2016 Community Health Needs Assessment

Kaiser Foundation Hospital – Oakland and
Kaiser Foundation Hospital – Richmond
License #140000052

Approved by KFH Board of Directors
September 21, 2016

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

KAISER PERMANENTE®

KAISER PERMANENTE NORTHERN CALIFORNIA REGION
COMMUNITY BENEFIT
CHNA REPORT FOR KFH-OAKLAND AND KFH-RICHMOND

ACKNOWLEDGEMENTS

This report was prepared by Applied Survey Research (ASR) on behalf of the hospitals listed in this report. ASR gratefully acknowledges the contributions of the following individuals:

- Diana Camacho, **John Muir Health**
- Molly Bergstrom, **Kaiser Permanente – Diablo Area**
- Jean Nudelman, **Kaiser Permanente – East Bay Area**
- Debra Lambert, **Kaiser Permanente – Greater Southern Alameda Area**
- Michael Cobb, **St. Rose Hospital**
- Sue Fairbanks, **San Ramon Regional Medical Center**
- Karen Reid, **San Ramon Regional Medical Center**
- Tim Traver, **San Ramon Regional Medical Center**
- Denise Bouillerce, **Stanford Health Care – ValleyCare**
- Shelby Salonga, **Stanford Health Care – ValleyCare**
- Adam Davis, **UCSF Benioff Children's Hospital Oakland**
- Lucy Hernandez, **Washington Hospital Healthcare System**
- Ruth Traylor, **Washington Hospital Healthcare System**

ASR is also pleased to acknowledge the contributions of the following individuals:

- Dale Ainsworth, **California State University, Sacramento**
- Marianne Balin, **Kaiser Permanente – Diablo Area**
- Debi Ford, **San Ramon Regional Medical Center**
- Susan Miranda, **Kaiser Permanente – Greater Southern Alameda Area**
- Dana Williamson, **Kaiser Permanente – Northern California Region**

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

BAY AREA OFFICE
1871 The Alameda, Suite 180
San Jose, CA 95126
Phone: (408) 247-8319| Fax: (408) 260-7749

TABLE OF CONTENTS

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 completed 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-Oakland and KFH-Richmond 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-Oakland and KFH-Richmond worked with UCSF Benioff Children's Hospital Oakland to understand health needs in their shared service areas. KFH-Oakland and KFH-Richmond 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-Oakland and KFH-Richmond service areas where available. Where service area was not available, county data were used including data from local public health departments. If indicators for KFH-Oakland and KFH-Richmond performed poorly against a target, 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 targets. (See Section VI for more information.)

Community Health Needs Identified for KFH-Oakland (KFH-O) and KFH-Richmond (KFH-R) 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.	Youth levels of obesity are worse in the KFH-O and KFH-R service areas than in the state overall. Black and Latino youth are disproportionately obese compared to youth overall in the service areas. Community input indicates that obesity among youth is of highest concern, and lack of access to affordable, healthy food is driving this health need.
2. 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 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.	Rates of domestic violence and assault injury in KFH-O and KFH-R service areas are higher than the state averages. In addition, homicide and school suspension rates in the KFH-O and KFH-R service areas are worse than state rates. In both services areas, ethnic disparities are stark, with Blacks having much higher homicide mortality rates than those of other ethnicities. Community input indicates that gang violence is a major issue, and that there are not enough programs/providers to address violence in the community.
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 child's life, even if social conditions subsequently improve.	The percentage of residents who experienced food insecurity at some point during the year is higher in KFH-O and KFH-R service areas than the HP2020 goal. In the KFH-O and KFH-R service areas, more than one in eight residents experience food insecurity. In addition, in the KFH-O service area, the proportions of Black, Latino, Asian, Native American, and Pacific Islander residents and residents of "some other race", living below the Federal Poverty Level (FPL) are higher than the overall state average. Community input suggests that affordable housing is a major issue.
4. Mental health	Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the	The rate of suicide in Contra Costa County is higher than the HP2020 goal and the rate of severe mental illness emergencies in Alameda

Health need	Why is it important?	What do the data say?
	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.	County is substantially higher than the state average. In addition, the rates of ER visits for intentional injuries (including self-harm) among youth in the KFH-O and KFH-R service areas are higher than the state. Community input indicates that cultural/language barriers make it harder to access mental health care, and that the lack of linkages between primary care and mental health care is negatively impacting community health.
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.	Levels of excessive alcohol consumption ("binge drinking") among adults are higher in both service areas than the state average. In addition, data available on alcohol use shows that KFH-O and KFH-R service area residents may be using alcohol more frequently than Californians overall. Community feedback indicates that residents are using drugs and alcohol to self-medicate, and alcohol is especially easy to access.
6. 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.	More than 1 in 10 residents in the KFH-O and KFH-R service areas are uninsured. Nonwhites in both service areas are more likely to be uninsured and to lack a consistent source of primary care. There are also higher rates of preventable hospital events in both service areas compared to the state average. A higher percentage of people delayed or had difficulty obtaining care in Alameda County compared to the HP2020 objective. The community input indicates that insurance premiums and co-payments are too high and wait times for appointments are too long.

Health need	Why is it important?	What do the data say?
7. Sexually transmitted infections	Sexually transmitted infections are diseases that are primarily transmitted through direct sexual contact with an infected individual or their discharge (such as blood or semen). They include HIV/AIDS, syphilis, chlamydia, gonorrhea, and genital herpes. Some, if left untreated, can be fatal (HIV), or can affect fertility among those of child-bearing age.[1] Communicable diseases such as sexually transmitted infections are closely monitored to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and to allocate resources effectively.	HIV/AIDS continues to be a concern. There is a high prevalence rate of HIV among Blacks in both Alameda and Contra Costa counties. In the KFH-O service area, HIV rates are higher than the state. The rate of reported AIDS cases is higher in Contra Costa County (which contains the KFH-R service area) than the HP2020 goal. The community input indicates that there is a concern related to education of adolescents about sexual health.
8. Asthma	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 prevalence rates among adults are higher in the KFH-O and KFH-R service areas than the state average. In the KFH-O and KFH-R service area, nearly one in six adults have asthma. In the counties containing the service areas, about one in five children have asthma. Community input about asthma was focused on younger children.
9. Infectious diseases non-STIs)	Infectious diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood). 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.	Pertussis cases in both Alameda and Contra Costa counties more than tripled between 2013 and 2014. The Alameda County Public Health Department has expressed concern over the "pertussis epidemic" in both counties.
10. 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	In the KFH-O and KFH-R service areas, incidence rates of breast, colorectal, and prostate cancer are too high compared to national/state targets. For Contra Costa County, death rates from breast and colorectal cancer are higher than the

[1] *CDC Fact Sheet: Staying Healthy and Preventing STDs.* Centers for Disease Control and Prevention. Web. January 2016.

Health need	Why is it important?	What do the data say?
	burden, along with the availability and accessibility of high-quality screening.	HP2020 goals. In addition, Blacks and Whites in both service areas have higher cancer mortality rates and colorectal and prostate cancer incidence rates than the state. Key informant input suggests that Blacks in the community have worse cancer outcomes than those of other ethnicities.

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. Needs were then prioritized by a group that included representatives from KFH-Oakland, KFH-Richmond, 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.[2]

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,[3] 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).[4] Previous years (2011 and 2012) had seen the uninsured rate at 14%, demonstrating an unexpected increase between 2011 and 2013 in Alameda County.[5] Also according to the California Health Interview Survey, in 2014 18% of the population aged 18-64 in Contra Costa County was not insured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013, when 16% of that population was uninsured.[5]

Although some Alameda County and Contra Costa 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).[3]

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.[6] 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%).[7] 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.

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

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

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

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

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

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

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 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-Oakland and KFH-Richmond 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

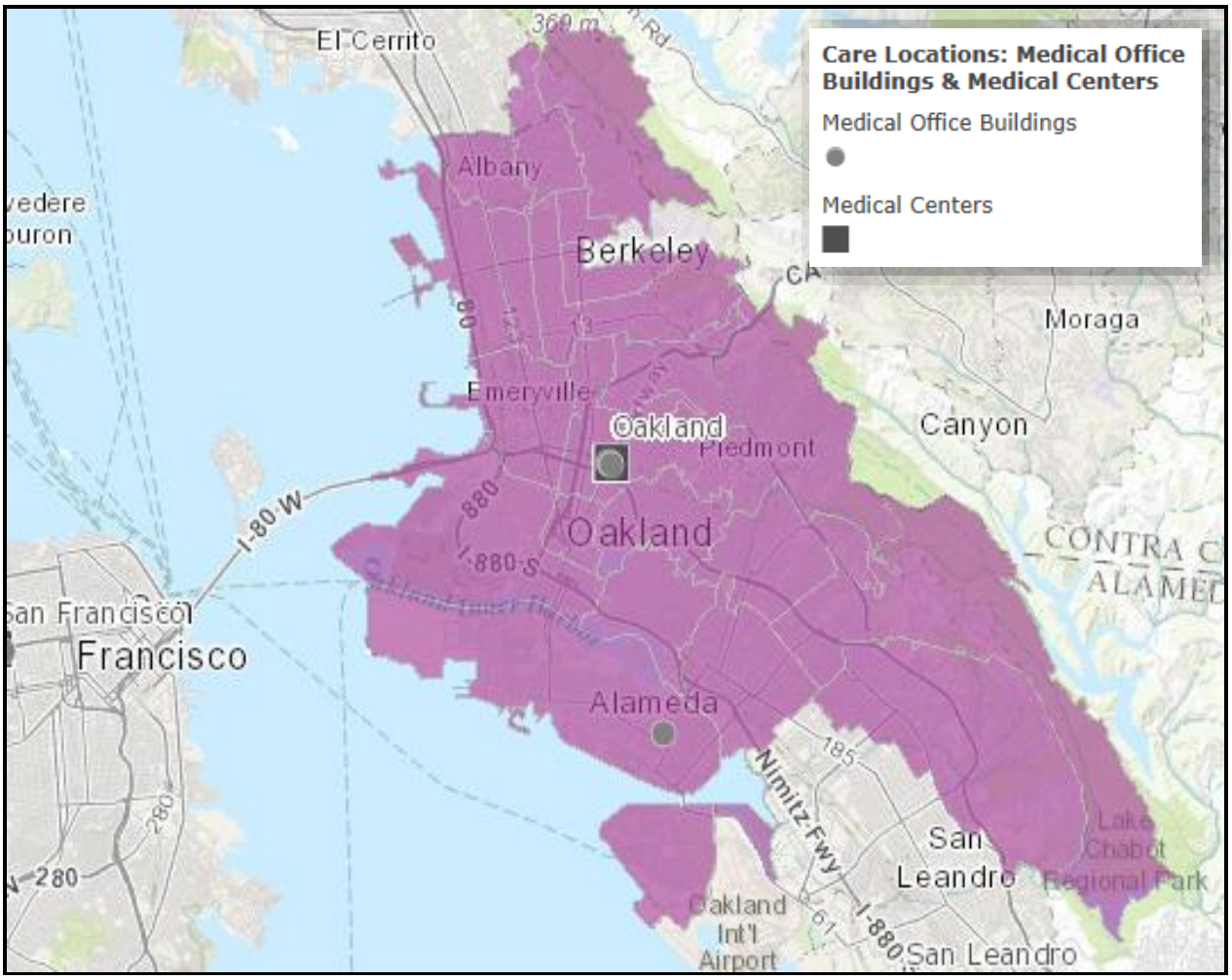
Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and Description of Community Served

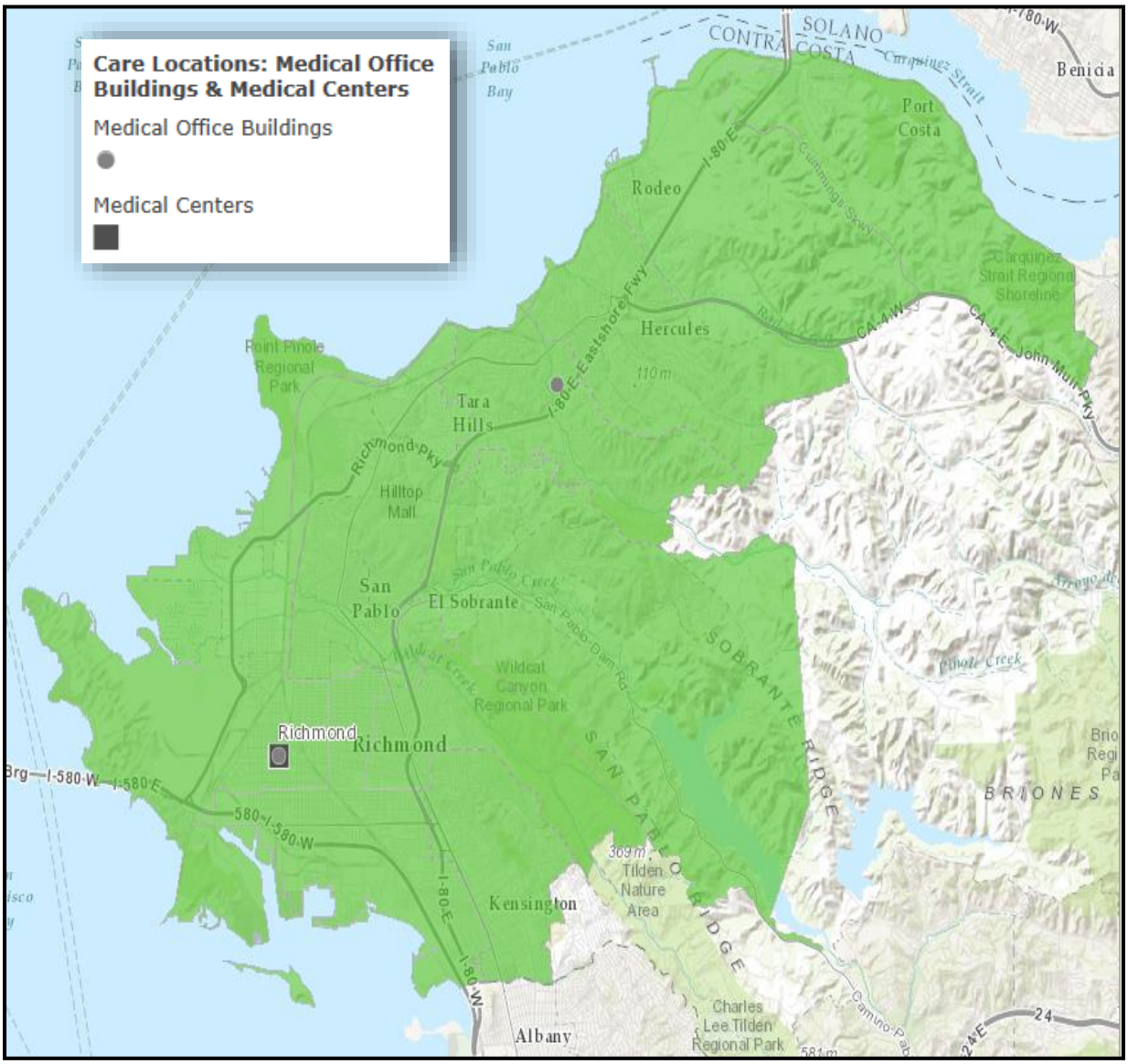
Because KFH Oakland and KFH Richmond share a hospital license, they are considered a single hospital facility by the IRS for the purposes of CHNA. Since the two hospital service areas are located in different counties, there are differences between populations, resources, and needs. So, while the results of the CHNA are combined into one report here, the data is presented separately in order to understand the differences between the two hospital geographies.

i. Maps of KFH-Oakland and KFH-Richmond service areas

KFH-Oakland Service Area Map



KFH-Richmond Service Area Map



ii. Geographic description of the communities served

The KFH-Oakland service area includes the major cities of Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont in Alameda County, as well as unincorporated areas covered by the map above.

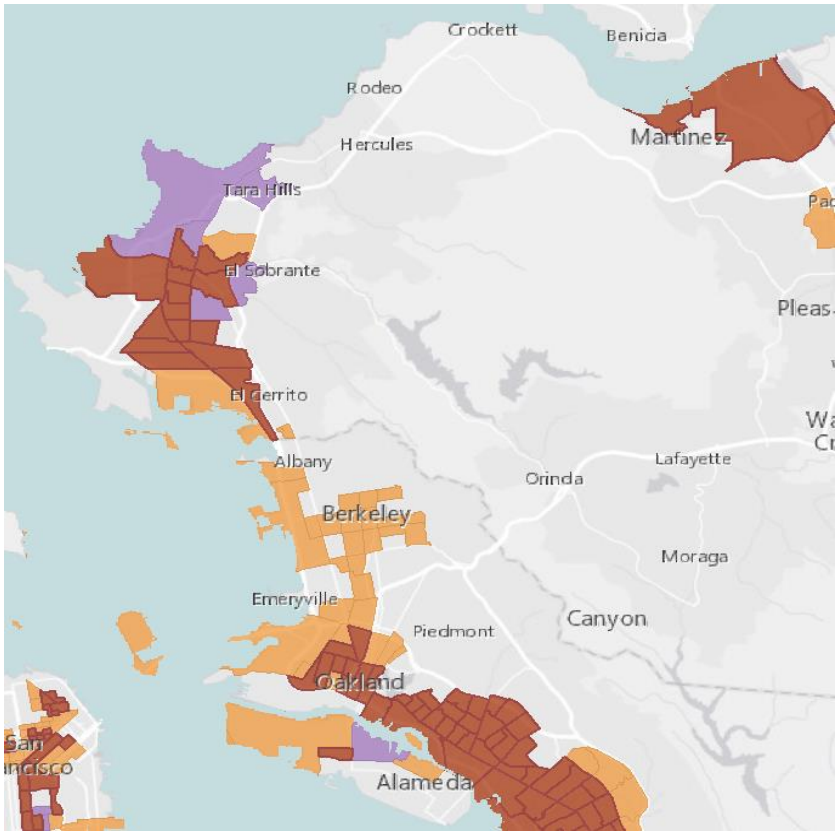
The KFH-Richmond service area includes the major cities and towns of Crockett, El Cerrito, El Sobrante, Hercules, Pinole, Richmond, Rodeo, and San Pablo in Contra Costa County, as well as unincorporated areas covered by the map above.

iii. Demographic profile of communities served

Demographic Data	KFH Oakland	KFH Richmond
Total Population	574,123	251,325
White	48.36%	46.8%
Black	17.51%	17.31%
Asian	20.93%	19.19%
Native American/ Alaskan Native	0.6%	0.48%
Pacific Islander/ Native Hawaiian	0.48%	0.37%
Some Other Race	5.72%	9.67%
Multiple Races	6.4%	6.19%
Hispanic/Latino	16.69%	33.99%

Socio-economic Data	KFH Oakland	KFH Richmond
Living in Poverty (<200% FPL)	33.43%	33.59%
Children in Poverty	20.43%	19.75%
Unemployed	6.6%	6.9%
Uninsured	12.32%	16.35%
No High School Diploma	12.5%	18.7%

KFH-Oakland and KFH-Richmond Service Areas Vulnerability Footprint



The orange shading shows areas where the percentage of population living at-or-below 100% of the Federal Poverty Level (FPL) exceeds 16%. The purple shading shows areas where the percentage of the population with no high school diploma exceeds 18%. 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.

Over half (56%) of the children in the KFH-Oakland service area and nearly three quarters (71%) of the children in the KFH-Richmond service area are eligible for Free & Reduced-Price lunch (NCES Common Core of Data 2013-14), while more than one in five children (20% in the KFH-Oakland service area and 22% in the KFH-Richmond service area) lives in a household with income below 100% of the Federal Poverty level (U.S. Census Bureau, American Community Survey, 2009-2013). Over one in 10 people (13%) in the KFH-Oakland service area are uninsured, while nearly one in five (18%) in the KFH-Richmond service area 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-Oakland and KFH-Richmond 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-Oakland and KFH-Richmond worked together. The Hospitals then used the primary and secondary data collected that pertained to their respective service areas for identification of needs.

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 its 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.

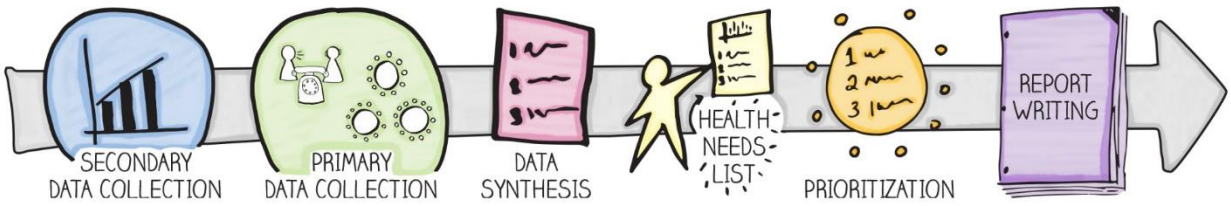
Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Alameda, Contra Costa, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties,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

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

In 2013, our hospitals 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 hospitals, 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-Oakland and KFH-Richmond 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-Oakland and KFH-Richmond 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.

Data for 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.

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

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

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-Oakland and KFH-Richmond service area data. If data were not available for this area, 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 59 individuals through focus groups and individual interviews.

In all, ASR consulted with 39 professional community representatives of various organizations and sectors through 21 key informant interviews and two focus group (which included 18 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 and City Public Health (8)
- Other health centers or systems (9)
- Mental/Behavioral health or violence prevention providers (6)
- School system representatives (2)
- City or county government representatives (1)
- Nonprofit agencies providing basic needs (2)
- Other nonprofit agencies serving children, seniors, veterans, and/or families (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 interview).

a. Key Informant Interviews

ASR conducted primary research via key informant interviews with 21 Alameda and Contra Costa County experts from various organizations. Between June and October 2015, experts including the 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

Two focus groups with stakeholders were 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, 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 Groups with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Medically underserved	UCSF Benioff Children's Hospital Oakland	09/02/15	9
Children	Contra Costa County Child Care Council (CCCCC)	09/28/15	9

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

c. Resident Input

Resident focus groups were conducted between September 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, 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 and Contra Costa counties, the Hospitals targeted participants who are medically underserved, in poverty, of a minority population, and/or who are socially, linguistically, or geographically isolated. Two focus groups were held with community members.

These resident groups were planned in various geographic locations around the service areas. Residents were recruited by nonprofit hosts, such as Alameda County Care Alliance, who works to improve care and respond to needs in the community.

Details of Focus Groups with Residents

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Caregivers	Alameda County Care Alliance	09/10/15	6
Spanish-speaking minority, low-income, youth	UCSF Benioff Children's Hospital Oakland and Allen Temple Baptist Church	10/14/15	14

Twenty community members participated in the focus group discussions in Alameda and Contra Costa Counties. All participants were asked to complete an anonymous demographic survey, the results of which are reflected below.

- 100% of participants (20) completed a survey.
- 70% (14) of participants were Latino. 25% were Black, and 5% did not report their ethnicity.

- 60% (12) were under 18 years old, and 10% were age 65 or older.

- 5% (1) were uninsured, while 70% had benefits through Medi-Cal, Medicare, or another public health insurance program. 20% had private insurance of some kind (including Kaiser), and 5% did not report what type of insurance they had.

- Residents lived in various areas of the counties: Oakland (8), Pittsburg and Hayward (3 each), Berkeley, Fremont, Newark (1 each), and other unidentified parts of the counties (3).

- 60% (12) reported coming from households with an annual income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Alameda County and Contra Costa County for two adults with no children (Alameda County $38,817; Contra Costa County $38,169). More than one-third (35%) came from households earning under $25,000 per year, which is below Federal Poverty Level for a family of four. This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California. One-quarter of respondents did not report their household income.

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

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 the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, our hospitals had not received written comments about previous CHNA reports. KFH-Oakland and KFH-Richmond 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"

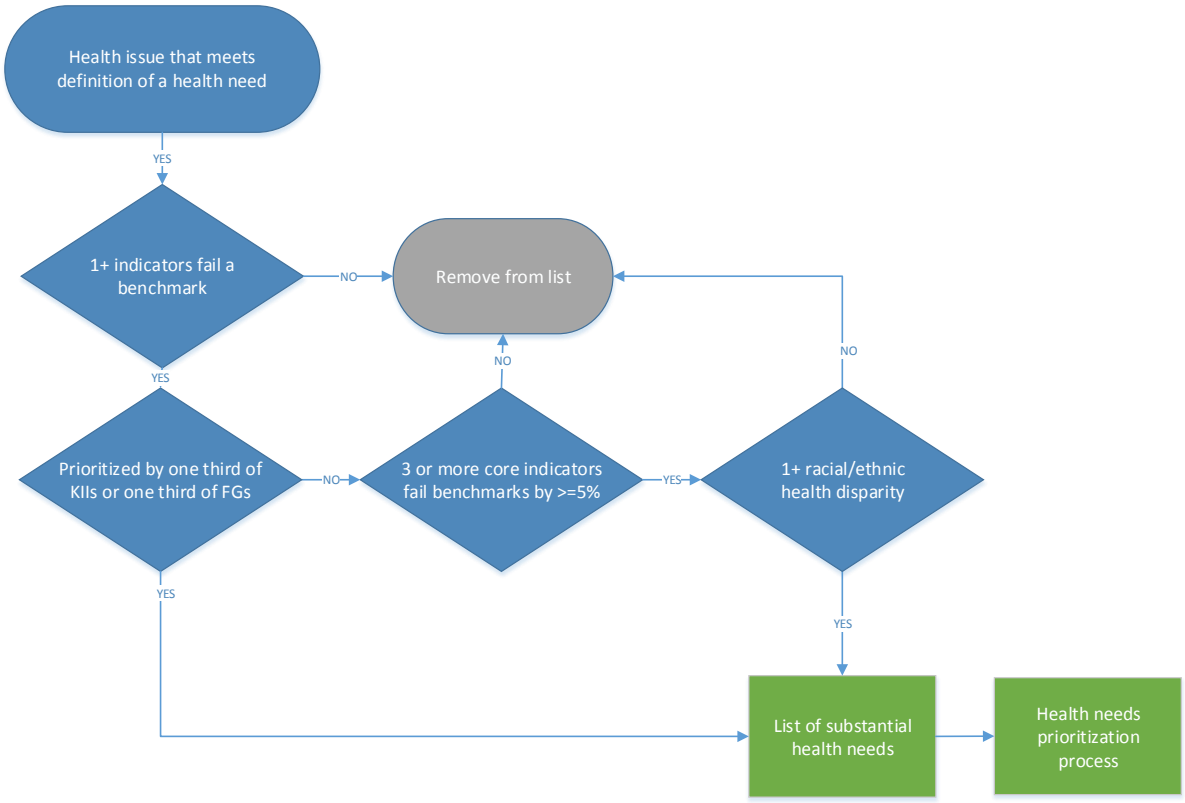
For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.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

KFH-Oakland & KFH-Richmond Health Needs Identification Process



A total of 10 health conditions or drivers fit the main three criteria above or the conditional criteria and were retained as community health needs. The list of needs, in priority order, is found below.

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

Before beginning the prioritization process, KFH-Oakland and KFH-Richmond 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 it's potential to cause death or disability) and its degree of poor performance against the relevant target
- **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.
- **Good interventions exist:** Interventions for this health need exist that are both effective and feasible. The interventions may be fully evidence-based, or may be "promising practices" (practices that have strong data showing positive outcomes, but not yet enough research or replication to support an "evidence-based" classification).
- **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 working list was then created, listing each of the health needs in alphabetical order and offering the first three prioritization criteria for rating. Community representatives and representatives of the local hospitals rated each of the health needs on each of the first four prioritization criteria during an in-person meeting in January 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 for each criterion, for each need. 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 need scores ranged between 1.95 and 2.80 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.

Rank	Health Need	Overall Average Priority Score
1	Obesity, Diabetes, Healthy Eating/Active Living	2.80
2	Violence/Injury Prevention	2.78
3	Economic Security	2.75
4	Mental Health	2.65
5	Substance Abuse (Alcohol, Tobacco, and Other Drugs)	2.58
6	Healthcare Access & Delivery, Including Primary & Specialty Care	2.55
7	Sexually Transmitted Infections	2.34
8	Asthma	2.25
9	Infectious Diseases (non-STIs)	2.13
10	Cancer	1.95

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

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 locally as marked by higher levels of youth obesity in the KFH-Oakland and KFH-Richmond service areas than in the state overall. Black and Latino youth are disproportionately obese compared to youth overall in the service areas. 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. Community input indicates that obesity among youth is of highest concern, and lack of access to affordable, healthy food is driving this health need. In the East Bay area, residents felt there was not enough nutrition and health education available. The community also noted that students get progressively heavier between elementary school and high school.

2. **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 locally as demonstrated by higher rates of domestic violence and assault injury in the service areas than the state averages. In addition, homicide and school suspension in the KFH-Oakland and KFH-Richmond service areas are worse than state rates. In both services areas, ethnic disparities are stark, with Blacks having much higher homicide mortality rates than those of other ethnicities. Community input indicates that gang violence is a major issue, and that there are not enough programs/providers to address violence in the community. In the East Bay, residents explained that exposure to violence is connected to health problems later in life, both physical and mental (related to the trauma of living in an environment where there is crime happening).

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 locally as illustrated by the percentage of residents who experienced food insecurity at some point during the year, which in both service areas is higher than the HP2020 goal. In the KFH-Oakland and KFH-Richmond service areas, more than one in eight residents experience food insecurity. In addition, in the KFH-Oakland service area, the proportions of Black, Latino, Asian, Native American and Pacific Islander residents and residents of "some other race", living below the Federal Poverty Level (FPL) are higher than the overall state average. In the East Bay, residents felt the lack of full-access supermarkets and the cost of food is keeping people away from healthy food. Community input suggests that affordable housing is a major issue, and even if a policy is passed to ease the cost of housing, the available housing stock is still limited.

4. **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 locally as evidenced by the rate of suicide in Contra Costa County, which is higher than the HP2020 goal and the rate of severe mental illness emergencies in Alameda County, which is substantially higher than the state average. In addition, the suicide rate in the KFH-Richmond service area and the rate of ER visits for intentional injuries (including self-harm) among youth in the KFH-Oakland and KFH-Richmond service areas are higher than the state. Community input indicates that cultural/language barriers make it harder to access mental health care, and that the lack of linkages between primary care and mental health care is negatively impacting community health. In the East Bay, residents noted that there is a shortage of services, both for prevention/early intervention and for inpatient treatment, and that there is a lack of providers who are culturally diverse.

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 locally as marked by levels of excessive alcohol consumption among adults in both service areas, which are higher

than the state average. In addition, data available on alcohol use shows that KFH-Oakland and KFH-Richmond service area residents may be using alcohol more frequently than Californians overall. Community feedback indicates that residents are using drugs and alcohol to self-medicate, and alcohol is especially easy to access. In the East Bay, the community expressed concern about treatment options and that many are too expensive for people to use.

6. 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 as marked by high rates of preventable hospital events in both service areas compared to the state average. In addition, in both service areas, nonwhites are more likely to be uninsured and to lack a consistent source of primary care. The community input indicates that insurance premiums and co-payments are too high and wait times for appointments are too long. In the East Bay, the community felt that there is a shortage of trained providers and in addition, in many cases, health facilities are far away from community members' homes.

7. **Sexually transmitted infections (STIs)** are diseases that are primarily transmitted through direct sexual contact with an infected individual or their discharge (such as blood or semen). They include HIV/AIDS, syphilis, chlamydia, gonorrhea, and genital herpes. Some, if left untreated, can be fatal (HIV), or can affect fertility among those of child-bearing age.[8] Communicable diseases such as sexually transmitted infections are closely monitored to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and to allocate resources effectively. STIs are a health need locally because HIV/AIDS continues to be a concern. There is a high prevalence rate of HIV among Blacks in both counties. In the KFH-Oakland service area, HIV rates are higher than the state. The rate of reported AIDS cases is higher in Contra Costa County (which contains the KFH-Richmond service area) than the HP2020 goals. The community input indicates that there is a concern related to education of adolescents about sexual health. In the East Bay, the community stated that having sex without a condom is more prevalent among Black residents. Community members also felt that there is an increase of HIV amongst men who have sex with men (MSM).

8. **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 locally as illustrated by higher asthma prevalence rates among adults in both service areas than the state average. In the KFH-Oakland and KFH-Richmond service area, nearly one in six adults have asthma. In the counties containing the service areas, about one in five children have asthma. Community input about asthma was focused on younger children. In the East Bay area, the community expressed concerns about how asthma can be managed when patients do not have a hospital nearby.

9. **Infectious diseases (non-STIs)** are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood). 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 are health needs locally

[8] *CDC Fact Sheet: Staying Healthy and Preventing STDs.* Centers for Disease Control and Prevention. Web. January 2016.

as evidenced by rates of pertussis rising over time in both Alameda and Contra Costa Counties. The Alameda County Public Health Department has expressed concern over the "pertussis epidemic" in both counties.

10. **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 as marked by higher incidence rates of breast, colorectal, and prostate cancer in the KFH-Oakland and KFH-Richmond service areas compared to HP2020 or state targets. Key informant input suggests that Blacks in the community have worse cancer outcomes than those of other ethnicities. In addition, Blacks and Whites in both service areas have higher cancer mortality rates and colorectal and prostate cancer incidence rates than the state.

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 are listed in Appendix G.

VII. KFH-OAKLAND AND KFH – RICHMOND 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH-Oakland and KFH-Richmond'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-Oakland and KFH-Richmond'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 www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-Oakland and KFH-Richmond in the 2013 Implementation Strategy Report.

1. Access to care
2. Healthy eating active living
3. Violence prevention
4. Asthma prevention & management (KFH-Richmond service area only)
5. Broader health care system needs in our communities

KFH-Oakland and KFH-Richmond are 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-Oakland and KFH-Richmond track outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016 KFH-Oakland and KFH-Richmond had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-Oakland and KFH-Richmond 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 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 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-Oakland awarded 197 grants totaling $4,782,427 in service of 2013 health needs and KFH-Richmond awarded 153 grants totaling $4,809,632 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-Oakland and KFH Richmond

service areas. During 2014-2015, a portion of money managed by this foundation was used to award 57 grants totaling $7,413,594 in the KFH Oakland service area and 49 grants totaling $2,070,750 in the KFH Richmond service area addressing 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-Oakland and KFH-Richmond 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-Oakland and KFH-Richmond 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 CARE (Oakland)

Long Term Goal:

- Increase number of low-income people who have access to appropriate health care services in northern Alameda County

Intermediate Goal:

- Increase access to, enrollment in, and maintenance of health care coverage
- Increase access to specialized, culturally appropriate care
- Increase the proportion of low-income individuals who have access to and receive appropriate and culturally competent primary care services.

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: 8,680 Medi-Cal members* • *2015: 7,364 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 - $2,677,074* • *2015: 2,697applications approved* • *2015: KFH - Dollars Awarded By Hospital - $3,129,458* • *2015: 2,678 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: 1,477 members receiving CHC* • *2015: 1,058 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 64 active KFH grants totaling $2,922,847 addressing Access to Care in the KFH-Oakland service area.[9] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 22 grants totaling $6,813,545 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Alameda County Healthy Homes Department	$50,000 over 2 years $25,000 in 2014 $25,000 in 2015	CHHAMP (Coordinated Healthy Housing and Asthma Management Program), a collaboration between Alameda County Healthy Homes Department and Alameda County Asthma Start Program will coordinate services for families of children with asthma by providing in-home asthma case management and mitigation of asthma triggers.	A total of 124 children were successfully discharged from the asthma management program this winter: 100% lowered or maintained the lowest level of asthma symptoms. and100% of families made a least one change to reduce asthma triggers in the home.

[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.

Street Level Health Project	$45,000 over 2 years $20,000 in 2014 $25,000 in 2015	Street Level's Health Access Program (HAP) providers a thrice-weekly, drop-in triage clinic where basic health issues (flu, colds, and skin conditions) are treated and more serious conditions (hypertension and diabetes) are diagnosed, initially treated, and referred into the health care system.	A total of 974 low-wage patients - immigrants from all over the world, accessed the clinic for 1466 clinic visits. In collaboration with Alameda County Health Care Services Agency, Street Level helped more than 350 immigrants enroll in Medi-Cal or HealthPAC.
Alameda Health Systems Foundation/Alameda Health System (AHS)	$400,000 over 2 years $200,000 in 2014 $200,000 in 2015 This grant impacts four 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 public hospital 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 $200,000 in 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 • 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 21015 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. A total of 19 procedures were performed on a total of 18 low-income and uninsured individuals at OA events at the KFH Oakland facility in 2014 and 2015.

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.	• Level or increased resources to maintain and expand services for the uninsured. • Extension of federal health center funding • Improved referral patterns and access to specialty care services for health center patients. • Increased provision of behavioral health services and billing for those services. • 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 • payment reform pilots were included in California's 1115 Medicaid waiver proposal approved by CMS 12/30/15
UCSF Benioff Children's Hospital Oakland	$5,000,000 in 2015 This grant impacts all KFH hospital service areas in Northern California Region.	This grant supports a capital campaign to build a Center for Advanced Outpatient Care, reorient the Oakland campus into distinct inpatient and outpatient zones, renovate critical care and surgical units, and address California seismic compliance standards.	The ultimate anticipated outcome is that in addition to renovated pediatric intensive care, neonatal intensive care units, and surgical services, the new six-story Center for Advanced Outpatient Care will provide ambulatory care for 70,000 pediatric patients annually.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		

Operation Access	In 2014 and 2015 KFH Oakland participated in an Operation Access event and KP physicians and other staff volunteered a total of 120 hours to help provide medical procedures to low-income, uninsured individuals.
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.
Prescott-Joseph Center for Community Enhancement (PJCCE)	Kaiser Permanente Northern California Region's MultiMedia Communications staff produced an online annual report and a general organizational brochure to support PJCCE's fundraising efforts.
Bret Harte and Frick middle schools; Alameda, Castlemont, Fremont Federation, and Oakland high schools; Oakland School for the Arts; Civicorps, Madison Park, and Roots International academies, Academy of Alameda and Envision Academy for Arts and Technology	KPET's *Secrets*, which uses the power of live theatre to communicate facts and dispel myths about HIV/AIDS and STIs, was performed for students at twelve East Bay Area schools. The characters model effective negotiation skills and encourage young people to discuss difficult topics with their partners, friends, and adults in their lives.

Oakland and Castlemont high schools	In honor of World AIDS Day, KPET hosted special performances of *Secrets* on December 2 (Oakland High) and December 4 (Castlemont High). In addition to a relatable performance that infused comedy and drama to address STI's and AIDS, the event featured a resource fair with a wealth of community resources such as mobile testing vans. In addition to a photo booth, a Kaiser Permanente information table and KPET performer/health educators were available to answer students' questions and distribute prizes and t-shirts. These outreach efforts are designed to debunk myths and bring valuable health education to schools.

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 I: ACCESS TO CARE (RICHMOND)

Long Term Goal:

- Increase the number of low-income people who have access to appropriate health care services in West Contra Costa County

Intermediate Goal:

- Increase access to, enrollment in, and maintenance of health care coverage
- Increase access to specialized, culturally appropriate care

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: 8,267 Medi-Cal members* • *2015: 7,596 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 - $1,056,092* • *2014: 824 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $515,065* • *2015: 800 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: 1,173 members receiving CHC* • *2015: 1,065 members receiving CHC*

Grant Highlights			
Summary of Impact: During 2014 and 2015, there were 38 active KFH grants totaling $2,914,914 addressing Access to Care in the KFH-Richmond service area.[10] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 19 grants totaling $1,517,093 that address this need. These grants are denoted by asterisks (*) in the table below.			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Brighter Beginnings	$10,000 in 2015	Brighter Beginnings' Family Health Clinic addresses existing health disparities by providing a new primary health care access point designed to meet the social and medical needs of low-income Richmond-area residents. The clinic delivers comprehensive, culturally competent care that is integrated with social services.	Brighter Beginnings will foster greater social and medical services integration by training staff and operationalizing referral points in client/patient service flow; use direct outreach efforts and paid third party resources to advertise and to promote the clinic in the local community; and promote clinic services via partner outreach, community convenings, and forming formal referral relationships with MOUs.
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. A total of 28 procedures were performed on 14 low-income and uninsured patients at OA events at KFH Richmond in 2014 and 2015.
Community Clinic Consortia of Contra Costa and Solano (CCCCCS)	$250,000 (over 2 years) $125,000 in in 2014 & 2015 This grant impacts five KFH hospital service areas in Northern California Region.	Core support for continued operations of CCCCCS's various activities to meet the needs of community health center (CHC) members, and the review, modification, and implementation of existing organizational strategic plan. CCCCC serves four health centers with 123,144 patients.	• improved Medi-Cal managed care patient assignment rates by creating quarterly reports shared with member health centers. • Improved/streamlined Medi-Cal application process to expedite eligibility determinations for patients • develop, secure funding for, and implement Contra Costa CARES, a local primary care access program for approximately 3,000 of the county's low-income, undocumented adults • increased long-term financial viability of CHCs • produced FY 15 financial dashboard and began efforts to use future dashboards to monitor financial reserves. Dashboards inform strategic the organization's financial decisions and have prompted CCCCCS staff to pursue

[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.

			opportunities to diversify revenue streams and increase sources of earned income
LifeLong Medical Care	$1,311,882 in 2015	Funds will enable LifeLong to strengthen the safety net for 18,000 primarily low-income residents in Contra Costa County. It will implement urgent care services, link them to primary care, and educate residents so they know how and where to get the health care they need.	Anticipated outcomes include: • increased availability of urgent care services in west Contra Costa County, especially for the low-income under- and uninsured • community members use the ER, primary care, and urgent care more appropriately • community members know their options for urgent care

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
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.
Operation Access	KP physicians and staff donated nearly 336 hours of time serving low-income and uninsured patients at OA events at KFH Richmond in 2014 & 2015.
Brighter Beginnings	In-kind donation of surplus office furniture, including four cubicle systems, file cabinets, and assorted office supplies. In addition, KFH-Richmond family physician is a monthly volunteer at Brighter Beginnings' Richmond family health clinic, caring for West County residents who lack a medical home.
Representatives from local nonprofits	Training for nonprofit representatives who got an overview of Kaiser Permanente Child Health Program (KPCHP), a review of eligibility and required documentation, and step by step instructions on completing the new KPCHP application. The goal is to reduce application errors and to enroll more children in the program. In total, 31 community representatives were trained: 23 attended a KPCHP training in Richmond and eight attended a training in Concord. One community representative then presented information to 17 community partners who work directly with youth in the schools. East Bay CB organized the Richmond training, conducted outreach, and provided snacks and thank you gifts for the participants.
Life Medical Care	Ten cubicles, file cabinets, and assorted office furniture were donated to Life clinics in Alameda and Contra Costa counties.
Mira Vista Elementary; Helms, Hercules, Korematsu, Lovonya Dejean, and Portola middle schools; Crespi Junior High; and De Anza Senior, Gateway to College (at Contra Costa College), Middle College, and Pinole Valley high schools.	KPET's *Secrets* was performed for 8th and 9th grade students at 11 schools in Contra Costa County. *Secrets* uses the power of live theatre to communicate facts and dispel myths about HIV/AIDS and STIs. The characters model effective negotiation skills and encourage young people to discuss difficult topics with their partners, friends, and adults in their lives.

PRIORITY HEALTH NEED II: HEALTHY EATING ACTIVE LIVING (Oakland)

Long Term Goals:

- Reduce the number of overweight and obese children, adolescents, and adults in low-income northern Alameda County.

Intermediate Goals:

- Increase healthy eating among children and families
- Increase physical activity in schools, community, and institutional settings

Grant Highlights

Summary of Impact: During 2015, there were 45 active KFH grants totaling $384,727 addressing Healthy Eating Active Living in the KFH-Oakland service area.[11] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 12 grants totaling $103,804 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Playworks Education Energized	$50,000 $25,000 in 2014 $25,000 in 2015	Playworks facilitates and inspires safe, healthy play via complementary strategies that together have the potential to reach every elementary school child in the U.S. A direct service strategy places a full-time Playworks coach in low-income elementary schools. The Playworks Training strategy provides expert professional development to adult educators at any and all elementary schools wishing to duplicate the model. Grant supports staffing costs for Playworks to deliver a combination of direct service and its new TeamUp programming.	The grant has helped Playworks serve 36,380 students; 508 youth were involved in the Junior Leadership program. Youth received training and junior coaches were in place in all partner schools. Conflict resolution skills were used by students in all schools. School staff reported increased levels of corporation, and reported a decreased in the instances of bullying in the playground.
HOPE (Health for Oakland's People and Environment) Collaborative	$50,000 over 2 years $20,000 in 2014 $30,000 in 2015	HOPE's Healthy Corner Store project is a sustainable model storeowners can manage beyond the partnership. It helps owners renovate their stores with the equipment and infrastructure to sell healthier food items; connects them with distributors that supply fresh, high-quality products and with low interest loans and small grants to finance the changes; and provides technical assistance in key areas such as marketing, technology, supply chain, pricing, menus and recipes, finance, operations, workforce, and	HOPE hosted an initial convening of 22 representatives from six community partner organizations. Seven community partners were confirmed, three of which were trained on store evaluation and ongoing monitoring. HOPE also conducted deeper assessments of 15 stores. Seven stores were accepted into the program. With remaining funding HOPE intends to: • finalize/implement new health/sustainability standards for healthy corner stores • maintain conversions (renovations, product inventory shifts, and staff/ storeowner training

[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.

		community relations. To ensure success, each store is paired with a local community-based organization. HOPE also leads an assessment of policy barriers and public/private incentives available for corner store conversions in Oakland, and works with city staff to address any policy barriers.	and capacity-building) at five pilot stores • modify design for a permanent program, using pilot program evaluation findings • ensure strong community engagement in store change process and program redesign • develop policy recommendations to address barriers to implementation and a resource list of public/private incentives available for corner store conversions in Oakland
Community Alliance With Family Farmers (CAFF)	$165,000 over 2 years $90,000 in 2014 $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.	264,080 individuals were reached. Outcomes included: • 12 fresh-cut products and blends were developed and sold to institutions, with overall sales of at least 100,000 pounds over the course of the project. • Four hospitals and six new school districts sourced at least ten new products. • At least 24 participating farmers increase produce sales due to new institutional markets • more than 250 participants learn 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

TransForm CA	$150,000 over two years $75,000 in 2014 & 2015	Support Bus Rapid Transit projects in the East Bay and South Bay to facilitate walking, bicycling, and car-free living.	• Successfully advocated for passage of Alameda County Measure BB that will provide funding for bike and pedestrian improvements and public transit. • Supported development of Bus Rapid Transit projects in East Bay and South Bay to facilitate walking, bicycling, and car-free living. • Supported cities to create and implement community plans that improve access to transit and healthy activities while increasing rates of walking and bicycling.
Emery Unified School District (EUSD)	$23,000 in 2014	EUSD will support a Wellness Champion Coordinator, Wellness Champion staff grants, and a train the trainer program for staff to implement Playworks and Transformative Life Skills (TLS) in the classroom.	Reach was 800 students and staff. Outcomes included: • All K-8 staff received four hours of The Power of Play training and implemented programming during class and recess, increasing student physical activity minutes by up to 40 minutes per week • All high school teachers participated in TLS trainings and implemented their knowledge of physical fitness and relaxation strategies in the classroom • Staff participation in fitness classes increased 20% (average). • Bikes were made available for use during staff and student drop-in programs and in learning centers • Increased lunch program participation by 16% • Knowledge of healthy food choices and understanding of Healthy and Hunger-Free Kids guidelines for portion control increased • Staff knowledge of federal nutrition guidelines will increased by 60%
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
YMCA of the East Bay	A physician from The Permanente Medical Group participated in a special screening of *Weight of the Nation for Kids* for 70 youth attending a YMCA summer camp and answered their questions about healthy weight, nutrition, and physical activity.		

Alameda County Community Food Bank	Through its warehouse, the Food Bank distributes more than 70,000 pounds of farm fresh produce each day. 1,092 KP employees, who together volunteered 3,686 hours, helped sort, inspect, and package some of the fruits and vegetables distributed through the Children's Food Distribution and Backpack program.
Oakland Unified School District's Burckhalter, Community United, Discovery Academy, Fred T. Korematsu, Glenview, Grass Valley, Horace Mann, Kaiser, Lafayette, and Wildwood elementary schools; Alameda Unified's Ruby Bridges and Maya Lin elementary schools	Performances of KPET's *The Best Me*, a fun-filled musical experience that follows four friends in their last year of elementary school. With help from the audience and a few fantastic new friends, they learn the importance of healthy eating, active living, and working together.

Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Alameda County Obesity Prevention Partnership	The collaborative aims to prevent obesity by implementing policy and environmental change strategies, and sharing community resources and events.	KFH-Oakland CB Specialist participated in the collaborative and shared Kaiser Permanente Child Health Program information, *Weight of the Nation* screenings kits, and annual grants program information.
Alameda County Obesity Task Force	The taskforce was charged with developing best practices and model programs for presentation to the Alameda County Board of Supervisors.	KFH-Oakland CB Specialist participated in the collaborative and helped shape the strategies that will be shared with the Board of Supervisors.

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 II: HEALTHY EATING ACTIVE LIVING (RICHMOND)

Long Term Goal:

- Reduce the number of overweight and obese children, adolescents, and adults in low-income West Contra Costa County communities

Intermediate Goals:

- Increase healthy eating among children and families
- Increase physical activity in schools, and community and institutional settings

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 44 active KFH grants totaling $396,607 addressing Healthy Eating Active Living in the KFH-Richmond service area.[12] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 12 grants totaling $158,565 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Healthy and Active Before 5 (HAB45)	$30,000 over 2 years $10,000 in 2014 $20,000 in 2015	HAB45 works to improve the health status of children 0 to 5, especially children of color from low-income families. Grant funds educating decision-makers on status of San Pablo parks and recommending improvements; providing TA to West County partner organizations on healthy organizational policy change; ensuring more families with young children have access to healthy food and activities at West County points of service. HAB45 will contribute to development and implementation of the San Pablo Childhood Obesity Prevention Task Force Community Action Plan Funds	HAB45 provided technical assistance to 10 agencies on Pledge the Practice program and continued support to First 5 West County Regional Group (WCRG) as WCRG moves from assessment to advocacy on the city of San Pablo's park improvements. It also conducted an evaluation of the policies. The work of this project is expected to impact 9,000 children and 8,000 adults. In addition, HAB45's park advocacy work has directly impacted 35 West County Regional Group members and 20 San Pablo residents who attended community workshops related to the San Pablo Parks assessment. Once the pending park improvements are implemented, indirect beneficiaries will include the 29,720 San Pablo residents (2012 Census data), of which 28% (8,322) are 18 or younger.
*Playworks	$95,000 in 2015 This grant impacts eight KFH hospital service areas in Northern California Region.	Supports Junior Coach Leadership Program in 70 low-income elementary schools in 10 Northern California school districts. Fourth and fifth grade students will be trained to support active play at recess, proactively encourage participation by all students, and identify and help resolve conflicts. The goal is an overall decrease in bullying and an increase in cooperation and physical activity among elementary students.	Expected reach is 1,050 individuals; expected outcomes include: • improved social and emotional learning competencies of participating junior coaches • increased physical activity and problem-solving skills among participants • increased physical activity at recess leads to decreased physical and verbal conflicts among students
Youth Enrichment	$45,000 over 2	YES' project, Navigating a Path Towards	About 362 people attended the fall family camps,

[12] 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.

Strategies (Y.E.S.)	years $20,000 in 2014 $25,000 in 2015	Wellness aims to reduce obesity by developing and supporting active behaviors by connecting Richmond residents to the outdoors; encouraging individual, family, and community-wide approaches to active living; and promoting institutional adoption of wellness strategies. The project will serve Richmond children, adults, and community members, including 20-25 adult Wellness Navigators (health and wellness leaders); 320-400 children and adults through Family Camp programming; and 500 community members participating in outdoor, health, and wellness activities.	community retreats that inspire community engagement, and cultivate self-awareness, connections, and team-building. Each camp weekend, youth 18 and under averaged 445 minutes of physical activity, while adults averaged 265 minutes. 97% of participants increased their knowledge about the benefits of nature through four activity slots provided throughout weekend.
Community Alliance With Family Farmers (CAFF)	$165,000 over 2 years $90,000 in 2014 $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.	132,040 individuals were reached. Outcomes included: • 12 fresh-cut products and blends were developed and sold to institutions, with overall sales of at least 100,000 pounds over the course of the project. • Three new school districts sourced at least ten new products. • At least 20 participating farmers experienced a 10% increase in sales
*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

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Contra Costa & Solano Community Food Bank	In-kind donation of 735 containers that preserve and extend life of fresh produce.
East Bay Center for Performing Arts	At East Bay Center's Live Healthy Through Dance programs at Lake and Dover elementary schools, two physicians from KFH-Richmond spoke with students about the importance of physical activity and healthy habits.
Richmond Main Street Initiative	A physician from KFH-Richmond staffed the Ask the Doc booth at Richmond Main Street Initiative's Healthy Village Farm. She provided community members with healthy living tips and health literature, and answered their medical questions.
Bayview Elementary, Sheldon Elementary, Valley View Elementary, Dover Elementary, Woodrow Wilson Elementary, Lake Elementary, Bayview Elementary, Downer Elementary, Murphy Elementary in West Contra Costa Unified School District.	Performances of KPET's *The Best Me*, a fun-filled musical experience that follows four friends in their last year of elementary school. With help from the audience and a few fantastic new friends, they learn the importance of healthy eating, active living, and working together.

Collaboration/Partnership Highlights		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Healthy and Active Before 5 (HAB45)	HAB45 is a Contra Costa County collaborative working to prevent early childhood obesity by building partnerships and creating environments for healthy eating and active play.	Kaiser Permanente is a founding member of and an active partner in HAB45, which has an action plan with eight principles that emphasize the importance of making the healthy choice the easy choice. Kaiser Permanente has connected its West Contra Costa County partners and faith community contacts with HAB45. As part of Pass the Policy, Pledge the Practice, HAB45 has supported 10 West Contra Costa nonprofits.
Building Blocks for Kids (BBK) Collaborative	In 2005, 27 nonprofit and county agencies; local, state, and federal government representatives; community members; and foundations formed BBK, a place-based group working to reverse poor health, low academic achievement, and lack of safety and self-sufficiency for children in Richmond's Iron Triangle. Kaiser Permanente is a longstanding BBK partner.	As both a funder and a collaborator in BBK's work, Kaiser Permanente provides input on projects the collaborative develops and implements. KFH-Richmond CB/CH Specialist participated in BBK's health and wellness and all hands meetings.

Richmond Healthy Eating, Active Living (HEAL) Collaborative	From 2011 through 2014, the nonprofit partners comprising the Richmond HEAL Collaborative focused on reducing calorie consumption, increasing consumption of fresh produce, and Increasing physical activity in community (parks, safe walking and biking routes) and institutional (schools and workplaces) settings.	CB staff a hosted and staffed three HEAL convenings with 25 to 30 community partners. At these meetings, representatives from various organizations shared information on their work, discussed projects, and formed new connections.

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: VIOLENCE PREVENTION (Oakland)

Long Term Goal:

- Reduce the number of adolescents, young adults, and people of color exposed to violence, including witnesses, survivors, and perpetrators

Intermediate Goals:

- Create and maintain safe environments in schools, residential neighborhoods, and workplace settings
- Increase skills building and employment opportunities for high-risk youth
- Increase access to services that identify, address, and prevent domestic violence
- Increase access to trauma-informed care, mental health services, and training

Grant Highlights

Summary of Impact: During 2015, there were 69 active KFH grants totaling $1,344,540 addressing Violence Prevention in the KFH-Oakland service area.[13] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling $178,124 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Berkeley Youth Alternatives (BYA)	$30,000 over 2 years $10,000 in 2014 $20,000 in 2015	BYA's Squash It program provides violence prevention, education, and training for 50 formerly incarcerated males and females 16 to 29 using outreach, education, and support. This includes community-based mental health services, case management,	Historically, BYA has worked with youth 16 to 21; this grant allowed it to expand services to include young adults through age 29. Results include 94 youth were reached; 49 workshops were completed; program staff taught a class on community violence prevention and social-

[13] 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.

		and violence prevention sessions, youth leadership opportunities, academic support and access to college-level tutors, enrichment activities (music production, dance, and art studio), and career readiness services (resume development, appearance, communication, punctuality, and financial literacy). Participants are encouraged to take part in BYA Youth Council activities promoting social justice.	emotional development to at-risk youth from Berkeley Technology Academy; and according to the Resilience Scale Survey, 33 participants demonstrated increased resilience.
*La Clinica De La Raza, Inc.	$135,000 over 2 years $40,000 in 2014 $95,000 in 2015	Using evidence-based Cognitive Behavioral Intervention for Trauma in Schools (CBITS), La Clínica will identify youth exposed to trauma, and connect impacted students to services at onsite school-based health centers (SBHC). A learning collaborative will support rapid adoption of CBITS practices across Alameda County. It will also host a staff retreat and offer clinical debriefing to enhance staff wellness and self-care.	2014 funding allowed La Clinica to screen 100 youth in grades 6 and 8 and connected them to onsite services as appropriate. 20 La Clínica staff were trained to use CBITS, and 20 OUSD staff received training regarding the impact of trauma on youth. Expected outcomes for the 2015 grant include: • up to 2,531 students and 169 staff reached at five schools • teachers and staff have increased opportunities to enhance understanding of trauma and SBHC services, and feel more equipped to manage vicarious trauma • clinicians take part in the learning collaborative • improved SBHC staff retention • youth experiencing trauma can access evidence-based group services onsite at their SBHC
*East Bay Agency for Children (EBAC)	$135,000 over 2 years $40,000 in 2014 $95,000 in 2015	To increase understanding of the impacts and symptoms of complex trauma on students, to manage vicarious trauma among educators, and to enhance mental health services for traumatized youth, EBAC will develop trauma-informed cultures and climates at four East Oakland schools.	2014 grant funding allowed 40 Health and Wellness Center staff to be trained to screen for trauma at Frick Middle School in Oakland. 313 students were screened, and identified youth were connected with services. 80% of youth completing the TAG curriculum gained a less pathologized understanding of themselves and their trauma, gained tangible skills to regulate feelings and behavior, and decreased truancy and expulsion. Expected outcomes for 2015 funding include:

			• 742 students and 58 staff reached at four schools • trauma-informed classroom approaches increase staff's confidence and ability to support students • youth learn tangible skills such as self-regulation tools, trigger identification, and safety awareness • reduced truancy/expulsion in targeted schools
*Alameda County Family Justice Center (ACFJC)	$90,000 in 2015	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
Ella Baker Center For Human Rights In California	$50,000 ($15K from KFH-Oakland $35K from Northern California Region, split with KFH-SF and KFH-Hayward)	Support for a community-driven research project in which families, business leaders, and advocates will co-create public safety and economic solutions to break cycles of violence and poverty.	Ella Baker Center reached 98 formerly incarcerated individuals and their family members who participated in focus groups and surveys. In partnership with Lawyers Committee for Civil Rights, the Center hosted a business summit that drew 143 participants from 112 businesses. Of the 90 who completed a survey, 43 said they have a decision-making role related to hiring. The Center conducted in-depth interviews with 15 local employers.
Youth UpRising (YU)	$250,000 in 2014	YU will formalize a structure to connect its core competencies with ongoing programs and work to link all four program tiers into an aligned and progressive pathway for youth. Through this grant, YU will also lead a planning process to identify opportunities to develop and support organizations to create community economic and social development.	• 45 young people have participated in social enterprises and 43 young people have participated in YU's Career Pathway/Accelerated College program. • 9 youth successfully entered YU Lead (Tier 3). 6 youth entered AmeriCorps to serve as youth leaders at Youth UpRising. • 3 drop-in programming/groups served 2,000 unduplicated youth.

			• Under the lead of YU, a constellation of community organizations launched Castlemont Community Transformation Schools that opened the doors last fall to 225 children in grades TK - 6th.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Various community-based organizations	A day-long trauma-informed care (TIC) training session for Kaiser Permanente clinicians and staff and community providers, including some of our local grantees. The session, led by a clinician and renowned TIC expert, drew 56 participants from across the East Bay. Participants gained valuable new skills and had the opportunity to network with colleagues in the field. CEUs (continuing medical education units) were available for clinicians. The training was coordinated by KFH-Oakland CB staff, who secured the meeting space and lunch/snacks.
Oakland School for the Arts, Urban Promise Academy, Montera Middle School, and Lincoln Child Center	KPET's *Nightmare on Puberty St*. a fast-paced show featuring current music and dance, encourages students to talk about critical health issues and ask questions. As with all KPET performances, it is provided free of charge to schools and communities.

PRIORITY HEALTH NEED III: VIOLENCE PREVENTION (RICHMOND)

Long Term Goal:

- Reduce the number of adolescents, young adults, and people of color exposed to violence, including witnesses, survivors, and perpetrators

Intermediate Goals:

- Create and maintain safe environments in schools, residential neighborhoods, and workplace settings
- Increase skills building and employment opportunities for high-risk youth
- Increase access to services that identify, address, and prevent domestic violence
- Increase access to trauma-informed mental health services and training

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 49 active KFH grants totaling $1,248,048 addressing Violence Prevention in the KFH-Richmond service area.[14] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $249,373 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
RYSE Youth Center	$50,000 over two years $20,000 in 2014 $30,000 in 2015	Part of RYSE's Community Health Department, Restorative Pathways Project (R2P2) offers intensive case management and mentoring for critically injured (gunshots, stabbings, assaults/beatings) young people	RYSE engaged 19 new participants during the grant period, and 17 ongoing participants for a total of 36 individual participants. 2 of the participants were self-referred after discharge from John Muir or another hospital. They also

[14] 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.

		13 to 25 who are referred to RYSE by John Muir Health's trauma center. Grant supports continued service of the intervention specialists (ISs), a primary, direct, and consistent link for participants and their families.	conducted 24 crisis assessments and reached three caregivers.
Stand! for Families Free of Violence	$135,000 over 2 years $20,000 in 2014 $115,000 in 2015	Stand!'s Youth Education Support Services (YESS) addresses teen dating violence (TDV) through education, multi-generational mentoring, confronting gender stereotypes, and promoting bystander intervention and youth leadership development. YESS also trains school personnel and community stakeholders on the dynamics of TDV, allowing the community to drive the educational process.	The 2014 grant allowed YESS! to reach 660 students via one-time school presentations and STAND! worked with 18 Youth Against Violence student leaders, using an enhanced leadership curriculum that addresses public speaking, speech-making, professional appearance, self-care, and trauma. Halfway through the 2015 grant period, 296 youth were reached; eight participated in the Youth Against Violence leadership series; 14 went through core trainings and became presenters and facilitators. In fall 2015, 148 youth were enrolled in the ER series.
*Contra Costa Family Justice Alliance (formerly West Contra Costa Family Justice Center)	$190,000	Contra Costa Family Justice Alliance will continue coordinating Regional Collaborative of Family Justice Centers, and oversee standardized service delivery for multiple, co-located agencies working together to end family violence and abuse. Grant provides continue support for the Richmond site, and matching funds toward expansion of a recently opened Concord site.	Expected results • 3,500 survivors of family and relationship violence and FJC staff throughout the region reached • Regional Collaborative of Family Justice Centers collaborates and shares best practices, and establishes standardized referral protocols, training, and strategy • victims of interpersonal violence (IPV) experience seamless service delivery, ensuring that more survivors seek services and realize self-sufficiency • increased community understanding of IPV and increased connections between community and the Alliance.
*James Morehouse Project (JMP)	$75,000 over 2 years $20,000 in 2014 $95,000 in 2015	JMP will strengthen clinical supports offered directly to trauma-impacted youth at El Cerrito High School, train and partner with staff and administrators to create trauma-sensitive classrooms and a restorative school climate, and support staff wellness to reduce burnout.	JMP serves the entire school community (1,300 students and 100 adult staff) through its Restorative Justice work and environmental school climate support and provided nearly 200 youth with more intensive ongoing counseling and youth development work. With remaining grant funds JMP hoped to reach up to 1,420

			students and 183 staff so that staff and faculty can identify trauma and use trauma-informed strategies in the classroom and teachers and providers receive restorative supports, to more effectively work with youth.
*West Contra Costa Unified School District (WCCUSD)	$95,000 in 2015	In partnership with Catholic Charities of the East Bay, WCCUSD will implement restorative and trauma-informed practices to support Pinole Middle School students. Clinical and youth advocacy professionals will provide mental health services, training, capacity building, and staff wellness supports.	Expected outcomes include: • 576 students and 29 staff reached at one school • youth show a decrease in trauma symptoms and depression, and indicate significant improvements in school behavior • improved school climate, as shown by California Healthy Kids Survey results • a restorative, trauma-informed approach improves staff's capacity to respond to students

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
West Contra Costa County School District (WCCCSD) high school students	Three KPET actor/peer educators and East Bay Area CB staff, worked with school-based health center (SBHC) leads at Kennedy High School to develop a conflict resolution workshop, Deuces Up!, for the 20 students on the SBHC advisory leadership teams at all six WCCCSD high schools. The KPET actor/peer educators presented the two-hour interactive workshop at Kennedy. Participants learned negotiation, conflict resolution, and decision making skills. The workshop also explored negotiation as a function of communication and provided youth with health education resources and promotional items.
Trauma-informed care (TIC) participants, local grantees, and Kaiser Permanente clinicians	East Bay Area staff coordinated a TIC training for community providers and Kaiser Permanente staff. They secured meeting space at Program Office and provided lunch and snacks. A renowned clinician and TIC specialist led this training for 56 participants from across the East Bay who gained valuable new skills and had the opportunity to network with colleagues in the field. Continuing Medical Education Unit (CEUs) were available for clinicians.
Rosie the Riveter Trust	KFH-Richmond physicians and staff participated in a career day event. Promo items were also provided. The four clinicians and staff attended the event, talking with 30 girls about their career and education paths.
Bayview, Cesar E. Chavez, Collins, Dover, Downer, Ellerhorst, Fairmont, Ford, Grant, Harding, Highland, Kensington-Hilltop, King, Lake, Madera, Mira Vista, Montalvin-Manor, Murphy, Olinda, Riverside, Shannon,	KPET provided a performance of *Nightmare on Puberty Street*, a fast-paced show featuring current music and dance. Performances were held for 5th and 6th graders at the listed schools. As with all KPET productions, Nightmare on Puberty Street was presented free of charge. The show encourages students to talk about critical health issues and to ask questions.

Sheldon, Stege, Stewart, Tara Hills, Valley View, Verde, and Woodrow Wilson elementary schools; Hercules Middle School; and Making Waves Academy	

Impact of Regional Initiatives

Youth and Trauma Informed Care:

Research has established the connection between childhood trauma and significant, long-term health issues in adulthood. Kaiser Permanente's Youth and Trauma-Informed Care (YTIC) initiative aims to cultivate trauma-informed environments in schools and community-based organizations to prioritize the relationships, trust, safety, and mindful interactions that are essential to helping youth heal from trauma and go on to lead healthy, productive lives. Grantees are supported to increase screening for trauma exposure among youth 12 to 18, provide mental health support and services onsite, strengthen referrals for long-term care, and increase awareness among teachers and staff of trauma signs and symptoms. Teacher and staff training also addresses how to manage their own stress, burnout, and even vicarious trauma and how to minimize the risks of re-traumatizing youth.

PRIORITY HEALTH NEED IV: ASTHMA PREVENTION AND MANAGEMENT (RICHMOND ONLY)

Long Term Goal:

- Reduce asthma episodes among high-risk children and adolescents residing in West Contra Costa County

Intermediate Goals:

- Improve asthma management among high-risk asthma sufferers, emphasizing environmental impacts and policies
- Improve asthma management among high-risk children and adolescents through behavioral and clinical strategies

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 3 active KFH grants totaling $100,000 addressing Asthma Prevention and Management in the KFH-Richmond service area.[15]

Grantee	Grant Amount	Project Description	Results to Date
Prescott-Joseph Center	$90,000 over 2 years $40,000 in 2014 $50,000 in 2015 (even split with KFH-Oakland)	Northern California Breathmobile® provides asthma evaluation, treatment, and education for youth in Alameda, Berkeley, Emeryville, Oakland, Richmond, San Leandro, San Lorenzo, and San Pablo. Licensed by the State of California as a free clinic, the Breathmobile®, is a sustainable, accessible, community-wide asthma management	Prescott-Joseph Center saw 238 asthma patients every 4-6 weeks at schools, head start and community centers.

[15] 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.

		program that shifts acute episodic care to regular preventive care in accordance with national standards.	
Community Energy Services Corporation (CESC)	$10,000 in 2015	CESC's Healthy Homes Program removes and remediates asthma triggers in households where asthma sufferers reside. These free services that reduce mold, wood rot, and dust mites, may include installation of fans, repairs to leaky plumbing, and general cleaning. Eligible households must meet the income criteria, and include at least one person who has been diagnosed with asthma that requires medication or hospitalization.	The grant allows CESC to expand its services into the City of Richmond and to provide asthma remediation services for an additional six to eight households.

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE (OAKLAND & RICHMOND)			
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 2015, Kaiser Foundation Hospital awarded 19 Workforce Development grants totaling $130,313 that served the KFH-Oakland service area.[16] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 14 grants totaling $286,779 that address this need. In addition, KFH Oakland provided trainings and education for 282 residents in their Graduate Medical Education program in 2014 and 299 residents in 2015, 32 nurse practitioners or other nursing beneficiaries in 2014 and 47 in 2015, and 30 other health (non-MD) beneficiaries as well as internships for 23 high school and college students (Summer Youth, INROADS, etc) for 2014-2015. KFH Richmond provided trainings and education for 0 residents in their Graduate Medical Education program, 18 nurse practitioners or other nursing beneficiaries in 2014 and 3 in 2015, and 25 other health (non-MD) beneficiaries as well as internships for 12 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.			
Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**

[16] 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.

Emerald Cities Collaborative	$75,000 in 2014 This grant impacts two KFH hospital service areas in Northern California Region.	To identify investment opportunities to expand health-related jobs and services in food production, processing and distribution, clean energy, building services, and related services in the Oakland/Richmond area.	Expected Outcomes: The completion of a Anchor Institution feasibility study that will include: Supply chain analyses, identifying the size and scope of procurement opportunities of Anchor partners Type and scale of local jobs and business opportunities from procurement opportunities Proposed community development strategy Assessment of investment needs and opportunities Assessment of potential health outcomes
Hispanas Organized for Political Equality (HOPE) California	$65,000 This grant impacts three KFH hospital service areas in Northern California Region	Supports expansion of statewide HOPE Youth Leadership Program (HYLP), to the Oakland area and augments the focus to include STEM (science, technology, engineering and math), with an emphasis on health care professions. HYLP prepares low-income, high school-aged Latinas for higher education, careers, civic participation, economic stability, and healthy lifestyles.	Expectation is that 150 program participants will: • demonstrate a personal path to achieving professional goals • build confidence in making decisions that impact their future • demonstrate a commitment to graduate high school and aspire to higher goals for themselves as advocates and leaders • demonstrate the ability to be responsible, informed decision-makers when it comes to their health and education • demonstrate confidence as a leader • expand their civic participation
*City of Oakland (Oakland only)	$35,000 in 2015	Classrooms2Careers Program (formerly Mayor's Summer Job Program), is based on the Earn & Learn model, a national initiative that prepares students 16 to 21 from educationally disadvantaged backgrounds for successful careers by combining career-oriented academic curriculum, relevant work experience, and student financial assistance.	Anticipated outcomes include: • all 360 youth in the program complete their internships and job readiness training • youth gain vocational skills, work ethic, communication skills, earned income, and awareness of the range of educational and career opportunities • youth are supported by community-based organizations to continue to study for a high school diploma or post-secondary credential, enroll in college, and/or pursue permanent employment
*The Regents of the University of California	$75,000 in 2015	UC Berkeley's Pre-College TRiO Programs African American Male Pipeline Project serves students interested in STEM careers	Anticipated outcomes include: • all of the 47 participants receive STEM-related education, tutoring, and mentoring

	This grant impacts two KFH hospital service areas in Northern California Region	who attend underperforming middle and high schools in West Contra Costa and Oakland. From 8th grade and through high school graduation, each student cohort receives individualized wraparound services, including college advising/preparation, academic support and enrichment, family engagement, cultural awareness activities, mentoring, workforce readiness, internships, field experience, leadership opportunities, and wellness support.	• participants gain the required occupational training and exposure to enter into STEM- and health-related careers • all participants are exposed to STEM-related careers via summer internships in the 10th, 11th and 12th grades • 75% of participants are accepted to the Health Pathway at their respective schools • 60% of participants major in a STEM-related area of study • participants finish high school with an academic record good enough for admission to a four-year post-secondary institution • all participants complete a rigorous, science-focused secondary school program of study • 100% of participants will complete the entrance requirement for UC/CSU with a minimum 3.0 GPA • 100% of students will graduate from HS having completed Calculus

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH (OAKLAND & RICHMOND)

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	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	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

	Northern California Region.	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.	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-Oakland and KFH-Richmond worked in collaboration with other nonprofit 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 targets.

After making this CHNA report publicly available in 2016, our hospitals 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 Need 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. City of Berkeley Public Health Division. Health Status Report. 2013.
28. Contra Costa Health Services and Hospital Council of Northern and Central California. Community Health Indicators for Contra Costa County. 2010.
29. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
30. Environmental Protection Agency, EPA Smart Location Database. 2011.
31. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
32. Feeding America. 2012.
33. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
34. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.

35. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
36. New America Foundation, Federal Education Budget Project. 2011.
37. Nielsen, Nielsen Site Reports. 2014.
38. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
39. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
40. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
41. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS Neighborhood Edition. 2015.
42. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS. 2015.
43. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
44. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
45. US Census Bureau, American Community Survey. 2009-2013.
46. US Census Bureau, American Housing Survey. 2011, 2013.
47. US Census Bureau, County Business Patterns. 2011.
48. US Census Bureau, County Business Patterns. 2012.
49. US Census Bureau, County Business Patterns. 2013.
50. US Census Bureau, Decennial Census. 2000-2010.
51. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
52. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
53. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
54. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
55. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
56. US Department of Education, EDFacts. 2011-2012.
57. US Department of Health & Human Services, Administration for Children and Families. 2014.
58. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
59. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
60. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
61. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
62. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Healthy People 2020. http://www.healthypeople.gov/ . 2015.
63. US Department of Housing and Urban Development. 2013.
64. US Department of Labor, Bureau of Labor Statistics. June 2015.
65. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
66. 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.
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.

Indicator Variable	Data Source
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, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health 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.

Indicator Variable	Data Source
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 Taking Medication (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Indicator Variable	Data Source
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 Resources and Services Administration. March 2015.

Indicator Variable	Data Source
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.

Indicator Variable	Data Source
Occupied Housing Units with One or More Substandard Conditions (Percentage)	US Census Bureau, American Community Survey. 2009-13.
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.

Indicator Variable	Data Source
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. 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

Indicator Variable	Data Source
	Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
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.

Indicator Variable	Data Source
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.
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)
City Government	Oakland Mayor's Office	Chief of Staff	Safety/violence	Leader	1, 3	Interview	08/24/15
City Health	City of Berkeley, Division of Public Health	Director of Public Health/ Health Officer	Public health	Leader	1, 2, 3	Interview	07/16/15
County Health	Alameda County Behavioral Health Services	Consumer Empowerment Manager	Mental health, substance use	Leader	1, 2, 3	Interview	09/04/15
County Health	Behavioral Health Services, Alameda County	Director	Mental health, substance use	Leader	1, 2, 3	Interview	08/26/15
County Health	Behavioral Health Services, Contra Costa County	Director	Behavioral health, mental health, homeless	Leader	1, 2, 3	Interview	09/22/15
County Health	Contra Costa Health Services	Assistant Director	Health services, public health	Leader	1, 2, 3	Interview	07/30/15
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

* 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/ rep-resentative/ member)	Target group repre-sented*	Consul-tation method	Date consulted (2015)
County Health/Public Health	Alameda County Public Health Department, Nurse Family Partnership	Nurse Manager	Low-income, access to care	Leader	1, 2, 3	Focus group	9/2/15
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
County Health/Public Health	Contra Costa County Public Health	Epidemiologist	Public health	Leader	1, 2, 3	Interview	06/24/15
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	Alameda Health Consortium	Director of Policy & Planning	Low-income, access to care	Leader	1, 3	Focus group	9/2/15
Local Health	Alameda Health System	Chief Strategy Officer	Low-income, access to care	Leader	1, 2, 3	Focus group	9/2/15
Local Health	Asian Health Services	Director of Program Planning & Development	Low-income, access to care, minority	Leader	1, 3	Focus group	9/2/15
Local Health	California Children's Services, Alameda County	Medical Director	Low-income, access to care	Leader	1, 2, 3	Focus group	9/2/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target group role (leader/ rep-resentative/ member)	Target group repre-sented*	Consul-tation method	Date consulted (2015)
Local Health	Community Clinic Consortium, Contra Costa & Solano Counties	Project Coordinator	Low-income, access to care	Leader	1, 2, 3	Focus group	9/2/15
Local Health	La Clinic de la Raza	Director of Medical Operations	Low-income, access to care, minority	Leader	1, 3	Focus group	9/2/15
Local Health	Lifelong Medical Care	Deputy Director	Low-income, access to care, underserved	Leader	1, 3	Focus group	9/2/15
Local Health	Operation Access	President & Chief Executive Officer	Low-income, access to care	Leader	1, 3	Focus group	9/2/15
Local Health	UCSF Benioff Children's Hospital Oakland	Practice Administrator for Child Development, Child Mental Health, and Rare Diseases	Public health, children	Leader	1, 3	Interview	08/21/15
Non-Profit	Abode Services	Executive Director	Access to care, low-income, homelessness	Leader	3	Interview	09/23/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target group role (leader/ representative/ member)	Target group represented*	Consultation method	Date consulted (2015)
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	Contra Costa County Child Care Council (CCCCC)	Child Care Provider	Children	Representative, Member	3	Focus group	9/28/15
Non-Profit	First 5 Alameda County	Senior Administrator	Children	Representative	3	Interview	08/27/15
Non-Profit	Healthy Richmond	Hub Manager	Healthy eating/ active living, safety, children	Leader	1, 3	Interview	09/01/15
Non-Profit	HOPE Collaborative	Project Director	Healthy eating/ active living, safety	Leader	1, 3	Interview	08/12/15
Non-Profit	Youth ALIVE!	Director	Safety/violence, youth	Leader	1, 3	Interview	09/04/15
Non-Profit	Youth in Mind	Executive Director	Safety/violence, youth	Leader	3	Interview	09/04/15
Non-Profit	Youth Uprising	Chief Executive Officer	Safety/violence, youth	Leader	1, 2, 3	Interview	09/08/15
N/A	Alameda County Care Alliance	N/A	Caregivers	Members (6)	3	Focus group	09/10/15
N/A	UCSF Benioff Children's Hospital Oakland and Allen Temple Baptist Church	N/A	Spanish-speaking minority, low-income, youth	Members (14)	3	Focus group	10/14/15

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 targets 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

KFH-Oakland and KFH-Richmond Prioritization

	Rank (1=Highest Priority)	Overall Average Score	Average Scores of Prioritization Criteria Used by Group				
			Severity of Need	Magnitude/ Scale of Need	Disparities/ Inequities Exist	Good Interventions Exist	Community Priority
Asthma	8	**2.25**	2.50	2.25	2.88	2.63	1.00
Cancer	10	**1.95**	2.38	2.13	2.25	2.00	1.00
Economic security	3	**2.75**	3.00	3.00	3.00	1.75	3.00
Healthcare access & delivery	6	**2.55**	2.38	2.50	2.88	2.00	3.00
Infectious diseases (non-STIs)	9	**2.13**	1.63	1.63	1.88	2.50	3.00
Mental health	4	**2.65**	2.88	2.88	2.75	1.75	3.00
Obesity, diabetes, and HEAL	1	**2.80**	2.75	3.00	2.88	2.38	3.00
Sexually transmitted infections	7	**2.34**	1.88	2.13	2.57	2.13	3.00
Substance abuse (ATOD)	5	**2.58**	2.88	2.75	2.38	1.88	3.00
Violence/injury prevention	2	**2.78**	3.00	3.00	2.88	2.00	3.00

Definitions:

A. **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 goal.

B. **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.

C. **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.

D. **Good interventions exist:** Interventions for this health need exist that are both effective and feasible. The interventions may be fully evidence-based, or may be "promising practices" (practices that have strong data showing positive outcomes, but not yet enough research or replication to support an "evidence-based" classification)

E. **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 policy changes you would recommend that could address these issues?
b) Are there existing assets or resources available to address these needs that people are not using? Why?
c) What other 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 <u>accessing</u> 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 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 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
Assets/Resources
• 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

Assets/Resources

- 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:
    - Cancer Genetics Program (UCSF Affiliated)
    - Community Outreach
    - Lymphedema Services
    - Radiation Oncology Center
    - Sandy Amos, RN Infusion Center
    - Women's Center
- Winton Wellness Center (AHS)
- Women's Cancer Resource Center

Health Need: Economic Security

Assets/Resources

- 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
- 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:
    - Corps- Food, Clothing, and Donation Services
    - USDA Commodity and Food Programs
- South Hayward Parish:
    - Emergency Food Pantry
    - 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

Assets/Resources

- 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
- 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, (not including STIs)
Assets/Resources
• Alameda Health System-Newark Wellness (Newark Health Center) • Ashland Free Medical Clinic • Davis Street Family Resource Center • REACH Ashland Youth Center (LaClinica Services) • Tiburcio Vasquez Health Center • Washington Hospital Healthcare System

Health Need: Mental Health

Assets/Resources

- 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.

- 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
- Schuman-Lilies Clinic Fremont
- Second Chance:

    - Anger Management
    - Hayward Center
    - Newark Center
- Seneca Center for Children and Families:
    - Public School-based Outpatient Counseling for HUSD
    - Willow Rock Center 23-hour Crisis Stabilization and Outpatient Services
- South Hayward Parish - Hayward Community Action Network
- St. Rose Hospital- Main
- Telecare Corp.:
    - Morton Bakar Center
    - Villa Fairmont Short Stay Program
    - Willow Rock Center Inpatient Services
- Terra Firma Diversion/Educational Services:
    - Court Ordered Adult Diversion Programs
    - Domestic Violence and Anger Management Classes
- The Latina Center (Richmond)
- Tiburcio Vasquez Health Center:
    - Behavioral Health Center
    - School based health services – Logan Health Center
    - School based health services – Tennyson Health Center
- Tri-City Health Center:
    - HIV/AIDS Care and Treatment Program
    - 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

Assets/Resources

- 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

- 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
    - 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:
    - Community Outreach
    - Diabetes Program
    - Outpatient Diabetes Center
- Washington on Wheels Mobile Health Clinic
- White Pony Express
- YMCA:
    - East Bay
    - Fremont/Newark

Health Need: Sexually Transmitted Infections
Assets/Resources
• AIDS Project of the East Bay (APEB) Grupo Fremont VIP • ACMC- Fairmont Campus (HIV Services) • Lighthouse Community Center- Free HIV Testing • Tri-City Health Center - HIV, Hep C and STD Testing

Health Need: Substance Abuse (including tobacco and alcohol)

Assets/Resources

- 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:

    - 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

Assets/Resources

- 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
- Zero Tolerance for Domestic Violence Initiative

Appendix H: Health Needs Profiles

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

Profile of KFH-Oakland & KFH-Richmond Service Areas 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 areas than in the state overall. The community has concerns about childhood asthma and asthma rates in certain geographic locations.

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-Oakland and KFH-Richmond service area, nearly one in six adults have asthma. In the counties containing the service areas, about one in five children have asthma. Black and Latino asthma patients and those of "other" or multiple ethnicities account for larger proportions of service areas' hospital discharges than at the state level. The community expressed concern about childhood asthma and asthma rates in certain geographic areas.

What Do the Data Show?

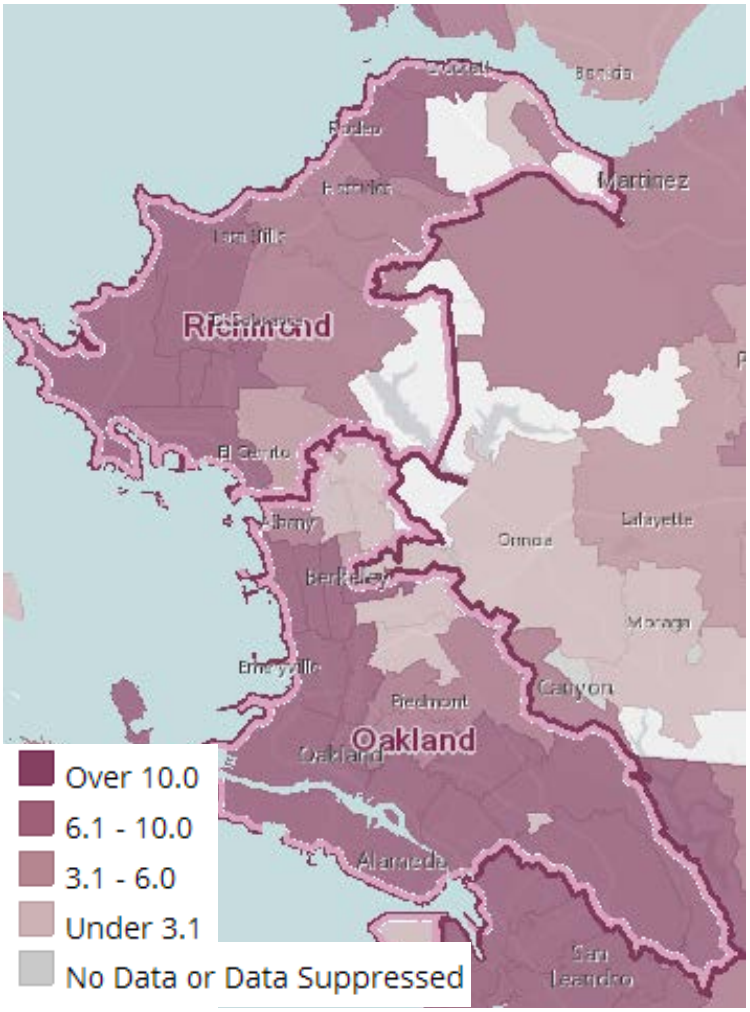
- Larger percentages of adults in the KFH-Oakland (16%) and KFH-Richmond (16%) service areas have asthma when compared to the state (14% adult asthma prevalence).[2]
- In both Alameda County (19% asthma prevalence ages 0-17) and Contra Costa County (19% asthma prevalence ages 0-14), there are greater proportions of children and teens with asthma compared to the state (15% asthma prevalence ages 1-17).[3]

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional analysis by CARES. 2011-12.
[3] *Alameda County Health Data Profile*, Alameda County Public Health Department, 2014 and *Community Health Indicators for Contra Costa County*, Contra Costa Health Services, 2010.

- Asthma patients accounted for 1.5% of all hospital discharges in the KFH-Oakland service area and 1.7% in the KFH-Richmond service area, compared to 0.9% of all hospital discharges in the state. There are ethnic disparities: Rates are substantially higher in the service areas than in the state among asthma patients who are Latino (1.8% KFH-Oakland service area, 1.6% KFH-Richmond service area), Black (2.6% and 2.8%, respectively), or of "other" or multiple ethnicities (2.8% and 3.4%, respectively).[4]

- There are geographic disparities in asthma hospitalization rates. The western portions of both service areas, the northernmost portion of the KFH-Richmond service area, and the southern portion of the KFH-Oakland service area have the highest asthma hospitalization rates.[4]

ASTHMA HOSPITAL DISCHARGE RATE PER 10,000, 2011



What Does the Community Say?

- Asthma is a "bigger deal" in elementary school.

- Providers have a lack of trusting relationships with early adolescents; teens don't know how to access services.

- Key informants note that heavy refinery areas (Richmond) have high rates of asthma.

- Key informants also indicated that West Oakland, East Oakland, and Havenscourt neighborhoods have high rates of asthma.

- Community has concerns about how asthma can be managed when patients do not have a hospital nearby.

[4] California Office of Statewide Health Planning & Development, OSHPD Patient Discharge Data. Additional analysis by CARES. 2011.

CANCER

Why Is It Important?

ETHNIC DISPARITIES IN CANCER RATES

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

Cancer is a term used for diseases in which abnormal cells divide uncontrollably and can invade other tissues. Cancer cells can spread to other parts of the body through the blood and lymph systems.[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. Nationally, Black men are more likely to get and die from cancer, followed by White and Latino 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?

Cancer incidence rates are close to state and 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.

What Do the Data Show?

- The cancer mortality rate in the KFH-Richmond service area is higher than the KFH-Oakland service area or the state; Blacks and Whites in both service areas and Pacific Islanders in the KFH-Richmond service area have higher mortality rates than the state as well (see table on next page).[5]
- The breast cancer incidence rates in the KFH-Oakland and KFH-Richmond service areas are slightly higher than the state, and also slightly higher than the state for Whites in both service areas and Blacks in the KFH-Oakland service area (see table on next page).[6] The age-adjusted breast cancer mortality rate in Contra Costa County (23.0) is higher than the HP2020 objective (20.7) and even higher for Blacks (35.8) and Whites (25.3) in the county.[7] Comparable data are not available for Alameda County.
  - ➥ The percentage of female Medicare enrollees over age 66 who received at least one mammogram in the past two years is slightly higher for the KFH-Oakland (60%) and KFH-Richmond (64%) service areas than the state overall (59%); data are not available by ethnicity or for other age groups.[8]
- While cervical cancer incidence rates in the KFH-Oakland and KFH-Richmond service areas generally are no higher than the HP2020 objective, they are worse for Latinas and White women in both areas (see table on next page).[6]

---

[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.
[5] University of Missouri, CARES. California Department of Public Health (CDPH), Death Public Use Data. 2010-12.
[6] NIH, National Cancer Institute, Surveillance, Epidemiology, & End Results Program. State Cancer Profiles. 2007-11.
[7] *Community Health Indicators for Contra Costa County*. Contra Costa Health Services. 2010.
[8] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.

ASR

- Nearly 79% of adult women in both service areas had a Pap test in the past three years, slightly higher than the state figure (78%); data are not available by ethnicity.[9]

- Colorectal and prostate cancer incidence rates are higher in both service areas than the HP2020 goals, with Blacks and Whites experiencing these cancers at even higher rates in both service areas, and Latinos in the KFH-Oakland service area experiencing colorectal cancer incidence at higher rates than the objective (see table below).[6] The age-adjusted colorectal cancer mortality rate in Contra Costa County (16.5) is higher than the HP2020 objective (14.5) and even higher for Blacks (31.1) countywide.[7] Comparable data are not available for Alameda County.
  - Over 61% of KFH-Oakland service area and nearly 67% of KFH-Richmond service area residents over age 50 had a colonoscopy/sigmoidoscopy, compared to only 58% in the state; data are not available by ethnicity.[8]
- The lung cancer incidence rate in the KFH-Richmond service area is higher than the KFH-Oakland service area or the state; Blacks and Whites in both service areas have higher incidence rates than the state as well (see table below).[6]
  - Only 11% of KFH-Oakland service area adults and 12% of the KFH-Richmond service area adults smoke tobacco (compared to 13% in the state); data are not available by ethnicity.[8]

CANCER MORTALITY AND INCIDENCE RATES

Indicator (per 100,000)	State or HP2020	Service Area		White	Black	Latino	Nat. Am	Asian	Pac Isl
Cancer mortality (age-adjusted)	157.1 (CA)	KFH-Oak	151.4	**168.2**	**203.8**	89.4	116.2	70.0	136.7
		KFH-Rich	**168.6**	**164.0**	**222.5**	97.0	107.3	66.7	**173.4**
Breast cancer incidence	122.4 (CA)	KFH-Oak	**123.1**	**133.2**	**122.9**	95.6	49.6	98.0	N/A
		KFH-Rich	**127.2**	**134.8**	121.7	97.4	71.6	104.2	N/A
Cervical cancer incidence (women)	7.1 (HP)	KFH-Oak	7.1	**7.3**	6.4	**9.5**	N/A	5.6	N/A
		KFH-Rich	7.0	**7.2**	7.1	**9.3**	N/A	5.0	N/A
Colorectal cancer incidence	38.7 (HP)	KFH-Oak	**41.7**	**43.3**	**53.6**	**39.4**	N/A	31.1	N/A
		KFH-Rich	**43.6**	**44.4**	**54.1**	38.4	N/A	31.1	N/A
Lung cancer incidence	49.5 (CA)	KFH-Oak	49.2	**51.9**	**68.5**	32.2	N/A	36.1	N/A
		KFH-Rich	**50.7**	**53.5**	**68.1**	31.3	N/A	30.1	N/A
Prostate cancer incidence (men)	136.4 (CA)	KFH-Oak	**137.4**	**142.9**	**213.4**	127.4	N/A	66.7	N/A
		KFH-Rich	**143.8**	**145.2**	**216.6**	134.2	N/A	82.1	N/A

Note: N/A = data not available. HP = Healthy People 2020.

What Did the Community Say?

[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via U.S. Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

- Comments mainly focused on poor health outcomes for Black residents with respect to cancer.

ECONOMIC SECURITY

Why Is It Important?

FOOD INSECURITY AND POVERTY TOO COMMON

More than 1 in 8 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?

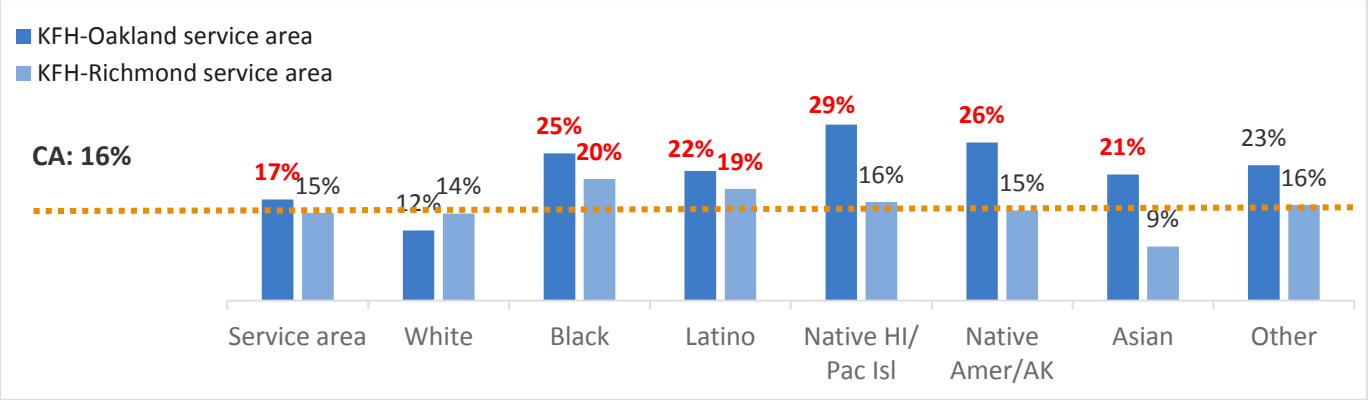
In the KFH-Oakland and KFH-Richmond service areas, more than one in eight residents experience food insecurity, and most ethnic groups have higher proportions living in poverty than others. High school graduation rates are also lower than the Healthy People 2020 (HP2020) goal. In the KFH-Richmond service area, fourth-grade reading proficiency is worse than the HP2020 goal and renters' housing cost burden is also higher than the state overall. The community expressed concern about the costs of housing and food, and about lack of job security.

What Do the Data Show?

Income

PERCENT OF HOUSEHOLDS LIVING AT OR BELOW 100% OF FEDERAL POVERTY LEVEL, 2009-13[3]

[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.
[3] US Census Bureau, American Community Survey. 2009-13.



- In the KFH-Oakland service area, the proportions of Black, Latino, Asian, and Pacific Islander residents, and residents of "some other race," living below the Federal Poverty Level (FPL) are higher than the state average. In addition, Native American residents are also living below 100% FPL in higher proportion than the state overall (see chart on page one).[3]
- While the proportions of households with children in which residents are living below 100% FPL in the KFH-Oakland and KFH-Richmond service areas (20% and 22%, respectively) are generally equivalent to or lower than the state average (22%), minority households with children in the service areas are more likely to be below 100% FPL than White households with children in the service areas.[3]

Basic Needs (Food & Shelter)

- Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. Compared to the Healthy People 2020 goal (6%), more than twice the proportion of households in the KFH-Oakland (16%) and KFH-Richmond (13%) service areas experienced food insecurity in the prior year.[4]
- The cost of housing in the Bay Area is high. Across the state, for 54% of renters, housing costs are more than 30% of their income (cost-burdened households). In the KFH-Richmond service area, 56% of households are cost-burdened (a slightly larger proportion than the state), while in the KFH-Oakland service area 53% are cost-burdened (a slightly smaller proportion than the state).[3]

Education

- An inability to read English well can hamper one's educational and later economic opportunities. Nearly half (47%) of fourth-grade students in the KFH-Richmond service area were reading below proficiency, worse than the HP2020 goal (36%) and the state average (36%). Only 33% of KFH-Oakland service area fourth-graders were reading below proficiency.[5]
- A high school diploma is often a requirement for a well-paying job. The four-year high school graduation rates for youth in the KFH-Oakland (76%) and KFH-Richmond (80%) service areas were lower than the HP2020 goal (82%).[5]

What Does the Community Say?

[4] Feeding America, 2012.
[5] California Department of Education, 2012-13.

- Gentrification is causing people not to feel at home in their own neighborhoods.
- Even if policy is passed to help ease the cost of housing, housing stock is still limited.
- Lower income jobs are less secure and easily succumb to the ups and downs of the economy.
- Difficult to think of your health when you are homeless.
- Lack of full-access supermarkets and cost of food is keeping people away from healthy food.

Profile of KFH-Oakland & KFH-Richmond Service Areas Health Needs

HEALTHCARE ACCESS AND DELIVERY

Why Is It Important?

LACK OF INSURANCE STILL AN ISSUE

More than 1 in 10 residents were uninsured in 2013; nonwhites are more likely to be uninsured and to lack a consistent source of primary 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 preventative services, and hospitalizations that could have been prevented.

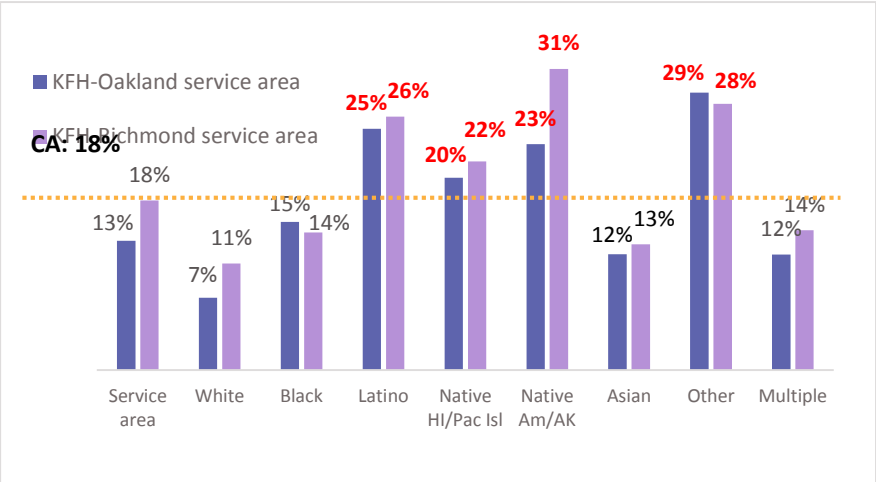
Why Is It a Community Health Need?

Wide disparities exist across multiple racial and ethnic groups in the uninsured population in the KFH-Oakland and KFH-Richmond service areas. The downstream indicator of preventable hospital events shows that residents of the service areas are more likely to be hospitalized for preventable issues than Californians overall. The community expressed concern about a variety of access issues, including language barriers, distance to facilities, inconvenient hours, and delivery issues including workforce shortages and patients' prior bad experiences.

What Do the Data Show?

- There are ethnic disparities in the uninsured population in the KFH-Oakland and KFH-Richmond service areas. Those in the service areas uninsured at percentages higher than the state average include Pacific Islanders, Latinos, Native

PERCENT UNINSURED IN SERVICE AREAS, 2009-13



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

Americans, and those of "some other race" (see chart).[2]

- In the KFH-Richmond service area, Latinos (18%) and Blacks (14%) were more likely to lack a consistent source of primary care than the service area population generally (10%); in the KFH-Oakland service area, Latinos (14%) and those of "some other race" (16%) were more likely to lack a consistent source of primary care than the service area population generally (12%). The state average was 14%.[3]
- The KFH-Oakland (93.0) and KFH-Richmond (101.3) service areas are higher than the state average (83.2) with regard to the age-adjusted patient discharge rate for preventable hospital events per 10,000 total population.[4]
- A much higher percentage of people delayed or had difficulty obtaining care in Alameda County (14%) compared to the Healthy People 2020 objective (4%).[4] There was no comparable data available for Contra Costa County.

What Does the Community Say?

- Language barriers keep people from seeking care; those for whom English is not their first language who do seek care have difficulty navigating the health system.
- Getting to and from appointments is difficult for patients who rely on public transportation. Cost of transportation is also a problem.
- In many cases, health facilities are far away from community members' homes.
- Primary care providers' (PCPs) hours are inconvenient for many community members.
- There is a shortage of trained providers.
- Some patients fear accessing care because of previous bad experiences.
- Special populations:
  - Undocumented (community indicates they tend to use EDs more because hours are more convenient).
  - Homeless (it is difficult to think of health care when you don't know where you are going to be sleeping or living).

[2] U.S. Census Bureau, American Community Survey. 2009-13.
[3] University of California Center for Health Policy Research, California Health Interview Survey (CHIS). 2011-12.
[4] CA Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data. Additional analysis by CARES. 2011.

Profile of KFH-Oakland & KFH-Richmond Service Areas Health Needs

INFECTIOUS DISEASES

Why Is It Important?

CHILD IMMUNIZATION RATES TOO LOW

In both service areas, the rates of childhood immunizations are lower among certain populations than targets.

Infectious diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood). 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.

Data on Sexually Transmitted Infections (STIs) are included in a separate health profile specific to this topic.

Why Is It a Community Health Need?

In both Alameda and Contra Costa Counties, rates of pertussis have been rising. Child immunizations do not meet objectives in the City of Berkeley (situated in the KFH-Oakland service area) or in Contra Costa County (location of the KFH-Richmond service area). In Contra Costa County, immunization statistics show disparities for Black children. In Alameda County, the tuberculosis rate is much higher than the Healthy People 2020 (HP2020) objective. The Alameda County Public Health Department has expressed concern over the "pertussis epidemic" in both the county and the state.

What Do the Data Show?

- The pertussis incidence rate (per 100,000) rose markedly between 2012 and 2014, increasing to 44.1 in Contra Costa County and 25.1 in Alameda County, compared to 29.3 for the state.[2] The City of Berkeley's pertussis rate was 48.6 in 2014.

- In the City of Berkeley, the percentage of kindergarteners immunized against seven childhood diseases (polio, mumps, measles, rubella, diphtheria, tetanus, and pertussis) is lower than Alameda County overall (80% versus 90%, respectively).[3] No perfectly comparable data are available for Contra Costa County, but in that county the percentage of 24-month-old children who are fully immunized against those seven diseases (80%) is lower than the HP2020 objective (90%). The percentage is even lower for Black children (67%) in Contra Costa County.[4]

[1] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[2] *Pertussis Report*. California Department of Public Health. Web. October 2015.
[3] *City of Berkeley Health Status Report*, City of Berkeley Public Health Division. 2013.
[4] *Community Health Indicators for Contra Costa County*, Contra Costa Health Services, December 2010.

- The tuberculosis (TB) incidence rate in Alameda County (7.9 per 100,000) is much higher than the HP2020 objective (1.0 per 100,000).[5] No comparable data are available for Contra Costa County.

What Did the Community Say?

- 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.

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

Profile of KFH-Oakland & KFH-Richmond Service Areas Health Needs

MENTAL HEALTH

Why Is It Important?

MENTAL HEALTH CARE IS GREATLY NEEDED

The rate of ER visits for intentional injuries among youth is higher in both service areas than the state; community concern includes youth suicide, trauma, and lack of services.

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 the 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]

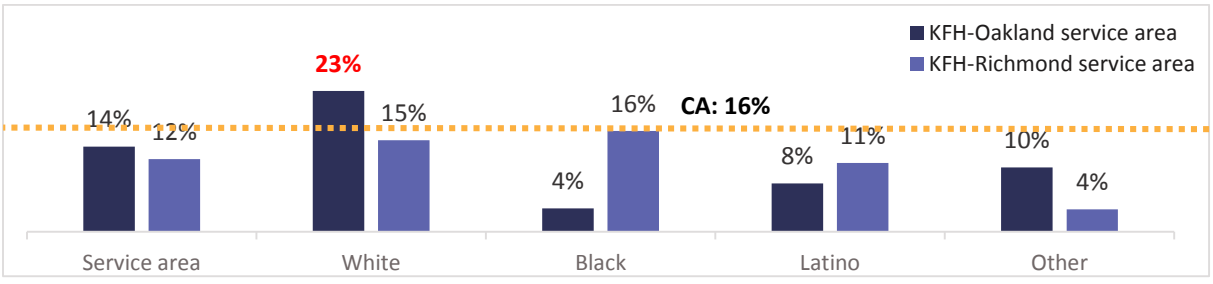
Why Is It a Community Health Need?

The suicide rate in the KFH-Richmond service area generally is higher than the state, and higher in both service areas for Whites. In the KFH-Oakland and KFH-Richmond service areas, the rate of ER visits for intentional injuries (including self-harm) among youth is higher than the state. In the KFH-Oakland service area, Whites report a need for mental health care at a higher percentage than the state average. Alameda County adults – particularly Black adults – are more likely to visit the Emergency Department (ED) for severe mental illness than adults in the state. The community is concerned about trauma, youth suicide, lack of services generally, and lack of coordination between systems.

What Do the Data Show?

- Whites in the KFH-Oakland service area report a need for mental health care at a higher percentage than the state or other ethnic groups in the service area, such as Blacks or Latinos (see chart below).

PERCENT OF ADULTS WHO NEEDED TO SEE A PROFESSIONAL FOR BEHAVIORAL HEALTH ISSUES IN THE PAST YEAR (SELF-REPORT), 2013-2014



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

- In Alameda County, adults are more likely to visit the ED for severe mental illness (408.5 per 100,000) compared to the state (301.7), and Black adults in the county are much worse off (1126.5).[2] Data are not available at the service area level.
- The rates of ER visits for intentional injury among youth (both attempted suicide and assault) per 100,000 population ages 13-20 in the KFH-Oakland (952.3) and KFH-Richmond (779.3) service areas were higher than the state (738.7).[3]
- The age-adjusted suicide morality rate per 100,000 in the KFH-Richmond service area (11.8) is higher than the state average (9.8) or the HP2020 objective (10.2). While the suicide rate in the KFH-Oakland service area (8.3) was not higher than these, White suicide rates in both service areas (13.0 in KFH-Oakland, 13.6 in KFH-Richmond) were much higher than those of other ethnic groups in the areas.[4] No data are available by age.

What Does the Community Say?

- Community feels that suicide is a big problem for pre-teens, youth (especially LGBTQ), and young adults.
- Community experiences chronic stress/trauma from life experiences related to unstable housing, unstable employment, and unsafe communities.
- Shortage of services noted both for prevention/early intervention and for inpatient treatment.
- One key informant stated, "We are inappropriately using jails/the criminal justice system to address mental health needs rather than the mental health system."
- Lack of providers who are culturally diverse.
- Need more/better provider training: Health professionals don't always recognize subtle signs, and there is a lack of providers trained in trauma-informed care, especially for children.
- Poor connection with larger health system: No sharing of medical records between PCP & mental health provider.

[2] *Healthy Alameda County*. Alameda County Public Health Department. Web. December 2015.
[3] California EpiCenter data platform for Overall Injury Surveillance. 2011-2013.
[4] California Department of Public Health (CDPH), Death Public Use Data. 2010-12.

Profile of KFH-Oakland & KFH-Richmond Service Areas 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.

HIGH LEVELS OF YOUTH OBESITY

Youth levels of obesity are worse in the service areas than in the state overall, and there are ethnic disparities. Environmental factors that vary across service areas contribute to youth being obese.

Why Is It a Community Health Need?

Youth levels of obesity are worse in the KFH-Oakland and KFH-Richmond service areas than the Healthy People 2020 (HP2020) objective. The KFH-Oakland service area also does worse in youth fruit and vegetable consumption and healthy food access than the state. The KFH-Richmond service area does worse in healthy food access, youth physical inactivity, and access to fitness/recreational facilities than the state. In both areas, there are ethnic disparities in diabetes prevalence. Community concerns very closely mirror the statistical data.

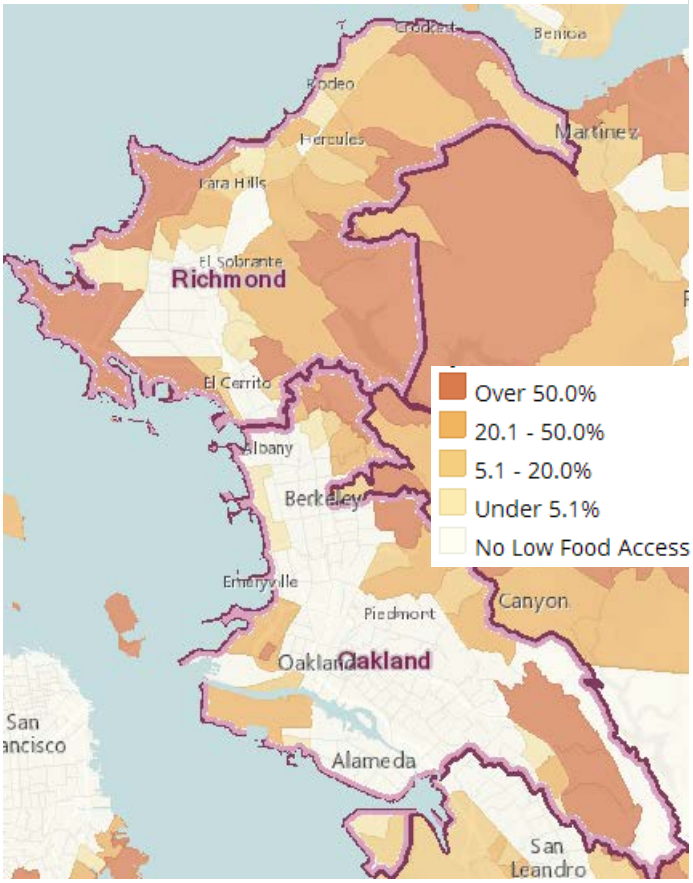
What Do the Data Show?

- In the KFH-Oakland and KFH-Richmond service areas, youth of certain ethnicities are disproportionately obese compared to youth in the service areas generally: Black (22% and 25%, respectively) and Latino (25% and 29%, respectively). Approximately 17% of youth in the KFH-Oakland service area and 24% in the KFH-Richmond service area are obese, greater proportions than the HP2020 objective (16%).[3] Racial and ethnic disproportionalities are reflected in adult obesity[4] and youth[3] and adult[4] overweight statistics as well.[9, 10]
- In the KFH-Oakland service area, a larger percentage of youth consume inadequate amounts of fruits and vegetables (59%) than the KFH-Richmond service area (36%) or the state (47%).[5]

[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.
[3] California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[5] University of California Center for Health Policy Research, California Health Interview Survey (CHIS). 2012.

- In the KFH-Oakland service area, there are more fast food restaurants (84.3)[6] and fewer WIC-authorized food stores (12.2)[7] per 100,000 residents than in the KFH-Richmond service area (56.8 and 12.7, respectively) or in the state (74.5 and 15.8, respectively). However, the KFH-Richmond service area has a greater percentage of its population living in a food desert (20%) than the KFH-Oakland service area (5%) or the state (14%).[7]
- Diabetes is prevalent among adults in the KFH-Oakland and KFH-Richmond service areas at similar percentages to the state (all 8%).[8] However, in Alameda County, higher percentages of Black (11%) and Native American (36%) residents are diabetic,[9] and in Contra Costa County, slightly higher percentages of Latino (9%) residents are diabetic.[10]
- Youth are less active in the KFH-Richmond service area than in the state (42% of KFH-Richmond service area youth are physically inactive, compared to 36% of KFH-Oakland service area and state youth). Ethnic disparities are similar to those for youth obesity.[3]
- There are fewer recreation and fitness facilities per 100,000 residents in the KFH-Richmond service area (3.7) than in the KFH-Oakland service area (9.8)[6] and the state (8.7).

POPULATION WITH LIMITED FOOD ACCESS (FOOD DESERT), 2010



What Does the Community Say?

- Community members stated that fast food is cheaper than healthy food.
- Many said it was easier to access fast food and that there was a lack of access to healthy foods (especially for those who rely on public transit).
- Community felt there was not enough nutrition and health education available.
- Key informants noted that obesity is a problem amongst children; students get progressively heavier between elementary school and high school.
- Community felt there was poor access to affordable, convenient recreational activities.

[6] U.S. Census Bureau, County Business Patterns. Additional analysis by CARES. 2012.
[7] U.S. Department of Agriculture (USDA), Economic Research Service, *Food Environment Atlas*. 2011.
[8] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[9] *Alameda County Health Data Profile*, Alameda County Public Health Department. 2014.
[10] *Community Health Indicators for Contra Costa County*, Contra Costa Health Services, December 2010.

Profile of KFH-Oakland & KFH-Richmond Service Areas Health Needs

SEXUALLY TRANSMITTED INFECTIONS

Why Is It Important?

Sexually transmitted infections are diseases that are primarily transmitted through direct sexual contact with an infected individual or their discharge (such as blood or semen). They include HIV/AIDS, syphilis, chlamydia, gonorrhea, and genital herpes. Some, if left untreated, can be fatal (HIV), or can affect fertility among those of child-bearing age.[1] Communicable diseases such as sexually transmitted infections are closely monitored to identify outbreaks and epidemics, provide preventive treatment and/or targeted education programs, and to allocate resources effectively.

HIV/AIDS CONTINUES TO BE A CONCERN

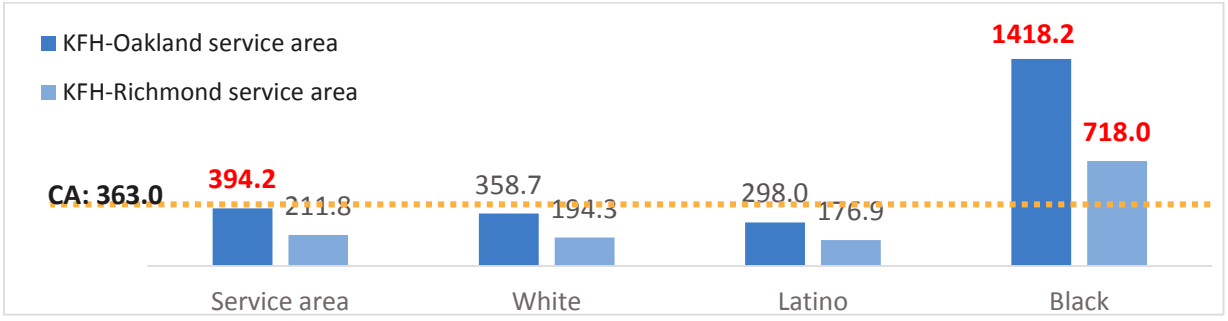
HIV rates in the KFH-Oakland service area are higher than CA, and Black residents have disproportionately higher rates. The rate of reported AIDS cases is much higher in Contra Costa County, which contains the KFH-Richmond service area, than the HP2020 objective.

Why Is It a Community Health Need?

In the KFH-Oakland service area, the statistics on HIV prevalence and HIV-related hospitalizations are worse than the state, and the statistics show disparities for Black residents. The City of Berkeley (one of the largest cities in the KFH-Oakland service area) has much higher rates of gonorrhea than the Healthy People 2020 (HP2020) objective. In Contra Costa County (location of the KFH-Richmond service area), rates of reported AIDS cases are higher than the HP2020 objective. The community expressed concern related to education of adolescents about sexual health.

What Do the Data Show?

HIV PREVALENCE RATE BY ETHNICITY, KFH-OAKLAND AND KFH-RICHMOND SERVICE AREAS, 2010[2]



- The HIV prevalence rate (per 100,000) is somewhat higher in the KFH-Oakland service area than in the state. HIV prevalence rates among Black residents in both service areas are disproportionately higher (see chart above).[2]

[1] *CDC Fact Sheet: Staying Healthy and Preventing STDs.* Centers for Disease Control and Prevention. Web. January 2016.
[2] 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.

- The rate of hospital discharges for HIV-related complications in the KFH-Oakland service area (2.7 per 10,000, age-adjusted) is higher than the rates in the KFH-Richmond service area and the state (respectively 1.7 and 2.0 per 10,000, age-adjusted).[3]

- In Contra Costa County, the rate of reported AIDS cases (6.9 per 100,000) is much higher than the HP2020 objective (1.0 per 100,000).[4] No comparable data are available for Alameda County.

- In the KFH-Oakland service area, the City of Berkeley's rate of gonorrhea incidence (160.8 per 100,000) is substantially higher than Alameda County's rate (143.9 per 100,000).[5] No comparable data are available for Contra Costa County.

What Did the Community Say?

- Key informants mentioned higher rates of chlamydia amongst Black communities generally, and high rates of gonorrhea among Black communities specifically in East Oakland.

- Community members stated that having sex without a condom is more prevalent among Black residents.

- Community members felt that Black residents are having sex at a younger age than others.

- Key informants noted an increase of HIV amongst men who have sex with men (MSM).

- Sexual health education and education on general healthy decision-making for adolescents is lacking.

[3] CA Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
[4] *Community Health Indicators for Contra Costa County*, Contra Costa Health Services, December 2010.
[5] *City of Berkeley Health Status Report*, City of Berkeley Public Health Division. 2013.

Profile of KFH-Oakland & KFH-Richmond Service Areas 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 in California generally.

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 about illegal drug use are not available, but the community expressed concern about drug use and the lack of treatment services available to address this problem. Data available on alcohol use show that KFH-Oakland and KFH-Richmond service area residents may be using alcohol more frequently than Californians generally.

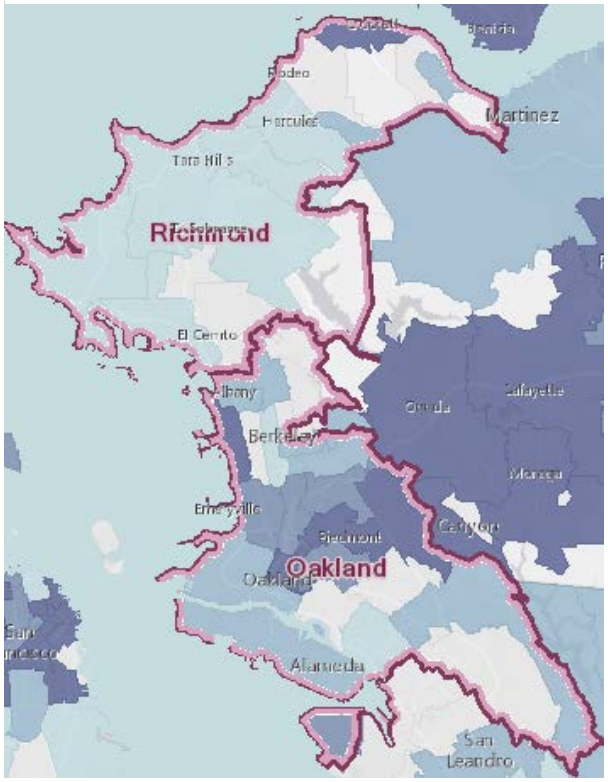
What Do the Data Show?

- In Alameda County, the rate of Emergency Room (ER) visits for substance abuse was 1501.1, higher than the state rate of 1234.1 per 100,000. Countywide, Blacks have much higher ER visit rates for substance abuse than those of other ethnicities.[3] Comparable data are not available for Contra Costa County.
- Over 14% of the KFH-Oakland service area residents' and over 13% of the KFH-Richmond service area residents' total household expenditures are towards alcohol, slightly higher than the state average (just under 13%).[4]
- The rates of binge drinking among adults in the KFH-Oakland and KFH-Richmond service areas (20% and 19%, respectively) are higher than the state average of 17%.[5]

[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.
[3] *Healthy Alameda County.* Alameda County Public Health Department. Web. December 2015.
[4] Nielsen, Nielsen SiteReports. 2014.

- The KFH-Oakland service area has 16.1 liquor stores per 100,000 residents, higher than the state target of 10.0. The KFH-Richmond service area only has 9.0 liquor stores per 100,000 residents.[6]

BEER, WINE, & LIQUOR STORES PER 100,000 RESIDENTS, 2012



What Does the Community Say?

- Easy to access alcohol; there is a liquor store on every corner.
- Concern about methamphetamine-induced heart failure was expressed.
- Prescription drugs are overly-prescribed; prescription drug deaths exceed motor vehicle crashes.
- Opiate-derived medication is not effectively managing pain.
- Community concerned that substance use causes poverty and leads to violence.
- Treatment options are a big concern; many are too expensive for people to use.
- Community states that LGBTQ youth have increased substance abuse rates.

[5] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
[6] U.S. Census Bureau, County Business Patterns. Additional analysis by CARES. 2012.

Profile of KFH-Oakland & KFH-Richmond Service Area Health Needs

VIOLENCE/INJURY PREVENTION

Why Is It Important?

VIOLENCE RATES WORSE THAN STATE

Homicide, domestic violence, and assault injury rates in both service areas are worse than state rates, and the community expressed concern about geographic and ethnic disparities.

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]

Why Is It a Community Health Need?

In the KFH-Oakland and KFH-Richmond service areas, indicators of violence such as homicide, domestic violence, assault injury, and school suspension rates are all worse than state or Healthy People 2020 (HP2020) objectives. The community expressed concern about geographic and ethnic disparities in rates of violence and the impact of violence on health outcomes.

What Do the Data Show?

- Indicators of violence are worse in the KFH-Oakland and KFH-Richmond service areas than in the state. For example:
  - ➥ The rates of domestic violence (non-fatal ER visits) per 100,000 females age 10 and over in the KFH-Oakland (12.0) and KFH-Richmond (12.2) service areas are much higher than the state rate (9.5).[4]

[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

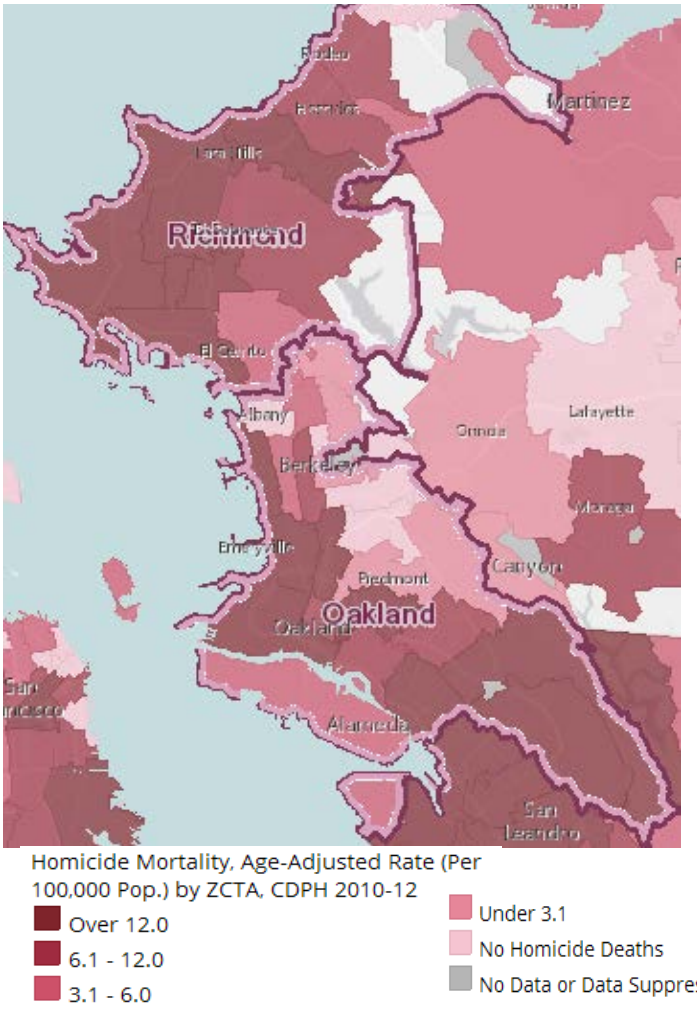
[4] California EpiCenter data platform for Overall Injury Surveillance, 2011-2013.

- The rates of assault injury (non-fatal ER visits) per 100,000 residents in the KFH-Oakland (393.5) and KFH-Richmond (316.0) service areas are higher than the state (290.3).[4]

- The age-adjusted homicide mortality rates (per 100,000 age-adjusted) in the KFH-Oakland and KFH-Richmond service areas (10.6 and 15.6, respectively) are above the HP2020 objective of 5.5. Ethnic disparities are stark, with Blacks having much higher homicide mortality rates (42.1 and 39.9, respectively) than those of other ethnicities.[5]

- 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-Oakland (7.1) and KFH-Richmond (13.3) service areas' rates of school suspensions per 100 enrolled students are much higher than the state (4.0).[6]

HOMICIDE RATE BY ZIP CODE, 2010-12



What Does the Community Say?

- Community believes that most violence is related to gangs (i.e., gang-on-gang violence), and that violence also is frequently related to the "drug war."
- Community members felt that Latinos and Blacks experience violence more often than others.
- There are few health professionals trained in trauma-informed care.
- People only receive acute ER care for violence (community sees no preventative/mental health services).
- Key informants explained that exposure to violence is connected to health problems later in life, both physical and mental (trauma of living in an environment where there is crime happening).
- Key informants noted that East Oakland has the poorest health outcomes in addition to violent crime, and that East Oakland, West Oakland, and Richmond have high violence and school dropout rates.

[5] California Department of Public Health (CDPH) Death Public Use Data. 2010-12.
[6] California Department of Education. 2013-14.