2019 Community Health Needs Assessment

NorthBay Healthcare
Board of Directors

NORTHBAY™ HEALTHCARE

NorthBay Healthcare Community Benefit -- CHNA Report

Contents

I. Introduction/background

A. About NorthBay Healthcare

NorthBay Healthcare opened its first hospital in 1960 and remains Solano County's only locally based, locally managed nonprofit healthcare organization. NorthBay Medical Center in Fairfield and NorthBay VacaValley Hospital in Vacaville are known for providing quality services.
Our hospitals offer 24-hour emergency care, intensive care, and sophisticated surgical and diagnostic services. Both have maintained accreditation from The Joint Commission on Accreditation of Healthcare Organizations. Our Emergency Departments include accredited Chest Pain Centers for acute cardiac care.
The 132-bed NorthBay Medical Center is a center of excellence for maternal and child services. Our Newborn Intensive Care Unit provides the most sophisticated services for premature or ill newborns within 50 miles. The hospital also hosts NorthBay Heart & Vascular Center, the only open-heart surgery center in the county, along with NorthBay Cancer Center, the county's first verified Level II Trauma Center and the Center for Neuroscience.
Our Center for Primary Care, with offices in Fairfield, Vacaville and Green Valley, comprises board-certified family practice physicians, internists and pediatricians and affiliated physician specialists throughout the Solano County region.

Our Vision: Advancing Medicine in Our Community

We bring sophisticated medical services to Solano County by recruiting highly trained physicians and staff who are vital to outstanding patient care. Our facilities are equipped with the latest technology to facilitate cutting-edge health care.

Our Mission: Compassionate Care, Advanced Medicine, Close to Home

NorthBay Healthcare leads the way in providing advanced medicine to the people of Solano County. Our compassion, our commitment to excellence, and the depth and breadth of our services are a testament to our enduring commitment to the local community. We strive to ensure that local residents remain near home for most of the healthcare services they'll need in their lifetimes.

B. 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 healthcare organizations 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 healthcare organizations 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.

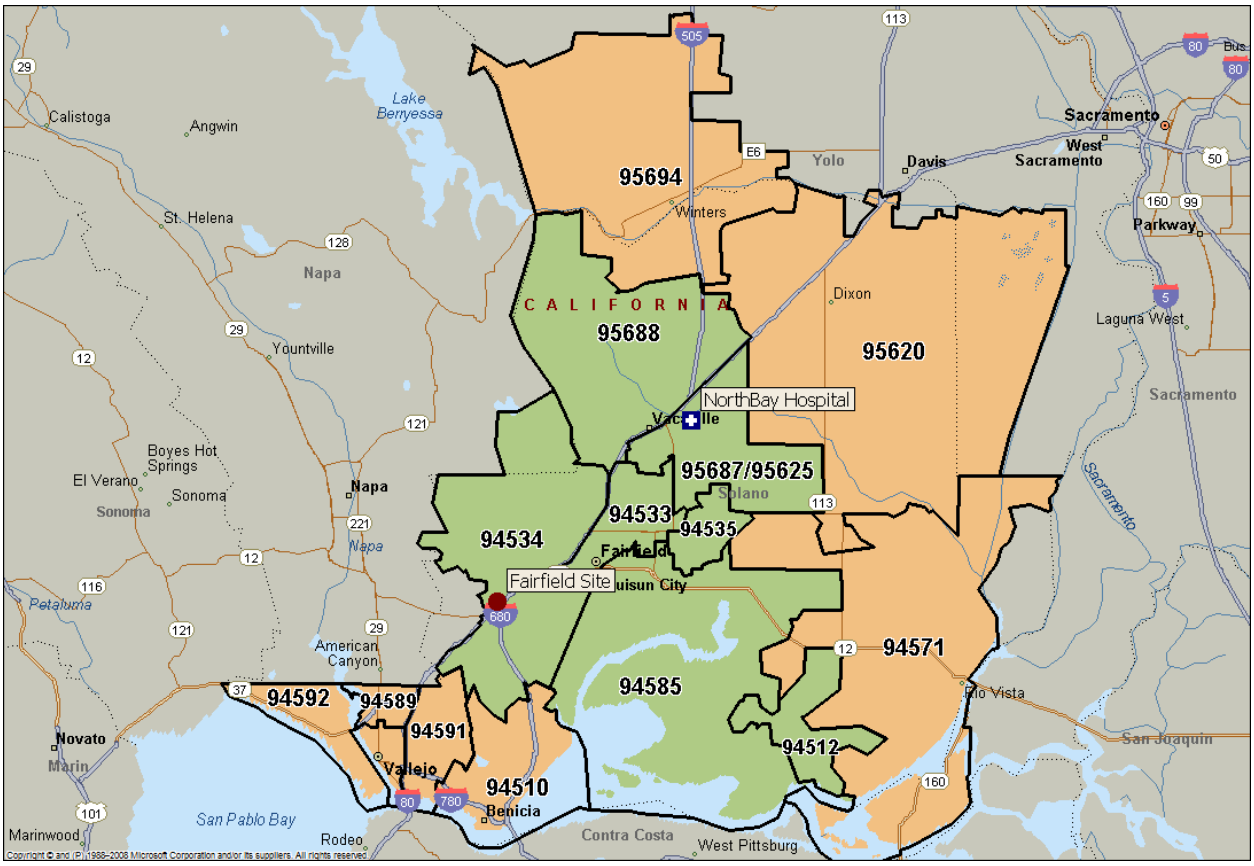
II. Upper Solano County

A. Definition of community served

The NorthBay Healthcare service area includes all residents in Solano County, with a concentration of residents in the Fairfield/ Vacaville/ Suisun communities.

B. Map and description of community served

i. Map



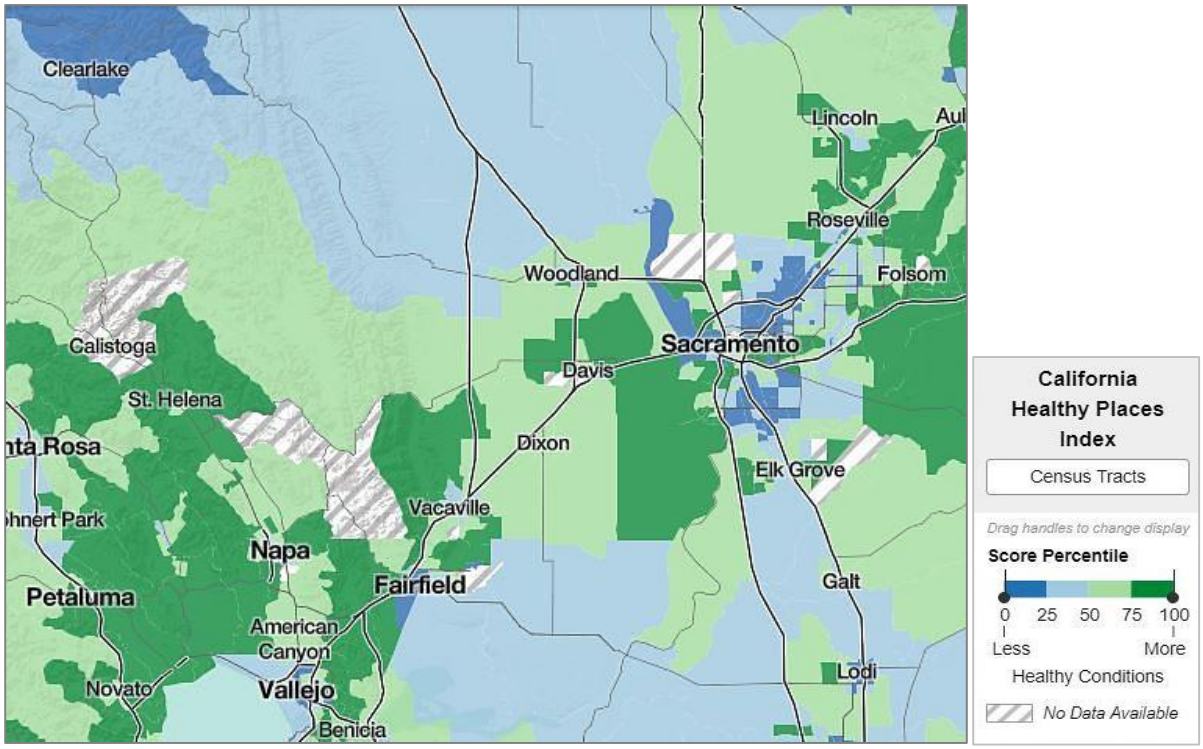
NorthBay Healthcare Service Area

ii. Geographic description of the community served

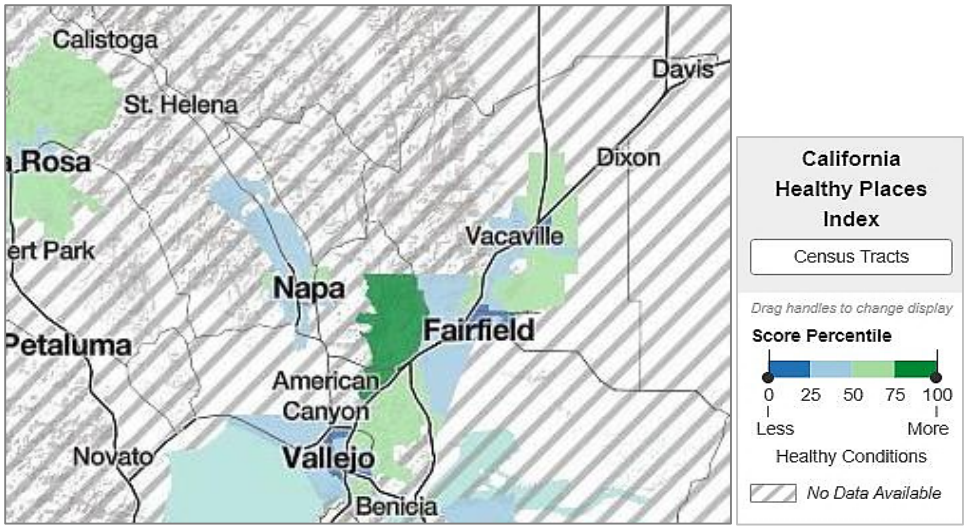
The NorthBay Healthcare service area includes all of Solano County communities with a concentration of residents in the central Solano communities of Fairfield, Suisun City, and

Vacaville. NorthBay Healthcare is centrally located along the Interstate 80 corridor in Solano County.

The map below represents access to family and community resources, referred to as social determinants of health, within the NorthBay Healthcare service area and surrounding geographic areas. Specifically, “healthy conditions” represent access to factors related to economic, social, and neighborhood resources, as well as a clean environment, education, transportation, housing, and health care, as measured in the California Healthy Places Index **(**https://map.healthyplacesindex.org/).



The map below represents the health outcomes of individuals living within the NorthBay Healthcare service area and surrounding geographic areas. Specifically, the map includes measures related to arthritis, asthma, blood pressure, cancer, heart disease, diabetes, birth weight, life expectancy, obesity, kidney disease, mental and physical health, pedestrian injury, cognitive and physical disabilities, and stroke as measured in the California Healthy Places Index (https://map.healthyplacesindex.org/). The comparison of the two maps presented (i.e., social determinants of health and health outcomes), highlights the correlation between access to family and community resources and health outcomes, such that reduced access to resources is associated with worse health outcomes.



iii. Demographic profile of the community served

Demographic profile: NorthBay

Race/Ethnicity	**# Pop.**	**% Pop.**
Total Population	287,540	100.0%
Hispanic or Latino, Asian	736	0.3%
Hispanic or Latino, Black or African American	1,068	0.4%
Hispanic or Latino, Multiple Race	6,127	2.1%
Hispanic or Latino, Native American/Alaskan Native	828	0.3%
Hispanic or Latino, Native Hawaiian/Pacific Islander	56	0.02%
Hispanic or Latino, Some Other Race	32,713	11.4%
Hispanic or Latino, White	37,311	13.0%
Non-Hispanic White	125,533	43.7%
Non-Hispanic, Asian	32,682	11.4%
Non-Hispanic, Black or African American	31,802	11.1%
Non-Hispanic, Multiple Race	15,079	5.3%
Non-Hispanic, Native American/Alaskan Native	856	0.3%
Non-Hispanic, Native Hawaiian/Pacific Islander	2,175	0.8%
Non-Hispanic, Some Other Race	574	0.2%

Socioeconomic Data	
Living in poverty (<100% federal poverty level)	11.3%
Children in poverty	16.6%
Unemployment	3.9%
Uninsured population	8.5%
Adults with no high school diploma	13.5%

III. Who was involved in the assessment?

A. NorthBay Healthcare and other partner organizations that collaborated on the assessment

NorthBay Healthcare worked with Kaiser and other partner organizations with similar service areas in Solano County at the onset of the CHNA to develop a coordinated approach to primary data collection. NorthBay Healthcare then collaborated with the same group to determine the list of significant health needs based on both primary and secondary data. NorthBay Healthcare specifically worked with Solano county partners, Kaiser Foundation, and local service providers to then prioritize the identified health needs (described in Section V-B).

Collaborative NorthBay Healthcare partners:

1. Kaiser Foundation
2. Sutter Health

Additional partners:

1. Solano County Health and Social Services
2. Community Health Insights (CHI)

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 offers deep experience assisting NorthBay Healthcare, 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 NorthBay Healthcare service areas in Roseville, Sacramento, San Bernardino, San Rafael, Santa Rosa, South Sacramento, 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

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

NorthBay Healthcare also used additional data sources beyond those included in the CHNA Data Platform. Solano County health department partners shared additional data from their internal platforms and studies, and other online sources were referenced (e.g., kidsdata.org, California Healthy Places Index).

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'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, NorthBay Healthcare also leveraged additional data sources beyond those included in the Kaiser 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 that 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 NorthBay Healthcare 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 (see Appendix E. Focus Group Protocol and Appendix F. Key Informant Interview and Group Interview Protocol). 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.

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 note taker. 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.

Harder+Company also coordinated with Sutter Health's CHNA consultant, Community Health Insights (CHI) for data collection in regions where service areas overlapped. CHI and Harder+Company conducted those activities independently and then shared transcripts (respondents were informed of this information sharing in the protocol). CHI recorded all data collection activities, which the Harder+Company team then had transcribed through an independent transcription service. In the case that participants did not give permission to record, CHI shared their notes from the interview with the Harder+Company team, who then coded the notes through the ATLAS.ti platform. For the data collection activities that CHI conducted in Spanish, notes were documented in English by the interviewer and therefore no quotations were available from these notes.

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

C. 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 NorthBay Healthcare 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, NorthBay Healthcare 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 Platform and other publically available data), as well as primary qualitative data collected from key informant interviews, provider focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Platform 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 Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

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

1. A health need category was identified as **high need based on secondary data** from the Kaiser CHNA Data Platform if it met *any* of the following conditions:
    - *Overall severity:* 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. NorthBay Healthcare 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 NorthBay Healthcare 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. (See Appendix I. Prioritization Meeting Participants for a full list of partner organizations that participated in the prioritization meeting.) 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 needs 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. Appendix D. Prioritization Scoring provides the specific breakdown of scores used for ranking and any weighting considerations across the three criteria.

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

1. Economic Security: Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. Intrinsically related to all health issues, from housing to behavioral health, economic security is a strong determinant of an individual's health outcomes. Residents of the Fairfield/Vacaville service area encounter many challenges when compared to California residents on the whole, such as decreased access to stores with healthy food and a lack of walkable destinations. For example, 22 percent of residents in the Fairfield/ Fairfield/Vacaville service area have low access to "healthy food stores" compared to 13 percent of residents in California.[1] Notably, the Fairfield/Vacaville service area has a lower proportion of cost-burdened households when compared to the state average, but large racial disparities in poverty incidence. For instance, Native American/Alaska Native children in Vacaville experience poverty at 5 times the rate of Asian children. The three subpopulations by race/ethnicity with the highest percentage of children living below 100 percent of the Federal Poverty Line (FPL) are Native American/Alaska Native (35 percent), Black (28 percent), and Hispanic (20 percent).[2] Residents and service providers identified many challenges related to maintaining economic security, such as unrealistic requirements for government assistance, and the need for better pay to be able to make ends meet.

2. Behavioral Health: Behavioral health is the foundation for healthy living and encompasses mental illness, substance use and overdoses, and access to service providers for preventive care and treatment. Fairfield/Vacaville service area residents face a range of behavioral health-related challenges, including a higher rate of excessive drinking, opioid prescription drug claims, and deaths by suicide, drug, or alcohol misuse, when compared to the state average. The non-Hispanic White population has the highest rate for suicide deaths at 17 per 100,000, nearly twice the state average.[3] Thirty-six percent of service area residents experience excessive drinking compared to 33 percent of residents across California[4]—and impaired driving deaths are also higher in the service area, with 32 percent of all motor vehicle crash deaths reporting that alcohol played a role compared to the state average of 29 percent.[5] Residents also smoke tobacco products at a higher rate and exhibit a higher incidence of lung cancer when compared to the state. Interviewees described several barriers to achieving behavioral health, including early-age use of substances, decreased social connectedness in their communities, and strong peer pressure, especially among youth. Community members also emphasized the need for increased access to mental health services.

3. Access to Care: Access to quality health care includes affordable health insurance, use of preventive care, and ultimately reduced risk of unnecessary disability and premature death.

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[1] USDA Food Access Research Atlas. (2014).
[2] American Community Survey. (2012-2016).
[3] National Vital Statistics System. (2011-2015).
[4] California Health Interview Survey. (2015-2016).
[5] Fatality Analysis Reporting System. (2011-2015).

Importantly, it is also one of the key drivers in achieving health equity. The Fairfield/Vacaville service area fares worse than the state across important access-related indicators, such as residents recently having a primary care visit and breast cancer incidence. For example, 61 percent of service area residents had a recent primary care visit compared to 73 percent of state residents.[6] While the Fairfield/Vacaville service area scores better than California on indicators such as total rate of uninsured residents, racial inequities persist. For example, Whites in the Fairfield/Vacaville service area are 2.5 times more likely to be insured compared to Native Hawaiian/Pacific Islanders. Native Alaskan/Native American and Hispanic/Latino populations also have higher percentages of individuals without health insurance at 15 and 14 percent respectively (compared to 9 percent for the service area overall).[7] Racial minority groups and lower income individuals also experience significant challenges in obtaining affordable care. Interviewees highlighted many barriers to accessing needed services, from a lack of culturally competent care, to not having sufficient time off work to go to the doctor.

4 and 5 (same score). HEAL: Healthy Eating and Active Living (HEAL) relates to Fairfield/Vacaville service area residents' ability to shape their health outcomes through nutrition and physical activity. There is a high rate of obesity among adults and youth in Vacaville, especially among minority populations. For example, Hispanic and non-Hispanic Native Hawaiian/Pacific Islander youth reflect the highest incidence of obesity, both at 28 percent compared to the state average of 20 percent.[8] Community members highlighted the barriers to eating nutritiously, as well as the high costs and behavioral change needed to live an active lifestyle. Lack of access to healthy grocery stores and the prevalence of fast food options were another important barrier to healthful eating highlighted by interviewees. In the Fairfield/Vacaville service area, 23 percent of residents do not live close to a supermarket, compared to 13 percent of California residents overall.[9] A healthy lifestyle greatly impacts the rates of chronic conditions like cardiovascular disease, stroke, and cancer, but is not equally attainable for all residents.

4 and 5 (same score). Violence and Injury Prevention: Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of the service area have higher rates of domestic violence hospitalizations, injury deaths (intentional and unintentional), and violent crimes compared to the state. For example, there are 11.4 incidents of domestic violence hospitalizations per 100,000 people in the Fairfield/Vacaville service area compared to 4.9 incidents in California.[10] Domestic violence hospital admissions are especially pronounced across the Solano County portion of the service area extending into the city of Vallejo. Violent crimes are also much higher than the state average, at a rate of 463 per 100,000 in the service

[6] Dartmouth Atlas of Health Care. (2014).
[7] American Community Survey. (2012 – 2016).
[8] FITNESSGRAM® Physical Fitness Testing. (2016-2017).
[9] USDA Food Access Research Atlas. (2014).
[10] California EpiCenter. (2013-2014).

area compared to 402 per 100,000 in California.[11] The incidence of violent crimes impacts community safety in many ways. Through interviews and focus groups with local stakeholders, several factors were identified as contributing to the effects of violence and injury, including existing trauma in the community, stress from economic insecurity, competing priorities of families to meet basic needs and support youth, and a lack of safe spaces. Many of these barriers disproportionately affect low-income individuals and people of color.

6. Housing: Access to safe, secure, and affordable housing is an important social determinant of health. Families with fewer financial resources are more likely to experience substandard housing conditions and the associated risks. The Fairfield/Fairfield/Vacaville service area has a lower proportion of cost-burdened households and a less severe housing problem when compared to the state of California. However, the region reflects clear disparities across race and ethnicity, and a prevalence of individuals and households experiencing homelessness. For example, across Solano County, nearly two-thirds of both American Indian/Alaska Native and Black/African American renters spend 30 percent or more of their income on rent, which is considered a cost-burdened household.[12] Focus group and interview respondents provided additional insights; they identified that families of color, older adults, and single parents are most affected by housing issues. Many also noted that housing barriers are escalating within the community, and there is a lack of affordable options for everyone. The closure of shelters, which provide a much needed safety net for many, and diminishing options for low-income families as well as an influx of residents from other regions (e.g., East Bay) have created additional stressors to housing in the community.

7. Maternal & Infant Health: Mothers in the Fairfield/Vacaville service area face many barriers related to their own well-being and that of their children. Children born in the Fairfield/Vacaville service area (specifically Solano County region) are slightly more likely to die as infants compared to children in the state of California. When broken down by race/ethnicity, disparities in infant mortality are starker; children born to women of color are roughly 30 percent more likely to die as infants when compared to their White peers.[13] Additionally, a higher percentage of Black/African American infants (12 percent) are born at a low birth weight compared to other subpopulations by race/ethnicity across both Solano County and the state.[14] Mothers in the region struggle with many issues that relate to child health and development, including experiencing discrimination within the health system, providing a healthy home life for their young children, and facing a lack of options for reproductive health care. Preschool enrollment is also lower in the service area at 43 percent compared to the state average of 49 percent.[15] Interviewees expressed a need for more services to support mothers of all ages and backgrounds.

[11] FBI Uniform Crime Reports. (2012-2014).
[12] American Community Survey 5-Year Estimates. (2012-2015).
[13] Area Health Resource File. (2006-2010).
[14] Kidsdata.org. (2013).
[15] American Community Survey. (2012-2016).

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

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

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

VII. Appendices

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
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E. Focus Group Protocol
F. Key Informant Interview and Group Interview Protocol
G. Focus Group Optional Participant Survey Results
H. Group Interview Optional Participant Survey Results
I. Prioritization Meeting Participants

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

	Source	Dates
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.	California Housing Consortium	2008-2014
2.	American Community Survey 5-Year Estimates	2011-2015
3.	American Community Survey 5-Year Estimates	2012-2016
4.	American Community Survey PUMS data analyzed by Bay Area Regional Health Inequities Initiative (BARHII) and Alameda County Public Health	2016
5.	Point-In-Time Survey, US Housing and Urban Development	2009-2017
6.	Solano County Oral Health Needs Assessment (unpublished)	2018
7.	Consolidated Planning/CHAS Data	2011-2015
8.	Look InsideKP Northern California	2011-2017
9.	California Department of Education	2016-2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Vacaville Family Resource Center (Senior Master Social Worker – FIRST)	1	Low-income	Service provider	8/28/18
2	Key Informant Interview	Winters Healthcare (Executive Director)	1	Health department representative	Service provider	8/23/18
3	Key Informant Interview	Solano County Board of Supervisors (Supervisor District 5)	1		Service provider	9/7/18
4	Key Informant Interview	Caminar (Executive Director and Director of Supported Housing for the Solano Region)	2	Health department representative, medically underserved, low-income	Service provider	8/8/18
5	Key Informant Interview	Solano County Department of Health and Social Services (Community Services Coordinator, mentally ill homeless outreach liaison)	1	Health department representative, medically-underserved	Service provider	8/21/18
6	Key Informant Interview	Solano County Public Health Department (Director of Public Health)	1	Health department representative, medically-underserved	Service provider	8/13/18
7	Key Informant Interview	Partnership HealthPlan (Chief Executive Officer)	1	Health department representative, low-income	Service provider	8/24/18
8	Key Informant Interview	Solano County Department of Health and Social Services (Director)	1	Health department representative, medically-underserved, low-income	Service provider	9/07/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
9	Group Interview	First 5 Solano and partner organizations: - Rio Vista CARE - Child Start Inc. - Solano Family and Children's Services - County of Solano (Mental Health Services) - Solano County Office of Education	7	Medically-underserved, low-income, minority	Service providers	8/30/18
10	Group Interview	Workforce Development Board (executive, administration and program staff)	12	Medically-underserved, Low-income, minority, health department representative	Service providers	9/20/18
11	Group Interview	The Leaven (executive and program staff)	4	Medically-underserved, low-income, minority	Service providers	9/20/18
12	Group Interview	Senior services providers: - Older and Disabled Adult Services (Social Services Supervisor) - Food Bank of Contra Costa and Solano (Program Director) - North Bay Regional Center (Physician) - North Bay Regional Center (Diversity and Equity Specialist) - Born to Age	5	Low-income, minority, medically-underserved, health department representative[16]	Service providers	9/28/18
Community residents						
13	Focus Group (split into two groups to accommodate high number of participants)	Vacaville Family Resource Center (program clients- youth)	9; 12	Low-income, minority	Community members	10/8/18
14	Focus Group	Black Infant Health clients	12	Medically-underserved, minority, low-income	Service providers, community members	9/26/18

[16] No surveys were completed; the target group representative categories refer to those mentioned on organizations' respective websites.

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
15	Focus Group	WIC (Vacaville) clients	9	Low-income, minority	Community members	10/1/18
16	Focus Group	Rio Vista residents	13	Low-income, minority	Service providers, community members	10/5/18
17	Focus Group (split into two groups to accommodate language differences)	The Leaven clients (English and Spanish-speaking parents, residents of Dana Dr. in Fairfield)	3 (Span.); 5 (Eng.)	Medically-underserved, low-income, minority	Community members	10/5/18

* Focus group and group interview participants completed an optional survey (see Appendix G. Focus Group Optional Participant Survey Results and Appendix H. Group Interview Optional Participant Survey Results). These data were used to inform representation of the four target groups during data collection events using the criteria outlined below:

- **Medically-underserved:**
  Focus Groups: One or more participant indicated they have “No Insurance”
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.
- **Low-income:**
  Focus Groups: One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.
- **Minority:**
  Focus Groups: One or more participant indicated their race/ethnicity as non-White.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the minority community.
- **Health department representative:**
  Focus Groups: N/A
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.

Appendix C. Health Need Profiles

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

Appendix D. Prioritization Scoring

2019 HEALTH NEEDS PRIORITIZATION SCORES: BREAKDOWN BY CRITERIA

Health Need	Rank 1= Highest Priority	Composite Weighted Score	Weighted Scores of Prioritization Criteria Used by Group		
			Severity	Disparities	Impact
Economic Security	1	130.5	46.5	60	24
Behavioral Health	2	118	33	56	29
Access to Care	3	117.5	34.5	62	21
HEAL	4	112	39	44	29
Violence & Injury Prevention	5	112	39	46	27
Housing	6	99	36	44	19
Maternal & Infant Health	7	67	24	24	19

Prioritization Criteria Definitions

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

Appendix E. Focus Group Protocol

Vacaville and Vallejo Service Areas

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

Introduction + Getting Settled (15 minutes)

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

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

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

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

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

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

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

Does anyone have any questions before we start?

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

1. Let's start by introducing ourselves.

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

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

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

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

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

[**PROBE:** It may be helpful to think about the following: specific geographic regions, demographics of the community (age, race/ethnicity, languages spoken) or the physical environment (rural, urban, local businesses, parks, community spaces, etc.)]

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

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

    Step 1

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

    Step 2

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

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

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

Health Issues - 15 Minutes (55 minutes left)

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

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

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

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

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

Challenges and Barriers - 10 Minutes (40 minutes left)

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

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

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

    b. PROMPT: For example, do you have access to fresh food, safe areas to exercise and recreate, community spaces to gather, etc.?

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

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

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

Solutions - 10 Minutes (30 minutes left)

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

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

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

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

Priorities - 15 minutes (25 minutes left)

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

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

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

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

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

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

Example for Santa Rosa:

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

Resources - 10 Minutes (10 minutes left)

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

    a. PROMPT:

        i. Barriers to accessing these resources.

        ii. New resources that have been created since 2016

        iii. New partnerships/projects/funding

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

    a. PROMPT:

        i. Service providers

        ii. Community leaders

        iii. Community groups

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

Community Ladder – Background and Directions

Question #3

Purpose

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

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

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

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

Step 1

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

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

Step 2

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

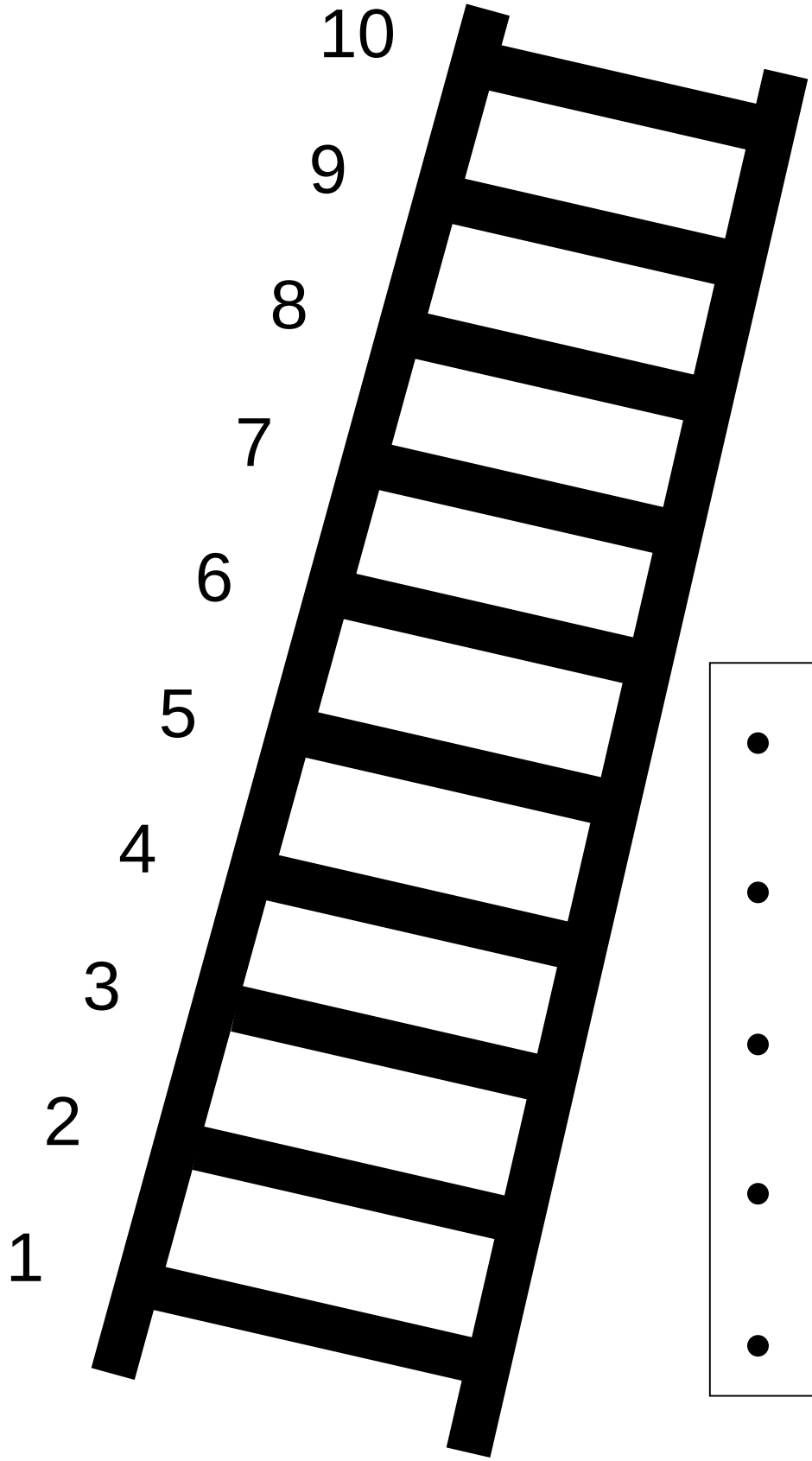
Step 3

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

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

Return to protocol

Note to facilitator: Return to the protocol and refer to the concepts discussed throughout the focus group as they relate to subsequent conversations.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1

Appendix F. Key Informant Interview and Group Interview Protocol

Solano County Service Areas

Introduction + Getting Settled 10 minutes

Hello my name is _____ from Harder+Company Community Research. We are working with several healthcare organizations [Kaiser, Sutter, NorthBay, etc.] to complete their 2019 Community Health Needs Assessments to better understand the health needs in this region. We are also working closely with Solano and Napa County health services partners to coordinate these efforts. We will be using the data collected during interviews as well as quantitative data to inform the report. We are collaborating with Sutter Health's consultant, Community Health Insights (CHI), to conduct primary and secondary data collection. The information from this interview may be shared with CHI research staff.

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

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

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

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

As I mentioned before, we encourage you to be honest and candid so we can truly understand the health needs of the community you serve.

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

Do you have any questions for me before we start?

Background- 10 minutes (50 minutes left)

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

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

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

Health Issues – 10 Minutes (40 minutes left)

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

3. What does a healthy environment look like?

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

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

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

Challenges/Barriers- 10 Minutes (30 minutes left)

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

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

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

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

Solutions -10 Minutes (20 minutes left)

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

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

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

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

Priorities- 5 minutes (10 minutes left)

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

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

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

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

Resources- 5 Minutes (5 minutes left)

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

    a. PROBE:

        i. Barriers to accessing these resources.

        ii. New resources that have been created since 2016

        iii. New partnerships/projects/funding

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

    a. PROMPT:

        i. Service providers

        ii. Community leaders

        iii. Community groups

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

Focus Group Optional Participant Survey

The participant survey was administered one time to all participants in each focus group conducted by Harder + Company Community Research. The anonymous, optional survey was designed to gather demographic information for participants of focus groups. The survey also seeks to understand the self-reported strength of participants' social support system.

Respondent Demographics

Exhibit 1. What is your zip code?

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

Exhibit 2. What is your race/ethnicity?

	N	%
Black/African American	13	25%
Hispanic/Latino/a	23	44%
Pacific Islander/Native Hawaiian	1	2%
White	9	17%
Multiple races	5	10%
Another race	1	2%
Total	52	100%

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

	N	%
Female/Woman	51	85%
Male/Man	9	15%
Total	60	100%

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

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

	N	%
Not employed, looking for work	9	16%
Not employed, choose not to work	7	12%
Self-employed	4	7%
Employed part-time	9	16%
Employed full-time	5	9%
Retired	7	12%
Full-time student	10	17%
Cannot work due to disability	1	2%
Other	6	10%
Total	58	100%

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

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

	N	%
No	18	32%
Yes	30	53%
Don't Know	9	16%
Total	57	100%

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

	N	%
0-10,000	5	11%
10,001-20,000	4	9%
20,001-30,000	5	11%
30,001-40,000	6	14%
40,001-50,000	7	16%
50,001-75,000	8	18%
75,001-100,000	4	9%
100,001+	5	11%
Total	44	100%

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

	N	%
1	9	16%
2	10	18%
3	13	23%
4	10	18%
5	10	18%
6+	5	9%
Total	57	100%

Exhibit 8. What is your current marital status?

	N	%
Single	27	48%
Not married, but living with partner	3	5%
Married	19	34%
Divorced	5	9%
Widowed	2	4%
Total	56	100%

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

	N	%
Less than high school	19	34%
High school diploma or GED	9	16%
Some college	8	14%
Associate or technical degree	2	4%
College degree	7	13%
Graduate or professional degree	7	13%
Other	4	7%
Total	56	100%

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

	N	%
No Insurance	3	5%
Medi-Cal	21	38%
Covered California	3	5%
Insurance bought directly by me or my partner	2	4%
Insurance provided by my job or my partner's job	10	18%
Other	9	16%
Don't know	7	13%
Total	55	100%

Social Support

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

	N	%
Enough people	32	63%
Too few people	11	22%
No one	8	16%
Total	51	100%

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

	N	%
Similar to other people	22	48%
More than most people	12	26%
Less than most people	12	26%
Total	46	100%

Group Interview Optional Participant Survey

The participant survey was administered one time to all participants in each group interview conducted by Harder + Company Community Research. The anonymous, optional survey was designed to gather information on individuals' organizational role and demographics.

Exhibit 1. What is your position in the organization?

	N	%
Executive Director	2	13%
Direct Service Provider	3	19%
Other	11	69%
Total	16	100%

Exhibit 2. How long have you been with the organization?

	N
Mean = 5 years	15

Exhibit 3. Do you identify as a leader, representative, or member of any of the following communities?* (Mark all that apply)

	N	%
Health Department or Health Care Sector	1	6%
Non-Health Care Sector (e.g., law enforcement, religion, education)	8	50%
Individuals with chronic conditions (e.g., diabetes, obesity, heart disease)	3	19%
Minority population	6	38%
Medically underserved	2	13%
Low-income	7	44%

*Total does not equal 100% as respondents selected multiple responses. N = 16

Exhibit 4. What topic area(s) does your organization support?* (*Mark all that apply*)

	N	%
Health	5	31%
Education	13	81%
Employment	12	75%
Housing	5	31%
Faith-Based	5	31%
Neighborhood/community well-being	7	44%
Poverty	6	38%
Criminal/juvenile justice	6	38%
Other	3	19%

*Total does not equal 100% as respondents selected multiple responses. N = 16

Exhibit 5. What age range do you primarily serve? (*Mark all that apply*)

	N	%
1-10 years old	4	25%
11-20 years old	0	0%
21-30 years old	6	38%
31-40 years old	4	31%
41-50 years old	5	31%
51-60 years old	3	19%
61-70 years old	1	6%
71+ years old	0	0%

*Total does not equal 100% as respondents selected multiple responses. N = 16

Exhibit 6. What areas/neighborhood/cities does your organization serve primarily?*

	N	%
Fairfield / Vallejo (Solano County)	1	9%
Fairfield, Napa, Suisun, Vacaville, Vallejo, Richmond, Concord	1	9%
Fairfield, Suisun, Vacaville, Vallejo, Rialto	1	9%
Low incomes areas of cities in Solano, Napa, Contra Costa and San Bernardino Counties	1	9%
Solano County	4	36%
Solano County Cities	1	9%
Solano County Vacaville, Fair, Dixon	1	9%
Vacaville, Fairfield, Napa, Benicia, Vallejo, Richmond, Rialto, Ontario	1	9%
Total	11	9%

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

Exhibit 7. What is your race/ethnicity?

	N	%
Asian	1	7%
Black/African American	2	13%
White	11	73%
Multiple races	1	7%
Total	15	100%

Appendix I. Prioritization Meeting Participants

	Organization
1.	NorthBay Healthcare
2.	NorthBay Healthcare
3.	Partnership HealthPlan of California
4.	Solano Coalition for Better Health
5.	Solano County Medical Services
6.	Solano County Public Health