

2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Santa Rosa Memorial Hospital

Santa Rosa, CA



To provide feedback on this CHNA or obtain a printed copy free of charge, please email Amy Ramirez at amy.ramirez2@providence.org

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MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

It is with great joy and pride that we present Providence Santa Rosa Memorial Hospital's Community Health Needs Assessment, a report that identifies the unmet needs of our neighbors.

By gathering and analyzing comprehensive data (both quantitative and qualitative), this report demonstrates how social determinants of health and health disparities are affecting residents in neighborhoods across Sonoma County. As demonstrated in the report, many residents face significant barriers to accessing care that can affect their overall health and well-being.

This information will guide how we provide resources to the most vulnerable individuals in our community over the next three years. We could not have collected this information alone and would like to thank all our partners who brought their diverse skills and expertise to this process.

We invite you to study the findings and join us in our efforts to improve and enhance the quality of life for individuals in the communities we serve.

With gratitude,

DocuSigned by:

Charles Kassis

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Chuck Kassis

Chief Executive Officer

Providence Santa Rosa Memorial Hospital

DocuSigned by:

Bruce Okrepkie

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Bruce Okrepkie

Chair of the Community Benefit Committee

Providence in Sonoma County

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Santa Rosa Memorial Hospital to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

The 2023 CHNA was approved by the Santa Rosa Memorial Hospital Community Benefit Committee on November 14, 2023, and made publicly available by December 28, 2023.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, hospital-level data, and public health data regarding health behaviors, morbidity, and mortality. To actively engage the community, we partnered with On the Margins, Inc. to conduct 3 listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted 14 key informant interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Lack of affordable housing with increased barriers for those with disabilities, older adults and the BBPIOC community.
- Limited access to and availability of behavioral health and substance use services.
- Limited access to primary and specialty medical care providers.
- Economic insecurities with increased barriers related to racism and discrimination.
- Strengths included community resiliency and community-based organization collaboration.

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

Identifying Top Health Priorities

Through a collaborative process engaging Providence Santa Rosa Memorial Hospital's Community Benefit Committee (CBC), the CBC identified the following priority areas listed in order of priority:

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

Publicly available data along with Providence hospitalization data show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care. Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members and caregivers all shared that lack of behavioral health and substance use services was a major barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox was also a commonly voiced need. Data showed particular concern for youth.

HOMELESSNESS AND HOUSING INSTABILITY

Over 25% of Sonoma County is experiencing severe house cost burden, spending 50% or more of their household income on housing. Additionally, over 2800 individuals were found to be experiencing homelessness in 2022. Most Key Informants identified the need for additional permanent supportive housing, housing accepting housing vouchers, affordable housing, and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

ACCESS TO HEALTH CARE AND DENTAL SERVICES

Fewer people saw a primary care doctor or dentist over the past year in 2022. This trend coupled with qualitative data expressing lack of primary medical and dental providers, highlighted lack of appropriate level of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

AGING ISSUES

There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. Older adults experiencing homelessness and housing instability as well as mental health issues due to isolation, is on the rise in Sonoma County. A lack of providers with experience specific to geriatric conditions is of concern.

RACISM AND DISCRIMINATION

The Community Benefit Committee and Community Health Investment department recognize that racism and discrimination is a crosscutting theme and root cause among all prioritized needs areas and agreed that racism and discrimination will be addressed explicitly in each prioritized need areas as outlined by our Community Health Improvement Plan (CHIP).

Petaluma Valley Hospital will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and

community strengths and capacity. The 2024-2026 CHIP will be approved and made publicly available no later than May 15, 2024.

Measuring Our Success: Results from the 2020 CHNA and 2021-2023 CHIP

This report evaluates the impact of the 2021-2023 CHIP. Santa Rosa Memorial Hospital responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2020 CHNA and 2021-2023 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the 2020 CHNA and 2021-2023 CHIP. The 2020 CHNA and 2021-2023 CHIP priorities were the following: housing instability and homelessness, mental health and substance use services, healthy equity: racism and discrimination, and access to health care.

A few of the key outcomes from the previous CHIP are listed below:

- \$6,600,000.00 Invested in 788 Permanent Supportive Housing Units in Sonoma County.
- Significant grants to Community-Based Organizations to increase capacity for behavioral health system navigation and direct patient behavioral health care.
- Addition of Substance Use Navigators at Santa Rosa Memorial and Petaluma Valley Hospitals and Naloxone distribution out of forementioned emergency departments.
- Outreach to Latinx community through expanded Mobile Health Clinic sites and Community Health Worker outreach via health screening events and fairs.
- Growth and expansion of CARE Network programs including addition of a Social Worker, RN, and Community Health Worker.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Santa Rosa Memorial Hospital is an acute care hospital founded in 1950 and located in Santa Rosa, CA. The hospital has 338 licensed beds, a staff of more than 2,000 caregivers and professional relationships with more than 430 local physicians. Major programs and services offered to the community include the following: critical care, cardiovascular care, stroke care, women’s and children’s services, cancer care, and orthopedics.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities:

<https://www.providence.org/about/annual-report>.

COLLABORATING PARTNERS AND CONTRACTOR

Collaborating Community Partners

Community Health Investment collaborated with the Health and Human Services Department of the County of Sonoma and received Area Agency on Aging data regarding Sonoma County's Older Adult Population. Additionally, Community Health Investment shared listening sessions data with The County of Sonoma for their 2023 Needs Assessment.

Contractor

When choosing a consultant to assist with the community listening sessions, it was of great importance to select an organization that had a trusted, culturally sensitive reputation in the community, especially the BBIPOC community. We chose On the Margins, LLC. for this reason.

On the Margin's collaborative work with Providence included a planning, engagement, and post-engagement phase. With the assistance of Corazon Healdsburg and Petaluma Family Resource Center, On the Margins recruited participants in the Santa Rosa, Healdsburg, and Petaluma service areas to participate in the listening sessions.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

Equity Framework

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life. At Providence, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion or socioeconomic status. Our health equity statement can be found online: <https://www.providence.org/about/health-equity>.

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets. Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

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



Approach

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



Community Engagement

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



Quantitative Data

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

Special consideration was given to uplifting the voices of those underrepresented in our community. When choosing Key Informants to interview, this department carefully chose individuals who were

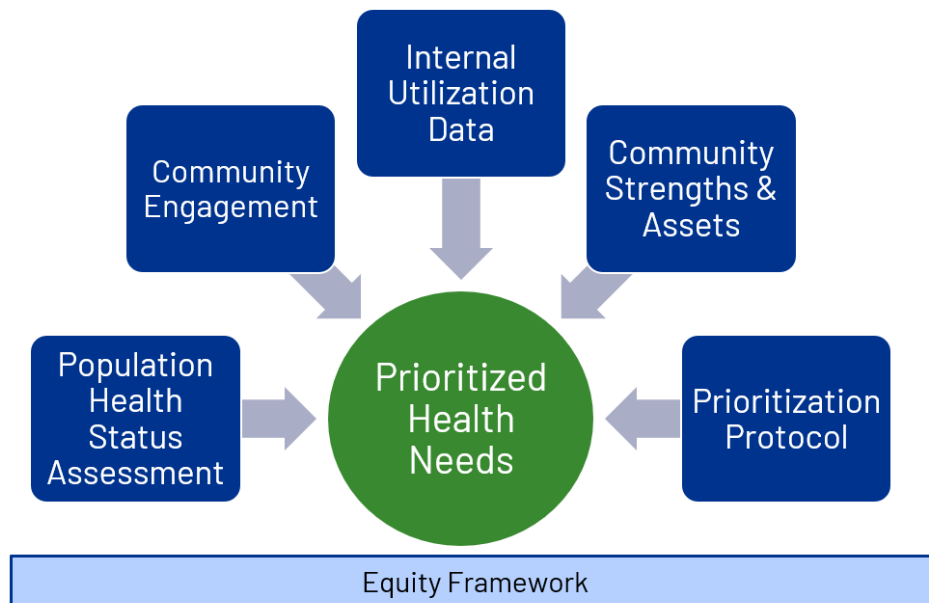
subject matter experts with eyes on both the day-to-day operations of their organizations as well as the experience of those who they aim to serve.

Additionally, when choosing a consultant to assist with the community listening sessions, it was of great importance to choose an organization that had a trusted, culturally sensitive reputation in the community, especially the BBIPOC community. We chose On the Margins, LLC for this reason.

On the Margin’s collaborative work with Providence included a planning, engagement, and post engagement phase. With the assistance of Corazon Healdsburg and Petaluma Family Resource Center, On the Margins recruited participants in the Santa Rosa, Healdsburg, and Petaluma service areas to participate in the listening sessions.

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed-methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



*modified MAPP Framework

Data Sources

In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
<ul style="list-style-type: none">• Key informant interviews• Community listening sessions• Internal hospital utilization data	<ul style="list-style-type: none">• American Community Survey• Behavioral Risk Factor Surveillance System (BRFSS)• U.S. Census Bureau• Sonoma County Homeless Point-in-Time Count Report• Sonoma County Health and Human Services

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

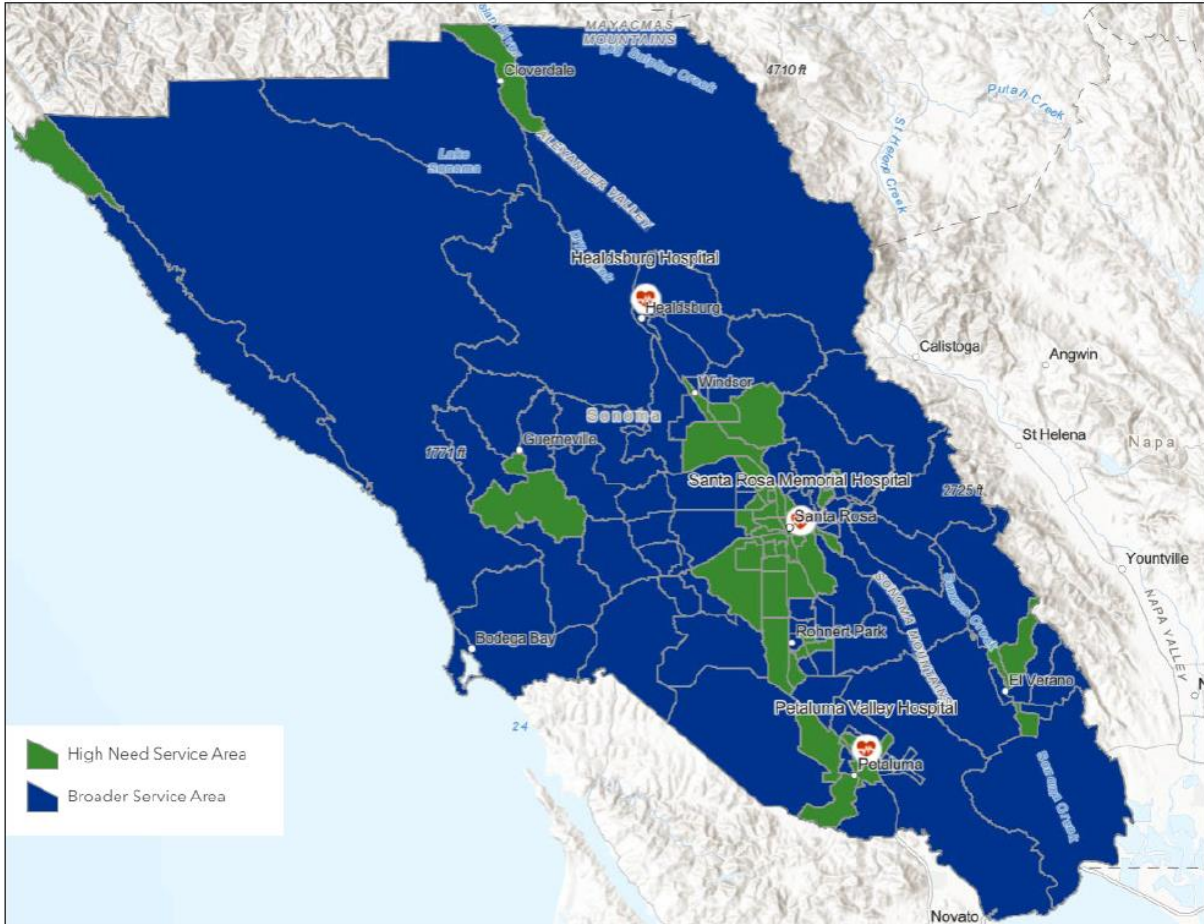
Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2020 CHNA and 2021-2023 CHIP reports, which were made widely available to the public via posting on the internet in December 2020 (CHNA) and May 2021 (CHIP), as well as through various channels with our community-based organization partners. No comments were received.

OUR COMMUNITY

Hospital Service Area and Community Served

Figure #1: Santa Rosa Memorial Hospital Service Area



Santa Rosa Memorial Hospital serves all of Sonoma County. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, Sonoma County serves as the boundary for the hospital’s service area.

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a “high need” service area and a “broader” service area, which together make up the Sonoma County Service Area. Based on work done by the Public Health Alliance of Southern California and their [Healthy Places Index](#)

(HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.¹

For this analysis, census tracts with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as “high need.” The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green. In the Sonoma County service area, 48 of 121 census tracts (39.7%) scored above the average of 25%, indicating a high need.

Community Demographics

The tables/graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here: [Sonoma County 2023 PSJH \(arcgis.com\)](https://arcgis.com)

POPULATION DEMOGRAPHICS

Table #1: Population Demographics for Sonoma County Service Areas

Indicator	Sonoma County	Sonoma Broader Area	Sonoma High Need Area
Population by Age Groups			
Total Population	492,498	274,845	217,653
Population Age Under 5	4.8% (23,689)	4.5% (12,231)	5.3% (11,458)
Population Age Under 18	19.7% (96,796)	18.1% (49,777)	21.6% (47,019)
Population Ages 18 to 34	20.6% (101,333)	18.1% (49,647)	23.7% (51,686)
Population Ages 35 to 54	25.5% (125,544)	25.0% (68,754)	26.1% (56,790)
Population Ages 55 to 64	14.4% (71,010)	15.9% (43,627)	12.6% (27,383)
Population Ages 65 to 84	17.5% (85,946)	20.2% (55,441)	14.0% (30,505)
Population Age 85 and Over	2.4% (11,869)	2.8% (7,599)	2.0% (4,270)
Population by Gender			
Female	50.9% (250,600)	51.0% (140,072)	50.8% (110,528)

¹ The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in [Limited English Households](#) (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Male	49.1% (241,898)	49.0% (134,773)	49.2% (107,125)
Population by Race			
American Indian and Alaska Native	1.1% (5,272)	0.8% (2,091)	1.5% (3,181)
Asian Population	4.4% (21,613)	4.1% (11,276)	4.7% (10,337)
Black or African American Population	1.6% (7,737)	1.1% (3,090)	2.1% (4,647)
Native Hawaiian And Other Pacific Islander Population	0.3% (1,640)	0.4% (994)	0.3% (646)
Other Race Population	13.2% (64,953)	7.3% (20,074)	20.6% (44,879)
Two or more Races Population	9.1% (44,801)	8.8% (24,088)	9.5% (20,713)
White Population	70.4% (346,482)	77.6% (213,232)	61.2% (133,250)
Population by Ethnicity			
Hispanic Population	27.5% (135,683)	19.4% (53,256)	37.9% (82,427)

In Sonoma County, younger people, those under the age of 55 years, are more likely to live in the high need service area. Older adults, those 55 years and above, are more likely to live in the broader service area, perhaps due in part to secondary and/or vacation homes.

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

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

In Sonoma County, approximately 6.5% of the population are veterans, slightly higher than the 4.8% in the state of California.

INCOME INDICATORS

Table #2: Income Indicators for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
Median Income	\$117,926	\$77,152	\$90,867	\$83,226
Data Source: American Community Survey, 2021 5-Year estimate				

Household median incomes includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many

households consist of only one person, average household income is usually less than average family income.

The broader service area has a median income of \$117,926, which is \$27,059 greater than Sonoma County and \$40,774 greater than the high need service area.

SEVERE HOUSING COST BURDEN

Table #3: Severe Housing Cost Burden for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
Percent of Renter Households with Severe Housing Cost Burden	25.4%	27.9%	25.0%	26.3%
Data Source: American Community Survey, Estimates based on 2021 5-year estimate				

Severe housing cost burden is defined as renter households that are spending 50% or more of their income on housing costs. About 25% of households in Sonoma County are severely housing cost burdened, which is slightly lower than the state of California overall.

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

HEALTH INDICATORS

Please refer to the Sonoma County Data Hub 2023 to review each of the following health indicators mapped at the census tract level: [Sonoma County 2023 PSJH \(arcgis.com\)](https://arcgis.com)

The hub provides data on each indicator in the Sonoma County high need and broader need service areas, and California, as well as information about the importance of each indicator.

Table #4: Severe Housing Cost Burden for Sonoma County Service Areas

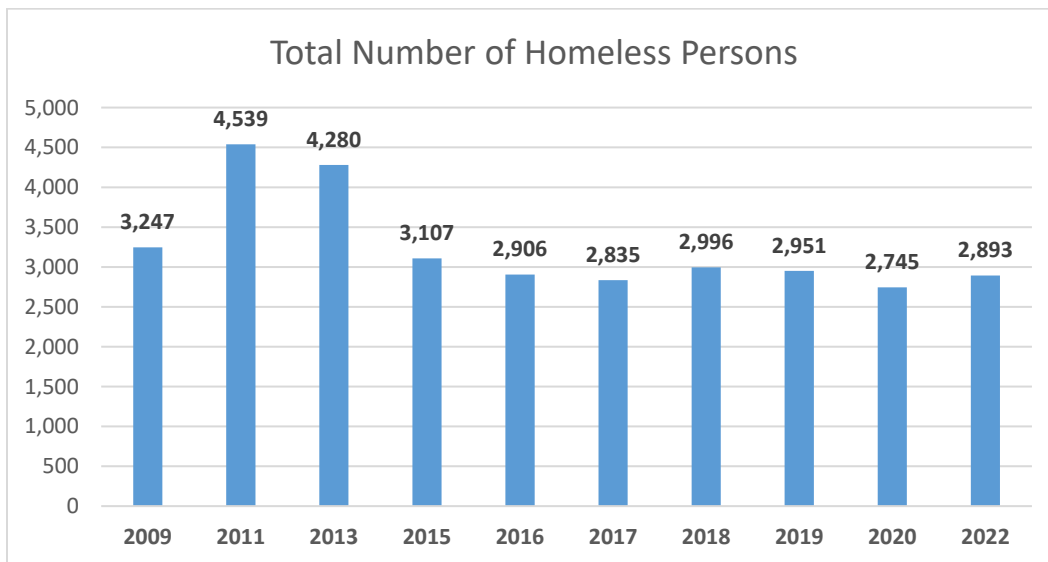
Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
% of Renter Households Experiencing Severe Housing Cost Burden*	25.4%	27.9%	25.0%	26.3%

Data Source: American Community Survey, 2021 5-year estimate

*Renter households spending more than 50% of income on housing costs.

Severe housing cost burden is related to health disparities. When families spend more than 50% of their income on housing they are forced to choose between other basic necessities, often sacrificing health care.

Table #5: Sonoma County Homeless Point-in-Time Count



Data Source: [Sonoma County Homeless Point-in-Time Count](https://www.sonomacountyhomeless.org/), 2022

This bar graph shows the number of homeless individuals counted through the annual Point-in-Time Count conducted annually in Sonoma County every January.

While the number of people experiencing homelessness is still high, investments over the past two years in permanent supportive housing units have positively impacted the homelessness crisis, lowering the amount of homeless individuals since 2011. The 2017 fires did create additional homelessness, possibly changing the trajectory of the permanent supportive housing impact.

Table #6: Behavioral Health and Substance Use Indicators

Indicator	Sonoma County	California
% of adults reporting their mental health is “not good” for 14 days or more in a month	14.2% (Worsening Trend from 12.3% in 2019)	12.9%
% of adults reporting depression	17.7% (Worsening Trend from 17.0% in 2019)	14.2%
% of adults reporting binge drinking in the past 30 days	19.9% (Worsening Trend from 19.1% in 2019)	16.6%
% of adults reporting smoking	11.8% (Worsening Trend from 11.4% in 2019)	9.0%
Data Source: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2020 Trending information is from 2019 to 2020 and should be interpreted with caution given the short time frame		

According to the CDC, “Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease, such as, physical inactivity, smoking, excessive drinking, and insufficient sleep. Mental health is an important component of Health-related quality of life (HRQOL), a multi-dimensional concept that focuses on the impact of health status on quality of life.”²

Behavioral Health and Substance Use Disorders are on the rise in Sonoma County and are among the top avoidable emergency room diagnoses at Santa Rosa Memorial and Petaluma Valley hospitals. According to the community input, lack of behavioral health providers and lower levels of care for behavioral health and substance use contribute to this crisis.

² CDC Division of Population Health. PLACES Measure Definitions: Health Status, 2021

Table #7: Access to Health Care Indicators

Indicator	Sonoma County	California
% of adults reporting fair or poor health status (self-rated)	12.3% (Improving Trend from 15.7% in 2019)	14.2%
% of adults visiting a doctor for routine checkup within the past year	63.2% (Worsening Trend from 68.2% in 2019)	64.8%
% of Population Uninsured	5.9%	7.2%
<small>Data Source for fair or poor health and routine checkup: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2020 Data Source for population uninsured: American Community Survey, 2021 5-year estimate Trending information is from 2019 to 2020 and should be interpreted with caution given the short time frame</small>		

According to Healthy People 2030, “Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health.”³ A lack of providers in Sonoma County paired with additional barriers for the BBIPOC community create access challenges and subsequent health related disparities.

According to the community input, Sonoma County is experiencing a shortage of primary and specialty providers, making it very challenging to access care. Appointment availability at both Federally Qualified Health Clinics and Primary Care offices are weeks to months out, causing individuals to access emergency departments for primary-level care or forgoing care.

Table #8: Economic Insecurity Indicators

Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
Household Median Income	\$117,926	\$77,152	\$90,867	\$83,226
% Unemployment	4.8%	5.3%	5.1%	6.5%
<small>Data Source: American Community Survey, 2021 5-Year Estimate</small>				

Household median incomes includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

³ Healthy People 2030. Social Determinants of Health Literature Summaries: Access to Health Services.

While the household median income presents as higher than the state average, the cost of living paired with high housing costs in Sonoma County creates economic insecurity for many. Additionally, many families are part of multifamily households out of necessity, which is often related to other health-related disparities.

See [Appendix 1](#) for additional Population Health Data

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

In 2022, our data showed the following key insights:

- Almost 44% of the AED visits were from patients living in ZIP Codes 95407 (15.8%), 95401 (15.7%), and 95404 (12.1%).
- Patients self-identifying as American Indian or Alaska Native had a higher percentage of ED visits that were potentially avoidable (36.5%) compared to the overall population (30.7%).
- The most common diagnoses for all avoidable visits during this time were substance use disorders, urinary tract infections, and skin infections.

For additional information regarding these findings, please contact Amy Ramirez, amy.ramirez2@providence.org.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Santa Rosa Memorial Hospital conducted 14 key informant interviews with representatives from community-based organizations and in partnership with On the Margins, LLC, conducted 3 listening sessions with community members. Additionally, representatives from Community Health Investment conducted 1 Providence Caregiver listening session. During these interviews and listening sessions, community members and nonprofit and government key informants discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions.

See [Appendix 2](#) for methodology and participant details. For the full report of findings from the community listening sessions, see [Appendix 5](#).

Summary of Community Listening Sessions

Listening session participants expressed themes of school bullying, grief, isolation, anxiety, and depression for their children with concerns about safety and nutrition at Sonoma County schools.

Participants advocated for free or low-cost youth programming beyond the school day to assist with social-emotional development.

Participants shared experiences of financial hardships, the need to work long hours, and the inability to afford housing, indicating that these take a heavy emotional toll and impact their overall health.

Some participants disclosed that they had recently been evicted, and many participants expressed a need for more housing assistance and low-income housing communities.

Themes of racism and discrimination were expressed with special concerns for racism in schools and the workplace. Participants felt that dignity, protection, and opportunity would improve if community leaders came from communities of color.

Participants expressed a desire for culturally responsive healthcare providers and healthcare services and to behavioral health services. Petaluma residents were very concerned about the closing of the family birth center in Petaluma.

Participants identified outreach services such as mobile health and health fairs as being of great value as there is distrust and fears associated with visiting hospitals and clinics. Participants highlighted the value of community health workers and recommended that health systems invest more in community health work.

Participants advocated for trainings and seminars to develop workforce skills and support community networking with a special request for peer support programs.

Open spaces and nature were of great importance to participants and connection to other community members, especially elders.

Participants identified community-based organizations that are making an impact on their communities.

See [Appendix 5](#) for a copy of the complete Community Listening Session Report.

Community-Defined Health and Strengths

Caregivers were asked to describe their vision of a healthy community and key informants were asked to highlight community strengths:

Vision for a Health Community	Community Strengths
<ul style="list-style-type: none">•Older adults are respected and included•The community is invested in children and encourages their growth and learning•People engage in community events and gather outside•The community is well-maintained, with green spaces, art, and clean streets•All people are included and heard•Basic needs for health care, housing, and childcare are met•Economic and educational opportunities exist•The community is safe•Transportation meets needs	<ul style="list-style-type: none">•Community members are resilient and resourceful and persevere despite disasters and challenges•Community members are connected and look out for one another•Community members are engaged in and have knowledge about how to meet community needs•Organizations in Sonoma County are interconnected and striving to find more opportunities for effective collaboration

Community Needs

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Homelessness and housing instability

A lack of affordable housing was a concern for most key informants, particularly because many families spend a majority of their income on rent, making meeting other basic needs difficult. Even with a full time job, housing can still be too expensive, particularly for people with low incomes and households with one income. The price of housing increased in the COVID-19 pandemic as people moved into the area, and a lack of housing stock continues to be a concern. Key informants and caregivers shared there is a need for more permanent supportive housing with wraparound support and more shelter beds. Key informants also shared there is a need for non-congregate shelters and rentals that accept housing

vouchers. More services to support people experiencing homelessness are also needed, including more street-based medicine and safe parking areas.

Key informants shared some groups experience more challenges with safe, stable housing: older adults, trans or non-binary people, agricultural workers, families seeking shelter placements, domestic violence survivors, Indigenous peoples, peoples with disabilities, people with behavioral health challenges, and Black, Brown, Indigenous, and People of Color (BBIPOC) individuals. Although, a lack of housing stock and affordable housing affects the entire community, especially because it makes it difficult for workers to stay in the community and to recruit workforce. The COVID-19 pandemic exacerbated housing-related needs and challenges in the community. While there was more money being invested towards homelessness prevention and rapid rehousing, once rental protections ended, people lost their housing, and the effects are still being felt.

Behavioral health challenges and access to care (mental health and substance use/misuse)

Most key informants shared that accessing behavioral health service, including mental health and substance use/misuse services, is difficult. Stress from trying to meet families' basic needs can contribute to more behavioral health challenges. Key informants and caregivers spoke to needing more substance use disorder (SUD) treatment services, including medical detox, as well as more funding for crisis intervention teams and more focus on prevention of crises. Key informants also identified a need for more peer navigators and care coordinators, as well as expanded hours for and on-demand mental health services. Key informants and caregivers emphasized more mental health providers, especially those that are bilingual and bicultural, are needed. Transportation and a lack of understanding of the importance of mental health and how to talk about it can contribute to people not accessing care. Key informants emphasized concern for the well-being of young people, particularly school-age children, and identified them as a high-priority group with unmet behavioral health needs. As a result of the pandemic, young people are experiencing increased anxiety and depression, as well as substance use/misuse and behavioral issues. Caregivers would like to see more education to prevent youth substance use/misuse. People experiencing homelessness, older adults, and people with intellectual disabilities may also experience unique barriers to accessing behavioral health care.

MEDIUM PRIORITY UNMET HEALTH-RELATED NEEDS

Economic insecurity

Economic insecurity affects many other needs, including educational opportunities, food resources, employment, transportation, and physical and mental health. Key informants shared that for people with low incomes or households with single incomes, the cost of housing can make meeting other needs very difficult. Key informants discussed the importance jobs that pay a living wage and provide sick leave so that people can care for themselves and their families. The local economy is primarily rooted in tourist-based services and the service industry, which contributes to young people leaving the community for other employment

opportunities. Education is foundational to economic security; key informants would like to see more support for school success to ensure all students have access to a quality education. The pandemic has contributed to students falling behind and put more pressure on educators to help address the resulting learning gaps.

Key informants were particularly concerned about farmworkers and how racism contributes to exploitative working conditions. People living on fixed incomes from Social Security or Disability, such as older adults, may experience more economic insecurity and homelessness. COVID-19 is still a concern for workers, as those without paid sick leave may not have the option of taking time off of work. The stress from trying to meet basic needs can also contribute to sickness, and ultimately means spending more money on health care.

Aging issues

Key informants shared that there is a large population of older adults in Sonoma County and to meet the needs associated with aging, there needs to be more support services. They identified older adults as a priority population and shared that some parts of Sonoma County, such as some southern areas, may not have sufficient services to meet the growing needs. Key informants were particularly concerned about many older adults experiencing homelessness or housing instability. With the high cost of housing, older adults living on a fixed income from Social Security or Disability may not be able to afford their housing and there is a large population of people over the age of 60 years that are experiencing homelessness, meaning shelters need to ensure accessibility. There is also a need for more specialists in Sonoma County for aging adult health needs, as well as transportation for older adults to get to care. Technology can be a barrier for some older adults in accessing care. Key informants are seeing high demand for meal delivery services for older adults that started during the COVID-19 pandemic. Food insecurity may disproportionately affect older adults. Mental health is also a concern for older adults, particularly due to increased isolation. Key informants spoke to wanting to see a senior center where there are wraparound services and activities.

Access to health care services

Key informants shared that primary care and specialty care can be difficult to access across the county and, in particular, in certain areas that may be more rural. Key informants and caregivers shared there is a need for more access to specialists and bilingual and bicultural providers, as well as Community Health Workers (CHWs), for meeting the needs of underserved communities. Key informants identified a need for more street-based or mobile health care to support people experiencing homelessness. Caregivers would like to see more in-home health care and skilled providers for medically complex patients. Accessing care in the northern and southern parts of Sonoma County can be more difficult with Emergency Medical Transport times being some of the longest in the state of California in northern Sonoma County. Accessing pharmacies can also be challenging. Transportation, appointment times during work hours, the high cost of medical care and insurance, and technology barriers prevent people from accessing needed care.

Populations that may experience these and other barriers to care include the following: agricultural workers, the immigrant community, people experiencing homelessness, older adults, and people lacking health insurance. Telehealth has reduced transportation barriers for some people. The COVID-19 pandemic affected care, with some people losing their insurance and others delaying their preventive care screenings. This contributes to more unmanaged chronic conditions and undiagnosed issues. COVID-19 also contributes to turnover and difficulties with health care staffing, meaning longer wait times. Key informants spoke to the importance of continuing to build up the health care work force through training pipelines and internships.

In addition to homelessness and housing instability, behavioral health, and access to health care services, caregivers also spoke to a few other needs:

- Improved access to affordable, healthy food
- Affordable gyms and access to physical activity
- Free clothing and furniture

Challenges in Obtaining Community Input

While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person.

Additionally, On the Margins expressed barriers to recruiting youth and seniors as well as LGBTQIA+ community members for the listening sessions.

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by interview participants through a weighted ranking process and by community members through discussion and theming of the data. Additionally, needs were identified after review of the quantitative data.

The Santa Rosa Memorial Hospital Community Benefit Committee (CBC) reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

- Homelessness & Housing Instability
- Economic Insecurity
- Behavioral Health & Substance Use Disorder
- Racism and Discrimination
- Access to Health Care and Dental Services
- Aging Issues

Identification and Prioritization of Significant Health Needs The following criteria were used in the prioritization process:

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

2023 Priority Needs

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process, listed in order of priority.

BEHAVIORAL HEALTH AND SUBSTANCE USE

Publicly available data along with Providence hospitalization data show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care. Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members and caregivers all

shared that lack of behavioral health and substance use services was a major barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox were also commonly voiced needs. Data showed particular concern for youth.

HOMELESSNESS AND HOUSING INSTABILITY

Over 25% of Sonoma County is experiencing severe house cost burden, spending 50% or more of their household income on housing. Additionally, over 2800 individuals were found to be experiencing homelessness in 2022. Most Key Informants identified the need for additional permanent supportive housing, housing accepting housing vouchers, affordable housing and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

ACCESS TO HEALTH AND DENTAL CARE

Fewer people saw a primary care doctor or dentist over the past year in 2022. This trend coupled with qualitative data expressing lack of primary, medical and dental providers highlighted lack of appropriate level of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

AGING ISSUES

There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. Older adults experiencing homelessness and housing instability as well as mental health issues due to isolation is on the rise in Sonoma County. A lack of providers with experience with geriatric conditions is of concern.

RACISM AND DISCRIMINATION

While the need area “Racism and Discrimination” was not voted as a top priority by our Community Benefit Committee, the Committee and Community Health Investment department recognize that racism and discrimination was a crosscutting theme and root cause among all prioritized needs areas and will be specifically addressed in each prioritized need area as outlined by our Community Health Improvement Plan.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health, Kaiser Permanente, Sutter Health, Santa Rosa Community Health, Petaluma Health Center, Sonoma County Indian Health, Alliance Medical Center, Alexander Valley Medical Center, and West County Health Centers. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs.

See [Appendix 3](#) for a full list of resources potentially available to address the significant health needs.

EVALUATION OF 2021-2023 CHIP

The 2020 CHNA and 2021-2023 CHIP priorities were the following: Homelessness and Housing Instability, Mental Health and Substance Use Services, Access to Health Care, and Health Equity. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). Santa Rosa Memorial Hospital responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table #9: Outcomes from 2021-2023 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Homelessness and Housing Instability	Generation Housing	Housing Policy and Activism	Community and government awareness of Sonoma County barriers to housing development.
Homelessness and Housing Instability	Catholic Charities	Medical Respite Permanent Supportive Housing Units Homeless Services Navigation	38 medical respite Beds, 64 units of Permanent Supportive Housing (PSH), and navigation support for community and caregivers.
Homelessness and Housing Instability	Burbank Housing	Permanent Supportive Housing projects in Petaluma and Santa Rosa for chronically homeless individuals and families	60 units of PSH at Studios at Montero and 49 PSH units at Petaluma River Place.
Homelessness and Housing Instability	Committee on the Shelterless	Permanent Supportive Housing for High Utilizers of Emergency Services experiencing homelessness	11 units of PSH
Homelessness and Housing Instability	The Living Room	Permanent Supportive Housing for Women and Children	Funded outstanding loan for home for women and children

Behavioral Health and Substance Use	Athena House	Housing and Treatment Services for Women and Women with Children	Provided gap funding to maintain programming and housing for women in treatment for 1 year.
Behavioral Health/Substance Use	Buckelew Programs	Behavioral Health System Navigation	System navigation for families experiencing a behavioral health crisis.
Behavioral Health/Substance Use	Mother's Care	Therapy/education/support for pre and postpartum mothers and mothers' support systems	Primary annual funder for coalition of therapists for low-income patients.
Behavioral Health/Substance Use	NAMI Sonoma County	Peer Support and System Navigation	Provided annual grants for programming and navigation support.
Behavioral Health/Substance Use	Mentis/Hannah Center	Community Education	Provided grant to facilitate psychoeducational series to all community members.
Behavioral Health/Substance Use	Humanidad	Therapy and System Navigation	Bilingual/Bicultural therapy for low income and behavioral health system navigation.
Behavioral Health/Substance Use	Petaluma SAFE Team	Crisis Response Mobile Support Team	Provided grant funding for operations of crisis response team as well as substance use navigation (Sober Circle).
Access to Health Care	Santa Rosa Community Health	Homeless Care Transitions and Emergency Room Divergence	Annual grant funding for Santa Rosa Community Health patients experiencing homelessness for case

			management and health system navigation.
Access to Health Care	Alexander Valley Health Care Clinic	Behavioral Health Services at Primary Care Clinic	Provided capital grant funding toward behavioral health unit of new clinic building.
Access to Health Care	Alliance Medical Center	Mobile Optometry Unit	Primary funder for this unit which provides optometry services for Medi-Cal adults and children.
Access to Health Care	Ceres Community Project	Medically Tailored Home Delivered Meals	Funded operational costs to provide meals to patients with a variety of chronic health conditions.
Access to Health Care	Athletic Rehab Clinic	Outpatient Physical Rehab for un and underinsured youth	Medi-Cal youth athletes provided with needed rehab services.
Health Equity	Made in Santa Rosa	Anti-Bullying School Program	Funding for operational costs to host anti-bullying education to students and staff at Sonoma County Schools.
Health Equity	Legal Aid of Sonoma County	Legal Services for Low-Income	Low-income individuals in hospital, home and shelter settings.
Health Equity	On the Margins Dale Program	Advocacy and Mentoring Program for High School Age Youth	Social justice and advocacy groups grown in Sonoma County Schools.


Addressing Identified Needs


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

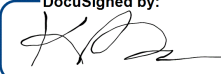
Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Santa Rosa Memorial Hospital and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Benefit Committee⁴ of the hospital on November 14, 2023. The final report was made widely available by December 28, 2023.

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Chuck Kassis
Chief Executive, Santa Rosa Memorial Hospital
Providence

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Date
Bruce Okrepkie
Chair, Santa Rosa Memorial Hospital Community Benefit Committee

DocuSigned by:

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11/29/2023
Date
Kenya Beckmann
Chief Philanthropy and Health Equity Officer, South Division
Providence

CHNA/CHIP Contact:

Amy Ramirez
Manager, Community Health Investment
1111 Sonoma Avenue, Lower Level, Santa Rosa, CA 95405
amy.ramirez2@providence.org

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

⁴ See [Appendix 4](#): Santa Rosa Memorial Hospital Community Benefit Committee

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Apx 1_Table 1. Population Below 200% FPL for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population Below 200% Federal Poverty Level	14.6%	26.7%	20.1%
Data Source: American Community Survey, 2021			

According to the U.S. Census Bureau, the total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold.

Apx 1_Table 2. Population in Limited English Households for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population in Limited English Households	2.0%	8.0%	4.7%
Data Source: American Community Survey, 2021			

This variable identifies population 5 years and older living in households that may need English-language assistance. A “Limited English-speaking household” is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English “Very well.”

Apx 1_ Table 3. Population with at Least a High School Education for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Population with a High School Diploma	92.4%	82.5%	89.2%
Data Source: American Community Survey, 2021			

According to Healthy People 2030, “A high school diploma is a standard requirement for most jobs and for higher education opportunities. Dropping out of high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.”⁵

Apx 1_ Table 4. Percent of Labor Force Unemployed for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Unemployed Population	4.8%	5.3%	5.1%
Data Source: American Community Survey, 2021			

According to the County Health Rankings & Roadmaps, “The unemployed population experiences worse health and higher mortality rates than the employed population. Unemployment has been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality, especially suicide. Because employer-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care.”⁶

Apx 1_ Table 5. Percent of Households Receiving SNAP Benefits for Sonoma County Service Areas

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Percent of Households Receiving SNAP Benefits	1.9%	8.9%	5.9%
Data Source: American Community Survey, 2021			

Households receiving SNAP is used as a proxy measure to identify households that may be experiencing food insecurity.

⁵ Healthy People 2030. Social Determinants of Health Literature Summaries: High School Graduation.

⁶ County Health Rankings & Roadmaps. Unemployment, 2023.

Appendix 2: Community Input

METHODOLOGY

Participants

In partnership with On the Margins, Inc., the hospital completed 3 listening sessions that included a total of 38 participants. The sessions took place between April and May 2023.

Apx 2_Table 1: Community Input

Community Input Type	Population	Community Partner	Location	Date	Language
Caregiver Listening Session	Providence Caregivers	N/A	1111 Sonoma Ave, Santa Rosa, CA 95405	June 14, 2023	English
Community Listening Session	Santa Rosa – 8 participants Healdsburg – 1 participant Windsor – 1 participant 73% - Latinx 5% - Indigenous/Native American 1% - prefer not to say 100% - Female Average Age: 46 years	La Plaza	1221 Farmers Lane, Santa Rosa, CA 95405	April 17, 2023	English, Spanish, Mixteco, Purepecha

Community Listening Session	Healdsburg – 10 participants Cloverdale – 3 participants Geyserville – 1 participant 86% - Latinx 7% - non-Hispanic 86% - Female 14% - Male Average Age: 42 years	Corazon Healdsburg	1557 Healdsburg Ave, Healdsburg, CA 95448	April 24 th , 2023	English, Spanish, Mixteco, Mayan
Community Listening Session	Petaluma – 13 participants 70% - Latinx 15% - Middle Eastern 15% - White 77% - Female 23% - Male Average Age: 35 years	Petaluma Family Resource Center	421 S. McDowell Blvd, Petaluma, CA 94954	April 17 th , 2023	English, Dari, Arabic, Spanish

The hospital completed 14 key informant interviews that included a total of 16 participants. The interviews took place between May and June 2023.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Interim Health Officer from Sonoma County Public Health as a key informant to ensure the input from a state, local, tribal, or regional governmental public health department.

Apx 1_Table 2. Key Community Key Informant Participants

Organization	Name	Title	Sector
Buckelew Programs	KT Swan	Program Director	Behavioral health, community-based organization
Catholic Charities of the Diocese of Santa Rosa	Stephanie Merrida-Grant	Assistant Director of Outreach and Engagement	Social services, homeless services, community-based organization
Committee on the Shelterless	Chris Cabral	Chief Executive Officer	Social services, community-based organization
County of Sonoma, Public Health	Kismet Baldwin-Santana, MD	Interim Health Officer	Public health, local government agency
Generation Housing	Jen Klose	Executive Director	Affordable housing, community-based organization
Healthcare Foundation of Northern Sonoma County	Kimberly Bender	Executive Director	Philanthropy, healthcare, community-based organization
Latino Service Providers	Stephanie Manieri	Executive Director	Social services, community-based organization
Legal Aid of Sonoma County	Tasha Bollinger	Medical Legal Partnership Attorney	Social services, community-based organization
	Esther Lemus	Supervising Attorney	

Mendonoma Health Alliance	Micheline White	Executive Director	Healthcare, social services, community-based organization
Petaluma Health Center	Annie Nicol	Director of Health Services	Healthcare, community-based organization
Petaluma Health Care District	Ramona Faith	Chief Executive Officer	Social services, community-based organization
	Elece Hempel	Secretary of PHCD (Executive Director of Petaluma People Services Center)	
Providence Petaluma Valley and Healdsburg Hospital	Troy Gideon	Chief Administrative Officer	Hospital
Providence Santa Rosa Memorial Hospital	Chuck Kassis	Chief Executive	Hospital
Reach for Home	Margaret Sluyk	Chief Executive Officer	Social services, community-based organization

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions:

- Community members’ definitions of health and well-being
- The community needs
- The community strengths

For the key informant interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2023 CHNAs:

- The community served by the key informant’s organization
- The community strengths

- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

The facilitation guides provided instructions on how to conduct a key informant interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a key informant interview and listening session and were provided question guides.

Data Collection

Key informant interviews were conducted virtually, and information was collected in one of two ways: 1) recorded with the participant’s permission or 2) a note taker documented the conversation. Two note takers documented the listening session conversations.

Analysis

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

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions using a merged set of notes. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

Limitations

While key informants and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

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

FINDINGS FROM KEY INFORMANT INTERVIEWS

Community Strengths

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these strengths to address needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community members are resilient and resourceful and persevere despite disasters and challenges

Community members are resilient and resourceful. Many key informants shared that the people in Sonoma County have overcome two major fires, a pandemic, and more. They have lost homes, lost loved ones, experienced extreme weather, and are still thriving. Key informants said that despite what happens, people persevere.

Service recipients are good at asking questions and asking for help. They know what works best for them but may need someone to come alongside them to guide them. They are especially good at problem solving and finding ways to be innovative and creative. Key informants shared examples of Latino/a immigrants finding ways to survive and overcome hardships despite obstacles, and another example of people experiencing homelessness persevering in times of difficulty.

Community members are connected and look out for one another

The people of Sonoma County look out for one another by bringing food, sharing resources, and pulling together in times of hardship.

“I would say we’re also a very connected community. If somebody is impacted by a tragedy, the rest of the community really pulls together and supports that individual who needs help or that family who needs help.”—Key Informant

Families look out for one another, with young people working hard to care for their parents and parents working hard to provide better futures for their children. The strength of the families themselves is an asset to Sonoma County.

“I can think of so many examples with some of the young people I work with that are living at home, going to school, working, helping to support their family, and moving ahead to make a change in the future for their family.”—Key Informant

This tight knit community stems from a sense of pride; people love their community and feel connected to it. Many people give back to the community by volunteering, a strength which can be leveraged by community-based organizations.

Community members are engaged in and have knowledge about how to meet community needs

A lot of community members are engaged and involved in the work of improving the community and meeting needs. People are ready and willing to help the community. People have their own experience and knowledge about what works well and what is needed. Many neighborhood groups are already having these conversations and bringing people together. This strength can be leveraged by ensuring feedback loops are in place to hear directly from people.

“I think part of it is actually reaching out to our community and making space and having them share a voice and helping leverage what they’re doing and what their ask is.”—Key Informant

Community Health Workers (CHWs) have deep trust established within their communities, typically with groups that are not often heard. Leverage this strength by expanding the CHW scope and building their capacity to ensure more community members can be involved.

Ensure that people doing work in the community are compensated for their time and receive the support they need. Organizations can engage with their patients and clients to ensure their voices are heard and that people with lived experience are included in decision making. Key informants noted that organizations do not necessarily have all the answers or solutions and need to make space for community members to engage in community-based work.

There is a genuine commitment to centering equity in Sonoma County and part of that commitment should be elevating voices that are not typically heard or centered in conversations.

Organizations in Sonoma County are interconnected and striving to find more opportunities for effective collaboration

Key informants described organizations as interconnected and working together to provide a network of care to people in Sonoma County. The COVID-19 pandemic increased the opportunities for collaboration between partners; a lot of that collaboration is still taking place. There are more meetings and conversations between service providers, as well as more awareness of what is going on in the community. Community partners are also more connected and working together to address complex needs like housing instability and food insecurity. Health systems are coordinating to better fill gaps in community services while avoiding duplication.

While there are a lot of collaborations and partnerships happening, most key informants spoke to opportunities to improve, including the following:

- Improve collaboration between health care and social service providers serving the same population, particularly people experiencing homelessness.

*“We can do great things together and not only just health providers, other shelters, outreach teams, day centers, we really are one team serving the same population.”—
Key Informant*

- Focus on increasing the capacity of organization so that they can increase the quality of their care. Clients generally want more than just “quick touch” services.

“If we could increase our capacity, so we could increase our quality, then we would be more successful.”—Key Informant

- Share resources and apply for grants together: There are limited resources and funding in the community. Organization can come together to complement one another to have a greater impact.

“I think that we have to do a better job of leveraging each other so that we can be more efficient with the resources that we have. Because without that leverage, you know, many of us will fail in what we’re trying to do because there’s just not enough money, time, or resources to go around to meet the unmet need.”—Key Informant

- Align priorities and plans: Collaborate across the county on CHNAs and CHIPs to ensure that the county is moving towards the same goals. This can also facilitate pooling resources and sharing data.
- Focus on advocacy: For many issues, like affordable housing, access to health care, and farmworker working conditions, there needs to be advocacy efforts. Community members want to have a voice in how systems operate, therefore bring in community voice to these efforts. Advocacy can help approach problems upstream, instead of only addressing crises and urgent

issues. Collaborative efforts to change housing policy and acknowledge “this is a problem we all need solved,” is important.

- Work across sectors to break down silos: Many organizations are working towards improving health equity, which will require aligned efforts across sectors. Knowing what others are doing and being able to refer between organizations in different sectors will help improve care for clients and patients.
- Leverage schools: Schools are connected to many families. Leverage and expand what is already working well.

High Priority Unmet Health-Related Needs

Key informants were asked to identify their top five health-related needs in the community. Two needs were prioritized by most key informants and with high priority. Three additional needs were categorized as medium priority. Key informants were most concerned about the following health-related needs:

1. Homelessness and housing instability
2. Behavioral health challenges and access to care (mental health and substance use/misuse)

Homelessness and housing instability

A lack of affordable housing was a concern for most key informants, particularly because many families are severely housing cost burdened, meaning they spend more than 50% of their income on rent. This is particularly true for people with low incomes. When people spend a majority of their income on housing or are living unsheltered, meeting other basic needs is really difficult.

“It’s hard to talk about anything else specifically until that basic need [for housing] is met.”—Key Informant

Key informants shared their organizations receive calls from many families seeking housing and financial resources to help people keep their homes. It is considered one of the biggest issues and is a very common concern. Even people with full-time, stable employment may have difficulty meeting housing costs, particularly in a single-income household. Even housing that is meant to be affordable can still be too expensive for some families.

“It’s just become impossible, you know, to afford anything because even ‘affordable housing’ is not affordable for a lot of people.”—Key Informant

The COVID-19 pandemic affected housing stock and the affordability of housing. Key informants saw people move into the area during the pandemic and pay very high prices for housing. Now some of them are using those homes for vacation or short-term rentals. This has increased rental prices. Housing availability and affordability continue to be a concern for most.

Key informants shared that there is not enough housing available in the community. They would like to see more types of housing:

- Permanent supportive housing: For people with higher acuity needs, more wraparound support to help people stabilize and easily access services is needed. Specifically, case managers on site are important. There are many people staying in shelters that want to be placed into permanent housing, but none is available.
- Non-congregate shelters: Key informants spoke to the benefits of non-congregate shelters where there are individual units where people can close a door and feel safe. For people who have experienced trauma or assault, such as survivors of domestic violence, they may not feel safe in a congregate shelter space.
- Rentals that accept housing vouchers: Key informants spoke to the importance of educating landlords about the housing voucher program. Developing more housing is difficult because of a lack of space, but supporting landlords to take vouchers at market rate could open up more affordable housing options. Key informants shared that even people with a housing voucher sit on waiting lists for housing to be available.

Increasing services and supports for people experiencing homelessness is also important. Many people that are experiencing homelessness are from the community or have lived in the community and want to stay. Needed services include the following:

- More street-based medicine to support people living unsheltered, in encampments, and in their vehicles: People experiencing homelessness experience more barriers to needed health care services. Street-based or mobile health care can bring services to where people are and make accessing care easier.
- Safe parking: Finding safe parking or areas to register to park can be another barrier for people that are sleeping in their car or wanting to stay in a shelter.

Key informants shared some groups or populations experience more challenges with safe, stable housing:

- Older adults: Key informants were particularly concerned about many older adults experiencing homelessness or housing instability. With the high cost of housing, older adults living on a fixed income from Social Security or Disability may not be able to afford their housing. Adult children or other family may leave older family members at shelters if they are no longer able to house them. Ensuring that shelters and permanent supportive housing are accessible for older adults is critical. For example, many bottom bunks in shelters are often taken, but older adults may not be able to access a top bunk.
- Trans or non-binary people: People identifying as trans or non-binary may not have safe housing or shelter options.
- Families seeking shelter placements: There are not enough family shelters in Sonoma County; those that exist are under-resourced to deal with the trauma that many children are experiencing from homelessness. In particular, ages zero to five are critical for child

development and housing instability and homelessness negatively affects wellbeing and development.

- Domestic violence survivors: A lack of resources may prevent domestic violence survivors from leaving unsafe situations, particularly if they are not able to afford housing on their own.
- Indigenous peoples: Housing is available to tribal members, but it can be limited. While many Indigenous peoples want to remain in their community with their families and history, they may not have the economic opportunities for financial stability and safe housing.
- People with intellectual disabilities: There is a need for more housing specifically to support people living with intellectual disabilities.
- People with behavioral health challenges: There is a need for more housing specifically to support people living with behavioral health challenges.
- Black, Brown, Indigenous, and People of Color (BBIPOC) communities: Due to racism, some BBIPOC individuals may have lower incomes and therefore spend more of their income on housing. This housing cost burden affects economic security and ability to meet other needs.

A lack of housing affects the entire community. It makes it more difficult for workers to stay in the community and to recruit workers to Sonoma County. The COVID-19 pandemic exacerbated housing-related needs and challenges in the community. Positively, there was more money being invested towards homelessness prevention and rapid rehousing, which meant it was actually easier to serve lower acuity clients and subsidize housing for longer. As rental protections ended, people did lose their housing and the effects are still being felt. People that lost their homes may still be living in overcrowded homes with multiple families or in vehicles.

Behavioral health challenges and access to care (mental health and substance use/misuse)

Most key informants shared that accessing behavioral health services, including mental health and substance use/misuse services, is difficult. They shared there are limited mental health services across the entire county, but in particular in more rural areas, such as in the northernmost parts.

Behavioral health is closely connected to economic security. Key informants shared that they see families worried about meeting their basic needs, like affording food and medical care, which can cause stress and trauma on families focused on survival.

Key informants spoke to a variety of behavioral health needs across Sonoma County:

- Behavioral health crisis response and crisis prevention: While there are crisis intervention teams, there needs to be more funding and resources allocated to these teams to ensure capacity and staffing. People may be diverted to the Emergency Department (ED) for a behavioral health crisis where there are not enough resources or capacity to meet those needs either. For people that may not need to be hospitalized in the ED, but cannot stay at home or in a shelter, there are few stabilization options. Key informants emphasized the importance of

preventing crises and investing in more proactive services that support people before a crisis. Upstream, preventive efforts include creating a culture of wellness where people feel safe and connected. People not able to get the support they need for anxiety or depression can end up in a crisis situation.

- Peer navigators and care coordinators: People with behavioral health challenges may cycle through the system, moving through the ED, a psychiatric hospital, a primary care provider, and other community services. There are not always navigators or coordinators following individuals through that system and providing needed navigation support. Connecting with people before they are discharged from the hospital is important to ensure that they receive timely follow-up care. Focusing on navigators that can build relationships with folks and have their own lived experience can help address needs.
- More mental health providers, especially those that are bilingual and bicultural: More mental health providers in general are needed to meet the demand, particularly as there has been high turnover in the community. Many key informants shared there is a need for more providers that are bilingual and that are bicultural.

“There’s a huge shortage of appropriate, culturally sensitive mental health providers.”—Key Informant

Investing in workforce pipelines to develop more behavioral health providers is needed. Leveraging interns or behavioral health students to gain experience and exposure in the community is one approach for building up the local workforce.

- Substance use disorder (SUD) treatment services, including medical detox: Key informants shared there is a need for a medical detox. Additionally, people seeking recovery may have difficulty accessing a bed, particularly people with low incomes may have more difficulty.
- Expanded hours for and on-demand mental health services: People may not be able to access services during traditional business hours. Expanded hours when appointments are available, as well as on-demand services to meet people in real time could improve access. People that are ready to get help and seeking services can best be engaged in that moment, whereas scheduling them for an appointment a month out means they might lose that readiness.

Barriers to accessing behavioral health services include the following:

- Transportation: People need more than just a bus ticket to appointments; they may need support navigating how to get to an appointment.
- Lack of understanding of the importance of mental health: In many cultures, including the Latino/a culture, families may not have conversations about mental health challenges and the need to address trauma to prevent negative impact on the individual and family.

Specific populations that may experience these barriers and more include the following:

- Young people: Young people, particularly school-age children, were emphasized as a high-priority group that needs additional behavioral health supports. Key informants have seen increased behavioral challenges as a result of the pandemic. Increased anxiety, depression, and other mental health challenges in young people are alarming to many. There is a need for more mental health resources and therapy options for young people, particularly in north Sonoma County.

“We are not doing enough to serve our youth.”—Key Informant

Key informants shared that schools cannot meet all of the mental health needs of students; community partners need to be involved in efforts. Virtual mental health services have been beneficial for young people because parents do not need to leave their jobs to drive them to therapy.

Other concerns for young people include bullying in school, contributing to isolation and loneliness. Alcohol and substance use is also concerning, with some students not having positive coping skills and lacking access to after-school activities, like sports, to engage them with peers.

- People experiencing homelessness: There is a lack of funding for behavioral health services for people experiencing homelessness, which makes it difficult to ensure access to ongoing care. These services are needed to help people transition from homelessness into permanent housing and remain stably housed. People living unsheltered may also need additional support getting to their appointments, such as navigating transportation and receiving reminders.
- Older adults: Increased isolation, particularly due to the pandemic, has affected older adults’ mental health.
- People with intellectual disabilities: Sonoma County lacks behavioral health services specifically designed to serve people with intellectual disabilities.

Key informants discussed the importance of re-engaging people that may have disengaged from their behavioral health care during the pandemic. Additionally, since some providers left during the pandemic, there may be patients that are hesitant to build a relationship and start over with a new provider.

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by key informants:

3. Economic insecurity
4. Aging issues
5. Access to health care services

Economic insecurity

In Sonoma County, there are people on either end of the economic spectrum: those with access to a lot of resources and higher incomes, and those with a lack of resources and lower incomes. Key informants spoke to the disparity in incomes in Sonoma County.

Economic insecurity affects everything else, including educational opportunities, food resources, employment, and transportation. It also affects people's health and well-being. Economic insecurity contributes to mental health issues, housing instability, and food insecurity. The high cost of housing means many families spend more than half of their income on rent. This disproportionately affects BBIPOC community members and young families.

Even people with full-time, stable employment may have difficulty meeting housing costs, particularly in a single-income household. Community organizations get a lot of requests for financial assistance for rent or other bills, including utility and phone bills. Families are forced to make spending tradeoffs, sometimes sacrificing medical care or other necessities.

“We definitely see people making a lot of decisions to be able to meet their basic needs and usually what goes unmet when they're trying to make their rent, pay their bills to keep the lights on, quite literally it's health care. So people go without health care.”—Key Informant

Key informants discussed the importance of jobs that support people's well-being, meaning they pay a living wage and provide paid sick leave. This ensures people can care for their families and themselves. The local economy is primarily rooted in tourist-based services and the service industry and has transitioned away from the historical focus on logging, farming, and fishing. This contributes to young people leaving the community to seek other employment opportunities.

Key informants were particularly concerned about economic security for the following populations:

- **Farmworkers:** Racism and exploitative working conditions for agricultural workers contributes to a lack of economic mobility and other needs, such as substandard housing and a lack of health care. Key informants described the experience of local farmworkers as economic injustice stemming from racism.
- **Older adults and people with disabilities:** Older adults or people with disabilities living on a fixed income from Social Security or Disability may experience more economic insecurity with the rising cost of living. Documentation needed to access these benefits can be a barrier; certain information may need to be documented in medical records for qualification. A lack of alignment between the health care and public benefits systems can make it difficult for people to qualify for the benefits they need to meet their basic needs.

COVID-19 continues to affect the economic well-being of community members. Workers without paid sick leave may not have the flexibility or safety net to stay home from work to quarantine or recuperate. For people that are worried about eviction, behind on utilities, and trying to feed their families, taking

time off from work is not an option. The stress from trying to meet basic needs can also contribute to sickness, and ultimately means spending more money on health care.

“People are still getting sick, and they cannot work, but they do anyway because they don’t have a safety net at all. They’re close to the bone. They’re facing evictions. They’re behind on their utilities. They don’t have enough food to put on the table, so they’re spending time running around to food pantries just to put food on the table. ... [COVID-19] is becoming less visible to those of us who are like ‘we’re back to normal.’”—Key Informant

Economic security is also connected to education. Key informants would like to see more support for school success to ensure that all students have access to a quality education in Sonoma County. There can be an opportunity gap in quality education in the county. Particularly due to the COVID-19 pandemic, some students are a year or more behind in their learning. There is a need for more academic tutoring to get students back on track, as well as support for educators that are experiencing stress in meeting the demands of the student population.

“I really am concerned about the school environment and how we can get them back on track and what resources that we can provide to help get our students to a place where they feel safe, and they feel that people are supporting their health and wellbeing.”—Key Informant

Aging issues

Key informants shared that there is a large population of older adults in Sonoma County and to meet the needs associated with aging, there needs to be more support services. They identified older adults as a priority population and shared that some parts of Sonoma County, such as some southern areas, may not have sufficient services to meet the growing needs.

Aging concerns were related to economic stability and housing, access to care and transportation, food security, and mental health and socialization.

Key informants were particularly concerned about many older adults experiencing homelessness or housing instability. With the high cost of housing, older adults living on a fixed income from Social Security or Disability may not be able to afford their housing. Adult children or other family may leave older family members at shelters if they are no longer able to house them. There is a large population of people over the age of 60 years that are experiencing homelessness.

Ensuring that shelters and permanent supportive housing are accessible for older adults is critical. For example, many bottom bunks in shelters are often taken, but older adults may not be able to access a top bunk.

As the older adult population in Sonoma County grows, so does the demand for specialists to meet their health needs. Specifically, cardiologists, neurologists, and orthopedists were identified as needed

specialties for the aging population. Transportation to appointments, particularly specialists outside of the area, can be a barrier for many older adults. Riding the bus may be difficult for some older adults.

A lot of health care resources require access to technology, which has gotten more complicated. Older adults may not have a smart phone or computer, or the technology skills needed to make appointments or navigate other health resources online.

During the COVID-19 pandemic, the demand for food delivery for older adults sharply increased and the demand has stayed high. Key informants were concerned about older adults accessing food on their own, particularly if they have to carry groceries on public transportation.

Mental health and socialization for older adults is also a priority. Increased isolation, particularly due to the pandemic, has affected older adults' mental health. Some people may have declined during the pandemic, particularly due to less socialization and activity. Key informants spoke to wanting to see a senior center where there are wraparound services and activities.

“People who, especially 60 and older, who aged in place, they got weaker and have had, you know, it's like they aged 10 years in the three years [of the pandemic].”—

Key Informant

Access to health care services

Key informants spoke to a variety of health care needs in the community. They shared that primary care and specialty care can be difficult to access across the county and, in particular, in certain parts that may be more rural. They discussed the following needs for Sonoma County:

- More specialty care: Particularly in the northern and southern parts of the county, there is a need for more specialists. Specialties that were named included cardiologists, neurologists, orthopedists, and women's health care providers.
- Bilingual and bicultural providers, as well as increased interpreter services: More providers that are bilingual in English and Spanish and bicultural are needed to serve the Spanish-speaking population. Ensuring interpreters are easy and convenient to access will help patients get responsive care.
- Street-based or mobile health care: More outreach teams to people living unsheltered are critical because many people experiencing homelessness may not be able to access care through clinics and hospitals. People may be afraid to seek medical care; they may be worried about receiving a diagnosis that they do not understand or are not able to manage. Having medical care available on site where people already are can be less scary with fewer barriers to care. This helps build relationships and provides real-time crisis intervention.

“People are dying in encampments due to their fears of clinics and hospitals. If we had teams building those relationships and meeting people where they're at, I feel we would have a healthier community.”—Key Informant

- Leverage Community Health Workers (CHWs)/ Promotores: Lay health workers, like CHWs, are critical for connecting individuals and groups to services. Expanding their scope and leveraging their relationships in the community to help people navigate complex systems and access care is a way to build upon a strength that already exists.

“I don’t know how we could do the work that we do without Community Health Workers.”—Key Informant

Accessing care in the northern and southern parts of Sonoma County can be more difficult. Emergency Medical Transport times are some of the longest in the state of California on the northernmost edge of Sonoma County and into Mendocino County. There are also no local pharmacies in that area.

Barriers to care include the following:

- Transportation: Getting to appointments can be very challenging for people without a car, particularly for older adults and people experiencing homelessness. It can be difficult for people staying in a shelter far away from their appointment or for people experiencing homelessness without reliable transportation to get to care. Traveling to specialty care outside the community can be difficult and take time. Mobile health services could reduce transportation barriers and is important for equity.
- Appointment times: Taking time off of work for a medical appointment is not possible for some people, particularly people who cannot afford to lose wages. More convenient access to care, like walk-in appointments, may be helpful. Limited appointment times may contribute to worsening and unmanaged chronic conditions.
- Cost of care and insurance: People are forced to make spending tradeoffs between paying for rent, other bills, food, and health care. They may not be able to afford their health insurance or medical care. Key informants saw people drop their health insurance in the pandemic because of the cost.

“They don’t have health care insurance because they see that as something they can’t afford. ... They’re living paycheck to paycheck. They don’t have, you know, any extra income to... pay for other resources that support their health. ... We know that all of these have compounding effects and, you know, the constant stress and kind of trauma that our families have to go through because they’re simply trying to survive.”—Key Informant

- Lack of comfort with or access to technology: A lot of health care resources require access to technology, which has gotten more complicated. People may not have a smart phone or computer, or the technology skills needed to make appointments or navigate other health resources online.

Populations that may experience these and additional barriers to care include the following:

- **Agricultural workers:** A lack of insurance and sick leave from their employer makes accessing care difficult. Racism and exploitative working conditions contribute to substandard housing and resulting health concerns. People may continue working despite asthma and other issues.
- **Immigrant community:** The health care system can be complicated and difficult to navigate. Immigrants may be disconnected from services and unfamiliar with how to navigate care.
- **People experiencing homelessness:** People living unsheltered may be afraid of accessing care and may experience multiple barriers to care. Street-based medicine may help bring care to people and reduce barriers. More communication between hospitals and homeless providers could ensure that people get the care they need. When the hospital discharges a patient reporting experiencing homelessness, they need to be connected with an organization that provides support to help them get their prescriptions and other follow-up care.
- **Older adults:** Transportation barriers, particularly to farther away specialty care, can prevent older adults from accessing care.
- **People lacking health insurance:** Community members may not know what services are available to them even without health insurance. Fear of being turned away can prevent people from seeking the services. Better messaging should stress, “it’s okay to go there, no one is going to turn you away.”

The COVID-19 pandemic affected access to health care services. People may have delayed accessing their preventive or regular health care appointments. Without regular screenings, some conditions, like cancers went undiagnosed for longer and some chronic conditions were not well managed. Some people lost their health insurance when they lost employment or could no longer afford to pay for insurance. It has been challenging to get people back into care and stabilized. COVID-19 also affected health care staffing, contributing to longer wait times. Key informants spoke to the importance of continuing to build up the health care work force through training pipelines and internships.

Positively, telehealth has improved access to care for some people and reduced transportation barriers.

FINDINGS FROM CAREGIVER LISTENING SESSION

Vision for a Healthy Community

Caregivers shared their vision for a healthy community:

- **Older adults are respected and included:** Healthy communities ensure older adults know they are cared for and connected to the community. Elders need to be respected and have opportunities to share their stories and experiences. In a healthy community, younger community members check in on older adults and include them in events. There are adequate resources to meet their needs, like a senior center, senior housing, accessible housing, and food

programs. Older adults have opportunities to share their hobbies and skills with the younger generation.

- **The community is invested in children and encourages their growth and learning:** In a healthy community there are multiple adults, such as coaches, teachers, spiritual leaders, and bus drivers who know and support each child. There is affordable childcare and after-school activities for children.
- **People engage in community events and gather outside:** In a healthy community, people can be seen playing outside, attending fairs and parades, sharing food, and gathering in parks. People come together with music and food and there are free activities for families.
- **The community is well-maintained, with green spaces, art, and clean streets:** A healthy community looks cared for. There are green spaces, like community gardens and parks. There is art and the buildings are not run down. The streets are clean and well maintained.
- **All people are included and heard:** In a healthy community, diversity is celebrated, and everyone is included. Older adults feel respected and important. Language access ensures all people can access information in their preferred language. Cooking classes share recipes from diverse cultures.
- **Basic needs for health care, housing, and childcare are met:** In a healthy community all people have the ability to meet their basic needs; people have access to affordable housing, physical and mental health services, and affordable childcare.
- **Economic and educational opportunities exist:** In a healthy community people are paid livable wages. There are opportunities for students to gain experience through internships and training.
- **The community is safe:** People are safe and comfortable in a healthy community. There is safer driving and less crime.
- **Transportation meets needs:** In a healthy community people utilize public transportation and transportation is more environmentally friendly.

Unmet Health-Related Needs

Caregivers were asked to discuss community health-related needs. The following themes emerged:

- **Access to health care:** Caregivers shared a need for more of the following types of health care providers: medical providers, specialists, urgent care staff, and Community Health Workers. More lab services and health education are also needed. To meet the needs of specific populations, the following services are needed:
 - More in-home care and home health care for older adults
 - Preventive care, like eye screenings, in schools and pediatric specialists
 - Skilled caregivers for medically complex patients
 - Language access for Spanish-speaking patients and those that speak other languages besides English

- Temporary housing or lodging for patients traveling for care or procedures.

More health education for prevention is also needed.

- **Behavioral health:** There is a need for improved mental health and substance use disorder (SUD) treatment in Sonoma County. Caregivers noted a need for a medical detox, a specialized behavioral health unit, and an inpatient treatment facility for individuals with low incomes. More behavioral health staff are needed across the county, including more staff at Sonoma County, a behavioral health team in the CARE Network, and a psychiatrist at Providence. Higher pay for behavioral health providers is needed to recruit them. More funding to expand the Crisis Response team is needed to serve the entire region. To address increasing substance use/misuse, more education to young people about the risks is needed.
- **Food security:** Improved access to affordable, healthy food is needed across Sonoma County. Using grassroots food distribution is one way to get people needed food. Providing cooking and nutrition classes could also benefit people.
- **Physical activity:** More access to gyms and fitness centers is needed, particularly for people with low incomes. Outdoor gyms and workout equipment is also desired. Safe parks and trails for physical activity, as well as free activities for children are needed.
- **Housing:** More housing and shelter beds are needed. Specifically, permanent supportive housing with supportive services and housing alternatives that are safe and clean would be beneficial.
- **Clothing and furniture:** Free clothing and furniture is needed. A grassroots clothing distribution and clothing closets could meet this need.

Appendix 3: Community Resources Available to Address Significant Health Needs

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

Apx 2_ Table 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Legal Aid	Neighborhood Legal Services	Advocates for individuals, families, and communities through a combination of individual representation, high impact litigation, and public policy.	144 S. E Street, Santa Rosa, CA, 95404	Legal, Individual and Community Advocacy
Hospital	Kaiser Permanente	Primary medical care services	401 Bicentennial Way, Santa Rosa, CA 95403	Access to Care Health Care
Hospital	Sutter Santa Rosa Regional Hospital	Primary medical care services	30 Mark West Springs Road, Santa Rosa, CA 95403	Access to Care Health Care
Federally Qualified Health Center	Santa Rosa Community Health	Primary medical care services	3569 Round Barn Circle, Santa Rosa, CA 95403	Access to Care Health Care
Community Health Center	Sonoma County Indian Health Project, Inc.	Medical, dental, nutritional, behavioral health, pharmacy, and health education services	144 Stony Point Road, Santa Rosa, CA 95401	Access to Health Care

Federally Qualified Health Center	Alliance Medical Center	Medical, dental, behavioral health services and Community Wellness Center	1381 University Avenue, Healdsburg, CA 95448	Access to Health Care, Behavioral Health
Federally Qualified Health Center	Petaluma Health Center	Medical, dental, behavioral health and specialty services	1179 N McDowell Blvd, Petaluma, CA 94954	Access to Health Care
Health Care District	Healthy Petaluma	Community Owned and Operated Public Agency	1425 N McDowell Blvd, Suite 105, Petaluma, CA 94954	Access to Health Care
Community-based, faith-based nonprofit organization	Catholic Charities of the Diocese of Santa Rosa	Shelter, housing, and homeless services	987 Airway Court, Santa Rosa, CA 95403	Housing Instability and Homelessness
Community-based nonprofit organization	The Committee on the Shelterless (COTS)	Shelter, housing, and homeless services	900 Hopper St, Petaluma, CA 94952	Housing Instability and Homelessness
Community-based nonprofit organization	Buckelew Programs	Counseling, therapy, case management, and service navigation services	2300 Northpoint Pkwy, Santa Rosa, CA 95407	Behavioral Health & Substance Use Disorders
Community-based nonprofit organization	West County Community Services	Counseling, therapy, case management, and service navigation services	16390 Main St, Guerneville, CA 95446	Behavioral Health & Substance Use Disorders

Community-based nonprofit organization	Petaluma People Services Center	Counseling, therapy, case management, and service navigation services	1500 Petaluma Blvd S, Petaluma, CA 94952	Behavioral Health & Substance Use Disorders
Community-based nonprofit organization	Community Support Network	Homeless and Behavioral Health service provider	1410 Guerneville Rd, Santa Rosa, CA, 95403	Homelessness and Behavioral Health
Community-based nonprofit organization	Ceres Community Project	Home delivered, medically tailored meals	7351 Bodega Ave, Sebastopol, CA, 95472	Food Insecurity

Appendix 4: Santa Rosa Memorial Hospital Community Benefit Committee

Apx 4_ Table 1. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Efren Carrillo	Chief Executive Officer	Gallaher Community Housing	Affordable Housing
Jason Cunningham, DO	Chief Executive Officer	West County Health Centers	Healthcare
Sister Nadine McGinnis	Board Member	Santa Rosa Memorial Hospital	
Karin Demarest	Principal Consultant	Demarest Strategy Group	Strategy Consulting
Ramona Faith	Chief Executive Officer	Healthy Petaluma District & Foundation, formerly Petaluma Health Care District	Healthcare
Robert Feiwell, MD	Neuroradiology Specialist	Providence Santa Rosa Memorial Hospital	Healthcare
Monica Ferguson, MD	Regional Medical Director, Quality and Population Health	Providence Medical Group	Healthcare
Barry Friedman	President and Chief Executive Officer Board Member	Friedman’s Home Improvements Santa Rosa Memorial Hospital	
Chuck Kassis	Chief Executive	Providence Santa Rosa Memorial Hospital	Healthcare
Jeff Kolin	Board Member	Santa Rosa Memorial Hospital	

Karissa Kruse	President Board Member	Sonoma County Winegrowers Santa Rosa Memorial Hospital	
Debbie Meekins	Board Member	Santa Rosa Memorial Hospital	
Bruce Okrepkie	Board Member	Santa Rosa Memorial Hospital	
Shirley Ward	Board Member	Santa Rosa Memorial Hospital	

Appendix 5: Community Listening Session Report



Providence

LISTENING SESSION

REPORT

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FACILITATORS

Daniela G. Domínguez, Psy.D., is an assistant professor at the University of San Francisco's (USF) Counseling Psychology Department and the founder of On the Margins. She works in the areas of Latinx mental health, antiracism, migrant justice, and trauma informed care. Her program of research has focused on understanding how Latinx communities heal from trauma and use specific strategies to access positive health. Grounded in Critical Race Theory (CRT; Crenshaw, 1989), Domínguez uses critical and political methodological approaches in reaction to one-size-fits-all traditional paradigms of doing research, assessment, and evaluation. Her most recent publications encourage psychologists to distance themselves from the Eurocentric epistemologies that dominate the field of psychology today, and to move toward a critical race epistemology that understands knowledge as being shaped by membership in multiple subordinated groups and interlocking systems of oppression. The Society of Counseling Psychologists awarded her the 2019 Early Career Award for Distinguished Professional Contributions to Counseling Psychology and the 2020 Social Justice Award. In 2021, the National Latinx Psychological Association awarded her the Star Vega Distinguished Service Contributions Award for her contributions to the Latinx community.

Cindy Berríos, LCSW is a Licensed Clinical Social Worker with almost 20 years' experience in the social services, non-profit sector. She has extensive experience providing therapy services, as well as program creation and implementation, budget management, and staff development. Her areas of interest and study are trauma, intimate partner, family and community violence, sexual assault, and child sexual abuse. She believes that healing from trauma happens in the community and through collective care. She is trained in Level II EMDR and is a graduate of the Center for Mind Body Medicine. She also completed a post graduate certificate program and fellowship at the Psychoanalytic Center of Philadelphia. She holds a Bachelor of Arts in French and Political Science from Gettysburg College and a Master of Social Work with a specialization in cross-cultural children, youth, and families from Temple University. She also serves as Adjunct Faculty for the University of San Francisco's Counseling Psychology Department.

Gricelda Correa Martinez, B.A is the oldest of six children, a first generation immigrant born in Michoacán Mexico and raised in Sonoma County for the majority of her life. She has

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spent her life in the public school system, graduated from Elsie Allen High School, received three associate degrees from SRJC before deciding to transfer to obtain her BA from SSU School of Hutchins with a minor in Women’s Health.

She has many interests, some of which have been shaped by her life experiences and others that are driven by her advocacy for the people she loves and cares about. She considers herself to be a life-long learner open to explore different perspectives, keeping an open mind and diving into her curiosity. She is especially interested in reproductive justice. She became more involved in reproductive health and justice through her work at Santa Rosa Community Health when she started volunteering as a peer educator. She later became a sexual health educator, co-chair for the Teen Health Advocacy Coalition, and chair for the Reproductive Educator Sub-Committee.

She is also a trained facilitator in Mind-Body techniques through the Center for Mind Body Medicine and the Sonoma Community Resilience Collaborative. She is interested in learning to heal from generational, personal and community trauma through techniques that have been passed down by our ancestors.

RESEARCH ASSISTANT

Addison Pickrell is a high school student at Technology High School, a youth activist, and research analyst working with On the Margins. He has participated as a member of the Sonoma County Junior Human Rights Commission and On the Margins’s ¡DALE! Youth Program. He has collaborated with several local organizations in the Sonoma County area. His main focus has been connecting the fields of mathematics and social justice and community organizing, helping to bridge the gap between these vastly different fields. Addison focused on the data analysis and collection in the project, where he utilized KH Coder and clustering to highlight key focus areas in the community. He will be attending the University of California, Berkeley in Fall of 2023.

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Introduction

On the Margins supported Providence Health through the conduct of three listening sessions and three member checkings (i.e., follow-up sessions). Information gleaned from these six sessions aim to inform Providence’s Community Health Needs Assessment (CHNA) which seeks to understand the greatest areas of need/assets, with a special focus on communities on the margins of society. Using data and information collected, Providence aims to develop solutions reflected in its community health investment plans, or CHIPs.

On the Margins (OTM) prides itself on creating and delivering culturally responsive and needs/assets-based listening sessions. OTM’s collaborative work with Providence included three phases: (1) the planning phase, (2) the engagement phase, and (3) the post-engagement phase. Next, we discuss the methodology used for data collection and analysis.

Methodology

1. Planning Phase

Organization and Design

As part of a literature review, OTM collected and organized existing community data reports from Providence Health to understand previously used CHNA approaches. To successfully plan the listening sessions, staff from Providence Health provided OTM with the protocol questions to be used for data collection during the three listening sessions. OTM offered suggestions and feedback on protocols and procedures to ensure culturally responsive interactions with participants (Appendix A: Protocol Questions).

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Recruitment and Communication with Participants

OTM recruited participants in the Petaluma, Santa Rosa, and Healdsburg areas with the support of local community-based organizations, including La Plaza, Corazon Healdsburg, and the Petaluma Family Resource Center.

Planning and Scheduling

OTM staff organized and planned all listening session necessities including venue, day care, food and beverage, equipment, art supplies, distribution of gift card incentives, and contracting with a bilingual/bicultural interpreter and transcriber. Donations were offered to each hosting organization for venue rental (\$1000 amount for each organization).

2. Engagement Phase

Listening Sessions

The listening sessions took place in April, 2023 at: the Family Resource Center in Petaluma, La Plaza in Santa Rosa, and Corazon Healdsburg in Healdsburg (see Table I. Schedule). Each engagement consisted of set-up, facilitation, debrief, and transcription. Each listening session had 10-15 participants to facilitate a more intimate environment for active listening (see Findings section for specific participant demographic information).

Table I. Schedule for Listening Sessions

Santa Rosa Listening Session	MONDAY APRIL 17, 2023 10:30 A.M.-12:30 P.M.	LA PLAZA
Healdsburg Listening Session	MONDAY APRIL 24, 2023 6-8 P.M.	CORAZON HEALDSBURG
Petaluma Listening Session	MONDAY APRIL 17, 2023 6-8 P.M.	PETALUMA FAMILY RESOURCE CENTER

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OTM facilitators began all three listening sessions with rapport building and sharing a light meal with participants. During check-in, each participant received a \$100 gift card for their attendance. During the first half hour of the listening session, the facilitators described the purpose of the listening session and community agreements/aspirations. Subsequently, OTM facilitators harnessed their knowledge of microskills to create a brave space where community members could listen and learn from each other. Listening sessions have the potential to help bring transparency to the conversation, increase trust, and develop strong listening skills among participants. Listening sessions tend to encourage full participation, reflection, and embrace a pluralistic view of meaning by inviting multiple interpretations rather than zeroing in on one perspective or opinion.

During the listening session, protocol questions (see Appendix A: Protocol Questions) were used to help participants visualize the future of the healthy community they want to live, create, and play in. Although OTM facilitators used an interview protocol as a guide, the listening session was participatory in nature, with members negotiating not only the direction but also the ways in which they wanted to share their opinions. Listening sessions were audio-recorded to capture participants' full accounts and responses to facilitators' questions. All listening sessions offered interpretation by local interpreter, Manuel Gonzalez. The Santa Rosa listening session was offered in Spanish and therefore, interpretation was not required. All participants in Santa Rosa spoke Spanish.

After each listening session, the facilitators debriefed and documented reflective thoughts, observations, or interpretations of the listening session. GoTranscript transcribed all listening session recordings. Next, we discuss the post-engagement phase.

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3. Post-Engagement Phase

Transcription and Analysis

At the conclusion of the engagement phase, the facilitators then compiled all data collected (notes and transcriptions) and created a HIPAA compliant folder with raw data (e.g., transcriptions, drawings, and facilitator notes) from the listening sessions.

The data was processed using two-steps: (1) initial cleaning, and (2) final cleaning. Initial cleaning was used to identify key nouns, adjectives or phrases that emphasized participants' needs, desires, and visions for a healthy community. Spanish responses did not go through the cleaning process to maintain the highest level of accuracy.

After cleaning the data, OTM used Braun and Clarke's (2006) thematic analysis (TA) as an analytic method because it provides accessible and rigorous procedures for generating codes (i.e., building blocks for themes) and crafting themes from qualitative data (Braune & Clark, 2006). Braun and Clarke (2016) describe themes as patterns of meaning that are "actively crafted by the researcher, reflecting interpretative choices, instead of pre-existing the analysis" process (p. 740). While qualitative methods such as phenomenological analysis (Smith & Osborn, 2003) and conversation analysis (Hutchby & Wooffitt, 1998) provide limited flexibility in how the analytic method is used, TA provides both theoretical freedom and rigor. TA was used because of its theoretical flexibility, compatibility with social constructionist paradigms, and emphasis on subjective researcher interpretation rather than positivist-empiricist assumptions (Braun & Clarke, 2006).

An inductive approach was used to code the data "without trying to fit it into a preexisting coding frame, or the researchers' analytic preconceptions" (Braun & Clarke, 2016. p. 83). To conduct the analysis in a reliable and rigorous way, OTM researchers read participants' transcripts multiple times, generated initial codes, and searched for common themes. Data analysis was performed with KH Coder, an open-source qualitative data analysis (QDA) software.

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KH Coder was developed by Koichi Higuchi, a professor of Sociology at Ritsumeikan University in Kyoto, Japan, and released in 2015. The researchers coded prevalent themes, revised the codes; collapsed and clustered the codes that shared unifying features; and reviewed the individually identified themes (Braun & Clark, 2006).

A. Bigram Extraction

The data went through a process of clustering to find common compound nouns and two-word phrases (bigrams) utilizing the Python libraries numpy, pandas, scikit-learn, NLTK (Natural Language Tool-Kit), and textblob. The transcripts were exported as text files, which were then encoded and split into noun phrases, which were then split further into two-word bigrams (two written units) and ordered by frequency of occurrence. The code is as follows:

Table 2. Code used for Bigram Extraction

```
import numpy as np
import pandas as pd
from sklearn.feature_extraction.text import CountVectorizer
from nltk.corpus import stopwords
from textblob import TextBlob

words = open("[Transcript File]", "r", encoding="utf8").read()
file = str(words)
blob = TextBlob(file)
secondblob = blob.noun_phrases
frame = pd.DataFrame(secondblob)
frame.columns = ['bigrams']
stoppinglist = stopwords.words('spanish')
vect = CountVectorizer(stop_words=stoppinglist, ngram_range=(2,2))
bigrams = vect.fit_transform(frame['bigrams'])
freqvals = bigrams.toarray().sum(axis=0)
vocab = vect.vocabulary_
frame_bigram = pd.DataFrame(sorted([(freqvals[i], k) for k,i in vocab.items()],
reverse=True)).rename(columns={0: 'frequency', 1:'bigram'})
frame_bigram.to_csv('open.csv', encoding='utf-8-sig')
```

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For reference, the code above takes a transcript file, processes it for “noun phrases”, and transforms it into a data frame to analyze and observe the results. Encoding is used to preserve latin diacritics and accent marks in Spanish text.

B. Jaccard Index, Similarity Matrices, and Co-Occurrence Networks

To detect correlation between two groups of items, Jaccard coefficients were used. They are a simple but effective method of finding the degree of association between two groups, most notably the clustered groups of text developed in the coding rule section above. The Jaccard index is given based on the frequency of all common related phrases between two groups divided by the total number of phrases as a whole. The Jaccard index of any two groups must be between or either 0 and 1. The researchers created a similarity matrix that describes the index between one group and another. This matrix can be interpreted as a graph known as a co-occurrence network, where the vertices are the categories themselves, and the lines between them are weighted based upon the Jaccard index between them (see Appendix to review the co-occurrence network graphs).

C. Drawings

During the three listening sessions, community members drew out visual accompaniments that described their understanding of a healthy community. These drawings were cross-referenced to ensure that the dominant themes identified by the thematic analysis were in alignment with participants’ artwork.

Member Checking

We conducted three in person member checkings. Member checkings, also known as participant or respondent validation, is a technique for exploring the credibility of results. We shared the findings with the listening session participants to check for accuracy and resonance with their experiences. Necessary revisions were made before the report was submitted.

Table 3. Schedule for Member Checking

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Petaluma Follow-up Session	MONDAY MAY 15, 2023 6-8 P.M.	PETALUMA FAMILY RESOURCE CENTER
Santa Rosa Follow-up Session	MONDAY MAY 15, 2023 10:30 AM-12:30 PM	LA PLAZA
Healdsburg Follow-up Session	TUESDAY May 2, 2023 6-8 PM	CORAZON HEALDSBURG

Next, we discuss participant demographics.

Participant Demographics

A. Healdsburg Listening Session Demographics; 14 participants

City	(10/14; 71%) Healdsburg, (3/14; 21%) Windsor, (1/14; 7%) Geyserville
Gender	(12/14; 86%) Female, (2/14; 14%) Male
Sexual Orientation	(10/14; 71%) Heterosexual, (4/14; 28%) Prefer not to Say
Race/Ethnicity	(12/14; 86%) Hispanic/Latino/e/x/Spanish origin, (1/14; 7%) Prefer not to Say, (1/14; 7%) Non-hispanic/latino/e/x/Spanish <ul style="list-style-type: none"> ● (12/14; 86%) Mexican-American, Chicano/a/e, Mexican Origin ● (1/14; 7%) Prefer not to say

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	<ul style="list-style-type: none"> (1/14; 7%) Not of Mexican-American, Mexican, Chicano/a/e Origin
Language Spoken	(2/14; 14%) Mixteco, (1/14; 7%) Mayan; (14/14; 100%, Spanish)
Average Age	42
Age Range	Highest Age: 54, Lowest Age: 34
Zip Code Data	(10/14; 71%) 95448, (1/14; 7%) 95441, (3/14; 21%) 95492

B. Petaluma Listening Session Demographics; 13 participants

City	(13/13; 100%) Petaluma
Gender	(10/13; 77%) Female, (3/13; 23%) Male
Sexual Orientation	(11/13; 85%) Straight/Heterosexual, (2/13; 15%) Prefer not to Say
Race/Ethnicity	(9/13; 70%) Hispanic/Latine/x, (2/13; 15%) Middle Eastern/Arabic, (2/13; 15%) White <ul style="list-style-type: none"> (9/13; 70%) Mexican/Mexican-American, Chicax (2/13; 15%) Not of Hispanic/Latinx/Spanish Origin (2/13; 15%) Central American Origin
Languages Spoken	(1/13; 8%) Dari, (1/13; 8%) Arabic, (11/13; 85%) Spanish, (5/13; 38%) English

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Average Age	35
Age Range	Highest Age: 45, Lowest Age: 19
Zip Code Data	(10/13; 77%) 94954, (3/13; 23%) 94952

C. Santa Rosa Listening Session Demographics; 11 participants

City	(8/11; 73%) Santa Rosa, (1/11; 9.1%) Healdsburg, (1/11; 9.1%) Sonoma, (1/11; 9.1%) Windsor
Gender	(11/11; 100%) Female
Sexual Orientation	(5/11; 45.5%) Straight/Heterosexual, (1/11; 9.1%) Gay, (5/11; 45.5%) Prefer not to Say
Race/Ethnicity	(8/11; 73%) Hispanic/Latine/x; (1/11; 9.1%) Prefer not to Say, (5/11; 45.5%) Indigenous/Native American <ul style="list-style-type: none"> • (1/11; 9.1%) Prefer not to Say (Origin) • (3/11; 27.3%) Mexican-American, Chicane/x, Latine/x • (5/11; 45.5%) Mixteco, Triqui, Chatino, or other Indigenous Community • (2/11; 18.2%) Other Hispanic, Latine/x, or Spanish Origin
Languages Spoken	(3/11; 27.3%) English, (5/11; 45.5%) Mixteco, (1/11; 9.1%) Purépecha, (11/11; 100%) Spanish
Average Age	46.45

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Age Range	Highest Age: 70, Lowest Age: 31
Zip Code Data	(2/11; 18.2%) 95448, (1/11; 9.1%) 95492, (1/11; 9.1%) 95476, (1/11; 9.1%) 95402, (4/11; 36.4%) 95407, (1/11; 9.1%) 95404, (1/11; 9.1%) 95403

D. Total Demographics for All Listening Sessions; 38 participants

City	(13/38; 34.2%) Petaluma (11/38; 28.9%) Healdsburg (8/38; 21.1%) Santa Rosa (4/38; 10.5%) Windsor (1/38; 2.6%) Geyserville (1/38; 2.6%) Sonoma
Gender	(5/38; 13.2%) Male (33/38; 86.8%) Female
Sexual Orientation	(2/38; 5.3%) Queer/Gay (11/38; 28.9%) Prefer not to Say (25/38; 65.8%) Heterosexual/Straight
Race/Ethnicity	(2/38; 5.3%) White (2/38; 5.3%) Middle-Eastern/Arabic (29/38; 76.3%) Hispanic/Latino/e/x/Spanish origin (5/38; 13.2%) Prefer not to Say <ul style="list-style-type: none"> ○ (3/38; 7.9%) Non-Latinx/Hispanic Origin ○ (28/38; 73.7%) Latinx/Hispanic/Mexican American Origin ○ (2/38; 5.3%) Central American ○ (5/38; 13.2%) Indigenous/Native American
Language Spoken	(1/38; 2.6%) Dari

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	(1/38; 2.6%) Arabic (8/38; 21.1%) English (7/38; 18.4%) Mixteco (1/38; 2.6%) Mayan (1/38; 2.6%) Purepecha (34/38; 89.5%) Spanish
Average age	Average: 40.89 ○ (2/38; 5.3%) Did not respond with an age
Age range	Highest Age: 70, Lowest Age: 19
Zip Code Data	95448 (12/38; 31.5%) 94954 (11/38; 28.9%) 95492 (4/38; 10.5%) 95476 (1/38; 2.6%) 95404 (1/38; 2.6%) 95402 (1/38; 2.6%) 95407 (4/38; 10.5%) 94952 (3/38; 7.9%) 95441 (1/38; 2.6%)

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Results from Healdsburg

Needs and Desires in Healdsburg

Prevalent Theme 1: Active, healthy, and joyful children

Subtheme: Desire for schools that prioritize socioemotional health, joy, care, and an anti-bullying culture

“I noticed my son would get easily irritated. Because of the pandemic, there are many mental health concerns.”

“I have a daughter. She is 20 years old...The incident that happened in Montgomery really impacted her. She would come home crying, stressed, sad, because of everything that was happening at that school.”

“Right now, more children need to be paid attention to and heard when it comes to bullying. We need to address bullying in a timely manner before it becomes a critical situation.”

Subtheme: Desire for free extracurricular or beyond the bell-programs for children

“I think that sports are needed for children and young people, because there are none for children there [referring to Geyserville]. That's what I honestly think...”

“We need more [program] scholarships for the children because sometimes the rent is really expensive and we cannot pay for certain services. Sometimes there are programs, like the summer camp is approaching, and many of us won't be able to send our children because the cost is too expensive.”

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Prevalent Theme 2: Increased access for uninsured, low-income, non-English speaking, individuals with disabilities, and other marginalized communities

Subtheme: Desire improved local mental health and social services for communities on the margins

“I live in Windsor and there is little [mental health] support there. I have to drive my daughter all the way to Santa Rosa by highway 12 for counseling. It is very far.”

“My child has special needs. I have advocated for children with disabilities and that makes me stronger. Here, there are many children who do not receive the services and therapies that they need, so one must travel all the way to Santa Rosa. Services are far away, sometimes people have to go all the way to Napa.”

“Our community needs more support from the hospitals. There are people who do not have resources or have low resources. Sometimes if they do not have Medi-Cal or insurance, they are denied services or the opportunity to be seen at the hospital.”

“Many of us do not have access to insurance and can’t go to the clinics. I speak Mixteco and accessing services is complicated. There are times that even in Spanish I say, “What does that mean?”

“People need to know that there is support out here. Right now, in our community, depression and anxiety are visiting us. We have gone through difficult times and there have been suicides. That concerns us, because we wonder why we didn’t see the warning signs. There needs to be trust in the community so that people can talk about it.”

“I am someone who often gets nervous and I am always afraid but I have to be strong because my daughter is experiencing anxiety and depression and she is not getting the support she needs at school.”

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Subtheme: Desire for programs offered in the afternoons and with childcare for working parents

“It would help if the programs were in the afternoon. Maybe if they did them in the afternoon, because there are a lot of people who work in the morning.”

“Child care is needed, because not all parents have someone to take care of their children.”

Prevalent Theme 3: Justice for racial, low income, and LGBTQIA2+ communities

Subtheme: Desire to address the racism that is prevalent

“Where I work, I am a [occupation de-identified for confidentiality]. People pass me by and they don’t even look at me...They don’t see me or say hello. Yes, there is much racism. Sometimes, we stay silent. We [those who are discriminated against] need to talk and not stay quiet...For me, it’s racism. It is completely racism, because there are corporations, there are some... they consume us, we are work machines [to them]...many of us don’t have enough to eat and we don’t tell them anything out of fear, out of fear of losing our job.”

“Our [Latino] children are suffering. Sometimes because teachers make fun of them, or I don’t know how to explain it. Many children are suffering but sometimes they don’t tell us....We are also hearing from other parents that say that their children are being mistreated in school.”

“Where I am from in my ranchito in Mexico, everyone greets you and says, “Good morning”. Here it is different. Here, you greet others, and they don’t greet you back.”

Subtheme: Desire to confront the economic exploitation and housing crisis

“I was offered a job and the person that hired me told me they were going to pay me an amount per hour. After I was done with the job, they didn’t pay me and only gave me soup to eat. So I said, ‘Thank you and left right away’.”

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“People often work 40 hours, they get home, they have to clean, take care of the children, take care of the house, whatever. Then the person who worked 40 hours is already exhausted. Perhaps if I could find a job where I made the same income working fewer hours, I could seek more support services.”

“We are being displaced by the housing crisis. Rent is out of control in Healdsburg and nearby communities.”

Subtheme: Desire respect for LGBTQIA2+ individuals

“We need more respect for people with diverse sexual orientations.”

Prevalent Theme 4: Intergenerational and collective care and healing

Subtheme: Desire increased care and attention for elders

“We need to visit and talk with our elders, especially those that live alone; we need to ask—Do our elders need something? When I walk, I say, ‘Hi, how are you? Do you need anything?’ to see if they want to talk.”

Subtheme: Desire more programs that amplify social and peer support by and for women

“A place where we can say, ‘amiga [friend], I am here to listen’.”

“We need spaces where women can talk, unload, let off steam.”

“I would like there to be something like just for women, for mothers. To get out, sometimes you need to work through the stress that you experience at home. Speak with someone.”

Strengths in Healdsburg

Prevalent Theme 5: Strong relationship between family, friends, and community-rooted organizations

Subtheme: Finding meaning, strength, and support from family members

“I am often very anxious but my strength is my family. It is what I love most...”

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“I have two teenage daughters, and I tell them, ‘Stop, look in the mirror and say, “How beautiful we woke up today. We are pretty.” I am going to walk down the street with my head held high. If I greet him and he doesn't greet me, maybe tomorrow, and if not tomorrow, the day after’.”

Subtheme: Existing peer support and fellowship from women

“There is a group of women that teaches you to self-care and care for others and they always start with something that says, ‘If I don't love myself, I can't love others. If I don't respect myself, I can't respect others.’ This group is very nice because it is all women and they also help you with natural medicine to deal with stress and anxiety.”

“We are very good friends, since we work in the same place, there-- We are strong and are together for everything. It is the strength that we both have, we are there for each other. Solidarity between one and the other.”

Subtheme: Support from community-rooted organizations

“Corazón Healdsburg is also a source of strength for me. When I come, I feel better and I have learned a lot. It feels great to meet so many new friends.”

Prevalent Theme 6: Strong and healthy relationship to the land and outdoors

“I love to walk in the park.”

“We are teaching our children about equality and that we must respect nature. I am a part of an organization that is focused on conservation and protecting our land and to thank the Earth for everything it has given us.”

Prevalent Theme 7: Strong advocacy among community leaders, community health workers and patient navigators

Subtheme: Strong outreach among community health workers or promotoras/es

“That’s why sometimes I have my chat group, I have my organizations to which I belong, I share the information and that’s how we share in community...I tell them, “Hey, look, there’s this program. There’s the program as you can see, if you like it, this is my number, call me, we’ll register you or if you want to register, I’ll send you the link”, like this.”

Subtheme: Strong advocacy and activism among local community leaders

“We have gone to stand outside the wineries, outside the fields, to demand that there be respect for those workers, we have gone to court to stand there so that we can be heard. I don’t work in the fields, my husband doesn’t work in the fields, but that doesn’t stop me from supporting my people, raising my voice for them. When we started going to the meetings, we were 15, 20, and now we are going to the meetings with more than 100 people. Sometimes we have more than 300, 400 people who are joining the protests. Our voice is being heard.”

Results from Santa Rosa

Needs in Santa Rosa

Prevalent Theme 1. Desire to overcome racism, anti-indigeneity, anti-immigrant discrimination, and individualism

Subtheme: Feeling shame when asking for help due to the presence of anti-indigeneity and racism

“They don’t ask for help because they already have that wound that— ‘Oh, we are going to be judged—‘Oh, look, the Oaxaquita.’ ‘La cintita’, they tell us. Out of fear of pity and judgment, they do not seek services [referring to the Mixteco community].”

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“Many do not know where to go, or they are afraid because they do not have papers [immigration documentation] or do not have valid information.”

“The ‘patron’ [boss], takes [economic] advantage of us. He steps on us. Even when we are injured, we are forced to work. I think they take advantage of us because we are undocumented.”

Subtheme: Desire for solidarity in the community instead of individualism

“If I don't spend time with my neighbor, if I don't spend time with my friend, with anyone, I'll never learn the power of what I can do. If there is no integration and participation as members of the community, we will continue to see a decline, we will be unable to support others.”

Prevalent Theme 2: Desire to have schools with teachers who promote respect and who are actively working to eradicate bullying

“That there be respect at school, that there be no more bullying, that teachers pay more attention to our children, because sometimes they don't pay attention. The children sometimes are hitting each other, and well, there is no responsibility from the teachers to pay more attention to our children.”

“Right now children are suffering a lot of bullying.”

“I have heard how teachers will punish Mexican children more than American children. Like, they will take the phone away from the Mexican student but not the white student.”

Prevalent Theme 3: Outreach directly to indigenous, immigrant, undocumented, and/or uninsured communities, especially those who speak languages other than English

“In my indigenous community, they ask—Where can I apply for Medicare? Where can I go to the hospital? What can I say? What can I do? Where do I get the information to apply for papers [immigration documentation]?...They are afraid to go to the hospital and they speak another language. If they knew about

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their rights, as a person who can go to an emergency room to receive good and affordable services, they would go to a doctor.”

“If my community received more information and education, they would be healthy in many ways, they would have access.”

“We have seen in the community when people do not have insurance... you look at the faces of concern not knowing what to do and how to get into the [healthcare] system.”

Subtheme: Need to identify and share the resources that already exist in neighborhoods

“We have to identify the resources in the community that help people to navigate the system— ‘You can go here,’ or, ‘You can go there.’ It is important in each neighborhood to identify a house or a person who knows the systems.”

“Identify the people who have gifts and knowledge, identify the resources that exist in that community. If there is a hospital, if there is a clinic or a center where they give food, it needs to be mapped.”

“Maybe we need to start some meetings with people in the community, to identify what they know how to do and ask— “What do you know how to do?” For example, she may have a talent that I didn't even know about.”

Prevalent Theme 4: Need to offer dental, psychological, and holistic health services to marginalized communities

Subtheme: Accessible dental health services

“His teeth fell out [referring to a member of the community]. To date he says he doesn't know how he ended up with no teeth, because he can't go to the doctor-- It's very expensive. I know that person very closely and I feel that he has already entered into a depression.”

“I know one person who suffers from diabetes and he said, ‘I didn't know why my teeth fell out. I went to the doctor and they said, “Oh, it's because you have diabetes.”’ He is going to go out of the country to fix his teeth because it is more affordable.”

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Subtheme: Accessible mental health services, especially due to the fears and losses associated with the pandemic

"In our community there is a fear that we are going to get sick and we will not know where to go... I think, COVID affected many families. Many people are in a state of mind that has not healed. Right now we are processing everything we experienced, the fear we had, the suffering and grief of all those who died throughout this pandemic."

"I would like to know how to deal with stress because many of us, not just me, we don't know where to go, we don't know what to do with the stress. We need support from psychologists."

"I would like a little more value to be given to mental health, because these last two years with the pandemic, many [psychological] diseases were born and seeing the statistics anxiety and depression is on the rise."

Subtheme: Holistic health and better nutrition, especially in the schools

"Something I want in my community is holistic health."

"Because if you don't eat well, you won't be well....those junk foods that you sometimes eat on the street, hamburgers, sausages, they are things that do not nourish you. One must eat nutritious food to be healthy."

"Health is eating well. Children need to eat well to have the energy to be able to study and play at school. Because if they don't; they won't have the strength to walk or play."

"At school they only give him [i.e., son] bread, hamburgers, tamales, and chicken nuggets. Those are foods that are highly processed and the truth is that the school must improve its food."

"At school, the children eat bread and the milk is full of sugar. They give them things with little nutritional value."

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Prevalent Topic 5. More employment opportunities, jobs with higher wages, and more affordable housing

“Because if you give them [the community members] good wages, they will pay for their own needs.”

“If you have high rents, you just work to pay your expenses.”

Prevalent Topic 6. Training and workshops for the community

“I think that if affordable training and workshops are offered, our community will benefit, because we can distribute that information around.”

“First we have to be healthy ourselves to be able to help others. I would like to learn how to deal with stress so that those around me can be better taken care of.”

“I want more education.”

Strengths in Santa Rosa

Prevalent Theme 7. Family well-being and healthy upbringing for children is a priority

“If I'm fine, my children are fine. When I am under a lot of pressure, they feel it. I am working on being fine.”

“The education that I am trying to give my children so that in about 40 years, when I am no longer in this world, my children will say, “You know what? I learned all of this from this lady.”

Prevalent Theme 8. Strength in outreach, advocacy, and activism

Subtheme: The strength of the outreach of health promoters and trusted messengers

“If we show up at tabling events, distribute flyers and information, the community is stronger.”

“I work with the people I know who need it. I take them to their appointments and to apply for services. That is how I am helping them.”

“We are already doing good work. It's just a matter of reinforcing and strengthening the good work so that our community can be heard.”

“Sometimes I may not know the information myself. But I take the person to someone who does know. There, they can be helped. It is about connecting people.”

Subtheme: Health fairs and community events support health

“The outreach that large community fairs do, where vaccination clinics arrive, for example, where the mobile consulate arrives, for example. The clinics are of-- Even blood pressure checks are in sight. All that helps.”

“Right now I really enjoy when I go downtown and there are [community] events. The people eat outside and listen to music, the trees, cars going by... There is also a lot of information that they give out there, food, music, there is everything and that is what I like.”

Subtheme: Strength in coalition building

“Something that has worked a lot are coalitions. With the pandemic, many groups came together and said—‘Let's see, what are we going to do? What does the community need?’ We saw meetings, funds, masks, batteries. I believe that this can be done continuously, let's not wait for another disaster to come back together.”

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Subtheme: Advocacy and activism

“There are councils in the clinics that you can be part of and say, “You know what? I want to participate in this council because I have seen that the receptionist does not speak Spanish or does not speak other languages.” Now the interpreters have improved and all that. I got involved.”

“As they say, we all have the right, with [immigration] papers and without papers, to have insurance so that they also give you the attention that everyone deserves. That they give you good customer service when you arrive at a reception. We all deserve respect... It doesn't matter, we don't have to be self-conscious, with papers and without papers, we need to exercise our rights.”

Prevalent Theme 9. Wisdom of the elderly and senior citizens

“I tell them, ‘These sentences are from your grandfather,’ or, ‘These sentences are from my grandfather.’ In our culture, we value our grandparents.”

“Grandparents and elders are full of love and wisdom. They help you feel protected.”

Prevalent Theme 10. Mother Earth

“I believe in the land, and when we take root and are proud of who we are, where we come from, but also where we are going. When we really ground and anchor ourselves in mother earth, the world will change for our children, and even more so if we make them work with the land.”

“Mother Earth gives us so much health. I always say, “Take off your shoes, walk on the dirt, it's the least you can do. It's the simplest and cheapest way to de-stress, because we all suffer from stress.”

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Results from Petaluma

Needs in Petaluma

Topic 1. A community without racism and with economic equality

“I want a community where I feel safe, understood, without racism, without different economic levels, feel appreciated and be able to be happy.”

“I want a community where there is no differences due to some economic or racial situation.”

“I want a community where there is no kind of, you can say racism or something like that. So that whatever community we go to, that we are all equal.”

“We want to feel included, to feel taken into account...that there be equity.”

Theme 2. Leadership that truly represents the people who live in the Petaluma community

“We will know that the community is healthy when the people who are making the rules and making the decisions look like the people who are living in the communities. Because it means they are taking the people living in the communities seriously.”

Theme 3. Access to multilingual, culturally appropriate, mobile, humane, prompt, and low-cost health and learning services for the family

Subtheme: Services in different languages, not just English and Spanish

“Language is a very big barrier. Many of the services are only in English and Spanish, but there are other languages. People who are migrating here, who don't speak those [two] languages, so they can't receive the services or don't know how... expanding the number of languages spoken in the different services would help.”

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Subtheme: Humanizing and culturally appropriate services

“Cultural services that align with the people who live in our communities. [Providers] that understand our cultures...that they don't say how, "You have to change your thinking", because many say, "No, that thinking is wrong and not appropriate", so they make you feel less. People are not going to go to services where they are told that their thinking is wrong.”

“It's not just that they understand you in your language, but that they understand you as a human being, as a person. Because I have seen and I have had some experiences with doctors that it takes three months to schedule two hours to see him and after three questions the appointment ends.”

Subtheme: Mobile clinics

“I think that the fact that mobile clinics bring their programs to the schools for children, for example, is very helpful, because it is a way that we make sure that all children receive their check-up, or know what needs they have. and keep them healthy.”

“There are people who cannot come here due to lack of transportation, or lack of information.”

“I think it is a great help for the community to bring these services closer. Bring them closer so that all children have access to them.”

Subtheme: Accessible and frequent health services for people with disabilities

“In my case, I have a child with special needs, they take care of you when you already have an emergency, not when you need it.”

Subtheme: Couples and family educational services in Petaluma

“We would also need to have some program that provides family education or education for couples. Education on how we can guide our children so that they do not go looking for information outside in the streets. Family health is important to me, especially the health of the couple. To be able to give children good mental and emotional health.”

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Subtheme: Medical services for pregnant people in Petaluma

“That pregnant women have or have access to be able to go to the nearest hospital or clinic, and not have to depend on having to drive so far to another city to be treated. I mention this because I heard that there will be a closure of some hospitals where they will not be able to provide delivery services to pregnant women.”

“It is something that not only harms the pregnant woman, it also harms the baby, it harms the husband, who is the one who is going to take the wife and the child to the hospital, the child that is going to be born, and it also harms the family, because sometimes there are older children who need to take their mother to the hospital.”

Theme 4. Safe, clean, and emergency-prepared schools, streets, parks, and churches

Subtheme: Concern about school safety due to violence and recent deaths

“The distrust that one already has is that the child goes to school and that something is going to happen. I think that sometimes a little bit of help can also be said, for the children, with therapies. Because right now with everything that has happened in various schools, which have resulted in children dying. I think that too, I feel that a little more is needed, it could be help or something like that.”

Subtheme: Concern about danger and crime on the streets

“In the streets, the gangs are also making the streets insecure. If we want to go out and we don't feel safe, we are not physically, mentally or emotionally calm.”

“Offering security, and by this I mean offering security in the streets, in the schools, in the churches, in the entire community, because as they mentioned before, many things are happening in schools, many things are happening in the streets, in churches are going through a lot. We need more security.”

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Subtheme: Cleaner parks and streets

“One of the things that would be healthier for the community is to have groups to help clean up, like clean up parks, things like that that keep the community cleaner to be healthier.”

Subtheme: Community prepared for COVID, fire, or other emergency

“Here in Petaluma we realize that a lot of things are happening in the schools, everything that we also went through due to COVID, and that lets us know that we are not having the security, a very healthy mentality for everything that we are experiencing. We need the support of both hospitals and firefighters, and others for fires, it is also another thing that does not allow us to have a clean or calm mind that it is possible that in the future a fire will come again.”

Theme 5. Need available, accessible, and prompt mental health services in the Petaluma community and its schools

“We have a right to mental health, especially because of what the pandemic has left us with, to make our community even safer.”

“I called the clinic and they don't have services right now. It's like you realize we really need therapy, but psychological therapy...because many of us need counseling or therapy and we don't have it.”

“The fact that you have to travel long distances, or that you talk to them and they give them to you for one, two or three months out, you lose interest.”

“More mental health services... If your mental health is good, it affects your whole health and how you live your life...Right now I feel that mental health services are ... In and of themselves, they are not accessible. I feel that right now you have to have a crisis to receive services.”

“That they also offer the children that mental help, if they need it, because they feel intimidated or afraid of what happens in another school.”

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Theme 6. Need better nutrition in schools and communities

“I know that school menus are of great help to many, to many families, but they are not always the healthiest they have to be, but they include a lot of flour; things that make them gain a lot of weight. In recent times, many obese children have been seen, with childhood diabetes, and this may even be due to the food that is offered in schools.”

Theme 7. Need support for unsheltered and low income communities

“Also, thinking about people who are homeless, those who are on the street. Maybe open more places to receive them and offer them counseling, because many of them are also not healthy when they are on the street.”

“Now, you see many more people living on the street and you see that no, they are not well, but sometimes you cannot help them and they cannot receive help for whatever reason.”

Theme 8. Need navigators and health promoters who can support individuals who do not read, monolingual, and/or elderly people

“I saw that change in me, but it took me many years to understand the system and I've also had many experiences helping people in the clinic who sometimes don't understand or don't even know how to write or read and they say to them, "Fill out this sheet and...". They don't know, they need someone to guide them, to help them.”

“I have done it many times, because I see elderly people or simply illiterate people who need that help, that connection with the community, that understanding of the system.”

Theme 9. Free, safe, and affordable transportation

“I think we need affordable school buses because sometimes the husband work and doesn't have car, because that happened at the school. We don't afford two

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cars and my home once ... and I've got work. You have to have another car ... I think it's good thing to have the school buses for kids."

Strengths in Petaluma

Theme 10. Technology supports health

"Another success of the medical service is that when you have an appointment and they send you a text before, two or three days before. If I had forgotten the appointment, or it always happens to me, now it doesn't happen to me anymore because there is always a reminder."

"Now If you go to the doctor or to the laboratory to have an exam, you can have the results digitally on your phone. You can have it the next day or two days. I have also seen here in the clinic, in the laboratory that they talk to you if they see that something is not right in your exams, and they talk to you so that you can schedule an appointment and follow up on that problem."

Theme 11. Better communication between schools and parents since COVID

"Schools have done some things right. For example, my son was late, they send me a message, "Your son was late for class", in the morning, and suddenly –"Your son was absent on such a day", that is, like you're at the keeping an eye on what your son is doing, if he is not going to school or why he was late."

"They keep us informed about COVID. They send out several announcements."

Theme 12. Family financial aid and learning services within schools and clinics

Subtheme: Diaper and Food Bank

"Here at this school we have different programs to educate families. We have the program of what is AVANCE, it is here in the community. We have the family resource center, which is also inside the school. It offers the diaper bank, the

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food bank, the food pantry. There are several pantry delivery points. What I understand, here in the area.”

Subtheme: Learning programs such as PASITOS, AVANCE, and English classes

“The services we offer are also for families, to guide them and also help them learn to reach a goal, as a family. We have PASITOS, there are more programs, the Advance, the English classes. I think that the English classes have grown a lot.”

Subtheme: Nutrition classes in clinics

“I have also seen in the clinic that they encourage children to eat healthier. I have noticed it in my children. My kid was-- Supposedly they said he had a fatty liver or something. I was taking him to the clinic and he even told me, “Mom this is healthier for me. Look, I can cook this for myself.”

“Regarding places like clinics, hospitals, I have also seen many projects on how to have a better diet or how to lead a healthier life.”

Theme 13. Open areas to walk with the family, de-stress, and enjoy

“I feel like, as a community in Petaluma, there have been a lot of places to walk and feel safe...so I think that’s a positive thing in Petaluma that there are a lot of places to hang out with your family and walk.”

“During the pandemic, there were many parks that opened different paths for people to go out to exercise, to go out as a family, to enjoy nature, and to not be so isolated or cooped up all the time that people had to stay in at home.”

“Parks are places where you can de-stress, laugh, enjoy yourself, and live with others. More when you meet friends, family, you see smiling children, running, playing freely, for me that is community.”

Theme 14. Activities for elders and seniors

“What I really liked is that they used a lot of volunteers, who were older, advanced people. I don’t know exactly what [program] it was, but I saw many

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elders happily working to put up advertisements on the edges of the parks, fix up the gardens, and plant plants in the big parks.”

“I like to go for a walk and I see that there are many older people who go for a walk in the parks, because they also feel included in the reforestation of the parks and also so that it helps them to go out and not be locked in. houses.”

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Summary:

Participants expressed a desire to see schools, educators, community members, and leaders who actively address racism, injustice, and bullying. Across all listening sessions, participants advocated for supportive learning environments that enhance students' developmental, social, emotional, and academic learning. Parents reported concerns about the presence of racism, bullying, and student violence at school, and wondered if this may be due to the multiple impacts caused by the pandemic. Participants in Healdsburg and Petaluma referenced the death of a student at Montgomery High School as a source of stress and anxiety for both parents and children. Participants identified grief, loss, isolation, anxiety, depression, and low self-esteem as some of the concerns currently experienced by their children. In terms of possible solutions that could help alleviate some of these concerns, they indicated that fun, free, or low cost youth programming could help promote the social, psychological, and physical development of their children beyond the regular school day. In terms of factors that may negatively impact their children's healthy development, they identified poor nutrition at the schools. According to participants, the high fat, high sugars, and excessive sodium food their children are eating at school are not setting them up for academic success and wellbeing.

Participants shared their financial hardships and indicated that these take a heavy emotional toll and impact their health. They stated that there is a clear mismatch between their actual wages and what they need to earn to afford their housing costs. A couple of participants shared, with sadness and concern for the future, that they were recently evicted from their house. All participants advocated for more housing assistance for low income communities and individuals who are unsheltered. Some stated that although they qualify for affordable housing, they have been placed on long waitlists, which increases their frustration and anxiety.

In addition, participants explained that working longer hours to make ends meet is stressful and hinders their ability to be more present for their families and/or participate in programs offered during traditional working hours. Parents indicated that their difficulties

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affording rent and groceries, often means cutting back on the extracurricular, health, and healing activities that would support their and their children’s enrichment. They expressed a desire for social service and educational programs offered in the afternoons and with childcare for working parents.

Participants of Color shared a few examples of their experiences with racial discrimination. Participants in Petaluma, Healdsburg, and Santa Rosa described different learning opportunities for BIPOC¹ and white students. Some indicated that teachers discipline BIPOC students more harshly, which they believe impacts their children’s educational and health outcomes. A few participants shared instances in which their employers have failed to pay them for work done and described their behavior as “racist” and “exploitative.” Indigenous participants indicated that they and/or their children are often mocked, mistreated, and discriminated against. A couple of undocumented participants stated that their employers will often overwork them and exploit them given their immigration status, even when they are injured. Participants expressed a desire to experience more dignity, protection, respect, fair treatment, access, and opportunity. Some wondered if conditions for Black, Indigenous, and other communities of Color would improve if local leaders came from their own communities.

Participants discussed the need for increased access to culturally responsive services for uninsured, low-income, non-English speaking, individuals with disabilities, and other marginalized communities. They named the shortage of health providers, especially among bilingual and multicultural practitioners. Indigenous participants stated that the shortage of health services offered in Indigenous languages impedes the delivery of health care to their communities. Another factor that hinders service utilization is the need for vehicle access as well as the distance required to reach needed services. Participants from Petaluma and Healdsburg indicated that it is not uncommon for them to have to travel to Santa Rosa for health services, which they described as complicated. Those with children with disabilities reported that traveling outside of their local community for services can sometimes feel like an impossible

¹ Black, Indigenous, and Other Students of Color

task and advocated for long-term disability-inclusive systems. Participants in Petaluma expressed concerns about the closure of the birthing center at Petaluma Valley Hospital and wondered how this will impact the health of their friends and families.

Access to proper mental health was a key issue for participants. They were curious to know why despite the growing demand for psychological support, mental health investments are not being prioritized across Sonoma County. They emphasized the importance of building capacity for bilingual and multicultural providers to help eliminate health disparities. Additionally, participants advocated for more holistic approaches that consider all dimensions of wellness, including spiritual and psychological health. Some discussed being placed on long waitlists for counseling services. According to participants, there will continue to be a mental health crisis unless this shortage is addressed.

Participants identified outreach service delivery as one possible solution to overcoming the distance, communication, and fears associated with visiting clinics, hospitals, or providers. They stated that community health representatives, promotores, peers and frontline public health professionals are often trusted individuals who could support such outreach. Indigenous and/or Latinx participants claimed that community health workers have played a critical role in promoting community-based health education and prevention in communities historically underserved by local clinics and hospitals. They recommended ongoing collaboration between healthcare facilities and community health workers to promote health equity, prioritizing communities with the greatest health risks. They indicated that mobile clinics, health fairs, and partnerships between organizations are helpful resources to their community.

Participants described an interest in training, leadership opportunities (e.g., workshops and seminars), fellowship programs that could facilitate network development and better prepare them to support their communities, families, and/or children. They are looking forward to additional training on psychological health, workforce development, community organizing, civic engagement, equity, and justice (i.e., racial, economic, and gender justice). Participants who identified as women expressed a desire for peer-support programs that could help increase

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their connection to friends and neighbors, which they say could alleviate loneliness and isolation.

Although participants identified several needs, they also identified several strengths and protective factors. They identified “the family” and “elders” as important sources of support. They described elders as essential transmitters of knowledge, values, and culture, who they believe contribute to intergenerational and collective care and healing. They did note, however, that while there are many elders who are integrated into community activities, it is not uncommon to see elders who are experiencing loneliness and isolation. They see organizations who work with elders as a source of community strength and wish more could be done to help integrate them into community programs where different generations can learn from each other.

They indicated that amid stress, they often turn to wilderness areas and the outdoors as a way to improve mental health. They stated that spending time alone or with their families in green spaces has benefited them due to the healing powers of, as one participant said– “Mother Nature.” Many added that they have also found health benefits in advocacy and have said it can be empowering when community members come together, organize for justice, and speak up. Participants endorsed their ability to collectively advocate for social change, as a source of deep strength that helps them to withstand stress and discrimination. They identified being rooted in culture, tradition, and land as restorative.

Participants stated that another source of strength are the community-based organizations that are accountable to community members who are marginalized. The organizations who are committed to community-rooted practices, promoting racial equity, and creating lasting social change were described as essential to their health. They expressed a desire to see more organizations that offer bilingual and multicultural programs focused on family engagement, childhood development and couples and parenting education. Participants named the program PASITOS, AVANCE, and the Petaluma Family Resource Center’s English classes as valuable resources for families.

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Common shared themes between the three listening sessions included access to essential resources (whether it be health and clinic services, information regarding these resources and community supports, and access via supporting bilingual and multicultural approaches to support), a shared desire for youth development and support (supporting youth in schools and their well-being as well as addressing safety concerns and bullying on campus), and activism and social justice initiatives to support communities all across the board. Across Sonoma County, as a reflection of ongoing events in regards to school safety and social justice initiatives, community members want to have more input and information as to how their community supports its members' wellbeing. This includes supporting groups that have been historically marginalized, such as racial/ethnic minorities, LGBTQ+ community members, and members with disabilities. Within these broad themes, there were specific discussions on how these supports would be beneficial, and were unique to the context of each listening session.

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APPENDIX A

Protocol Questions Listening Session

Questions About Healthy Community

1. What makes a *healthy community*?
 - a. What do we mean by health?
 - b. What do we mean by community?
2. How can you tell when your community is healthy?
 - a. What does a healthy community look like for families?
 - b. What does a healthy community look like for your children or young people?
 - c. What does a healthy community look like for older adults?

Questions about Needs

1. What's needed? What more could be done to help your community be healthier?
 - a. What's needed to help your community be physically healthy?
 - b. What's needed to help your community be mentally and emotionally healthy?
 - c. What's needed to help your community be safe?
 - d. What's needed to ensure all members of your community can experience healthy lives?

Questions about Strengths

1. What's working? What are the resources that CURRENTLY help your community to be healthy?
 - a. Are there people that help your community be healthy?
 - b. Are there places people can go that help them be healthy?
 - c. Are there programs that help your community be healthy?
 - d. How do community members help each other be healthy?

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Preguntas de Protocolo Sesión de Escucha

Preguntas sobre comunidad saludable

1. ¿Qué hace a una comunidad saludable?
 - a. ¿Qué entendemos por salud?
 - b. ¿Qué entendemos por comunidad?
2. ¿Cómo puede saber uno cuándo su comunidad está saludable?
 - a. ¿Qué es una comunidad saludable para las familias?
 - b. ¿Qué es una comunidad saludable para los niños o jóvenes?
 - c. ¿Qué es una comunidad saludable para los adultos mayores o personas de la tercera edad?

Preguntas sobre necesidades

1. ¿Qué se necesita? ¿Qué más se podría hacer para ayudar a su comunidad a ser más saludable?
 - a. ¿Qué se necesita para ayudar a su comunidad a estar físicamente saludable?
 - b. ¿Qué se necesita para ayudar a su comunidad a estar mental y emocionalmente saludable?
 - c. ¿Qué se necesita para ayudar a su comunidad a estar más segura?
 - d. ¿Qué se necesita para garantizar que todos los miembros de su comunidad puedan tener una vida más saludable?

Preguntas sobre fortalezas

1. ¿Qué está funcionando? ¿Cuáles son los recursos que actualmente ayudan a su comunidad a estar saludable?
 - a. ¿Hay personas que ayudan a su comunidad a estar saludable?
 - b. ¿Hay lugares a los que las personas van que les ayuda a estar más saludables?
 - c. ¿Existen programas que ayudan a su comunidad a estar saludable?
 - d. ¿Cómo se ayudan los miembros de la comunidad unos a otros a estar saludables?

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Note:

"Organization"- "Informacion"- "Grupo"- "Comunidad"----highlights a need for information, access to information, and outreach/support to marginalized communities throughout the area.

"Niño"- "Escuela"- "Padre"- "Hijo"- "Nombre"- "Esposo"- "Casa"----highlights the connection between schools and family home-life; supporting students in schools helps support families and communities throughout Sonoma County.

"Ayuda"- "Apoyo"- "Programa"----these are all connected to major chunks throughout the graph, indicating a need for aid/help, support, and needs for programs on families, youth, and community members.

Frequent Word Charts; Healdsburg

Overall Frequency	Frequent Nouns	Frequent Adjectives	Frequent Verbs
ser	vez	bueno	ser
no	comunidad	mejor	estar
estar	persona	fuerte	haber
haber	escuela	mismo	ir
ir	niño	saludable	decir
decir	hijo	junto	tener
tener	familia	bonito	hacer
también	cosa	feliz	poder
vez	gente	grande	dar
comunidad	trabajo	nuevo	saber
mas	ayuda	importante	querer
hacer	grupo	igual	pasar
persona	información	triste	pensar
poder	día	positivo	hablar
dar	fortaleza	seguro	ver

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Frequent Bigrams Chart for Healdsburg

Frequency	Bigram	Frequency	Bigram
8	tal vez	2	través arte
6	corazón healdsburg	2	trabajadores campo
5	muchas veces	2	todas ayudas
4	santa rosa	2	siento tranquila
4	quedamos callados	2	siento bien
3	ser fuerte	2	ser saludables
3	redes sociales	2	queremos tener
3	quiere decir	2	puras mujeres
3	puede haber	2	puede ser
3	podría decir	2	ponga cosas
3	mucha ayuda	2	poder trabajar
3	hace falta	2	podemos ser
3	haber gente	2	personas amables
2	viniendo aquí	2	pasando depresión
2	veces veo	2	nueva generación
2	veces quedamos	2	muchas cosas

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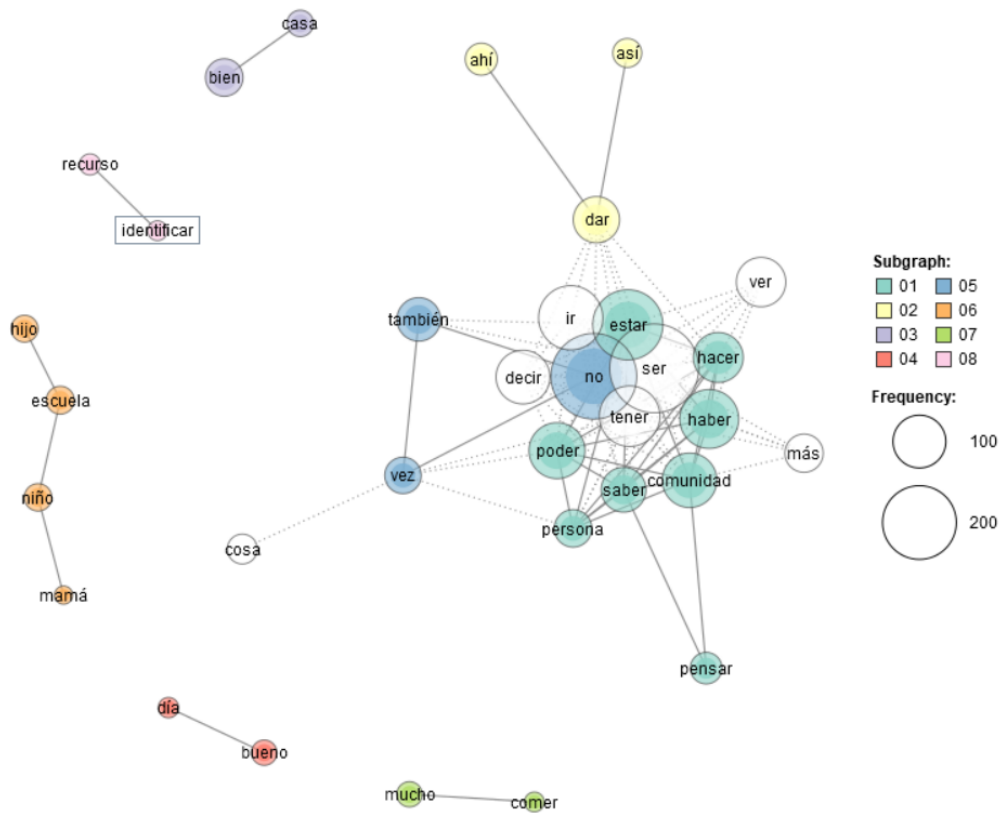
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Santa Rosa Co-Occurrence Networks

Co-Occurrence Network; Santa Rosa



Note:

Subgraph 06 highlights the connections between schools and student families; events happening in schools directly affect families in the community.

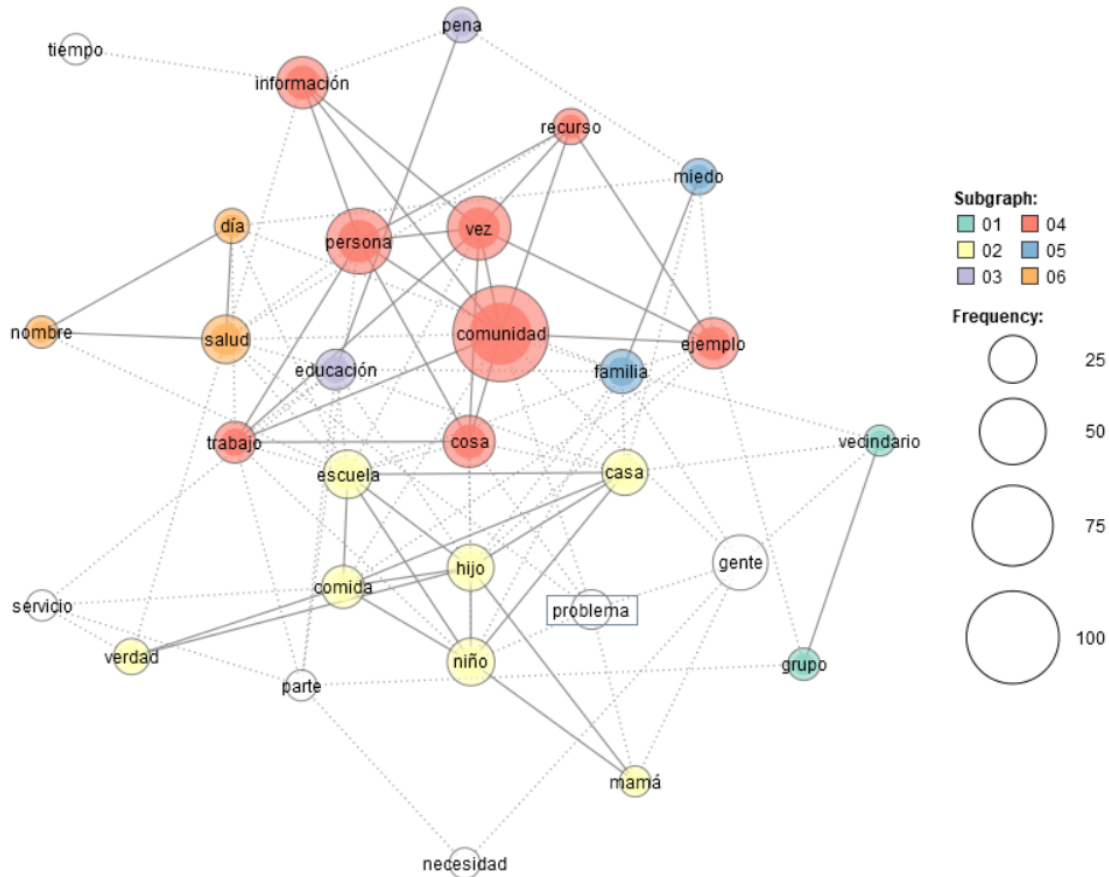
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Nouns Co-Occurrence Network for Santa Rosa Transcript



Note:

Subgraph 04 highlights the connection between communities, resources, and information. Community members see having a source of information and knowledge as essential, and that there is a lack of it in the community. Subgraph 03 highlights the connection between grief and education that community members feel due to the recent incidents of violence in Santa Rosa schools. Subgraph 05’s tangential connection to Subgraph 03 highlights a further connection between families and schools, and how parents feel nervous sending their children to schools.

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Frequent Words Chart; Santa Rosa

Overall Frequency	Nouns	Adjectives	Verbs
ser	comunidad	bueno	ser
no	persona	importante	estar
estar	vez	sano	ir
ir	gente	mejor	tener
tener	cosa	mismo	haber
haber	información	grande	poder
poder	ejemplo	pequeño	decir
comunidad	escuela	propio	hacer
decir	salud	saludable	ver
hacer	niño	diferente	dar
ver	hijo	puro	saber
dar	casa	simple	ayudar
saber	familia	junto	pensar
también	comida	nuevo	poner
más	trabajo	nutritivo	llegar

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Frequent Bigrams Chart; Santa Rosa

Frequency	Bigram	Frequency	Bigram
9	comunidad sana	3	hacer cambio
6	da peña	3	dónde ir
5	puedo hacer	3	cómo voy
5	muchas cosas	3	cosas buenas
5	mucha gente	2	vez ayuden
5	identificar recursos	2	veo comunidad
4	puedes hacer	2	veo cabizbaja
4	puede hacer	2	veces si
4	poder ayudar	2	veces personas
4	ver cómo	2	unas juntas
3	tal vez	2	todas cosas
3	pueden ir	2	tener conversaciones
3	propia lengua	2	tan sólo
3	podemos hacer	2	tal si
3	podemos ayudar	2	siento chiquita
3	pequeños problemas	2	ser recurso

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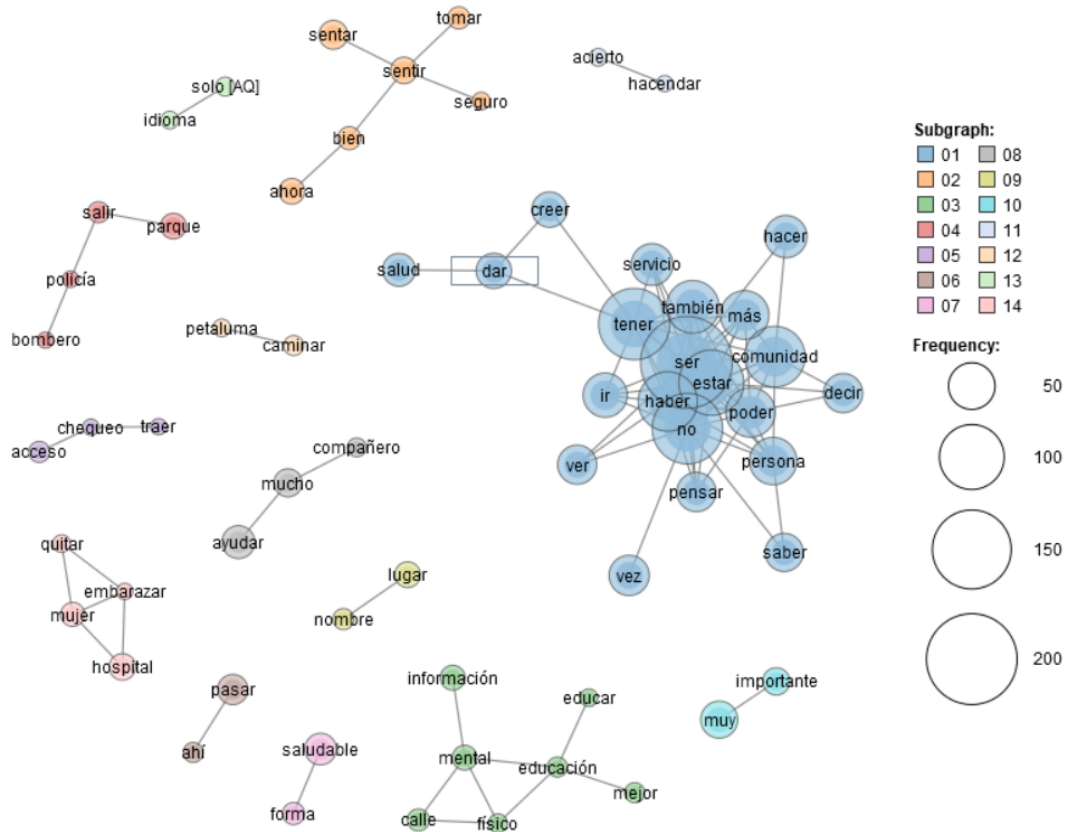
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Petaluma Co-Occurrence Networks

Nouns Co-Occurrence Network for Petaluma Transcript



Note:

Subgraph 04 talks about the need for first responders, and Subgraph 13 talks about the need for more public education and public health information on physical and mental health. Subgraph 11 talks about farming in petaluma, and an emphasis on the needs of the local agricultural community. Subgraph 08 discusses the need for community-based support and support groups, citing the emphasis of networks and connections in this aid process.

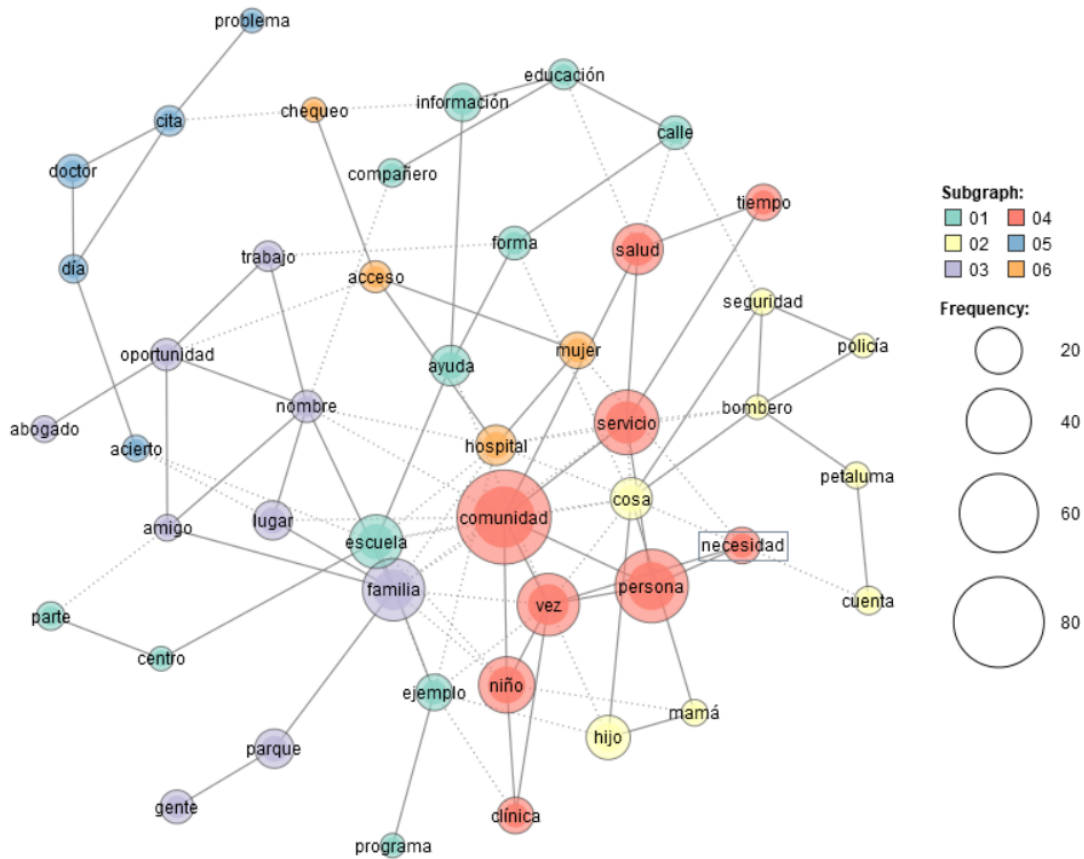
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Noun Co-Occurrence Network for Petaluma Transcript (Spanish)



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Frequent Words Chart for Petaluma (Spanish)

Overall Frequency	Nouns	Adjectives	Verbs
ser	comunidad	saludable	ser
tener	persona	bueno	tener
no	servicio	importante	estar
estar	familia	mental	haber
comunidad	vex	diferente	poder
haber	niño	sano	ir
también	escuela	gran	hacer
poder	salud	mismo	decir
más	hijo	mejor	pensar
persona	cosa	fisico	ver
ir	ayuda	solo	saber
hacer	hospital	grande	creer
servicio	lugear	igual	dar
familia	parque	seguro	ayudar
vez	información	mayor	pasar

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Frequent Bigrams Chart for Petaluma (Spanish)

Frequency	Bigram	Frequency	Bigram
6	tal vez	2	tres diferentes
5	muchas cosas	2	todas personas
4	puede decir	2	toda mujer
4	pasando muchas	2	tener comunicación
4	comunidad sana	2	sé cómo
4	cada persona	2	servicios recibimos
3	siendo escuchados	2	servicio médico
3	ser escuchados	2	ser humano
3	puede ser	2	school buses
3	poder ayudar	2	revisar nuevamente
3	mujer embarazada	2	pueden venir
3	muchas personas	2	pueden recibir
3	llegó tarde	2	pueden hacer
3	gran ayuda	2	poder dar
3	creo importante	2	pienos educarnos
2	tres meses	2	personas viviendo

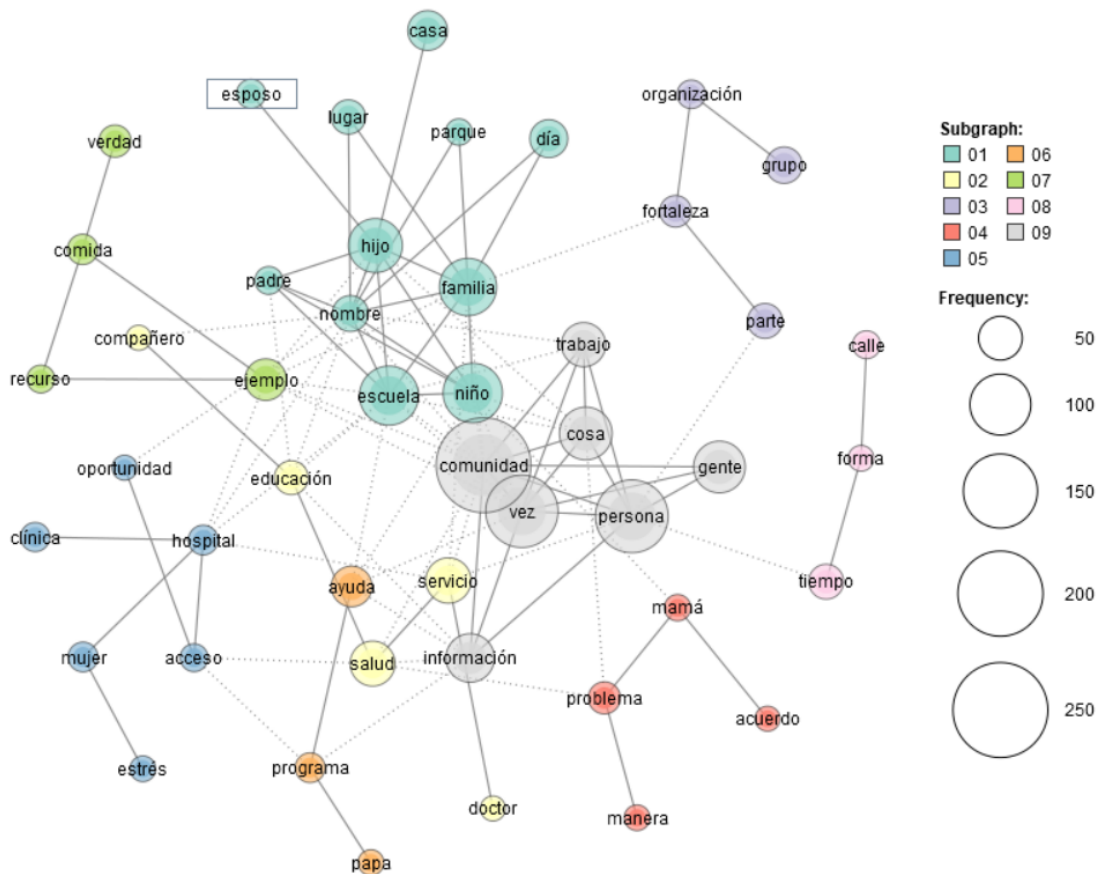
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Cumulative Co-Occurrence Network (Nouns)



The cumulative co-occurrence network highlights the sum of the three listening sessions, with Subgraph 01 highlighting the connections between families, schools, and activity spaces, Subgraph 02 describing essential services for the community and the support community members need, and Subgraph 05 highlights the need for accessible health centers and clinic in Sonoma County.

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