2016 Community Health Needs Assessment

Kaiser Foundation Hospital—Vallejo
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Approved by KFH Board of Directors
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CHNA REPORT FOR KFH—VALLEJO

Acknowledgements

Many individuals and organizations participated in the success of this Community Health Needs Assessment.

Partner hospitals have worked closely together throughout the CHNA to insure the CHNA complied with the requirements of the Affordable Care Act and included data on which to build effective implementation strategies. Members of the Napa County CHNA Advisory Group include:

- Napa County Health and Human Services Agency
  - o Jennifer Henn, Epidemiologist
- Live Healthy Napa County
  - o Jennifer Henn
- Kaiser Permanente
  - o Cynthia Verrett, Community Benefit Manager
- St. Helena Hospital Napa Valley
  - o Mayra Vega, Director of Client Services
- St. Joseph Health Queen of the Valley Medical Center
  - o Dana Codron, Executive Director of Community Outreach
  - o Elizabeth Alessio, Community Benefit Coordinator
- Consultants
  - o Harder+Company Community Research and Raimi + Associates were instrumental in supporting the community health need prioritization process by presenting extensive data in a useful way and facilitating a meaningful conversation that resulted in the establishment of community priorities on which future decisions can be based. The team also prepared this report.

Several other organizations were also instrumental to the CHNA process, including:

- o Multiple social service and nonprofit organizations who helped coordinate and recruit participants for focus groups, participated in key informant interviews, and attended the prioritization session.
- o Community members who participated in focus groups and provided invaluable insight into the needs of their community.

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

The KFH—Vallejo service area has an aging population, and substantial disparities in socioeconomic status. These issues present challenges for the health of residents. After a review of service area data, key stakeholders and residents identified eight specific health needs in the KFH—Vallejo service area.

1. **Education:** Educational attainment is strongly correlated with health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.

   Among residents served by KFH—Vallejo, extreme disparities exist among subpopulations in key educational outcomes. Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school. In Napa County, only 22.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts; only 39.0% passed in Mathematics.[1] For all students, harassment and bullying in schools were also raised as issues of high concern.

2. **Economic and Housing Insecurity:** Economic resources such as jobs paying a livable wage, stable and affordable housing, as well as access to healthy food, medical care, and safe environments can impact access to opportunities to be healthy.

   The high cost of living in the region exacerbates issues related to economic security and stable housing. Among all households in the KFH—Vallejo service area, 44.3% spend 30% or more of household income on housing costs.[2] Malnutrition and food insecurity are also key issues for residents, as many are forced to spend most of their income on housing, but do not qualify for public benefits.

3. **Violence and Injury:** Violence and injury is a broad topic that covers many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others.

   In the KFH—Vallejo service area, in recent years, there were 10.2 non-fatal emergency room visits due to domestic violence per 100,000 females (age 10+).[3] The area also experiences a high risk of

[1] California Department of Education, 2013-14.
[2] US Census Bureau, American Community Survey, 2009-13.
[3] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.

violent crime, with a 308.5 per 100,000 population assault rate,[4] and a 7.1 per 100,000 population homicide rate.[5]

4. **Mental Health:** Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.

   Mental health was raised as a high concern. Most notably, KFH—Vallejo service area residents have a high risk of suicide. The suicide rate in the service area is 11.8 per 100,000 residents; it is 12.7 per 100,000 among Napa County residents.[6] Older adults, transition age youth, LGBTQ youth, and Latinos were noted as populations of high concern for mental health issues. Social stigma and the geographic distribution of treatment facilities were considered as barriers to receiving appropriate mental health services.

5. **Obesity and Diabetes:** Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese.[7] Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes.

   In the KFH—Vallejo service area, an estimated 26.7% of adults are obese,[8] and 38.4% are overweight.[9] Among youth, 18.4% are obese and 20.7% are overweight.[10] Access to affordable healthy food was identified as a concern, particularly in specific areas of Napa County including American Canyon and rural communities. Since economic disadvantage is strongly linked to barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as older adults and residents experiencing homelessness, are disproportionately affected by this health need.

6. **Access to Primary and Oral Health Care:** Ability to utilize and pay for comprehensive, affordable, quality physical and mental health care is essential in order to maximize the prevention, early intervention, and treatment of health conditions. Nationwide, there is a focus on integrating oral health services into primary care. Utilization of oral health care is extremely important to health, as tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.

   With the implementation of the ACA, many adults have access to insurance coverage and regular healthcare. However, disparities persist. Premiums for health insurance remain high, and many providers do not accept Medi-Cal or have long waiting lists. Dental insurance was not included in recent health insurance reform, and 40.3% of the adult population in the KFH-Service Area lacks dental insurance.[11]

7. **Substance Use**: Use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences.

   In the KFH—Vallejo service area, substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults, 20.9% of residents report heavy alcohol

[4] 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.
[5] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[6] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[7] http://www.cdc.gov/obesity/adult/defining.html
[8] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[10] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[11] California Health Interview Survey, 2009.

consumption.[12] Youth were noted as a high risk population, and data indicates that in the prior 30 days 11.8% of 11th grade students in Napa County reported using cigarettes, 22.8% reported binge drinking, and 24.9% reported using marijuana.[13]

8. **Cancers:** Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth.[14] Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options.

   Compared to California state averages, KFH—Vallejo service area has higher incidence of breast, prostate, colon and rectum, and lung cancer, as well as a higher all-cancer mortality rate. Racial/ethnic disparities exist in cancer morbidity and mortality.

C. Summary of Needs Assessment Methodology and Process

The CHNA process used a mixed-methods approach to collect and compile data to provide a robust assessment of health among residents in the KFH—Vallejo service area. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. Data sources included:

- Analysis of over 150 health indicators from publicly-available data sources such as the California Health Interview Survey, American Community Survey, and the California Healthy Kids Survey. Secondary data were organized by a framework developed from Kaiser Permanente's list of potential health needs, and expanded to include a broad list of needs relevant to Napa County.
- Interviews were conducted with 18 key informants in Napa County and four key informants in relevant areas of Solano County. Interviewees included representatives from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted.
- Four focus groups were conducted in Napa County in Spanish and English, and two in relevant areas of Solano County in English, representing populations identified as having worse health outcomes or at risk for worse health outcomes.

Data were used to score each health need. All health needs identified in the concurrent Napa County Community Health Needs Assessment process were considered to be health needs in the KFH Vallejo service area, as Napa County represents a large portion of the KFH—Vallejo service area. Additional data specific to areas of Solano County in the KFH—Vallejo service area were considered to identify any additional health needs. Potential health needs were included in the prioritization process if:

a. Multiple indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, the benchmark used was the California state average).
b. The health issue was identified as a key theme in at least half of interviews OR in at least one focus group.

KFH—Vallejo hospital leadership convened on February 16, 2016, to review the identified health needs, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the county. The group built upon the community process used to prioritize health needs in Napa County on December 18, 2015. After reviewing the data, the KFH—Vallejo hospital leadership added one additional health need, Violence and Unintentional Injury, to the prioritized list of health needs that emerged from the Napa County CHNA process. Utilizing the Criteria Weighting Method, which enabled

[12] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[13] California Healthy Kids Survey, 2011-13.
[14] American Cancer Society. Accessed at http://www.cancer.org/cancer/cancerbasics/what-is-cancer, December 2015.

consideration of each health area using four criteria: severity, disparities, impact, and prevention the KFH-Vallejo leadership prioritized the health needs for the service area.

The CHNA is an important first step towards taking action to effect positive changes in the health and well-being of county residents. The results will be used to inform the development of an implementation strategy for each hospital outlining the priority health needs the hospital will address. These strategies will build on community assets and resources, as well as on evidence-based strategies, wherever possible.

The CHNA and the implementation strategy will be developed to contribute to action in a strategic, innovative, and equitable way.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente

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 CHNAs 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 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 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.

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

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 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, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

The Napa County CHNA Advisory Group 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—Vallejo 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/kp.

III. COMMUNITY SERVED

In order to determine the health needs of the KFH—Vallejo service area, it is first important to understand the communities of interest. The following section describes the service area community by

geography, demographics, and socioeconomic indicators, as well as indicators of overall health, and climate and the physical environment.

A. Kaiser Permanente's Definition of Community Served

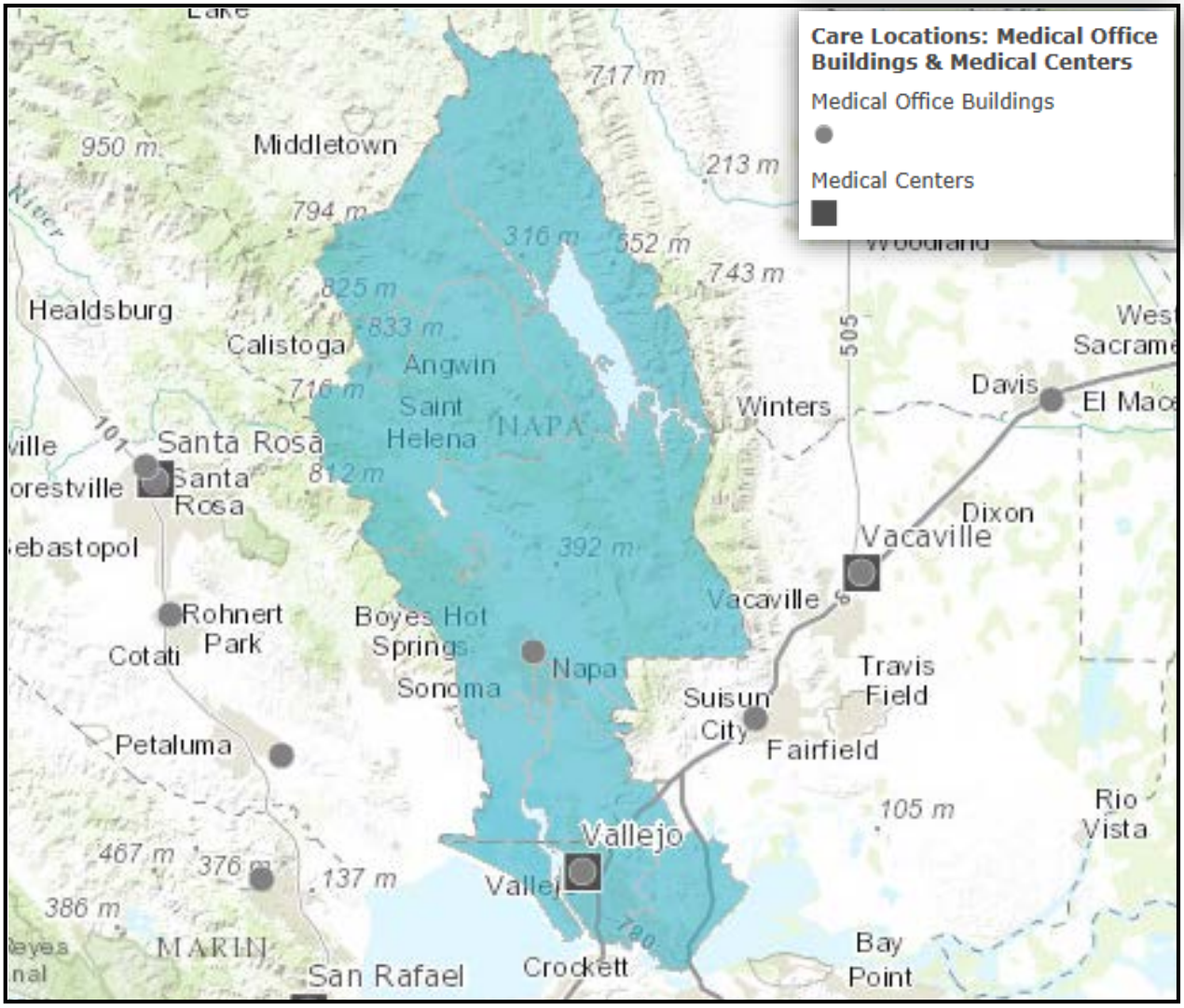
Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

In the spirit of collaboration, the Napa County CHNA Advisory Group produced a county-wide CHNA which considered all of Napa County as the service area. KFH—Vallejo service area includes all of Napa County, as well as Vallejo and Benicia in the primary service area; as such, this institution has taken into consideration the results of the Napa County CHNA and additional data relevant to the areas of Vallejo and Benicia to produce this CHNA.

B. Map and Description of Community Served

i. Map

The map below depicts the KFH—Vallejo primary service area, the geographic region assessed in this CHNA.



ii. Geographic Description of the Communities Served

The Kaiser Foundation Hospital-Vallejo service area includes communities in Napa and Solano counties. The major communities are Benicia and Vallejo in Solano County and American Canyon, Calistoga, Napa, Oakville, Rutherford, St. Helena, and Yountville in Napa County. The service area is further defined by Highway 29 leading from Vallejo to Napa and Interstate 80 in Solano County.

iii. Demographic Profile

The following demographic and socioeconomic data provide an overall picture of the KFH—Vallejo service area population. While the KFH—Vallejo service area is comprised of generally healthy and affluent communities, especially compared to California as a whole, stark disparities exist. The area has a growing senior population, and has substantial disparities in socioeconomic status. These issues present challenges for the health of KFH—Vallejo service area residents. KFH—Vallejo service area data are presented throughout this report where available; Napa County data is presented as the primary estimate of consideration where KFH—Vallejo service area data is not available.

KFH Vallejo Demographic Data	
Total Population	281,059
White	61.67%
Black	10.62%
Asian	15%
Native American/ Alaskan Native	0.58%
Pacific Islander/ Native Hawaiian	0.5%
Some Other Race	6.19%
Multiple Races	5.44%
Hispanic/Latino	27.63%

KFH Fremont Socio-economic Data	
Living in Poverty (<200% FPL)	30.35%
Children in Poverty	18.18%
Unemployed	7.8%
Uninsured	14.15%
No High School Diploma	14.1%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

Because a large proportion of the KFH—Vallejo service area includes all of Napa County, KFH—Vallejo participated in the Napa County CHNA Advisory Group on their CHNA. The KFH—Vallejo staff then worked separately with the same consultant team to add in and consider data for the two Solano County cities included in the KFH—Vallejo service area to determine a list of health needs for the whole KFH—Vallejo service area.

A. Identity of Hospitals that Collaborated on the Assessment

Kaiser Foundation Hospital-Vallejo collaborated with St. Joseph Health Queen of the Valley Medical Center and St. Helena Hospital on data collection and interpretation for Napa County.

B. Other Partner Organizations that Collaborated on the Assessment

The Napa County hospitals, in partnership with the following organizations, made up the Napa County CHNA Advisory Group:

- Napa County Health and Human Services Agency
- Live Healthy Napa County: Formed in 2012 as a public-private-community partnership, Live Healthy Napa County (LHNC) convenes representatives from health and healthcare organizations, business, public safety, education, government, and the general public, to build strategies to realize a shared vision of a healthier Napa County. LHNC aims to increase the wellbeing and quality of life for all individuals, families, and communities in Napa County by

moving away from a focus exclusively on sickness and disease to one based on prevention and wellness. Live Healthy Napa County recognizes that health starts long before illness – in our homes, schools, and jobs – and the ability to make meaningful change to improve health requires the collective impact of actors from different sectors committed to a shared agenda. Only a comprehensive approach that considers the effects of social, environmental, and economic factors on health will create sustainable change. To this end, LHNC has collaborated closely with the nonprofit hospitals in Napa County to engage in this CHNA process which brings together countywide partners to identify and prioritize issues affecting health and wellness.

C. Identity and Qualifications of Consultants Used to Conduct the Assessment

- **Harder+Company Community Research:** Harder+Company Community Research is a comprehensive social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-based evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts – including conducting needs assessments; developing and operationalizing strategic plans; engaging and gathering meaningful input from community members; and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation which is essential to both healthcare reform and the CHNA process in particular. Harder+Company is also the evaluation partner on several other CHNAs throughout the state including in Marin, San Joaquin, and Sonoma Counties.
- **Raimi + Associates:** Raimi + Associates is a community planning, research, and evaluation firm with offices in Riverside, Los Angeles, and Berkeley. Raimi + Associates' mission is to provide consulting services that support community health, sustainable neighborhoods, and social equity. Raimi + Associates is nationally recognized for its commitment to elevating community health in all aspects of its work. The Raimi + Associates' team views community health broadly, and seeks to integrate cross-sector perspectives into their projects. They use data to understand how a range of factors—or social determinants of health—affect the health of communities. The firm brings deep expertise in qualitative and quantitative research methods, including community surveys, focus groups, key informant interviews, reviewing secondary data sources, and crafting innovative policies for community assessments, community change evaluation, and strategic planning. Raimi + Associates has a successful track record partnering effectively with nonprofits, government agencies, community collaboratives, and foundations to achieve their long-term visions.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

Harder+Company and Raimi + Associates staff used a mixed-methods approach to collecting and compiling data to develop a robust assessment of community health. A broad lens on qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. The following section outlines the data collection and analysis methods used to conduct the KFH—Vallejo CHNA.

A. Secondary Data

i. Sources and Dates of Secondary Data Used in the Assessment

Kaiser Foundation Hospital-Vallejo first worked with the Napa County CHNA Advisory Group to examine data for Napa County. The Napa County CHNA Advisory Group used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publicly available data sources. Additional secondary data was compiled and reviewed from existing sources including California Health Interview Survey, American Community Survey, and California Healthy Kids Survey, among other sources. Where more recent data was readily available and current estimates were critical to assessing changing landscapes such as health insurance status, Kaiser Permanente CHNA Data Platform information was updated as new data was publicly released to reflect more recent data. In addition to statewide and national survey data, previous community health assessments and other relevant external reports were reviewed to identify additional existing data on indicators at the county level. In addition to a review of Napa County data, the consultants worked with KFH—Vallejo staff to examine KFH—Vallejo service area-specific data to determine what impact, if any, the cities of Benicia and Vallejo in Solano County had on the data. KFH—Vallejo service area data is included alongside Napa County data where available. For details on the specific source and year for each indicator reported, please see Appendix B.

ii. Methodology for Collection, Interpretation and Analysis of Secondary Data

Secondary data was organized by a framework of potential health need, and a comprehensive list of health need areas were explored during this assessment process. This framework was developed from Kaiser Permanente's list of potential health needs, which was based on the most commonly identified health needs from the 2013 CHNA cycle, and expanded to include a broad list of needs relevant to this region. The consulting team and Napa County CHNA Advisory Group finalized this framework in advance of analysis.

Where available, KFH—Vallejo service area data and Napa County data were considered alongside relevant benchmarks including the California state average, Healthy People 2020, and the United States average. Each indicator was compared to a relevant benchmark, most often the California state average. These scores were used to generate an average score for each potential health need. If no appropriate benchmark was available, an indicator could not be scored; however, such indicators remain in the final data book (Appendix B) and were used to provide supplementary information about identified health needs. In areas of particular health concern, data were also collected at smaller geographies, where available, to allow for more in-depth analysis and identification of community health issues. Data on gender and race/ethnicity breakdowns were analyzed for key indicators where subpopulation estimates were available.

B. Community Input

i. Description of the Community Input Process

Community input was provided by a broad range of community members and leaders provided community input through key informant interviews and focus groups. The consultant team interviewed individuals who were identified as having valuable knowledge, information, and expertise relevant to the health needs of the community. Interviewees included representatives from the local public health department as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Other individuals from various sectors with expertise of local health needs were also consulted.

A total of 18 key informant interviews were conducted for the Napa County CHNA. Because the KFH—Vallejo service area also includes Benicia and Vallejo, two cities in Solano County, the 18

Napa County interviews were considered alongside primary data that were collected in Solano County by Valley Vision for the Solano County CHNA. Four interviews (including group interviews) conducted with Benicia and Vallejo residents and stakeholders for the Solano County CHNA, and were included in the analysis because the KFH—Vallejo service area includes these two cities. For a complete list of individuals who provided input, see Appendix C.

Additionally, four focus groups were conducted throughout Napa County. These groups were intentionally sampled to reach specific subpopulations of the county that were identified as having worse health outcomes or at risk for having worse health outcomes than the general population in Napa County. These subpopulations included youth county-wide, as well as residents in American Canyon and Calistoga. Focus groups were monolingual, conducted in either English or Spanish. Two additional focus groups conducted in Solano County by Valley Vision were also considered in this analysis because they included residents from Benicia and Vallejo, which are part of the KFH—Vallejo service area. For more information about specific populations reached in focus groups, see Appendix C.

ii. Methodology for Collection and Interpretation of Primary Data

Napa County CHNA interview and focus group protocols, designed to explore the top health needs in the community, as well as a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing drivers of health needs, were developed by the consulting team and reviewed by the Napa County CHNA Advisory Group. Solano County interview and focus group protocols were designed by Valley Vision with support from partners in Solano County. For more information about data collection methodology and protocols, see Appendix D.

All qualitative data for Napa County was coded and analyzed using Atlas.ti software. The consultant team coded transcripts for information related to each potential health need, as well as to identify comments related to specific drivers of health needs, subpopulations or geographic regions disproportionately affected, existing assets or resources, and community recommendations for change. At the onset of analysis, the consultant team coded one interview transcript and one focus group transcript to ensure inter-coder reliability and minimize bias. Transcripts from Solano County CHNA data collection were coded in Microsoft Word using the same robust codebook.

The consultant team analyzed the transcripts to identify common themes across interviewees and focus group participants, as well as specific themes that emerged within a particular focus group or in a key leader interview. Health need identification in qualitative data was based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions of that particular health need within each transcript.

C. Written Comments

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

As of the time of this CHNA report development, KFH—Vallejo had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data Limitations and Information Gaps

The Kaiser Permanente CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. While changes to the platform are ongoing, the data presented in this report reflect estimates from the Kaiser Permanente CHNA data platform on September 9, 2015. Supplementary secondary data were obtained from reliable data platforms including U.S. Census Bureau American FactFinder, AskCHIS, and others. However, as with any secondary data estimates, there are some limitations. With attention to these limitations, the process of identifying health needs was based on triangulating primary data and multiple indicators of secondary data estimates. The following considerations may result in unavoidable bias in the analysis:

- Some relevant drivers of health needs could not be explored in secondary data because information was not available.
- Many data were available only at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data related to age, ethnicity, race, and gender are not available for all data indicators, limiting the ability to examine disparities of health within the community. Data only available at the county level could also not be considered for the KFH—Vallejo service area population; Napa County data is considered in this case.
- In all cases where secondary data estimates by race/ethnicity are reported, the categories presented reflect those collected by the original data source, which results in inconsistencies in racial labels within this report.
- For some county level indicators, data are available but reported estimates are statistically unstable; in this case estimates are reported but instability is noted. Information about statistical stability was not available for KFH—Vallejo service area population data.
- Secondary data collection was subject to differences in rounding from different data sources; i.e., Kaiser Platform indicators generated from county-level data now round to the nearest tenth decimal place. Figures for all indicators generated from ZIP codes, census tracts, and points/addresses round to the nearest hundredth decimal places, and other data sources may report only to the nearest tenth or whole number.
- Data are not always collected on a yearly basis, meaning that some data estimates are several years old and may not reflect the current health status of the population. In particular, data reported from prior to 2013 should be treated cautiously in planning and decision-making.
- California state averages and, where available, United States national averages are provided for context. No analysis of statistical significance was done to compare county data to a benchmark; thus, these benchmarks are intended to provide contextual guidance and do not intend to imply a statistically significant difference between county and benchmark data.

Primary data collection and the prioritization process are also subject to information gaps and limitations. The following limitations should be considered in assessing validity of the primary data.

- Themes identified during interviews and focus groups reflect the experience of individuals selected to provide input; the Napa County CHNA Advisory Group sought to receive input from a robust and diverse group of stakeholders to minimize this bias.
- The final prioritized list of health needs is also subject to the affiliation and experience of the individuals who attended the Prioritization Day event, and to how those individuals voted on that particular day. The final scores are close in number, and therefore suggest that all identified health needs are important to stakeholders in the KFH—Vallejo service area. Nonetheless, they have been prioritized according to the final average scores, and are assigned a corresponding rank order.

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-related outcome (e.g., access to care), the related conditions that contribute to a defined health need, (e.g., access to housing), or the health need itself (e.g., cancers). In this context, potential health needs are intended to identify a condition or related set of conditions, rather than a specific population of high need. Within each health need, high risk populations are explored as well. For this reason, information about needs of specific at-risk subpopulations such as older adults is included within the context of the health needs. Health needs are identified through the comprehensive identification, interpretation, and analysis process of a robust set of primary and secondary data.

A total of 18 potential health needs were examined, as outlined in the Table below.

Health Need	Definition
Access to Care	Data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health
Access to Housing	Data related to cost, quality, availability, and access to housing
Asthma and COPD	Known drivers of asthma and other respiratory diseases, and health outcomes related to these conditions
Cancers	Known drivers of cancers, and health outcomes related to cancers
Child Mental and Emotional Development	Data related to development of mental and emotional health in young children, particularly age 0-5
Climate and Health	Data related to climate and environment, and related health outcomes
CVD and Stroke	Known drivers of heart disease and stroke, and related cardiovascular health outcomes
Economic Security	Data related to economic well-being, food insecurity, and drivers of poverty including educational attainment
Education	Data related to educational attainment and academic success, from preschool through post-secondary education
HIV/AIDS/STD	Known drivers of sexually transmitted infections including HIV, and related STI and AIDS outcomes
Mental Health	Data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes
Obesity and Diabetes	Data related to healthy eating and food access, physical fitness and active living, overweight/obesity prevalence, and downstream health outcomes including diabetes
Oral Health	Data related to access to oral health care, utilization of oral health preventative services, and oral health disease prevalence

Overall Health	Data related to overall community health including self-rated health and all-cause mortality
Pregnancy and Birth Outcomes	Data related to behaviors, care, and outcomes occurring during gestation, birth, and infancy; includes health status of both mother and infant
Substance Abuse and Tobacco	Data related to all forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs
Vaccine-Preventable Infectious Disease	Data related to vaccination rates and prevalence of vaccine-preventable disease
Violence and Injury	Data related to intended and unintended injury such as violent crime, motor vehicle accidents, domestic violence, and child abuse

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

The first step in the process of identifying health needs for the KFH—Vallejo was to work with the Napa County CHNA Advisory Group to identify the community health needs for Napa County. All secondary data was scored against a benchmark, in most cases the California state estimate, and a score was applied to each potential health need based on the aggregate score of the indicators assigned to that health need. Additionally, content analysis was used to analyze key themes in both the Key Leader Interviews and Focus Groups. Section V contains more information on quantitative and qualitative data analysis.

Potential health needs were identified as a health need in Napa County if:

a. Multiple indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% “worse” than the benchmark comparison estimate (in most cases, the benchmark used was the California state average).
b. The health issue was identified as a key theme in at least nine interviews OR in at least one focus group.

If a health need was mentioned overwhelmingly in primary data but did not meet the criteria for secondary data, the analysis team conducted an additional search of secondary data to confirm that all valid and reliable data concurred with the initial secondary data and to examine whether indicators within the health need disproportionately impact specific geographic, age, or racial/ethnic subpopulations. In the few cases where a potential health need demonstrated strong evidence of being an issue in either qualitative or quantitative data, but not both, the Napa County CHNA Advisory Group discussed and came to consensus about whether or not to include the health need.

The consultant team summarized the results of the analysis in a matrix which was then reviewed and discussed by the Napa County CHNA Advisory Group.

The consultant team and Napa County CHNA Advisory Group identified ten health needs which met the first criteria of having at least two distinct indicators that performed >1% worse than benchmark estimates. Of these, five met the additional criteria of being identified as a theme in key leader interviews and focus groups and were thus designated as health needs. One potential health need, Access to Housing, did not met the criteria for inclusion as a health need based on its secondary data score, though it was a significant theme in the majority of interviews and focus groups. Therefore, the Napa County CHNA Advisory Group decided to include data about Access to

Housing along with Economic Insecurity (which met both criteria for inclusion) because access to safe and affordable housing is very closely linked to economic security.

The Napa County CHNA Advisory Group also decided to combine two other interrelated potential health needs that met the criteria for inclusion when considered together but not separately. Specifically, Access to Care did not meet the secondary data criteria, but was a strong theme in primary data. Similarly, Oral Health was not a salient theme in interviews and focus groups but secondary data revealed that there are important issues related to *access* to oral health care. As a result, these two health needs are presented together as Access to Primary and Oral Health Care for Napa County. Finally, the potential health need of Cancers demonstrated considerable need in secondary data, but was not identified as a theme in primary data. The Napa County CHNA Advisory Group reasoned that this may indicate a lack of knowledge about cancer incidence and mortality in Napa County. In order to address this gap, the Napa County CHNA Advisory Group decided to include Cancers as an identified health need.

All of the health needs identified in Napa County are considered to be health needs in the KFH—Vallejo service area, as Napa County makes up a large proportion of the KFH—Vallejo service area. Secondary data specific to the KFH—Vallejo service area, as well as relevant interview and focus group data obtained during the Solano County CHNA process, were considered using the same criteria and methodology described for Napa County to identify any *additional* health needs for the KFH—Vallejo service area. Only one additional health need, Violence and Injury, met these criteria. Therefore, a total of eight health needs were identified for the KFH—Vallejo service area.

B. Process and Criteria Used for Prioritization of the Health Needs

The prioritization of KFH—Vallejo health needs started with the Napa CHNA collaborative process. The Criteria Weighting Method—a rigorous mathematical process whereby participants establish a relevant set of criteria and assign a priority ranking to issues based on how they measure against the criteria—was used first to prioritize the seven health needs in Napa County. This method was selected as it enabled consideration of each health need from different perspectives, and allowed the Napa County CHNA Advisory Group to weight certain criteria and use a multiplier effect in the final score.

To determine the scoring criteria, Napa County CHNA Advisory Group members reviewed a list of potential criteria and selected a total of four criteria as seen below:

Criteria	Definition
Severity	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Disparities	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
Prevention	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.
Co-benefit	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.

In order to develop a weighted formula to use in prioritization, each member of the Napa CHNA Advisory Group assigned a weight to each criterion between 1 and 5. A weight of 1 indicated the criterion is not that important in prioritizing health issues whereas a weight of 5 indicated the criterion is extremely important in prioritizing health issues. The average of weights assigned by members of the Napa CHNA Advisory Group for each criterion were used to develop the formula below to provide a

final formula to use in scoring health needs for prioritization.

Overall Score= (2*Severity) + (2*Disparities) + (1*Prevention) + (1*Co-benefit)

In order to review and prioritize identified health needs, a half-day prioritization session was first held on December 18, 2015, at the St. Joseph Health Queen of the Valley Medical Center, and a second prioritization session was held on February 16, 2016, at KFH—Vallejo for the additional health need. At the first prioritization session, a total of 34 stakeholders representing sectors such as health, education, public safety, and child welfare attended. The goals of the meeting were to: review health needs identified in Napa County; discuss key findings from the CHNA; and prioritize health needs in Napa County. After each health need was reviewed and discussed, participants voted on each health need using the four criteria discussed above.

After the Napa County prioritization process was complete, leadership at KFH—Vallejo reviewed data specific to the KFH—Vallejo service area for the additional health need, Violence and Injury, and scored the new health need based on the same methodology and criteria relative to the other scored health needs. The weighted score determined its place in the prioritized list of health needs. For more information about the matrix used to score each health need, see Appendix E. The table below outlines the results of the voting on each health need.

Health Needs in Priority Order					
Final Results		**Unweighted Scores by Criteria**			
Health Need	**Weighted Score**	**Severity**	**Disparities**	**Prevention**	**Co-benefit**
1. Education	**37.37**	6.13	6.36	6.09	6.30
2. Economic and Housing Insecurity	**36.39**	6.39	6.18	5.27	5.97
3. Violence and Injury	**34.68**	6.67	5.5	4.17	6.17
4. Mental Health	**34.71**	6.15	5.53	5.27	6.09
5. Obesity and Diabetes	**33.68**	5.69	5.29	5.97	5.77
6. Access to Primary and Oral Health Care	**32.52**	5.52	5.42	5.09	5.55
7. Substance Use	**32.09**	5.77	4.83	5.09	5.80
8. Cancers	**27.57**	5.00	4.41	4.31	4.43

C. Prioritized Description of the Community Health Needs Identified Through the CHNA

In descending priority order, the following health needs for the KFH—Vallejo service area have been prioritized as follows:

1. **Education:** Educational attainment is strongly correlated with health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.

   Among residents served by KFH—Vallejo, extreme disparities exist among subpopulations in key educational outcomes. Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school. In Napa County, only 22.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts; only 39.0%

passed in Mathematics.[15] For all students, harassment and bullying in schools were also raised as issues of high concern.

2. **Economic and Housing Insecurity:** Economic resources such as jobs paying a livable wage, stable and affordable housing, as well as access to healthy food, medical care, and safe environments can impact access to opportunities to be healthy.

   The high cost of living in the region exacerbates issues related to economic security and stable housing. Among all households in the KFH—Vallejo service area, 44.3% spend 30% or more of household income on housing costs.[16] Malnutrition and food insecurity are also key issues for residents, as many are forced to spend most of their income on housing, and do not qualify for public benefits.

3. **Violence and Injury:** Violence and injury is a broad topic that covers many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others.

   In the KFH—Vallejo service area, in recent years, there were 10.2 non-fatal emergency room visits due to domestic violence per 100,000 females (age 10+).[17] The area also experiences a high risk of violent crime, with a 308.5 per 100,000 population assault rate,[18] and a 7.1 per 100,000 population homicide rate.[19]

4. **Mental Health:** Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.

   Mental health was raised as a high concern. Most notably, KFH—Vallejo service area residents have a high risk of suicide. The suicide rate in the service area is 11.8 per 100,000 residents; it is 12.7 per 100,000 among Napa County residents.[20] Older adults, transition age youth, LGBTQ youth, and Latinos were noted as populations of high concern for mental health issues. Social stigma and the geographic distribution of resources were considered as barriers to receiving appropriate mental health services.

5. **Obesity and Diabetes:** Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese.[21] Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes.

   In the KFH—Vallejo service area, an estimated 26.7% of adults are obese,[22] and 38.4% are overweight.[23] Among youth, 18.4% are obese and 20.7% are overweight.[24] Access to affordable healthy food was identified as a concern, particularly in specific areas of Napa County including American Canyon and rural communities. Since economic disadvantage is strongly linked to

[15] California Department of Education, 2013-14.
[16] US Census Bureau, American Community Survey, 2009-13.
[17] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.
[18] 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.
[19] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[20] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[21] http://www.cdc.gov/obesity/adult/defining.html
[22] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[23] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[24] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.

barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as older adults and residents experiencing homelessness, are disproportionately affected by this health need.

6. **Access to Primary and Oral Health Care:** Ability to utilize and pay for comprehensive, affordable, quality physical and mental health care is essential in order to maximize the prevention, early intervention, and treatment of health conditions. Nationwide, there is a focus on integrating oral health services into primary care. Utilization of oral health care is extremely important to health, as tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.

   With the implementation of the ACA, many adults have access to insurance coverage and regular healthcare. However, disparities persist. Premiums for health insurance remain high, and many providers do not accept Medi-Cal or have long waiting lists. Dental insurance was not included in recent health insurance reform, and 40.3% of the adult population in the KFH-Service Area lacks dental insurance.[25]

7. **Substance Use**: Use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences.

   In the KFH—Vallejo service area, substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults, 20.9% of residents report heavy alcohol consumption.[26] Youth were noted as a high risk population, and data indicates that in the prior 30 days 11.8% of 11th grade students in Napa County reported using cigarettes, 22.8% reported binge drinking, and 24.9% reported using marijuana.[27]

8. **Cancers:** Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth.[28] Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options.

   Compared to California state averages, KFH—Vallejo service area has higher incidence of breast, prostate, colon and rectum, and lung cancer, as well as a higher all-cancer mortality rate. Racial/ethnic disparities exist in cancer morbidity and mortality.

The eight health needs that emerged as top concerns among residents in the KFH—Vallejo service area highlights the importance that participants in this process give to addressing the social determinants of health in order to build a healthier and stronger community. Access to quality education, safe and affordable housing, and economic stability rose to the top of the list of prioritized health needs. This list of health needs underscores the importance of multi-sector collaboration and cross-cutting strategies that address multiple health needs simultaneously.

In addition to the supporting data presented for each identified health need, several cross-cutting themes emerged in the primary data that speak to a broader consideration of community structure and cohesion. In working towards equal opportunities for people to lead safe, active, and healthy lifestyles, residents and key stakeholders cited challenges related to isolation that impact specific populations within the county and the community as a whole. In Napa County poor access to transportation contributes to this isolation, as well as social norms segregating different

[25] California Health Interview Survey, 2009.
[26] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[27] California Healthy Kids Survey, 2011-13.
[28] American Cancer Society. Accessed at http://www.cancer.org/cancer/cancerbasics/what-is-cancer, December 2015.

subpopulations within communities county-wide. In particular, older adults were noted as a population often suffering from social isolation, as well as those for whom immigration status or language is a barrier to social cohesion in the community at large. Discrimination towards people experiencing homelessness was also raised as a concern among stakeholders, as well as discrimination towards members of the LGBTQ population. For many residents, feelings of invisibility, segregation, and isolation can have profound impacts on both mental and physical health, as well as on overall quality of life.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

The KFH—Vallejo service area has a rich network of community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of community resources available to respond to each community identified health need, as identified in qualitative data and by the Napa County CHNA Advisory Group, are indicated in each health need profile in Appendix A. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference http://211bayarea.org/napa/.

VII. KFH—VALLEJO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH—Vallejo'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—Vallejo'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—Vallejo in the 2013 Implementation Strategy Report.

1. Lack of employment and vocational training
2. Lack of safe places to walk, bike, exercise, or play
3. Lack of access to culturally appropriate, affordable health care (including prevention and treatment)
4. Access to affordable healthy food
5. Lack of substance abuse treatment and rehabilitation

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

As of the documentation of this CHNA Report in March 2016, KFH—Vallejo had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH—Vallejo 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 Vallejo awarded 135 grants totaling $1,925,574 in service of 2013 health needs. Additionally, KFH in Northern California 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 Vallejo service area. During 2014-2015, a portion of money managed by this foundation was used to award 35 grants totaling $334,073 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH Vallejo 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 Vallejo 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 CULTURALLY APPROPRIATE, AFFORDABLE HEALTH SERVICES

Long Term Goal:

- Increase the number of individuals who have access to and receive appropriate health care services in the KFH-Vallejo service area

Intermediate Goal:

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

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 16,750 Medi-Cal members* • *2015: 16,557 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 - $2,224,563* • *2014: 2,220 applications awarded* • *2015: KFH - Dollars Awarded By Hospital - $1,984,268* • *2015: 3,865 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: 1,924 members receiving CHC* • *2015: 1,718 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 55 active KFH grants totaling $1,160,479 addressing Access to Culturally Appropriate, Affordable Health Services in the KFH-Vallejo service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 14 grants totaling $122,467 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Children's Network of Solano County	$165,000 over 2 years $75,000 in 2014 $90,000 in 2015 (even split with KFH-Vacaville)	Solano Resource Connection, a Children's Network program, uses nine city-level family resource centers (FRCs) to help low-income families access housing, food, medical care, and other essential services. FRCs have three strategies for keeping families from falling deeper into poverty:	As a result of the 2014 grant, FRCs helped 408 low-income families take advantage of stimulus and economic recovery programs to prevent them from falling deeper into poverty. Of the 84 families that completed a pre-/post-survey, 83 remained stable or showed improvement in the four outcome indicators.

		1. maintain and access service provider networks to preserve the basic needs safety net in each Solano County city 2. help families access programs that provide health care access, food assistance, and other essential services 3. offer one-time-only, last-resort financial assistance for emergency basic needs	As of Dec.31, 2015, the FRCs assisted 240 low-income families. Of the 69 families that completed FDMs, 53 remained stable or showed improvement in the four outcome indicators.
Redwood Community Health Coalition (RCHC)	$400,000 over 2 years $209,501.15 in 2014 $190,498.85 in 2015 This grant impacts five KFH hospital service areas in Northern California Region.	This grant will strengthen core infrastructure to increase access to high-quality care for underserved patients and communities served by health centers; support health centers to continually improve operational capabilities, coordination of care, and workforce development; and support the Triple Aim infrastructure and management of the health center Accountable Care Organization (ACO).	RCHC has 6,685 PHASE patients and outcomes include: • increased health coaching skills among consortia/clinic staff using a comprehensive training/coaching program; 40 people were trained and three were trained as trainers • participated in a county-wide committee with leaders from the county's major health care delivery systems to develop an approach to reduce heart attacks and strokes; all leaders agreed to base the county-wide strategy on the PHASE clinical guidelines • worked with other delivery systems to create data sharing agreements and identify which data sets can be shared across systems • improved parts of a learning community to share promising practices with clinics; added PHASE resources to program website
*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. Twenty six procedures were performed on 20 low-income and uninsured patients at an Operation Access event at KFH Vallejo in 2015.
Community Clinic Consortia of Contra	$250,000 over 2 years	Core support for continued operations of CCCCCS's various activities to meet the needs of community health center (CHC)	• improved Medi-Cal managed care patient assignment rates by creating quarterly reports shared with member health centers.

Costa and Solano (CCCCCS)	$125,000 in 2014 & 2015 This grant impacts five KFH hospital service areas in Northern California Region.	members, and the review, modification, and implementation of existing organizational strategic plan. CCCCC serves four health centers with 123,144 patients.	• 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 opportunities to diversify revenue streams and increase sources of earned income
Olé Health	$100,000 in 2015	Project will serve 4,000 low-income, uninsured, and newly insured Fairfield residents of all ages who lack a primary care home by providing dental care in a setting that integrates primary, preventive, dental, and behavioral health services.	Anticipated outcomes include: • establishing a primary care and dental clinic in Fairfield • create four dental operatories at the site and recruit six staff who will meet the dental needs of Solano County residents, particularly youth 1 to 20

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
La Clínica de la Raza	As part of its charity care program, KFH-Vallejo has a partnership agreement that allows La Clínica to refer up to 10 patients per month to a KPSOARS (Kaiser Permanente Specialist Offering Access to Referral Services) physician.	In 2014 & 2015 KPSOARS physicians treated 135 patients, providing specialty care such as orthopedic, gastroenterology, neurology, women's health services, and EKGs valued at more than $1M.

Multiple community-based organizations in Solano County	KP VIPS (Kaiser Permanente Volunteers-In-Public-Service), a program supported by KFH Vacaville and KFH Vallejo, allows clinicians to volunteer and provide high-quality clinical and educational assistance to community agencies and clinics.	KP VIPS currently supports 10 projects at Solano County organizations, including Opportunity House, La Clínica de la Raza, and Vallejo Unified School District's school-based clinic at Jesse Bethel High. In 2015, nearly 30 clinicians donated more than 680 hours, providing consultations, health screenings and education, and other clinical services for more than 1,000 patients annually.
Bi-National Health Alliance of Napa County (fiscal agent: Napa County Hispanic Network)	Bi-National Health Alliance of Napa County is a collaborative comprising various Napa County Latino service providers (including Community Clinic Ole) and community members working to raise awareness of and address specific health needs of the Latino community living in Napa County.	KFH-Vallejo hosted the Bi-National Health Fair at its KFH-Napa medical office building and parking lot. KFH-Vallejo also provided volunteers, health screenings, education materials, and giveaway items.
In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Solano Midnight Sun Foundation	In November 2015, Kaiser Permanente Napa-Solano Area and Solano Midnight Sun Foundation entered into a community medical service agreement to annually provide up to 50 uninsured men and women with screening and diagnostic services at no cost.	
Operation Access	KP physicians and staff volunteered a total of 27.5 hours to serve low-income and uninsured patients at an OA event at KFH Vallejo in 2015.	
Vallejo City Unified School District (VCUSD)	A survey on the health behaviors and wellness of middle and high school students was administered in VCUSD. It was conducted by 12 Kaiser Permanente Family Medicine residents who are each paired with a school to help improve student health and well-being. Survey results will be used to create a specific program for each school.	
Solano County Senior Coalition – Health and Social Services	The county's older and disabled adults program, Solano County Mini-Medical School: Aging with Vitality, received a merit award from California State Association of Counties. The mini-series aims to normalize the aging process and inspire participants to be proactive by making healthy lifestyle choices. Modeled after University of California, Davis' Mini-Medical School, the award brings state-wide recognition to healthy living. Napa-Solano Area Physician-In-Chief played a key role in supporting this program.	
All PHASE Grantees	To increase clinical expertise in the safety net, Quality and Operations Support (QOS), a Kaiser Permanente Northern California Region TPMG (The Permanente Medical Group) department, helped develop a PHASE data collection tool. QOS staff provided expert consultation on complex clinical data issues, such as reviewing national reporting standards, defining meaningful data, and understanding data collection methodology. This included: • conducting clinical training webinars • wireside/webinar on PHASE clinical guidelines • presentation at convening on Kaiser Permanente's approach to PHASE • presentation to various clinical peer groups through CHCN, SFCCC, etc.	

	• individual consultation to staff at PHASE grantee organizations • individual consultation to Community Benefit Programs staff Kaiser Permanente Northern California Region's Regional Health Education (RHE) also provided assistance to PHASE grantees: • conducted two seven-hour Motivating Change trainings (24 participants each) to enable clinical staff who implement (or will) PHASE to increase their skills with regard to enhancing patients' internal motivations to make health behavior changes • provided access to patient education documents related to PHASE
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.

Impact of Regional Initiatives

PHASE:

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

PRIORITY HEALTH NEED II: ACCESS TO AFFORDABLE, HEALTHY FOODS

Long Term Goals:

- Reduce obesity and increase the number of residents who maintain a healthy weight

Intermediate Goals:

- Increase healthy eating, especially among youth in low-income communities

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 43 active KFH grants totaling $361,714 addressing Access to Affordable, Healthy Food

in the KFH-Vallejo service area.[29] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling $53,095 that address this need. These grants are denoted by asterisks (*) in the table below.			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
American Heart Association (AHA)	$105,000 over 2 years $45,000 in 2014 $60,000 in 2015 (even split with KFH-Vallejo)	Supports AHA's Kids Cook with Heart, hands-on culinary programs led by trained professional chefs. The curriculum, which aims to address childhood obesity, will teach children 11 to 18 at three Vallejo schools (20-week program) and four Fairfield schools (10-week program) how to cook and eat in healthier ways.	As a result of 2014 and 2015 funding Nearly 200 students 11 to 18 from two schools Fairfield and two in Vallejo, participated and learned how to prepare meals using fresh ingredients and less fat, sugar, and salt. In addition, they share the information with their parents, beginning a cycle of change.
Food Bank of Contra Costa and Solano	$50,000 over 2 years $25,000 in 2014 & 2015 (even split with KFH-Vallejo)	Supports the Food Bank's Farm 2 Kids program, which provides fresh produce for children attending afterschool programs in low-income neighborhoods. This project is supported by KFH Vacaville and KFH Vallejo hospitals.	For the 2014-2015 school year, 2,477 children were enrolled in Farm 2 Kids at 28 schools throughout Solano County. For the 2015-2016 school year, 2,643 children at 28 Solano County schools are enrolled in Farm 2 Kids. As part of the program, they take home a 3 to 5 pound bag of fresh produce each week and receive lessons about the benefits of eating fresh produce and the importance of healthy diet choices.
Meals On Wheels of Solano County (MOWSC)	$40,000 over 2 years $20,000 in 2014 & 2015 (even split with KFH-Vallejo)	The only program of its kind in the area for people 60 and older, MOWSC's elder nutrition program delivers healthy and nutritious meals to homebound seniors and provides meals for other elderly individuals who dine at senior and community centers.	As of November 2015, over 90,000 healthy and nutritious meals were home-delivered to over 1,000 clients and over 17,000 meals were served to over 800 clients at congregate dining sites.
Benicia Unified School District	$15,000 in 2015	Benicia USD's nutrition education program is a standards-based curriculum designed to encourage healthy eating choices by engaging elementary schoolchildren in hands-on learning, exploration, and cooking activities with fresh, affordable foods from diverse cultures.	In fall 2015, nearly 3,000 pre-K through 5th grade students at four schools participated in Harvest of the Month. Parent volunteers lead fresh fruit/vegetable tastings in the classroom. Healthy Cooking with Kids, a six-week after-school program gave 150 students hands-on cooking lessons. In addition, roughly 3,000 parents, principals, and teachers learned about and tasted

[29] 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.

			Food & Nutrition Services' healthy new meals; and 50 teachers and food service staff received nutritional training.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
Grace Patterson Elementary (VCUSD)	KPET supported various activities at the school to decrease obesity and encourage students to maintain a healthy weight by introducing 'Walking Wednesday activities to promote physical activity. KPET mascots Super Weevil and Cardia Heart made appearances at school. Hundreds of students and the school faculty attended the Kick off events. They enjoyed an afternoon of activities and learned physical activity and walking tips.		
Vallejo City USD and Benicia USD	A performance from KPET The Best Me that targets elementary school age youth to promote healthy eating and physical activity. Promote the consumption of fresh fruits, vegetables and water. The performance served several hundred students, faculty and families for special Family Night events. Educational workshops were conducted in the classroom with students to further promote healthy messages.		

PRIORITY HEALTH NEED III: LACK OF SAFE PLACES TO WALK, BIKE, EXERCISE, OR PLAY

Long Term Goal:

- Improve safety and crime prevention in the KFH-Vacaville service area

Intermediate Goals:

- Reduce events that result in violent injury to children and adults
- Increase the use of safe, green, active public spaces

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 21 active KFH grants totaling $299,193 addressing Lack of Safe Places to Walk, Bike, Exercise, or Play in the KFH-Vallejo service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $104,374 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Benicia Unified School District	$30,000 over 2 years $15,000 in 2014 & 2015	Second Step is a well-regarded and research-based program. Benicia USD will use its curriculum and small group (2 to 4 students per group) program to provide direct social skills training and lessons led by a specially trained guidance assistant.	As a result of the 2014 grant, 112 students from four schools were served through 502 group sessions. Quantitative and qualitative results showed a definite impact; teachers consistently observe that by program's end, participants exhibit greater overall school competence and adjustment. Parents also report positive changes in their child during the program.

			As part of the current grant, Second Step will reach an additional 1,300 students. The Small Group Program will serve approximately 110 students who are identified as 'at-risk'.
The Leaven	$95,000 over 2 years $45,000 in 2014 $50,000 in 2015 (even split with KFH-Vallejo)	With nine Solano County sites, The Leaven works primarily with at-risk first through fifth graders, providing extra support to help them avoid gangs, dropping out, etc. Many participants live in extremely low-income households and more than 8 in 10 are racial/ethnic minorities.	The Leaven has provided afterschool tutoring and mentoring programs as well as healthy living programs that encourage daily physical activity and consumption of fresh fruit and vegetables to more than 140 students at three new sites. The Leaven plans to open two new afterschool tutoring centers, one in Vallejo and another in Napa, by Spring 2016.
Girls On The Run (GOTR) Napa & Solano	$20,000 in 2015 (even split with KFH-Vallejo)	GOTR is a transformational learning program for girls 8 to 13 that teaches life skills through dynamic, conversation-based lessons and running.	From July-Dec 2015, GOTR served 414 girls in schools throughout Napa and Solano counties, including American Canyon, Napa, St. Helena, Calistoga, Angwin, Benicia, Fairfield, Suisun, Vallejo and Vacaville.
*Golden Gate National Parks Conservancy	$300,000 over 2 years $150,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region.	Golden Gate National Parks Conservancy and Institute at the Golden Gate will coordinate the Healthy Parks Healthy People (HPHP) Bay Area program, a collaborative of park and health agencies designed to increase the accessibility and use of parks for activities that promote health.	Expected reach is 10,000 people and expected outcomes include: • HPHP program leaders trained to run effective park programs that engage target populations, including low-income, ethnic minorities, high-risk youth, seniors, and those referred by health care and social service providers • to ensure long-term sustainability, at least one person at each park agency is trained as an HPHP programming trainer • all nine Bay Area public health departments/ health systems actively prescribe HPHP for at-risk youth, seniors, ethnic minorities, and low-income community residents • an HPHP blueprint model/toolkit based on lessons learned in the Bay Area is created for other parts of California and the U.S.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Napa Valley Language Academy; River and Harvest middle schools	KPET's *Nightmare on Puberty Street* and related workshops use live theatre to present facts and dispel myths about issues many middle school students face each day. Students learn to deal with negative peer pressure, build healthy relationships, cope with depression and thoughts of suicide, communicate about health and social issues with parents and other adults, and build self-esteem.
Johnston Cooper, Dan Mini and Elsa Widenman elementary schools	KPET presented *PEACE Signs* (a school assembly, student and teacher workshops, and a family night performance), which addresses bullying, conflict resolution, violence prevention, and positive behaviors. Over a one-week period, KPET's performer/educators worked with students and teachers to provide nine educational workshops for hundreds of students, teachers, and other adults.
Liberty High Continuation School	Nearly 80 students and six teachers at this Benicia continuation high school attended a performance of Secrets, a live theater performance that presents facts and dispels myths about HIF/AIDS and STIs, and participated in two-day workshops that addressed topics highlighted in the performance and provided guidance on how to respond when faced with many of the issues.

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 IV: LACK OF EMPLOYMENT AND VOCATIONAL TRAINING

Long Term Goal:

- Improve the socioeconomic status of residents in the KFH-Vacaville service area

Intermediate Goals:

- Increase graduation rates, especially in the African American and Latino communities
- Adults earn a certificate of high school equivalency

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 16 active KFH grants totaling $104,188 addressing Lack of Employment and Vocational

Training in the KFH-Vallejo service area.[30] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 5 grants totaling $22,795 that address this need. These grants are denoted by asterisks (*) in the table below. In addition, KFH Vallejo provided trainings and education for 57 residents in their Graduate Medical Education program in 2014 and 53 residents in 2015, 28 nurse practitioners or other nursing beneficiaries in 2014 and 38 in 2015, and 35 other health (non-MD) beneficiaries as well as internships for 23 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grantee	Grant Amount	Project Description	Results to Date
On the Move (OTM)	$95,000 over 2 years $45,000 in 2014 $50,000 in 2015	OTM's Project LEEP (Leadership, Employment, and Education Program) provides workforce development, leadership training, practical experiences, and college readiness support for Napa County's low-income, transition-age, and Latino youth. LEEP integrates pre-employment skills, hands-on career exploration, and educational counseling to support long-term employment, self-sufficiency, and financial sustainability.	As of December 2015, over 890 youth. Nearly 300 LEEP participants have received pre-employment training; 226 received individualized career counseling; 86 participated in volunteer activities; 59 served as program interns, leading special projects and gaining project management skills; 86 got hands-on work experience, employment coaching, and job placements; 261 received educational assessments and counseling; 187 developed and implemented long-term education plans with support from a team of coaches and peers; 20 participated in higher education cohorts and maintained enrollment in a college or university; and 33 employers committed to providing jobs where youth could get "youth friendly" certification.
Global Center for Success	$9,000 in 2015	This adult education and skills training program supports low-income, homeless, and underserved adults in the Vallejo/Mare Island area.	From Aug to Nov. 2015, the program provided services to 23 individuals: • 8 students participated in GED classes • 11 took job development classes (9 got part-time temporary work and 2 got permanent jobs) • 7 enrolled in basic skills classes (financial literacy, 3; intro computer, 4)

Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Rise Together Solano	Supports United Way of the Bay Area's goal to	The CB Manager co-leads the Workforce Development workgroup,

[30] 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.

	reduce poverty by 50% in six bay area counties, including Solano, by creating pathways out of poverty. Primary focus areas are housing, access to healthy food, workforce development for youth and young adults, full service community schools, and supporting seniors.	which has evolved, added new members, and hosted a kickoff launch for a Solano County youth employment program in January 2016. The group works closely with Workforce Investment Board of Solano County, United Way of the Bay Area, Solano Community College, Fairfield-Suisun and Vallejo City school districts, Solano County Office of Education, Fairfield-Suisun Chamber of Commerce, Andrew Young Foundation, Job Squad, and a Fairfield city Councilmember.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/**
Kaiser Permanente Summer Youth Employment Program (SYEP)	SYEP interns toured the Kaiser Permanente School of Allied Health Sciences and enjoyed a presentation by the admissions director on the school's commitment and programs offered. Interns also visited Kaiser Permanente Educational Theatre's offices to learn about its program and services, which are provided free to school districts throughout Northern California, and were excited to hear that KP has employment opportunities in theatre arts.

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

KFH Research Highlights

Long Term Goal:

- To increase awareness of the changing health needs of diverse communities

Intermediate Goal:

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

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
UCLA Center for Health Policy Research *	$2,100,000 over 4 years 1,158,200 over 2014 & 2015 This grant impacts all KFH hospital service areas in	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. APPENDICES

A. **Health Need Profiles**
B. **Secondary Data, Sources, and Dates**
C. **Community Input Tracking Form**
D. **Primary Data Collection Protocols**
E. **Prioritization Scoring Matrix**

Appendix A

Kaiser Foundation Hospital-Vallejo CHNA Health Need Profiles

Contents

Indicator Key

Throughout the health need profiles, California state average estimates are included where available for reference. Differences between Napa County and California state estimates are not necessarily statistically significant, and are color coded as follows:

≥ 2% better than benchmark data

Within 2% better than benchmark data

≥ Worse than benchmark data

Access to Primary and Oral Health Care

Access to comprehensive, affordable, quality primary and oral health care is critical to the prevention, early intervention, and treatment of health conditions. With the implementation of the Affordable Care Act (ACA), many people are now able to access insurance coverage and access regular primary healthcare. However, some issues related to access to primary care still persist. Specifically, the cost of care, including insurance premiums and medications, is a serious barrier to access. Since the ACA did not increase dental insurance coverage, a large percentage of adults still lack dental insurance and a significant percentage of youth do not receive regular dental exams. Additionally, recruiting health care providers has been difficult given the high cost of living in Napa County. Interviewees indicate that this impacts the availability of providers and thus may prolong appointment wait times. Furthermore, disparities in access to primary and dental care exist throughout the county. Residents in isolated rural areas must travel to access needed services and facilities, and as a result many often do not access health care. Older adults have specific needs that present additional barriers to accessing care, such as mobility and transportation challenges. Immigration status and stigma are also noted barriers that prevent people from accessing available care; undocumented immigrants are not eligible for health insurance under the ACA.

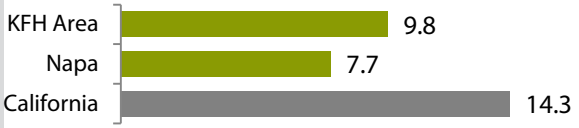
Key Data

Indicators

Access to Primary Care Physicians[1]

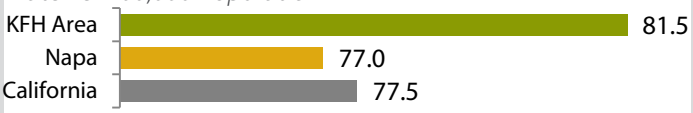
Rate Per 100,000 Population

Percentage of Population without a Regular Doctor[2]



Access to Dentists[3]

Rate Per 100,000 Population



"I think that if we are talking about social determinants of health—having an education, and food […] and **having health insurance is important**."
– Interviewee

"It is important for everyone, especially children and families and older adults, to have **a medical home** to ensure access to primary care."
– Interviewee

Key Themes from Qualitative Data

Access to Primary Care

- Even with ACA, insurance premiums are too high for some residents
- Preventive care is key to avoiding emergency room visits
- Difficulty recruiting health providers due to the high cost of living in Napa County

Access to Oral Health Care

- Large proportion of population lack dental health insurance
- High cost of dental care
- Higher rates of no recent dental exam among youth

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Access to Primary and Oral Health Care (continued)

Additional Data and Key Drivers

Additional Data: Oral Health Care

Poor Dental Health

Percent of adults with poor dental health [4]

KFH Area	Napa	California
9.9	7.6	11.3

Lack of Affordable Dental Care, Youth

% of youth unable to afford dental care [5]

KFH Area	Napa	California
2.8	4.1	6.3

"There are **limited number of places people can go to for dental care**; people need to travel far distances."
– Interviewee

"Restorative dental care for older adults is very expensive. Very **few providers take Medi-Cal for dental care**."
– Interviewee

Additional Data: Primary and Mental Health Care

Lack of Primary Care Professionals

% of population living in primary health care professional shortage area [6 †]

KFH Area	Napa	California
0.7	1.3	25.2

"There are **long wait periods** before appointments are available. For one resident, it was 8 months."
– Interviewee

Access to Mental Health Providers

Rate per 100,000 population [7]

KFH Area	Napa	California
206	247	157

Driver: Insurance Coverage

Uninsured Population

% of population without health insurance [8]

KFH Area	Napa	California
14.2	13.9	16.7

Lack of Dental Health Insurance, Adults

% of adults without dental insurance [9]

KFH Area	Napa	California
40.3	43.7	40.9

Insured Population Receiving Medi-Cal

% of insured population receiving Medi-Cal [10]

KFH Area	Napa	California
19.5	16.0	24.4

"Health insurance is necessary for access to primary care; a large population in Napa County still does not have health insurance. Even with health insurance, premiums are high."
– Interviewee

"Access to insurance has improved because of ACA, [but] I'm not certain that everyone is accessing [it]. ER [use] is higher, because people are using it because they can't find a doctor."
– Interviewee

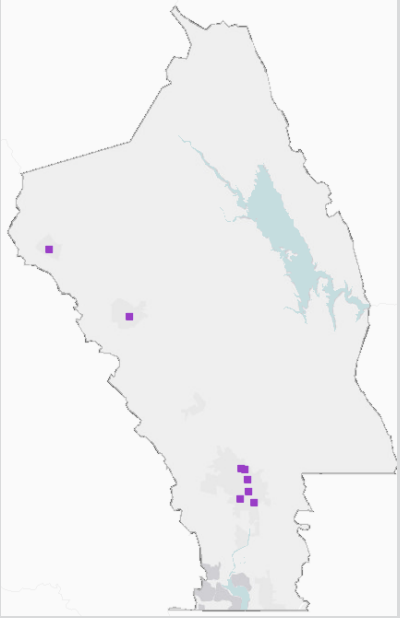
"Medications are also very expensive and are not fully covered by health insurance or Medi-Cal."
– Interviewee

† Primary Care Health Professional Shortage Area (HPSA) is defined as an area with 3,500 or more people per primary care physician (U.S. Department of Health and Human Services, http://www.hrsa.gov/shortage/). As a note, there is no generally accepted ratio of physician to population ratio. Care needs of an individual community will vary due to a myriad of factors. Additionally, this indicator does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area.

Access to Primary and Oral Health Care (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Federally Qualified Health Centers[11]

The map displays geographic disparities in location of federally qualified health centers. The majority of centers are located in the southern part of the county in and around the City of Napa.

Key

- Federally Qualified Health Centers

Populations at Greatest Risk

Older adults

Older adults present specific needs and challenges to accessing health care, such as mental health needs. Seniors also have transportation barriers and challenges, especially in rural areas of the county.

Other disparities

- Qualitative data indicates populations with **lower socioeconomic status**, such as agricultural workers, face barriers to health care access.
- Qualitative data details the stigma that **undocumented workers** related to their immigration status, which often affects their ability to access health care.
- **Rural areas** of the county do not have immediate access to preventive care, education, or resources.
- In 2012-13, nearly 20% of **transgender people** reported that their healthcare providers did not display sensitivity or competency regarding LGBTQ needs.[12]

"The clients that we serve are low income families, seniors, and youth, and my big problem with **Benicia** [is that] it's kind of an isolated area and there are no hospitals there." – Interviewee

Access to Primary and Oral Health Care (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Community Health Initiative

Family Resource Centers

Federally Qualified Health Centers

Community Recommendations for Change

Expand Accessibility

- Expand mobile dental clinic van services for children to provide oral health care for older adults
- Expand health care service hours to evenings and weekends
- Strengthen transportation services, especially for older adults
- Offer hospital shuttle service
- Support separate healthcare networks to fill service gaps, particularly in geographically isolated regions, and offer services to out-of-network patients
- Offer health care home visits, particularly for older adults in geographically isolated areas like Calistoga

Provide Culturally Competent Care

- Continue efforts to ensure that community-based organizations and health providers provide culturally competent care

Increase Awareness of Resources

- Increase marketing and outreach efforts to promote awareness of existing health care resources

Increase Affordable Housing to Promote the Growth of the Health Workforce

According to one interviewee, "**The high cost of living is driving a lot of people to live outside of Napa County**. I'll say that from our perspective, it's very, very difficult to recruit physicians and clinicians to the area because a lot of folks who would want to work for us are young, recent graduates from medical school, and they are coming out of school with a lot of debt. Once they come to Napa and look at the housing cost, they choose to work elsewhere because of the disparities between income and cost of living. That is definitely taking quite a toll. I think that's true both for behavioral health clinicians and also primary care clinicians. At some point Napa County should look at ways to create and sustain some lower-income affordable places to live. **They are going to end up in a situation where it is increasingly difficult to recruit professionals – highly needed professionals – into the area because of the housing situation.**"

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2012.
[2] University of California Center for Health Policy Research, California Health Interview Survey, 2011-12.
[3] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2013.
[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2006-10.
[5] University of California Center for Health Policy Research, California Health Interview Survey, 2009.
[6] Ibid.
[7] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[8] US Census Bureau, American Community Survey, 2010-14.
[9] University of California Center for Health Policy Research, California Health Interview Survey, 2009.
[10] US Census Bureau, American Community Survey, 2010-14.
[11] US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, Sept. 2015.
[12] LGBTQ Connection, "Napa County LGBTQ Needs Assessment," 2012-13.

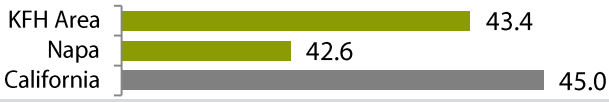
Economic & Housing Insecurity

Economic security is a key determinant of health: having limited economic resources can impact access to opportunities to be healthy, including access to healthy food, medical care, and safe environments.[1] Access to stable, affordable housing also contributes to a strong foundation for good health, whereas substandard housing and homelessness exacerbate other physical and mental health issues. A high cost of living contributes to both economic and housing issues. In Napa County, while many economic indicators such as unemployment and housing costs rank better than statewide, the cost of living is higher in the county than other parts of the state, forcing families who work in Napa to move and live outside the county. Malnutrition and food insecurity are also key issues for residents, as many are forced to spend most of their income on housing, and do not qualify for public benefits. Community members and key stakeholders recommended increasing access to affordable housing, childcare, and healthy food.

Key Data

Indicators

Percent of Households Spending 30% or More of Household Income on Housing Cost[2]



HUD-Assisted Units (per 10,000 housing units)[3],†

Percent of Population Living 200% Below Federal Poverty Level[4]

"**The number one issue for our community is lack of affordable housing.** Increasingly, it is more difficult to live here. The supply of housing is down which creates multiple issues for older adults when families move away and are left without support. As they grow older, there are increasing challenges at lower income levels."

– Interviewee

"It's all about systems change. Systems are designed to produce the outcomes they produce. **If you want to change the outcomes you have to change the system; if you want to change the system you have to change the culture.**"

– Interviewee

Key Themes from Qualitative Data

- Lack of affordable housing causes many who work in Napa to live outside the county
- Low 4th grade reading levels predict later educational success, which can lead to poverty, unemployment, and barriers to healthcare access (e.g., low health literacy/education)
- Lack of affordable childcare is a major financial stressor on families
- Cost of living is so high many are unable to afford food or housing but do not qualify for public benefits
- Homelessness among families and youth

† Reports counts of all housing units receiving assistance through the US Department of Housing and Urban Development (HUD). Assistance programs include Section 8 housing choice vouchers, Section 8 Moderate Rehabilitation and New Construction, public housing projects, and other multifamily assistance projects. Units receiving Low Income Housing Tax Credit assistance are excluded from this summary.

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Economic & Housing Insecurity

Additional Data

Housing Stock and Quality

Vacant Housing Units
% of housing units that are vacant[5,†]

KFH Area	Napa	California
10.1	9.9	8.6

Substandard Housing
% of housing with substandard housing[6]

KFH Area	Napa	California
45.2	44.4	48.4

Overcrowded Housing
% of adults living in overcrowded conditions (>1.5 persons/room)[7]

Napa	California
3.6	5.2

"People are living in storage sheds and garages that are really uninhabitable. Some people even live in their cars, because **there is not enough housing**."
– Interviewee

Poverty and Unemployment

Children in Poverty
% of children (age <18) living below 100% of Federal Poverty Level[8]

KFH Area	Napa	California
18.2	14.0	22.7

Older Adults in Poverty
% of adults (age 65+) living below 100% of Federal Poverty Level[9]

Napa	California
6.8	9.9

Unemployment Rate
% of civilian non-institutionalized population age 16 and older that is unemployed[10]

KFH Area	Napa	California
6.1	5.6	6.8

Children Eligible for Free/Reduced Price Lunch
% of public school students eligible for free or reduced price lunches[11]

KFH Area	Napa	California
50.9	45.4	58.1

"Even though I only had enough money to pay for my car and rent and 500 dollars in my account, I didn't qualify for food stamps, even with my dependent."
– Focus Group Participant

Population Receiving SNAP
% of the population receiving Supplemental Assistance Program (SNAP) benefits[12]

KFH Area	Napa	California
7.6	5.3	10.6

Food Insecurity
% of the population that experienced food insecurity at some point during the report year[13]

KFH Area	Napa	California
13.8	12.0	16.2

" We surveyed our patients, and about 40% of them indicated that close to the end of the month they were **running out of food due to lack of money**."
– Interviewee

Households with No Vehicles
Number of households with no motor vehicle[14]

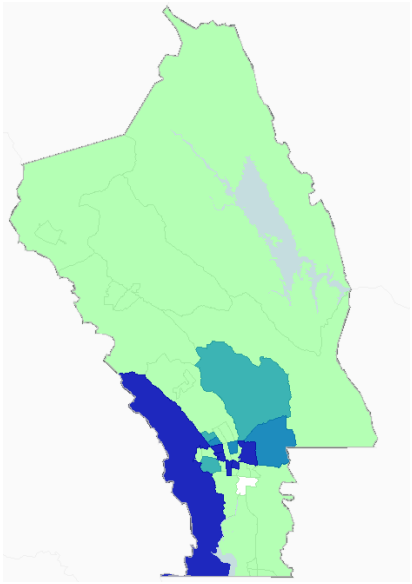
KFH Area	Napa	California
5.9	4.6	7.8

† Vacant housing reported as an indicator of blight across the city. Research demonstrates links between foreclosed, vacant, and abandoned properties with reduced property values, increased crime, increased risk to public health and welfare, and increased costs for municipal governments. (U.S. Department of Housing and Urban Development, Evidence Matters, Winter 2014).

Economic & Housing Insecurity

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

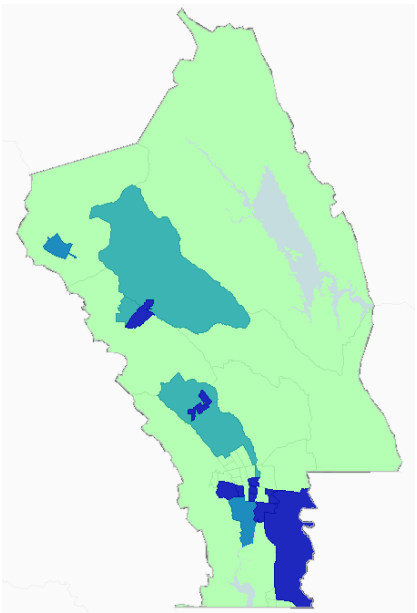


Population of Children (Age 0-17) Living Below 50% of Federal Poverty Level, Percent by Tract[15]

The map displays geographic disparities of children living in extreme poverty across Napa County. Across the county, extreme disparities exist in childhood poverty rates.

Key

- Over 13.0%
- 9.1 - 13.0%
- 5.1 - 9.0%
- Under 5.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed



Population of Older Adults (65+) Living Below 50% of Federal Poverty Level, Percent by Tract[16]

The map displays geographic disparities of older adults living in extreme poverty across Napa County. Geographic regions with high rates of poverty among older adults differ from regions with high rates of childhood poverty.

Key

- Over 3.0%
- 2.1 - 3.0%
- 1.1 - 2.0%
- Under 1.1%
- No Population Age 65+ Reported
- No Data or Data Suppressed

Populations with Greatest Risk

Racial/Ethnic disparities

Interviewees and focus group participants identified Latino residents as being at particularly high risk of experiencing problems accessing quality housing in Napa County.

Economic & Housing Insecurity

Assets and Recommendations

Examples of Existing Community Assets †

Early Childhood Programs	Food Assistance Programs	Homeless Services and Shelters
		

Community Recommendations for Change

- Enforce a living wage
- Advocate for agricultural workers' rights
- Implement policy changes that address affordable housing
- Increase access to affordable child care
- Increase access to affordable housing
- Increase access to affordable grocery stores
- Increase access to educational opportunities (e.g., post-secondary education)

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] "Health & Poverty," Institute for Research on Poverty, Accessed October 19, 2015, http://www.irp.wisc.edu/research/health.htm.
[2] US Census Bureau, American Community Survey, 2010-14.
[3] US Department of Housing and Urban Development, 2013.
[4] US Census Bureau, American Community Survey, 2010-14.
[5] US Census Bureau, American Community Survey, 2009-13.
[6] Ibid.
[7] Ibid.
[8] US Census Bureau, American Community Survey, 2010-14.
[9] US Census Bureau, American Community Survey, 2009-13.
[10] US Department of Labor Bureau of Labor Statistics, June 2015.
[11] National Center for Education Statistics, NCES - Common Core of Data, 2013-14.
[12] US Census Bureau Small Area Income & Poverty Estimates, 2011.
[13] Feeding America, 2012.
[14] US Census Bureau, American Community Survey, 2009-13.
[15] Ibid.
[16] Ibid.

Violence and Unintentional Injury

Injury and violence prevention are broad topics that cover many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others. Data indicate that violence – particularly violent crime, domestic violence, homicide, and robbery – are of greater concern in the Vallejo and Benicia than in Napa County, though there are some areas of high concern in Napa such as assault and the unintentional injury mortality rate. Key stakeholders identified domestic violence, gang violence, police relations, and unsafe neighborhood conditions as core issues to address in their community.

Key Data

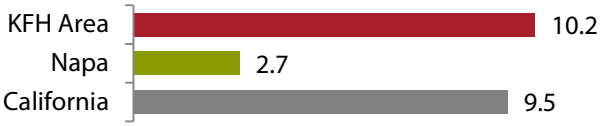
Indicators

Assault Rate[1]

Per 100,000 Population

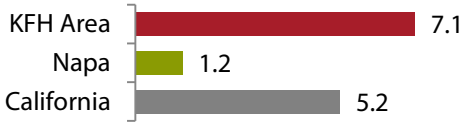
Domestic Violence Injuries [2,3]

Non-fatal emergency department visits for domestic violence per 100,000 Females Age 10+



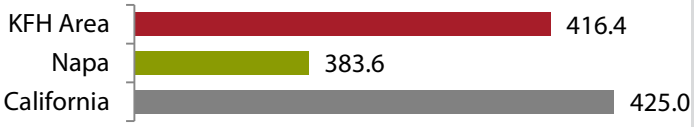
Homicide, Age-Adjusted Mortality Rate[4]

Per 100,000 Population



Violent Crime Rate[5]

Age-adjusted; Per 100,000 Population



"[In] downtown Vallejo […there's] a **cycle of poverty** because there's not a lot of resources, so [when] people grow up and [still] don't have the resource, they **end up being poor [and] turning to drugs and gang violence**."

– Focus Group Participant

Key Themes from Qualitative Data

- Gun violence and homicide
- Trauma resulting from exposure to violence
- Link between poverty and violence
- Perceived police mistreatment of the mentally ill
- Distrust of law enforcement
- Domestic violence
- Stigma and poverty make it difficult for victims to escape domestic violence
- Gang violence

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Violence and Unintentional Injury (continued)

Additional Data and Key Drivers

Youth Intentional Injuries

Intentional Injury Mortality Rate, Youth
Age-Adjusted; per 100,000[6]

KFH Area	Napa	California
857.0	537.9	738.7

Youth Gang Involvement

Gang Involvement among Youth
Percentage of 11th grade students reporting current gang involvement [7]

Napa	California
8.1	7.5

Rape

Rape
Rate; per 100,000[8]

KFH Area	Napa	California
26.2	22.5	21.0

Robbery

Robbery
Per 100,000[9]

KFH Area	Napa	California
115.2	51.0	149.5

Unintentional Injuries

Unintentional Injury Mortality Rate
Age-Adjusted; per 100,000[10]

Napa	California
30.7	27.9

Pedestrian Accident Mortality Rate
Age-Adjusted; per 100,000[11]

KFH Area	Napa	California
1.4	1.1	2.0

Domestic Violence and Child Maltreatment

Adverse Childhood Experiences (ACEs)
Percent of Adults That Have Experienced 4+ Adverse Childhood Experiences (ACEs) before age 18[12]

Sonoma/Napa *(combined for stability)*	California
22.0	16.7

Substantiated Allegations of Child Maltreatment
(per 100,000 children ages 0-17) [13]

Napa	California
8.1	9.0

"Kids grow up in homes where they're abused and **it's a cycle**, they start abusing their kids and partners and that [...] really needs to be addressed because **if they can't find a way to escape** those unhealthy relationships, **it's just going to get worse and worse**."
– Focus Group Participant

Risk Factor: Substance Abuse

Alcohol Abuse, Adults
Estimated % of Adults Drinking Excessively (Age-Adjusted) [14, 15]

KFH Area	Napa	California
20.9	21.3	17.2

"**Binge drinking** has additional downstream **effects on violence, injury, family cohesion, and traffic crashes**."
– Interviewee

Risk Factor: Suspensions

Suspension
Rate of suspension per 100 enrolled K-12 public school students[16]

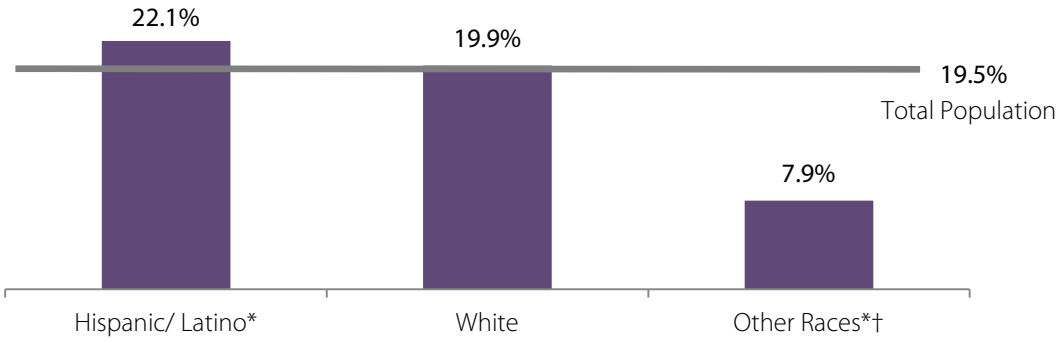
KFH Area	Napa	California
25.8	3.5	4.0

"**In Vallejo we have a high level of crime** and it's been getting worse and worse [...] my doctor told me that I had PTSD because of the fact that I've been seeing probably over 15 people die in front of me. [...] Especially the males, they don't know how to cope with it. [...] I feel because **they don't think we have support from the community to make us feel that we are safe.** The police are already shooting at them, so they're feeling like they are all against each other instead of feeling like they are loved by each other and helping to support and build each other."
– Focus Group Participant

Violence and Unintentional Injury (continued)

Populations Disproportionately Affected

Percent of Adults Reporting Ever Having Experienced Physical or Sexual Violence by an Intimate Partner Since Age 18[17]



* Data are statistically unstable; interpret with caution.
†Other races: American Indian/ Alaska Native, African American, Asian, Native Hawaiian/ Pacific Islander, Multiracial

"I think because of the housing situation, we have a lot of clients that are **doubled and tripled up in houses**. This is a **risk factor for domestic and sexual abuse**. Living in close quarters and sometimes living with people who are not actually relatives creates a high level of stress, and makes people more vulnerable to things like sexual abuse."
– Interviewee

Key themes from stakeholder interviews provided indications of some areas of the county and populations disproportionately impacted by violence:

- **Low income communities, undocumented residents, and residents that speak English as a second language** whose fear and mistrust of law enforcement presents obstacles to escaping domestic violence
- Violence in **Vallejo**

Violence and Unintentional Injury (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Napa Emergency Women's Services (NEWS)

Robert Wood Johnson Foundation Program (Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol)

Wolf Center

Community Recommendations for Change

- Provide culturally appropriate services (e.g., for South Asian, Latino/a, LGBTQ) and resources that address intimate partner violence
- Increase the capacity of emergency women's shelters
- Provide mental health training to law enforcement
- Provide legal services to victims of domestic violence
- Provide housing assistance to people escaping violence and abuse
- Provide violence prevention education and work to shift cultural norms (e.g., creating healthier relationships, identifying situations that are unhealthy and warning signs of sexual abuse

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] 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.
[2] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.
[3] This indicator reports the rate of non-fatal emergency department visits coded as "batter by spouse/partner." These rates are likely underestimates (e.g., because not all crimes are reported, and not everyone goes to the hospital for domestic violence injuries for a variety of reason).
[4] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[5] 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.
[6] California EpiCenter Data Platform for Overall Injury Surveillance, 2011-2013.
[7] California Healthy Kids Survey, 2011-13.
[8] 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.
[9] 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.
[10] California Department of Public Health County Health Profiles/NVSS report, 2011-13.
[11] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.

[12] A Hidden Crisis: Findings on Adverse Childhood Experiences in California, Center for Youth Wellness, 2008-13.
[13] UC Berkeley Child Maltreatment publication from Children's Bureau, 2013, http://cssr.berkeley.edu/ucb_childwelfare/refRates.aspx.
[14] 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.
[15] This indicator reports the percentage of adults age 18 and older who self-report heavy alcohol consumption, which is defined as more than two drinks per day on average for men and one drink per day on average for women.
[16] California Department of Education, 2013-14.
[17] University of California Center for Health Policy Research, California Health Interview Survey, 2009.

Education

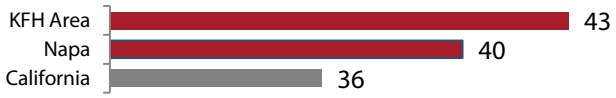
Educational attainment is a key determinant of health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.[1] Completing formal education is a key pathway to employment and to higher paying jobs that can provide the means to lead a healthier life.[2] From preschool to post-secondary education, primary and secondary data indicate that retention and quality education are key needs. Bullying and harassment among students is also a concern in Napa County. While key education outcomes, such as high school graduation rate, are higher for Napa County than Vallejo, Benicia, and the rest of California, evidence of extreme racial/ethnic disparities remain concerning. In particular, secondary data reveal that Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school.[3] To improve county-wide access and decrease disparities, community members and key stakeholders recommended strategies such as increasing support for programs that work closely with low performing students to improve access to post-secondary education.

Key Data

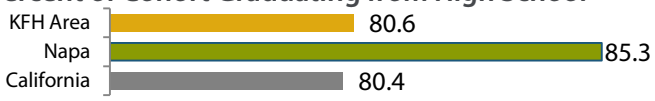
Indicators

Percent of Children (age 3-4) Enrolled in Pre-School[4]

Percent of Fourth Grade Children Scoring Below the "Proficient" Level on English Language Arts California Standards Test[5]



Percent of Cohort Graduating from High School[6]



"There needs to be attention [paid to] performance in schools, especially with **English as a second language [students]**. This carries on into high school, so there needs to be a lot of effort in K-12. There are not enough counselors to go around for students that need additional support."
– Interviewee

Key Themes from Qualitative Data

- High numbers of students do not complete high school, especially among Latino students
- Educational needs of English Language Learners and Hispanic/Latino students are not identified and addressed at a young age
- Educational attainment for ELL students is poor; gaps need to be addressed sooner (e.g., higher dropout rates)
- Harassment and bullying occurs frequently in schools

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Education (continued)

Additional Data

Early Childhood Education

Head Start Program Facilities

Rate of Head Start program facilities per 10,000 children under age 5[7]

KFH Area	Napa	California
5.4	7.4	6.3

English Language Learners

English Language Performance (Grade 10)

% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts[8]

Napa: All	Napa: ELL	California: ELL
85.0	22.0	38.0

Math Performance (Grade 10)

% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in Math[9]

Napa: All	Napa: ELL	California: ELL
87.0	39.0	54.0

Retention/Discipline

Expulsion

Rate of expulsion per 100 enrolled K-12 public school students[10]

KFH Area	Napa	California
0.07	0.02	0.05

Suspension

Rate of suspension per 100 enrolled K-12 public school students[11]

KFH Area	Napa	California
25.8	3.51	4.04

Educational Attainment

Less than High School Diploma

% of population age 25+ with no high school diploma or equivalent [12]

KFH Area	Napa	California
14.3	16.9	18.8

"If [low-performing students] never get caught up, then they will continue to be disadvantaged. **English Language Learners are at a disadvantage**, so there is some connection to the trajectory, which starts in 3rd [and 4th] grade. I think the dropout rate does not fully capture what fully happens."

– Interviewee

Education (continued)

Populations Disproportionately Affected

Populations at Greatest Risk

Percentage of Students Dropping out of High School by Race/Ethnicity, 2013-2014[13]

	Napa County
Overall	10.0
African American (Not Hispanic)	14.0
American Indian/Alaska Native (Not Hispanic)	23.1
Asian (Not Hispanic)	5.0
Filipino (Not Hispanic)	2.9
Hispanic/Latino	14.2
Pacific Islander (Not Hispanic)	10.0
White (Not Hispanic)	5.8
Multiracial (Not Hispanic)	8.0

Percentage of Students Dropping out of High School by Program, 2013-2014[14]

	Napa County
All Students	10.0
English Learners	22.4
Migrant Education	20.0
Special Education	18.3
Socioeconomically Disadvantaged	15.0

Interviewees and focus group participants highlighted that Latino students, in particular, are at risk of low educational attainment or poor academic performance.

One interviewee said, "My primary work is with Latino families and Latino kids. The county has not identified the educational equity disparities. The disparities…for post high school education are huge. **We don't have a graduation problem; we have a group that graduates that are un-educated and un-skilled.** So many of those kids have straight Ds or they have not taken the right classes in order to apply for a UC or a CSU, so they are going nowhere."

Education (continued)

Assets and Recommendations

Examples of Existing Community Assets †

Robotics STEM course for middle school students

Community-based organizations focused on strengthening early childhood education

UC Davis Math Institute (works with middle school students the summer before high school)

Community Recommendations for Change

- Continue support for programs that work closely with low performing students to help them become college-ready and to ensure access to post-secondary education
- Increase financial aid support, especially for high-need populations
- Partner with Napa Valley College
- Develop career tracks to encourage students to pursue careers in the healthcare field
- Increase services/resources in schools
- Provide college counseling for all students
- Strengthen early childhood education system
- Bridge the education gap between students who are English Language Learners and English speaking students

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] "Exploring the Social Determinants of Health: Education and Health," Robert Wood Johnson Foundation, Accessed October 19, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447.
[2] Napa County Community Health Assessment Report, 2013
[3] Ibid.
[4] US Census Bureau, American Community Survey, 2014.
[5] California Department of Education, 2012-13.
[6] California Department of Education, 2013.
[7] US Department of Health & Human Services Administration for Children and Families, 2014.
[8] California Department of Education, 2013-14.
[9] Ibid.
[10] California Department of Education, 2013-14.
[11] Ibid.
[12] US Census Bureau American Community Survey, 2010-14
[13] California Department of Education, 2013-14.
[14] Ibid.

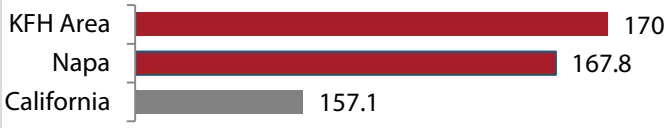
Cancers

Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth.[1] Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options. Cancer is the second leading cause of death in the United States,[2] and has emerged as an important health need in Napa County according to a review of county health data. For example, KFH-Vallejo service area residents experience a higher rate of all-cancer mortality, as well as a higher incidence of breast, prostate, colon and rectum, and lung cancer compared to California on average. Disparities in incidence and mortality exist across racial/ethnic subpopulations in the county. While cancer did not emerge as an important theme in primary data during this assessment process, secondary data revealed concerning trends, indicating a need to educate community members and stakeholders about the risk of many types of cancer in this area.

Key Data

Indicators

All-Cancer Mortaity Rate[3]
Age-Adjusted, Rate Per 100,000 Population



"We do have a **higher cancer rate** than you might expect. I am not sure how to explain that."

-Interviewee

Cancer Incidence by Primary Site[4]
Age-Adjusted, Rate Per 100,000 Population

	KFH Area	Napa County	California	United States
Cervical Cancer*	6.8	6.2	7.8	7.8
Breast Cancer*	128.4	125.4	122.4	122.7
Prostate Cancer**	165.3	173.8	136.4	142.3
Colon and Rectum Cancer	45.4	45.4	41.5	43.3
Lung Cancer	61.3	62.0	49.5	64.9

*Rate per 100,000 female population
** Rate per 100,000 male population

Notes on Limited Primary Data

Although cancer is a leading cause of death in Napa County, it was not a key theme in focus groups or Key Informant Interviews. The limited references to cancer in primary data may be due in part to the following factors:

- Lack of education about high rates of cancer morbidity and mortality; and
- Low priority of cancer compared to social needs such as affordable housing or economic security among community members.

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Cancers (continued)

Key Drivers and Additional Data

Key Driver: Physical Environment

Liquor Store Access
Rate of liquor stores per 100,000 population[5]

KFH Area	Napa	California
20.3	36.6	10.0

Air Quality, PM 2.5
% of days exceeding standards of Particulate Matter 2.5, pop. adjusted average[6]

KFH Area	Napa	California
6.3	6.3	4.2

Pesticide Use

1,259,700

pounds of pesticides applied in Napa in 2013.[7]

Key Driver: Health Behaviors

Excessive Alcohol Consumption, Adult
% of adults age 18 and older who self-report heavy alcohol consumption[8]

KFH Area	Napa	California
20.9	21.3	17.2

Low Fruit and Vegetable Consumption, Adult
% of adults (18+) who self-report consuming <5 servings of fruits and vegetables each day[9]

KFH Area	Napa	California
71.5	64.7	71.5

Physical Inactivity, Adult
% of adults (20+) who self-report that they perform no leisure time activity[10]

KFH Area	Napa	California
15.9	13.4	16.6

Key Driver: Related Health Conditions

Overweight, Adult
% of adults (18+) who self-report Body Mass Index (BMI) between 25.0 and 30.0[11]

KFH Area	Napa	California
38.4	37.0	35.8

Obesity, Adult
% of adults (20+) who self-report Body Mass Index (BMI) > 30.0[12]

KFH Area	Napa	California
26.7	24.0	22.3

Additional Data: Screenings and Clinical Care

Colon Cancer Screening
% of adults (50+) who self-report that they ever had a sigmoidoscopy or colonoscopy, age-adjusted[13]

KFH Area	Napa	California
61.2	58.3	57.9

Pap Test Screening
% of women (18+) who self-report that they have had a Pap test in the past three years, age-adjusted[14]

KFH Area	Napa	California
78.0	75.0	78.3

Breast Cancer Screening, Older Adults
% of female Medicare enrollees (67-69+) who have received one or more mammograms in the past two years[15]

KFH Area	Napa	California
56.2	63.5	59.3

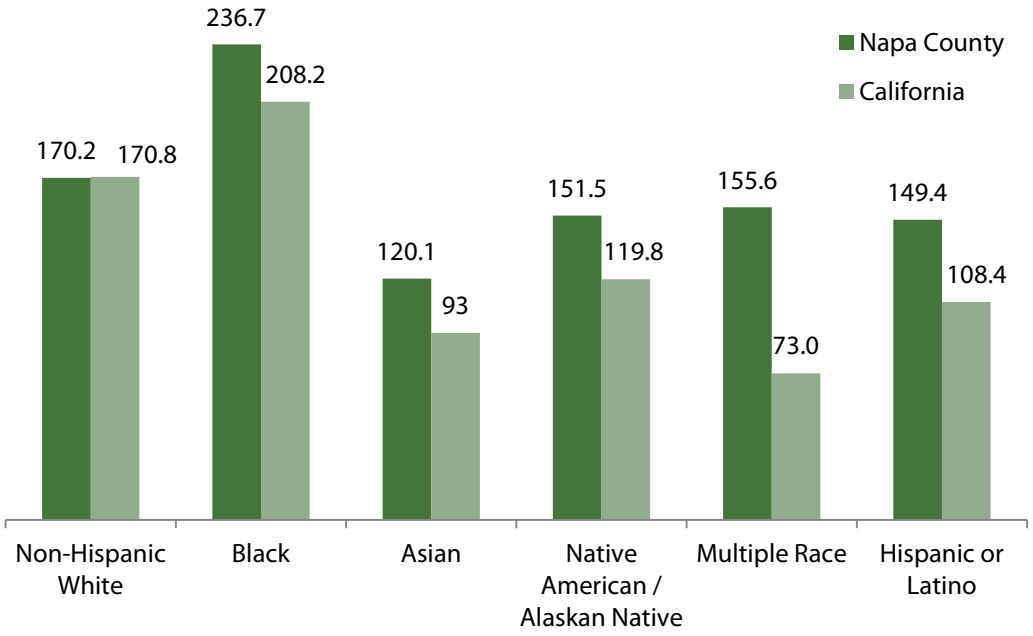
Cancers (continued)

Populations Disproportionately Affected

Racial/Ethnic Populations with Greatest Risk

Cancer Mortality

Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity[16]

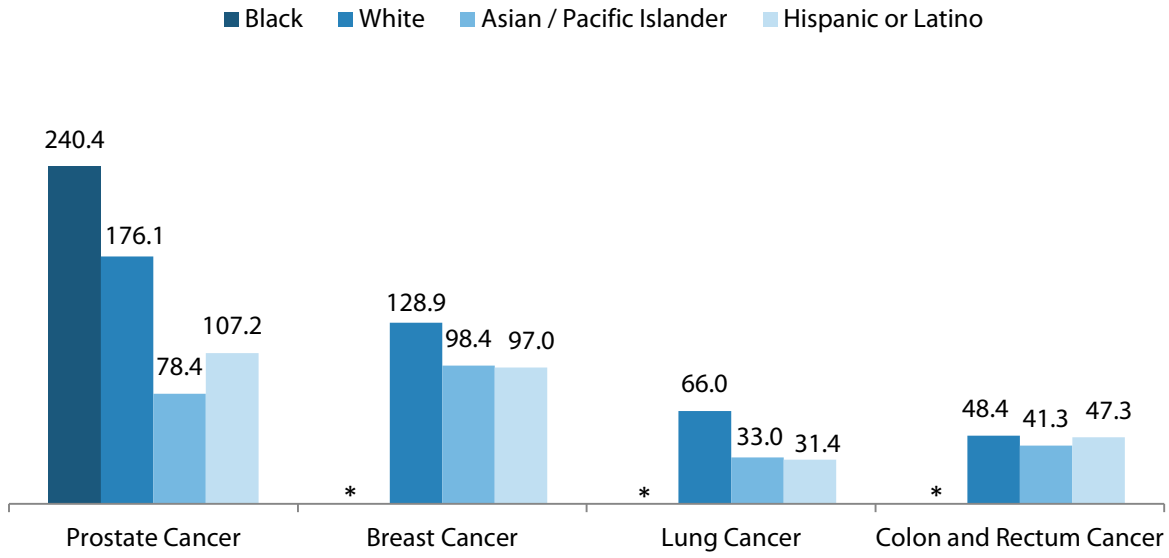


Cancers (continued)

Populations Disproportionately Affected

Annual Cancer Incidence by Primary Site

Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity[17]



**Races not shown are suppressed due to small numbers.*
*** Rate per 100,000 male population.*
**** Rate per 100,000 female population.*

Examples of Existing Community Assets†

Hospitals

American Cancer Society

Cancer Rehabilitation at Synergy Medical Fitness Center

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] American Cancer Society. Accessed at http://www.cancer.org/cancer/cancerbasics/what-is-cancer, December 2015.
[2] Centers for Disease Control. Accessed at http://www.cdc.gov/cancer/dcpc/data/types.htm, December 2015.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[4] National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2007-11.
[5] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[6] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008.
[7] California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting, 2013.
[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the US Department of Health & Human Services, Health Indicators Warehouse, 2005-09.

[10] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[11] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[12] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[13] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[14] Ibid.
[15] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[16] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[17] National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2007-11.

Mental Health

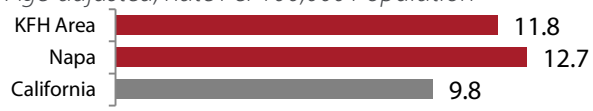
Mental health includes emotional, behavioral, and social well-being. Poor mental health — including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder — has profound consequences on health behavior choices and physical health.[1,2] Stressors such as economic insecurity, harassment and bullying in school, and lack of social and emotional support are significant determinants of mental health. In Napa, mental health emerged as a key concern among community members and other key stakeholders, as well as in some existing secondary data sources. Notably, the suicide rate in the KFH-Vallejo service area is higher than both the statewide rate and the Healthy People 2020 objective. Accessing mental health services can be challenging in Napa County, and there is limited capacity to meet needs. Older adults, youth — particularly LGBTQ youth, Latinos, and Native Americans face unique challenges in accessing mental health care. Emotional stress related to economic instability, such as struggling to provide basic needs like affordable housing, is an important concern throughout Napa County.

Key Data

Indicators

Suicide Rate[3]

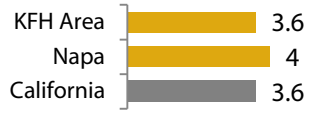
Age-adjusted; Rate Per 100,000 Population



"Some families […] **struggle with accessing** mental health or behavioral health services because there is a **social stigma** associated with that."

– Interviewee

Average Number of Mentally Unhealthy Days/Month[4]



"Many of our clients are suffering from mental health and substance abuse issues. They often have been suffering from years from very stressful, traumatic life situations, sometimes even from childhood."

– Interviewee

Youth Intentional Injury[5]

Rate Per 100,000 Population

Key Themes from Qualitative Data

Health Outcomes and Drivers:

- Economic insecurity is an important source of stress
- Harassment and bullying is a concern among youth
- High suicide risk, particularly among Latinos

Access to Mental Health Services:

- High need for mental health services and perception of limited capacity to meet demand
- Older adults, especially those who are isolated, have higher needs for mental health services
- Resistance to seeking treatment due to stigma
- High needs among LGBTQ youth
- Disparities exist related to the location of mental health treatment facilities across the county

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Mental Health (continued)

Additional Data and Key Drivers

Additional Data: Related Health Outcomes

Depression, Older Adults
% of Medicare beneficiaries with depression[6]

KFH Area	Napa	California
11.9	12.8	13.4

Depression, Youth
% of 11th grade students who felt sad or hopeless almost every day for 2 weeks or more[7]

Napa	California
32.5	32.5

"We certainly know there is a really high demand for [mental health] services, and we **do not have enough capacity to meet the demand**. So that is a big problem."
– Interviewee

Key Driver: Access to Mental Health Care

Adults Needing Treatment
% of adults reporting need for treatment for mental health, or use of alcohol /drug[8]

KFH Area	Napa	California
12.9	11.3	15.9

Mental Health Providers
Rate of mental health providers per 100,000 population[9]

KFH Area	Napa	California
206	247	157

"I feel that we need more mental health services, more places to go. If you are **on Medi-Cal** and from Napa County, they **offer certain services, but not all**."
– Focus Group Participant

Key Driver: Social Support and Stress

Social Support, Adult
% adults without adequate social / emotional support (age-adjusted)[10]

KFH Area	Napa	California
22.2	21.0	24.6

Harassment for Sexual Orientation, Youth
% of 11th grade students reporting harassment related to sexual orientation[11]

Napa	California
8.3	7.6

"Mental health is a huge issue. There are huge gaps in providing services. **Police really don't know how to deal with it** and it results in one problem after another… including death."
– Interviewee

"People are afraid of the police and when it comes to mental health issues people **are not calling the police anymore for fear** that their kids or their family members are going to get either arrested, or worse. This is especially true in Vallejo."
– Interviewee

Key Driver: Social and Economic Risks

Exposure to Violence
Age-adjusted homicide mortality rate; per 100,000 population)[12]

KFH Area	Napa	California
7.1	1.2	5.2

Exposure to Poverty
% population with income at or below 200% Federal Poverty Line[13]

KFH Area	Napa	California
30.4	28.1	36.4

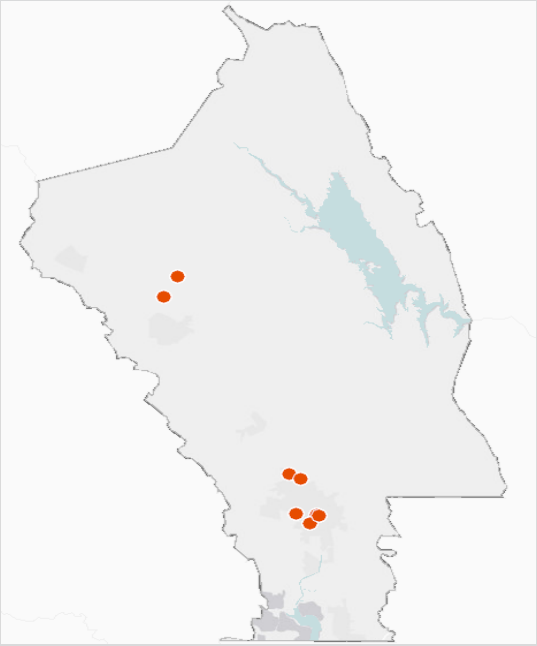
Substandard Housing
% of occupied housing units with one or more substandard conditions[14]

KFH Area	Napa	California
45.2	44.4	48.4

Mental Health (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Mental Health Treatment and Prevention Resources[15]

Primary data indicates a lack of available and accessible mental health care services. Secondary data corroborates this finding. This map displays the location of the few mental health treatment facilities in the county, and the areas in which treatment is concentrated. In particular, many geographic regions outside of Calistoga and the City of Napa experience limited access to mental health treatment and prevention resources.

Key

- Mental Health Treatment Facilities

Populations with Greatest Risk

Age disparities

Focus group participants and interviewees noted that **older adults**, particularly those who are socially isolated, are less likely to access mental health services.

Youth, notably **transition age youth and LGBTQ youth**, are also disproportionately affected by mental health issues. Primary and secondary data identified bullying and harassment in schools as a key issue.

Racial/Ethnic disparities

Although suicide risk is high on average for Napa County residents compared to California state, Latino residents are one group with disproportionately high risk. **27.9%** of Latinos in Napa County report **ever having seriously thought about suicide**, compared to 10.3% on average across racial groups.[16]

"Four groups are being focused on in Napa County based on the number of people accessing mental health services. **Native Americans, Latinos, LGBTQ, and Veterans—those are the groups identified as not accessing mental health services**."

- Interviewee

Mental Health (continued)

Assets and Recommendations

Examples of Existing Community Assets †

Mental Health Centers

Strong partnerships and sense of community

Mobile Crisis Team

Community Recommendations for Change

Increase Access to Mental Health Services

- Increase mental health services for older adults, especially at day centers and adult shelters
- Increase access to mental health specialists, particularly in Calistoga
- Ensure mental health services are culturally appropriate, and available in Spanish
- Decrease stigma related to accessing mental health services (for Latinos)
- Increase outpatient services

Increase Interventions for Youth

- Increase mental health intervention staff in schools
- Focus efforts on reducing/eliminating harassment and bullying among youth, especially LGBTQ youth

"We need to think of behavioral or mental health as **part of primary care**. We need to embed in these [services] in various places."
- Interviewee

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] Chapman DP, Perry GS, Strine TW. "The Vital Link Between Chronic Disease and Depressive Disorders," Preventing Chronic Disease, 2005; 2(1):A14.
[2] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: the Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine ,1998; 14:245–258.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[5] California EpiCenter data platform for Overall Injury Surveillance, 2011-13.
[6] Centers for Medicare and Medicaid Services, 2012.
[7] California Healthy Kids Survey, 2011-13.
[8] University of California Center for Health Policy Research, California Health Interview Survey, 2013-2014.
[9] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[10] 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.

[11] California Healthy Kids Survey, 2011-13.
[12] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[13] U.S. Census Bureau, American Community Survey, 2010-14.
[14] U.S. Census Bureau, American Community Survey, 2009-13.
[15] "Napa County Homeless Point-In-Time Census & Survey Comprehensive Report, "Napa County Taskforce for the Homeless, 2015.
[16] Substance Abuse and Mental Health Services Administration, 2014.
[17] California Health Interview Survey, 2014.

Substance Abuse

Substance abuse is defined as harmful or hazardous use of psychoactive substance, and can include use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, which may have profound health consequences. [1] Substance use and abuse was identified as a health need in existing data sources, and emerged as a salient theme in interviews and focus groups. For example, among both adults and youth the percent of the population drinking heavily is higher for this area than California overall. Youth were identified as a population of high concern, as binge drinking, e-cigarette use, and drug use were all noted as rising trends among younger residents. Residents and stakeholders noted tobacco cessation programs and community-based organizations focused on addressing substance abuse issues as resources.

Key Data

Indicators

Percent of Adults Smoking Cigarettes[2]

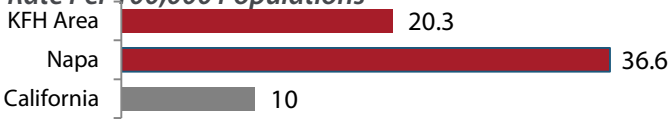
Age-Adjusted

Percent of Adults Reporting Heavy Alcohol Consumption[3]

Age-Adjusted

Liquor Store Access[4]

Rate Per 100,000 Populations



"**Drugs and alcohol – this is a significant issue in the community**, which taxes emergency services and hospitals and creates problems in peoples' lives. It's a growing problem among the younger population."

– Interviewee

Key Themes from Qualitative Data

Effects of Substance Use and Abuse

- Mental health and substance abuse are connected to other health and economic problems.
- Binge drinking can affect other issues including family cohesion, violence, injury, and traffic crashes.
- Substance abuse can decrease chance of graduating high school.
- Drinking and smoking in parks often limits children's use of the park.

Co-morbidity of Substance Use and Mental Health

- Alcohol or drug use can be a symptom of depression.
- Service systems within and across the county that address these health issues operate separately; however the root causes of the problems are intertwined.

"Many of our clients *[domestic violence victims]* are suffering from mental health and substance abuse issues. They often have been suffering with years of **very stressful, traumatic life situations**, sometimes even from childhood." – Interviewee

† A liquor store is defined by North American Industry Classification System (NAICS) Code 445310 as a business primarily engaged in retailing packaged alcoholic beverages, such as beer, wine, and spirits.

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Substance Abuse (continued)

Additional Data

Tobacco Use

Cigarette Smoking, Youth
% of 11th grade students reporting cigarette use within the last 30 days[5]

11.8	10.2
Napa	California

Key Theme About Cigarette Use

- Tobacco is on the rise in school aged children.

Key Themes About E-cigarettes

- Decrease in smoking rate; increase in e-cigarette use
- Fruit flavors and marketing are designed to attract youth
- Evidence of carcinogenic effects
- Further research needed on health effects

Alcohol Use

Binge Drinking, Youth
% of 11th grade students reporting binge drinking at least once within the last 30 days[6]

22.8	20.7
Napa	California

Key Themes from Qualitative Data

- Safe use of alcohol is a problem among both adults and youth
- Binge drinking is increasing
- Binge drinking leads to poor health choices
- Wine industry is a primary employer in the county

Drug Use

Marijuana Use, Youth
% of 11th grade students reporting marijuana use within the last 30 days[7]

24.9	22.0
Napa	California

Key Themes from Qualitative Data

- Easy to obtain recreational marijuana
- High prevalence of medical marijuana
- High prevalence of street drugs

Clinical Care

Key Themes from Qualitative Data
Barriers to Receiving Treatment:

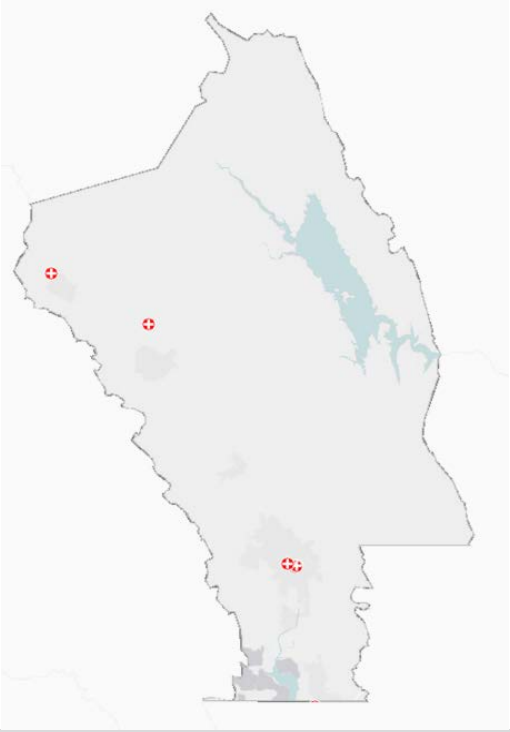
- There is a lack of services, particularly for hospitalization.
- Maintaining confidentiality in support groups is difficult in a small community.
- Stigma or fear (especially among young people) exists about seeking help for substance abuse.
- Residents do not know about ways to enter treatment proactively (e.g., without first being apprehended by law enforcement).
- Support groups for depression and alcohol abuse are too expensive.

"As far as substance abuse, I am just not sure that the services are available to [community members] in an accessible way."
– Interviewee

Substance Abuse (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Substance Abuse Treatment Facilities[7]
The map corroborates primary data themes related to substance abuse treatment options, including the lack of treatment facilities for substance abuse throughout the county.

Key
Substance Abuse Treatment Facility

Interviewees and focus group participants noted that the stigma associated with seeking treatment is another barrier to receiving clinical services. This issue may be greater among youth than other populations.

Substance Abuse (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Napa County Health and Human Services Agency; Alcohol and Drug Services (ADS)

Nonprofit CBOs providing: Mental Health (e.g., Mentis, Aldea); ADS Services (e.g., Wolfe Center, McAllister); Alcoholics Anonymous

St. Helena Hospital

Community Recommendations for Change

Increase Partnership with Schools

- Increase after-school programs and increase opportunities for inexpensive, safe youth activities
- Offer immediate intervention services to youth (rather than allowing the problem to go untreated)
- Increase parent education about drugs and alcohol abuse among youth

Use Policy Strategies to Decrease Substance Use

- Support e-cigarette regulation regarding marketing to youth

"[In Benicia] we don't have any drug or substance abuse counselor, either in the schools or really in the community to refer kids with substance abuse issues. So that's something we could use."

– Interviewee

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] World Health Organization, Health Topics: Substance abuse, http://www.who.int/topics/substance_abuse/en/, Accessed December 2015.
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[3] Ibid.
[4] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[5] California Healthy Kids Survey, 2011-13.
[6] Ibid.
[7] Ibid.

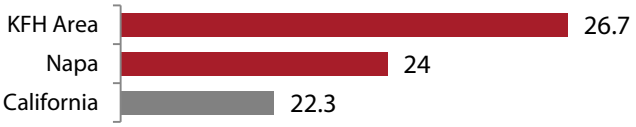
Obesity and Diabetes

Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent some of the leading causes of death nationwide.[1] There is a high prevalence of adults and youth who are obese or overweight throughout the county. Primary and secondary data indicate that throughout the area access to *affordable* healthy food is limited, and lack of physical activity may be driven in part by a lack of affordable exercise options and a lack of time. Specific geographic regions in Napa County, including rural communities, Vallejo, and American Canyon, experience disproportionately high levels of inadequate access to healthy food compared to other areas of the county.

Key Data

Indicators

Percent of Adults Obese (BMI > 30.0)[2]



Percent of Youth Obese (BMI > 30.0)[3]

Percent of Adults Diagnosed with Diabetes[4]

Age-adjusted

"**Obesity and poor nutrition** is huge and crosses all ages and lifestyles."
– Interviewee

"The issue of nutrition affects our clients. They are living on such low incomes that in order to make their money stretch, they are not able to afford fruits and vegetables. So I think obesity and health issues related to diet and exercise are part of their lives. **Many are living in survival mode.** They are working hard for low incomes, sometimes working two jobs, and that affects their ability to enjoy life in general."
– Interviewee

Key Themes from Qualitative Data

Poor Nutrition

- Poor access to healthy and affordable foods, particularly for low-income residents
- Several grocery stores have recently closed
- High consumption of sugary beverages
- Many residents are food insecure
- Lack of access to information about nutrition
- Lack of knowledge of healthy, culturally appropriate recipes
- Farmer's markets are accessible, but expensive

Lack of Physical Activity

- Trend towards more sedentary lifestyles (e.g., increased screen time among children and adults)
- Lack of adequate, affordable recreational facilities
- Long work hours and long commute time limits time to exercise
- Lack of safe, walkable roads in rural areas

Note: California state average estimates are included for reference. Differences between service area or Napa County and California state estimates are not necessarily statistically significant.

Obesity and Diabetes (continued)

Additional Data and Key Drivers

Additional Data: Clinical Care

Diabetes Hospitalizations
Age-adjusted discharge rate per 10,000 pop.[5]

KFH Area	Napa	California
7.7	7.4	10.4

Diabetes Management, Older Adult
% of diabetic Medicare patients with hemoglobin A1c (hA1c) test a in the past year[6†]

KFH Area	Napa	California
76.6	80.1	81.5

Additional Data: Related Health Outcomes

Overweight, Adult
of adults (18+) who self-report Body Mass Index (BMI) between 25.0 and 30.0[7]

KFH Area	Napa	California
38.4	37.0	35.9

"The number one cause of death is **cardiovascular disease**. As an underlying risk factor: obesity is part of this. We have a high obesity rate in the county."
-- Interviewee

Overweight, Youth
% of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) for body composition[8]

KFH Area	Napa	California
20.7	19.5	19.3

Stroke Mortality
Age-adjusted mortality rate per 100,000 pop.[9]

KFH Area	Napa	California
40.8	38.0	37.4

Ischaemic Heart Disease Mortality
Age-adjusted mortality rate per 100,000 pop.[10]

KFH Area	Napa	California
156.9	152.9	163.2

Heart Disease Prevalence
% of adults (18+) ever told by a doctor that they have coronary heart disease or angina[11]

KFH Area	Napa	California
8.8	9.9	6.3

Key Driver: Nutrition

Low Fruit and Vegetable Consumption, Adult
% adults consuming <5 servings of fruit and vegetables[12]

KFH Area	Napa	California
71.5	64.7	71.5

Low Fruit and Vegetable Consumption, Youth
% youth age 2-13 consuming <5 servings of fruit and vegetables[15]

KFH Area	Napa	California
47.5	51.6	47.4

WIC Authorized Food Stores
% of food stores authorized to accept WIC program benefits per 100,000 pop vegetables[13]

Napa	California
17.4	15.8

Fast Food
Fast food establishments per 100,000 pop.[14]

KFH Area	Napa	California
63.0	63.0	74.5

Grocery Stores
Grocery stores per 100,000 pop.[16]

KFH Area	Napa	California
22.5	27.8	21.5

† Hemoglobin A1c (hA1c) test is a blood test which measures blood sugar levels and is used for diabetes management.

Obesity and Diabetes (continued)

Key Driver: Physical Activity

Low Physical Activity, Adult
% adults with no leisure time activity[17]

15.9	13.4	16.6
KFH Area	Napa	California

Low Physical Activity, Youth
% youth in grades 5,7,9 with "high risk" or "needs improvement" aerobic capacity[19]

39.8	31.1	35.9
KFH Area	Napa	California

"So it's the safety and crime in the area that's preventing people from being outdoors and feeling safe to walk around even around their neighborhood."
-- Interviewee

"It's really hard to exercise in Vallejo because, like if you wanted to run, it's kind of dangerous and you have no open space [where it is] free to exercise."
–Focus Group Participant

Park Access
% population living ½ mile from a park[18]

70.0	57.6	58.6
KFH Area	Napa	California

Fitness Centers
Recreation and fitness centers per 100,000 pop.[20, ††]

10.9	12.5	8.7
KFH Area	Napa	California

Key Driver: Social and Economic Risks

"Poverty is a big issue. The average person who is **struggling financially** is not able to access healthy foods."
– Interviewee

Food Insecurity
% population experiencing food insecurity[21]

13.8	12.0	16.2
KFH Area	Napa	California

"Food insecurity in Napa largely reflects **economic status**…This has probably not improved much. For children, this is extremely important."
– Interviewee

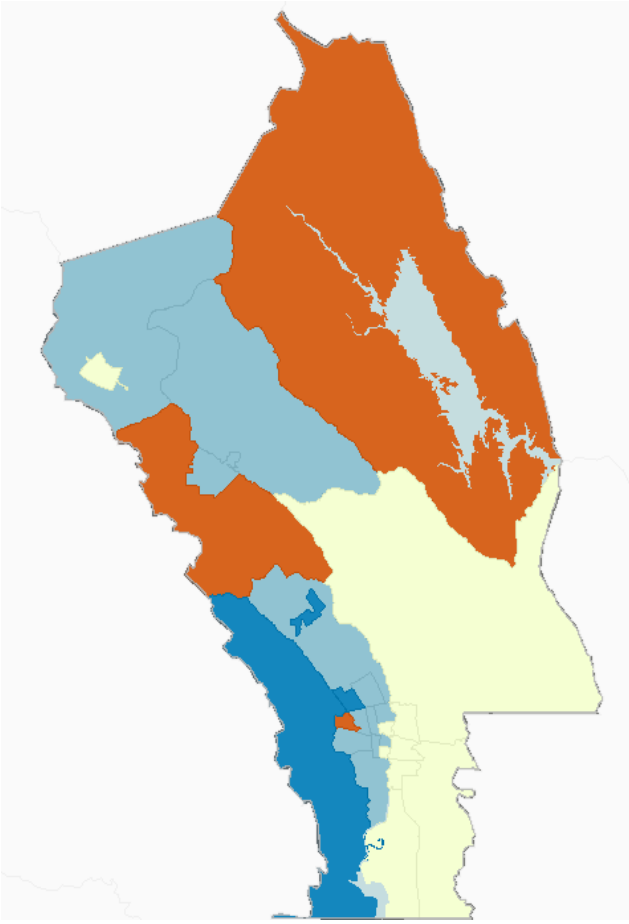
"There's a huge food desert in Vallejo right in the middle of what most people acknowledge as the poor part of town […] the food that has nutritional value of any kind you have to travel for miles just to get to, and then even then it's expensive."
-- Interviewee

† Fitness and recreation centers (defined by North American Industry Classification System (NAICS) code 713940) are establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. The method used to identify recreational facilities in the County Business Patterns data does not include YMCAs and intramural/amateur sports clubs, both of which may be important venues for physical activity, especially for low- and middle-income community members. Furthermore, this measure does not account for the opportunity to engage in fitness activities in parks or other public areas.

Obesity and Diabetes (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Modified Retail Food Environmental Index Score by Tract[22]

The Modified Retail Food Environmental Index (mRFEI) measures the number of healthy and less healthy food retailers in an area. The mRFEI represents the percentage of health food retailers (including supermarkets, larger grocery stores, supercenters, and produce stores) within census tracts or ½ mile from the tract boundary. This does not include farmers markets. This map displays geographic disparities in access to healthy foods across Napa County.

Interviewees and focus group participants noted that **American Canyon and rural areas of the county have low access to healthy foods**. **Young children, older adults, and the Latino population** were also noted as populations at high risk for food insecurity and low access to healthy foods.

One interviewee noted, "A lot of our low income families don't have transportation. They are going to these little corner stores with all the junk food. So there doesn't seem to be anything to motivate these small stores to sell healthier stuff."

Key

- Index Score Over 30 (High Access)
- Index Score 15 - 30 (Moderate Access)
- Index Score 5 - 15 (Low Access)
- Index Score Under 5 (Poor Access)
- No Healthy Retail Food Outlet (No Access)
- No Retail Food Outlets Present (Food Desert)

Populations with Greatest Risk

Age disparities

Interviewees and focus groups highlighted that obesity is a serious concern for **older adults**. While obesity is an issue across the lifespan, interviewees noted that obesity is a risk factor for dementia, and that there is an increased risk of dementia from high blood sugar. Physical activity, nutritious food, and loneliness are highly predictive of dementia. Older adults living on fixed and low income may go without meals because they need to make difficult financial decisions between spending money on medication and on food.

Other disparities

Residents experiencing homelessness were also noted as a population of high risk. The food available to families in shelters is often unhealthy (e.g., pizza and soda), and residents living in cars do not have the means to cook.

Obesity and Diabetes (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Food Banks (e.g., The Full Service Community Schools Initiative)

Community Gardens

Parks, Trails and Walkable Communities

Community Recommendations for Change

Increase Accessibility of Healthy Foods

- Create safe, welcoming places such as community gardens, school gardens, and farmers markets
- Change nutrition policies (e.g., remove sugary beverages from school settings)
- Engage local faith-based and nonprofit groups to deliver vegetable boxes to low-income households

Increase Opportunities for Physical Activity

- Offer a warmer pool, or raise the temperature of the public pool on designated day each week, so that it is accessible to seniors (e.g., in partnership with the Arthritis Foundation)
- Strengthen partnerships between cities, school districts, nonprofits, and local foundations to increase wellness activities in communities (e.g., provide more low-cost or free exercise classes)
- Enhance the safety of roads and sidewalks to make Napa County more walkable, especially for people with disabilities

"Make fresh fruits and vegetables cheaper and more readily available so that single moms **will be able to make a healthier choice**. You can keep educating about these things and they know it but given their living situation they are not going to choose the healthiest option."

– Interviewee

Increase Education about Healthy Eating and Active Living

- Provide culturally relevant nutrition information and cooking classes at community fairs (e.g., for Latino, Indian, and Asian communities)
- Provide multilingual education about healthy food choices
- Include prenatal and early life nutrition as a topic in prenatal programs
- Utilize physicians, integrative medicine specialists, or nutritionists to educate parents and children in a school setting

"Educating people is not enough. It's not enough to say it's just about education. **We need to restructure things so that the healthy choice is the easy choice.**"

– Interviewee

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] "Obesity Health Risks," Harvard School of Public Health, Obesity Prevention Source, Accessed November 2015, http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/.
[2] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[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] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011.
[6] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[8] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[9] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[10] Ibid.
[11] University of California Center for Health Policy Research, California Health Interview Survey, 2011-12.
[12] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2005-09.
[13] US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
[14] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[15] University of California Center for Health Policy Research, California Health Interview Survey, 2011-12.
[16] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[17] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[18] US Census Bureau, Decennial Census. ESRI Map Gallery, 2010.
[19] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[20] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[21] Feeding America. Child Food Insecurity Data, 2012.
[22] Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, 2011.

Health Indicators								Benchmarks		Needs Score				
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Napa County Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	KFH Service Area	Napa County	Difference Between KFH Service Area and State Value	Stastistically unstable County
Access to Care	Core	Access to Dentists	2013	Clinical Care	Rate	140,326	n/a	77.5	63.2	Above Benchmark	81.5	77.0	4.05	
		Access to Primary Care	2012	Clinical Care	Rate	139,045	n/a	77.3	74.5	Above Benchmark	87.5	98.5	10.25	
		Lack of a Consistent Source of Primary Care	2011-12	Clinical Care	Percentage	133,000	n/a	14.3%	no data	Below Benchmark	9.8%	7.7%	-4.50%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	206.2	247.2	49.2	
	Related	Insurance - Uninsured Population	2010-14	Social & Economic Factors	Percentage	137,294	n/a	16.7%	14.2%	Below Benchmark	14.2%	13.9%	-2.50%	
		Federally Qualified Health Centers	2014, June	Clinical Care	Rate	136,484	n/a	2.0	1.9	Above Benchmark	7.7	5.9	5.77	
		Health Professional Shortage Area - Primary Care	2015, March	Clinical Care	Percentage	136,484	n/a	25.2%	34.1%	Below Benchmark	0.7%	1.3%	-24.53%	
		Preventable Hospital Events	2011	Clinical Care	Rate		n/a	83.2	no data	Below Benchmark	87.7	78.84	4.53	
		Insurance - Population Receiving Medicaid	2010-14	Social & Economic Factors	Percentage	137,294	n/a	24.4%	20.8%	Below Benchmark	19.5%	16.0%	-4.90%	
		Health Professional Shortage Area - Dental	2015, March	Clinical Care	Percentage	136,484	n/a	4.9%	32.0%	Below Benchmark	0.0%	0.0%	-4.93%	
		Cancer Screening - Mammogram	2012	Clinical Care	Percentage	918	n/a	59.3%	63.0%	Above Benchmark	56.2%	63.5%	-3.10%	
		Cancer Screening - Pap Test	2006-12	Clinical Care	Percentage	86,293	n/a	78.3%	78.5%	Above Benchmark	78.0%	75.0%	-0.30%	
		Cancer Screening - Sigmoid/Colonoscopy	2006-12	Clinical Care	Percentage	37,694	n/a	57.9%	61.3%	Above Benchmark	61.2%	58.3%	3.30%	
Access to Housing	Core	Housing - Vacant Housing	2009-13	Physical Environment	Percentage	54,851	n/a	8.6%	12.5%	Below Benchmark	10.1%	9.9%	1.49%	
		Housing - Cost Burdened Households	2010-14	Physical Environment	Percentage	49,631	n/a	45.0%	34.9%	Below Benchmark	43.4%	42.6%	-1.60%	
		Housing - Substandard Housing	2009-13	Physical Environment	Percentage	49,431	n/a	48.4%	36.1%	Below Benchmark	45.2%	44.4%	-3.21%	
		Housing - Assisted Housing	2013	Physical Environment	Rate	204,572	n/a	368.3	384.3	Below Benchmark	433.85	399.39	65.55	
		Percent living in overcrowded housing conditions (>1.5 persons/room)	2009-13	Physical Environment	Percentage		n/a	5.2%	2.1%	Below Benchmark	n/a	3.6%		
Asthma and COPD	Core	Asthma - Prevalence	2011-12	Health Outcomes	Percentage	96,628	n/a	14.2%	13.4%	Below Benchmark	22.7%	13.8%	8.49%	
		Percent of children ever diagnosed with asthma (ages 0-17)	2013-2014, 2013-US	Health Outcomes	Percentage		n/a	14.5%	12.7%	Below Benchmark	n/a	20.5%		x
		Asthma - Hospitalizations	2011	Health Outcomes	Rate		n/a	8.9	no data	Below Benchmark	7.3	7.0	-1.58	
	Related	Air Quality - Ozone (O3)	2008	Physical Environment	Percentage	136,484	n/a	2.5%	0.5%	Below Benchmark	0.1%	0.2%	-2.33%	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	11.2%	8.6%	-1.60%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage		n/a	1.0%	1.6%	Below Benchmark	1.0%	suppressed	0.02%	
		Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	6.3%	2.16%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	26.7%	24.0%	4.38%	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	38.4%	37.0%	2.55%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	18.4%	14.8%	-0.56%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	20.7%	19.5%	1.40%	
	Core	Cancer Incidence - Breast	2007-11	Health Outcomes	Rate	67,925	n/a	122.4	122.7	Below Benchmark	128.4	125.4	5.99	
		Mortality - Cancer	2010-12	Health Outcomes	Rate	136,484	<= 160.6	157.1	no data	Below Benchmark	170.0	167.8	12.91	
		Cancer Incidence - Cervical	2007-11	Health Outcomes	Rate	67,925	<= 7.1	7.8	7.8	Below Benchmark	6.8	6.2	-0.99	
		Cancer Incidence - Colon and Rectum	2007-11	Health Outcomes	Rate	135,377	<= 38.7	41.5	43.3	Below Benchmark	45.4	45.4	3.85	

Health Indicators								Benchmarks		Needs Score				
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Cancers		Cancer Incidence - Prostate	2007-11	Health Outcomes	Rate	67,452	n/a	136.4	142.3	Below Benchmark	165.3	173.8	28.86	
		Prostate cancer age adjusted mortality rate	2011-2013, 2013-US	Health Outcomes	Rate/100,000		<= 21.2	20.2	19.2	Below Benchmark	n/a	23.4		
		Cancer Incidence - Lung	2007-11	Health Outcomes	Rate	135,377	n/a	49.5	64.9	Below Benchmark	61.3	62.0	11.79	
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	20.9%	21.3%	3.70%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage		n/a	12.9%	14.3%	Below Benchmark	13.2%	suppressed	0.28%	
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	20.3	36.6	10.27	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	38.4%	37.0%	2.55%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	26.7%	24.0%	4.38%	
		Cancer Screening - Mammogram	2012	Clinical Care	Percentage	918	n/a	59.3%	63.0%	Above Benchmark	56.2%	63.5%	-3.10%	
		Low Fruit/Vegetable Consumption (Adult)	2005-09	Health Behaviors	Percentage	101,137	n/a	71.5%	75.7%	Below Benchmark	71.5%	64.7%	0.00%	
		Fruit/Vegetable Expenditures	2014	Health Behaviors	Percentage		n/a	14.1%	12.7%	Above Benchmark	14.1%	suppressed	0.04%	
	Related	Food Security - Food Desert Population	2010	Social & Economic Factors	Percentage	136,484	n/a	14.3%	23.6%	Below Benchmark	18.4%	13.0%	4.05%	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	11.2%	8.6%	-1.60%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage		n/a	1.0%	1.6%	Below Benchmark	1.0%	suppressed	0.02%	
		Cancer Screening - Pap Test	2006-12	Clinical Care	Percentage	86,293	n/a	78.3%	78.5%	Above Benchmark	78.0%	75.0%	-0.30%	
		Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	15.9%	13.4%	-0.69%	
		Cancer Screening - Sigmoid/Colonoscopy	2006-12	Clinical Care	Percentage	37,694	n/a	57.9%	61.3%	Above Benchmark	61.2%	58.3%	3.30%	
		Pesticide Use - Pounds of Pesticides Applied	2013	Physical Environment	Number	n/a	n/a	n/a	n/a	n/a	n/a	1,259,700		
		Pesticide Use - Rank of Pesticide Use Among CA Counties	2013	Physical Environment	Rank	n/a	n/a	n/a	n/a	n/a	n/a	26.0		
		Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	6.3%	2.16%	
Child Mental and Emotional Development		Poverty - Children Below 100% FPL	2009-13	Social & Economic Factors	Percentage	134,215	n/a	22.2%	21.6%	Below Benchmark	18.0%	14.1%	-4.20%	
	Core	Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	2011-2013, 2013-US	Health Outcomes	Percentage		n/a	32.5%	31.7%	Below Benchmark	n/a	32.5%		
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	2011-2013	Social & Economic Factors	Percentage		n/a	7.6%	no data	Below Benchmark	n/a	8.3%		
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	2014, 2013- US	Social & Economic Factors	Rate/1,000		<=8.5	9.0	9.1	Below Benchmark	n/a	8.1		
		Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	6.3%	2.16%	
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	15.2%	14.4%	12.51%	
		Air Quality - Ozone (O3)	2008	Physical Environment	Percentage	136,484	n/a	2.5%	0.5%	Below Benchmark	0.1%	0.2%	-2.33%	
		Climate & Health - Heat Index Days	2014	Physical Environment	Percentage	4,015	n/a	0.6%	4.7%	Below Benchmark	0.0%	0.0%	-0.63%	
	Core	Climate & Health - Drought Severity	2012-14	Physical Environment	Percentage		n/a	92.8%	45.9%	Below Benchmark	90.9%	93.0%	-1.90%	
		Climate & Health - Heat Stress Events	2005-12	Physical Environment	Rate	152	n/a	11.1	no data	Below Benchmark	12.1	13.7	1	
		Asthma - Hospitalizations	2011	Health Outcomes	Rate		n/a	8.9	no data	Below Benchmark	7.3	7.0	-1.58	
		Percent of children ever diagnosed with asthma (ages 17 and below)	2013-2014, 2013-US	Health Outcomes	Percentage		n/a	14.5%	12.7%	Below Benchmark	n/a	20.5%		
		Asthma - Prevalence	2011-12	Health Outcomes	Percentage	96,628	n/a	14.2%	13.4%	Below Benchmark	22.7%	13.8%	8.49%	

Health Indicators								Benchmarks		Needs Score				
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Climate and Health		Low Birth Weight	2011	Health Outcomes	Percentage	136,484	n/a	6.8%	no data	Below Benchmark	7.0%	6.0%	0.21%	
		Transit - Road Network Density	2011	Physical Environment	Rate	789	n/a	4.3	2.0	Below Benchmark	2.9	1.4	-1.38	
		Transit - Public Transit within 0.5 Miles	2011	Physical Environment	Percentage	136,484	n/a	15.5%	8.1%	Above Benchmark	0.8%	0.0%	-14.70%	
		Climate & Health - Canopy Cover	2011	Physical Environment	Percentage	136,484	n/a	15.1%	24.7%	Above Benchmark	26.4%	14.6%	11.27%	
		Climate & Health - No Access to Air Conditioning	2011, 2013	Physical Environment	Percentage	54,759	n/a	33.8%	11.4%	Below Benchmark	no data	no data		
	Related	Diabetes Hospitalizations	2011	Health Outcomes	Rate		n/a	10.4	no data	Below Benchmark	7.7	7.4	-2.75	
		Mental Health - Poor Mental Health Days	2006-12	Health Outcomes	Rate	104,042	n/a	3.6	3.5	Below Benchmark	3.6	4.0	0	
		Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	156.9	152.9	-6.31	
		Commute to Work - Alone in Car	2009-13	Health Behaviors	Percentage	64,876	n/a	73.2%	76.4%	Below Benchmark	74.7%	76.1%	1.50%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	26.7%	24.0%	4.38%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	18.4%	14.8%	-0.56%	
CVD/Stroke		Heart Disease Prevalence	2011-12	Health Outcomes	Percentage	102,000	n/a	6.3%	no data	Below Benchmark	8.8%	9.9%	2.50%	
	Core	Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	156.9	152.9	-6.31	
		Mortality - Stroke	2010-12	Health Outcomes	Rate	136,484	n/a	37.4	no data	Below Benchmark	40.8	38.0	3.38	
		Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	15.9%	13.4%	-0.69%	
		Physical Inactivity (Youth)	2013-14	Health Behaviors	Percentage	4,724	n/a	35.9%	no data	Below Benchmark	39.8%	31.1%	3.85%	
		Park Access	2010	Physical Environment	Percentage	136,484	n/a	58.6%	no data	Above Benchmark	70.0%	57.6%	11.44%	
		Transit - Walkability	2012	Physical Environment	percentage		n/a	1.7%	2.0%	Below Benchmark	0.0%	no data	-1.65%	
		Recreation and Fitness Facility Access	2012	Physical Environment	Rate	136,484	n/a	8.7	9.4	Above Benchmark	10.9	12.5	2.21	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	11.2%	8.6%	-4.20%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage		n/a	1.0%	1.6%	Below Benchmark	1.0%	suppressed	0.02%	
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	20.9%	21.3%	3.70%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage		n/a	12.9%	14.3%	Below Benchmark	13.2%	suppressed	0.28%	
	Related	Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	20.3	36.6	10.27	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	38.4%	37.0%	2.55%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	26.7%	24.0%	4.38%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	20.7%	19.5%	1.40%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	18.4%	14.8%	-0.56%	
		Diabetes Prevalence	2012	Health Outcomes	Percentage	103,923	n/a	8.1%	9.1%	Below Benchmark	8.2%	6.8%	0.15%	
		Diabetes Hospitalizations	2011	Health Outcomes	Rate		n/a	10.4	no data	Below Benchmark	7.7	7.4	-2.75	
		Diabetes Management (Hemoglobin A1c Test)	2012	Clinical Care	Percentage	11,517	n/a	81.5%	84.6%	Above Benchmark	76.6%	80.1%	-4.86%	
		High Blood Pressure - Unmanaged	2006-10	Clinical Care	Percentage	102,821	n/a	30.3%	21.7%	Below Benchmark	37.2%	47.5%	6.90%	
		Economic Security - Unemployment Rate	June, 2015	Social & Economic Factors	Rate	74,915	n/a	6.8	5.4	Below Benchmark	6.1	5.6	-0.7	

Health Indicators								Benchmarks		Needs Score				
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Napa County Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	KFH Service Area	Napa County	Difference Between KFH Service Area and State Value	Stastistically unstable County
Economic Security	Core	Income Inequality	2009-13	Social & Economic Factors	Rate	49,431	n/a	0.5	0.5	Below Benchmark	no data	0.5		
		Poverty - Population Below 100% FPL	2009-13	Social & Economic Factors	Percentage	134,215	n/a	15.9%	15.4%	Below Benchmark	12.8%	10.1%	-3.12%	
		Poverty - Population Below 200% FPL	2010-14	Social & Economic Factors	Percentage	135,571	n/a	36.4%	no data	Below Benchmark	30.4%	28.1%	-6.00%	
		Poverty - Children Below 100% FPL	2010-14	Social & Economic Factors	Percentage	135,571	n/a	22.7%	no data	Below Benchmark	18.2%	14.0%	-4.50%	
	Related	Education - High School Graduation Rate	2013	Social & Economic Factors	Rate	1,630	>= 82.4	80.4	no data	Above Benchmark	80.6	85.3	0.2	
		Education - Reading Below Proficiency	2012-13	Social & Economic Factors	Percentage	1,475	<= 36.3%	36.0%	no data	Below Benchmark	43.0%	40.0%	7.00%	
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	20.3	36.6	10.27	
		Children Eligible for Free/Reduced Price Lunch	2013-14	Social & Economic Factors	Percentage	20,844	n/a	58.1%	52.4%	Below Benchmark	50.9%	45.4%	-7.28%	
		Food Security - Population Receiving SNAP	2011	Social & Economic Factors	Percentage	133,788	n/a	10.6%	15.2%	Below Benchmark	7.6%	5.3%	-2.97%	
		Insurance - Population Receiving Medicaid	2010-14	Social & Economic Factors	Percentage	137,294	n/a	24.4%	20.8%	Below Benchmark	19.5%	16.0%	-4.90%	
		Education - Less than High School Diploma (or Equivalent)	2009-13	Social & Economic Factors	Percentage	93,928	n/a	18.8%	14.0%	Below Benchmark	14.3%	16.9%	-4.45%	
		Insurance - Uninsured Population	2010-14	Social & Economic Factors	Percentage	137,294	n/a	16.7%	14.2%	Below Benchmark	14.2%	13.9%	-2.50%	
		Education - School Enrollment Age 3-4	2009-13	Social & Economic Factors	Percentage	3,150	n/a	49.1%	47.7%	Above Benchmark	47.0%	51.9%	-2.08%	
		Education - Head Start Program Facilities	2014	Social & Economic Factors	Rate	8,131	n/a	6.3	7.6	Above Benchmark	5.4	7.4	-0.99	
		Food Security - School Breakfast Program	2013	Social & Economic Factors	Rate		n/a	3.9	4.2	Below Benchmark	3.9	no data	0	
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	13.8%	12.0%	-2.48%	
		Housing - Vacant Housing	2009-13	Physical Environment	Percentage	54,851	n/a	8.6%	12.5%	Below Benchmark	10.1%	9.9%	1.49%	
		Housing - Cost Burdened Households	2010-14	Physical Environment	Percentage	49,631	n/a	45.0%	34.9%	Below Benchmark	43.4%	42.6%	-1.60%	
		Housing - Substandard Housing	2009-13	Physical Environment	Percentage	49,431	n/a	48.4%	36.1%	Below Benchmark	45.2%	44.4%	-3.21%	
		Housing - Assisted Housing	2013	Physical Environment	Rate	54,759	n/a	368.3	384.3	Below Benchmark	433.9	399.4	65.55	
		Economic Security - Commute Over 60 Minutes	2009-13	Social & Economic Factors	Percentage	61,338	n/a	10.1%	8.1%	Below Benchmark	13.3%	9.0%	-1.10%	
		Economic Security - Households with No Vehicle	2009-13	Social & Economic Factors	Percentage	49,431	n/a	7.8%	9.1%	Below Benchmark	5.9%	4.6%	-1.87%	
		Percent People 65 years or Older In Poverty (100%FPL)	2009-13	Social & Economic Factors	Percentage		n/a	9.9%	9.4%	Below Benchmark	no data	6.8%		
		Percent living in overcrowded housing conditions (>1.5 persons/room)	2009-13	Physical Environment	Percentage		n/a	5.2%	2.1%	Below Benchmark	no data	3.6%		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts (ELA)	2013-14 school year	Social & Economic Factors	Percentage		n/a	38.0%	no data	Above Benchmark	no data	22.0%		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	2013-14 school year	Social & Economic Factors	Percentage		n/a	54.0%	no data	Above Benchmark	no data	39.0%		
Education	Core	Education - High School Graduation Rate	2013	Social & Economic Factors	Rate	1,630	>= 82.4	80.4	no data	Above Benchmark	80.6	85.3	0.2	
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts (ELA)	2013-14 school year	Social & Economic Factors	Percentage		n/a	38.0%	no data	Above Benchmark	n/a	22.0%		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	2013-14 school year	Social & Economic Factors	Percentage		n/a	54.0%	no data	Above Benchmark	n/a	39.0%		
		Education - Reading Below Proficiency	2012-13	Social & Economic Factors	Percentage	1,475	<= 36.3%	36.0%	no data	Below Benchmark	43.0%	40.0%	7.00%	
		Education - Less than High School Diploma (or Equivalent)	2009-13	Social & Economic Factors	Percentage	93,928	n/a	18.8%	14.0%	Below Benchmark	14.3%	16.9%	-4.45%	
		Education - School Enrollment Age 3-4	2009-13	Social & Economic Factors	Percentage	3,150	n/a	49.1%	47.7%	Above Benchmark	47.0%	51.9%	-2.08%	
		Education - Head Start Program Facilities	2014	Social & Economic Factors	Rate	8,131	n/a	6.3	7.6	Above Benchmark	5.4	7.4	-0.99	

Health Indicators								Benchmarks		Needs Score				
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Napa County Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	KFH Service Area	Napa County	Difference Between KFH Service Area and State Value	Stastistically unstable County
		Violence - School Suspensions	2013-14	Social & Economic Factors	Rate	41,712	n/a	4.0	no data	Below Benchmark	25.8	3.5	21.71	
		Violence - School Expulsions	2013-14	Social & Economic Factors	Rate	41,712	n/a	0.1	no data	Below Benchmark	0.1	0.0	0.02	
HIV/AIDS/STDs	Core	STD - Chlamydia	2012	Health Outcomes	Rate	138,088	n/a	444.9	456.7	Below Benchmark	387.9	248.4	-57.01	
		STD - HIV Prevalence	2010	Health Outcomes	Rate	114,754	n/a	363.0	340.4	Below Benchmark	259.6	165.1	-103.4	
		STD - HIV Hospitalizations	2011	Health Outcomes	Rate		n/a	2.0	no data	Below Benchmark	1.1	0.7	-0.92	
	Related	STD - No HIV Screening	2011-12	Clinical Care	Percentage	83,211	n/a	60.8%	62.8%	Below Benchmark	61.0%	62.5%	0.17%	
Mental Health	Core	Mortality - Suicide	2010-12	Health Outcomes	Rate	136,484	<= 10.2	9.8	no data	Below Benchmark	11.8	12.7	2.03	
		Mental Health - Poor Mental Health Days	2006-12	Health Outcomes	Rate	104,042	n/a	3.6	3.47	Below Benchmark	3.6	4	0	
		Mental Health - Depression Among Medicare Beneficiaries	2012	Health Outcomes	Percentage	14,183	n/a	13.4%	15.5%	Below Benchmark	11.9%	12.8%	-1.49%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	206.2	247.2	49.2	
		Mental Health - Needing Mental Health Care	2013-14	Health Outcomes	Percentage	105,000	n/a	15.9%	no data	Below Benchmark	12.9%	11.3%	-3.00%	
	Related	Lack of Social or Emotional Support	2006-12	Social & Economic Factors	Percentage	104,042	n/a	24.6%	20.7%	Below Benchmark	22.2%	21.0%	-2.40%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	206.2	247.2	49.2	
		Violence - Youth Intentional Injury	2011-13	Social & Economic Factors	Rate	15,181	n/a	738.7	no data	Below Benchmark	857.0	537.9	118.3	
		Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	2011-2013, 2013-US	Health Outcomes	Percentage		n/a	32.5%	31.7%	Below Benchmark	n/a	32.5%		
Obesity/HEAL/ Diabetes	Core	Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	38.4%	37.0%	2.55%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	26.7%	24.0%	4.38%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	20.7%	19.5%	1.40%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	18.4%	14.8%	-0.56%	
		Diabetes Prevalence	2012	Health Outcomes	Percentage	103,923	n/a	8.1%	9.1%	Below Benchmark	8.2%	6.8%	0.15%	
		Diabetes Hospitalizations	2011	Health Outcomes	Rate		n/a	10.4	no data	Below Benchmark	7.7	7.4	-2.75	
		Percent of adults who have diabetes (20+ years old)	2014, 2012-US	Health Outcomes	Percentage		n/a	9.3%	12.3%	Below Benchmark	n/a	4.3%		
		Heart Disease Prevalence	2011-12	Health Outcomes	Percentage	102,000	n/a	6.3%	no data	Below Benchmark	8.8%	9.9%	2.50%	
		Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	156.9	152.9	-6.31	
		Mortality - Stroke	2010-12	Health Outcomes	Rate	136,484	n/a	37.4	no data	Below Benchmark	40.8	38.0	3.38	
		Low Fruit/Vegetable Consumption (Adult)	2005-09	Health Behaviors	Percentage	101,137	n/a	71.5%	75.7%	Below Benchmark	71.5%	64.7%	-6.80%	
		Low Fruit/Vegetable Consumption (Youth)	2011-12	Health Behaviors	Percentage	16,000	n/a	47.4%	no data	Below Benchmark	47.5%	51.6%	0.10%	
		Fruit/Vegetable Expenditures	2014	Health Behaviors	Percentage		n/a	14.1%	12.7%	Above Benchmark	14.1%	suppressed	0.04%	
		Soft Drink Expenditures	2014	Health Behaviors	Percentage		n/a	3.6%	4.0%	Below Benchmark	3.5%	suppressed	-0.14%	
		Food Environment - Fast Food Restaurants	2011	Physical Environment	Rate	136,484	n/a	74.5	72.0	Below Benchmark	63.0	63.0	-11.51	
		Food Environment - Grocery Stores	2011	Physical Environment	Rate	136,484	n/a	21.5	21.1	Above Benchmark	22.5	27.8	0.94	
		Food Environment - WIC-Authorized Food Stores	2011	Physical Environment	Rate	138,088	n/a	15.8	15.6	Above Benchmark	14.2	17.4	-1.6	
		Food Security - Food Desert Population	2010	Social & Economic Factors	Percentage	136,484	n/a	14.3%	23.6%	Below Benchmark	18.4%	13.0%	4.05%	

Health Indicators								Benchmarks		Needs Score				
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		Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	15.9%	13.4%	-0.69%	
		Physical Inactivity (Youth)	2013-14	Health Behaviors	Percentage	4,724	n/a	35.9%	no data	Below Benchmark	39.8%	31.1%	3.85%	
	Related	Park Access	2010	Physical Environment	Percentage	136,484	n/a	58.6%	no data	Above Benchmark	70.0%	57.6%	11.44%	
		Transit - Walkability	2012	Physical Environment	percentage		n/a	1.7%	2.0%	Below Benchmark	0.0%	no data	-1.65%	
		Recreation and Fitness Facility Access	2012	Physical Environment	Rate	136,484	n/a	8.7	9.4	Above Benchmark	10.9	12.5	2.21	
		Breastfeeding (Any)	2012	Health Behaviors	percentage	1,194	n/a	93.0%	no data	Above Benchmark	95.8%	97.6%	2.81%	
		Breastfeeding (Exclusive)	2012	Health Behaviors	Percentage	1,194	n/a	64.8%	no data	Above Benchmark	82.5%	87.3%	17.73%	
		Food Security - School Breakfast Program	2013	Social & Economic Factors	Rate		n/a	3.9	4.2	Below Benchmark	3.9	no data	0	
		Economic Security - Commute Over 60 Minutes	2009-13	Social & Economic Factors	Percentage	61,338	n/a	10.1%	8.1%	Below Benchmark	13.3%	9.0%	3.17%	
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	13.8%	12.0%	-2.48%	
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	15.2%	14.4%	12.51%	
		Commute to Work - Walking/Biking	2009-13	Health Behaviors	Percentage	64,876	n/a	3.8%	3.4%	Above Benchmark	3.6%	5.1%	-0.22%	
		Diabetes Management (Hemoglobin A1c Test)	2012	Clinical Care	Percentage	11,517	n/a	81.5%	84.6%	Above Benchmark	76.6%	80.1%	-4.86%	
		Commute to Work - Alone in Car	2009-13	Health Behaviors	Percentage	64,876	n/a	73.2%	76.4%	Below Benchmark	74.7%	76.1%	1.50%	
		Percent of children age 2-11 drinking one or more sugar sweetened beverages per day	2011-12	Health Behaviors	Percentage		n/a	27.0%	no data	Below Benchmark	n/a	18.6%		
		Percent of 5th, 7th and 9th graders who are physically fit ** (in the healthy fitness zone for aerobic capacity)	2013-14 school year	Health Behaviors	Percentage		n/a	64.1%	no data	Above Benchmark	n/a	68.9%		
		Walking/Biking/Skating to School	2011-12	Health Behaviors	Percentage	27,778	n/a	43.0%	no data	Above Benchmark	33.6%	36.0%	-9.40%	
Oral Health	Core	Poor Dental Health	2006-10	Health Outcomes	Percentage	102,821	n/a	11.3%	15.7%	Below Benchmark	9.9%	7.6%	-1.37%	
		Dental Care - No Recent Exam (Adult)	2006-10	Clinical Care	Percentage	102,821	n/a	30.5%	30.2%	Below Benchmark	20.9%	12.4%	-9.61%	
		Dental Care - No Recent Exam (Youth)	2013-14	Clinical Care	Percentage	18,000	n/a	18.5%	no data	Below Benchmark	22.0%	42.6%	3.50%	x
		Absence of Dental Insurance Coverage	2009	Clinical Care	Percentage	96,000	n/a	40.9%	no data	Below Benchmark	40.3%	43.7%	-0.60%	
		Health Professional Shortage Area - Dental	2015, March	Clinical Care	Percentage	136,484	n/a	4.9%	32.0%	Below Benchmark	0.0%	0.0%	-4.93%	
	Related	Soft Drink Expenditures	2014	Health Behaviors	Percentage		n/a	3.6%	4.0%	Below Benchmark	3.5%	suppressed	-0.14%	
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	15.2%	14.4%	12.51%	
		Dental Care - Lack of Affordability (Youth)	2009	Clinical Care	Percentage	31,000	n/a	6.3%	no data	Below Benchmark	2.8%	4.1%	-3.50%	
		Access to Dentists	2013	Clinical Care	Rate	140,326	n/a	77.5	63.2	Above Benchmark	81.5	77.0	4.05	
Overall Health		Poor General Health	2006-12	Health Outcomes	Percentage	104,042	n/a	18.4%	15.7%	Below Benchmark	17.1%	16.7%	-1.30%	
		Mortality - Premature Death	2008-10	Health Outcomes	Rate	138,088	n/a	5594.0	6851.0	Below Benchmark	5879.0	5308.0	285	
	Core	Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	70.2%	68.7%	6.80%	
		Percent of adults age 65+ with a physical, mental or emotional disability	2014	Health Outcomes	Percentage		n/a	51.0%	no data	Below Benchmark	n/a	53.0%		
		Population with Any Disability	2009-13	Demographics	Percentage	135,843	n/a	10.1%	12.1%	Below Benchmark	11.2%	10.8%	1.07%	
		Low Birth Weight	2011	Health Outcomes	Percentage	136,484	n/a	6.8%	no data	Below Benchmark	7.0%	6.0%	0.21%	
	Core	Infant Mortality	2006-10	Health Outcomes	Rate	8,265	<= 6.0	5.0	6.5	Below Benchmark	5.8	5.4	0.8	

Health Indicators								Benchmarks		Needs Score				
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Pregnancy and Birth Outcomes		Lack of Prenatal Care	2011	Clinical Care	Percentage	136,484	n/a	3.1%	no data	Below Benchmark	3.9%	no data	0.71%	
		Teen Births (Under Age 20)	2011	Social & Economic Factors	Rate	17,138	n/a	8.5	no data	Below Benchmark	7.4	6.0	-1.1	
	Related	Breastfeeding (Any)	2012	Health Behaviors	percentage	1,194	n/a	93.0%	no data	Above Benchmark	95.8%	97.6%	2.81%	
		Breastfeeding (Exclusive)	2012	Health Behaviors	Percentage	1,194	n/a	64.8%	no data	Above Benchmark	82.5%	87.3%	17.73%	
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	13.8%	12.0%	-2.48%	
Substance Abuse/Tobacco	Core	Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	11.2%	8.6%	-1.60%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage		n/a	1.0%	1.6%	Below Benchmark	1.0%	suppressed	0.02%	
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	20.9%	21.3%	3.70%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage		n/a	12.9%	14.3%	Below Benchmark	13.2%	suppressed	0.28%	
	Related	Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	20.3	36.6	10.27	
		Percent of 11th grade students binge drinking at least once in month prior	2011-13, 2013-US	Health Behaviors	Percentage		n/a	20.7%	24.6%	Below Benchmark	n/a	22.8%		
		Percent of 11th grade students using cigarettes any time within last 30 days	2011-13, 2013-US	Health Behaviors	Percentage		<= 21.0%	10.2%	21.1%	Below Benchmark	n/a	11.8%		
		Percent of 11th grade students reporting marijuana use within the last 30 days	2011-13 , 2013-US	Health Behaviors	Percentage		n/a	22.0%	25.5%	Below Benchmark	n/a	24.9%		
Vaccine-Preventable Infectious Disease	Core	Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	70.2%	68.7%	6.80%	
		Percent of kindergarteners with all required immunizations	2014-15	Clinical Care	Percentage		>= 95.0%	90.4%	no data	Above Benchmark	n/a	93.7%		
Violence/Injury Prevention	Core	Mortality - Homicide	2010-12	Health Outcomes	Rate	136,484	<= 5.5	5.2	no data	Below Benchmark	7.1	1.2	1.92	
		Mortality - Suicide	2010-12	Health Outcomes	Rate	136,484	<= 10.2	9.8	no data	Below Benchmark	11.8	12.7	2.03	
		Mortality - Motor Vehicle Accident	2010-12	Health Outcomes	Rate	136,484	<= 12.4	5.2	no data	Below Benchmark	4.4	4.0	-0.8	
		Mortality - Pedestrian Accident	2010-12	Health Outcomes	Rate	136,484	<= 1.3	2.0	no data	Below Benchmark	1.4	1.1	-0.56	
		Violence - Youth Intentional Injury	2011-13	Social & Economic Factors	Rate	15,181	n/a	738.7	no data	Below Benchmark	857.0	537.9	118.3	
		Violence - Assault (Injury)	2011-13	Social & Economic Factors	Rate	138,519	n/a	290.3	no data	Below Benchmark	315.4	193.2	25.1	
		Violence - Domestic Violence	2011-13	Social & Economic Factors	Rate	61,326	n/a	9.5	no data	Below Benchmark	10.2	2.7	0.7	
		Violence - Assault (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	249.4	246.9	Below Benchmark	270.2	308.5	20.8	
		Violence - Robbery (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	149.5	116.4	Below Benchmark	115.2	51.0	-34.3	
	Related	Violence - All Violent Crimes	2010-12	Social & Economic Factors	Rate	137,980	n/a	425.0	395.5	Below Benchmark	416.4	383.6	-8.6	
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	20.9%	21.3%	3.70%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage		n/a	12.9%	14.3%	Below Benchmark	13.2%	suppressed	0.28%	
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	20.3	36.6	10.27	
		Transit - Walkability	2012	Physical Environment	Percentage		n/a	1.7%	2.0%	Below Benchmark	0.0%	no data	-1.65%	
		Violence - Rape (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	21.0	27.3	Below Benchmark	26.2	22.5	5.2	
		Violence - School Suspensions	2013-14	Social & Economic Factors	Rate	41,712	n/a	4.0	no data	Below Benchmark	25.8	3.5	21.71	
		Violence - School Expulsions	2013-14	Social & Economic Factors	Rate	41,712	n/a	0.1	no data	Below Benchmark	0.1	0.0	-0.03	
		Percentage of 11th grade students reporting current gang involvement	2012-13	Social & Economic Factors	Percentage		n/a	7.5%	no data	Below Benchmark	n/a	8.1%		

Health Indicators								Benchmarks		Needs Score				
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Napa County Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	KFH Service Area	Napa County	Difference Between KFH Service Area and State Value	Stastistically unstable County
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	2011-2013	Social & Economic Factors	Percentage		n/a	7.6%	no data	Below Benchmark	n/a	8.3%		
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	2014, 2013- US	Social & Economic Factors	Rate/1,000		<=8.5	9.0	9.1	Below Benchmark	n/a	8.1		
		Unintentional injuries age-adjusted mortality rate per 100,000 population	2011-13, 2013-US	Health Outcomes	Rate		<= 36.4	27.9	39.4	Below Benchmark	n/a	30.7		
Older Adult Health	Core	Alzheimer's disease age adjusted mortality rate	2001-13, 2013-US	Health Outcomes	Rate/100,000		n/a	30.8	23.5	Below Benchmark	n/a	31.0		
		Percent People 65 years or Older In Poverty (100%FPL)	2009-13	Social & Economic Factors	Percentage		n/a	9.9%	9.4%	Below Benchmark	n/a	6.8%		
		Percent of adults age 65+ with a physical, mental or emotional disability	2014	Health Outcomes	Percentage		n/a	51.0%	no data	Below Benchmark	n/a	53.0%		
		Elder Index (Single elder head of household), percentage above 100% FPL, but below the Elder Index	2011	Social & Economic Factors	Percentage		n/a	30.9%	no data		n/a	33.4%		
		Elder Index (Elder Couple), percentage above 100% FPL, but below the Elder Index	2011	Social & Economic Factors	Percentage		n/a	20.7%	no data		n/a	13.1%		
		Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	70.2%	68.7%	6.80%	

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Absence of Dental Insurance Coverage	Percent Adults Without Dental Insurance	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2009.
Access to Dentists	Dentists, Rate per 100,000 Pop.	Total Population, 2013	US Department of Health & Human Services,Health Resources and Services Administration,Area Health Resource File. 2013.
Access to Mental Health Providers	Mental Health Care Provider Rate (Per 100,000 Population)	Estimated Population	University of Wisconsin Population Health Institute,County Health Rankings. 2014.
Access to Primary Care	Primary Care Physicians, Rate per 100,000 Pop.	Total Population, 2012	US Department of Health & Human Services,Health Resources and Services Administration,Area Health Resource File. 2012.
Air Quality - Ozone (O3)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Total Population	Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network. 2008.
Air Quality - Particulate Matter 2.5	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Total Population	Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network. 2008.
Alcohol - Excessive Consumption	Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	Total Population 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.
Alcohol - Expenditures	Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
Alzheimer's age adjusted mortality rate	Alzheimer's age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
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.
Asthma - Prevalence	Percent Adults with Asthma	Survey Population(Adults Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Breastfeeding (Any)	Percentage of Mothers Breastfeeding (Any)	Total In-Hospital Births	California Department of Public Health,CDPH - Breastfeeding Statistics. 2012.
Breastfeeding (Exclusive)	Percentage of Mothers Breastfeeding (Exclusively)	Total In-Hospital Births	California Department of Public Health,CDPH - Breastfeeding Statistics. 2012.
Cancer Incidence - Breast	Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	Female Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Cervical	Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	Female Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Colon and Rectum	Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	Total Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Cancer Incidence - Lung	Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	Total Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Prostate	Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	Male Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Screening - Mammogram	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Female Medicare Enrollees Age 67-69	Dartmouth College Institute for Health Policy & Clinical Practice,Dartmouth Atlas of Health Care. 2012.
Cancer Screening - Pap Test	Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	Female Population 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.
Cancer Screening - Sigmoid/Colonoscopy	Percent Adults Screened for Colon Cancer (Age-Adjusted)	Total Population Age 50+	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.
Change in Total Population	Percent Population Change, 2000-2010	Total Population, 2000 Census	US Census Bureau,Decennial Census. 2000 - 2010.
Children Eligible for Free/Reduced Price Lunch	Percent Students Eligible for Free or Reduced Price Lunch	Total Students	National Center for Education Statistics,NCES - Common Core of Data. 2013-14.
Climate & Health - Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Total Population	Multi-Resolution Land Characteristics Consortium,National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Climate & Health - Drought Severity	Percentage of Weeks in Drought (Any)		US,Drought,Monitor.,2012-14.
Climate & Health - Heat Index Days	Percentage of Weather Observations with High Heat Index Values:%	Total Weather Observations	National Oceanic and Atmospheric Administration,North America Land Data Assimilation System (NLDAS) . Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
Climate & Health - Heat Stress Events	Heat-related Emergency Department Visits, Rate per 100,000 Population	Number of Heat-related Emergency Room Visits	California Department of Public Health,CDPH - Tracking. 2005-12.
Climate & Health - No Access to Air Conditioning	Percentage of Housing Units with No Air Conditioning	Total Occupied Housing Units (2010)	US Census Bureau,American Housing Survey. 2011, 2013.
Commute to Work - Alone in Car	Percentage of Workers Commuting by Car, Alone	Population Age 16+	US Census Bureau,American Community Survey. 2009-13.
Commute to Work - Walking/Biking	Percentage Walking or Biking to Work	Population Age 16+	US Census Bureau,American Community Survey. 2009-13.
Dental Care - Lack of Affordability (Youth)	Percent Population Age 5-17 Unable to Afford Dental Care	Estimated Total Population Age 5-17	University of California Center for Health Policy Research,California Health Interview Survey. 2009.
Dental Care - No Recent Exam (Adult)	Percent Adults Without Recent Dental Exam	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Dental Care - No Recent Exam (Youth)	Percent Youth Without Recent Dental Exam	Estimated Total Population Age 2-13	University of California Center for Health Policy Research,California Health Interview Survey. 2013-14.
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.
Diabetes Management (Hemoglobin A1c Test)	Percent Medicare Enrollees with Diabetes with Annual Exam	Total Medicare Enrollees	Dartmouth College Institute for Health Policy & Clinical Practice,Dartmouth Atlas of Health Care. 2012.
Diabetes Prevalence	Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Drinking Water Safety	Percentage of Population Potentially Exposed to Unsafe Drinking Water	Estimated Total Population	University of Wisconsin Population Health Institute,County Health Rankings. 2012-13.
Economic Security - Commute Over 60 Minutes	Percentage of Workers Commuting More than 60 Minutes	Population Age 16+ that Commutes to Work	US Census Bureau,American Community Survey. 2009-13.
Economic Security - Households with No Vehicle	Percentage of Households with No Motor Vehicle	Total Occupied Households	US Census Bureau,American Community Survey. 2009-13.
Economic Security - Unemployment Rate	Unemployment Rate	Labor Force	US Department of Labor,Bureau of Labor Statistics. 2015 - June.
Education - Head Start Program Facilities	Head Start Programs Rate (Per 10,000 Children Under Age 5)	Total Children Under Age 5	US Department of Health & Human Services,Administration for Children and Families. 2014.
Education - High School Graduation Rate	Cohort Graduation Rate	Cohort Size	California,Department,of,Education.,2013.
Education - Less than High School Diploma (or Equivalent)	Percent Population Age 25+ with No High School Diploma	Total Population Age 25+	US Census Bureau,American Community Survey. 2009-13.
Education - Reading Below Proficiency	Percentage of Grade 4 ELA Test Score Not Proficient	Total Students with Scores	California,Department,of,Education.,2012-13.
Education - School Enrollment Age 3-4	Percentage of Population Age 3-4 Enrolled in School	Population Age 3-4	US Census Bureau,American Community Survey. 2014.
Elder Index from UCLA center for Health Policy Research - economic security for older adults	Elder Index from UCLA center for Health Policy Research - economic security for older adults	Total Adults 65+	UCLA, http://healthpolicy.ucla.edu/programs/health-disparities/elder-health/Documents/Hidden%20Poor%20By%20County.pdf
Federally Qualified Health Centers	Federally Qualified Health Centers, Rate per 100,000 Population	Total Population	US Department of Health & Human Services,Center for Medicare & Medicaid Services,Provider of Services File. June 2014.
Female Population	Percent Female Population	Total Population	US Census Bureau,American Community Survey. 2009-13.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Food Environment - Fast Food Restaurants	Fast Food Restaurants, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2011.
Food Environment - Grocery Stores	Grocery Stores, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2011.
Food Environment - WIC-Authorized Food Stores	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	Total Population (2011 Estimate)	US Department of Agriculture,Economic Research Service,USDA - Food Environment Atlas. 2011.
Food Security - Food Desert Population	Percent Population with Low Food Access	Total Population	US Department of Agriculture,Economic Research Service,USDA - Food Access Research Atlas. 2010.
Food Security - Food Insecurity Rate	Percentage of the Population with Food Insecurity	Total Population	Feeding,America.,2012.
Food Security - Population Receiving SNAP	Percent Population Receiving SNAP Benefits	Total Population	US Census Bureau,Small Area Income & Poverty Estimates. 2011.
Food Security - School Breakfast Program	Average Daily School Breakfast Program Participation Rate	Total Population	US Department of Agriculture,Food and Nutrition Service,USDA - Child Nutrition Program. 2013.
Fruit/Vegetable Expenditures	Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
Health Professional Shortage Area - Dental	Percentage of Population Living in a HPSA	Total Area Population	US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration. March 2015.
Health Professional Shortage Area - Primary Care	Percentage of Population Living in a HPSA	Total Area Population	US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration. March 2015.
Heart Disease Prevalence	Percent Adults with Heart Disease	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
High Blood Pressure - Unmanaged	Percent Adults with High Blood Pressure Not Taking Medication	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Hispanic Population	Percent Population Hispanic or Latino	Total Population	US Census Bureau,American Community Survey. 2009-13.
Housing - Assisted Housing	HUD-Assisted Units, Rate per 10,000 Housing Units	Total Housing Units (2010)	US,Department,of,Housing,and,Urban,Development.,2013.
Housing - Cost Burdened Households	Percentage of Households where Housing Costs Exceed 30% of Income	Total Households	US Census Bureau,American Community Survey. 2010-14.
Housing - Substandard Housing	Percent Occupied Housing Units with One or More Substandard Conditions	Total Occupied Housing Units	US Census Bureau,American Community Survey. 2009-13.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Housing - Vacant Housing	Vacant Housing Units, Percent	Total Housing Units	US Census Bureau,American Community Survey. 2009-13.
Income Inequality	Gini Index Value	Total Households	US Census Bureau,American Community Survey. 2009-13.
Infant Mortality	Infant Mortality Rate (Per 1,000 Births)	Total 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.
Insurance - Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid	Total Population(For Whom Insurance Status is Determined)	US Census Bureau,American Community Survey, 2010-14.
Insurance - Uninsured Population	Percent Uninsured Population	Total Population (For Whom Insurance Status is Determined)	US Census Bureau,American Community Survey. 2010-14.
Lack of a Consistent Source of Primary Care	Percentage Without Regular Doctor	Estimated Total Population	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
Lack of Prenatal Care	Percent Mothers with Late or No Prenatal Care	Total Population	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Lack of Social or Emotional Support	Percent Adults Without Adequate Social / Emotional Support (Age-Adjusted)	Total Population 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.
Linguistically Isolated Households	Percent Linguistically Isolated Population	Total Population Age 5+	US Census Bureau,American Community Survey. 2009-13.
Liquor Store Access	Liquor Stores, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2012.
Low Birth Weight	Percent Low Birth Weight Births	Total Population	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Low Fruit/Vegetable Consumption (Adult)	Percent Adults with Inadequate Fruit / Vegetable Consumption	Total Population(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. 2005-09.
Low Fruit/Vegetable Consumption (Youth)	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	Estimated Total Population Age 2-13	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
Male Population	Percent Male Population	Total Population	US Census Bureau,American Community Survey. 2009-13.
Median Age	Median Age	Total Population	US Census Bureau,American Community Survey. 2009-13.
Mental Health - Depression Among Medicare Beneficiaries	Percentage of Medicare Beneficiaries with Depression	Total Medicare Beneficiaries	Centers,for,Medicare,and,Medicaid,Services.,2012.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Mental Health - Needing Mental Health Care	Percentage with Poor Mental Health	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2013-14.
Mental Health - Poor Mental Health Days	Average Number of Mentally Unhealthy Days per Month	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
Mortality - Cancer	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Homicide	Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Ischaemic Heart Disease	Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Motor Vehicle Accident	Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Pedestrian Accident	Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Premature Death	Years of Potential Life Lost, Rate per 100,000 Population	Total Population, 2008-2010 Average	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.
Mortality - Stroke	Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Suicide	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Obesity (Adult)	Percent Adults with BMI > 30.0 (Obese)	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Obesity (Youth)	Percent Obese	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.
Overweight (Adult)	Percent Adults Overweight	Survey Population(Adults Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight (Youth)	Percent Overweight	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.
Park Access	Percent Population Within 1/2 Mile of a Park	Total Population, 2010 Census	US Census Bureau,Decennial Census. ESRI Map Gallery. 2010.
Percent living in overcrowded housing conditions (>1.5 persons/room)	Percent living in overcrowded housing conditions (>1.5 persons/room)	Total Population	ACS, 2009-2013, table number B25014

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Percent of 11th grade students binge drinking at least once in the month prior	Percent of 11th grade students binge drinking at least once in the month prior	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students reporting driving after drinking (respondent or by friend)	Percent of 11th grade students reporting driving after drinking (respondent or by friend)	11th Grade Students	CHKS/YRBSS, (no other info given)
Percent of 11th grade students reporting harassment on school property related to their sexual orientation	Percent of 11th grade students reporting harassment on school property related to their sexual orientation	11th Grade Students	CHKS, 2011-2013
Percent of 11th grade students reporting marijuana use within the last 30 days	Percent of 11th grade students reporting marijuana use within the last 30 days	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students using cigarettes any time within last 30 days	Percent of 11th grade students using cigarettes any time within last 30 days	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of adults age 65+ with a physical, mental or emotional disability	Percent of adults age 65+ with a physical, mental or emotional disability	Total Adults 65+	CHIS, 2014
Percent of children age 2-11 drinking one or more sugar sweetened beverages per day	Percent of children age 2-11 drinking one or more sugar sweetened beverages per day	Total Youth 2-11	CHIS policy report
Percent of children ever diagnosed with asthma (ages 17 and below)	Percent of children ever diagnosed with asthma (ages 17 and below)	Total Youth 0-17	CHIS/NHIS
Percent of kindergarteners with all required immunizations	Percent of kindergarteners with all required immunizations	Kindergarten students	CDPH, 2014-15, kindergarten table
Percent People 65 years or Older In Poverty	Percent People 65 years or Older In Poverty	Total Adults 65+	ACS, 2009-2013, table number S1703
Percentage of 11th grade students reporting current gang involvement	Percentage of 11th grade students reporting current gang involvement	11th Grade Students	CHKS, 2011-2013
Pesticide Use - Pounds of Pesticides Applied	Pounds of Agricultural Pesticides Used in 2013	N/A	California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting (PUR) Data. 2013.
Pesticide Use - Rank of Pesticide Use Among CA Counties			California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting (PUR) Data. 2013.
Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Physical Inactivity (Youth)	Percent Physically Inactive	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Pneumonia Vaccinations (Age 65+)	Percent Population Age 65+ with Pneumonia Vaccination (Age-Adjusted)	Total 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	Percent Adults with Poor Dental Health	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor General Health	Percent Adults with Poor or Fair Health (Age-Adjusted)	Total Population 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.
Population Age 0-4	Percent Population Age 0-4	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 18-24	Percent Population Age 18-24	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 25-34	Percent Population Age 25-34	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 35-44	Percent Population Age 35-44	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 45-54	Percent Population Age 45-54	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 5-17	Percent Population Age 5-17	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 55-64	Percent Population Age 55-64	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population Age 65+	Percent Population Age 65+	Total Population	US Census Bureau,American Community Survey. 2009-13.
Population with Any Disability	Percent Population with a Disability	Total Population (For Whom Disability Status Is Determined)	US Census Bureau,American Community Survey. 2009-13.
Population with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency	Total Population	US Census Bureau,American Community Survey. 2009-13.
Poverty - Children Below 100% FPL	Percent Population Under Age 18 in Poverty	Total Population	US Census Bureau,American Community Survey. 2010-14.
Poverty - Population Below 100% FPL	Percent Population in Poverty	Total Population	US Census Bureau,American Community Survey. 2010-14.
Poverty - Population Below 200% FPL	Percent Population with Income at or Below 200% FPL	Total Population	US Census Bureau,American Community Survey. 2010-14.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
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.
Prostate cancer age adjusted mortality rate	Prostate cancer age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
Recreation and Fitness Facility Access	Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2012.
Soft Drink Expenditures	Soda Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
STD - Chlamydia	Chlamydia Infection Rate (Per 100,000 Pop.)	Total Population	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.
STD - 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.
STD - HIV Prevalence	Population with HIV / AIDS, Rate (Per 100,000 Pop.)	Total Population	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.
STD - No HIV Screening	Percent Adults Never Screened for HIV / AIDS	Survey Population(Smokers Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Substantiated allegations of child maltreatment per 1,000 children ages 0-17	Substantiated allegations of child maltreatment per 1,000 children ages 0-17	Total Youth 0-17	UC Berkeley/child maltreatment 2013 publication from Children's Bureau, http://cssr.berkeley.edu/ucb_childwelfare/refRates.aspx
Teen Births (Under Age 20)	Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	Female PopulationUnder Age 20	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Tobacco Expenditures	Cigarette Expenditures, Percentage of Total Household Expenditures		Nielsen,Nielsen SiteReports. 2014.
Tobacco Usage	Percent Population Smoking Cigarettes(Age-Adjusted)	Total Population 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.
Total Population	Population Density (Per Square Mile)	Total Population	US Census Bureau,American Community Survey. 2009-13.
Transit - Public Transit within 0.5 Miles	Percentage of Population within Half Mile of Public Transit	Total Population	Environmental Protection Agency,EPA Smart Location Database. 2011.
Transit - Road Network Density	Total Road Network Density (Road Miles per Acre)	Total Area (Acres)	Environmental Protection Agency,EPA Smart Location Database. 2011.
Transit - Walkability	Percent Population Living in Car Dependent (Almost Exclusively) Cities		Walk,Score®.,2012.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Unintentional injuries age adjusted mortality rate	Unintentional injuries age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
Violence - All Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)	Total Population	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.
Violence - Assault (Crime)	Assault Rate (Per 100,000 Pop.)	Total Population	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.
Violence - Assault (Injury)	Assault Injuries, Rate per 100,000 Population	Total Population	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. 2009-11.
Violence - Domestic Violence	Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	Females Age 10+	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. 2009-11.
Violence - Rape (Crime)	Rape Rate (Per 100,000 Pop.)	Total Population	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.
Violence - Robbery (Crime)	Robbery Rate (Per 100,000 Pop.)	Total Population	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.
Violence - School Expulsions	Expulsion Rate	Total Student Enrollment	California,Department,of,Education.,
Violence - School Suspensions	Suspension Rate	Total Student Enrollment	California,Department,of,Education.,
Violence - Youth Intentional Injury	Intentional Injuries, Rate per 100,000 Population (Youth Age 13 - 20)	Total Youth Age 13-20	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. 2009-11.
Walking/Biking/Skating to School	Percentage Walking/Skating/Biking to School	Estimated Total Population Age 5-17	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.

Data Collection Method	Title/Name	Number	Target Group(s) Represented* (interviewee or at least one participant in the focus group self-identified as a leader, member, or representative of the following populations)					Date Input Was Gathered
Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
NAPA COUNTY								
Interview	Executive Director, First 5 Napa County	1						10/8/15
Interview	Executive Director, Up Valley Family Centers	1			X	X	X	10/5/15
Interview	Director, Napa County Health & Human Services	1	X	X	X	X	X	10/2/15
Interview	Program Director, South Napa Shelter	1					X	9/23/15
Interview	Mayor, American Canyon	1			X	X	X	10/7/15
Interview	Director, American Canyon Family Resource Center	1			X	X	X	10/6/15
Interview	Previous Executive Director, On the Move	1			X		X	9/17/15
Interview	Program Director, Napa Valley Hospice and Adult Day Services	1			X			10/5/15

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Lead Facilitator, Napa Valley Hospice and Adult Day Services	1						9/29/15
Interview	Executive Director, Napa Emergency Women's Services	1			X		X	10/16/15
Interview	Program Director, VOICES/On The Move	1			X	X	X	10/14/15
Interview	Director, Napa Valley Unified School District Student Services	1		X	X	X	X	10/2/15
Interview	CEO, Queen of the Valley	1		X	X	X	X	10/6/15
Interview	CEO, St. Helena Hospital Napa Valley	1		X	X	X	X	10/7/15
Interview	Physician In Charge, Kaiser Permanente Napa Solano	1		X	X	X	X	10/6/15
Interview	CEO, Clinic Ole Federally Qualified Health Center	1						9/21/15
Interview	Public Health Officer, Napa County Health & Human Services	1	X					11/4/15
Interview	Public Health Officer, California Health Workforce	1	X	X	X	X	X	10/20/15

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Focus Group	Calistoga; Latino Population	10		X	X	X		10/13/15
Focus Group	Calistoga; Older Adult Population	13		X	X	X		10/13/15
Focus Group	County-wide; Youth Population	10		X	X	X		10/15/15
Focus Group	American Canyon; General Population	14		X	X	X		10/21/15
SOLANO COUNTY								
Interview	Family Resource Centers	5			X	X	X	08/19/15
Interview	Housing and Community Development	1						10/1/15
Interview	La Clinica Benicia CAC Health Plan Partnership	4						8/14/15
Interview	Planned Parenthood	1						8/7/15
Interview	Family Resource Centers	5			X	X	X	08/19/15
Focus Group	Youth Internship Program	22						07/31/15
Focus Group	Parent Leadership Program	2						08/27/15

* Indicates self-identification of interviewees or focus group participants as a leader, member, or representative of each specified population. In some cases, individuals did not self-identify as a representative of any of the listed groups. Data about self-identified target group(s) represented by interviewee or focus group participants not obtained for data collected in Solano County.

Kaiser Foundation Hospital-Vallejo
Community Health Needs Assessment
Appendix D. Primary Data Collection Protocols
Napa County Key Informant Interview Protocol
FINAL

Introduction

Hello, my name is _____ and I work for Harder+Company Community Research/ Raimi+Associates. We are working with Napa County Public Health and several Napa non-profit hospitals on a comprehensive community health assessment, including Kaiser Permanente, Queen of the Valley Medical Center, County of Napa, and St. Helena Hospital.

You have been identified as an individual with extensive and important knowledge of the *[Napa County Community / Specific subpopulation of Napa County]* that can help us with the CHNA -- to help ensure that we get a clear picture of health-related issues that impact our Napa County residents. We are very interested in having you share thoughts and ideas that go beyond access to medical care, taking into consideration social, economic, and environmental factors that impact health. Your input will inform the development of the CHNA as well as a community health implementation plan for all of Napa County

This interview will take about 30-45 minutes. Our discussion today will be incorporated into the Community Health Needs Assessment for Napa County. Everything we talk about today is confidential. That means that when I write up a report of what was said, I won't use your name or any other information to identify who you are. However, there is always a chance that someone is able to identify what you said.

Do you have any questions so far?

Before we start talking about the specifics, I want to make sure you know that, during this interview:
There is no right or wrong answer, just your ideas.
It's ok if you don't have an answer or opinion about a particular question. It is just as important for us to know that too. "I don't know" is an ok thing to say. And finally,
If at any time while we are talking you are not sure what I mean or have questions, do not hesitate to ask questions and let me know.

I would like to take notes and record during the interview so that I make sure that I get your statements exactly how you stated them.
Is it ok for me to take notes? Great! Just as a reminder, since I will be typing notes, there might be some short delays to make sure I am able to capture everything you say.
Is it ok for me to record our conversation?
Before we begin, do you have any questions?

Questions
a) Would you give me a brief description of your organization, and your role there?

b) Within Napa County, what geographic area do you primarily serve?

1. a) What are the *most important health needs* that have the greatest impact on overall health in Napa County?

b) What are the specific populations that are most adversely affected by the health problems you just mentioned?

c) The following were identified as priority health issues during the previous CHNA process in 2013:

1. Drug and Alcohol Abuse
2. Inactivity/lack of exercise
3. Unsafe roads/Sidewalk conditions
4. Mental health issues
5. Agricultural pesticides

Can you tell me how aware you are of these health issues? How do they impact overall health in Napa County? In what ways have these health issues changed in recent years?

d) What existing community assets and resources could be used to address these health issues and inequities [and the health issues you think are most important]?

2. a) What health behaviors do you think have the biggest influence on the issues we just discussed in your community?

b) The following were identified as significant health behaviors during the previous CHNA process in 2013:

a. Binge drinking (In 2009, 38% of adults in Napa reported binge drinking at least once in the past year)
b. Tobacco use (13.8% of adults were current tobacco users)
c. Child consumption of sugary beverages (41% of children between ages 2-11 were drinking 1 or more sugar sweetened beverages every day)
d. Inadequate consumption of fruits and vegetables among children (55% of children in Napa County were eating the recommended amount of fruits and vegetables on a daily basis)
e. Harassment among youth (In 2011-2012, 27% of 11th graders and 33% of 9th graders reported being harassed on school property during the previous 12 months)

Can you tell me how aware you are of these health behaviors? How do they impact overall health in Napa County? In what ways have these health behaviors changed in recent years?

c) What existing community assets and resources could be used to address these health issues and inequities [i.e. the health issues we just mentioned or those you identified earlier]?

3. a) Are you aware of social factors that influence on the issues we've discussed for your clients/your community? If so, what social issues have the largest influence on these health issues?

b) Are you aware of economic factors that influence the issues we've discussed for your clients/your community? If so, what economic issues have the largest influence on these health issues?

c) The following were identified as socioeconomic conditions in Napa during the previous CHNA process in 2013:

1. Lack of health insurance (In 2011, an estimated 15.8% of Napa residents were uninsured)
2. Food insecurity (In 2009. 52.2% of households in Napa with incomes below 200% of the Federal Poverty Line reported being food insecure)
3. Lack of access to public transportation (In 2013, populations in the Northeastern region of the county did not have access to public transportation service)
4. Performance in school, especially among English Language Learners (45% of 3rd graders and 62% of 4th graders earned a proficient or advanced score in English Language Arts during 2011-2012 school year. Only 15% of English Language Learners earned a proficient or advanced score.)
5. High school dropout among Hispanics/Latinos, English Language Learners, Special Education students, and socioeconomically disadvantaged students (In 2010-2011, the Napa County high school dropout rate was 13.3%. This rate was higher among Hispanics/Latinos, English Language Learners, Special Education students, and socioeconomically disadvantaged students.)

Can you tell me how aware you are of these socioeconomic conditions? How do they impact overall health in Napa County? In what ways have these conditions changed in recent years?

d) What existing community resources could be used to address these health issues and inequities?

4. a) Are you aware of <u>environmental factors</u> that influence the issues we've discussed for your clients/your community? If so, which factors have the biggest influence on overall health in your community?

   b) The following were identified as environmental conditions in Napa during the previous CHNA process in 2013:

   1. Pollution (From 2007-2009, Napa County experienced an average annual ambient fine particulate matter of 8.5mg/m3, compared to CA 11.7 mg/m3. The mean number of unhealthy days of ozone exposure was 0.21 during 2007-2009.)
   2. Pesticide usage (In 2009, 1,542,059 pounds of pesticides were applied in Napa.)
   3. Adequate recreational facilities (Napa County had 13.2 recreational facilities per 100,000 people.)
   4. Access to grocery stores (Napa County had 27.8 grocery stores per 100,000 people.)

   Can you tell me how aware you are of these environmental factors? How do they impact overall health in Napa County? In what ways have these conditions changed?

   c) What existing community resources could be used to address these health issues and inequities?

5. What are the challenges Napa County faces in addressing the health needs you mentioned previously?

   a. Are there any current trends that may have an important impact on the health of Napa County residents?

b. Are there any challenges that may impact economic opportunities in the community? Access to health care services? Community engagement? Public safety?

6. a) Do you have suggestions for systems-level collaborations or changes that could help to address the inequities we just talked about?

   b) Looking across all sectors, who are some current or potential community partners that we have not yet engaged who could help to impact these issues?

We have a brief demographics question we would like to ask. These are strictly for tracking purposes and you do not have to answer these questions if you don't want to.

7. Do you identify as a leader, representative, or member of any of the following communities? Please select all that apply.
   - ☐ Individuals with chronic conditions
   - ☐ Minorities
   - ☐ Medically underserved
   - ☐ Low-income

Those are all the questions I have for you today. Do you have anything else you would like to add?

Thank you for taking the time to have this conversation! The information that you provided will be very helpful not only for the needs assessment but also in crafting actions to address those needs.

Kaiser Foundation Hospital-Vallejo
Community Health Needs Assessment
Napa County Focus Group Protocol
FINAL

Hi everyone. My name is _____ and I will be facilitating today's group. This is _____ and he/she will be taking notes and may jump in with any additional questions throughout the group.

First, we want to thank you for agreeing to be a part of this discussion, which will last about 1-2 hours. Napa County healthcare workers really want to improve the health of your community, and many of those people are sitting at the table together to think about the best ways to do this. The information we gather today will be used as part of a collaborative needs assessment that will help Kaiser Permanente, Queen of the Valley, Adventist Health, and Napa County Public Health to work together to determine what they can do to improve health in Napa County. Additionally, as a part of the Affordable Care Act, the federal government requires nonprofit hospitals to conduct community health needs assessments every three years, and to use the results of these assessments to implement plans to improve community health. This assessment will also fulfill this requirement for the hospitals. Harder+Company and Raimi+Associates are the organizations leading the assessment for the nonprofit hospitals in your area.

In this health needs assessment, we want to be sure to bring in voices that are not always represented. One of the reasons we are having this focus group is because we are really interested in the needs of *[XX group across the county/The community in XX location]*. Please keep this lens in mind as we talk about your experience in your community.
Before we begin, I'd like to talk about a few guidelines for our discussion.

- There are no right or wrong answers.
- Every opinion counts. We will respect other's opinions. It is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.
- Everyone should have an equal chance to speak. Please speak one at a time and do not interrupt anyone else.
- Do not hesitate to ask questions if you are not sure what we mean by something.
- Because we have a limited amount of time and a lot to discuss, I may need to interrupt you to give everyone a chance to speak, or to get to all the questions.
- What's said here, stays here. Everything we discuss today is completely confidential. We will summarize what the group had to say, but will not tell anyone who said what. Your names will never be mentioned. We also ask that you not repeat what is said here outside this room.
- We'd also like to record our conversation. Our note taker will be taking notes so that we remember what people had to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

How do these guidelines sound to everyone? Do you have any questions before we begin?

Introductions/Background

1) Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

Quality of life in community

2) Briefly, please describe what it is like to live in your community.

3) From your perspective, what are the biggest health issues among [criteria of this FG, e.g. the Latino community in Calistoga]?

    3a. Of the health issues you've mentioned, which would you say are the most important or urgent to address? Why?

4) What do you think are some of the biggest reasons why these health issues occur in your community?

    4b. What things keep you and your family from being as healthy as they could be?

5) From your perspective, what health services are lacking for you and the people you know in your community?

5b) From your perspective, what health services are difficult to access for you and the people you know in your community?

- Follow up: What other challenges keep individuals from seeking help?

6) Has the Affordable Care Act [may also be known as Covered California, Obamacare] had any impact on you or the people you know in your community?

Community Assets, Barriers, and Gaps

7) Outside of healthcare, what resources exist in your community to help you and the people you know to live healthy lives?

7a. What are the barriers to accessing these resources?

7b. What resources are missing?

What is needed to improve health?

8) What do you think is [or who is] needed to improve your health or the health of the people you know in your community?

9) Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?

Please make sure to fill out the quick survey before you leave!
Thank you so much for your time!

Thank you for participating in today's discussion group. We would like to ask you a few questions to understand who attended our groups. This survey is VOLUNTARY which means that do not have to participate. It is anonymous- your answers will not be tied to your name or any other personal information and we will report answers of the group as a whole.

1. What race/ethnicity do you identify as? (Please select all that apply.)

☐ Black/African American

☐ White/Caucasian

☐ Hispanic/Latino

☐ Native American

☐ Asian (if checked, please select a choice below):

- o Cambodian
- o Hmong
- o Vietnamese
- o Filipino
- o Other: _____
- o Chinese
- o Pakistani
- o Japanese
- o Thai
- o Korean
- o Laotian
- o East Indian
- o Native Hawaiian or Pacific Islander

2. What is your current gender identity? (Check one that best describes your current gender identity.)

☐ Male ☐ Female ☐ Genderqueer / Gender non-conforming

☐ Trans man ☐ Trans woman ☐ Another gender identity (Fill in the blank.)

☐ Declined to answer _____

3. Do you consider yourself to be…? (Check one that best describes your current sexual orientation.)

☐ Heterosexual or straight ☐ Lesbian ☐ Gay

☐ Bisexual ☐ Queer ☐ Another identity (Fill in the blank.)

☐ Declined to answer _____

4. Do you identify as a person with chronic conditions, or a leader or representative of individuals with chronic conditions?

☐ Yes ☐ No ☐ Declined to answer

5. What is your age group?

☐ 14-24 ☐ 45-64

☐ 25-44 ☐ 65+

6. What is the zip code where you live?

_____ _____ _____ _____ _____

NEXT PAGE →

7. Have you ever served in the U.S. armed forces?

- ☐ Yes
- ☐ No
- ☐ Declined to answer

8. An Advance Directive for Health Care is a document in which you can write down your health care choices and name a person you trust to speak for you about health care matters. Do you have an Advance Directive for Health Care?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

9. What would you estimate your monthly household income is?

- ☐ $0 to $4,999
- ☐ $5,000 to $9,999
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $44,999
- ☐ $45,000 to $54,999
- ☐ $55,000 to $64,999
- ☐ $65,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 and Over

10. How many people, including you, live in your house (this includes everyone related to each other by blood, marriage or a marriage-like relationship including partners and foster children)?

___

Thank you for completing this survey!

VALLEY VISION

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Key Informant Interview Guide

Gathering Information for a Community Health Assessment

Good [morning, afternoon, evening]!

My name is [name] and I'm an employee at Valley Vision, a local, nonprofit consulting firm. Today I will be gathering information, thoughts and opinions from you as part of a community health needs assessment that will inform local leaders on the specific health needs of the community you serve.

As a part of the Affordable Care Act, the federal government requires nonprofit hospitals to conduct community health needs assessments every three years, and to use the results of these assessments to implement plans to improve community health. Valley Vision is the organization leading the assessment for the nonprofit hospitals in your area, which include [insert appropriate hospitals].

You've been identified as an individual with significant knowledge about the health of the community you serve. I have several important questions I'd like to ask you; please feel free to respond openly and candidly to every question. You can also refuse to answer any question or stop the interview at any time.

I will be recording our interview to be sure I capture everything you say. Our team will then transcribe the recording and analyze the transcriptions in order to paint a complete picture of the health needs of the community you serve. Although this interview is confidential, we may use quotes from the transcription in the writing of our final report. However, the quotes *will not* be attributed directly to you.

Before we get started I want to ask you to sign an informed consent document. By signing it, you agree to participate in this interview and give us permission to both record and use the recording in the larger needs assessment [introduce informed consent form and get signed before beginning interview].

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Key Informant Interview Guide

Gathering Information for a Community Health Assessment

Objective 1: To understand the community served by the provider or resident.

1. **Please, tell me about the community you serve.**
    - **Follow Up**: What are the specific geographic areas and/or populations served?
    - Probe for:

      Who? Where? Racial/ethnic make-up, physical environment *(urban/ rural, large/small)*

2. **How would you describe the quality of life in the community you serve?**

Objective 2: To identify and prioritize the significant health needs of the community and groups / locations that struggle with health issues the most

3. **Please describe the health of the community you serve.**
    - Probe for:

      What are the biggest health issues and/or conditions that the community struggles with?

4. **Of the health issues you've mentioned, which would you say are the most important or urgent to address?**
    - **Follow up**: How would you rank these health issues in terms of importance?

5. **What specific locations struggle with health issues the most?**
    - **Follow up**: What specific groups in the community struggle with these health issues the most?
    - Probe for:
        - Socio-demographic make-up (race/ethnic, age, gender, sexual orientation)
        - Disparities/inequities
        - Community subgroups
        - Where do these groups live (area concentration)?

Objective 3: To determine the drivers which influence the health status of the community.

6. **What are the challenges to being healthy for the community you serve?**
    - Probe for challenges/barriers to healthy living on multiple levels:
        - *Individual behavior (Individual/group choices):*
            - Activities or behaviors of specific groups?
            - Attitudes and beliefs of specific groups?
            - Cultural or community norms or beliefs in the community around what it is to be "healthy"?
            - Stress, anxiety and coping strategies of specific groups?
        - *Physical Environment (Physical structure and living conditions):*
            - Sidewalks, building structures, streetlights
            - Transportation routes
            - Places to engage in activity
            - Access to healthy foods
            - Access to preventative services and healthcare
            - Perception of safety

7. **What policies, laws, or regulations prevent the community from living healthy lives?**
    - Probe for:

      Anything you can think of on the local level? The state level? The federal level?

8. **Are you aware of any current or upcoming changes to policies, laws, or regulations that may affect the health of the community?**
    - **Follow up:** What about any upcoming trends, factors, or events that may affect the health of the community?

Objective 4: To determine opportunities and resources for living healthy in the community.

9. **What resources exist in the community to help people live healthy lives?**
    - Probe for:
        - What are the barriers to accessing these resources?
        - What are gaps in these resources? What resources are missing?

10. **What would you say has been the impact of the Affordable Care Act** [may also be known as Covered California, Obamacare] **on the community you serve?**
    - Probe for:
        - Coverage
        - Access to care
        - Identification of providers
        - Quality of care, etc.
        - Changes in individual health-seeking behaviors

Objective 5: To determine the requisites needed to improve the health of the community.

11. **What is [or who is] needed to improve the health of your community?**

Objective 6: To acquire input from persons representing the broad interests of the community.

12. **Can you recommend 1 or 2 additional people, groups or organizations you think would be <u>most</u> important to speak to about the health of the community?**
    - Probe for:
        1 to 2 people, group or organization recommendations

13. **Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?**

VALLEY VISION

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Focus Group Guide

Gathering Information for a Community Health Assessment

Good [morning, afternoon, evening]!

We are _____ (name) and _____ (name), from Valley Vision, a local, nonprofit consulting firm. Today we will be gathering information, thoughts and opinions from you as part of a community health needs assessment that will inform local leaders on the specific health needs of the community you live in.

As a part of the Affordable Care Act, the federal government requires nonprofit hospitals to conduct community health needs assessments every three years, and to use the results of these assessments to implement plans to improve community health. Valley Vision is the organization leading the assessment for the nonprofit hospitals in your area, which include [insert appropriate hospitals].

You've been identified as a source of significant knowledge about the health of your community. We have several important questions we'd like to ask you; please feel free to respond openly and candidly to every question. You can also refuse to answer any question or leave the focus group at any time.

We will be recording during this focus group to be sure we capture everything you say. Our team will then transcribe the recording and analyze the transcriptions in order to paint a complete picture of the health needs of you community. Although this interview is confidential, we may use quotes from the transcription in the writing of our final report. However, the quotes *will not* be attributed directly to you.

Before we get started I want to ask you to sign an informed consent document. By signing it, you agree to participate in this interview and give us permission to both record and use the recording in the larger needs assessment [introduce informed consent form and get signed before beginning interview].

VALLEY VISION

Connect. Partner. Impact.

Focus Group Guide

Gathering Information for a Community Health Assessment

Objective 1: To understand the community served by the provider or resident.

1. **Please, tell me about your community.**
    - **Follow Up**: What are the specific geographic areas and/or who are the populations who live there?
    - Probe for:

      Who? Where? Racial/ethnic make-up, physical environment *(urban/ rural, large/small)*

2. **How would you describe the quality of life in your community?**

Objective 2: To identify and prioritize the significant health needs of the community and groups / locations that struggle with health issues the most

3. **Please describe the health of your community.**
    - Probe for:

      What are the biggest health issues and/or conditions that the community struggles with?

4. **Of the health issues you've mentioned, which would you say are the most important or urgent to address?**
    - **Follow up**: How would you rank these health issues in terms of importance?

5. **What specific locations struggle with health issues the most?**
    - **Follow up**: What specific groups in the community struggle with these health issues the most?
    - Probe for:
        - Socio-demographic make-up (race/ethnic, age, gender, sexual orientation)
        - Disparities/inequities
        - Community subgroups
        - Where do these groups live (area concentration)?

Objective 3: To determine the drivers which influence the health status of the community.

6. **What are the challenges to being healthy in your community?**
    - Probe for challenges/barriers to healthy living on multiple levels:
        - *Individual behavior (Individual/group choices):*
            - Activities or behaviors of specific groups?
            - Attitudes and beliefs of specific groups?
            - Cultural or community norms or beliefs in the community around what it is to be "healthy"?
            - Stress, anxiety and coping strategies of specific groups?
        - *Physical Environment (Physical structure and living conditions):*
            - Sidewalks, building structures, streetlights
            - Transportation routes
            - Places to engage in activity
            - Access to healthy foods
            - Access to preventative services and healthcare
            - Perception of safety

7. **What policies, laws, or regulations prevent your community from being healthy?**
    - Probe for:

      What about on the local level? The state level? The federal level?

8. **Are you aware of any current or upcoming changes to policies, laws, or regulations that may affect the health of the community?**
    - **Follow up:** What about any upcoming trends, factors, or events that may affect the health of the community?

Objective 4: To determine opportunities and resources for living healthy in the community.

9. **What resources exist in your community to help people live healthy lives?**
    - Probe for:
        - What are the barriers to accessing these resources?
        - What are gaps in these resources? What resources are missing?

10. **What would you say has been the impact of the Affordable Care Act** [may also be known as Covered California, Obamacare] **on your community?**
    - Probe for:
        - Coverage
        - Access to care
        - Identification of providers
        - Quality of care, etc.
        - Changes in individual health-seeking behaviors

Objective 5: To determine the requisites needed to improve the health of the community.

11. **What is [or who is] needed to improve the health of your community?**

Objective 6: To acquire input from persons representing the broad interests of the community.

12. **Can you recommend 1 or 2 additional people, groups or organizations you think would be <u>most</u> important to speak to about the health of your community?**
    - Probe for:
        1 to 2 people, group or organization recommendations

13. **Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?**

Kaiser Foundation Hospital-Vallejo
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Appendix E. Prioritization Scoring Matrix

Instructions: For each health need, write down a score between 1 to 7 for each criterion (1 being the lowest and 7 being the highest score possible). For example, if an issue is nearly impossible to prevent, it could be assigned a 1 in "Prevention" but may receive a score of 6 in "Severity". You will then use the clickers to indicate your score for each health need and criterion. Once everyone scores each health need, the scores will be averaged and multiplied by the weighting value to determine an overall score for each health need.

Health Need	Severity	Disparities	Prevention	Co-Benefit
	2	2	1	1
Access to Primary and Oral Health Care				
Economic and Housing Insecurity				
Education				
Cancers				
Mental Health				
Substance Abuse				
Obesity and Diabetes				
Violence and Injury				