2016 Community Health Needs Assessment

Kaiser Foundation Hospital - Fremont
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Approved by KFH Board of Directors
September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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Applied Survey Research is a social research firm dedicated to helping people build better communities.

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements. This 2016 assessment is the second such assessment conducted since the ACA was enacted and builds upon the information and understanding that resulted from the 2013 CHNA. This assessment includes feedback from the community and experts in public health, clinical care, and others. This CHNA serves as the basis for implementation strategies that are required to be filed with the IRS as part of the hospital organization's 2016 Form 990, Schedule H, four and a half months into the next taxable year (May 15, 2017 for Kaiser Foundation Hospitals).

B. Summary of Prioritized Needs

KFH-Fremont originally worked with 11 hospitals in Contra Costa and Alameda counties to develop a coordinated approach to primary data collection. This allowed non-profit hospitals in the area to take advantage of economies of scale and to avoid overburdening the community with multiple requests for information.

Community input was obtained during the summer and fall of 2015 via key informant interviews with local health experts, focus groups with community leaders and representatives, and focus groups with community residents. Secondary data were obtained from a variety of sources – see Appendix A for a complete list.

Based on community input and secondary data, KFH-Fremont worked with KFH-San Leandro, Washington Hospital Healthcare System, and St. Rose Hospital to understand health needs in their shared service areas. KFH-Fremont, KFH-San Leandro, Washington Hospital Healthcare System, and St. Rose Hospital then identified local community stakeholders to assist with prioritizing (ranking) the list of health needs via a multiple-criteria scoring system. These needs are listed below in priority order, from highest to lowest.

Please note that data indicators in the descriptions below were gathered from the KFH- Fremont service area where available. Where service area was not available, county data were used including data from local public health departments. If indicators for KFH- Fremont performed poorly against a benchmark, it met the first criteria for being defined as a health need. If no data were available for the service area, county data were used to compare to benchmarks. (See Section VI for more information.)

Community Health Needs Identified for KFH-Fremont, in Order of Priority

Health need	Why is it important?	What do the data say?
1. Obesity, diabetes, and healthy eating/active living	Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives.	The KFH-Fremont service area has issues related to access to healthy food – the ratio of fast food establishments and WIC-authorized food stores to residents and the proportion of residents who live in a food desert are all worse than the state. Youth levels of inadequate fruit & vegetable consumption are also worse in the KFH-Fremont service area than in the state. Residents reflect these issues with their concern about access to healthy foods.
2. Mental health	Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health.	In the KFH-Fremont service area, the rate of ER visits for injury due to intentional self-harm among youth is higher than the state and Healthy People 2020 (HP2020) goal. The suicide rate among Whites in the service area is higher than the state; the rate of severe mental-illness related ED visits by Blacks in the county is much higher than the state. The community feels there are not enough providers, and insurance coverage is limited.
3. Economic security	Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the	In the KFH-Fremont service area, nearly one in six residents experience food insecurity, and some ethnic groups have higher proportions living in poverty than others. The community expressed concern about low wages, access to employment, and lack of affordable housing.

Health need	Why is it important?	What do the data say?
	child's life, even if social conditions subsequently improve.	
4. Cardiovascular disease and stroke	Nationally, more than 1 in 3 adults (81.1 million) live with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death respectively, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease.	In the KFH-Fremont service area, the mortality rate due to ischemic heart disease is higher than the HP2020 objective, and some ethnic groups have disproportionately higher rates of death than others from both heart disease and stroke. Also, the percentage of those with hypertension in the county is slightly higher than the state average. In addition to remarking on the lack of access to healthy food and open spaces for exercise, the community expressed concern about heart disease and its risk factors among certain ethnic populations.
5. Substance abuse, including alcohol, tobacco, and other drugs	Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide.	Data available on alcohol use show that KFH-Fremont service area residents may be using alcohol more frequently than Californians generally do. Data about illegal drug use are not available, but the community expressed concern about drug and alcohol use and the lack of treatment services available to address this problem. Countywide, Blacks have much higher ER visit rates for substance abuse than those of other ethnicities.
6. Violence and injury prevention	Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse	In the KFH-Fremont service area, the Black population experiences homicide at a much higher rate than do populations of other ethnicities. In addition, the school suspension rate is worse than the state rate. The community expressed concern

Health need	Why is it important?	What do the data say?
	disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth.	about unsafe streets and domestic violence.
7. Healthcare access & delivery, including primary & specialty care	Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life.	Wide disparities exist across multiple racial and ethnic groups in the uninsured population in the KFH-Fremont service area. The percentages of people in the county who had a usual source of care and who delayed or had difficulty obtaining care are both worse than the HP2020 objectives. The community is concerned about issues of affordability, lack of health system literacy, the limited supply of providers, inconvenient office hours, and the lack of integration of mental and physical healthcare.
8. Cancer	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues. It is the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening.	In the KFH-Fremont service area, cancer incidence rates are close to state averages or HP2020 goals, but incidence and mortality rates show ethnic disparities. Available data on cancer screening show service area rates that are similar or better than the state. Community comments mostly focused on the difficulty of transportation to and from treatment.
9. Asthma	Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and	In the KFH-Fremont service area, nearly one in six adults and fully one in five children have asthma. Black asthma patients account for a larger proportion of service area

Health need	Why is it important?	What do the data say?
	obstruction. These episodes can range in severity from mild to life-threatening. Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and being overweight. Asthma is considered a significant public health burden and its prevalence has been rising since 1980.	hospital discharges than at the state level. The community expressed concern about childhood asthma.
10. Infectious diseases, including sexually transmitted infections (STIs)	Infectious diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood or semen). Infectious diseases remain a major cause of illness, disability, and death. People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection.	In the KFH-Fremont service area, HIV-related hospital discharge statistics show disparities for Black residents. In Alameda County, the statistics on HIV prevalence are worse than the state and show similar disparities. Also, the tuberculosis rate is much higher than the HP2020 objective, and pertussis cases have been rising in the county. The community expressed concern related to education of adolescents about sexual health.
11. Maternal and infant health	The topic area of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birthweight, infant mortality, teen births, breastfeeding, and access to prenatal care. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and	In the KFH-Fremont service area, the statistics on Head Start Program enrollment and food insecurity are worse than the state. Also, the infant mortality rate shows ethnic disparities. The community felt sexual health education & general healthy decision-making for teens was lacking

Health need	Why is it important?	What do the data say?
	enable children to reach their full potential.	

C. Summary of Needs Assessment Methodology and Process

In November 2015, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria including criteria specific to individual hospitals or subgroups of hospitals. Needs were then prioritized by a group that included representatives from KFH-Fremont, KFH-San Leandro, Washington Hospital Healthcare System, St. Rose Hospital, and community representatives using a second set of criteria. The results of the prioritization are included in Section VI-B.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

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

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

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

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

B. About Kaiser Permanente Community Benefit

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

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

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

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

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

The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. The report also includes a description of the impact of implemented strategies identified in the previous implementation strategy report. The 2016 CHNA meets both state (SB697) and federal (ACA) requirements.

D. Impact of the Affordable Care Act (ACA)

The intent of ACA is to increase number of insured and make it affordable through Medi-Cal expansion and healthcare exchanges implemented by participating states. While the ACA has expanded coverage to care for many people and families, there still exists a large population of people who remain uninsured as well as those who experience barriers to healthcare, including costs of healthcare premiums and services and getting access to timely, coordinated, culturally appropriate services.

The federal definition of community health needs includes the social determinants of health in addition to morbidity and mortality. This broad definition of health needs is indicative of the wider focus on both upstream and downstream factors that contribute to health. Such an expanded view presents opportunities for nonprofit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health, including the social determinants of health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, ACA created more incentives for health care providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

State and County Context

The last CHNA report conducted was in 2013, before the full implementation of the Affordable

Care Act (ACA). Healthcare access was a top concern for the community and nonprofit hospitals and remains so in 2016.

Following the institution of the ACA in January 2014, Medi-Cal was expanded in California to low-income adults who were not previously eligible for coverage. Specifically, adults earning less than 138% of the Federal Poverty Level (approximately $15,856 annually for an individual) are now eligible for Medi-Cal. In 2014, "Covered California," a State Health Benefit Exchange, was created to provide a marketplace for healthcare coverage for any Californian. In addition, Americans and legal residents with incomes between 139% and 400% of the Federal Poverty Level can benefit from subsidized premiums.[1]

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,[2] according to data cited by the California Healthcare Foundation. According to the California Health Interview Survey, in 2013 19% of the population aged 18-64 in Alameda County was not insured (191,000 people).[3] Previous years (2011 and 2012) had seen the uninsured rate at 14%, demonstrating an unexpected increase between 2011 and 2013 in Alameda County.[4]

Although some Alameda County residents may have obtained health insurance for the first time, health insurance costs, the cost of care, and access to timely appointments, remains a concern. As discussed later in this report, residents (including those whose insurance plans did not change since ACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. Indeed, professionals who participated in this assessment also expressed concern about the lack of a sufficient number of doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance. This is supported by evidence that there was an increase in the proportion of people who said they had forgone care because they could not get an appointment (from 5% in 2013 to 8% in 2014).[2]

Although 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports. While health care access is important in achieving health, a broader view takes into consideration the influence of other factors including income, education, and where a person lives. These factors are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves influenced by policy choices. These underlying social and economic factors cluster and accumulate over one's life, and influence health inequities across different populations and places.[5] According to the Robert Wood Johnson Foundation's approach of what creates good health, health outcomes are largely shaped by social and economic factors (40%), followed by health behaviors (30%), clinical care (20%) and the physical environment (10%).[6] In order to address the bigger picture of what creates good health, health care systems are increasingly extending beyond the walls of medical offices to the places where people live, learn, work, and play.

E. Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced

[1] http://www.healthforcalifornia.com/covered-california

[2] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411/

[3] Insured/uninsured figures for Alameda County for 2014 are not considered statistically stable.

[4] California Health Interview Survey (CHIS), 2011-2014. Retrieved Dec. 11, 2015 from http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography

[5] Santa Clara County Public Health Department, 2014 *Santa Clara County Community Health Assessment*.

[6] http://www.countyhealthrankings.org/our-approach

compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

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

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

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

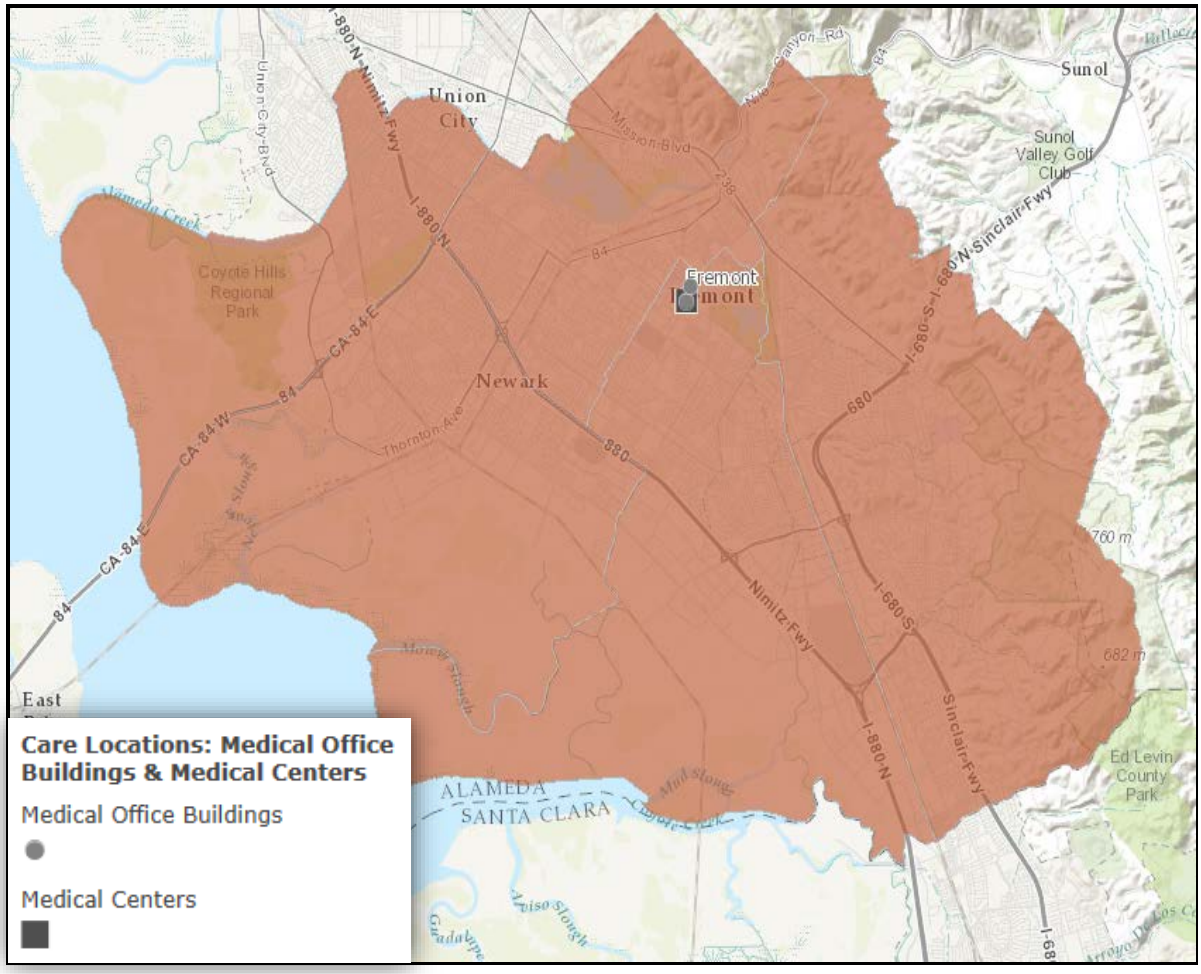
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

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

B. **Map and Description of Community Served**

i. Map of KFH-Fremont service area



ii. Geographic description of the community served (towns, counties, and/or zip codes)

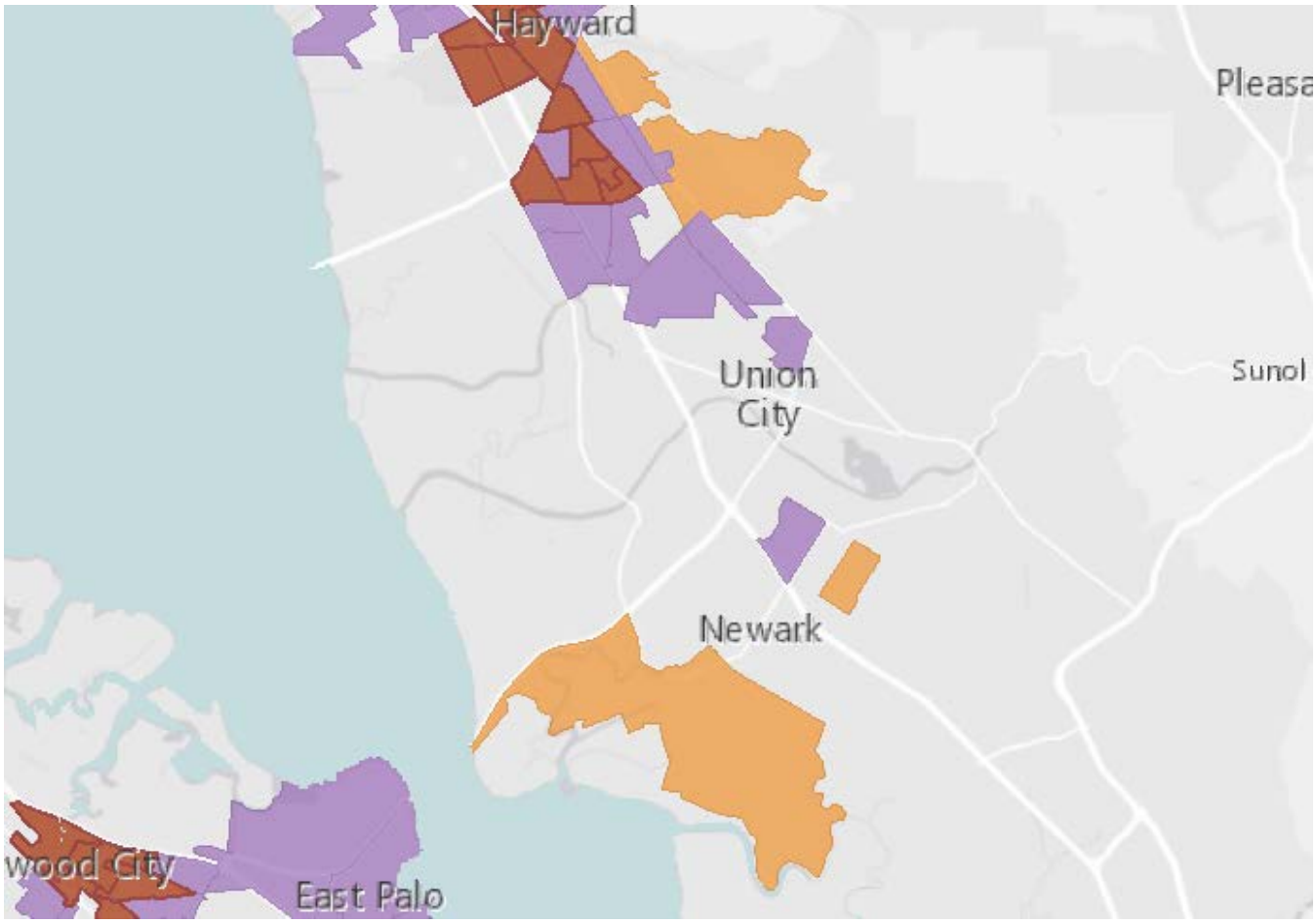
The KFH-Fremont service area covers the southern part of the Alameda County. The cities served include Fremont and Newark. The map above shows the service area which also includes unincorporated areas.

iii. Demographic profile of community served

KFH Fremont Demographic Data	
Total Population	265,391
White	30.67%
Black	3.84%
Asian	48.45%
Native American/ Alaskan Native	0.56%
Pacific Islander/ Native Hawaiian	0.71%
Some Other Race	9.23%
Multiple Races	6.54%
Hispanic/Latino	17.22%

KFH Fremont Socio-economic Data	
Living in Poverty (<200% FPL)	17.36%
Children in Poverty	7.77%
Unemployed	6.6%
Uninsured	8.02%
No High School Diploma	9.1%

KFH-Fremont Vulnerability Footprint



The orange shading shows areas where the percentage of population living at-or-below 100% of the Federal Poverty Level (FPL) exceeds the state rate of 16%. The purple shading shows areas where the percentage of the population with no high school diploma exceeds the HP2020 objective of 18% (i.e., 82.4% with a high school diploma or higher). Educational attainment is determined for all non-institutionalized persons age 25 and older. Dark red areas indicate that the census tract is above these thresholds (worse) for both educational attainment and poverty.

Close one quarter (24%) of the children in the KFH-Fremont service area are eligible for Free & Reduced-Price lunch (NCES Common Core of Data 2013-14), while close to one in ten children (8%) lives in a household with income below 100% of the Federal Poverty level (U.S. Census Bureau, American Community Survey, 2009-2013). Nearly one in 10 people (9%) in the community are uninsured (U.S. Census Bureau, American Community Survey, 2009-2013)

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

KFH-Fremont originally worked with 11 other hospitals ("the Hospitals") in Contra Costa and Alameda counties to develop a coordinated approach to primary data collection. The Hospitals agreed to enlist the assistance of Applied Survey Research to conduct the assessment, agreed on

secondary data sources, and agreed on common protocols for primary data collection (key informant interviews and focus groups) across both counties. This allowed non-profit hospitals in the area to take advantage of economies of scale and to avoid overburdening the community with multiple requests for information.

Most of the Hospitals then collaborated with one or more of the Hospitals with similar service areas to decide on criteria for identifying significant health needs; KFH-Fremont worked with KFH-San Leandro, Washington Hospital Healthcare System, and St. Rose Hospital. The Hospitals then used the primary and secondary data collected that pertained to their respective service areas for identification of needs. KFH-Fremont, KFH-San Leandro, Washington Hospital Healthcare System, and St. Rose Hospital then identified local community stakeholders to assist with prioritizing (ranking) the list of health needs via a multiple-criteria scoring system.

Collaborative hospital partners

- John Muir Health
- Kaiser Foundation Hospital - Antioch
- Kaiser Foundation Hospital - Walnut Creek
- Kaiser Foundation Hospital – Oakland
- Kaiser Foundation Hospital - Richmond
- Kaiser Foundation Hospital – Fremont
- Kaiser Foundation Hospital - San Leandro
- St. Rose Hospital
- San Ramon Regional Hospital
- Stanford Health Care – ValleyCare
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

B. **Other partner organizations that collaborated on the assessment**

While there was no formal collaboration between the Hospitals and other organizations, the Hospitals invited representatives from the public health departments of the City of Berkley, County of Alameda, and the County of Contra Costa to one of their first joint meetings. These representatives presented local public health data and shared about local efforts to improve health outcomes. The Hospitals discussed these issues with these public health representatives and increased their knowledge of the health needs in their respective communities.

C. **Identity and qualifications of consultants used to conduct the assessment**

The community health needs assessment was completed by Applied Survey Research (ASR), a nonprofit social research firm. For this assessment ASR conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the process of identification of community health needs and assets and of prioritization of community health needs and documented the process and findings into a report.

ASR was uniquely suited to provide the Hospitals with consulting services relevant to conducting the CHNA. The team that participated in the work –Dr. Jennifer van Stelle, Abigail Stevens, Angie Aguirre, Samantha Green, Martine Watkins, Chandrika Rao, Melanie Espino, Kristin Ko, James Connery, Christina Connery, Emmeline Taylor, Paige Combs, and sub-contractors Dr. Julie Absey,

Robin Dean, Lynn Baskett, and Nancy Ducos – brought together diverse, complementary skill sets and various schools of thought (public health, anthropology, sociology, social ethics, psychology, education, public affairs, healthcare administration, and public policy).

In addition to their research and academic credentials, the ASR team has a 35-year history of working with vulnerable and underserved populations including young children, teen mothers, seniors, low-income families, immigrant families, families who have experienced domestic violence and child maltreatment, the homeless, and children and families with disabilities.

ASR's expertise in community assessments is well-recognized. ASR won a first place award in 2007 for having the best community assessment project in the country. They accomplish successful assessments by using mixed research methods to help understand the needs in question and by putting the research into action through designing and facilitating strategic planning efforts with stakeholders.

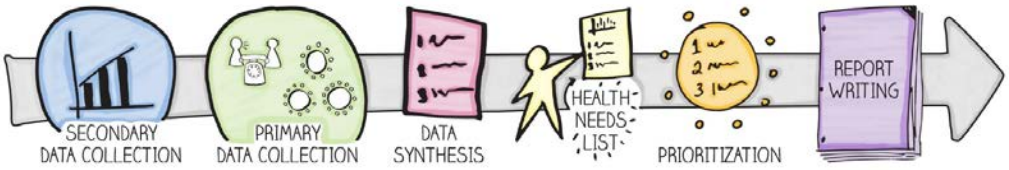
Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Alameda, Contra Costa, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties, Marin County, Nevada County, Pajaro Valley, and Solano and Napa Counties.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

In 2013, our hospital identified community health needs in a process that met the IRS requirements of the CHNA. During this first CHNA study, the research focused on identifying health conditions, and secondarily the drivers of those conditions (including healthcare access). In the 2016 study, the Hospitals, including our hospital, built upon this work by using a combined list of identified needs from 2013 to ask about any additional important community needs, and delving deeper into questions about healthcare access, drivers of prioritized health needs and barriers to health, and solutions to the prioritized health needs. We also specifically sought to understand how the Affordable Care Act implementation impacted residents' access to healthcare, including affordability of care.

As described above, KFH-Fremont worked in collaboration with the Hospitals on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over five months and culminated in a written CHNA report in spring of 2016.

CHNA Process



A. Secondary data

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

KFH-Fremont used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

Data from the UCLA data platform for the California Health Interview Survey (AskCHIS), and other online sources were also collected. In addition, ASR collected data from the Alameda County Public Health Department, Contra Costa County Health Services, and the City of Berkeley Public Health Division.

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

ASR used a spreadsheet to list indicator data. Data were collected primarily through the KP CHNA Data Platform (www.chna.org/kp) and public health department reports. (See Appendix B for a list of indicators on which data were gathered.) ASR retained the health need categories used in the Kaiser Permanente CHNA data platform export file (rubric) and integrated data indicators from other sources into the rubric.

ASR compared secondary data indicators to Healthy People 2020 targets and state averages/proportions in order to assess whether the indicators perform poorly against these benchmarks. Also, indicator data for racial/ethnic subgroups were reviewed in order to ascertain whether there are disparate outcomes and conditions for people in the community. Where possible, ASR used KFH-Fremont service area data. If data were not available at the service area level, county data were used.

ASR presented this data and analysis of which indicators failed the benchmarks to the Hospitals. The Hospitals decided to retain health needs for which at least one data indicator performed poorly against a benchmark and later applied other criteria.

B. Community input

i. Description of the community input process

The Hospitals contracted with Applied Survey Research (ASR) to conduct the primary research. Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix C.

In all, ASR gathered community input from 54 individuals through focus groups and individual interviews.

In all, ASR consulted with 44 professional community representatives of various organizations and sectors through 18 key informant interviews and three focus groups (which included 26 participants). These representatives either work in the health field or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- County Public Health (5)
- Other health centers or systems (11)
- Mental/Behavioral health or violence prevention providers (12)
- School system representatives (2)
- City or county government representatives (3)
- Nonprofit agencies providing basic needs (11)

See Appendix C for the titles and expertise of key stakeholders along with the date and mode of consultation (focus group or key informant interviews).

a. Key Informant Interviews

ASR conducted primary research via key informant interviews with 18 Alameda experts from various organizations. Between June and October 2015, experts including the county public health officers, community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

Experts were interviewed in person or by telephone for approximately one hour. Informants were asked to identify the top needs of their constituencies, including specific groups or areas with greater or special needs; how access to healthcare has changed in the post-Affordable Care Act environment; drivers of the health needs they identified and barriers to health; and suggested solutions for the health needs they identified, including existing or needed resources.

b. Stakeholder Focus Groups

Three focus groups with stakeholders were conducted between August and October 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, health care access and barriers thereto, and assets and resources that exist or are needed to address the community's top health needs, including policies, programs, etc.

Details of Focus Group with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Mental health	National Alliance on Mental Illness	08/20/15	8
Minority	Washington Hospital	09/02/15	8
Veterans	U.S. Department of Veterans Affairs, Oakland Vet Center	09/23/15	10

Please see Appendix C for a full list of community leaders/stakeholders consulted and their credentials.

c. Resident Input

A resident focus group was conducted in September 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, the community's experience of health care access and barriers thereto, and assets and resources that exist or are needed to address the community's top health needs.

In order to provide a voice to the community they serve in Alameda County, the Hospitals targeted participants who were medically underserved, in poverty, and/or socially or linguistically isolated. One focus group was held with community members.

This resident group was held in Union City, a relatively central location in southern Alameda County. Residents were recruited by the nonprofit host, Centro De Servicios, who serves uninsured residents.

Details of Focus Group with Residents

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Immigrant population	Centro De Servicios	09/18/15	10

Ten community members participated in the focus group discussions in Alameda County. All participants were asked to complete an anonymous demographic survey, the results of which are reflected below.

- 100% of participants (10) completed a survey.
- 100% (10) of participants were Latino.
- 100% (10) were between the ages of 18 and 64 years old. 50% were younger than 40, and 50% were 40 or older.
- 10% (1) were uninsured, while 40% had benefits through Medi-Cal or Medicare. The rest

had private insurance.

- Residents lived in various areas of southern Alameda County: Hayward (7), Union City (2), and Cherryland (1).
- 80% (8) reported having an annual household income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Alameda County for two adults with no children ($38,817). This demonstrates a fair level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

ii. Methodology for collection and interpretation

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups and interviews had been conducted, the team used qualitative research software tools to analyze the information. ASR then tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in key informant interviews. This tabulation was used in part to assess community health priorities.

See Appendix F for key informant interview and focus group protocols.

C. **Written comments to 2013 CHNA**

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

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

D. **Data limitations and information gaps**

The KP CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

ASR and the Hospitals were limited in their ability to assess some of the identified community health needs due to a lack of secondary data. Such limitations included data on sub-populations, such as foreign born, the LGBTQ population and incarcerated individuals. Health topics in which data are limited include: bullying, substance abuse (particularly, use of illegal drugs and misuse of prescription medication), use of e-cigarettes and related behaviors such as vaping, dental health (particularly dental caries), consumption of sugar-sweetened beverages (SSBs), elder health, disabilities, flu vaccines, quality of life and stressors, police-associated violence, human trafficking, discrimination and perceptions related to race, sexual behaviors, and extended data on breastfeeding.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. **Identifying community health needs**

i. Definition of "health need"

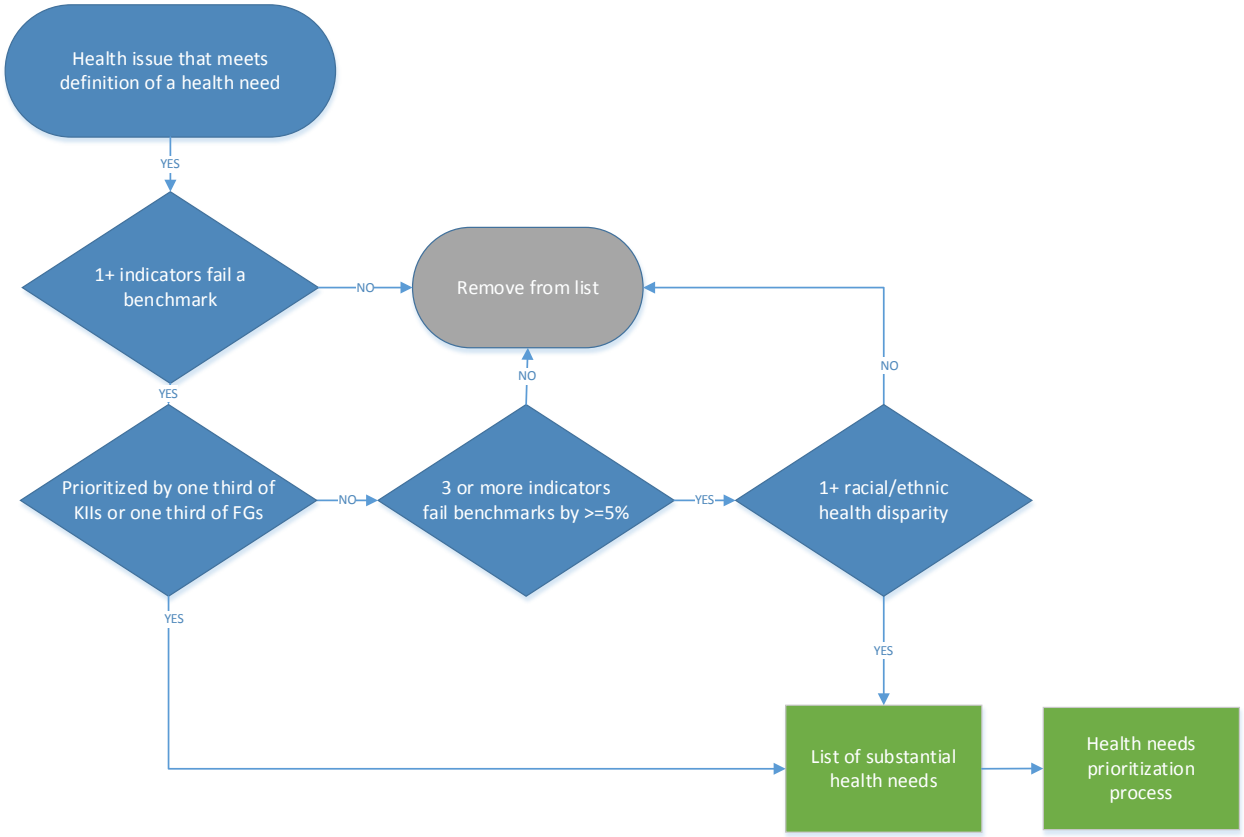
For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.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

Definition	Example(s)
Health **outcome**: A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality	Diabetes prevalence Diabetes mortality
Health **condition**: A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome	Diabetes
Health **driver**: A behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health	Poor nutrition Lack of screenings / diabetes management Access to healthy foods Access to fast food
Health **indicator**: A characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly)	Percent of population with inadequate fruit and vegetable consumption Percent of diagnosed diabetics who have had a recent blood sugar test

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

To identify the community's health needs, ASR and the Hospitals gathered data on 150+ health indicators and gathered community input. (See Section V-A and V-B for details.) Following data collection, ASR followed the process shown in the diagram on the next page to identify which health needs were significant.

KFH-Fremont Health Needs Identification Process



A total of 11 health conditions or drivers fit all criteria or conditional criteria and were retained as community health needs. The list of needs, in priority order, is described later in the report.

B. **Process and criteria used for prioritization of the health needs**

Before beginning the prioritization process, KFH-Fremont chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Multiplier effect**: A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.
- **Community priority:** The community prioritizes the issue over other issues on which it has expressed concern during the CHNA primary data collection process. ASR rated this criterion based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.

Scoring Criteria 1-3: The score levels for the prioritization criteria were:

3: Strongly meets criteria, or is of great concern
2: Meets criteria, or is of some concern
1: Does not meet criteria, or is not of concern

A survey was then created, listing each of the health needs in alphabetical order. Community representatives and representatives of the local, participating hospitals rated each of the health needs on each of the first four prioritization criteria via an online survey in February, 2016. ASR assigned ratings to the fifth criterion based on how many key informants and focus groups prioritized the health need.

Combining the Scores: For each of the first four criteria, group members' ratings were combined and averaged to obtain a combined score. Then, the mean was calculated based on the five criteria scores for an overall prioritization score for each health need.

List of Prioritized Needs: The overall need scores ranged between 1.78 and 2.83 on a scale of 1-3 with 1 being the lowest priority possible and 3 being the highest priority possible. The needs are ranked by prioritization score in the table below. The specific scores for each of the five criteria used to generate the overall community health needs prioritization scores may be viewed in Appendix E.

Prioritized Needs Ranking and Average Priority Score

Rank	KFH-Fremont Health Need	Overall Average Priority Score
1	Obesity, Diabetes, Healthy Eating/Active Living	2.83
2	Mental Health	2.74
3	Economic Security	2.60
4	Cardiovascular Disease/Stroke	2.59
5	Substance Abuse (Alcohol, Tobacco, and Other Drugs)	2.58
6	Violence/Injury Prevention	2.48
7	Healthcare Access & Delivery, Including Primary & Specialty Care	2.41
8	Cancer	2.18
9	Asthma	1.91
10	Infectious Diseases, Including Sexually Transmitted Infections	1.87
11	Maternal & Child Health	1.78

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

KFH-Fremont service area data were used in analysis where available, and described below. Where service area data were not available, county data were used.

1. Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting

healthy food and physical environments allows people to make healthier choices and live healthier lives. **Obesity, diabetes, and healthy eating/active living** are health needs in the KFH-Fremont service area as marked by rates of fruit and vegetable consumption among youth that are worse than the state, lower proportions of adults who bike or walk to work than the state, higher proportions of residents who experienced food insecurity, and slightly lower percentages of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages. The service area also contains a higher percentage of residents living in areas designated as food deserts than the state average. Additionally, the ratios of fast food establishments and WIC-authorized food stores to residents in the KFH-Fremont service area are worse than the state. Community input about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity. The Greater Southern Alameda Area community input indicated that lack of access to affordable, healthy food is driving this health need. Community input also indicated that Latinos and Blacks tend to have higher levels of obesity, diabetes, and hypertension. Additionally, community members mentioned that providers do not give culturally-specific nutrition recommendations.

2. **Mental health** is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to the community and society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health. Mental health is a health need in the KFH-Fremont service area as illustrated by the rate of Emergency Department visits for injury due to intentional self-harm among youth (including attempted suicide), which is higher than the state rate. Whites in the service area report a need for mental health care at a higher percentage than the state and other ethnic groups in the service area. Similarly, Whites in the KFH-Fremont service area commit suicide at rates higher than the HP2020 target and rates higher than those of other ethnic groups in the service area. In Alameda County, the rate of severe mental illness emergencies is substantially higher than the state rate, and the rate is much higher among Black county residents compared to the rate for the state. In the Greater Southern Alameda Area, the community specifically mentioned the lack of mental health providers and also lack of "placement care" and behavioral health services for adolescents. Community members also spoke of experiencing poor discharge procedures and lack of follow-up after mental health emergencies.

3. Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve. **Economic security** is a health need in the KFH-Fremont service area as illustrated by the percentage of residents who experienced food insecurity at some point during the year, which is more than twice as high as the HP2020 goal. Additionally, some ethnic groups in the service area have higher proportions living in poverty than others. For example, the proportion of Black service area residents living below the federal poverty level (FPL) is higher than the state average, and Black households with children are also much more likely to be below FPL than other households with children in the service area. In the Greater Southern Alameda Area, community input suggests that affordable housing is a major issue. Community members also specifically mentioned that there are fewer well-paying jobs to make ends meet and residents are underemployed.

4. Nationally, more than 1 in 3 adults (81.1 million) live with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death respectively in the nation, **heart disease and stroke** result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease. Cardiovascular disease and stroke are health needs in the KFH-Fremont service area as demonstrated by a high rate of mortality from ischemic heart disease, which fails the Healthy People 2020 objective. Some ethnic groups in the service area have disproportionately higher rates of death than others from both heart disease and stroke. For example, the highest rates of heart disease mortality across the service area are found among Native Hawaiians/Pacific Islanders and Blacks. These ethnic groups also experience stroke mortality at much higher rates than HP2020 objective. The Black population in Alameda County also has higher proportions of residents with high blood pressure (AKA hypertension) and heart disease prevalence than other ethnic populations in the county. Community input indicates that the focus of concern is on the drivers of these diseases, diet and exercise. A key informant specifically indicated that there are increasing numbers of Afghani and Indian residents with cardiac problems.

5. **Substance abuse** has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide. Substance abuse (including tobacco and alcohol) is a health need in the KFH-Fremont service area as evidenced by the level of excessive alcohol consumption among adults, which is higher than the state average. Related to this, service area residents are spending a larger proportion of their household budgets on alcohol than Californians generally. In Alameda County, the rate of Emergency Room (ER) visits for substance abuse is higher than the state, and is especially high for Black county residents. The Greater Southern Alameda Area community expressed concern about having only one sobering center in the area, which is not sufficient to meet the need. The community also mentioned concerns about the growing number of residents addicted to prescription pain medication.

6. **Violence and intentional injury** contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. Violence and injury prevention are health needs the KFH-Fremont service area as demonstrated by a rate of school suspensions that is much higher than the state, and ethnic disparities in service area homicide rates. With regard to the latter, the populations of Blacks and Native Hawaiians/Pacific Islanders in the service area experience much higher rates of homicide than the HP2020 objective. Homicide rates are also worse in the city of Newark than in the rest of the KFH-Fremont service area. In Alameda County, indicators of violence such as rates of non-fatal ER visits for injuries due to both assault and domestic violence, and the rate of rapes, are all worse than state rates. In the Greater Southern Alameda Area, the community is especially concerned about domestic violence (DV), mentioning a lack of effective DV screening and few facilities/providers for DV victims. Community members also

worry about being attacked when they walk along the streets. The community felt there is a lack of empathy from health care and law enforcement towards victims.

7. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. **Healthcare access & delivery, including primary and specialty care,** is a health need in the KFH-Fremont service area as marked by wide disparities in insurance coverage across multiple racial and ethnic groups. Native Americans, Latinos, and those of "some other race" are uninsured in proportions that are more than double that of Whites in the service area. In Alameda County, a much higher percentage of people delayed or had difficulty obtaining care, and a smaller percentage of people had a usual source of care, compared to the respective HP2020 objectives. The Greater Southern Alameda Area community input indicates that insurance premiums and co-payments are too high and wait times for appointments are too long. The feedback also indicated that people lack knowledge of how the health system works and young people do not know how to access preventative care.

8. **Cancer** is a term used for diseases in which abnormal cells divide without control and can invade other tissues. It is the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening. Cancer is a health need in the KFH-Fremont service area as evidenced by incidence rates of breast, colorectal, and prostate cancer that are too high compared to HP2020 goals or state rates. Ethnic disparities exist: Cancer mortality rates and incidence rates were generally higher for Blacks and Whites in the service area compared to the state. Colorectal and cervical cancer incidence rates were also higher for Latinos in the service area. The Greater Southern Alameda Area community comments on cancer specifically focused on transportation issues, i.e., difficulty in getting to and from treatment.

9. **Asthma** is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life-threatening. Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and being overweight. Asthma is considered a significant public health burden and its prevalence has been rising since 1980. Asthma is a health need in the KFH-Fremont service area as marked by asthma prevalence rates among adults that are higher than the state average. Black asthma patients account for a larger proportion of hospital discharges in the service area than at the state level. In Alameda County, there is a greater proportion of children/teens with asthma compared to their age peers in the state. The Greater Southern Alameda Area community input about asthma was focused on younger children.

10. **Infectious diseases** are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood or semen). Infectious diseases remain a major cause of illness, disability, and death. People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on

the related consequences of infection. Infectious diseases, including sexually transmitted infections (STIs), are health needs in the KFH-Fremont service area as demonstrated by ethnic and age group disparities in HIV hospital discharges. Black service area residents comprised higher proportions of HIV hospital discharges compared to the state, while young service area residents (ages 1-19) comprised more than double the percentage of HIV hospital discharges compared to those age 20-44 in the service area. In Alameda County, the rate of HIV prevalence is higher than the state, and extraordinarily higher among Black county residents. Additionally, county residents have a higher rate of tuberculosis incidence than the HP2020 target and rising rates of pertussis. The Greater Southern Alameda Area community input suggests concerns that there was a lack of sexual health education and general healthy decision-making for teens.

11. The topic area of **maternal and child health** addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birth weight, infant mortality, teen births, breastfeeding, and access to prenatal care. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Maternal and infant health is a health need in the KFH-Fremont service area as evidenced by a rate of Head Start Program enrollment that is far below the state average. Also, the percentage of service area residents who experienced food insecurity at some point during the year is more than twice as high as the HP2020 goal. Finally, the proportion of Black households with children living below the Federal Poverty Level is higher in the service area than in the state. In the Alameda County, the infant mortality rate shows ethnic disparities, with the Black infant mortality rate disproportionately high. In the Greater Southern Alameda Area, community members felt that there was a lack of sexual health education and general healthy decision-making for teens.

For further details, please consult the Health Needs Profiles appended to this report as Appendix H.

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

Community resources available to respond to the community health needs are listed in Appendix G.

VII. KFH-FREMONT 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH-Fremont's 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Fremont's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit (http://share.kaiserpermanente.org/wp-content/uploads/2013/10/IS-Report-Fremont.pdf). For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-Fremont in the 2013 Implementation Strategy Report.

1. Access to Behavioral Health Care Services
2. Access to Affordable, Healthy Food
3. Access to a Safe and Healthy Environment
4. Access to Preventive Health Care Services

5. Broader Health Care System Needs in Our Communities

KFH-Fremont is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-Fremont tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-Fremont had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-Fremont will continue to monitor impact for strategies implemented in 2016.

B. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH-Fremont programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH-Fremont provided services for Medicaid beneficiaries, both members and non-members.

    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

    - Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

    - Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational

studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH-Fremont awarded 118 grants totaling $1,765,301 in service of 2013 health needs. Additionally, KP Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Fremont service area. During 2014-2015, a portion of money managed by this foundation was used to award 45 grants totaling $388,630 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH-Fremont donated several in-kind resources in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH-Fremont engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. **2013 Implementation Strategy Evaluation of Impact by Health Need**

PRIORITY HEALTH NEED I: ACCESS TO BEHAVIORAL HEALTH CARE SERVICES			
Long Term Goal: • Increase the number of residents, especially youth, who have access to appropriate behavioral health care services.			
Intermediate Goals: • Reduce barriers to behavioral health prevention and treatment programs among high-risk populations, especially youth • Decrease risks for mental, emotional, and behavioral disorders (including alcohol and other drug use) among high-risk populations, especially youth • Improve integration of primary care and behavioral health for high-risk populations, especially youth			
Grant Highlights			
Summary of Impact: During 2014 and 2015, there were 13 active KFH grants totaling $128,478 addressing Access To Behavioral Health Care Services in the KFH-Fremont service area.[7] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 4 grants totaling $48,929 that address this need. These grants are denoted by asterisks (*) in the table below.			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Abode Services	$30,000 in 2015 (even split with KFH-San Leandro)	Improve access to behavioral and mental health care among homeless individuals by building an interdisciplinary team, which is trained in the participant-centered, community-based Assertive Community Treatment (ACT) model of care, to offer integrated services. These services allow clients to access more regular primary care, manage medications, and avoid crises.	• 13 Health and Wellness Team members were trained • ACT implementation directly impacted 108 currently or formerly homeless people living with significant mental health disabilities and other complex needs • because of services provided through ACT, 93% of participants had fewer incidences of institutionalization or continued to avoid the necessity of institutionalization
Bay Area Women Against Rape (BAWAR)	$40,000 over 2 years $20,000 in 2014 & 2015 (even split with KFH-San Leandro)	Increase access to rape trauma syndrome support services for Spanish-speaking uninsured community members in the San Leandro, Hayward, Union City, Newark, and Fremont areas.	During 2014 and 2015: • 27 Spanish-speaking community members were recruited/trained to be state-certified rape crisis counselors; 14 passed the exams and were certified • extensive outreach campaign (visiting businesses, presentations, tabling,) was conducted, reaching 67,016 individuals • 2,116 counseling sessions were provided • two 10-session support groups were hosted

[7] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

			• 99 advocacy calls were made on behalf of Latino survivors of sexual assault • 99% of clients responding to a survey said the counseling services increased their mental health and confidence, and reduced their stress levels; and 100% said it helped them deal effectively with triggers.
National Alliance on Mental Illness Alameda County South (NAMI ACS)	$60,000 over 2 years $30,000 in 2014 & 2015 (even split with KFH-San Leandro)	Provide peer mentors to patients prior to being discharged from mental health facilities. The goal of the Mentors on Discharge program is to reduce patient re-hospitalization rates or to increase the length of time between re-hospitalizations.	2014: Of 28 mentor requests at John George Psychiatric Hospital, 20 patients were connected with a mentor. Of 10 mentor requests at Telecare Heritage Hospital, 7 were connected with a mentor. Of the 27 mentees, only one was re-hospitalized (less than 1% readmission rate. There were also 13 additional peer mentors who completed training and qualify as peer mentors through this program. • 29 of 34 (85%) mentor requests at John George Psychiatric Hospital were fulfilled • one mentor request was received and fulfilled at Telecare Heritage Hospital • among the 30 mentoring participants, nine (30%) were re-hospitalized • the number of days between re-admission was 75, greater than the 60-day baseline
Tri-City Health Center	$26,000 in 2015 (even split with KFH-San Leandro)	Provide comprehensive behavioral health services to identify, treat, and manage depression and other mental health issues among low-income youth.	• all pediatric patients 12 to 18 were screened for depression symptoms using PHQ-9 and PHQ-2, components of the evidence-based Patient Health Questionnaire screening tool • of 876 screened, 11% had a positive result • 95% of these patients were referred to a behavioral health provider (BHP) • almost 50% of referred patients were seen by a BHP; the others are either scheduled to be seen or declined services • pediatric providers/medical assistants and BHPs were trained on the integrated behavioral health program for pediatrics

City of Fremont, Youth and Family Services	$30,000 in 2014	Increase access to mental health services for Chinese youth and families by implementing culturally responsive psycho-education workshops for parents and the community.	Three workshops (85 attendees) and one parenting education family retreat (25 attendees), all focused on at-risk youth, were held in community settings. Topics included emotional health, bicultural parenting, effective communication skills, mental health symptoms, and stigma reduction. An educational PSA designed to increase awareness of and reduce stigma about mental health issues was developed. Informational brochures (*Anxiety Disorders* and *What is Counseling?*) were created in Mandarin and English. More than 100 people received brochures and referrals for mental health resources.

PRIORITY HEALTH NEED II: ACCESS TO AFFORDABLE, HEALTHY FOOD

Long Term Goal:

- Improve health and reduce obesity through the consumption of healthy foods

Intermediate Goals:

- Increase healthy eating among low-income youth and adults
- Expand policies that support easier access to affordable and healthy foods

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 37 active KFH grants totaling $324,607 addressing Access to Affordable, Healthy Food in the KFH-Fremont service area.[8] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 10 grants totaling $75,262 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Alameda County Community Food Bank	$40,000 over 2 years $10,000 in 2014 $30,000 in 2015 (even split with KFH-San Leandro)	To increase access to healthy food, the Food Bank's mobile pantry program partnered with four elementary schools in low-income, underserved Hayward and Newark neighborhoods to distribute nutritious foods and provide mini-nutrition education lessons and nutrition workshops. Food included peanut butter, canned tuna and chicken,	The food bank conducted two food distributions in 2014 where an average of 140 low-income households received 4,955 pounds of food (4,129 meals). In 2015, an average of 321 families (1,539 people) participated each month. Between January and September, 53,127 pounds of food (44,272 meals), including 27,610 pounds of produce (23,008 meals) were distributed. 833,381

[8] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

		brown rice, black/pinto beans, lentils, oatmeal, cereal, and low-fat milk.	pounds of produce (694,000 meals) were also distributed through a network of member agencies
Afghan Elderly Association	$25,000 in 2014	Provide culturally responsive nutritional education and increase access to low income Afghan seniors living in the Fremont area.	Afghan seniors (92) toured grocery stores; surveys showed that they learned where to buy and how to choose healthy, affordable foods at lower costs. Five cooking demos reached 70 to 80 new people each time. Ninety seniors attended an Afghan potluck that included cooked food and an educational presentation that emphasized eating less oil, salt, sugar, and saturated fat. A cookbook featuring healthy Afghan recipes (with nutritional labels and strategies for cooking affordable meals with low calorie ingredients) was published and distributed to 1,000 seniors.
Community Alliance With Family Farmers (CAFF)	$165,000 (over two years; $75,000 in 2015) This grant impacts five KFH hospital service areas in Northern California Region.	CAFF will help family farmers compete in larger markets and institutions and allow those markets and institutions to access locally sourced food through its supply chains.	• four hospitals and three school districts worked to increase their produce purchases through aggregated demand • four family farmers are now selling to the seven institutions • 257 participants learned farm-to-institution strategies at Farm-to-School Network conference
*Regional Parks Foundation	$85,000 in 2015 This grant impacts six KFH hospital service areas in Northern California Region.	Regional Parks Foundation will connect underserved and vulnerable communities to outdoor recreation opportunities within East Bay Regional Parks District (EBRPD). With a focus on increasing park access and engagement of at-risk youth, seniors, and communities of color that under-utilize parks, EBRPD staff will conduct targeted outreach, and offer transportation and programming tailored for the target populations. EBRPD staff will undergo cultural competency training to build capacity and to welcome and engage the intended communities.	Expected reach is 2,550 people and expected outcomes include: • 450 individuals from multi-ethnic communities enjoy park programs designed to increase physical activity, social cohesion, and connections to nature • 960 seniors get free transportation to outdoor physical activities to increase healthy living, flexibility, sensory perceptions, and social connections • 840 low-income youth participate in summer day camp programs at various EBRPD parks • up to 300 EBRPD staff take part in cultural competency training to more effectively encourage all communities to feel safe engaging in outdoor activities in EBRPD

*Golden Gate National Parks Conservancy	$300,000 over 2 years $150,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region	Golden Gate National Parks Conservancy and Institute at the Golden Gate will coordinate the Healthy Parks Healthy People (HPHP) Bay Area program, a collaborative of park and health agencies designed to increase the accessibility and use of parks for activities that promote health.	Expected reach is 10,000 people and expected outcomes include: • HPHP program leaders trained to run effective park programs that engage target populations, including low-income, ethnic minorities, high-risk youth, seniors, and those referred by health care and social service providers • to ensure long-term sustainability, at least one person at each park agency is trained as an HPHP programming trainer • all nine Bay Area public health departments/ health systems actively prescribe HPHP for at-risk youth, seniors, ethnic minorities, and low-income community residents • an HPHP blueprint model/toolkit based on lessons learned in the Bay Area is created for other parts of California and the U.S.

Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/Partnership Goal	Results to Date
Alameda County Obesity Prevention Program	To learn and be informed about activities regarding healthy food education and access in Alameda County, to build relationships for future collaboration between agencies, and to link resources to current grantees.	The collaborative's efforts have increased the knowledge of current activities and policies happening within the KFH-Fremont service area.

In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Alameda County Obesity Prevention Program	200 reusable fruit bags were donated to Alameda County Obesity Prevention Program to be distributed to families participating in its spring healthy food programs in the Fremont area.

Impact of Regional Initiatives

Parks Initiative:

The physical and mental health benefits of experiencing nature and outdoor physical activity are well-documented. Kaiser Permanente's investments in parks focus on increasing access to and use of safe parks and open spaces by low-income, underserved populations that have historically faced significant obstacles in accessing parks. By connecting people to parks, creating infrastructure enhancements in parks, and supporting policies to advance sustainability and improve culturally available services within park departments, we also aim to increase the competencies of local, regional, state, and national parks to effectively engage diverse communities. In addition to our monetary contributions, we are expanding volunteer opportunities in parks for Kaiser Permanente physicians and employees.

PRIORITY HEALTH NEED III: ACCESS TO SAFE AND HEALTHY ENVIRONMENTS

Long Term Goals:

- Improve safety and intentional injury prevention in high-risk, underserved communities

Intermediate Goals:

- Provide alternative opportunities for youth who are at high risk for violence
- Create safe environments where people live, work, play, and go to school

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 19 active KFH grants totaling $227,047 addressing Access to Safe and Healthy Environments in the KFH-Fremont service area.[9] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 4 grants totaling $71,676 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Afghan Coalition	$20,000 in 2015	Provide services to reduce patterns of domestic violence and youth-on-youth violence in the Afghan community and to promote positive skills among Afghan families to resolve conflicts and modify cultural practices that isolate women and children through physical and emotional abuse.	• 64 individuals and families were reached through support groups and counseling • pre/post surveys showed that more than 80% of participants make better choices when they are in a conflict situation; 93% better recognize their own part in conflicts and are able to apologize • Afghan Coalition staff were interviewed on Afghan TV about domestic violence prevention and the family unit, reaching at least 10,000 • an event celebrating the achievements of women in the Afghan community was held; 300 people attended and even more were exposed via Afghan TV • a domestic violence brochure was created and will be widely distributed
East Bay Agency for Children	$30,000 in 2015	Increase child assault prevention efforts and mandated reporting workshops to include Newark elementary schools; thereby benefiting a minimum of 840 previously unserved students and adults.	891 Newark Unified School District students, parents, teachers, and administrators attended 46 child assault prevention workshops: • adult skills-based workshops cover rights/ responsibilities; definitions of assault and abuse; responding to a child in crisis; and misconceptions about victims/offenders

[9] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

			• children's workshops teach skills/tools to handle unsafe, abusive situations (bullying, cyberbullying, child abduction, internet safety, and sexual assault), and include interactive and age-appropriate role play and practice • evaluations showed that 90% of adults increased their ability to make referrals, respond to a child in crisis, access support services, understand rights/responsibilities, reinforce prevention strategies, and recognize common misconceptions • 80% of children showed increased ability to stand up for themselves or others • 75% of children demonstrated their ability to retain training information and remember strategies taught
Eden Youth and Family Center	$150,000 over 2 years $75,000 in 2014 & 2015 (even split with KFH-San Leandro)	Eden's tattoo removal program provides bi-monthly laser treatments to remove visible tattoos, access to real-world work experience through volunteer commitments, monthly peer support groups, and resources for youth to transition out of the gang/drug lifestyle and to become productive members of society. It aims to help youth make better life choices by providing positive alternatives so that they can distance themselves from past gang and/or drug involvement.	During 2014 and 2015 there were 355 tattoo removal program participants; reached through recruitment efforts in schools, juvenile justice hall and justice center, and the community. Four peer support groups were held in Fremont, Hayward and San Leandro, and Community service commitment placements were made for program participants. 50 participants completed the 25-hour community service commitment; the others are working towards that goal.
Niroga Institute	$30,000 in 2015	Niroga's Dynamic Mindfulness curriculum aims to decrease bullying and violent behavior, to heal trauma, and to interrupt the cycle of violence. The goal is to provide skills in stress resilience, self-awareness, self-regulation, and healthy relationships to students and teachers of two underserved elementary schools to support community safety.	• Niroga teachers facilitated twice weekly Dynamic Mindfulness practice lessons in 21 classrooms at the two schools • pre/post assessment showed substantial and statistically significant improvements in prosocial behavior, motivation to learn, reading scores, and math scores • Niroga provided a training and eight follow-up sessions to prepare teachers and school administrators to facilitate Dynamic Mindfulness in their classrooms

*Alameda County Family Justice Center (ACFJC)	$90,000 in 2015 This grant impacts three KFH hospital service areas in Northern California Region.	ACFJC will implement STEP-UP (Survivor Training and Empowerment Program-Utilizing your Potential) to empower domestic violence (DV) survivors by offering computer and financial literacy training, professional development classes, empowerment workshops, and English as a Second Language (ESL) tutoring.	Anticipated reach is 200 DV survivors. The aim is for participants to: • understand their personal finances, the importance of managing debt, and how to create a budget • develop personal strengths, skills, and barriers • have a basic resume and cover letter • learn interview skills • find and apply for jobs they find interesting • remain employed

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Kidango	On Kaiser Permanente's Martin Luther King Day of Service, 30 Kaiser Permanente employees volunteered their time to beautify the exterior of Kidango. They cleaned and repainted the building walls, painted kid friendly images on a toy shed and created a garden.
Milani Elementary	At the KP Educational Theater *Peace Signs* Family Night, CB staff were on staff and families were able to openly chat and ask questions about resources available to them.
Safe Alternatives to Violent Environments (SAVE)	As part of a care package, 50 umbrellas were distributed to SAVE clients to help them transition into safer environments.

PRIORITY HEALTH NEED IV: ACCESS TO PREVENTIVE HEALTH CARE SERVICES

Long Term Goal:

- Increase the number of individuals who have access to and receive appropriate health care services

Intermediate Goal:

- Increase the number of low-income people who enroll in or maintain health care coverage
- Increase the number of low-income, uninsured people who have access to health care
- Increase access to culturally competent, high-quality health care services for low-income, uninsured individuals

KFH-Administered Program Highlights		
KFH Program Name	**KFH Program Description**	**Results to Date**
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 3,917 Medi-Cal members* • *2015: 3,095 Medi-Cal members*

Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $2,048,886* • *2014: 1,239 Applications approved* • *2015: KFH - Dollars Awarded By Hospital - $1,213,353* • *2015: 1,166 Applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 927 members receiving CHC* • *2015: 813 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 33 active KFH grants totaling $1,016,106 addressing Access to Preventive Health Care Services in the KFH-Fremont service area.[10] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 16 grants totaling $108,211 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Alameda Health Systems Foundation/Alameda Health System (AHS)	$400,000 over 2 years $200,000 in 2014 & 2015 This grant impacts three KFH hospital service areas in Northern California Region.	Implementation of PHASE (Prevent Heart Attacks And Strokes Everyday) will allow AHS to improve care provided to people at risk of cardiovascular disease. AHS will focus on adults seen in its ambulatory clinics who have uncontrolled diabetes or hypertension. It will implement/advance the use of multidisciplinary care teams, clinical guidelines, health coaching protocols, and clinic/provider dashboards to improve health outcomes.	• AHS has 5,327patients in the PHASE program. • establishing standard data report with quality, accurate, usable data improved clinicians' ability to use clinical data at point of care • comprehensive assessments at two clinic sites identified key operational and systems areas needing improvement • co-visits with nurses and providers, using a developing standard of work flow, increased effectiveness of team-based care
Community Health Center Network (CHCN)	$400,000 over 2 years $200,000 in 2014 & 2015 This grant impacts three KFH hospital service areas in Northern California Region.	Supports CHCN's successful use of PHASE among member health centers by: • optimizing EHR (electronic health record) protocols to include prompts for better chronic disease management • expanding eligible patients to include best practices in hypertension management • driving clinical data analytics at the provider level to fuel practice improvement	• 34,044 CHCN patients are in the PHASE program. • sophisticated technology data analytics tool means standardized data can now be reported by provider, by clinic site, and across the consortia, increasing the ability to use data in decision making at multiple levels • improved access to clinical, pharmacy, and claims data increased CHCN's ability to provide targeted PHASE medication counselling

[10] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

			• training clinics sites how to use data to drive improvement increased staff data literacy skills and ability to use data to drive decisions
*Operation Access (OA)	$300,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region.	Core support to organize OA's network of 41 medical centers and 1,400 medical professionals who donate surgical, specialty, and diagnostic services to 1,500 low-income, uninsured people residing in nine Bay Area counties.	With 1,274 staff/physician volunteers providing more than 700 services at 14 hospitals in 2015, Kaiser Permanente is the largest health system participant. In 2014 and 2015 a total of 76 procedures were performed on 59 low-income and uninsured patients at Operation Access events at KFH Fremont.
Alameda Health Consortium (AHC)	$250,000 over two years $125,000 in 2014 & 2015 This grant impacts three KFH hospital service areas in Northern California Region.	AHC will work with community health centers (CHC) to plan and prepare for upcoming state changes in Medi-Cal payments and new state policies that emphasize Triple Aim to improve care for patients with complex physical and behavioral health conditions. AHC serves eight health center corporations who serve 184,000 patients.	• secured $20M commitment for FY 2015-16 from Alameda County Board of Supervisors to subsidize health center services for 21,000 low-income uninsured patients and to improve access and behavioral health integration • along with other regional/national consortia associations, effectively advocated Congress to extend federal CHC funding to 2017 • collaborated with the county; provided training/ technical assistance on integrated behavioral health to CHCs, increasing the number of patients seen by a behavioral health provider from 5,000 in 2009 to 12,000 in 2014 (240%) • secured Mental Health Services Act funding for eight FQHCs to each create a new care coordinator position to support referrals and care transitions of patients moving between FQHCs and specialty mental health organizations • led FQHC payment reform efforts • payment reform pilots were included in California's 1115 Medicaid waiver proposal approved by CMS 12/30/15

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Alameda County Funders Forum	This coalition of funders contributes to Alameda County agencies.	The Forum meets regularly to share resources and to identify trends and gaps within Alameda County

Fremont Funders Collaborative	Collaborative members exchange information, ideas, and resources about grant making and identify community-based organizations in Fremont and Newark	Funders were introduced and connected to some of the nonprofit community-based organizations in the Fremont/Newark area that KFH-Fremont has funded.
Asian American Donor Program (AADP)	To engage and recruit individuals to register to become a potential bone marrow donor.	KFH-Fremont supported AADP by providing a recruitment table at the KFH-Fremont farmers' market.
South County Partnership Collaborative	Health clinics exchange information, ideas, and resources on serving South County.	Kaiser Permanente was able to identify community needs and strengthen safety net partnerships.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
HERS Breast Cancer Foundation	Reusable fruit bags were distributed to 1,000 participants in the 16th Annual HERS Breast Cancer Foundation Walk/Run.
Operation Access (OA)	KP physicians and staff donated a total of 1196 hours of time volunteering at OA events at KFH Fremont in 2014 and 2015
LIFE Elder Care	Pill boxes were distributed to 200 active participants in LIFE Elder Care programs.
Tri-City Health Center (TCHC)	• 130 pieces of office furniture from San Leandro construction trailers • 30 KP employee volunteers organized medical records and eliminated old records for MLK Jr Day of Servic • In-kind communications support helped develop, design, and print patient handbooks for distribution to 20,000 TCHC patients.
All PHASE Grantees	To increase clinical expertise in the safety net, Quality and Operations Support (QOS), a Kaiser Permanente Northern California Region TPMG (The Permanente Medical Group) department, helped develop a PHASE data collection tool. QOS staff provided expert consultation on complex clinical data issues, such as reviewing national reporting standards, defining meaningful data, and understanding data collection methodology. This included: • conducting clinical training webinars • wireside/webinar on PHASE clinical guidelines • presentation at convening on Kaiser Permanente's approach to PHASE • presentation to various clinical peer groups through CHCN, SFCCC, etc. • individual consultation to staff at PHASE grantee organizations • individual consultation to Community Benefit Programs staff Kaiser Permanente Northern California Region's Regional Health Education (RHE) also provided assistance to PHASE grantees: • conducted two seven-hour Motivating Change trainings (24 participants each) to enable clinical staff who implement (or will) PHASE to increase their skills with regard to enhancing patients' internal motivations to make health behavior changes • provided access to patient education documents related to PHASE
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.

Impact of Regional Initiatives
PHASE: PHASE (Prevent Heart Attacks And Strokes Everyday) is a program developed by Kaiser Permanente to advance population-based, chronic care management. Using evidence-based clinical interventions and supporting lifestyle changes, PHASE enables health care providers to provide cost-effective treatment for people at greatest risk for developing coronary vascular disease. By implementing PHASE, Kaiser Permanente has reduced heart attacks and stroke-related hospital admissions among its own members by 60%. To reach more people with this life saving program, Kaiser Permanente began sharing PHASE with the safety net health care providers in 2006. KP provides grant support and technical assistance to advance the safety net's operations and systems required to implement, sustain and spread the PHASE program. By sharing PHASE with community health providers, KP supports development of a community-wide standard of care and advances the safety net's capacity to build robust population health management systems and to collectively reduce heart attacks and strokes across the community.

PRIORITY HEALTH NEED V: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE

KFH Workforce Development Highlights
Long Term Goal: • To address health care workforce shortages and cultural and linguistic disparities in the health care workforce
Intermediate Goal: • Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care
Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 16 Workforce Development grants totaling $69,063 that served the KFH-Fremont service area.[11] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 9 grants totaling $53,210 that address this need. In addition, KFH Freemont provided trainings and education for 14 residents in their Graduate Medical Education program in 2014 and 12 residents in 2015, 17 nurse practitioners or other nursing beneficiaries in 2014 and 5 in 2015, and 10 other health (non-MD) beneficiaries as well as internships for 21 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
*Vision Y Compromiso	$98,093 in 2015 This grant impacts 16 KFH hospital service areas in Northern California Region	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities

[11] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

			• increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks
*Diversity in Health Training Institute	$95,000 in 2015 This grant impacts eight KFH hospital service areas in Northern California Region	The Institute will help members of immigrant and refugee communities in Alameda and Contra Costa counties work towards careers in health care through training and providing access to educational resources, and by expanding job readiness for work in allied health professions.	Expected reach is 60 participants, with at least 48 completing the program and achieving one or more of the following: • improved English language and workplace skills • work experience in a health care setting • increased job readiness and employment skills, with some leading to job training or jobs in allied health • enroll in/complete a health care education program or attain a license or certificate • secure financial aid • maintain/advance in a health care job
*Students Rising Above (SRA)	$50,000 in 2015 This grant impacts 15 KFH hospital service areas in Northern California Region	SRA's College2Careers program enables low-income, first-generation college students from the greater Bay Area to attain college degrees and enter careers in science, technology engineering and math (STEM) and health care through college preparation, college and financial aid application support, tutoring, health care, tuition assistance, career development, mentoring, internships, and college-to-workforce transition support.	Anticipated outcomes include • through College2Careers' tutoring workshops and webinars, 182 youth in SRA's College and Workforce Success Program gain the job readiness skills and knowledge needed for STEM and health care careers • via online webinars and informational interview videos with professionals from underserved socio-economic communities, more than 200 users of the web-based resource College2CareersHub are encouraged to consider majoring in STEM/health care fields
*Physicians Medical Forum (PMF)	$150,000 in 2015 This grant impacts 16 KFH hospital service areas in Northern California Region	PMF's Doctors On Board (DOB) Pipeline and Community Health Ambassadors (CHA) programs aim to increase the pipeline of African American and other under-represented minority medical students, residents, and physicians in Northern California who want to pursue careers in medicine. Through DOB, health care professionals mentor students and workshops help students prepare for the	Anticipated outcomes include: • 250 DOB students mentored annually by faculty, physicians, medical students, residents, and other health care professionals • 250 DOB students participate in workshops to prepare them for SAT/MCAT tests, essay/ writing skills, and interviewing/communication skills • 25 CHA students work with medical students, residents, and physicians to become prepared for medical school and with community-based

		process of working towards a health care career. Through CHA, students work in teams with community-based organizations to design and help implement health education programs to improve the health of their communities and better prepare them for health care careers.	organizations to develop multimedia community service/learning projects on a health-related topic

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Soulciety	Support for the REACH Rescue EMT Program.	REACH students have clinical assignments in the emergency departments at KFH-San Leandro and KFH-Fremont. Thus far, two rotations of students have gone through the program.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Arroyo High School	• A CB staff member spoke to 30 11th graders about non-traditional health care career options. After the presentation, two students reached out with additional questions. • 25 students participated in a KFH-San Leandro Emergency Department disaster drill. Appropriately made-up, they portrayed victims and helped hospital staff train and practice their skills in the event of a disaster. Participating students received t-shirts and reusable fruit bags.
Winton Middle School	A physical therapist, pharmacist, and nurse represented Kaiser Permanente at the school's Career Day and answered career-related questions from 7th and 8th graders.
REACH Ashland Youth Center	Two pharmacists represented Kaiser Permanente at the youth center's Career Day and answered career-related questions from youth members of the REACH Ashland Youth Center.
Chavez Middle School / FACES of the Future Coalition	CB staff participated in a site-visit to show support for the FACES program. More than 500 Chavez students attended four presentations on health topics such as exercise and drug use that were conducted by students in the FACES program. KFH-San Leandro also provided 25 reusable water bottles.
Soulciety	Two Kaiser Permanente staff, a physical therapist and a nurse, mentored two Soulciety interns and helped guide them towards pursuing careers in physical therapy and nursing.

PRIORITY HEALTH NEED V: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH

KFH Research Highlights
Long Term Goal: • To increase awareness of the changing health needs of diverse communities
Intermediate Goal:

- **I**ncrease access to, and the availability of, relevant public health and clinical care data and research

Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
UCLA Center for Health Policy Research	$2,100,000 over 4 years 1,158,200 over 2014 & 2015 This grant impacts all KFH hospital service areas in Northern California Region.	Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.	CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews. In addition, funding has supported the AskCHIS NE tool which has allowed the Center to: • Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology. • Develop and deploy AskCHIS NE. • Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

In addition to the CHIS grants, two research programs in the Kaiser Permanente Northern California Region Community Benefit portfolio – the Division of Research (DOR) and Northern California Nursing Research (NCNR) – also conduct activities that benefit all Northern California KFH hospitals and the communities they serve.

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

DOR Projects	Project Information
Central Research Committee (CRC)	Information on recent CRC studies can be found at: **http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx**
Clinical Research Unit (CCRU)	CCRU offers consultation, direction, support, and operational oversight to Kaiser Permanente Northern California clinician researchers on planning for and conducting clinical trials and other types of clinical research; and provides administrative leadership, training, and operational support to more than 40 regional clinical research coordinators. CCRU statistics include more than 420 clinical trials and more than 370 FDA-regulated clinical trials. In 2015, the CCRU expanded access to clinical trials at all 21 KPNC medical centers.
Research Program on Genes, Environment and Health (RPGEH)	RPGEH is working to develop a research resource linking the EHRs, collected bio-specimens, and questionnaire data of participating KPNC members to enable large-scale research on genetic and environmental influences on health and disease; and to utilize the resource to conduct and publish research that contributes new knowledge with the potential to improve the health of our members and communities. By the end of 2014, RPGEH had enrolled and collected specimens from more than 200,000 adult KPNC members, had received completed health and behavior questionnaires from more than 430,000 members; and had genotyped DNA samples from more than 100,000 participants, linked the genetic data with EHRs and survey data, and made it available to more than 30 research projects

A complete list of DOR's 2015 research projects is at **http://www.dor.kaiser.org/external/dorexternal/research/studies.aspx**. Here are a few highlights:

Research Project Title	Alignment with CB Priorities
Risk of Cancer among Asian Americans (2014)	Research and Scholarly Activity
Racial and Ethnic Disparities in Breastfeeding and Child Overweight and Obesity (2014)	Healthy Eating, Active Living
Transition from Healthy Families to Medi-Cal: The Behavioral Health Carve-Out and Implications for Disparities in Care (2014)	Access to Care Mental/Behavioral Health
Health Impact of Matching Latino Patients with Spanish-Speaking Primary Care Providers (2014)	Access to Care
Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention – Susan Brown	Access to care
Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young – Steven Sidney	Access to care
Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes – Monique Hedderson	Access to care
Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs – Susan Brown	HEAL
The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization – Kelly Young-Wolff	HEAL
Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention – Cynthia Campbell	Mental/Behavioral Health
Integrating Addiction Research in Health Systems: The Addiction Research Network – Cynthia Campbell	Mental/Behavioral Health
RPGEH Project Title	**Alignment with CB Priorities**
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity

RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

The main audience for NCNR-supported research is Kaiser Permanente and non-Kaiser Permanente health care professionals (nurses, physicians, allied health professionals), community-based organizations, and the community-at-large. Findings are available at the Nursing Pathways NCNR website: https://nursingpathways.kp.org/ncal/research/index.html,

Alignment with CB Priorities	Project Title	Principal Investigator
Serve low-income, underrepresented, vulnerable populations located in the Northern California Region service area	**1.** *A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.* **2.** *Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.*	**1.** Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing **2.** Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University
Reduce health disparities.	**1.** *Making sense of dementia: exploring the use of the markers of assimilation of problematic experiences in dementia scale to understand how couples process a diagnosis of dementia.* **2.** *MIDAS data on elder abuse reporting in KP NCAL.* **3.** *Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.* **4.** *Transforming health care through improving care transitions: A duty to embrace.* **5.** *New trends in global childhood mortality rates.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA **3.** Tracy Trail-Mahan, et al., KFH-Santa Clara **4.** Michelle Camicia, KFH-Vallejo Rehabilitation Center **5.** Deborah McBride, KFH-Oakland
Promote equity in health care and the health professions.	**1.** *Family needs at the bedside.* **2.** *Grounded theory qualitative study to answer the question, "What behaviors and environmental factors contribute to emergency department nurse job fatigue/burnout and how pervasive is it?"* **3.** *A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.* **4.** *Electronic and social media: The legal and ethical issues for health care.* **5.** *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center **2.** Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED. **3.** Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL **4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. CONCLUSION

KFH-Fremont worked in collaboration with other non-profit hospitals in Alameda and Contra Costa counties to meet the requirements of the federally required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and doing new primary research as a team, the Hospitals were able to collectively understand the community's perception of health needs and prioritize health needs with an understanding of how each compares against benchmarks.

After making this CHNA report publicly available in 2016, our hospital will develop individual implementation plans based on this shared data.

IX. APPENDICES

A. Secondary Data Sources and Dates

B. List of Indicators on Which Data Were Gathered

C. Persons Representing the Broad Interests of the Community

D. Glossary

E. 2016 Health Needs Prioritization Scores: Breakdown by Criteria

F. CHNA Qualitative Data Collection Protocols

G. Community Assets and Resources

H. Health Needs Profiles

APPENDIX A: Secondary Data Sources and Dates

1. Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
2. Alameda County Public Health Department. http://www.healthyalamedacounty.org/ . Various.
3. California Department of Education. 2012-2013.
4. California Department of Education. 2013.
5. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
6. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
7. California Department of Public Health, CDPH – Breastfeeding Statistics. 2012.
8. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
9. California Department of Public Health, CDPH – Tracking. 2005-2012.
10. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
11. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
12. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
13. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
15. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
16. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
17. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
18. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
19. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
20. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
21. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
22. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
23. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
24. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
25. Centers for Medicare and Medicaid Services. 2012.
26. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
27. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
28. Environmental Protection Agency, EPA Smart Location Database. 2011.
29. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
30. Feeding America. 2012.
31. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
32. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
33. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.

34. New America Foundation, Federal Education Budget Project. 2011.
35. Nielsen, Nielsen Site Reports. 2014.
36. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
37. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
38. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
39. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS Neighborhood Edition. 2015.
40. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS. 2015.
41. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
42. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
43. US Census Bureau, American Community Survey. 2009-2013.
44. US Census Bureau, American Housing Survey. 2011, 2013.
45. US Census Bureau, County Business Patterns. 2011.
46. US Census Bureau, County Business Patterns. 2012.
47. US Census Bureau, County Business Patterns. 2013.
48. US Census Bureau, Decennial Census. 2000-2010.
49. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
50. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
51. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
52. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
53. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
54. US Department of Education, EDFacts. 2011-2012.
55. US Department of Health & Human Services, Administration for Children and Families. 2014.
56. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
57. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
58. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
59. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
60. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Healthy People 2020. http://www.healthypeople.gov/ . 2015.
61. US Department of Housing and Urban Development. 2013.
62. US Department of Labor, Bureau of Labor Statistics. June 2015.
63. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
64. US Drought Monitor. 2012-2014

APPENDIX B: List of Indicators on Which Data Were Gathered

Indicator Variable	Data Source
Age 0-4 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 18-24 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 25-34 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 35-44 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 45-54 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 5-17 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 55-64 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 65+ (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Assault Injuries Rate (per 100,000 Population)	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Assault Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Asthma Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data, additional data analysis by CARES, 2011, **and** Alameda County Public Health Department. Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.

Indicator Variable	Data Source
Asthma Prevalence (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Average Daily School Breakfast Program Participation Rate	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program. 2013.
Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
BMI > 30.0 Prevalence (Obese) (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
Breast Cancer Deaths (Rate per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Childhood (0-14) Asthma Hospitalization Rate (per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Children and Teens with Asthma (1-17) (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Children Who Visited Dentist Within Past 12 Months (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Chlamydia Infection Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2012.
Cigarette Expenditures, Percentage of Total Household Expenditures	Nielsen, Nielsen Site Reports. 2014.
Colorectal Cancer Deaths Rate (per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Coronary Heart Disease Hospitalization Rate (per 100,000 (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Dentists, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
Depression (Percentage, Medicare Beneficiaries)	Centers for Medicare, and, Medicaid, Services. 2012.
Diabetes Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diagnosed Diabetes Prevalence (Age-Adjusted) (Percentage,	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health

Indicator Variable	Data Source
Adults)	Promotion, 2012, and Alameda County Public Health Department, Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Disability (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Domestic Violence Injuries Rate (per 100,000 Population (Females Age 10+))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Drought Weeks (Any) (Percentage)	US, Drought, Monitor. 2012-14.
Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Fast Food Restaurants, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Federally Qualified Health Centers, Rate (per 100,000 Population)	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
Female Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Food Insecurity (Percentage, Population)	Feeding, America. 2012.
Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Full Immunization at 24 Months (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Gini Index Value (Income Inequality)	US Census Bureau, American Community Survey. 2009-13.
Grade 4 ELA Test Score Not Proficient (Percentage)	California, Department of Education., 2012-13.
Grocery Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Head Start Programs Rate (Per 10,000 Children Under Age 5)	US Department of Health & Human Services, Administration for Children and Families. 2014.
Heart Disease Prevalence (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Heat-related Emergency Department Visits, Rate (per 100,000 Population)	California Department of Public Health, CDPH - Tracking. 2005-12.
Hemoglobin A1c Test, Annual (Percentage, Medicare Enrollees with Diabetes)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
High Blood Pressure and Not	Centers for Disease Control and Prevention, Behavioral

Indicator Variable	Data Source
Taking Medication (Percentage, Adults)	Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
High Blood Pressure Prevalence (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
High School Cohort Graduation Rate	California, Department of Education. 2013.
Hispanic or Latino (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HIV Hospitalizations Age-Adjusted Discharge Rate (per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Households where Housing Costs Exceed 30% of Income (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HUD-Assisted Units, Rate (per 10,000 Housing Units)	US Department of Housing and Urban Development. 2013.
Inadequate Fruit / Vegetable Consumption (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09.
Inadequate Fruit/Vegetable Consumption (percentage, Population Age 2-13)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Income at or Below 200% FPL (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Infant Mortality Rate (Per 1, 000 Births)	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.
Insured Population Receiving Medicaid (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Intentional Injuries, Rate (per 100,000 Population (Youth Age 13 - 20))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Limited English Proficiency (Percentage, Population Age 5+)	US Census Bureau, American Community Survey. 2009-13.
Linguistically Isolated Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Liquor Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Live Within 1/2 Mile of a Park (Percentage, Population)	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.
Live within Half Mile of Public Transit (Percentage, Population)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Living in a HPSA-Dental (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health

Indicator Variable	Data Source
	Resources and Services Administration. March 2015.
Living in a HPSA-Primary Care (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.
Living in Car Dependent (Almost Exclusively) Cities (Percentage)	Walk Score®. 2012.
Low Birth Weight Births (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Low Food Access (Percentage, Population)	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.
Male Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Mammogram in Past 2 Year (Percentage, Female Medicare Enrollees)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
Median Age	US Census Bureau, American Community Survey. 2009-13.
Mental Health Care Provider Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2014.
Missed School Days Due to Dental Problem (At Least One Day) (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Mothers Breastfeeding (Any) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers Breastfeeding (Exclusively) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers with Late or No Prenatal Care (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Never Screened for HIV / AIDS (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
No Air Conditioning (Percentage, Housing Units)	US Census Bureau, American Housing Survey. 2011, 2013.
No High School Diploma (Percentage, Population Age 25+)	US Census Bureau, American Community Survey. 2009-13.
No Leisure Time Physical Activity (Percentage, Population)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
No Motor Vehicle (Percentage, Households)	US Census Bureau, American Community Survey. 2009-13.
Obese Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Obesity (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012, and UCLA Center for Health Policy Research, AskCHIS, 2015.
Occupied Housing Units with One or More Substandard Conditions	US Census Bureau, American Community Survey. 2009-13.

Indicator Variable	Data Source
(Percentage)	
Overweight (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Ozone (03) - Days Exceeding Standards, Pop. Adjusted Average (Percentage)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Particulate Matter 2.5 - Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
People Delayed or had Difficulty Obtaining Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
People with a Usual Source of Health Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Physically Inactive Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccination (Age-Adjusted) (Percentage, Population Age 65+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Poor Dental Health (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor Mental Health (Percentage, Adults 18+)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Poor or Fair Health (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Population Change, 2000-2010 (Percentage)	US Census Bureau, Decennial Census. 2000 - 2010.
Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2009-13.
Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Population with HIV / AIDS, Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2010.
Potentially Exposed to Unsafe Drinking Water (Percentage, Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Poverty (Percentage, Population)	US Census Bureau, American Community Survey.

Indicator Variable	Data Source
	2009-13.
Poverty, Children (Percentage, Population Under Age 18)	US Census Bureau, American Community Survey. 2009-13.
Pre-School Enrollment (Percentage, Population Age 3-4)	US Census Bureau, American Community Survey. 2009-13.
Preventable Hospital Events Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Primary Care Physicians, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
Rape Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Rate of Reported AIDS Cases (per 100,000)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Receiving SNAP Benefits (Percentage, Population)	US Census Bureau, Small Area Income & Poverty Estimates. 2011.
Recreation and Fitness Facilities, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Regular Pap Test (Age-Adjusted) (Percentage, Adults Females Age 18+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Robbery Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
School Expulsion Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
School Suspension Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
Screened for Colon Cancer (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Severe Mental Illness Related Emergency Department Visits (Rate per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Smoking Cigarettes (Age-Adjusted) (Percentage, Population)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Soda Expenditures, Percentage of	Nielsen, Nielsen SiteReports. 2014.

Indicator Variable	Data Source
Total Food-At-Home Expenditures	
Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Students Eligible for Free or Reduced Price Lunch (Percentage)	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.
Substance Use Emergency Department Visit Rate (Rate per 100,000 (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Teen Birth Rate (Per 1, 000 Female Pop. Under Age 20)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Teens Who Engage in Regular Physical Activity (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Tuberculosis Incidence Rate (per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Unable to Afford Dental Care, Youth (Percentage, Population Age 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2015 - June.
Uninsured Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Vacant Housing Units (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Walking or Biking to Work (Percentage, Aged 16+)	US Census Bureau, American Community Survey. 2009-13.
Walking/Skating/Biking to School (Percentage, Aged 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Weather Observations with High Heat Index Values (Percentage)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Without Adequate Social / Emotional Support (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Without Dental Insurance (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.

Indicator Variable	Data Source
Without Recent Dental Exam (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Without Regular Doctor (Percentage, Total Population)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Workers Commuting by Car, Alone (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Workers Commuting More than 60 Minutes (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Years of Potential Life Lost, Rate (per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2008-10.
Youth Without Recent Dental Exam (Percentage)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.

APPENDIX C: Persons Representing the Broad Interests of the Community

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
County Health/Public Health	Alameda County Public Health	Epidemiologist	Public health	Leader	1, 2, 3	Interview	06/24/15
County Health/Public Health	Alameda County Public Health	Deputy Director	Public health	Leader	1, 2, 3	Interview	08/27/15
County Health/Public Health	Alameda County Public Health Department, Healthy Living for Life	Nutritionist	Healthy eating/ active living	Representative	1, 3	Interview	09/08/15
County Health/Public Health	Alameda County Public Health/Health Care Services	Medical Director	Public health	Leader	1, 2, 3	Interview	08/10/15
County Health/Public Health	Alameda County Public Health/Health Care Services	Director, Public Health Officer	Public health	Leader	1, 2, 3	Interview	08/10/15
Education	Health Pathways, Oakland Unified School District	Director	Education, child health	Leader	1, 3	Interview	09/03/15
Education	Health Pathways, Oakland Unified School District	Coordinator, Health Access/School-Based Health Centers	Education, child health	Leader	1, 3	Interview	09/03/15
Local Health	Citizens for Better Community	Dentist, Health Committee Chair	Minority	Leader, Member	1, 3	Focus group	09/02/15

* Target group represented:
1: Public health knowledge/expertise
2: Federal, tribal, regional, state, or local health departments/agencies
3: Represent target populations: a) medically underserved, b) low-income, c) minority

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Local Health	Kaiser Permanente	Associate Physician	Minority	Leader, Member	1, 3	Focus group	09/02/15
Local Health	Kaiser Permanente	Psychiatrist	Minority	Leader, Member	1, 3	Focus group	09/02/15
Local Health	Tiburcio Vasquez Health Center	Chief Executive Officer	Low-income, underserved	Leader	1, 3	Interview	08/31/15
Local Health	Tri-City Health Center	Development Officer	Low-income, underserved	Leader	1, 3	Interview	10/19/15
Local Health	Tri-City Health Center	Chief Executive Officer	Low-income, underserved	Leader	1, 3	Interview	10/19/15
Local Health	U.S. Department of Veterans Affairs, Martinez Outpatient Clinic	Caregiver Support Coordinator	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Local Health	Washington Hospital Healthcare System	Emergency Services Administrator	Public health, low-income, underserved	Representative	1, 3	Interview	09/18/15
Local Health	Washington Hospital Healthcare System	Continuing Care Coordinator	Mental health	Representative	1, 3	Interview	10/14/15
Local Health	Washington's Womens' Center	Clinic Coordinator	Low-income, underserved, women	Leader	1, 3	Interview	10/01/15
Local Health	Washington's Womens' Health Specialists	Obstetrician-Gynecologist	Low-income, underserved, women	Leader	1, 3	Interview	10/01/15
Non-Profit	Abode Services	Executive Director	Access to care, low-income, homelessness	Leader	3	Interview	09/23/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Non-Profit	American Lung Association	Regional Advocacy Director	Tobacco policy, minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	American Red Cross Northern California Coastal Region	Director, International Services and Service to the Armed Forces	Veterans	Leader	3	Focus group	9/23/15
Non-Profit	Armed Forces Services Corporation	Financial Coach	Veterans	Leader	3	Focus group	9/23/15
Non-Profit	Canine Guardians Assistance Dogs	Trainer	Veterans, disabilities	Leader	1, 3	Focus group	9/23/15
Non-Profit	Canine Guardians Assistance Dogs	Executive Director	Veterans, disabilities	Leader	1, 3	Focus group	9/23/15
Non-Profit	Citizens for Better Community	Treasurer	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	Davis Street Family Resource Center	Executive Director	Low-income, underserved	Leader	3	Interview	08/24/15
Non-Profit	East Bay Community Recovery Project	Case Manager/ Housing Specialist	Veterans, housing	Leader	1, 3	Focus group	9/23/15
Non-Profit	Employment Development Department, Eden Area Multiservice Center	Veteran Representative	Veterans, employment	Leader	3	Focus group	9/23/15
Non-Profit	Filipinos 4 Justice	Youth Services Director	Minority	Leader, Member	3	Focus group	09/02/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Rep-resentative/ Member	Target Group Repre-sented*	Consul-tation Method	Date Consul-ted (2015)
Non-Profit	Filipinos 4 Justice	Youth Counselor	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	Rotary Club Fremont	Past President, International Services Committee Chair	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	SAVE (Safe Alternatives to Violent Environments)	Director of Programs	Safety/violence	Leader	3	Interview	10/08/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Non-Profit	The Coming Home Project	Clinical Coordinator	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Non-Profit	Tri-City Elder Coalition	Karen Grimsich, Administrator, Aging & Family Services	Older adults	Leader	3	Interview	08/04/15
Non-Profit	U.S. Department of Veterans Affairs, Oakland Vet Center	Counselor	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Non-Profit	Veterans Yoga Project	Founder & Executive Director	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
N/A	Centro De Servicios	N/A	Immigrant population	Members (10)	3	Focus group	09/18/15

APPENDIX D: Glossary

Abbreviation	Term	Description/Notes
AC	Alameda County	
BRFSS	Behavioral Risk Factor Surveillance System	Survey implemented by CDC
CA	California	
CCC	Contra Costa County	
CDC	Centers for Disease Control and Prevention	
CDE	California Department of Education	
CDHS	California Department of Health Services	
CDPH	California Department of Public Health	
CHNA	Community Health Needs Assessment	
DHHS	United States Department of Health and Human Services	
DV	Domestic violence	
FPL	Federal poverty level	An annual metric of income levels determined by DHHS.
HIV	Human immunodeficiency virus	Sexually transmitted virus that can lead to AIDS.
HP2020	Healthy People 2020	National, 10-year aspirational goals set by federal agencies & finalized by a federal interagency workgroup under the auspices of the U.S. Office of Disease Prevention and Health Promotion, managed by DHHS.
HUD	United States Department of Housing and Urban Development	
LGBTQI	Lesbian/ Gay/ Bisexual/ Transgender/ Questioning/ Intersex	
PHD	Public health department	

APPENDIX E: 2016 Health Needs Prioritization Scores: Breakdown by Criteria

Health Need	Rank (1=High-est Priority)	Overall Average Score	Average Scores of Prioritization Criteria Used by Group				
			Severity of need	Magnitude / scale of need	Clear disparities or inequities	Multiplier effect	Com-munity priority
Asthma	**9**	1.91	2.00	2.14	2.29	2.14	1.00
Cancer	**8**	2.18	1.71	1.86	2.14	2.17	3.00
Cardiovascular disease & stroke	**4**	2.59	2.29	2.29	2.86	2.50	3.00
Economic security	**3**	2.60	2.14	2.43	2.71	2.71	3.00
Healthcare access & delivery, including primary & specialty care	**7**	2.41	2.14	1.86	2.57	2.50	3.00
Infectious diseases, including STIs	**10**	1.87	2.00	1.67	2.50	2.17	1.00
Maternal & child health	**11**	1.78	1.57	1.86	2.29	2.17	1.00
Mental health	**2**	2.74	2.71	2.57	2.71	2.71	3.00
Obesity, diabetes, & healthy eating/active living	**1**	2.83	2.57	2.86	2.71	3.00	3.00
Substance abuse, including alcohol, tobacco, and other drugs	**5**	2.58	2.14	2.50	2.57	2.71	3.00
Violence/injury prevention	**6**	2.48	2.57	2.57	2.71	2.57	2.00

Definitions:

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.

- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

- **Multiplier effect**: A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

- **Community priority:** The community prioritizes the issue over other issues on which it has expressed concern during the CHNA primary data collection process. ASR rated this criterion based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.

APPENDIX F: CHNA Qualitative Data Collection Protocols

Professionals (Providers) Focus Group Protocol

Introductory remarks

Welcome and thanks

What the project is about:

- We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
- Identifying unmet health needs in your community, extending beyond patients.
- Ultimately, to invest in community health strategies that will lead to better health outcomes.

Why we're here (put on flipchart page):

- Learn about health needs in your community
- Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment
- Talk about impact of various other things that influence health
- Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed

What we'll do with the information you tell us today

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all focus group discussions will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Focus Group Questions

1. Community Health Needs & Prioritization

When your local hospitals did their Community Health Needs Assessments in 2013, these are the health needs that came up. *(Using a list based on all of the needs identified by any hospital. List is at end of protocol.) (Show list on flipchart page.)*

a. We'd like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on this list that should be added. *(Write them on the list.)*
   i. Overall?
   ii. Specific needs for groups by gender, age, ethnicity, geography, etc.?

Define unmet health needs: Needs that are not being addressed very well. For example, maybe we don't know how to prevent these problems, or we don't have enough medicines or treatments, or maybe there aren't enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

b. Please think about the top three from the list (including the added needs, if any) you believe are the most important to address in your community – the needs that still need attention.

You'll find some sticky colored dots on the table; once you've decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

We will discuss your ideas on how these might be able to be addressed later in our conversation.

c. Any particular subpopulations that are disproportionately affected? *(Prompt for ethnic minorities, LGBTQ, low-income population, urban vs. rural/geographically isolated, etc.)* Any other trends you are seeing in the past 5 years or so? How are the needs changing? We will discuss your ideas on how these might be able to be addressed later in our conversation.

2. Access to Care

We would like to get your perspective on how access has changed in the post-Affordable Care Act environment.

a) Based on your observations and interactions with the clients you serve, to what extent are your clients aware of how to obtain health care? *(Explain if needed: Where to find a clinic, how to make an appointment, etc.)*
b) To what extent are your clients aware of how to obtain health insurance?
c) What barriers to access still exist? *(Focus on comparison pre- and post-ACA)*
   i. Is the same proportion still medically uninsured/under-insured; or is it a smaller proportion, or a larger proportion than before ACA?
   ii. Do more people, the same, or fewer people have a primary care physician than before ACA?
   iii. Are people using the ER as primary care to the same degree, less, or more than before ACA?
   iv. Is the same proportion of the community facing difficulties affording health care, or is it a smaller proportion, or a greater proportion than before ACA?
d) Now thinking about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

3. Drivers/Barriers

What other drivers or barriers are contributing to the health needs that you prioritized? We will talk about solutions in just a minute.

Prompts if they are having trouble thinking of anything:

- Transportation
- Housing
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues

- Being victims of abuse, bullying, or crime

4. Suggestions/Improvements/Solutions

Now that we have discussed the most challenging health needs and issues related to access to care, we are going to ask you about some possible solutions. **For the needs you prioritized earlier…**

a) Are there any <u>policy</u> changes you would recommend that could address these issues?
b) Are there <u>existing</u> assets or resources available to address these needs that people are not using? Why?
c) What <u>other</u> assets or resources are needed?

Resource question prompts, if they are having trouble thinking of anything

- Specific new/expanded programs or services?
- Increase knowledge/understanding?
- Address underlying drivers like poverty, crime, education?
- Facilities (incl. hospitals/clinics)
- Infrastructure (transportation, technology, equipment)
- Staffing (incl. medical professionals)
- Information/educational materials
- Funding
- Collaborations and partnerships
- Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- The final Community Health Needs Assessment Report will be published in approximately March 2016 on all of the hospitals' websites

Residents (Non-Professionals) Focus Group Protocol

Introductory remarks

Welcome and thanks

What the project is about:

- We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
- Identifying unmet health needs in your community, extending beyond patients.
- Ultimately, to invest in community health strategies that will lead to better health outcomes.

Why we're here (put on flipchart page):

- Learn about health needs in your community
- Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment
- Talk about impact of various other things that influence health
- Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed

What we'll do with the information you tell us today

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all focus group discussions will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Focus Group Questions

1. Community Health Needs & Prioritization

When your local hospitals did their Community Health Needs Assessments in 2013, these are the health needs that came up. *(Using a list based on all of the needs identified by any hospital. List is at end of protocol.) (Show list on flipchart page.)*

a. We'd like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on this list that should be added. *(Write them on the list.)*
   i. Overall?
   ii. Specific needs for groups by gender, age, ethnicity, geography, etc.?

Define unmet health needs: Needs that are not being addressed very well. For example, maybe we don't know how to prevent these problems, or we don't have enough medicines or treatments, or maybe there aren't enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

b. Please think about the top three from the list (including the added needs, if any) you believe are the most important to address in your community – the needs that still need attention.

   You'll find some sticky colored dots on the table; once you've decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

   We will discuss your ideas on how these might be able to be addressed later in our conversation.

2. Access to Care

We are interested in hearing from you about your experiences accessing health services in your community.

a) First, a little about health insurance:
   i. Have any of you enrolled in health insurance in the last two years…
      - For the first time?
      - After a lapse in insurance?
   ii. What has kept you from enrolling, or from getting better coverage?

b) Now, some questions about the "coverage" (benefits) that you do have:
   i. Do you have more or better insurance "coverage" than you had two years ago, or is it the same, or worse?
   ii. Are you more likely now, than you were two years ago, to visit a primary care doctor instead of ER or urgent care; or are you just as likely as before; or less likely?

c) What prevents you from getting the health care you need?

d) Now thinking about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

3. Care Drivers/Barriers

What else is influencing the health needs that you prioritized? We will talk about solutions in just a minute.

Prompts if they seem to be having trouble coming up with anything:

- Transportation
- Housing or the built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

4. Suggestions/Improvements/Solutions

- Specific new/expanded programs or services?
- Increase knowledge/understanding?
- Address underlying drivers like poverty, crime, education?
- Facilities (incl. hospitals/clinics)
- Infrastructure (transportation, technology, equipment)
- Staffing (incl. medical professionals)
- Information/educational materials
- Funding
- Collaborations and partnerships
- Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- The final Community Health Needs Assessment Report will be published in approximately March 2016 on all of the hospitals' websites
- Collect surveys
- Pass out incentives and get signed receipts

Key Informant Interview Protocol

Introduction

What the project is about:

- We are helping the non-profit hospitals in Alameda and Contra Costa Counties conduct a Community Health Needs Assessment, required by the IRS and the State of California.
- Identifying unmet health needs in our community, extending beyond patients.
- Ultimately, to invest in community health strategies that will lead to better health outcomes.

You were chosen to be interviewed for your particular perspective on health in your community ("regarding [topic]" – *if chosen for special topic and not overall perspective on health, identify here*).

What we'll do with the information you tell us today:

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all interviews will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Preamble

Our questions mainly relate to:

1. Health needs
2. Healthcare access in the post-Affordable Care Act environment
3. Other challenges contributing to health needs
4. Suggestions/solutions (both in terms of policies and in terms of local resources)

Interview questions

1. Background
First, please tell me a little about your current role and the organization you work for.
2. Health needs
Next, we would like to get your opinion on the top health needs among those you serve. a) In your opinion, which health needs do you believe are the most important to address among those you serve/your constituency? b) In your opinion, what are the health needs that are not being met very well right now among those you serve/your constituency? c) Are there any specific groups that have greater health needs, or special health needs? i. Differences by gender ii. Within specific ethnic groups iii. Among different age groups like seniors or children iv. Within different parts of the county v. Any other specific groups *If they identified more than three health needs, ask question d; if not, go on to section 3.* d) Which would you say are the most urgent or pressing of all the health needs that you've named?
3. Challenges: Access to healthcare – post-ACA
We would like to get your perspective on how <u>access</u> has changed in the post-Affordable Care Act environment.

a) Based on your observations and interactions with the clients you serve, to what extent are clients aware of how to obtain health care? *(Explain if needed: Where to find a clinic, how to make an appointment, etc.)*
b) To what extent are clients aware of how to obtain health insurance?
c) What barriers to access still exist? *(Focus on comparison pre- and post-ACA)*
    i. Is the same proportion still medically uninsured/under-insured?
    ii. Do more people or fewer people have a primary care physician?
    iii. Are people using the ER as primary care to the same degree?
    iv. Is the same proportion of the community facing difficulties affording health care?
d) Now thinking specifically about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

4. Other Challenges

Are there any other drivers or barriers that are contributing to health needs? We will talk about solutions in just a minute.

Prompts if they are having trouble thinking of anything:

- Transportation
- Housing
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

5. Suggestions/Improvements/Solutions

Now that we have discussed health needs and issues related to access to care, we are going to ask you about some possible solutions. **In order to maintain or improve the health of your community…**

a) Are there any policy changes you would recommend that could address these issues? Consider those that are readily achievable and politically feasible.
b) Are there existing resources available to address these needs? If so, why aren't people using them?
c) What other resources are needed?
d) Of the resources/solutions to improve health, which do you feel is the most significant improvement needed, second, and third?

Resource question prompts if they are having trouble thinking of anything:

- Specific new/expanded programs or services?
- Increase knowledge/understanding?
- Address underlying drivers like poverty, crime, education?
- Facilities (incl. hospitals/clinics)
- Infrastructure (transportation, technology, equipment)
- Staffing (incl. medical professionals)

- Information/educational materials
- Funding
- Collaborations and partnerships
- Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- Final CHNA report will be published in Spring 2016 on all of the hospitals' websites

Poster – Alameda/Contra Costa Counties Health Needs 2013
Access to preventative, primary, and specialty care (e.g., geography, language, cost, insurance eligibility)
Active living (increased exercise & activity)
Asthma (prevention/management)
Delivery of preventative, primary, and specialty care (e.g., quality of services, coordination of care)
Dental care (access to services)
Economic security (poverty)
Education/vocational training programs
Health literacy/health education (incl. adequate Spanish/other lang. capacity, health resources) and appropriate referral
Healthy eating (affordable healthy food, abundance of fast food, food insecurity, nutrition)
Mental health (services affordable, local)
Parenting skills & support
Peri-natal care (Black populations)
Pollution/clean environment (air, waste, etc.)
Substance abuse (treatment services affordable, local)
Transportation (safe, reliable, accessible)
Violence (safe environment, violence prevention, outdoor safety, safe places to be active)

APPENDIX G: Community Assets and Resources

The following resources are available to respond to the identified health needs of the community.

Overall:

Existing Health Care Facilities

- Alta Bates Summit Medical Center
    - Oakland
    - Berkeley
- Contra Costa Regional Medical Center
- Eden Medical Center
- Ernest Cowell Memorial Hospital
- Fern Lodge
- Fremont Hospital
- Gilmore Hospital
- Highland Hospital
- John Muir Medical Center
    - Concord
    - Walnut Creek
- John Muir Behavioral Health Center
- Kaiser Permanente – Diablo (Antioch and Walnut Creek)
- Kaiser Permanente – East Bay (Oakland and Richmond)
- Kaiser Permanente – Greater Southern Alameda (Fremont and San Leandro)
- Kindred Hospital San Francisco Bay Area
- San Leandro Hospital
- St. Rose Hospital
- San Ramon Regional Medical Center
- Stanford Health Care – ValleyCare Medical Center
- Sutter Delta Medical Center
- Telecare Heritage Psychiatric Health Facility
- UCSF Benioff Children's Hospital – Oakland
- U.S. Naval Hospital
- Veteran's Administration Hospital
    - Livermore
    - Martinez
- Washington Hospital
- Willow Rock Center (psychiatric)

Existing Federally Qualified Health Centers

- Alameda County Health Care Services
    - Mobile Van #2 (San Leandro)
- Albert J. Thomas Medical Clinic
- Alcatraz Avenue Medical Group
- Asian Health Services

    - 8th Street Satellite
    - Webster Street
- Axis Community Health
    - Livermore
    - Pleasanton
- Berkeley Primary Care Access Clinic
- Casa del Sol
- East Oakland Health Center
- Frank Kiang Medical Center
- La Clinica
    - Monument (Concord)
    - Pittsburg-Medical
    - Oakley
- La Clinica de la Raza
    - 9th Street, Oakland
    - 12th Street, Oakland
- Lifelong Ashby Health Center
- Lifelong Brookside Community Health Center
    - Richmond
    - San Pablo
- Lifelong Dental Care
- Lifelong Dr. William M. Jenkins Pediatric Center
- Lifelong Medical Care
    - Albany
    - East Oakland
    - Eastmont
    - Howard Daniel Clinic
    - Oakland (Supportive Housing Program)
    - Richmond
- Native American Health Center
- Over 60 Health
- San Antonio Neighborhood Health Center
- Tiburcio Vasquez Health Center
    - Union City
    - Hayward
    - San Leandro
- Tri-City Health Center
    - Main Street Village, Fremont
- West Oakland Health Council
- William Byron Rumford Medical Clinic

Other Existing Community Resources and Programs for Each Health Need:

Health Need: Asthma
• Abode Services • Alameda County Lead Prevention Program • Alameda County Public Health Department Community Services • Alameda Health Consortium • Alameda Health System-Newark Wellness (Newark Health Center) • American Lung Association • Ashland Free Medical Clinic • Asthma Start • Berkeley Public Health Department • Davis Street Family Resource Center • Drivers for Survivors • Eden Youth and Family Center - Hayward Day Labor Center • EdenFit Supervised Exercise Program • Fremont Family Resource Center • Friends of Alameda County Court Appointed Special Advocates • Grupo VIP Fremont • Healthy Oakland Healthy Communities • La Clinica de la Raza • Lifelong Medical Care Program • Northern California Breathmobile • Oakland/Berkeley Community Action to Fight Asthma Program • RAMP - Regional Asthma Management and Prevention Program, Public Health institute • REACH Ashland Youth Center • St. Rose Hospital- Main • Tiburcio Vasquez Health Center • Tri-City Health Center • Tri-City Medical Services • Washington Hospital and Health Care Services • Washington Hospital Healthcare System, Respiratory Care • Washington on Wheels Mobile Health Clinic (W.OW.) • Winton Wellness Center (AHS)

Health Need: Cancer
• Alameda Health System-Newark Wellness (Newark Health Center) • American Cancer Society • American Lung Association • Ashland Free Medical Center • Asian American Cancer Support Network (AACSN) • Bay Area Cancer Connections • Breast Cancer Connections • Breast Cancer Fund • Cancer Prevention Institute Of California (CPIC) - Cancer Detection Program: Every Woman Counts Call Center • Davis Street Family Resource Center • Drivers for Survivors, Inc. • Family Resource Center • HERS Breast Cancer Foundation • La Clinica de la Raza • Northern California Cancer Center • Project Open Hand • REACH Ashland Youth Center • Tiburcio Vasquez Health Center • Tri-City Health Center • Washington Hospital Healthcare System: o Cancer Genetics Program (UCSF Affiliated) o Community Outreach o Lymphedema Services o Radiation Oncology Center o Sandy Amos, RN Infusion Center o Women's Center • Winton Wellness Center (AHS) • Women's Cancer Resource Center

Health Need: Cardiovascular Disease and Stroke
• Alameda Health System-Newark Wellness (Newark Health Center) • Alameda Network of Care • American Heart Association • American Stroke Association • Ashland Free Medical Center • City of San Leandro Recreation and Human Services- Senior Community Center • Davis Street Family Resource Center • East Bay Services to the Developmentally Disabled: Evergreen Senior Center • Eden Youth and Family Center - Hayward Day Labor Center • EdenFit Supervised Exercise Program • La Clinica de la Raza • REACH Ashland Youth Center • South Hayward Parish • St. Rose Hospital- Main Washington on Wheels Mobile Health Clinic • Stroke Family Support Network • Tiburcio Vasquez Health Center • Tri-City Health Center • Tri-City Medical Services • Washington Hospital and Health Care Services • Washington Hospital Healthcare System: o Cardiovascular Services o Community Outreach o Outpatient Diabetes Center • Washington on Wheels Mobile Health Clinic (W.O.W) • Winton Wellness Center (AHS) • YMCA East Bay

Health Need: Economic Security

- Abode Services
  - HOPE Project Mobile Health Clinic
  - Project Independence
- Alameda County Community Food Bank
- Alameda County Early Head Start and Head Start
- Alameda County Homeless Project- Hayward (incl. Special Needs Housing)
- Alameda County Housing and Community Development Shelter and Care
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Alameda County Social Services Department
- America Works (ex-convicts)
- Antioch/East Contra Costa Health and Wealth Initiative
- Berkeley City College CalWORKS program
- Berkeley Public Library Adult Literacy Program
- Brighter Beginnings
- Building Blocks for Kids Collaborative
- Building Opportunities for Self-Sufficiency (BOSS)- Short-term Special Needs Housing
- Catholic Charities of the East Bay
- Center for Independent Living Employment Academy
- Centro de Servicios
- Child, Family and Community Services (CFCS)- Southern Alameda County Early Head Start and Head Start
- City of Berkeley Health, Housing and Community Services Department
- City of Dublin Senior Center
- City of Oakland Department of Human Services
- Community Resources for Independent Living (CRIL)
- Computer Technologies Program
- Contra Costa County Employment & Human Services
- Contra Costa County Early Head Start and Head Start
- EBALDC – East Bay Asian Local Development Corporation
- Economic Opportunity Council
- East Bay Community Foundation
- East Bay Community Law Center
- East Bay Green Jobs Corps
- East Oakland Youth Development Center
- East Richmond Youth Development Center
- Eden I&R, Inc.
- Emergency Shelter Program, Inc.
- Ensuring Opportunity Contra Costa
- Fremont Healthy Start (A Program of East Bay Agency for Children)
- Fremont Resource Center
- Friends of Alameda County Court Appointed Special Advocates
- Hope for the Heart- Food Distribution
- Inter-City Services (Veterans Employment Related Assistance, and Workforce Training Program)
- Monument Community Partnership & Michael Chavez Center for Economic Opportunity
- Monument Impact

Health Need: Economic Security

• One Stop Center
• Operation Dignity (veterans)
• Opportunity Junction
• Richmond Health Equity Partnership
• Richmond Works
• San Lorenzo Family Help Center- Ecumenical Food Pantry
• Safe Alternative to Violent Environments (SAVE)
• Salvation Army Hayward:
  o Corps- Food, Clothing, and Donation Services
  o USDA Commodity and Food Programs
• South Hayward Parish:
  o Emergency Food Pantry
  o Hayward Community Action Network
• SparkPoint Bay Point
• The Stride Center
• Tri-City One-Stop Career Center (Employment Development Department)
• Tri-City Volunteers Food Bank & Thrift Store
• Tri-Valley Community Foundation
• Youth Employment Partnership

Health Need: Health Care Access & Delivery, Including Primary and Specialty Care

- Abode Services:
  - HOPE Mobile Health Clinic
- ACMC:
  - Fairmont Campus
  - Winton Wellness Center
- Alameda County Health Care Services – School Health Services
- Alameda County - South County Homeless Project- Hayward - Special Needs Housing
- Alameda Health System-Newark Wellness (Newark Health Center)
- Alzheimer's Services of the East Bay Adult Day Healthcare Center - Hayward Center
- American Diabetes Association
- American Heart Association
- Ashland Free Medical Cinic
- Axis Community Health
- Berkeley Free Clinic
- Birthright of San Lorenzo
- Brighter Beginnings
- Brookside Community Health Center
- Building Opportunities for Self-Sufficiency (BOSS)- Short-term, Special Needs Housing
- Centro de Servicios
- Child, Family, and Community Services (CFCS)- Burke Cal- SAFE Program
- CPIC – Community Education
- Coalition
- Concord RotaCare Clinic
- Contra Costa County Health Services Health Centers
- Deaf Counseling Advocacy and Referral Agency
- East Bay Agency for Children
- Eden Information and Referral
- Eden Medical Center- Outpatient Rehab
- Eden Youth and Family Center:
  - Hayward Day Labor Center
  - New Start Tattoo Removal
- Emergency Shelter Program, Inc.
- Every Woman Counts
- Fremont Resource Center
- George Mark Children's Home
- Gray Panthers
- Healthy Richmond
- Jewish Family & Children's Services of the East Bay
- JMH Mobile Health Clinic
- Kaiser:
  - Fremont Medical Center
  - Hayward Medical Center
  - Union City Medical Center
- La Clinica de La Raza
- La Familia – FRC - Fuller
- LIFE Eldercare, Inc. - VIP Rides Program

Health Need: Health Care Access & Delivery, Including Primary and Specialty Care

- LifeLong Medical Care
- Lighthouse Community Center
- Native American Health Center
- Operation Access
- Planned Parenthood:
    - Mar Monte
    - Shasta Pacific
- Pregnancy Choices Clinic
- Ronald McDonald Care Mobile Dental Clinic
- RotaCare Clinic
- Silva Pediatric Medical Clinic
- Second Chance Hayward Center
- Serra Center - Intermediate Care Facility for the Developmentally Disabled - Handicapped (ICF- DDH) and ILS/Supported Living Services
- South Hayward Parish- Hayward Community Action Network
- St. Rose Hospital:
    - Main
    - Silva Pediatric Medical Clinic
    - Women's Center
    - Women's Imaging Center
- St. Vincent de Paul RotaCare Clinic
- Sutter Delta Community Clinic
- The Latina Center
- Tiburcio Vasquez Health Center:
    - Family Support Services
    - Hayward Clinic
    - School Based Health Services- Logan Health Center
    - School Based Health Services- Tennyson Health Center
    - Union City Clinic
    - Union City Clinic
- Tri-City Health Center:
    - Harm Reduction
    - LGBT Services
    - Teen City Health Clinic
- United Seniors of Oakland and Alameda County
- Respite Care Shelter for the Homeless
- Washington on Wheels Mobile Health Clinic
- Washington Township Medical Foundation

Health Need: Infectious Diseases, Including STIs
• AIDS Project of the East Bay (APEB) Grupo Fremont VIP • Alameda Health System-Newark Wellness (Newark Health Center) • ACMC- Fairmont Campus (HIV Services) • Ashland Free Medical Clinic • Davis Street Family Resource Center • Lighthouse Community Center- Free HIV Testing • REACH Ashland Youth Center (LaClinica Services) • Tiburcio Vasquez Health Center • Tri-City Health Center - HIV, Hep C and STD Testing • Washington Hospital Healthcare System

Health Need: Maternal and Infant Health
• Alameda County Nutrition Services - Women, Infants, and Children (WIC) • Bay Area Communities for Health Education (BACHE) • Cal-SAFE Horizon School-Age Parent Program • Child Care Resources and Referral Line • City of Fremont Youth and Family Services • Community Child Care Council (4C's) of Alameda County • First Five of Alameda County • Fremont Healthy Start (A Program of East Bay Agency for Children) • LARPD Extended Student Services • Love Never Fails Mentors for Positive Change • Planned Parenthood • St. Rose Hospital – Silva Pediatric Medical Clinic • Tri-Valley Haven • Washington Hospital Healthcare System, Maternal Child Education Center

Health Need: Mental Health

- Abode Services:
  - Greater HOPE (Homeless Outreach and People Empowerment)
  - HOPE Project Mobile Health Clinic
  - Project Independence
  - STAY (Supportive Housing for Transitional Aged Youth)
- ACBHCS:
  - Crisis Response Program
  - Eden Children's Services
  - Geriatric Assessment & Response Team
  - Tri-City Children's Outpatient Services
  - Tri-City Community Support Center
- ACMC:
  - John George Psych Pavilion
  - Outpatient Psychiatric Services
- Alameda County Health Care Services Agency
- Alameda County Housing and Community Development Shelter + Care
- Alameda County Tri-City Children and Youth Service
- Alzheimer's Services of the East Bay Adult Day Healthcare Center - Hayward Center
- Ashland Youth Center
- Axis Community Health Adult Behavioral Health Services
- Bay Area Community Services, Inc., including Adult Day Care Services
- Boldly Me
- Building Opportunities for Self-Sufficiency (BOSS):
  - Behavioral Health Care Transitional Housing
  - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward
- Cal-SAFE - Tri-City Cal-SAFE Program
- Centro de Servicios
- Chabot- Women in Transition
- Child Abuse Listening Interviewing Center - CASA
- Child Family and Community Services (CFCS):
  - Burke Cal-SAFE Program
  - Southern Alameda County Early Head Start and Head Start
- Christian Counseling Centers, Inc.:
  - Fremont Christian Counseling Center
  - Hayward Christian Counseling Center
- City of Berkeley Health, Housing and Community Services Department
- Community Health for Asian Americans
- Concord Family Services Center
- Contra Costa Crisis Center
- Contra Costa Health Services
- Crockett Counseling Center
- Davis Street Family Resource Center
- Deaf Counseling Advocacy and Referral Agency
- Early Childhood Mental Health Program
- East Bay Agency for Children- Child Assault Prevention Training Center
- East Bay Services to the Developmentally Disabled- Evergreen Senior Center
- East Bay Community Recovery Project- Hayward Outpatient Division
- Eden I&R, Inc.

Health Need: Mental Health

- Eden Youth and Family Service's Tattoo Removal Program
- Emergency Shelter Program, Inc.
- Familias Unidas
- Families Forward
- Family Education and Resource Center (FERC)
- Family Paths:
    - 24-hour Parent Support Hotline
    - Counseling Services
- FCHSD:
    - Fremont Senior Center
    - Youth and Family Services
- Fremont Hospital:
    - 23-Hour Behavioral Crisis Assessment
    - Acute Inpatient Care Program
    - Chemical Dependency Intensive Outpatient Program
- Filipino Advocates for Justice - Youth Development
- George Mark Children's Home
- Girls Inc.
- GOALS for Women (Oakland)
- HARPD – Matt Jimenez Community Center
- Horizons Family Counseling
    - Cronin House
    - Project Eden
- Jewish Family & Community Services East Bay
- JFK University – Concord Community Counseling Center
- John Muir Health Adolescent, Adult & Children's Psychiatric
- Programs
- Kidango, Inc.:
    - Early Head Start/Head Start Programs
    - Mental Health
    - Special Needs/Early Intervention Services
- La Cheim School, Inc
- La Clinica de la Raza, San Leandro
- La Familia Mental Health Services:
    - Outpatient Counseling Program
- Monument Impact – Mentes Positivas
- Multi Lingual Counseling Center, Inc.
- NAMI (National Alliance on Mental Illness):
    - Alameda County South
    - Contra Costa (National Alliance on Mental Illness)
    - Tri-Valley
- Power Program
- Pregnancy Choices Clinic
- Putnam Clubhouse
- REACH Ashland Youth Center
- Safe Alternative to Violent Environments (SAVE) - 24-Hour Crisis Line
- SAVE:
    - Emergency Shelter
    - Individual Counseling and Support Group

Health Need: Mental Health

• Schuman-Lilies Clinic Fremont
• Second Chance:
  o Anger Management
  o Hayward Center
  o Newark Center
• Seneca Center for Children and Families:
  o Public School-based Outpatient Counseling for HUSD
  o Willow Rock Center 23-hour Crisis Stabilization and Outpatient Services
• South Hayward Parish - Hayward Community Action Network
• St. Rose Hospital- Main
• Telecare Corp.:
  o Morton Bakar Center
  o Villa Fairmont Short Stay Program
  o Willow Rock Center Inpatient Services
• Terra Firma Diversion/Educational Services:
  o Court Ordered Adult Diversion Programs
  o Domestic Violence and Anger Management Classes
• The Latina Center (Richmond)
• Tiburcio Vasquez Health Center:
  o Behavioral Health Center
  o School based health services – Logan Health Center
  o School based health services – Tennyson Health Center
• Tri-City Health Center:
  o HIV/AIDS Care and Treatment Program
  o Women's Services
• Tri-Valley Axis Community Health Adult Behavioral Health Services
• Horizon Family Counseling
• USG – Department of Veterans Affairs (VA) - Fremont Outpatient Clinic
• Victory Outreach - Prison Counseling and Services; Residential Rehab Program - Hayward
• Washington Hospital Healthcare System - Health Connection
• Women on the Way Recovery Center

Health Need: Obesity, Diabetes, and Healthy Eating/Active Living

- 18 Reasons
- Abode Services
- ACPHD - WIC
- ACMC- Winton Wellness Center
- Alameda County Community Food Bank
- Alameda County Deputy Sheriffs' Activities League's- Dig Deep
- Alameda County Food Bank
- Alameda County Healthcare Services – School Health Services Coalition
- Alameda County Nutrition Services
- Alameda County Office of Education
- Alameda County Public Health Department
- Alzheimer's Services of the East Bay Adult Day Healthcare Center- Hayward Center
- Ambrose Recreation and Park District
- Ashland Free Medical Clinic
- BACS - Adult Day Care Services
- BOSS - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward
- Bay Point All Stars
- Bay Point Community Foundation
- Berkeley Food and Housing Project
- Boys & Girls Club of the Diablo Valley
- Building Blocks Collaborative
- Building Blocks for Kids Collaborative
- California State University, East Bay's Promise Neighborhood
- Center for Human Development
- Centro de Servicios
- CFCS - Southern Alameda County Early Head Start and Head Start
- Children's Emergency Food Bank
- City of Antioch
- City of Fremont Parks and Recreation Dept.
- City of Livermore
- City of Newark - Senior Center for Adults ages 55
- City of San Leandro Recreation and Human Services- Senior Community Center
- City Slicker Farms
- Commodity and Food Programs
- Community Child Care Council of Alameda County
- Contra Costa Health Services
- Cooking Matters/Three Squares
- East Bay Agency for Children
- East Bay Regional Parks
- East County Health and Wealth Initiative
- East County Kids N Motion
- East County Midnight Basketball
- Eden I&R, Inc.
- Eden Youth and Family Center:
    - Hayward Day Labor Center
    - New Start Tattoo Removal
- EdenFit Supervised Exercise Program

Health Need: Obesity, Diabetes, and Healthy Eating/Active Living

- Emergency Shelter Program, Inc.
- First 5 Contra Costa
- Food Bank of Contra Costa and Solano County
- Fremont Family Resource Center
- FCHSD - Fremont Senior Center
- Get Fit Antioch
- Greater Richmond Interfaith Programs
- Healthy and Active Before 5
- Healthy and Livable Pittsburg
- Hope for the Heart- Food Distribution
- JMH Faith & Health Partnership (seven churches offer exercise and active living programs and services, six churches offer healthy food programs and services)
- Kidango, Inc. Early Head Start/Head Start Programs
- La Clinica de la Raza- Healthy Start Clinic- San Lorenzo HS Health Center
- La Familia Counseling Services
- LIFE Eldercare, Inc. - Meals on Wheels
- Livermore Recreation & Park District
- LIFT for Teens
- Loaves and Fishes
- Local Ecology and Agriculture Fremont (LEAF)
- Meals on Wheels:
    - Senior Exercise Program
    - Senior Outreach Services
- Monument Crisis Center
- Monument Impact
- Oakland Food Policy Council
- Open Heart Kitchen
- Pogo Park
- Public Health Institute
- REACH Ashland Youth Center
- Salvation Army:
    - Hayward Corps- Food, Clothing, and Donation Services
    - Hayward Corps- Senior Center
    - Tri-Cities Corps Community Center - USDA Commodity and Food Programs
    - USDA Commodity and Food Programs
- San Leandro Boys and Girls Club
- San Leandro Health and Wellness Center
- San Leandro Unified School District
- San Lorenzo Family Help Center- Ecumenical Food Pantry
- Second Chance - Emergency Shelter
- Senior Support Program of the Tri-Valley
- Service Opportunities for Seniors – Meals on Wheels
- Shelter Inc.
- Silliman Activity and Family Aquatic Center
- Silva Pediatric Medical Clinic
- South Hayward Parish:
    - Emergency Food Pantry
    - Hayward Community Action Network

Health Need: Obesity, Diabetes, and Healthy Eating/Active Living
- o Senior Meal Site   - Spectrum Community Services, Inc.- Senior Nutrition and Activities Program   - St. Rose Hospital- Main   - Tri-City Free Breakfast Program   - Tri-City Health Center   - Tri-City Medical Services   - Tri-Valley Children's Emergency Food Bank   - Tri-Valley Open Heart Kitchen   - Senior Support Program of the Tri-Valley Children's Emergency Food Bank   - Tiburcio Vasquez Health Center (incl. WIC)   - United Seniors of Oakland and Alameda County   - Urban Tilth   - Village Community Resource Center   - Viola Blythe Community Service Center of Newark   - Washington Hospital and Health Care Services   - Washington Hospital Healthcare System: - o Community Outreach   - o Diabetes Program   - o Outpatient Diabetes Center   - Washington on Wheels Mobile Health Clinic   - White Pony Express   - YMCA: - o East Bay   - o Fremont/Newark

Health Need: Substance Abuse (including tobacco and alcohol)

- 12-Step programs (Al-Anon, Alcoholics Anonymous, Narcotics Anonymous)
- A Chance for Freedom
- Abode Services:
  - HOPE Project Mobile Health Clinic
  - Project Independence
- Adult Behavioral Health Services
- Alameda County Health Care Services Agency
- Alameda County Housing and Community Development Shelter + Care
- Alameda County Medical Center Substance Abuse program
- Al-Anon/Alateen- District 15- Oakland/Hayward Area
- Ashland Youth Center
- Axis Community Health (incl. Adult Behavioral Health Services)
- BACS – South County Wellness Center
- Building Opportunities for Self-Sufficiency (BOSS):
  - Behavioral Health Care Transitional Housing
  - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward
- Center for Human Development
- Christian Counseling Centers, Inc. Fremont Christian Counseling Center
- Contra Costa Health Services
- Crossroads Recovery Center
- Davis Street Family Resource Center
- Eden Youth and Family Service's Tattoo Removal Program
- Emergency Shelter Program, Inc.
- Fremont Hospital:
  - Chemical Dependency Intensive Outpatient Program
- Health Care Transitional Housing
- Horizon Services:
  - Cherry Hill Detox
  - CommPre
  - Project Eden
- HAART- Humanistic Alternative to Addiction – Methadone Maintenance & Detox Program
- John Muir Behavioral Health Center
- La Clinica de la Raza, San Leandro
- Latino Commission on Alcohol and Drug Abuse
- Lighthouse Community Center- 12 Step Meetings
- Narcotics Anonymous
- NAMI Alameda County South
- Neighborhood House
- New Bridge Foundation
- Options Recovery Service
- REACH project, Ashland Youth Center
- Safe Alternatives to Violent Environments (SAVE)
- Second Chance:
  - Hayward Center
  - Newark Center
  - PC 1000 Drug Division
- Terra Firma Diversion/Educational Services:

Health Need: Substance Abuse (including tobacco and alcohol)
- Court Ordered Adult Diversion Programs   - Drug Relapse Prevention, Drug Testing, and Youth Services   - Tiburcio Vasquez Health Center   - Tri-City Health Center   - Ujima: - East   - West   - Victory Outreach - Prison Counseling and Services; Residential Rehab Program - Hayward   - West Oakland Health Council   - Women on the Way Recovery Center

Health Need: Violence and Injury Prevention
• 1,000 Mothers Against Violence • Afghan Coalition • Alameda Family Services • Allen Temple Baptist Church Health and Social Services Ministries • BAWAR – Bay Area Women's Against Rape • Berkeley Youth Alternatives • Beyond Violence • Building Blocks for Kids Collaborative • Building Futures with Women and Children • Calico Center • California State University, East Bay's Promise Neighborhood • Center for Human Development • Centro Legal Services • City of Berkeley Health, Housing and Community Services Department • City of Richmond Office of Neighborhood Safety • Community Child Care Council (4C's) of Alameda County • Community Violence Solutions • Family Justice Center • Family Violence Law Center • Filipino Advocates for Justice • First Five Alameda County • Girls Inc. • Hayward Unified School District • Healing Circles of Hope • Healthy Richmond (sponsored by The California Endowment) • Herald Family Rebuilding • Kidpower Teenpower • La Familia Counseling Services • Mind Body Awareness Project • Oakland Unite! • One Day at a Time • Passion Society • Pogo Park • REACH Ashland Youth Center • Richmond Police Department • Ruby's Place • RYSE Youth Center • Victim Witness Assistance • Youth Alive! • Youth Intervention Network • Safe Alternatives to Violent Environments (SAVE) • San Leandro Boys and Girls Club • San Leandro Education Foundation • Soulciety • STAND! for Families Free of Domestic Violence • Victim Witness Assistance

Health Need: Violence and Injury Prevention
• Zero Tolerance for Domestic Violence Initiative

APPENDIX H: Health Needs Profiles

- Asthma
- Cancer
- Cardiovascular disease and stroke
- Economic security
- Healthcare access & delivery, including primary and specialty care
- Infectious diseases, including sexually transmitted infections (STIs)
- Maternal and infant health
- Mental health
- Obesity, diabetes, and healthy eating/active living
- Substance abuse, including alcohol, tobacco, and other drugs
- Violence and injury prevention

Profile of KFH-Fremont Service Area Health Needs

ASTHMA

Why Is It Important?

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath.[1] Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and overweight.

ASTHMA PREVALENCE TOO HIGH

Asthma prevalence is higher among adults and children/teens in the service area than in the state. Community is more aware of and concerned about childhood asthma than adult asthma.

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. The populations with higher rates of asthma include Blacks, people living below the Federal poverty level, children, and people with certain exposures in the workplace.[1]

Asthma is considered a significant public health burden and its prevalence has been rising since 1980.[1] Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Why Is It a Community Health Need?

In the KFH-Fremont service area, nearly one in six adults have asthma. Black asthma patients account for a larger proportion of KFH-Fremont service area hospital discharges than at the state level. In Alameda County, fully one in five children have asthma. The community expressed concern about childhood asthma.

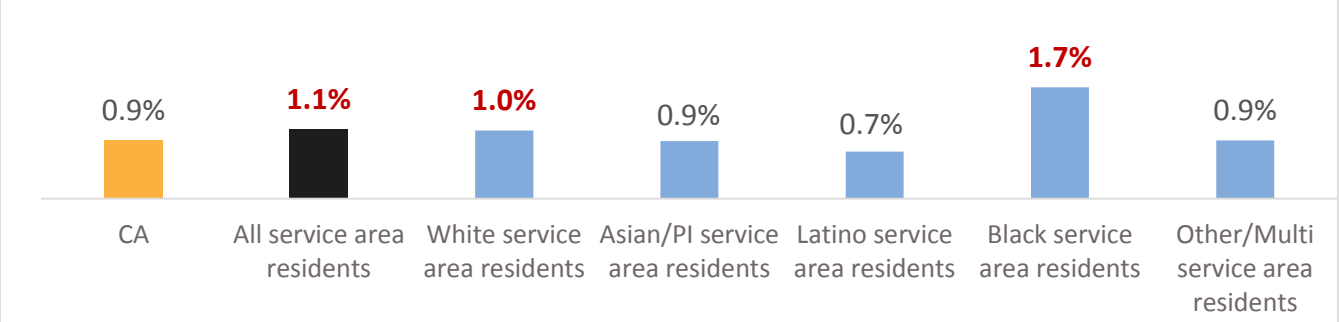
What Do the Data Show?

- A larger percentage of adults in the KFH-Fremont service area have asthma (16% adult asthma prevalence) when compared to the state (14% adult asthma prevalence).
- In Alameda County, there is a greater proportion of children and teens with asthma (19% asthma prevalence ages 0-17) compared to the state (15% asthma prevalence ages 1-17).[2] Data on asthma prevalence by age is not available at the sub-county level.

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[2] *Alameda County Health Data Profile*, Alameda County Public Health Department, 2014.

- Asthma patients accounted for a greater proportion of all hospital discharges in the KFH-Fremont service area than the state (see chart). There are ethnic disparities: Black asthma patients comprised even higher proportions of all hospital discharges in the service area than those of other ethnicities (see chart).

PATIENT DISCHARGES FOR ASTHMA AS PERCENT OF TOTAL DISCHARGES, 2011



Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.

What Does the Community Say?

- Asthma is a "bigger deal" in elementary school.
- Community has concerns about how asthma will be managed without a hospital nearby.
- Lack of trusting relationships with early adolescents; they don't know how to access services.
- Depending on the time of the year, high number of pediatric respiratory problems.

Profile of KFH-Fremont Service Area Health Needs

CANCER

Why Is It Important?

ETHNIC DISPARITIES IN CANCER INCIDENCE RATES

Service area incidence rates for various cancers are higher for certain ethnicities.

Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues. Cancer cells can spread to other parts of the body through the blood and lymph systems. There are more than 100 kinds of cancer.[1] Cancer is the second most common cause of death in the United States.[2] Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening and vaccination services.

Nationally, Black men are more likely to get and die from cancer, followed by White, Latino, American Indian/Alaskan Native, and Asian/Pacific Islander men.[3] Among women, White women are more likely to get cancer, and Black women are more likely to die from cancer.[3] Complex and interrelated factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most salient factors are associated with a lack of health care coverage and low socioeconomic status (SES).[4]

Why Is It a Community Health Need?

In the KFH-Fremont service area, cancer incidence rates are close to state averages or Healthy People 2020 (HP2020) goals, but incidence and mortality rates show ethnic disparities. Available data on cancer screening show service area rates that are similar or better than the state. Community comments mostly focused on the difficulty of transportation to and from treatment.

What Do the Data Show?

CANCER DATA FAILING STATE AVERAGES OR HEALTHY PEOPLE 2020 TARGETS

Indicator (per 100,000)	Service Area	Target/ Average*	White	Black	Latino	Asian	Pac Isl	Am. In
Cancer mortality (age-adjusted)	140.3	157.1 (CA)	**168.3**	**203.7**	89.3	70.0	136.5	116.2
Breast cancer incidence	**123.1**	122.4 (CA)	**133.2**	**122.9**	95.6	98	N/A	49.4
Cervical cancer incidence (women)	7.1	7.1 (HP)	**7.3**	6.4	**9.5**	5.6	N/A	N/A
Colorectal cancer incidence	**41.7**	38.7 (HP)	**43.3**	**53.6**	**39.4**	31.2	N/A	N/A
Lung cancer incidence	49.2	49.5 (CA)	**51.9**	**68.5**	32.2	36.1	N/A	N/A
Prostate cancer incidence	**137.3**	136.4 (CA)	**142.9**	**213.4**	127.4	66.6	N/A	N/A

[1] *How to Prevent Cancer or Find It Early*. Cancer Prevention and Control, Centers for Disease Control and Prevention. Web. Dec. 2015.
[2] *Fast Stats, Leading Causes of Death*. Centers for Disease Control and Prevention. Web. Dec. 2015.
[3] *Cancer Rates by Race and Ethnicity.* Cancer Prevention and Control, Centers for Disease Control and Prevention. Web. Dec. 2015.
[4] *Cancer Health Disparities*. National Cancer Institute. Web. Dec. 2015.

Source: National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11; California Department of Health Death Statistical Tables. 2012, Table 5-20. N/A = data not available. *HP = Healthy People 2020 target.

- While the cancer mortality rate for all residents in the KFH-Fremont service area is lower than the state, Black and White residents in the service area have higher mortality rates than those of other ethnicities (see table).

- The breast cancer incidence rate in the service area is slightly higher than the state and also slightly higher for White and Black service area residents (see table).

  - The percentage of female Medicare enrollees age 67 or older who received at least one mammogram in the past two years is slightly higher for the service area (60%) than the state (59%); data are not available by ethnicity or for other age groups.

- While the cervical cancer incidence rate for all residents in the KFH-Fremont service area is no higher than the HP2020 objective, it is higher for Latinas and White women in the service area (see table).

  - Nearly 79% of adult women in the service area had a Pap test in the past three years, slightly higher than the state figure (78%); data are not available by ethnicity.

- Colorectal and prostate cancer incidence rates are higher in the service area than the HP2020 target or the state average, with Blacks and Whites experiencing these cancers at even higher rates (see table).

  - Over 61% of the service area has had a colonoscopy or sigmoidoscopy, compared to only 58% in the state; data are not available by ethnicity.

  - Inadequate fruit and vegetable consumption, a driver of colorectal cancer, was slightly worse in the service area (73%) than in the state (72%).

- In the KFH-Fremont service area, the lung cancer incidence rate for all residents combined is slightly lower than the state rate, but much higher for Black residents of the service area and somewhat higher for White service area residents as well (see table).

  - Only 11% of the service area population smokes tobacco (compared to 13% in the state); data are not available by ethnicity.

What Did the Community Say?

- Comments mainly focused on transportation issues (difficulty in getting to and from treatment).

Profile of KFH-Fremont Service Area Health Needs

CARDIOVASCULAR DISEASE/STROKE

Why Is It Important?

Nationally, more than 1 in 3 adults (81.1 million) live with one or more types of cardiovascular disease.[1] In addition to being the first and third leading causes of death, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.[1] There are significant disparities based on gender, age, race/ethnicity, geographic area, and socioeconomic status in the prevalence of risk factors, access to timely treatment, treatment outcomes, and mortality.

ETHNIC DISPARITIES IN CVD & STROKE DEATHS

The rate of heart disease mortality is higher in the service area than in the state; Blacks and Pacific Islanders disproportionately die from both heart disease and stroke.

The primary risk factors[1] for heart disease and stroke that are controllable include:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

These risk factors cause changes in the heart and blood vessels that over time can lead to heart attacks, heart failure, and strokes. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease. *See the health profile on **Obesity, Diabetes, and Healthy Eating/Active Living** for information about these particular risk factors. Other risk factors are addressed in this health profile.*

Why Is It a Community Health Need?

In the KFH-Fremont service area, the mortality rate due to ischemic heart disease is higher than the Healthy People 2020 (HP2020) objective, and some ethnic groups have disproportionately higher rates of death than others from both heart disease and stroke. Also, the percentage of those with hypertension in the county is slightly higher than the state average. In addition to remarking on the lack of access to healthy food and open spaces for exercise, the community expressed concern about heart disease and its risk factors among certain ethnic populations.

What Do the Data Show?

- While only 6% of all adults combined in the KFH-Fremont service area have heart disease, no worse than the state (6%), Black adults in the service area are more likely than other service area adults to have heart disease (10%).

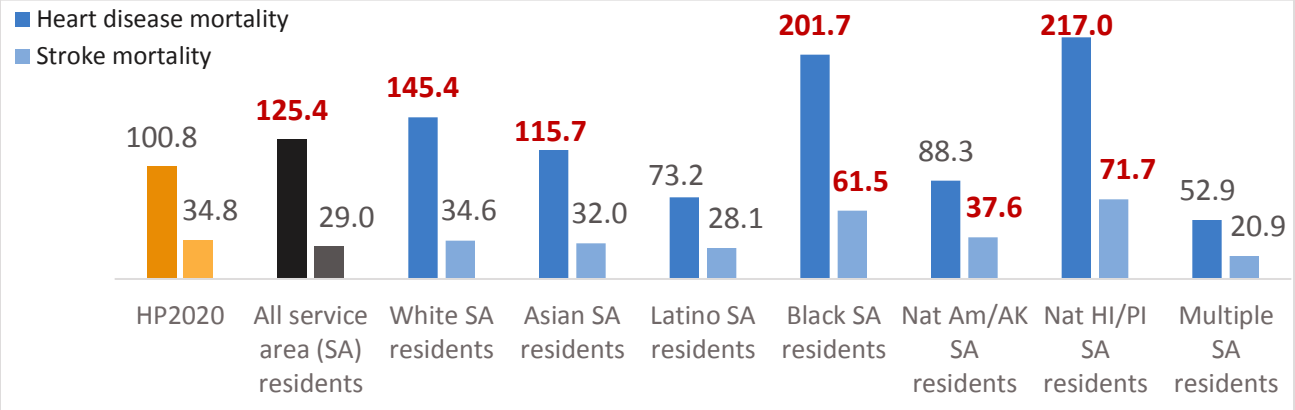
[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- High blood pressure (AKA hypertension) is associated with heart disease and stroke. One quarter (25%) of Alameda County residents have high blood pressure, which is below the state percentage (27%); however, county Blacks (40%) more often have high blood pressure than those of other ethnicities in the county.[2] Data are not available for this indicator at the sub-county level.

- In the KFH-Fremont service area, the age-adjusted rate of ischemic heart disease mortality per 100,000 is higher than the HP2020 objective (see chart). There are also ethnic disparities in heart disease mortality across the service area, with the highest rates found among Native Hawaiians/Pacific Islanders and Blacks (see chart).

- The KFH-Fremont service area has a lower stroke age-adjusted mortality rate per 100,000 than the HP2020 objective; however, Blacks and Pacific Islanders in the service area experience stroke mortality at much higher rates than the HP2020 objective (see chart).

MORTALITY RATES PER 100,000, AGE-ADJUSTED, 2010-2012



University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH – Death Public Use Data. 2010-12.

What Does the Community Say?

- In specific geographic areas, there are few/no supermarkets or farmers' markets offering healthy food.

- There is a lack of access to open spaces for exercise.

- Key informants noted:

  - ➥ Seeing an increase in the number of Afghani and Indian residents with cardiac problems.
  - ➥ There are lots of multiple diagnoses (e.g., obesity, hypertension, asthma all co-occurring).
  - ➥ Latinos & Blacks tend to have higher levels of hypertension and other risk factors.

[2] *Alameda County Health Data Profile*, Alameda County Public Health Department, 2014.

Profile of KFH-Fremont Service Area Health Needs

ECONOMIC SECURITY

Why Is It Important?

FOOD INSECURITY TOO COMMON

Nearly 1 in 6 residents experience food insecurity, and some ethnic groups have much higher proportions living in poverty than others.

An individual's health-related behaviors, surrounding physical environments, and health care all contribute significantly to how long and how well we live. However, none of these factors is as important to population health as are the social and economic environments in which we live, learn, work, and play.[1] These economic and social conditions are referred to as the "social determinants of health." Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care.[1] For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve.[1] By working to establish policies that positively influence economic and social conditions, we can improve health for large numbers of people in ways that can be sustained over time.[2]

Why Is It a Community Health Need?

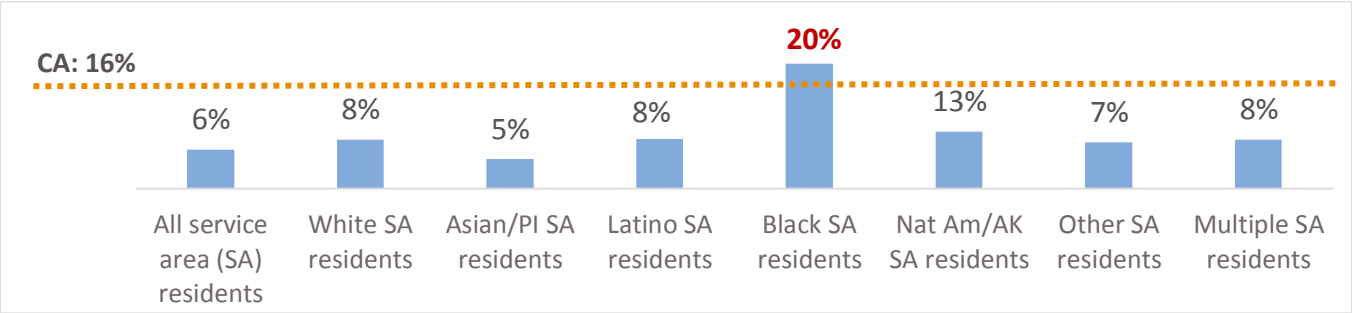
In the KFH-Fremont service area, nearly one in six residents experience food insecurity, and some ethnic groups have higher proportions living in poverty than others. The community expressed concern about low wages, food insecurity, access to employment, and lack of affordable housing.

What Do the Data Show?

- In the KFH-Fremont service area, the proportion of Black residents living below the Federal Poverty Level (FPL) is higher than the average for all state residents (see chart).

PERCENT OF HOUSEHOLDS LIVING AT OR BELOW 100% OF FEDERAL POVERTY LEVEL, 2009-13

[1] *Social Determinants of Health: How Social and Economic Factors Affect Health*. County of Los Angeles Public Health. 2013.
[2] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015



Source: US Census Bureau, American Community Survey. 2009-13.

- While the proportion of households with children that are below 100% FPL in the KFH-Fremont service area is lower than the state average (8% versus 22%), Black households with children are much more likely to be below 100% FPL (36%) than other households with children in the service area.
- Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. Compared to the Healthy People 2020 objective (6%), more than twice the proportion of households in the KFH-Fremont service area experienced food insecurity in the prior year (16%).

What Does the Community Say?

- Affordable housing is limited; multiple families are living in single family homes.
- A key informant noted that Latinos and Blacks have the highest foreclosure rates.
- Too few full-time jobs; residents are underemployed.
- Available jobs do not pay enough; people are working two or more jobs and still not making ends meet.
- Immigration status makes it difficult to obtain employment (e.g., have no Social Security card).
- Background checks and criminal backgrounds are making it difficult for residents to obtain employment.
- Residents are experiencing food insecurity: Families are stretching one weeks' worth of food to three weeks.

Profile of KFH-Fremont Service Area Health Needs

HEALTHCARE ACCESS AND DELIVERY

Why Is It Important?

LACK OF INSURANCE STILL AN ISSUE

Nearly 1 in 10 residents were uninsured in 2013, and nonwhites were more likely to be uninsured. Nearly one in six residents delayed or had difficulty obtaining care.

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.[1] Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. As reflected in the community comments, barriers to receiving quality care include: lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. As illustrated in the data below, these barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented.

Why Is It a Community Health Need?

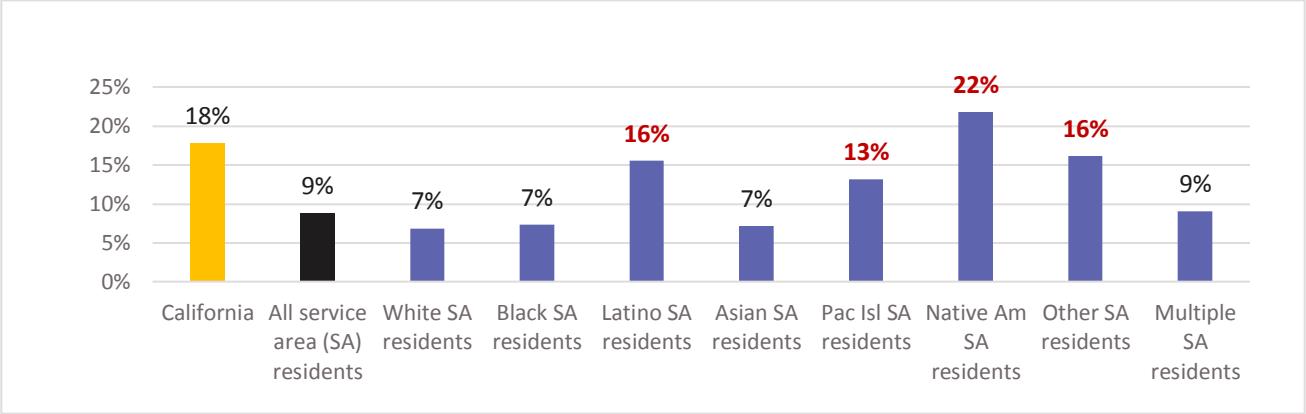
Wide disparities exist across multiple racial and ethnic groups in the uninsured population in the KFH-Fremont service area. The percentages of people in the county who had a usual source of care and who delayed or had difficulty obtaining care are both worse than the Healthy People 2020 (HP2020) objectives. The community is concerned about issues of affordability, lack of health system literacy, the limited supply of providers, inconvenient office hours, and the lack of integration of mental and physical healthcare.

What Do the Data Show?

- There are ethnic disparities in the population of uninsured in the KFH-Fremont service area. Groups in the service area uninsured at percentages higher than the state average include Pacific Islanders, Native Americans, and those of "some other race" (see chart).
- In Alameda County, a smaller percentage of people had a usual source of care (88%) compared to the HP2020 objective (95%). Data are not available for this indicator at the sub-county level.
- A much higher percentage of people delayed or had difficulty obtaining care in Alameda County (14%) compared to the HP2020 objective (4.2%). Data are not available for this indicator at the sub-county level.

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

PERCENT UNINSURED IN SERVICE AREA, 2009-2013



Source: US Census Bureau. 2013. American Community Survey 5-Year Estimates 2009-13.

What Does the Community Say?

- Issues of coverage/cost:
  - Insurance does not cover the care that is needed.
  - Insurance and co-payments are too high.
- Lack of health system literacy:
  - People lack knowledge of how the health system works.
  - Young people do not know how to access preventative care.
- Delivery issues:
  - Emergency Rooms (ERs) still used because of inconvenient clinic and hospital hours, lack of providers.
  - Wait times in the office are too long.
- Other problems:
  - Providers don't connect mental health to physical health.
  - Homeless population using ERs as shelter.

Profile of KFH-Fremont Service Area Health Needs

INFECTIOUS DISEASES

Why Is It Important?

HIV/AIDS CONTINUES TO BE A CONCERN

A larger proportion of area residents have HIV compared to the state, and Black residents have disproportionately higher rates.

Infectious diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood or semen). Infectious diseases remain a major cause of illness, disability, and death. People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection.[1] Infectious diseases are closely monitored to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and to allocate resources effectively.

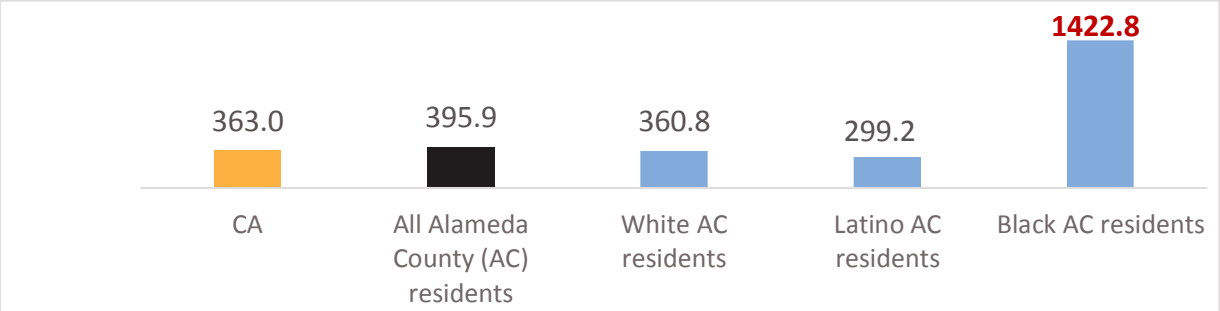
Why Is It a Community Health Need?

In the KFH-Fremont service area, HIV-related hospital discharge statistics show disparities for Black residents. In Alameda County, the statistics on HIV prevalence are worse than the state and show similar disparities. Also, the tuberculosis rate is much higher than the Healthy People 2020 (HP2020) objective, and pertussis cases have been rising in the county. The community expressed concern related to education of adolescents about sexual health.

What Do the Data Show?

- The HIV prevalence rate is higher in Alameda County than in the state, and the HIV prevalence rate among Black residents of the county is disproportionately higher (see chart). Data are not available for this indicator at the sub-county level.

HIV PREVALENCE RATE BY ETHNICITY, ALAMEDA COUNTY, 2010



Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2010.

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- HIV patients accounted for 0.06% of all hospital discharges in the KFH-Fremont service area, compared to 0.14% of all hospital discharges in the state; however, Black HIV patients comprised 0.60% of all hospital discharges in the service area. Young HIV patients (ages 1-19) comprised 0.11% of all hospital discharges in the service area, while those ages 20-44 comprised half that (0.05%), and those ages 45-64 comprised 0.18%.

- The tuberculosis (TB) incidence rate is 7.9 per 100,000 residents in Alameda County, much higher than the HP2020 objective of 1.0.[2] Data are not available for this indicator at the sub-county level.

- The pertussis incidence rate (per 100,000) has been rising over the past three years to 25.1 in Alameda County (from 62 cases in 2012 to 364 cases in 2014), compared to 29.3 for the state.[3] Data are not available for this indicator at the sub-county level.

What Did the Community Say?

- While statistics for teen pregnancy are better in the service area than the state, the community felt sexual health education & general healthy decision-making for teens was lacking.

- The Alameda County Public Health Department notes that "the pertussis epidemic is continuing in California & Alameda County."

- Efforts in the state to require public schools to enforce immunization policies related to enrollment may have had a positive effect in 2015; data are not yet available.

[2] Healthy Communities Institute. 2015. *Healthy Alameda County*. Web. November 2015.
[3] *Pertussis Report*. California Department of Public Health. Web. October 2015.

Profile of KFH-Fremont Service Area Health Needs

MATERNAL AND CHILD HEALTH

Why Is It Important?

Improving the well-being of mothers, infants, and children is an important public health goal. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system.[1] The topic area of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birth-weight, infant mortality, teen births, breastfeeding, and access to prenatal care. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.[1]

LOW HEAD START PROGRAM ENROLLMENT

The Head Start Program enrollment rate is much lower in the service area than in the state. Also, the Black infant mortality rate is higher than the state average.

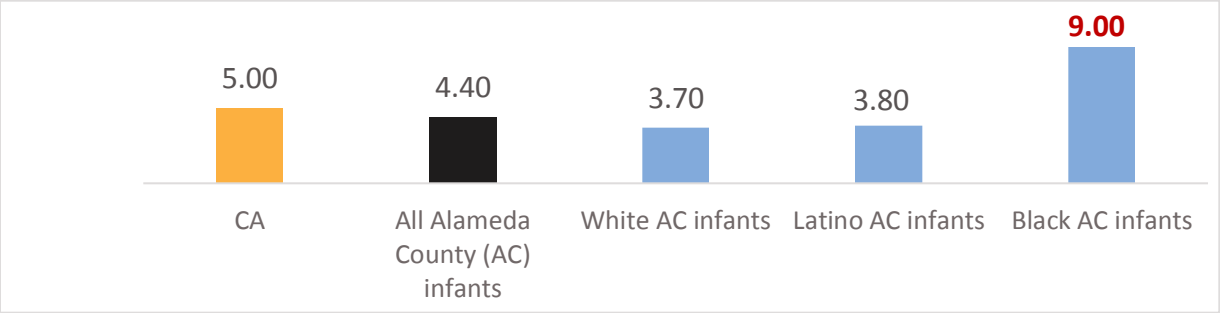
Why Is It a Community Health Need?

In the KFH-Fremont service area, the statistics on Head Start Program enrollment and food insecurity are worse than the state. Also, the infant mortality rate shows ethnic disparities. The community felt sexual health education & healthy decision-making for teens was lacking, and was concerned about food insecurity.

What Do the Data Show?

- While the infant mortality rate is lower in Alameda County than in the state, the Black infant mortality rate in Alameda County is disproportionately higher (see chart). Data for this indicator are not available at the sub-county level.

INFANT MORTALITY RATE BY ETHNICITY, ALAMEDA COUNTY, 2006-2010



Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- Head Start Program enrollment is relevant because access to education is a primary social determinant of health and is associated with increased economic opportunity, access to social resources (i.e., food access, and spaces and facilities for physical activity), and positive health status and outcomes. Only 2.2 per 10,000 children under the age of five in the KFH-Fremont service area attended a Head Start Program facility, far below the state average (6.3).

- While the proportion of households with children that are below 100% FPL in the KFH-Fremont service area is lower than the state average (8% versus 22%), Black households with children in the service area are much more likely to be below 100% FPL (36%) than other households with children in the service area.

- Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. It is also a sign of other community vulnerabilities, such as poverty, lack of access to social services, and insufficient food systems. Compared to the Healthy People 2020 objective (6%), more than twice the proportion of households in the KFH-Fremont service area experienced food insecurity in the prior year (16%).

- Positive indicator:

  ➥ Overall, a greater proportion of mothers are breastfeeding their babies during their hospital stay in Alameda County (96%) than in the state (93%).

What Did the Community Say?

- While statistics for teen pregnancy are better in the service area than the state, the community felt sexual health education & general healthy decision-making for teens was lacking.

- Residents are experiencing food insecurity: Families are stretching one weeks' worth of food to three weeks.

Profile of KFH-Fremont Service Area Health Needs

MENTAL HEALTH

Why Is It Important?

MENTAL HEALTH CARE LACKING

The rate of ER visits for self-inflicted injuries among youth is higher in the service area than the state, and the community feels there are not enough mental health providers.

Mental health is a state of successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. [1] Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[1]

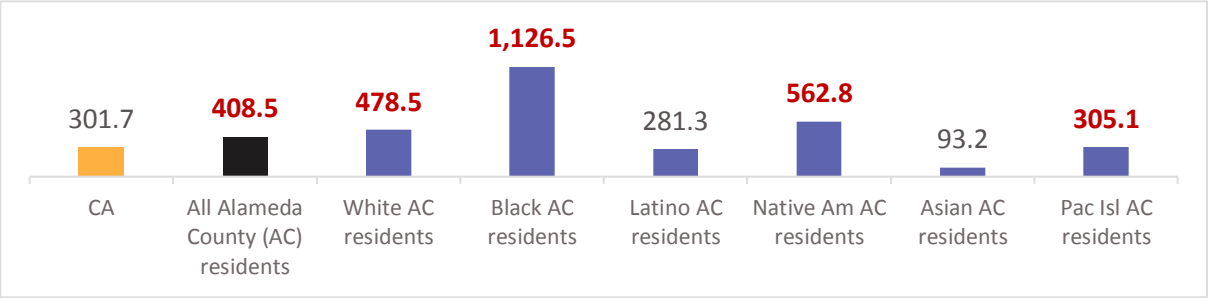
Why Is It a Community Health Need?

In the KFH-Fremont service area, the rate of ER visits for injury due to intentional self-harm among youth is higher than the state average and Healthy People 2020 (HP2020) goal. The suicide rate among Whites in the service area is higher than the state; the rate of severe mental-illness related ED visits by Blacks in the county is much higher than the state. The community feels there are not enough providers, and insurance coverage is limited.

What Do the Data Say?

- In Alameda County, Black adults are much more likely to visit the Emergency Department for severe mental illness compared to the rate for the state (see chart).[2] Data for this indicator are not available at the sub-county level.

RATE OF SEVERE MENTAL ILLNESS RELATED EMERGENCY DEPARTMENT VISITS, ALAMEDA COUNTY, 2011-2013



Source: OSHPD. 2011-2013.

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[2] Healthy Communities Institute. 2015. *Healthy Alameda County*. Web. November 2015.

- The rate of Emergency Department visits for injury due to intentional self-harm among youth (including attempted suicide) per 100,000 population ages 13-20 in the KFH-Fremont service area (954.1) is higher than the state rate (738.7).
- Whites in the KFH-Fremont service area report a need for mental health care at a higher percentage (23%) than the state (16%) or other ethnic groups in the service area, such as Blacks (4%) or Latinos (8%).
- White adults in the KFH-Fremont service area have a higher suicide morality rate (13.0 per 100,000) than the state average (9.8) or the HP2020 objective (10.2). White suicide rates in the service area are much higher than those of other ethnic groups in the service area: Latinos (4.1), Asians (4.8), and Blacks (5.8) all have rates that are much lower than the White rate and lower than both the state average and the HP2020 target.

What Does the Community Say?

- People do not consider mental health an illness.
- The community feels there is a lack of mental health providers.
- There is a lack of information as to where and who to speak with to obtain services.
- The community has experienced poor discharge procedures and lack of follow-up after mental health emergencies.
- There is a lack of “placement care” and behavioral health services for adolescents.
- A lot of mental health providers don't accept insurance.

Profile of KFH-Fremont Service Area Health Needs

OBESITY/DIABETES/HEAL (HEALTHY EATING ACTIVE LIVING)

Why Is It Important?

Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.[1] For example, having healthy food available and affordable in food retail and food service settings allows people to make healthier food choices. When healthy foods are not available, people may settle for foods that are higher in calories and lower in nutritional value.[2] Creating and supporting healthy food environments allow people to make healthier choices and live healthier lives.

LOW ACCESS TO HEALTHY FOOD

The ratio of fast food establishments to the number of residents is higher in the KFH-Fremont service area than in the state, as is the proportion of residents who live in a food desert.

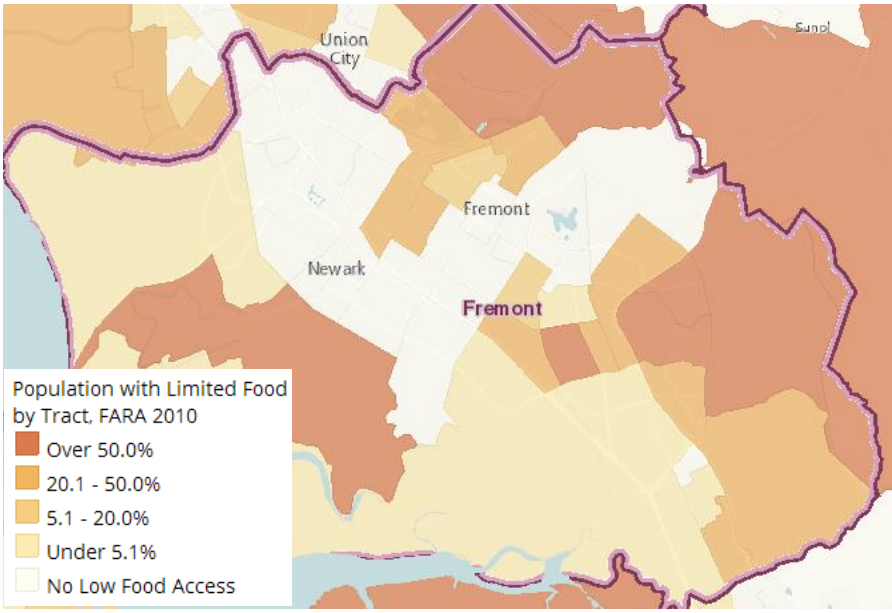
Why Is It a Community Health Need?

The KFH-Fremont service area has issues related to access to healthy food – the ratio of fast food establishments and WIC-authorized food stores to residents and the proportion of residents who live in a food desert are all worse than the state. Youth levels of inadequate fruit & vegetable consumption are also worse in the KFH-Fremont service area than in the state. Residents reflect these issues with their concern about access to healthy foods.

What Do the Data Show?

- There are more fast food establishments per 100,000 residents in the KFH-Fremont service area (83.4) than per 100,000 residents in the state (74.5).
- A food desert is defined as a low-income census tract where a substantial share of residents has low access to a supermarket or large grocery store. In the KFH-Fremont service area, 20% of residents live in areas designated as a food desert, which is much worse than the state average (14%). (See chart for service area details.)

FOOD DESERT POPULATION BY CENSUS TRACT, 2013-14



[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[2] *Healthy Food Environments*. Centers for Disease Control and Prevention. Web. December 2015.

- There are fewer WIC-authorized food stores per 100,000 residents in the KFH-Fremont service area (12.2) than in the state (15.8).
- In the KFH-Fremont service area, a larger percentage of youth consume inadequate amounts of fruits and vegetables (60%) than the state average of 47%.
- Half the proportion of adults walk or bike to work (2%) in the service area than the state average (4%).
- Diabetes management (annual hemoglobin A1c testing) among Medicare enrollees in the KFH-Fremont service area (80%) is slightly lower than the state (81%).

What Does the Community Say?

- There is a lack of access to healthy foods (i.e., fresh produce).
- Community feels it is expensive to eat healthy.
- Residents are experiencing food insecurity: Families are stretching one weeks' worth of food to three weeks.
- Lack of affordable sports and recreational activities for youth and adults (e.g., fitness classes, open spaces for exercise).
- Community believes culturally familiar food is unhealthy: "Eating healthy isn't always a top priority for new immigrants; eating food that is familiar to them provides comfort."
- Providers do not give culturally-specific nutrition recommendations.
- Key informants noted there are lots of multiple diagnoses (e.g., obesity, hypertension, asthma all co-occurring).
- Key informants stated that Latinos & Blacks tend to have higher levels of obesity, diabetes, and hypertension.

Data found in this 2016 Community Health Needs Assessment health profile was retrieved from the Community Commons platform unless otherwise noted. For more details, download the full CHNA report at http://share.kaiserpermanente.org/article/community-health-needs-assessments.

Profile of KFH-Fremont Service Area Health Needs

SUBSTANCE ABUSE

Why Is It Important?

ALCOHOL USE A CONCERN

Indicators of alcohol use show that service area residents may use alcohol more frequently than California residents generally do.

The abuse of substances, including alcohol, tobacco, and other drugs, has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases such as cancer, heart disease, and respiratory diseases.[1] The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime and suicide.[2] Advances in research have led to the development of effective evidence-based strategies to address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have shifted the research community's perspective on substance abuse. Substance abuse is now understood as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.[2]

Why Is It a Community Health Need?

Data available on alcohol use show that KFH-Fremont service area residents may be using alcohol more frequently than Californians generally do. Data about illegal drug use are not available, but the community expressed concern about drug and alcohol use and the lack of treatment services available to address this problem. Countywide, Blacks have much higher ER visit rates for substance abuse than those of other ethnicities.

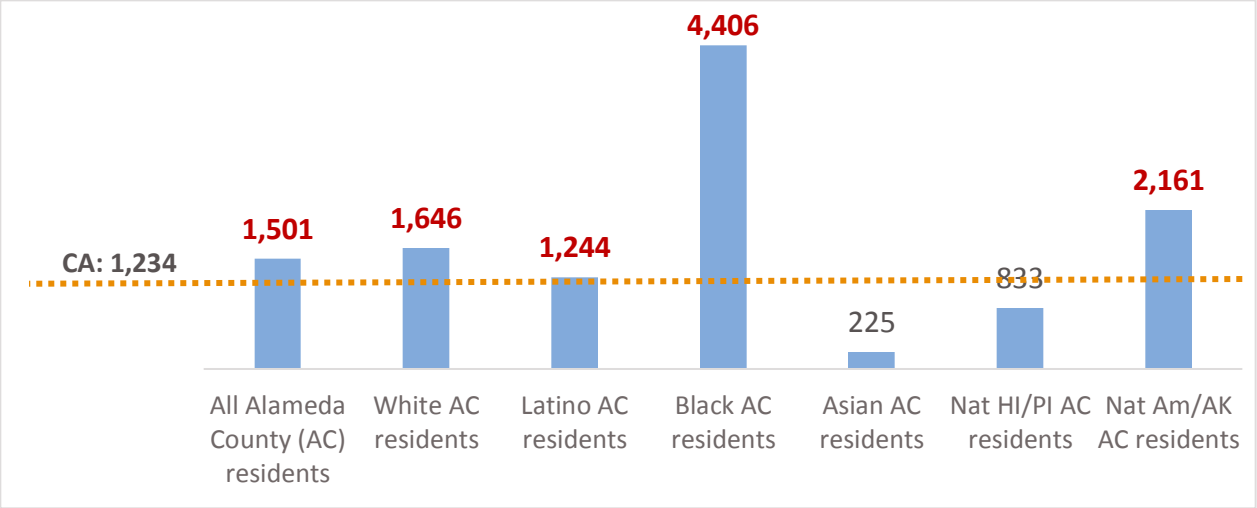
What Do the Data Show?

- The rate of binge drinking in the KFH-Fremont service area is 20%, higher than the state average of 17%.
- Nearly 14% of the KFH-Fremont service area residents' total household expenditures are towards alcohol, slightly higher than the state average (just under 13%).

[1] *Smoking and Tobacco Use, Health Effects*. Centers for Disease Control and Prevention. Web. December 2015.
[2] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- The Alameda County rate of Emergency Room (ER) visits for substance abuse is higher than the state rate. Countywide, Blacks have much higher ER visit rates for substance abuse than those of other ethnicities (see chart). Data for this indicator are not available at the sub-county level.

SUBSTANCE ABUSE EMERGENCY DEPARTMENT VISIT RATE IN ALAMEDA COUNTY, 2011-2013



Source: *Healthy Alameda County,* Alameda County Public Health Department. 2011-2013.

What Does the Community Say?

- Only one sobering center in the area; not enough capacity to meet need.
- Transportation to treatment programs is difficult (not enough public transit).
- ER is getting many drunk people that police won't take, leading to ER overcrowding.
- Community feels the number of residents addicted to prescription pain medication is growing.
- Community expressed concerns about Veterans' Administration (VA) substance abuse program in Alameda County ("not strong").

Profile of KFH-Fremont Service Area Health Needs

VIOLENCE/INJURY PREVENTION

Why Is It Important?

Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior, according to the World Health Organization's "World Report on Violence and Health."[1] Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. In one international study, individuals who reported feeling unsafe to go out in the day were 64% more likely to be in the lowest quartile of mental health.[2] Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. For example, a study in the San Francisco Bay area showed that youth who were exposed to violence showed higher rates of self-reported PTSD, depressive symptoms, and perpetration of violence.[3]

ETHNIC DISPARITIES IN HOMICIDE RATES

The Black service area population experiences homicide at a much higher rate than do populations of other ethnicities in the service area. Community members expressed concern about domestic violence.

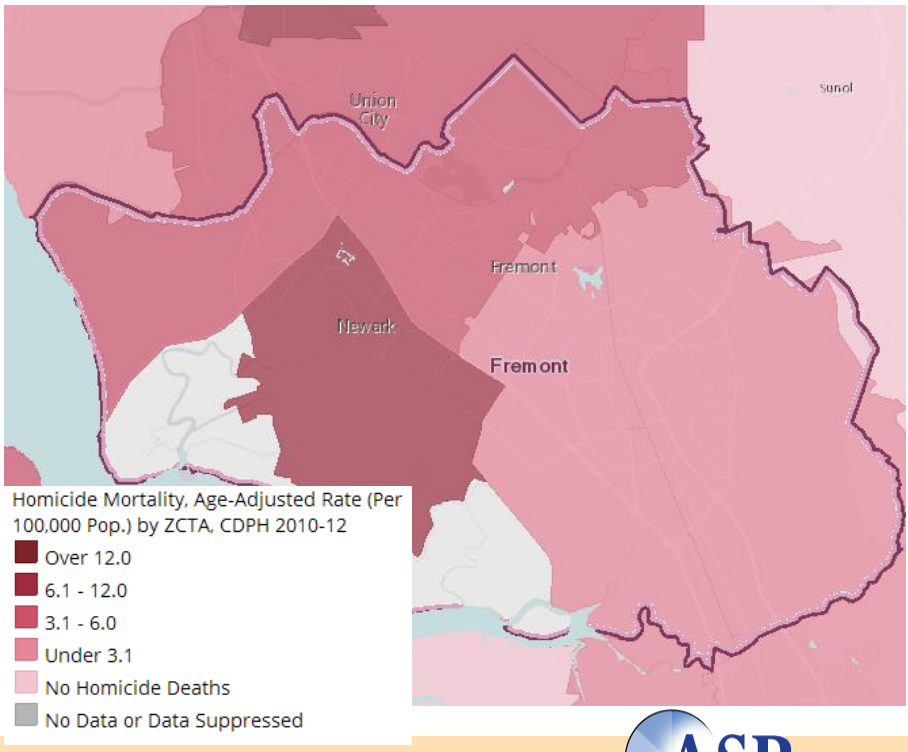
Why Is It a Community Health Need?

In the KFH-Fremont service area, the Black population experiences homicide at a much higher rate than do populations of other ethnicities. In addition, the school suspension rate is worse than the state rate. The community expressed concern about unsafe streets and domestic violence.

What Do the Data Show?

- The age-adjusted homicide mortality rate in the KFH-Fremont service area is 3.6, below the state average of 5.2. However, it is much higher in the city of Newark (see map), and ethnic disparities are stark, with Blacks in the KFH-Fremont service area having a homicide mortality rate (42.1) more than 15 times higher than Whites (2.3) and nearly eight times higher than Latinos (5.6). Native Hawaiians/Pacific Islanders, while only a small percentage of the Fremont service area population, have a high homicide mortality rate as well (12.9).

HOMICIDE RATE BY ZIP CODE, 2010



- Indicators of violence are worse in Alameda County than in the state (data are not available for these indicators at the sub-county level). For example:
  - The rate of rape in the county (30.8) is much higher than the state (21.0).
  - The rate of domestic violence (non-fatal ER visits) per 100,000 females age 10 and over in the county is much higher (12.0) than the state rate (9.5).
  - The rate of assault injury (non-fatal ER visits) in the county (394.2) is higher than the state (290.3).
- School suspensions are a relevant indicator because exclusionary school discipline policies are associated with engagement with the juvenile justice system and incarceration as an adult, as well as poor economic security and mental health outcomes. The KFH-Fremont service area's rate of school suspensions is much higher than the state (6.1 per 100 enrolled students compared to 4.0).

What Does the Community Say?

- People worry about being attacked when they walk along the streets.
- Community feels there is a lack of empathy from health care and law enforcement towards victims.
- Domestic violence (DV):
  - Lack of effective screening for DV victims. Often DV victims are prevented by abuser from having a primary care provider.
  - Poor communication/lack of connection between clinics and DV organizations for referrals.
  - Not enough providers and facilities for DV victims; existing facilities have wait lists.

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[1] Krug, E.G., Dalhberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (Eds.). (2002). World report on violence and health. World Health Organization, Geneva, Switzerland. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

[2] Guite, H.F., Clark, C., & Ackrill, G. (2006). The impact of the physical and urban environment on mental well-being. *Public Health 120:*1117-1126 as cited in Human Impact Partners. Retrieved from http://www.humanimpact.org/evidencebase/category/violent_crime_in_a_community_impacts_physical_and_mental_health

[3] Perez-Smith, A.M., Albus, K.E., & Weist, M.D. (2001). Exposure to violence and neighborhood affiliation among inner-city youth. *Journal of Clinical Child Psychology, 30*(4):464-472; Ozer, E.J. & McDonald, K.L. (2006). Exposure to violence and mental health among Chinese American urban adolescents. *Journal of Adolescent Health, 39*(1):73-79, as cited in Human Impact Partners retrieved from http://www.humanimpact.org/evidencebase/category/violent_crime_in_a_community_impacts_physical_and_mental_health