



2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Santa Rosa

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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-Santa Rosa

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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 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 approximately 120 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 key informant interviews, focus groups, and surveys. 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-Santa Rosa 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>.

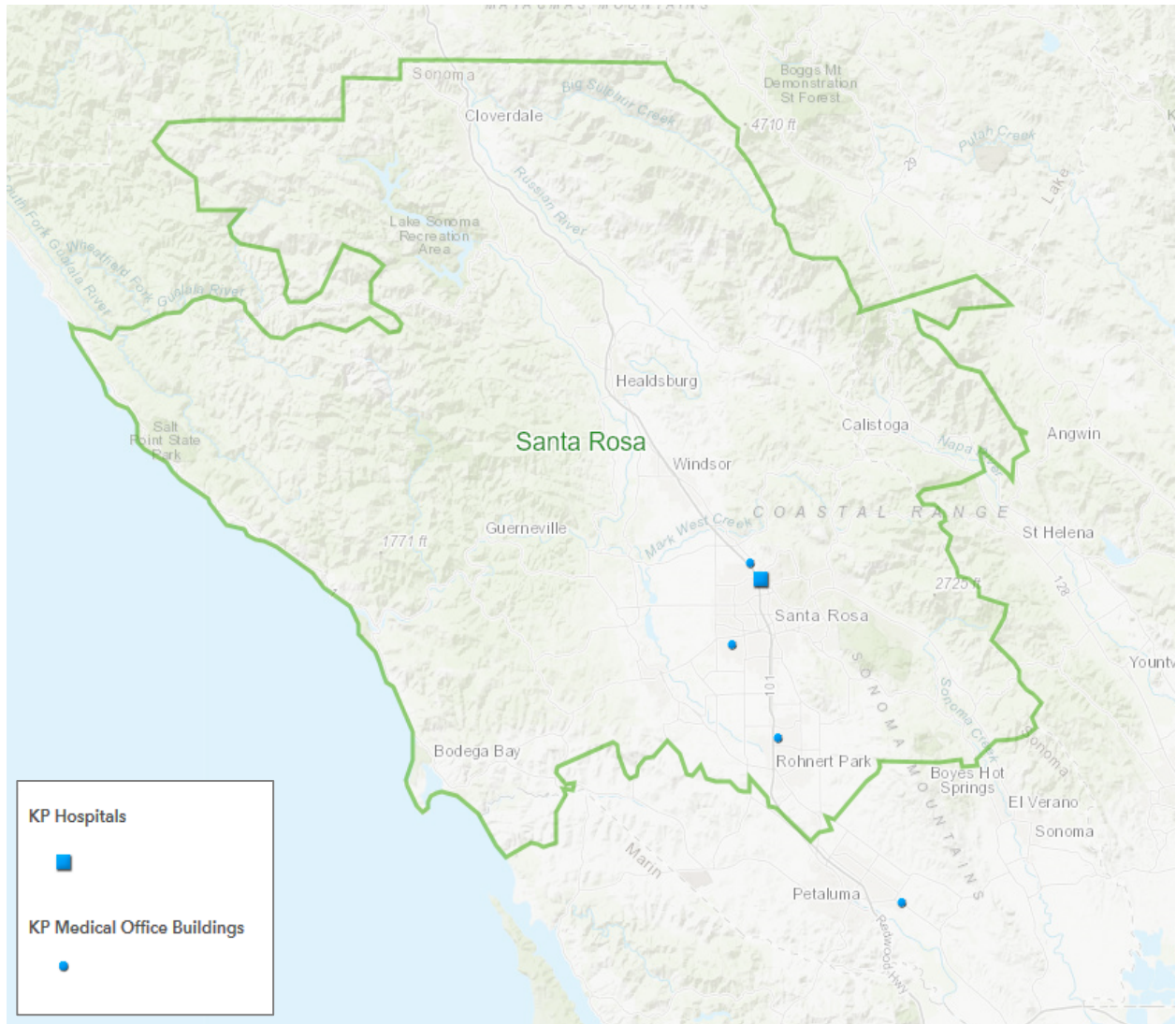
II. Community served

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-Santa Rosa Service Area

ii. Geographic description of the community served

The KFH-Santa Rosa service area includes a small section of Napa County (Calistoga and Woodleaf) and most of Sonoma County, except for a small southern portion of Sonoma County that includes the city of Petaluma. Cities in the KFH-Santa Rosa service area include Cloverdale, Cotati, Healdsburg, Rohnert Park, Santa Rosa, Sebastopol, Sonoma, and Windsor. The Kaiser Permanente data platform was the primary source of data for this report. However, Marin County data was used as a proxy for the service area when sub-county data was unavailable.

iii. Demographic profile of the community served

Demographic profile: KFH-Santa Rosa

Race/ethnicity		Socioeconomic Data	
Total Population	394,030	Living in poverty (<100% federal poverty level)	11.7%
Asian	4.1%	Children in poverty	13.8%
Black	1.7%	Unemployment	2.8%
Native American/Alaska Native	1.2%	Uninsured population	10.4%
Pacific Islander/Native Hawaiian	0.3%	Adults with no high school diploma	13.2%
Some other race	11.9%		
Multiple races	5.4%		
White	75.2%		
Hispanic/Latino	27.2%		

III. Who was involved in the assessment?

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

KFH-Santa Rosa worked with both hospital and other partner organizations with similar service areas in Sonoma County to form the Sonoma County CHNA Collaborative to support the 2019 CHNA. This group developed a coordinated approach to primary data collection, and then determined the list of significant health needs based on both primary and secondary data analysis. KFH-Santa Rosa then coordinated with these partners to engage a broader group of community stakeholders to prioritize the identified health needs (described in Section VI-B).

Collaborative hospital partners:

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

Additional partners:

1. Sonoma County Department of Health Services

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

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights

about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts—including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including the hospital service areas in Roseville, Sacramento, San Bernardino, San Rafael, South Sacramento, Vacaville, and Vallejo.

IV. Process and methods used to conduct the CHNA

A. Secondary data

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

KFH-Santa Rosa used the Kaiser Permanente CHNA Data Platform (<http://www.chna.org/kp>) to review approximately 130 indicators from publicly available data sources.

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

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

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

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-Santa Rosa 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 be included in the health need profiles (see Appendix A. Secondary data sources and dates for a list of additional data sources).

The Harder+Company team reviewed this additional data and included data points in the health need profiles that provided additional context or more up-to-date statistics to indicators already included in Kaiser's CHNA Data Platform. Each health need profile includes a reference section with a detailed list of all the secondary data sources used in that profile (see

Appendix C. Health Need Profiles).

The Harder+Company team did not conduct any additional analysis on secondary data. The CHNA Data Platform provides information about health disparities and data benchmarks, and the additional secondary data that was shared by CHNA partners often disaggregated data by, for example, region and race/ethnicity.

B. Community input

i. Description of who was consulted

A broad range of community members provided input through key informant interviews, group interviews, and focus groups. We consulted individuals with knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, we gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., race/ethnic minorities and 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-Santa Rosa service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries. For a complete list of participating organizations, see Appendix B. Community input tracking form. The consulting team developed interview and focus group protocols, which the CHNA Collaborative reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. We also asked participants 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 Z.

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

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

We 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, we made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, we 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 focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Portal groups approximately 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 indicators into health need categories similar to those identified in the Kaiser CHNA Data Portal. 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 Portal if it met *any* of the following conditions:
 - *Overall severity*: indicator Z-score much worse or worse than benchmark.
 - *Disparities*: indicator Z-score 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) or represented a unique need of the region.
2. A health need category was classified 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 high 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, residents, and others) to prioritize the health needs. Community benefits managers from KFH-Santa Rosa attended the meeting to observe and help facilitate, but did not vote. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

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

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

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Harder+Company then tallied the votes after the prioritization meeting and shared the final ranked list with participants via email.

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

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

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

1. **Housing and Homelessness:** Sonoma County’s high cost of living exacerbates issues related to health care access and affordability. More than half of renters in the county

spend 30 percent or more of their income on rent. A quarter of households in the KFH-Santa Rosa service area face poor conditions such as inadequate plumbing or kitchen facilities. There is also strong regional variation in home prices: Rohnert Park is the most affordable area with a median home selling for \$479,500, compared to Healdsburg, which is least affordable with a median home price of \$804,000.¹ The burden of housing costs exacerbates disparities; for example, Latino families in Sonoma (with median household incomes of \$55,675) fall below the minimum qualifying income for a median price home in the county (\$112,840).² Additionally, the number of individuals experiencing homelessness rose 6% to 2,988 since the October 2017 Sonoma Complex Fires.³ Homelessness exposes individuals to increased health risks on a variety of measures, and service providers have difficulty getting those experiencing chronic homelessness both off the street and into a continued care arrangement. 35 percent of those who are experiencing homelessness have psychiatric or emotional conditions, 33 percent experience drug or alcohol abuse, and 27 percent have chronic health problems.⁴ Individuals experiencing homelessness in Sonoma County identify across several race/ethnicities, with the majority identifying as White (62 percent) followed by Hispanic/Latino (28 percent) and multi-racial (21 percent). Focus group respondents reported that money spent on rent impedes their ability to afford preventative and urgent medical care. These issues were exacerbated by the October 2017 Sonoma Complex Fires, which both destroyed homes, and increased unemployment among the most disadvantaged.

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

¹ Bay Area Real Estate Information Services (2017).

² "Hispanic Demographic Trends." Economic Development Board (2017).

³ Point in Time Count, Sonoma County, Homeless Census and Survey. (2018).

⁴ Ibid.

⁵ American Community Survey (2013-17).

⁶ American Community Survey. (2012-16).

⁷ Educational and Workforce Development Report (2018).

grade math standards compared to only 19 percent of Hispanics.⁸ Focus group participants also expressed a desire for career and technical training to meet workforce needs, and felt classes on financial literacy and sexual health would particularly benefit the most disadvantaged residents.

- 3. Economic Security:** Economic security means having the financial resources, public supports, career, and educational opportunities necessary to be able to live one's life to the fullest. As such, this health need touches on every other health-related issue in the KFH-Santa Rosa community, from mental health to housing. While Sonoma County has slightly less economic inequality than California as a whole, there is significant racial and regional variation along economic measures. Child poverty (children living 100 percent below the federal poverty level) is especially high among Native American/Alaska Native (23 percent), Hispanic/Latino (19 percent) and Black (14 percent) community members in the KFH-Santa Rosa service area.⁹ Non-Hispanic Whites in the county have higher wages and rates of business ownership. For example, Whites have the highest average annual earnings (a salary measure distinct from income since it does not include pensions, stocks, and public assistance benefits) of \$36,647, followed by Asian Americans (\$32,495), African Americans (\$31,213), and Latinos (\$21,695).¹⁰ Additionally, 22 percent of seniors have incomes less than 200 percent of the federal poverty level.¹¹ The October 2017 Sonoma Complex Fires contributed to even greater economic inequality between racial and ethnic groups, as the most vulnerable residents work in occupations (e.g., agricultural work) affected by the fires. Community members voiced in focus groups that inequity between high- and low-income areas impacts community cohesion and leads some to feel underrepresented in political discussions, which can impact economic and health policy.
- 4. Access to Care:** Access to quality health care is important for maintaining health, preventing disease, and reducing avoidable disability and premature death. In terms of preventative investments, improving healthcare access is one of the key strategies to achieving health equity. While Sonoma County scores better than the California state average on many indicators measuring health care access, including a low uninsured rate (9 percent)¹² and a higher proportion of federally qualified health centers per the population, racial minorities and lower income individuals specifically face great challenges in obtaining affordable care. Only 70 percent of Black Medicare enrollees in the KFH-Santa Rosa Service area visited a primary care physician in the past year compared to 77 percent of Whites.¹³ Additionally, Latino children have three times the

⁸ Ibid.

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

¹⁰ "A Portrait of Sonoma" Sonoma County Human Development Report 2014.

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

¹² Small Area Health Insurance Estimates. (2015).

¹³ Dartmouth Atlas of Health Care. (2012).

rate of untreated dental cavities compared to their non-Hispanic White counterparts.¹⁴ Fewer Medicare beneficiaries in the KFH-Santa Rosa service area had a primary care visit in the past year (61 percent) compared to the state average of 72 percent.¹⁵ Additionally, 30 percent of farmworkers in the region have U.S.-based health insurance compared to 86 percent of Sonoma County adults overall.¹⁶ The county continues to work toward providing affordable and culturally competent care for all residents, especially its large Hispanic/Latino population. At the same time, focus group and interview respondents indicated several additional ways leaders can expand these supports to address disparities across the community, including increasing the number of bilingual service providers and expanding peer mentorship and resources that aid in health systems navigation.

- 5. Mental Health and Substance Use:** Residents in Sonoma County showed significant needs related to behavioral health. Compared to the state, residents of Sonoma County reported similar rates of contemplating suicide (10 percent and 13 percent, respectively).¹⁷ However, there are also racial differences. For example, 36 percent of Latino 9th graders in Sonoma County reported chronic sadness/hopelessness compared to 32 percent of White 9th graders.¹⁸ With respect to gender, men in Sonoma County have over three times the number of years of potential life lost before the age of 75 due to suicide compared to women.¹⁹ Community stakeholders expressed a desire to increase accessibility to mental health services, erase stigma, and develop a language to discuss mental health issues. Furthermore, feelings of depression, hopelessness, and anxiety or fear nearly doubled among at least one member of households in the year following 2017 Sonoma Complex Fires. In terms of substance use, residents of the KFH-Santa Rosa service area reported similar rates of excessive drinking compared to the state (20 percent and 18 percent, respectively).²⁰ However, Sonoma County has a rate of hospital visits due to opiate overdoses 80% higher than the California rate (18/100,000 and 10/100,000 respectively).²¹ Interviewees also identified concerns with the prevalence of vaping and marijuana, especially among youth.
- 6. Maternal and Child Health:** Mothers and infants in Sonoma County face a range of barriers to health, from excessive weight gain during pregnancy to factors that impact economic security and general well-being. These issues are further magnified by racial disparities. Minorities in the KFH-Santa Rosa service area experience a rate of infant

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

¹⁵ Dartmouth Atlas of Health Care. (2012).

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

¹⁷ California Health Interview Survey (2009-17)

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

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

²⁰ Behavioral Risk Factor Surveillance System.

²¹ CDPH Opioid Dashboard 2015-17

mortality 25% higher than Whites (5/1,000 and 4/1,000 respectively).²² Additionally, Hispanic/Latino populations have higher teen birth rates; 62 percent of teen births in the KFH-Santa Rosa service area are to Hispanic mothers.²³ Interviewees expressed frustration with a lack of childcare options and culturally competent educational resources related to sexual education. For example, 31 percent of Sonoma County's demand for care for children ages zero to twelve is unmet.²⁴ Further, maternal asthma is associated with a number of negative outcomes including premature birth, low birth weight, and neonatal death. Asthma during pregnancy disproportionately affects women in Sonoma (11 percent reported asthma during pregnancy) when compared to the state average (8 percent reported asthma before pregnancy).²⁵ Group interview participants highlighted how domestic workers in particular face sexual abuse and exposure to hazardous chemicals, which impact maternal and child health.

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

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

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

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

²⁵ MIHA Data snapshot, Sonoma County 2013-14.

²⁶ USDA Food Access Research Atlas.

²⁷ Fitnessgram Physical Fitness Testing (2017).

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

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

stakeholders emphasized that hunger and food insecurity have worsened since the 2017 Sonoma Complex Fires in concurrence with increased economic and housing insecurity.

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

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

³⁰ 2018 County Rankings (2016 BRFSS Data).

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

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

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

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

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

³⁶ FBI Uniform Crime Report. (2017).

³⁷ National Intimate Partner Violence Survey.

to Cloverdale and Geyserville with the highest rates (25 percent YPLL-75 each).³⁸ Finally, the impact of the 2017 Sonoma Complex Fires caused an increase in disaster-related injuries. Of the 40 percent of households with a member who experienced traumatic events during those fires, 8 percent suffered a significant disaster-related illness or injury to self or a family member.³⁹ Community stakeholders also expressed concern with personal safety while walking, and fear for undocumented community members who are vulnerable to injury.

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

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

Examples of community resources available to respond to each community-identified health need, as identified in qualitative data, are indicated in each health need brief found in

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

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

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-Santa Rosa 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Santa Rosa'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-Santa Rosa's 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 (www.kp.org/chna). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Santa Rosa in the 2016 Implementation Strategy Report.

1. Healthy Eating/Active Living
2. Access to Health Care
3. Behavioral Health
4. Early Childhood Development

KFH-Santa Rosa 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-Santa Rosa 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-Santa Rosa 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-Santa Rosa 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 grant making, 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-Santa Rosa awarded 317 grants amounting to a total of \$8,808,423.77 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-Santa Rosa service area. During 2017-2018, a portion of money managed by this foundation was used to award four grants totaling \$3,114,761.90 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-Santa Rosa 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, KFH-Santa Rosa 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-Santa Rosa Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care	<p><i>During 2017 and 2018, KFH-Santa Rosa awarded 73 grants totaling \$5,208,115.77 that address Access to Care in the KFH-Santa Rosa service area.</i></p>	<p><u>KP Medicaid and Charity Care:</u> In 2017 and 2018 KP served 17,871 and 17,009 Medi-Cal members respectively totaling \$37,380,660.74 worth of care. KP also provided a total of \$12,869,228.42 of Medical Financial Assistance (MFA) to 8,208 individuals in 2017 and 5,349 individuals in 2018.</p> <hr/> <p><u>Access to care programs:</u> KFH Santa Rosa awarded \$126,322 in grants to improve access to care for vulnerable populations. Key highlights:</p> <ul style="list-style-type: none"> A. Community Action Partnership Sonoma County received \$30,000 for its Save Our Smiles program to address the epidemic of dental disease in Sonoma County children by providing access to dental services and helping families overcome access barriers to dental care by providing services in schools and community locations. More than 1,100 students have received fluoride treatments and more than 600 have benefited from dental screenings. B. Jewish Community Free Clinic received \$30,000 in general operating support to ensure free health care services are made available to anyone in need. <hr/> <p><u>Operation Access:</u> Operation Access received a \$350,000 grant (evenly split between 15 KFH hospital service areas) to coordinate donated medical care and expand access to care for low-income uninsured adults in the Bay Area through its volunteer and hospital network. 669 staff/physician volunteers provided 650 surgical and diagnostic services at 11 facilities, reaching 521 adults.</p> <hr/> <p><u>211:</u> Volunteer Center of Sonoma County, Inc. received a \$50,000 grant to support 211's services to increase public benefit enrollment for low income Sonoma County community members. They expect to enroll a minimum of 200 individuals in CalFresh and/or refer them to Medicare.</p> <hr/> <p><u>PHASE:</u> Over the course of three years (2017-2019), Redwood Community Health Coalition (RCHC) is the recipient of a \$500K grant (evenly split between 3 KFH hospital service areas) to support the successful use of PHASE among member health center organizations. Strategies include developing a self-measured blood pressure monitoring program and facilitating peer sharing around quality improvement practices. RCHC is reaching over 25,000 patients through PHASE. 74% of their patients with diabetes and 68% of their patients with hypertension have their blood pressure controlled.</p>

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Healthy Eating Active Living	<i>During 2017 and 2018, KFH-Santa Rosa awarded 51 grants totaling \$653,824.76 that address Healthy Eating Active Living in the KFH-Santa Rosa service area.</i>	<p><u>Food insecurity.</u> Redwood Empire Food Bank (REFB) received a \$25,000 grant to support fresh produce distribution. REFB's Harvest Pantry served a weekly average of 190 families and 215 children 0 to 6 across seven Sonoma County sites and distributed approximately 226,000 pounds of nutritious food, including 158,575 pounds (70%) of fresh produce to participating families weekly, in addition to offering a series of three bilingual nutrition education lessons focusing on healthy eating and activity for the whole family. By offering nutritious food, free of charge, with a focus on the prevention of iron-deficiency anemia and obesity in young children, the pantry makes a positive impact on the lives of low-income families in the community.</p> <p><u>Childhood obesity.</u> The Center for Well-Being received a \$40,000 grant to implement safe and inclusive physical activity at school sites. Active Play Every Day provides 10 low-income Sonoma County schools with training, resources, and support to integrate daily physical activity into the school day, and a strategy to combat childhood obesity and the development of chronic disease later in life. More than 6,000 students benefit from this program, increasing their daily movement.</p> <p><u>CalFresh:</u> Redwood Community Health Coalition (RCHC) received a \$95,000 grant (evenly split between KFH-Rafael and KFH-Santa Rosa) to increase CalFresh participation by building health center capacity for outreach and in-reach. To date, outreach efforts have included staff presentations to service providers, tabling at health hubs, senior events and farmers markets. RCHC expects to assist 5,000 health center patients who are enrolled in Medi-Cal to enroll in CalFresh.</p> <p><u>Parks:</u> Community Action Partnership (CAP) of Sonoma County received a \$75,000 grant to make improvements to Roseland Elementary School community park and to offer programs designed to increase community use, particularly among low-income children and families. CAP collected baseline surveys from 306 community members to identify areas in need of improvement. Once complete, it is expected that park utilization will increase leading to an increase in community cohesion.</p>
Mental Health and Wellness	<i>During 2017 and 2018, KFH-Santa Rosa awarded 54 grants totaling \$1,288,711.94 that address Mental Health and Wellness in the KFH-Santa Rosa service area.</i>	<u>Mental health services:</u> Social Advocates for Youth received a \$35,000 grant to provide weekly therapeutic mental health services for up to 16 at-risk youth 18 to 24 enrolled in the agency's housing programs. The goal of the program is to build socio-emotional skills and decrease mental health symptoms to help youth become self-sufficient.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		<p><u>Community education.</u> National Alliance for Mental Health (NAMI) received a \$30,320 grant to support ongoing programs that build understanding of mental illness in community, teach warning signs, dispel misconceptions that contribute to the stigma that keeps people from seeking treatment, and provide support to families affected by mental illness. NAMI has been able to respond to more than 200 warm line callers – in addition to 50 wildfire survivors – within the first half of the reporting period.</p> <p><u>Safe Schools.</u> Community Matters received a \$15,000 grant to create safer school climates with improved social/emotional wellness by engaging, equipping, and empowering students to stand up and speak up when they witness bullying and cyber bullying. Funding supported the evidence-based Safe School Ambassadors (SSA) program at three Santa Rosa area schools.</p> <p><u>Stigma:</u> Lifeworks of Sonoma County received a \$90,000 grant to address mental health stigma and increase understanding of mental health and wellness among low-income Latino adolescents with dual diagnosed mental health conditions. Lifeworks will develop a bilingual parent education curricula, and launch a public education campaign. Lifeworks expects to reach 800 youth and families.</p> <p><u>Resilience:</u> Santa Rosa Community Health Centers received a \$98,000 grant to support Elsie Allen High School to develop a trauma informed school environment by providing behavioral health services to students, training teachers and staff on trauma informed practices and developing partnerships with new school leadership. The expected outcomes include increase referrals for services, improved coping skills among students and staff and increase awareness about mental/emotional health.</p>
Early Childhood Education	<p><i>During 2017 and 2018, KFH-Santa Rosa awarded 71 grants totaling \$514,491.37 that address Early Childhood Education in the KFH-Santa Rosa service area.</i></p>	<p><u>Nutrition education:</u> Community Child Care Council of Sonoma County received a \$20,000 grant to provide nutrition workshops and training for staff, child care providers, and parents at 12 child care centers. A standardized curriculum, including food demos and tastings that utilized seasonal produce, was rolled-out at every childcare setting.</p> <p><u>Parent advocacy:</u> The Living Room received a \$24,200 grant to better serve families in Sonoma County who are homeless or at risk for homelessness through a parent advocacy training program focused on parenting strategies and child development. Monthly trainings are on track to benefit more than 300 children.</p>

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		<p><u>Gym program</u>: The kinder gym program at River to Coast Children’s Services received a \$20,000 grant to support language development, promote social-emotional skills, increase opportunities for fine and gross motor skills, and perceptual and cognitive development through a relationship-based approach for all children. This project has reached more than 143 unduplicated parents year-to-date.</p>

VII. Appendices

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

ii. Additional sources

Appendix B. Community input tracking form

Appendix C. Health Need Profiles

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. A Report of the Surgeon General	2017
2. Alcohol and Other Drug Prevention Strategic Plan, County of Sonoma	2015-2020
3. American Journal of Epidemiology	2018
4. Bay Area Real Estate Information Services	2017
5. California Department of Public Health	2013-2015
6. CDPH Opioid Dashboard	2015-17
7. CDPH Vital Statistics Multiple Cause of Death Files & California Department of Public Health - Safe and Active Communities Branch	2015-17
8. California Health Care Foundation	2016
9. California Health Report	2016
10. California Healthy Kids Survey	2015-2016
11. California Office of Traffic Safety (OTS)	2016
12. County Rankings (BRFSS Data)	2016
13. Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018.	2018
14. Economic Development Board	2017
15. Educational and Workforce Development Report	2018
16. Feeding America	2016
17. International Journal of Occupational Medicine and Environmental Health	2016
18. Kaiser Permanente Look Inside	2018
19. Maternal and Infant Health Assessment (MIHA)	2013-2014
20. Measure of America analysis of California Department of Education data (DataQuest)	2011-2012
21. National Center for Health Statistics	2006-2012
22. National Intimate Partner Violence Survey	2015
23. North Bay Business Journal	2017
24. Proceedings of the National Academy of Sciences of the United States of America	2016
25. Public Library of Science	2018
26. Rapid Health Needs Assessment (CASPER)	2018
27. Small Area Health Insurance Estimates	2012
28. Sonoma County Area Agency on Aging	2012
29. Sonoma County Childcare Needs Assessment Update	2014
30. Sonoma County Dental Health Network Strategic Plan	2017-2020
31. Sonoma County Farmworker Health Survey	2013-2014
32. Sonoma County Human Development Report	2014
33. Sonoma County Maternal, Child and Adolescent Health (MCAH) Annual Report for the California Department of Public Health	2013
34. Sonoma County Point-in-Time Homeless Count and Survey	2018
35. Sonoma County Suicide and Self-harm Data from 2017 (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services.	(2017) 2018
36. Sonoma County Summary Measures of Health	2005-2015
37. U.S. Department of Education, EDfacts	2011-2012
38. US Census Quick Facts	2018

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	United Way (Director of Community Benefits)	1	Minority, Medically underserved, Low-income	Service provider	8/17/18
2	Key Informant Interview	Community Foundation Sonoma County (Executive Director)	1	Minority, Medically underserved, Low-income	Service provider	8/29/18
3	Key Informant Interview	John Jordan Foundation (Executive Director)	1	Minority, Medically Underserved, Low-income	Service provider	8/22/18
4	Key Informant Interview	Northern California Center for Well-Being (Director of Special Projects)	1	Minority, Medically Underserved, Low-income	Service provider	9/17/18
5	Key Informant Interview	Redwood Food Bank (Executive Director)	1	Minority, Low-income	Service provider	9/10/18
6	Key Informant Interview	Sonoma County Department of Behavioral Health (Medical Director for the Division of Behavioral Health); Sonoma County Department of Health Services (Healthy Communities Section Manager)	2	Health department representative, Medically underserved, Low-income	Service providers	10/8/18
7	Key Informant Interview	Sonoma County Family Justice Center (Executive Director)	1	Minority, Medically Underserved Low-income	Service provider	8/29/18
8	Key Informant Interview	West County Community Services (Executive Director)	1	Minority, Medically Underserved Low-income	Service provider	8/27/18

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

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

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

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

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

Medically underserved:

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

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

Low-income

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

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

Minority

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

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

Health department representative

Focus Groups: N/A

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

Appendix C. Health Need Profiles

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

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Access to Care

Access to quality health care is important for maintaining health, preventing disease, and reducing avoidable disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. While Sonoma County scores better than the California state average on many indicators measuring health care access including a low uninsured rate and a higher rate of federally qualified health centers, racial minorities and lower income individuals specifically face great challenges in obtaining affordable care. The county continues to work towards providing affordable and culturally competent care for all residents, especially its large Hispanic/Latino population; at the same time, focus group and interview respondents indicated several additional ways leaders can expand these supports to address disparities across the community.

Key Data

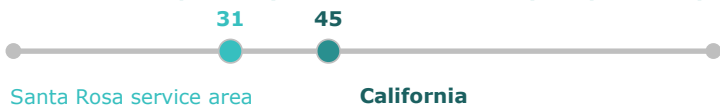
Indicators

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.

Uninsured population (under age 65)¹



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



Primary care visits in the past year, Medicare beneficiaries³



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



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

- Key Informant

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

- Key Informant

Community Identified Barriers



Physical Access/Transportation

- Long wait times after the Sonoma Complex Fires
- Long distances to travel for specialty care (e.g., mental health care)
- Long wait times to access a medical translator



System Navigation

- Language/cultural barriers
- Fear of deportation for accessing services
- Lack of broadband access affects use of telemedicine for rural residents

Populations Disproportionately Affected

Populations with Greatest Risk

70% of Black

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

77% of White

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

1/5

of Sonoma third graders have currently untreated cavities



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

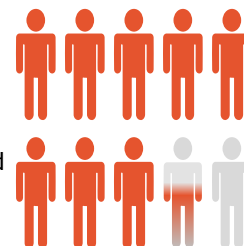
30%

of farmworkers have US-based health insurance



86%

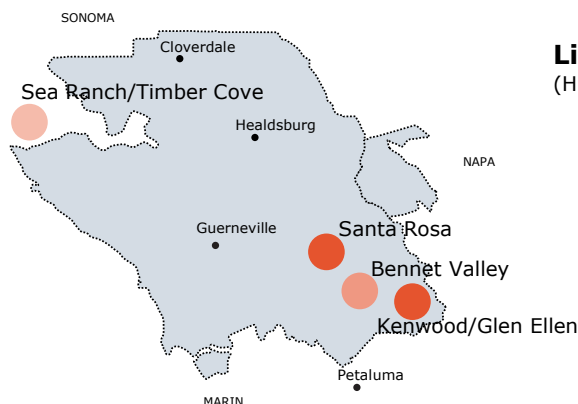
of Sonoma County adults have US-based health insurance⁷



Geographic Areas with Greatest Risk

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

- Key Informant



Life Expectancy⁸

(Highest and lowest census tracts)

85 Years

- Central Bennet Valley
- Sea Ranch/Timber Cove

75 Years

- Downtown Santa Rosa
- Kenwood/Glen Ellen

Emerging Needs

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

Sonoma Complex Fires:

63% Had difficulties accessing medication

53% Had difficulties accessing medical services⁹

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

In the western US, this has led to **9 additional days** per year of high fire potential.¹⁰

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

Assets and Ideas

Examples of Existing Community Assets



Low cost or free community clinics



Public assistance programs (such as Medi-Cal)



Mobile health clinics that reach vulnerable/high-risk populations



Strong sense of community

Ideas from Focus Groups and Interview Participants

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



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

Cardiovascular Disease, Stroke, and Tobacco Use

Cardiovascular disease (CVD) is the leading cause of death in the United States, and one of the top five causes of premature years of life lost across the regions of Sonoma County. There is a strong causal link between tobacco use and CVD, with more people dying from tobacco-caused CVD than lung cancer. Stroke is both a risk-factor for CVD and increases in likelihood among those who have had a heart attack. It is the fourth leading cause of death both nationally and in Sonoma. The CDC estimates that 90% of CVD related conditions are preventable; in Sonoma, a greater focus on prevention could address the high disparities that exist in the region by race/ethnicity as well as regional patterns of inequity. Incorporating social determinants of health in prevention efforts is essential.

Key Data

Indicators

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.

Ever diagnosed with heart disease¹



Percentage of adult population that smokes every day²



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



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

- Focus Group Participant
[original in Spanish]

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

- Key Informant

Community Identified Barriers



Complexities of cardiovascular health

- Stress and trauma related to high blood pressure and heart attacks
- Smoke from the Sonoma Complex Fires increased risk of cardiovascular complications in general population



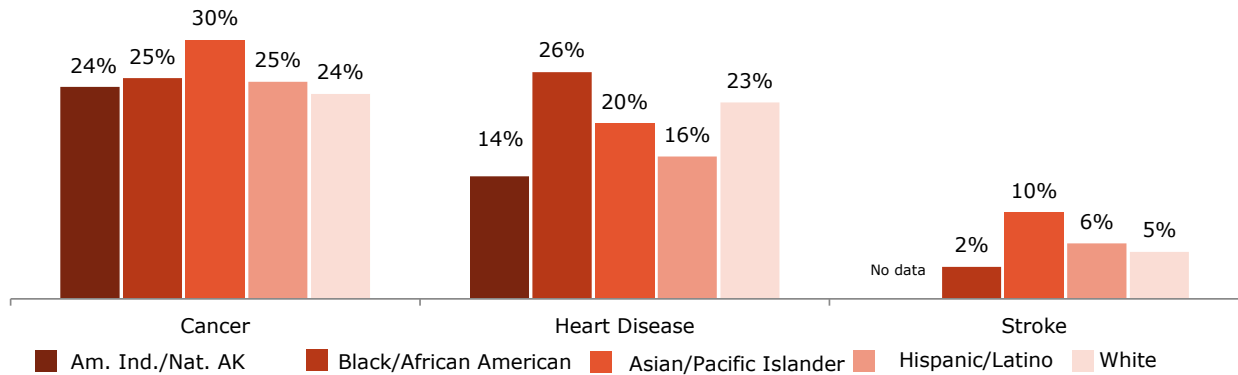
Evolving tobacco-related risks

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

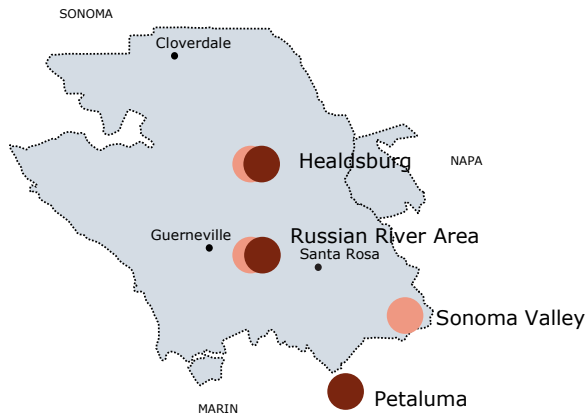
Populations Disproportionately Affected

Populations with Greatest Risk

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



Geographic Areas with Greatest Risk



Mortality, percent of total deaths⁵

Cancer Deaths

(Highest and lowest areas)

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

Heart Disease Deaths

(Highest and lowest areas)

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

Stroke Deaths

(Highest and lowest areas)

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

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

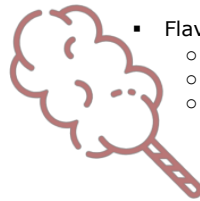
- Key Informant

Emerging Needs

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

- Key Informant

Marketing towards children?



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

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

Assets and Ideas

Examples of Existing Community Assets



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



Culturally appropriate cardiovascular health campaigns



Community centers that offer exercise classes



Public policy advocacy to limit sale of tobacco in all forms

Ideas from Focus Groups and Interview Participants

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



1. California Health Interview Survey (2015-17)
2. 2018 County Rankings (2016 BRFSS Data)
3. Interactive Atlas of Heart Disease and Stroke (2015)
4. California Department of Public Health, VRBIS Death Data 2013-2015
5. Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015
6. “Teen Vaping on the Rise” Kaiser Permanente Look Inside (2018)
7. Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018. MMWR Morb Mortal Wkly Rep 2018;67:1276–1277. DOI: <http://dx.doi.org/10.15585/mmwr.mm6745a5>.

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Economic Security

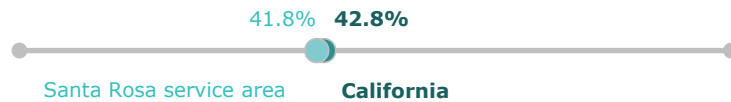
Economic security means having the financial resources, public supports, career and educational opportunities necessary to be able to live your fullest life. As such, this health need touches upon every other health-related issue in the Sonoma community from mental health to housing. While Sonoma has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

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.

Percent of households with costs exceeding 30% of income¹



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



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



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

- Focus Group Participant

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

- Key Informant

Community Identified Barriers



Income Inequality and Segregation

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



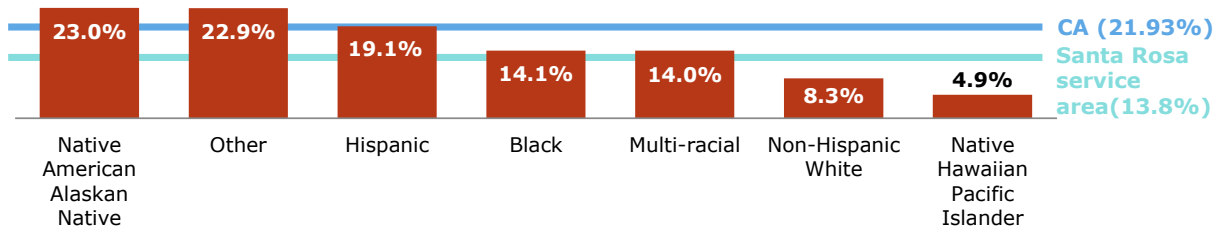
Financial and Social Barriers

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

Populations Disproportionately Affected

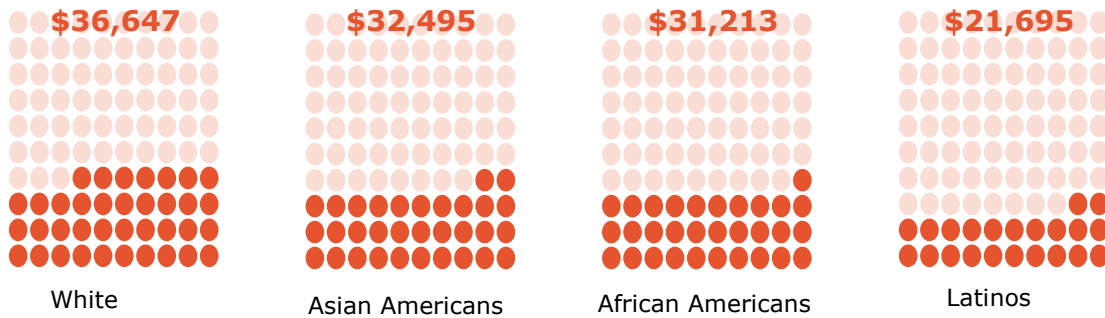
Populations with Greatest Risk

Children living below 100% of the federal poverty level⁴

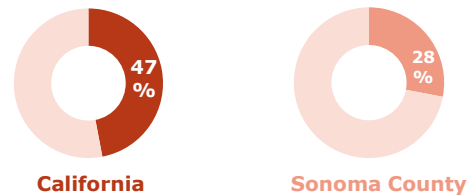


Median personal earning of households across Sonoma County⁵

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



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



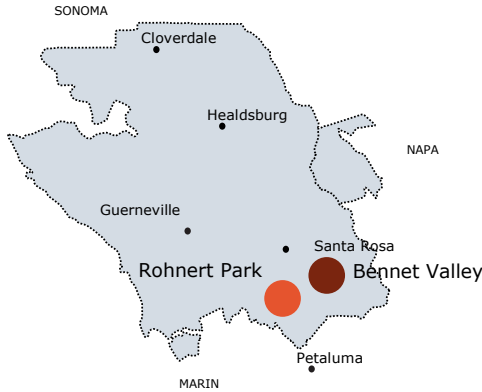
“ There are two very different communities in this county that people don't talk about. We see it, because we work in it. But I think that a lot of people who are not social service providers might not acknowledge that **there is a major gap between communities here.**

- Key Informant

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

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Annual earnings by census tract

Significant disparities in earnings separate census tracts within Sonoma County.

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

Emerging Needs

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

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

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

- Key Informant

Other emerging needs relate to demographic change. Seniors are increasing as a proportion of the population, and **22%** of Sonoma County seniors age 65 and older **have incomes less than 200%** of the Federal Poverty Level. ¹⁰



Assets and Ideas

Examples of Existing Community Assets



Low cost or free community clinics



Public assistance programs (such as Medi-Cal)



Partnerships among nonprofits to address complex issues related to economic insecurity



Community food banks/ pantries

Ideas from Focus Groups and Interview Participants

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



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

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Education

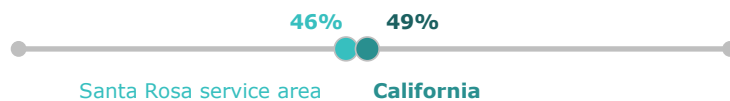
Education has consequences for public health because it shapes professional advancement and the pursuit of a stable life. Additionally, education provides the knowledge and cultural capital necessary for navigating complicated health systems and sorting through available resources to seek help. While some education outcomes are higher for Sonoma than the rest of California, in the Santa Rosa service area, only half of children attend preschool and two-in-five adults lack college education. In addition to the need for progress on these standard benchmarks, strong racial inequities persist in the school system. Racial minorities in the service area have lower rates of high school completion. Further, the proficiency gaps seen between Hispanic/Latino and non-Hispanic White students in early education persist throughout secondary school.

Key Data

Indicators

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.

Preschool enrollment¹



Adults with some post-secondary education²



High school graduation rate³



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

- Key Informant

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

- Key Informant

Community Identified Barriers



Educational inequity

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

Need for career & technical education

- Would address local workforce needs and boost economic opportunity

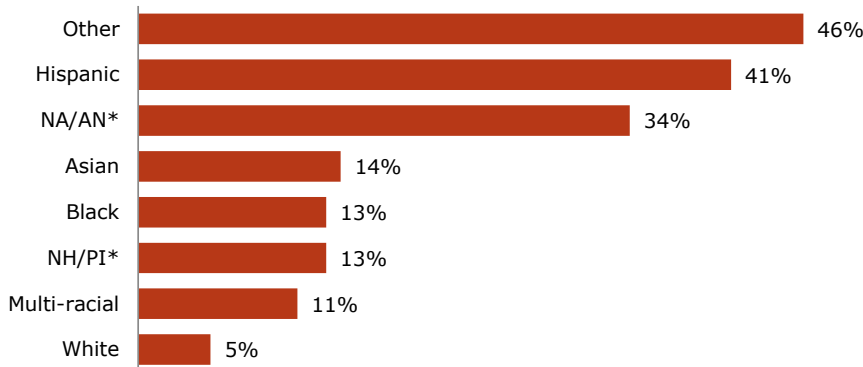
Need for community-based life-skills education

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

Populations Disproportionately Affected

Populations with Greatest Risk

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

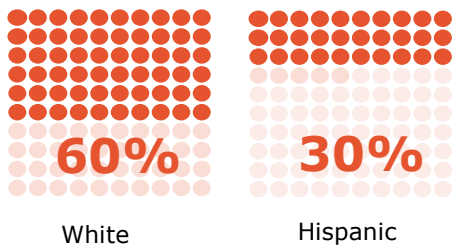


“The need for culturally competent education staff is a big issue. When all of your teachers are White, they don’t understand your culture, they don’t understand your language.”

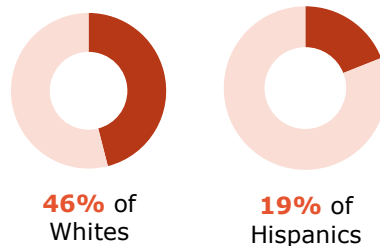
- Key Informant

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

Proportion earning proficient scores on 3rd grade literacy tests⁵

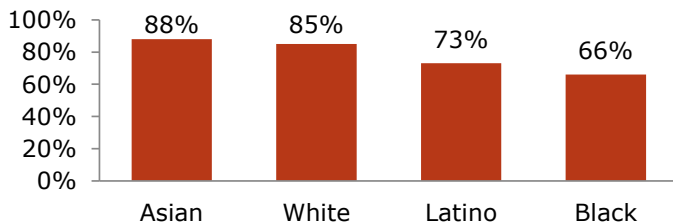


Proportion meeting or exceeding 11th grade math standards⁶

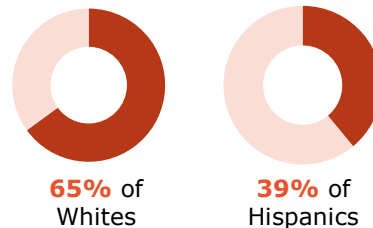


Of the **71,000** students enrolled in K-12 public schools, the majority are Hispanic/Latino (**45%**) or White (**43%**)⁷

Proportion of students to graduate on time by race/ethnicity⁸



Proportion enrolled in pre-school⁹



Geographic Areas with Greatest Risk

Only **0.4%** of adults lack a high school diploma in **North Oakmont**, compared to **46%** in **Roseland**. **Forestville** has **54%** K-12 enrollment, whereas **Windsor** has **100%**.¹⁰



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

- Focus Group Participant [original in Spanish]

Assets and Ideas

Examples of Existing Community Assets



Increased awareness of the importance of early childhood



Community-based education programs and partnerships



Financial and political capital that can be channeled to promote equity

Ideas from Focus Groups and Interview Participants

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



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

Healthy Eating, Active Living: Obesity and Diabetes

Nutritious food and an active lifestyle impacts community members’ well-being in a variety of ways, from mental health to the risk of developing obesity and diabetes. Many factors such as economic security, transportation, and access to safe parks and grocery stores contribute to peoples’ ability to lead a healthy lifestyle. Although the prevalence of diabetes in the region is similar to the state’s, significant racial disparities exist, especially among youth and other vulnerable populations such as farmworkers. Residents and stakeholders named access to educational resources for diabetes management, as well as access to healthy, affordable food as vital issues for their community’s overall wellness. Additionally, stakeholders emphasized that hunger and food insecurity have worsened since the 2017 Sonoma Complex Fires in concurrence with increased economic and housing insecurity.

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.

Diabetes prevalence¹

8.5% of total population in the Santa Rosa service area

8.37% in the state of California

Proximity to walkable destinations²

18.5% of total population in the Santa Rosa service area

29.03% in the state of California

Children living in food insecure households³

16.1% of total population in Sonoma County

19.1% in the state of California

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

- Key Informant

Community Identified Barriers



Barriers to active living

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



Food insecurity and hunger

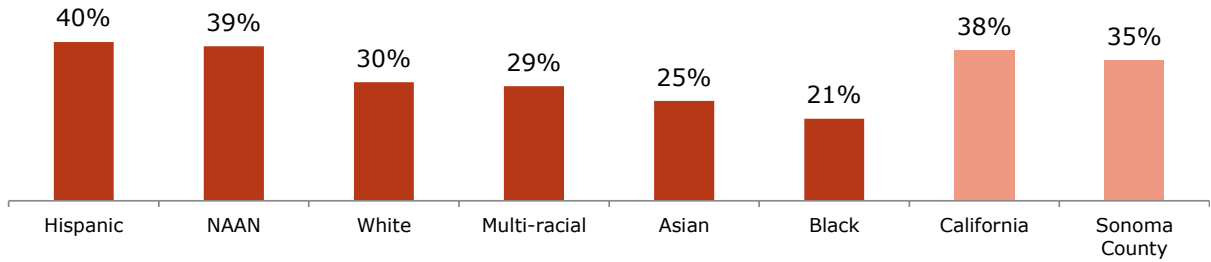
- Hunger is an emerging issue exacerbated by the 2017 Sonoma Complex Fires
- Parents concerned over the quality of food given at schools
- Healthy foods are more costly and time-consuming to prepare

Populations Disproportionately Affected

Populations with Greatest Risk

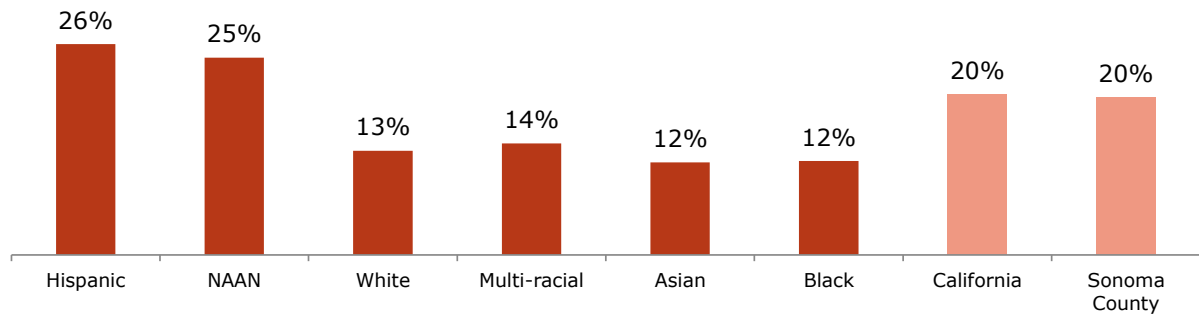
Physical inactivity rates among youth in the Santa Rosa service area

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



Obesity rates among youth in the Santa Rosa service area

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



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

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

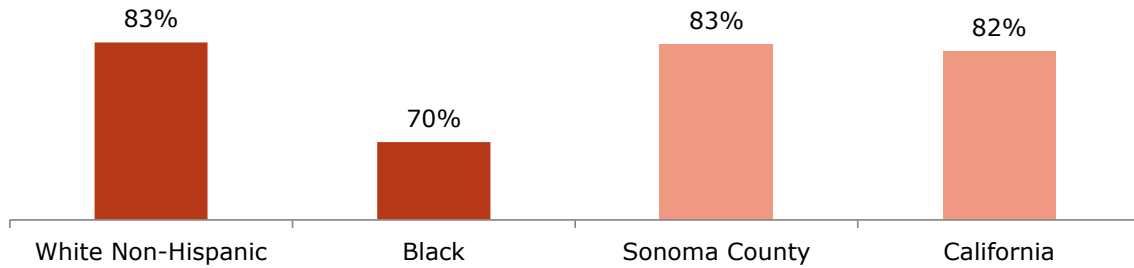
- Focus Group Participant [original in Spanish]

Populations Disproportionately Affected

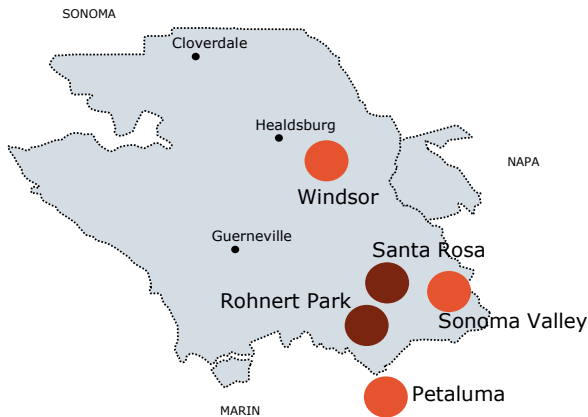
Populations with Greatest Risk

Diabetes management

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



Geographic Areas with the Greatest Risk



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

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

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



- Key Informant

Assets and Ideas

Examples of Existing Community Assets



Exercise, dancing classes for older adults



Community centers with sports programs and social gatherings for all ages



Diabetes management educational resources



Food banks/pantries

Ideas from Focus Groups and Interview Participants

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



1. California Health Interview Survey (2014-15)
2. USDA Food Access Research Atlas
3. Gundersen, C., et al. (2016). Map the Meal Gap 2016: Food insecurity and child food insecurity estimates at the county level. Feeding America.
4. Fitnessgram Physical Fitness Testing (2017)
5. Same as above.
6. Disparities in Health Insurance Coverage and Health Status Among Farmworkers, Sonoma County, California, 2013-2014
7. Dartmouth Atlas of Healthcare (2012)
8. Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015
9. Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America) (2014).

Housing and Homelessness

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

Key Data

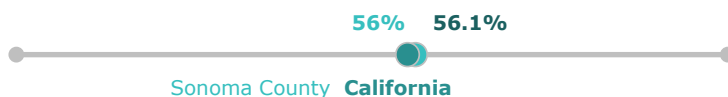
Indicators

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.

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



Renters spending 30% or more of household income on rent²



Proportion of individuals in Sonoma County experiencing homelessness who are sheltered and unsheltered



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

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

- Key Informant

Community Identified Barriers



Increasing population experiencing homelessness

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



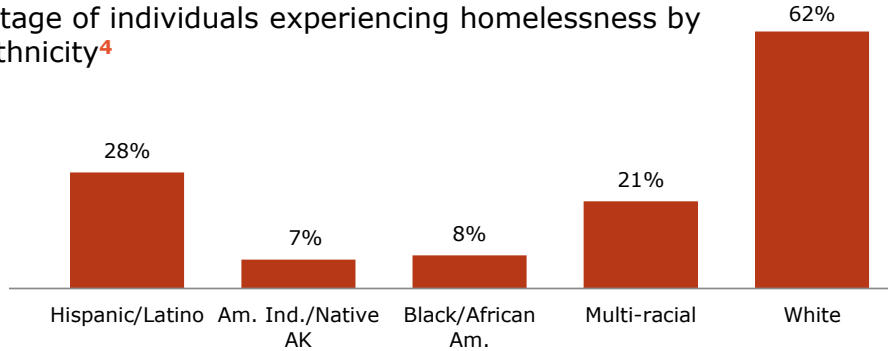
Unsustainably rising rent

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

Populations Disproportionately Affected

Populations with Greatest Risk

Percentage of individuals experiencing homelessness by race/ethnicity⁴



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

- Focus Group Participant

Characteristics of those who are [experiencing homelessness]⁵

35% Have psychiatric or emotional conditions



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



33% Experience drug or alcohol abuse



27% Have a physical disability



28% Have a post-traumatic stress disorder



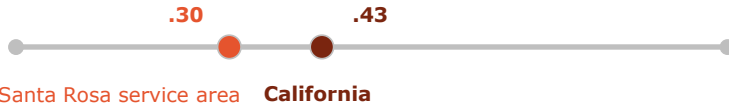
14% Have a traumatic brain injury



Populations Disproportionately Affected

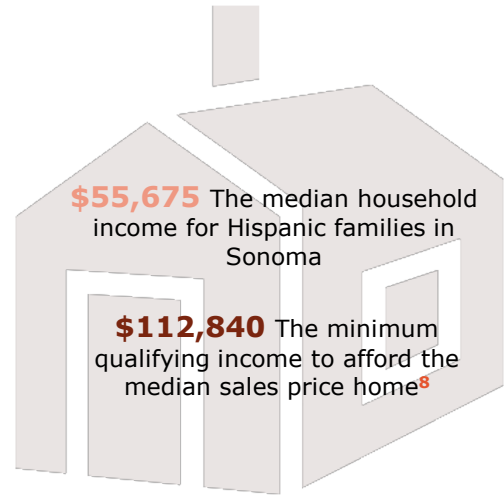
Populations with Greatest Risk

Racial Segregation Index (1 = maximum segregation) ⁶



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

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

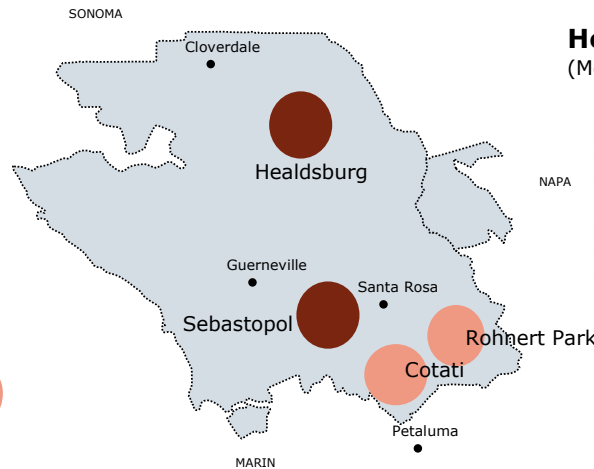


Geographic Areas with Greatest Risk

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



- Key Informant



Home Owner's Market⁹
(Median Home Sales Price)

- Least Affordable**
 - Healdsburg \$804,000
 - Sebastopol \$800,000
- Most Affordable**
 - Cotati \$479,500
 - Rohnert Park \$479,500

Emerging Needs

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

9.8%

said that their home was not livable during the fires¹⁰

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



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

- Key Informant

Assets and Ideas

Examples of Existing Community Assets



Mobile health clinics



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



Nonprofits and community organizations working to address housing crisis



Available shelters and affordable housing

Ideas from Focus Groups and Interview Participants

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



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

Maternal and Child Health

Mothers and infants in Sonoma County face a range of barriers to health, from excessive weight gain during pregnancy to factors which impact economic security and general well-being. These issues are further magnified by racial disparities. Minorities in the Santa Rosa service area experience higher rates of infant mortality and children born with low birth weight. Additionally, Hispanic/Latino populations have higher teen birthrates. Interviewees expressed frustration with a lack of childcare options and culturally competent educational resources related to sexual education. Further, maternal asthma is associated with a number of negative outcomes including premature birth, low birthweight, and neonatal death. Asthma during pregnancy disproportionately affects women in Sonoma when compared to the state average.

Key Data

Indicators

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.

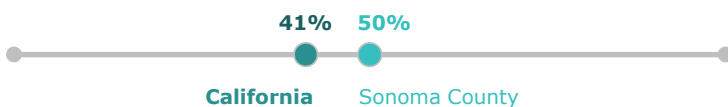
Births where the infant weighed less than 2,500 grams (low birth weight)¹



Women who reported having asthma before pregnancy²



Women who reported excessive weight gain during pregnancy³



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

- Key Informant

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

- Key Informant

Community Identified Barriers



Unequal access to high quality child care

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

Teenage pregnancy

- Culturally competent sexual health education needed

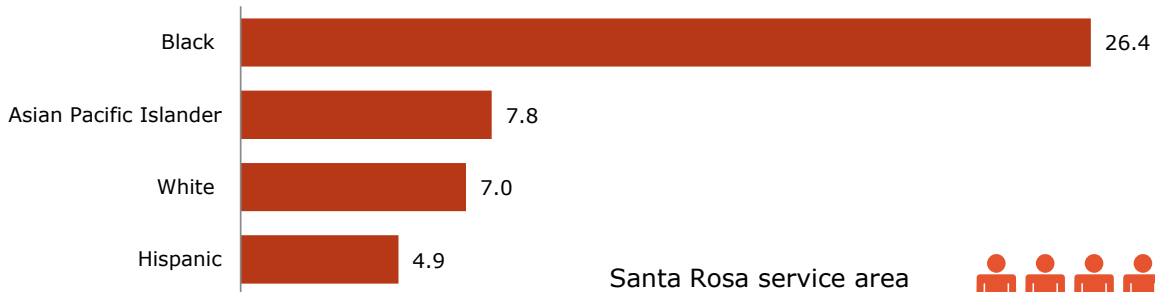
Unsafe conditions for immigrant mothers & children

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

Populations Disproportionately Affected

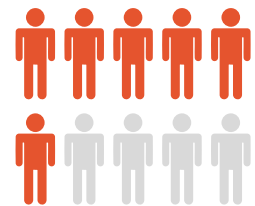
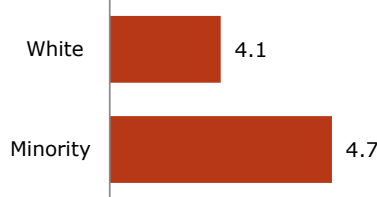
Populations with Greatest Risk

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



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

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



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

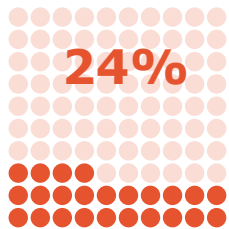
“ Working with our home-based providers we see a discrepancy in the quality of their programs, from nutrition to the environment. Most of our bilingual providers maybe didn't finish high school...so we're helping them get their child development knowledge so when they're working with infants and toddlers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

”

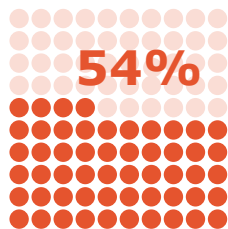
- Key Informant

Emerging Needs

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



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



Proportion of these households that reported worsened asthma symptoms following the Sonoma Complex Fires⁹

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

Assets and Ideas

Examples of Existing Community Assets



Increased awareness of importance of early childhood



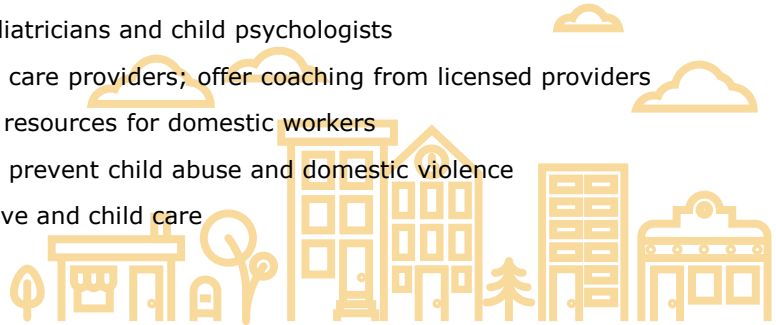
Early childhood organizations and resources



Play groups and parenting classes

Ideas from Focus Groups and Interview Participants

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



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

Mental Health & Substance Use

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

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 that seriously considered suicide¹



Adults reporting excessive drinking²



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



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

- Key Informant

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

- Key Informant

Community Identified Barriers



Need for mental health & substance use services

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

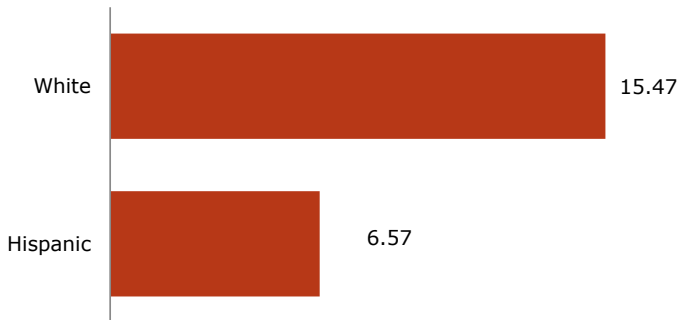
Barriers to services

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

Populations Disproportionately Affected

Populations with Greatest Risk

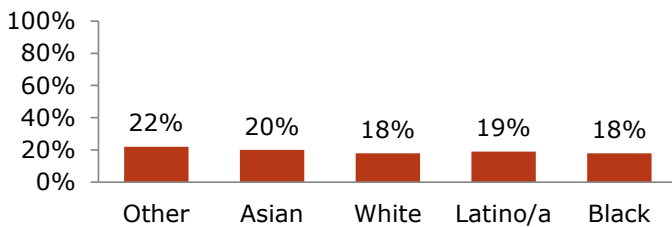
Age-adjusted rate of deaths by suicide per 100,000 population⁴



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

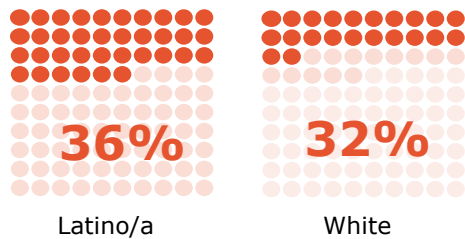
- Focus group participant
[original in Spanish]

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



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

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



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

- Focus group participant

Age-adjusted Drug poisoning deaths per 100,000

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

California
11.3

Sonoma
12.8

Females (Sonoma)
8.1

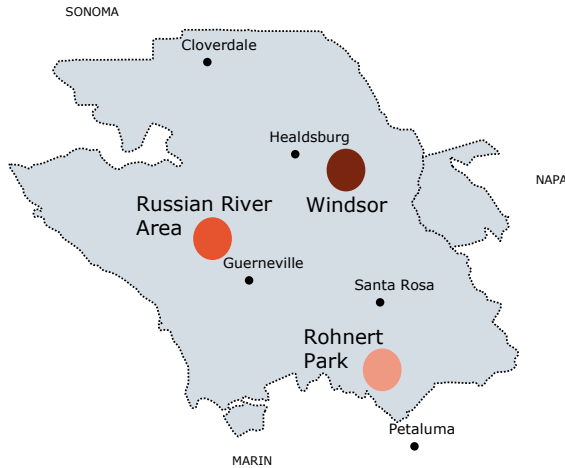
Males (Sonoma)
17.4

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

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

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



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

Emerging Needs

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

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

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

- Key Informant

59%

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

30%

before the fire ¹³

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

- Key Informant, Service Provider ”

Assets and Ideas

Examples of Existing Community Assets



Community organizations, committees, and support groups



Coordinated entry among service providers



School-based therapists

Ideas from Focus Groups and Interview Participants

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

1. California Health Interview Survey (2009-17)
2. Behavioral Risk Factor Surveillance System
3. CDPH Opioid Dashboard 2015-17
4. Sonoma County Suicide and Self-harm Data from 2017 (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services. (2018)
5. Sonoma County California Healthy Kids Survey Analysis (unpublished). Assessment and Epidemiology Team. Sonoma County Department of Health Services. (2018)
6. Same as above
7. Same as above.
8. CDPH Vital Statistics Multiple Cause of Death Files & California Department of Public Health - Safe and Active Communities Branch (2015-17) Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015
9. Same as above.
10. “Impact of anthropogenic climate change on wildfire across western US forests.” PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
11. Rapid Health Needs Assessment (CASPER) 2018
12. Same as above.

Violence and Injury Prevention

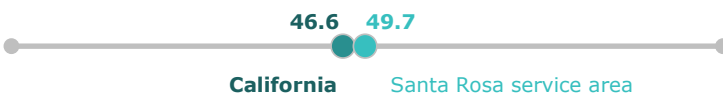
The Santa Rosa service area has a significantly lower rate of violent crime than California overall and a similar rate of deaths due to accidental injury. Work-related falls and other injuries disproportionately affect day laborers in the county. Sonoma County also has the second worst rate of vehicle collision deaths involving underage drinking and driving. Women of color experience higher rates of intimate partner violence, which is interlaced with issues of economic security and the risk of homelessness. Finally, the impact of the 2017 Sonoma Complex Fires caused an increase in disaster-related injuries. Community stakeholders expressed concern with personal safety while walking, and fear for undocumented community members who are vulnerable to injury.

Key Data

Indicators

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.

Injury deaths (rate per 100,000)¹



Traffic Safety²

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

Violent crimes (rate per 100,000)³



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

- Key Informant

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

- Focus Group Participant
[original in Spanish]

Community Identified Barriers



Vulnerability of undocumented community and foster youth

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



Violence (youth & family)

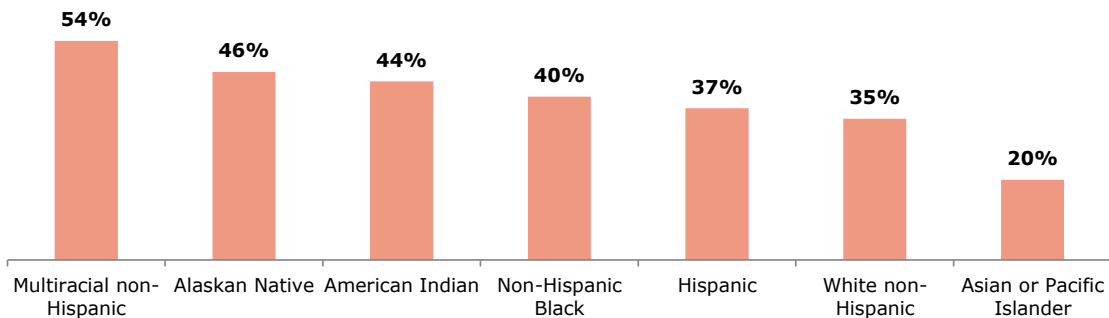
- Connection between violence and economic security, and substance use (circumstances exacerbated by the Sonoma Complex Fires)
- Bullying, violence, and gang presence in schools and among youth

Populations Disproportionately Affected

Populations with Greatest Risk

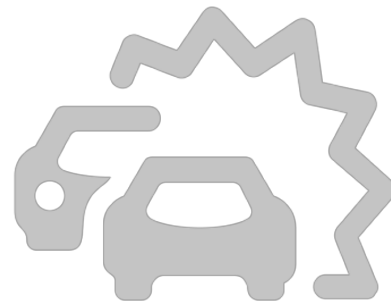
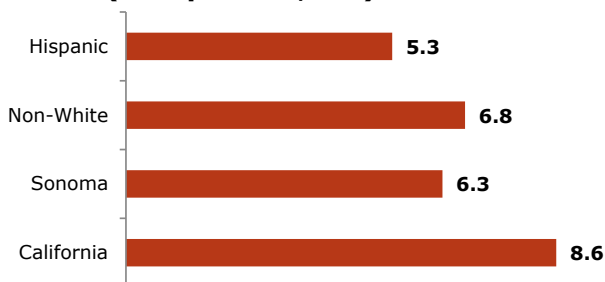
National prevalence of intimate partner violence⁴

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



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

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



Other Key Indicators

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

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

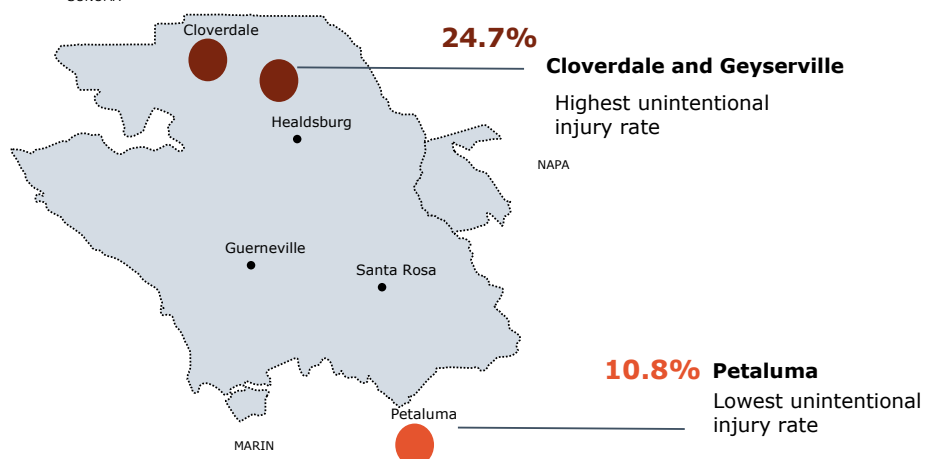
The damaging effects of high rates of crime and violence on health include causing chronic stress, discouraging outdoor exercise, and, at worst, resulting in injury or death.

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

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

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



Emerging Needs

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

Of the 40% of households with a member that experienced traumatic events during the October 2017 Sonoma Complex Fires¹⁰:

12.5% Reported having been trapped or delayed in an evacuation

7.3% Saw a serious injury of non-family member

7.9% Suffered a significant disaster related illness or injury to self or family member



Assets and Ideas

Examples of Existing Community Assets



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



Law enforcement; especially bilingual/bicultural officers



Housing and economic support resources for victims

Ideas from Focus Groups and Interview Participants

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



1. National Vital Statistics System (2016)
2. California Office of Traffic Safety, https://www.ots.ca.gov/Media_and_Research/Rankings/default.asp#what
3. FBI Uniform Crime Report 2017
4. National Intimate Partner Violence Survey. Note: National data, not Sonoma specific
5. National Vital Statistics System (2016)
6. "A Portrait of Sonoma" Sonoma County Human Development Report 2014
7. Sonoma County Summary Measures of Health: A review of life expectancy, disability status, leading causes of death and premature death with trends for 2005-2015
8. Same as above.
9. "Impact of anthropogenic climate change on wildfire across western US forests." PNAS October 18, 2016 113 (42) 11770-11775 <https://www.pnas.org/content/113/42/11770>
10. Rapid Health Assessment (CASPER) 2018

