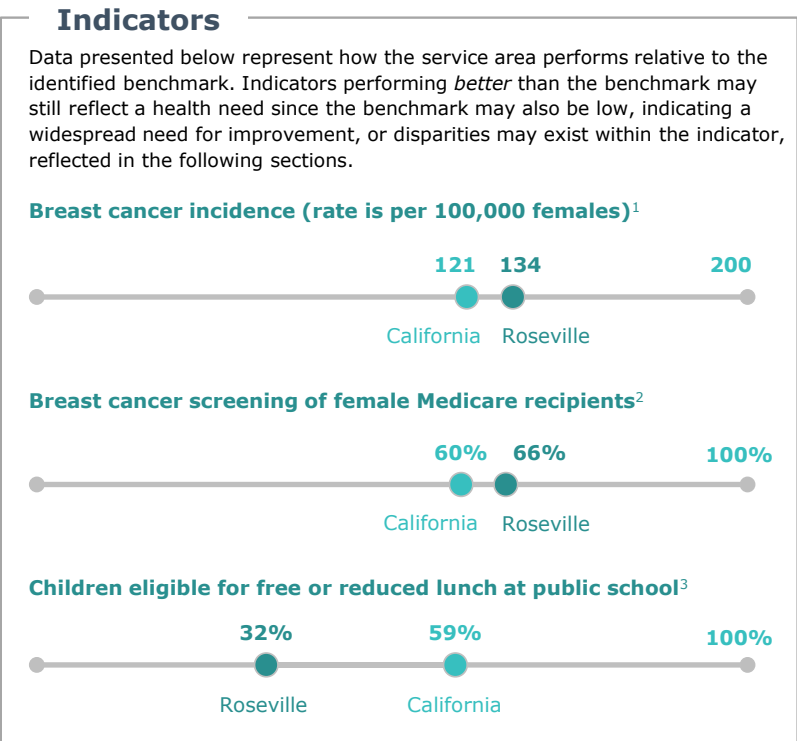
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- ² National Vital Statistics System. (2011-2015). Retrieved from <https://www.cdc.gov/nchs/nvss/index.htm>
- ³ Area Health Resource File. (2016). Retrieved from <https://data.hrsa.gov/>
- ⁴ National Vital Statistics System. (2011-2015). Retrieved from <https://www.cdc.gov/nchs/nvss/index.htm>
- ⁵ Area Health Resource File. (2016). Retrieved from <https://data.hrsa.gov/>
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- ⁷ Overview of the 2018 Placer County Homeless Count. (2018). Point-in time homeless count. Retrieved from <http://www.hrcscoc.org/point-in-time-count.html>

Kaiser Foundation Hospital – Roseville Service Area Community Health Needs Assessment

Women and Children's Well-Being

Women and children’s well-being reflects not only health outcomes, but also access to services, such as reproductive health, pre- and post-natal medical care, child care, and education. On average, within the Kaiser Permanent Roseville service area, women and children are faring relatively well compared to the state averages. For example, women receiving Medicare are more likely to report having breast cancer screenings and fewer children are eligible for free or reduced lunch. However, disparities within these indicators exist, with Black/African American women receiving fewer breast cancer screenings than White women, and infants of color being at greater risk of mortality. Further, within the Roseville service area, geographic disparities are prevalent regarding rates of preschool enrollment, domestic violence, and suicidal ideation by gay, lesbian, and bi-sexual students. Local stakeholders identified costly child care, lack of specialists, and knowledge of systems as barriers to women and children’s well-being.

Key Data



- #### Community Identified Barriers
-
- Costly child care
 - Lack of financially affordable services
 - Lack of knowledge of systems
 - Lack of access to specialists
 - Language barriers
 - Long waitlists for services
 - Stigma in accessing services

“There used to be a women’s health clinic in Lighthouse. You could receive annual women’s checkups right there, but now it is gone and those services are not accessible.
- Focus Group participant (translated from Spanish)

We provide the highest level of neonatal care in our area, besides in San Francisco. And so when people are here for extended periods of time with babies in the NICU, or they’re here as antepartum for prolonged periods of time, [there is no] resources for them for families to stay.”
- Focus Group participant

Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Breast cancer screenings⁴

On average, higher percentages of women received breast cancer screening in Roseville (66%) than California (60%).

57%

of Black/African American women received screenings

68%

of White women received screenings

Infant deaths (rate is per 1,000 births)⁵

5.5 The infant mortality rate for minority infants is **5.5** per 1,000 births

whereas

4.5 The infant mortality rate for White infants is **4.5** per 1,000 births

Geographic Areas with Greatest Risk



Common barriers related to women and children's well-being varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Lowest rates of preschool enrollment⁶ were in Amador, Sacramento, and Sutter Counties, as well as pockets of Placer (Auburn, Folsom, Lincoln, Roseville), El Dorado (Placerville), and Yuba (Yuba City) Counties. However, low rates were present across the HSA.

Not shown on map:* County-wide data indicated **higher suicidal ideation by gay, lesbian, and bi-sexual students⁷ in Amador, El Dorado, and Yuba counties than the state average in 2013-2015 (data not available for Placer County).

Emerging Needs

“I would say this year, we've seen the most mental health situations come up with the students...that we haven't seen in the past. So I know there's a need and now we just have to fill that need.”

- Service provider

Roseville residents and providers reported the following emerging community needs:

- Access to mental health services for children
- Fear of accessing needed services amongst the undocumented population
- Trauma amongst children of undocumented parents or mixed migratory status families

Assets and Ideas

Examples of Existing Community Assets

Roseville has many strengths. The following are assets identified by residents and providers.



Access to bilingual services



Kaiser Permanente mommy and me support groups



Activities for kids



Strong school engagement

“So I think language is very important in the doctor’s office, because if they can’t communicate how can they follow up [and] best serve their child’s need.”
- Service provider

Ideas from Focus Groups and Interview Participants

Roseville residents and providers shared their ideas for how best to meet the needs in the community.

- Provide access to low-cost women’s health centers
- Create mentorship programs for children and youth
- Provide low-cost child care for working parents
- Train educators and school-based staff on trauma informed practices
- Provide support groups for mothers with special needs children



References

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Appendix D. Prioritization Scoring

2019 HEALTH NEEDS PRIORITIZATION SCORES: BREAKDOWN BY CRITERIA

Health Need	Rank	Composite Weighted Score	Weighted Scores of Prioritization Criteria Used by Group		
	1= Highest Priority		Severity	Disparities	Impact
Access to Care	1	173.5	55.5	80	38
Mental and Behavioral Health	2	125.5	52.5	44	29
Economic Security	3	117	33	62	22
Women and Children's Well-Being	4	101.5	31.5	46	24
Healthy Eating and Active Living	5	90	30	38	22

Prioritization Criteria Definitions

Criteria	Definition	Weight used for scoring
Disparities	Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.	2
Severity	Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. <i>(Also considers the magnitude/scale of the need. The magnitude refers to the number of people affected by the health need.)</i>	1.5
Impact	The ability to create positive change around this issue including – potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.	1

Appendix E. Focus Group Protocol

Focus Group Protocol

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

Introduction + Getting Settled (15 minutes)

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

We are working for [Kaiser Permanente/OTHER] to help understand the health needs in this area. We will be using the information we collect during discussions like this and data from the health department and census to write our report. [Add if working with CHI/other consultant]: [HOSPITAL NAME(S)] hospitals are also doing similar research, so we are working with their consultant, [CONSULTANT] also. What we learn from this discussion will be shared with [CONSULTANT].

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

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

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

[FACILITATOR ADJUST AS NECESSARY, DEPENDING ON # OF SURVEYS FILLED AT ONSET]

I also have a short survey for you to fill out if you would like to. This will help us learn more about who is joining these conversations. The survey is anonymous, so you do not need to put your name on it and we will only use it in our report all together with everyone else's answers. If you haven't filled the survey out and would like to, please do so after we finish the discussion.

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

Does anyone have any questions before we start?

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

1. Let's start by introducing ourselves.
 - a. **Residents:** Please tell us your name, the town you live in, and one thing that you are proud of about your community.
 - b. **Service Providers:** Please tell us your name, your current position, and role within your organization.
2. We would like to hear about the community **where you live/that you serve**.
 - a. **Residents:** Tell us in a few words what you think of as "your community". What it is like to live in your community?
 - b. **Service Providers:** How would you define the communities and populations you serve?
3. Next, we would like to do a short activity.

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

Step 1

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

Step 2

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

Step 3

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

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

Health Issues – 15 Minutes (55 minutes left)

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

4. What do you think that a "healthy environment" is?
5. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?
 - a. PROMPT: Are needs more prevalent in a certain geographic area, or within a certain group of the community?
6. What issues are coming up lately in the community that may influence health needs?

Challenges and Barriers – 10 Minutes (40 minutes left)

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

7. What are the challenges or barriers to being healthy in your community?
 - a. PROMPT: I know [insert from above conversation if applicable] has already been mentioned, what are some other things that act as barriers or challenges?

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

8. From your perspective, what health services are difficult to access for you and the people you know in your community?
 - a. PROMPT: What challenges keep individuals from seeking help?

Solutions – 10 Minutes (30 minutes left)

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

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

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

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

Priorities – 15 minutes (25 minutes left)

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

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

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

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

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

12. **[TIME PERMITTING]** During the last Community Health Needs Assessment (conducted in 2015), *[insert top 2-3 key priority needs from 2016 CHNA here]* were all identified as key needs in this region. What do you think has *changed/stayed the same* in the community since 2015 that makes these priorities *less/more/equally* pressing?

Example for Santa Rosa:

- access to affordable, high quality early childhood education
- Improved equity in K-12 educational outcomes
- affordable housing
- enhanced access to jobs that pay a living wage

Resources – 10 Minutes (10 minutes left)

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

a. PROMPT:

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

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

a. PROMPT:

- Service providers
- Community leaders
- Community groups

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

Community Ladder – Background and Directions

Question #3

Purpose

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

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

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

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

Step 1

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

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

Step 2

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

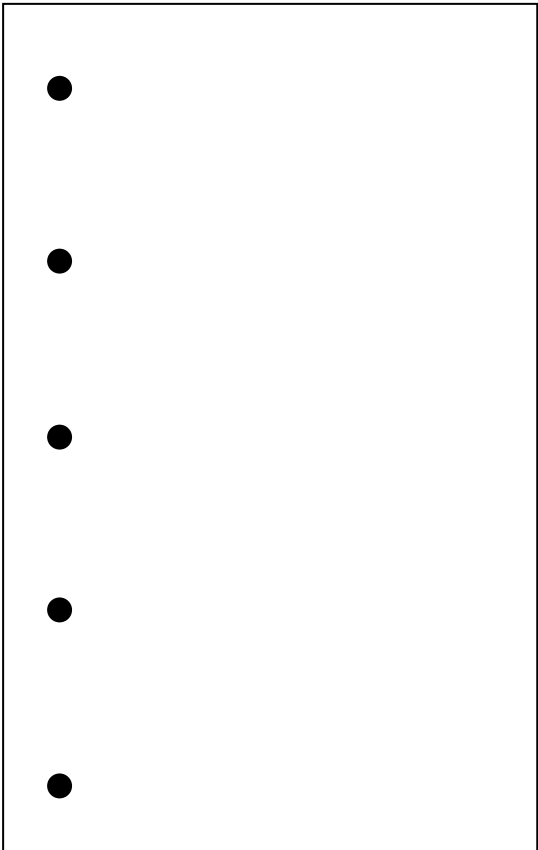
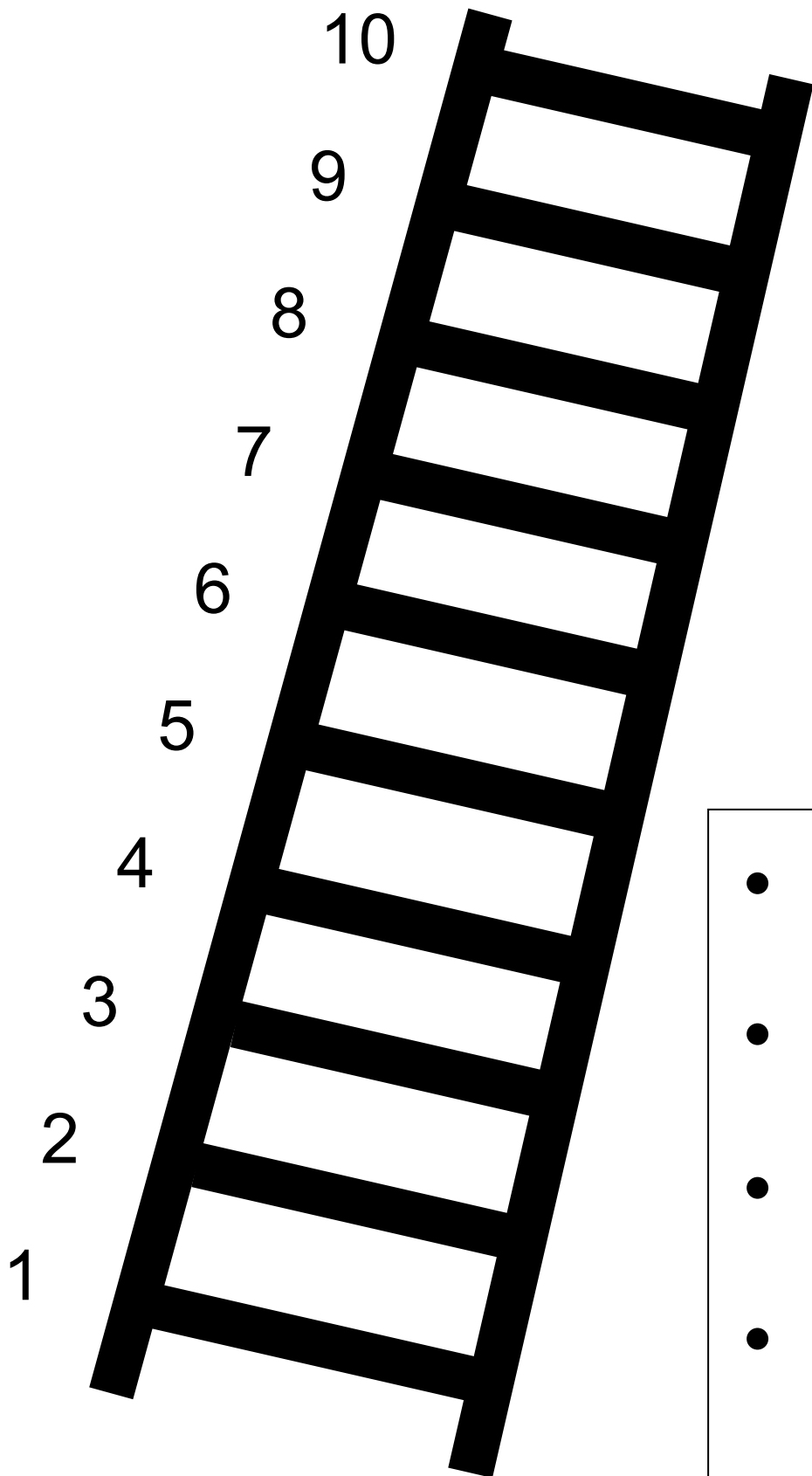
Step 3

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

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

Return to protocol

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



Appendix F. Group Interview Protocol

Group Interview Protocol

Introduction + Getting Settled (10 minutes)

Hello my name is _____ from Harder+Company Community Research. We have been hired by Kaiser Permanente to complete their 2019 Community Health Needs Assessment to better understand the health needs in this region. We will be using the data collected during interviews as well as quantitative data to inform the report. Dignity, Sutter, and UC Davis hospitals are also conducting their Community Health Needs Assessment. We are collaborating with their consultant, Community Health Insights (CHI), to conduct primary and secondary data collection. The information from this interview will be shared with CHI.

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

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

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

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

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

If no one objects, we would like to record this conversation. The recording will only be used to ensure that we accurately capture the conversation today. They will be shared with CHI and only reviewed by Harder+Company and CHI staff. Is it okay with everyone if I record?

Do you have any questions for me before we start?

Background – 10 minutes (50 minutes left)

16. Briefly, what is your current position and role within your organization?
17. How would you define the communities you serve and live in, as well as the population you serve?
 - a. It may be helpful to think about the following: specific geographic regions, the racial or ethnic makeup of the community or the physical environment

Health Issues – 10 Minutes (40 minutes left)

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

18. What does a healthy environment look like?
19. When thinking about your community in the context of the healthy community you just described, what are the biggest health needs in the community?
 - a. PROBE: Are needs more prevalent in a certain geographic area, or within a certain group of the community?
20. What have been some emerging issues in the community that may influence health needs?

Challenges/Barriers – 10 Minutes (30 minutes left)

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

21. What challenges or barriers exist in the community to being healthy?
 - a. PROMPT: I know *[insert from above conversation if applicable]* has already been mentioned, what are some other things that act as barriers or challenges?
 - b. PROMPT: **Reflect on what you have heard so far, ask about other types of barriers that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land)*

Solutions – 10 Minutes (20 minutes left)

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

22. What are some solutions that can address the barriers and challenges that you have identified?
 - a. PROMPT: **Reflect on what you have heard so far, ask about other types of barriers that may not have been mentioned yet, including the following: behaviors, social factors, economic factors, clinical care factors, or the physical environment (e.g., air, water, sound, land)*

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

Priorities – 5 minutes (10 minutes left)

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

23. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address in order to improve the health of the community?
24. Are these needs that have recently emerged or are long-standing?

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

Resources – 5 Minutes (5 minutes left)

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

a. PROBE:

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

26. Are there certain groups or individuals that you think would be helpful to speak with as we go forward with our Community Health Needs Assessment?

a. PROMPT:

- i. Service providers
- ii. Community leaders
- iii. Community groups

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