



# 2016 Community Health Needs Assessment

Kaiser Foundation Hospital Antioch  
License #550000614

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To provide feedback about this Community Health Needs Assessment, email [CHNA-communications@kp.org](mailto:CHNA-communications@kp.org)

KAISER PERMANENTE NORTHERN CALIFORNIA REGION  
COMMUNITY BENEFIT  
CHNA REPORT FOR KFH-ANTIOCH

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## **I. EXECUTIVE SUMMARY**

### **A. COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) BACKGROUND**

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

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

### **B. SUMMARY OF PRIORITIZED NEEDS**

KFH-Antioch originally worked with 11 hospitals in Contra Costa and Alameda counties to develop a coordinated approach to primary data collection. This allowed non-profit hospitals in the area to

take advantage of economies of scale and to avoid overburdening the community with multiple requests for information.

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

Based on community input and secondary data, KFH-Antioch worked with John Muir Health (JMH) to understand health needs in their shared service areas. KFH-Antioch and JMH then identified local community stakeholders to assist with prioritizing (ranking) the list of health needs via a multiple-criteria scoring system. These needs are listed below in priority order, from highest to lowest.

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

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

Health need	Why is it important?	What do the data say?
<b>1. Economic security</b>	Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child’s life, even if social conditions subsequently improve.	In the KFH-Antioch service area, residents experience food insecurity, and some ethnic groups have higher proportions that are living in poverty than others. Regarding education, the rate of students graduating from high school is lower than both the HP2020 benchmark and Contra Costa County overall. In addition, 18% of children in the KFH-Antioch service area were living in poverty compared to 14% of county children, and many children of color fare worse: Black (31%), Latino (26%), and those of “other” races (26%). In addition, the community felt that there was not enough job training for 18-25 year olds, and the community has too little affordable housing available.
<b>2. Obesity, diabetes, and healthy eating/active living</b>	Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments	There are higher rates of overweight among adults, higher rates of diabetes prevalence, and lower percentages of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages. In addition, in the KFH-Antioch service area ethnic disparities are evident. Latino and Black youth are much more likely to be obese than White or Asian youth. For instance, in the KFH-Antioch service area, 26% of Latino youth are obese as compared to 14% of Asian youth.



Health need	Why is it important?	What do the data say?
	allows people to make healthier choices and live healthier lives.	Also, a food desert is defined as a low-income census tract where a substantial share of residents have low access to a supermarket or large grocery store. In the KFH-Antioch service area, 20% of residents live in areas designated as a food desert, which is well above the state average (14%). Community members were concerned about the expense of eating healthy. They also felt that there were not enough affordable sports or recreational activities for youth and adults.
<b>3. Healthcare access &amp; delivery, including primary &amp; specialty care</b>	Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life.	Wide disparities exist across multiple racial and ethnic groups in the uninsured population. Also, Contra Costa County and the KFH-Antioch service area fall short of the benchmark in the rate of Federally Qualified Health Centers. The downstream indicator of preventable hospital events show that KFH-Antioch service area residents are far more likely to be hospitalized for preventable issues than Californians overall. In addition, 22% of Latinos, 16% of Native Hawaiian/Pacific Islanders, and 27% of those of an Other Race are uninsured as compared to 9% of Whites. In the service area overall there are 14% uninsured. Community members mentioned concerns about high cost of insurance, co-payments, and deductibles as well as how lack of insurance can cause stress that affects mental health.
<b>4. Oral/dental health</b>	Oral health is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.	County data indicates that many residents have low access to dental health care professionals, and that Black youth in the county are less likely to have had a recent dental exam. In addition, the community is concerned about oral/dental health. In the KFH-Antioch service area, one out of three focus groups prioritized oral health as a health need, and it was a top priority of a key informant.
<b>5. Mental health</b>	Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute	In the KFH-Antioch service area, more than 10% of residents in each ethnic group expressed a need for mental health care, and suicide rates are higher than the state and HP2020 objective. In addition, the youth intentional injury rate (non-fatal ER visits) in the KFH-Antioch service area is higher than the state average (779.3 per

Health need	Why is it important?	What do the data say?
	to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health.	100,000 population age 13-20 as compared to 738.7). In the KFH-Antioch service area, Black adults are much more likely to report a need for mental health care as compared to other racial and ethnic groups: 16% of Blacks reported a need for mental health care during the past 12 months as compared to 15% of Whites and 11% of Latinos. Community members indicated that cultural barriers and stigma were two reasons for why people weren't seeking mental health services. Pressure being places on children and adolescents to be high-achieving students was also mentioned as an issue that leads to poor mental health.
<b>6. Unintentional injuries</b>	Unintentional injuries are defined as those not purposely inflicted, and they are most often the result of accidents. The most common unintentional injuries result from motor vehicle crashes, falls, poisonings, suffocations, and drowning. Although most unintentional injuries are predictable and preventable, they are a major cause of premature death and lifelong disability. More individuals ages 15-44 die as a result of unintentional injuries than from any other cause. Unintentional injury is the fifth leading cause of death for all ages both in the U.S. and California.	Rates of unintentional injuries in the county and service area show that in some cases residents are more likely to suffer an unintentional injuries than Californians overall. Ethnic disparities are also evident in the data. The community is concerned about the impacts of older adult falls in the area. In addition, the mortality rate for pedestrian accidents in the KFH-Antioch service area (1.6 per 100,000) was higher than HP 2020 goal (1.3). Blacks in the KFH-Antioch service area have higher rates of motor vehicle crash mortality. In Contra Costa County, Blacks have higher rates of death due to unintentional injuries (43.2 per 100,000) than county residents overall (26.7) and California (36.4).
<b>7. Violence and injury prevention</b>	Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth.	In the KFH-Antioch service area, rates of homicide are above state and HP2020 benchmarks. Also, non-fatal emergency room (ER), visits for injury due to assault, and domestic violence are all much higher than state averages. In addition, the KFH-Antioch service area has a rate of school suspensions well above the state average (17.7 per 100 enrolled students compared to 4.0 for the state), and the rate of school expulsions per 100 enrolled students is above the state average (0.13 compared to 0.05). Community members mentioned a feeling of lacking trust in the police and a lack of domestic violence shelters in the area.
<b>8. Substance abuse, including</b>	Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause	Data about illegal drug use is not available, but the community expressed concern about drug use and the lack of treatment

Health need	Why is it important?	What do the data say?
<b>alcohol, tobacco, and other drugs</b>	many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide.	services available to address this problem. Data available on alcohol use shows that KFH-Antioch service area residents may be using alcohol more frequently than Californians overall. In addition, the rate of binge drinking in the KFH-Antioch service area is 19%, higher than the state average of 17%.

### C. SUMMARY OF NEEDS ASSESSMENT METHODOLOGY AND PROCESS

In November 2015, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then prioritized by a group that included representatives from KFH-Antioch, a representative from John Muir Health, and community representatives using a second set of criteria. The results of the prioritization are included in Section VI-B.

## II. INTRODUCTION/BACKGROUND

### A. ABOUT KAISER PERMANENTE (KP)

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

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

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

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

### B. ABOUT KAISER PERMANENTE COMMUNITY BENEFIT



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

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

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

### **C. PURPOSE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT**

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

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

### **D. IMPACT OF THE AFFORDABLE CARE ACT (ACA)**

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

The federal definition of community health needs includes the social determinants of health in addition to morbidity and mortality. This broad definition of health needs is indicative of the wider focus on both upstream and downstream factors that contribute to health. Such an expanded view

presents opportunities for nonprofit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health, including the social determinants of health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, ACA created more incentives for health care providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

### **State and County Context**

The last CHNA report conducted was in 2013, before the full implementation of the Affordable Care Act (ACA). Healthcare access was a top concern for the community and nonprofit hospitals and remains so in 2016.

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

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,<sup>2</sup> according to data cited by the California Healthcare Foundation. According to the California Health Interview Survey, in 2013, 19% of the population aged 18-64 in Alameda County was not insured (191,000 people).<sup>3</sup> Previous years (2011 and 2012) had seen the uninsured rate at 14%, demonstrating an unexpected increase between 2011 and 2013 in Alameda County.<sup>4</sup> Also according to the California Health Interview Survey, in 2014, 18% of the population aged 18-64 in Contra Costa County was not insured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013 when 16% of that population was uninsured.<sup>4</sup>

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

Although 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports. While health care access is important in achieving health, a broader view takes into

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<sup>1</sup> <http://www.healthforcalifornia.com/covered-california>

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

<sup>3</sup> Insured/uninsured figures for Alameda County for 2014 are not considered statistically stable.

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

consideration the influence of other factors including income, education, and where a person lives. These factors are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves influenced by policy choices. These underlying social and economic factors cluster and accumulate over one's life, and influence health inequities across different populations and places.<sup>5</sup> According to the Robert Wood Johnson Foundation's approach of what creates good health, health outcomes are largely shaped by social and economic factors (40%), followed by health behaviors (30%), clinical care (20%) and the physical environment (10%).<sup>6</sup> In order to address the bigger picture of what creates good health, health care systems are increasingly extending beyond the walls of medical offices to the places where people live, learn, work, and play.

## **E. KAISER PERMANENTE'S APPROACH TO COMMUNITY HEALTH NEEDS ASSESSMENT**

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

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

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

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

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

## **III. COMMUNITY SERVED**

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<sup>5</sup> Santa Clara County Public Health Department, 2014 *Santa Clara County Community Health Assessment*.

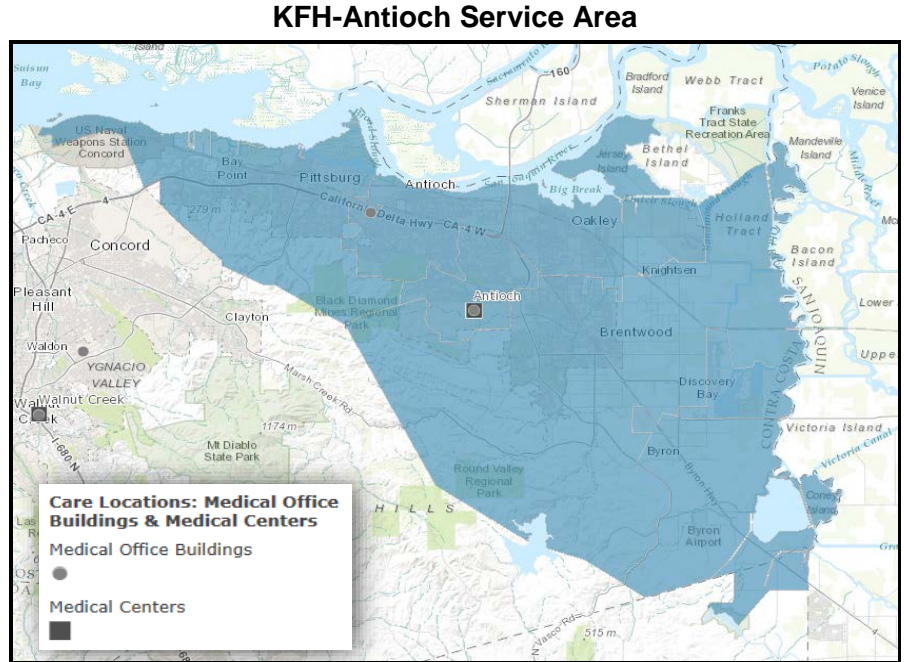
<sup>6</sup> <http://www.countyhealthrankings.org/our-approach>

**A. KAISER PERMANENTE’S DEFINITION OF COMMUNITY SERVED**

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

**B. MAP AND DESCRIPTION OF COMMUNITY SERVED**

**i. Map of KHF-Antioch service area**



**ii. Geographic description of the community served**

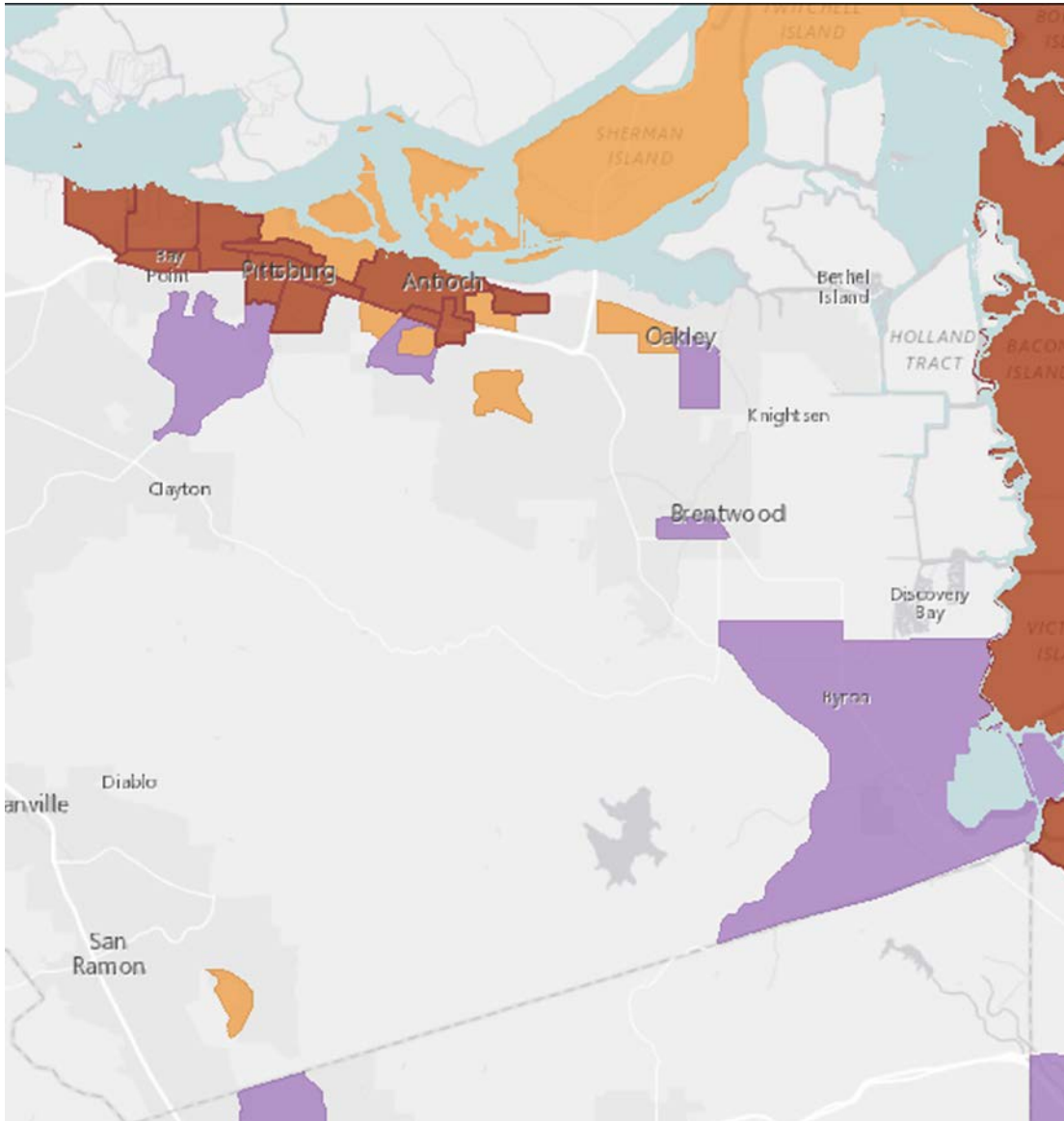
The KFH-Antioch service area comprises the eastern portion of Contra Costa County, which includes the major cities of Antioch, Bay Point, Brentwood, Knightsen, Oakley, and Pittsburg, as well as unincorporated areas shown in the map above.

**iii. Demographic profile of community served**

KFH Antioch Demographic Data	
Total Population	307,600
White	56.19%
Black	13.01%
Asian	10.4%
Native American/ Alaskan Native	0.73%
Pacific Islander/ Native Hawaiian	0.75%
Some Other Race	11.86%
Multiple Races	7.05%
Hispanic/Latino	34.4%

KFH Antioch Socio-economic Data	
Living in Poverty (<200% FPL)	31.78%
Children in Poverty	18.38%
Unemployed	6.9%
Uninsured	12.79%
No High School Diploma	15%

## East Contra Costa County Vulnerability Footprint



*Note that the parts of the KFH-Antioch service area not shown were identified as areas with less vulnerability.*

The orange shading shows areas where the percentage of population living at-or-below 100% of the Federal Poverty Level (FPL) exceeds 16% (the rate for California). The purple shading shows areas where the percentage of the population with no high school diploma exceeds the Healthy People 2020 target of 18% (i.e., 82% with a high school diploma or higher). Educational attainment is determined for all non-institutionalized persons age 25 and older. Dark red areas indicate that the census tract is above these thresholds (worse) for both educational attainment and poverty.

More than half (54%) of the children in KFH-Antioch are eligible for Free & Reduced-Price lunch (NCES Common Core of Data 2013-14), while nearly one in five (18%) lives in a household with income below 100% of the Federal Poverty level (U.S. Census Bureau, American Community Survey, 2009-2013). More than one in 10 people (14%) in the community are uninsured (U.S. Census Bureau, American Community Survey, 2009-2013).

## IV. WHO WAS INVOLVED IN THE ASSESSMENT



## **A. IDENTITY OF HOSPITALS THAT COLLABORATED ON THE ASSESSMENT**

KFH-Antioch originally worked with 11 other hospitals ("the Hospitals") in Contra Costa and Alameda counties to develop a coordinated approach to primary data collection. The Hospitals agreed to enlist the assistance of Applied Survey Research to conduct the assessment, agreed on secondary data sources, and agreed on common protocols for primary data collection (key informant interviews and focus groups) across both counties. This allowed non-profit hospitals in the area to take advantage of economies of scale and to avoid overburdening the community with multiple requests for information.

Most of the Hospitals then collaborated with one or more of the Hospitals with similar service areas to determine the list of significant health needs; KFH-Antioch worked with John Muir Health. KFH-Antioch also worked with John Muir Health to prioritize their shared health needs using an online survey (described in Section VI-B).

### **Collaborative hospital partners**

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

## **B. OTHER PARTNER ORGANIZATIONS THAT COLLABORATED ON THE ASSESSMENT**

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

## **C. IDENTITY AND QUALIFICATIONS OF CONSULTANTS USED TO CONDUCT THE ASSESSMENT**

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

ASR was uniquely suited to provide the Hospitals with consulting services relevant to conducting the CHNA. The team that participated in the work –Dr. Jennifer van Stelle, Abigail Stevens, Angie Aguirre, Samantha Green, Martine Watkins, Chandrika Rao, Melanie Espino, Kristin Ko, James Connery, Christina Connery, Emmeline Taylor, Paige Combs, and sub-contractors Dr. Julie Absey, Robin Dean, Lynn Baskett, and Nancy Ducos – brought together diverse, complementary skill sets and various schools of thought (public health, anthropology, sociology, social ethics, psychology, education, public affairs, healthcare administration, and public policy).

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

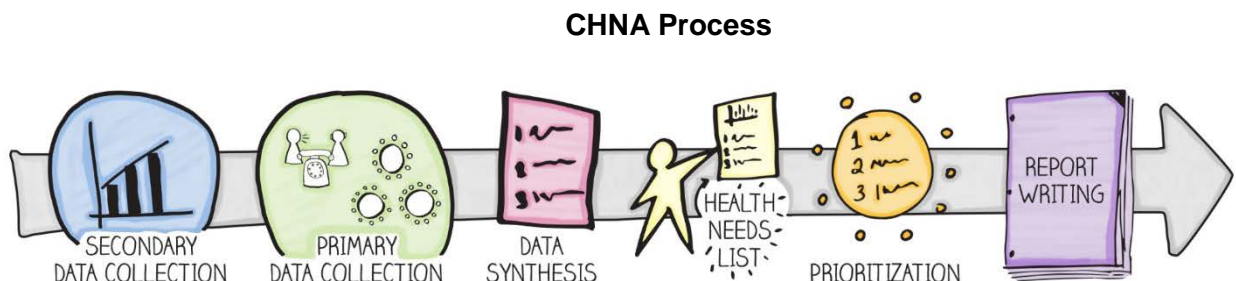
ASR’s expertise in community assessments is well-recognized. ASR won a first place award in 2007 for having the best community assessment project in the country. They accomplish successful assessments by using mixed research methods to help understand the needs in question and by putting the research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

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

## V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

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

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



## **A. SECONDARY DATA**

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

KFH-Antioch used the Kaiser Permanente CHNA Data Platform ([www.chna.org/kp](http://www.chna.org/kp)) to review over 150 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available.

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

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

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

ASR used a spreadsheet to list indicator data. Data were collected primarily through the KP CHNA Data Platform ([www.chna.org/kp](http://www.chna.org/kp))<sup>7</sup> and public health department reports. (See Appendix B for a list of indicators on which data were gathered.) ASR retained the health need categories used in the Kaiser Permanente CHNA data platform export file (rubric) and integrated data indicators from other sources into the rubric.

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

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

## **B. COMMUNITY INPUT**

### **i. Description of the community input process**

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

In all, ASR gathered community input from 28 individuals through focus groups and individual interviews.

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<sup>7</sup> Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system, found at [www.communitycommons.org](http://www.communitycommons.org)

# 28 Community Members

10 Professionals  
(1 focus group,  
4 interviews)

18 Non-professional Residents  
(2 focus groups)

In all, ASR consulted with 10 professional community representatives of various organizations and sectors through four key informant interviews and one focus group (with 6 participants). These representatives either work in the health field or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- County and City Public Health (8)
- Mental/Behavioral health or violence prevention providers (1)
- Other nonprofit agencies serving children, seniors, veterans, and/or families (1)

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

## a. Key Informant Interviews

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

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

## b. Stakeholder Focus Groups

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

### Details of Focus Group with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Community health workers from communities which are medically underserved, minority and/or low income	Pittsburg Health Center	09/08/2015	6

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

c. Resident Input

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

In order to provide a voice to the community it serves in Contra Costa County, the study team targeted participants who were medically underserved, in poverty, and/or socially or linguistically isolated. Two focus groups were held with community members.

These resident groups were planned in various geographic locations around the county. Residents were recruited by nonprofit hosts, such as First Five Contra Costa County, who serves low-income residents.

**Details of Focus Groups with Residents**

<b>Focus</b>	<b>Focus Group Host/Partner</b>	<b>Date</b>	<b>Number of Participants</b>
Low-income, minority (Black / African American)	Pittsburg High School African American Parent Group (PAAACT)	08/27/2015	7
Low-income, Spanish-speaking minority (Latino)	First 5 Contra Costa County	09/03/2015	11

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

- 100% of participants (18) completed a survey.
- 61% (11) of participants were Latino, and 39% were Black.
- 83% (15) were between the ages of 18 and 64 years old; of these, five were younger than 40, and ten were 40 or older. Two did not report their age, and one was age 65 or older.
- 11% (2) were uninsured, while 61% had benefits through Medi-Cal, Medicare, or another public health insurance program. The rest had private insurance.
- Residents lived in various areas of the county: Concord and Pittsburg (5 each), Antioch (3), Baypoint (2), and other unidentified parts of the county (3).
- 72% (13) reported having an annual household income of under \$45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Contra Costa County for two adults with no children (\$38,169). More than one-third (39%) earned under \$25,000 per year, which is below Federal Poverty Level for a family of four. This demonstrates a fair level of need among participants in an area where the cost of living is extremely high compared to other areas of California.



**ii. Methodology for collection and interpretation**

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulated all health needs that were mentioned, along with health drivers discussed. ASR then made a list of all of the conditions that had been mentioned by a focus group or key informant, counted how many groups or informants listed the conditions, and how many times they had been prioritized by a focus group.

See Appendix F for key informant interview and focus group protocols

**C. WRITTEN COMMENTS**

KP provided the public an opportunity to submit written comments on the facility’s previous CHNA Report through [CHNA-communications@kp.org](mailto:CHNA-communications@kp.org). This website will continue to allow for written community input on the facility’s most recently conducted CHNA Report.

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

**D. DATA LIMITATIONS AND INFORMATION GAPS**

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

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

**VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY’S HEALTH NEEDS**

**A. IDENTIFYING COMMUNITY HEALTH NEEDS**

**i. Definition of “health need”**

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

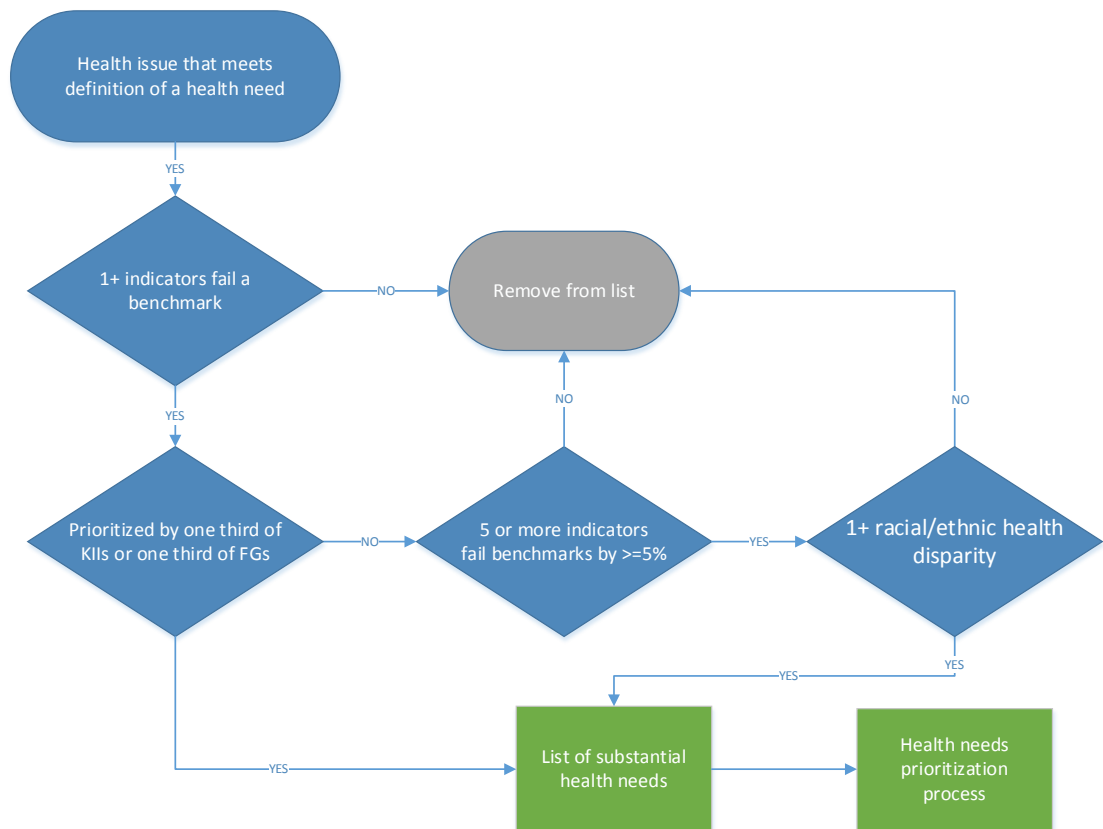
Definition	Example(s)
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Health <b>outcome</b> : A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality	Diabetes prevalence Diabetes mortality
Health <b>condition</b> : A disease, impairment,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

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

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

**KFH-Antioch Health Needs Identification Process**



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

## **B. PROCESS AND CRITERIA USED FOR PRIORITIZATION OF THE HEALTH NEEDS**

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

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

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

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

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

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

**List of Prioritized Needs:** The overall need scores ranged between 1.85 and 2.80 on a scale of 1-3 with 1 being the lowest priority possible and 3 being the highest priority possible. The needs are ranked by prioritization score in the table below. The specific scores for each of the four criteria used to generate the overall community health needs prioritization scores may be viewed in Appendix E.

**Prioritized Needs Ranking and Average Priority Score**

<b>Rank</b>	<b>KFH-Antioch Health Need</b>	<b>Overall Average Priority Score</b>
1	Economic Security	2.80
2	Obesity, Diabetes, Healthy Eating/Active Living	2.75
3	Healthcare Access & Delivery, Including Primary & Specialty Care	2.45
4	Oral/Dental Health	2.35
5	Mental Health	2.25
6	Unintentional Injuries	2.00
7	Violence/Injury Prevention	1.90
8	Substance Abuse (Alcohol, Tobacco, and Other Drugs)	1.85

**C. PRIORITIZED DESCRIPTION OF ALL THE COMMUNITY HEALTH NEEDS IDENTIFIED THROUGH THE CHNA**

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

- 1: Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child’s life, even if social conditions subsequently improve. **Economic security** is a health need locally as marked by the percentage of residents who experienced food insecurity at some point during the year, which is higher than the national benchmark. In addition, 18% of children in the KFH-Antioch service area were living in poverty compared to 14% of county children, and many children of color fare worse: Black (31%), Latino (26%), and those of “other” races (26%). Community input suggests that affordable housing is an issue. Community members felt that many people must choose either to buy medicine or pay their rent and eat.
- 2: Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives. **Obesity, diabetes, and healthy eating/active living** are health needs locally as illustrated by higher rates of overweight among adults, higher rates of diabetes prevalence, and lower percentages of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages. In addition, 20% of residents in the KFH-Antioch service area live in areas designated as a food desert, which is well above the state average (14%). Community input about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity. Community input indicates that there is a lack of education around linking mental health and healthy living, and that healthy food is often less affordable than the unhealthy food options.

- 3: Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. **Healthcare access & delivery, including primary and specialty care**, is a health need locally as demonstrated by high rates of preventable hospital events compared to the state average. In addition, 22% of Latinos, 16% of Native Hawaiian/Pacific Islanders, and 27% of those of an Other Race are uninsured as compared to 9% of Whites. In the service area overall there are 14% uninsured. The community input indicates that insurance premiums and co-payments are too high and wait times for appointments are too long. Community members also expressed a fear of accessing care because of previous bad experiences and a lack of information about where and how to obtain health insurance.
- 4: **Oral health** is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures. Oral/dental health is a health need locally as marked by a higher percentage of children in Contra Costa County who missed school days due to a dental problem compared to the state average. In addition, 9.3% of the county population is living in a Dental Health Professional Shortage Area (HPSA), which is higher than the state (4.9%). Community input indicates that dental care is not always covered by insurance, benefits are not sufficient, and providers often don't accept the dental insurance residents do have. Community members also expressed a want for a mobile dental clinic.
- 5: **Mental health** is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health. Mental health is a health need locally as evidenced by the rate of suicide in the KFH-Antioch service area, which is higher than the state and national benchmark. In addition, the youth intentional injury rate (non-fatal ER visits) in the KFH-Antioch service area is higher than the state average (779.3 per 100,000 population age 13-20 as compared to 738.7). Also in the KFH-Antioch service area, Black adults are much more likely to report a need for mental health care as compared to other racial and ethnic groups: 16% of Blacks reported a need for mental health care during the past 12 months as compared to 15% of Whites and 11% of Latinos. Community input indicates that cultural barriers make it harder to access mental health care. Community members also felt that primary care physicians are not educating patients about the link between well-being and disease prevention, and that primary care physicians are not making mental health referrals.
- 6: **Unintentional injuries** are defined as those not purposely inflicted, and they are most often the result of accidents. The most common unintentional injuries result from motor vehicle crashes, falls, poisonings, suffocations, and drowning. Although most unintentional injuries are predictable and preventable, they are a major cause of premature death and lifelong disability. More individuals ages 15-44 die as a result of unintentional injuries than from any other cause. Unintentional injury is the fifth leading cause of death for all ages both in the U.S. and



California. Unintentional injuries are health needs locally as evidenced by higher rates of unintentional injuries in the county and service than Californians overall. In addition, Blacks in Contra Costa County have higher rates of death due to unintentional injuries (43.2 per 100,000) than county residents overall (26.7) and California residents (36.4). Community input suggests that falls among the older adult population are especially of concern.

- 7: **Violence and intentional injury** contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. Violence and injury prevention are health needs locally as marked by rates of homicide well above the state and national average. In addition, racial and ethnic disparities are stark with Blacks having a homicide mortality rate 17 times higher than Whites and 18 times higher than Native Americans/Alaskan Natives, who have lowest rates. Community input indicates that gang violence is a major issue, and that there are a lack of domestic violence shelters in the community.
- 8: **Substance abuse** has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide. Substance abuse (including tobacco and alcohol) is a health need locally as demonstrated by levels of excessive alcohol consumption among adults, which are higher than the state average. In addition, 13% of KFH-Antioch service area residents' total household expenditures are towards alcohol, slightly higher than the state average (13%). Community feedback indicates that residents are using drugs and alcohol to help them sleep, and homeless residents may be using substances to help them cope with being on the street.

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

#### **D. COMMUNITY RESOURCES POTENTIALLY AVAILABLE TO RESPOND TO THE IDENTIFIED HEALTH NEEDS**

Community resources are listed in Appendix G.

### **VII. KFH-ANTIOCH CREEK 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT**

#### **A. PURPOSE OF 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT**

KFH-Antioch'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-Antioch's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit (<http://share.kaiserpermanente.org/wp-content/uploads/2013/10/IS-Report-Antioch.pdf>). For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-Antioch in the 2013 Implementation Strategy Report.

1. Peri-Natal care
2. Healthy eating
3. Increased exercise and activity
4. Primary care services and information (health literacy), including adequate Spanish capacity
5. Broader health care system needs in our communities (workforce development and research)

KFH-Antioch 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-Antioch tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-Antioch had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-Antioch 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 grant making, 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-Antioch awarded 156 grants totaling \$2,031,001 in service of 2013 health needs. Additionally, KP Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Antioch service area. During 2014-2015, a portion of money managed by this foundation was used to award 36 grants totaling \$335,359 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-Antioch 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-Antioch 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**

<b>PRIORITY HEALTH NEED I: PERINATAL CARE</b>			
<b>Long Term Goal:</b>			
<ul style="list-style-type: none"> <li>• Increase the proportion of mothers, particularly in the African American community, who receive appropriate perinatal care.</li> </ul>			
<b>Intermediate Goals:</b>			
<ul style="list-style-type: none"> <li>• Reduce barriers to health care coverage</li> <li>• Increase the number of pregnant women and infants who receive appropriate and culturally competent perinatal care.</li> </ul>			
<b>Grant Highlights</b>			
<b>Summary of Impact:</b> During 2014 and 2015, there were 13 active KFH grants totaling \$288,511 addressing Perinatal Care in the KFH-Antioch service area.			
<b>Grantee</b>	<b>Grant Amount</b>	<b>Project Description</b>	<b>Results to Date</b>
Contra Costa Health Services	\$95,000 over two years	Support for Healthy Families America (HFA), which provides home visitation for pregnant and post-partum women, with a focus on African American women in East Contra Costa.	As of Dec. 4, 2015, the two cycles of funding allowed 33 women to receive long-term supportive case management and education and enroll in presumptive Medi-Cal/pregnancy-related Medi-Cal, ensuring they receive appropriate prenatal care. In addition, 17 post partum/parenting women and 16 babies received services through HFA. In total they plan to serve an additional 20 pregnant African American women and 5 babies and their families by the end of the grant.
Contra Costa County	\$100,000 over 2 years  \$50,000 in 2014 & 2015	Grant funding provides support to the Contra Costa Women Infant and Children (WIC) program for a lactation consultant to increase breastfeeding among African American mothers in East Contra Costa County.	As of Dec. 4, 2015 the two cycles of funding had allowed Contra Costa County's WIC program to hire three experienced African American lactation consultants to reach African American mothers (with education and support) through Pittsburg Health Clinic, community events, and Healthy Start classes in East County. As a result, 315 women at Pittsburg Health Center and Pittsburg and Brentwood WIC offices have received lactation support and an additional 330 women were reached at various outreach events. The project plans to complete several hundred more lactation support contacts before the end of the current grant.

Brighter Beginnings	\$50,000 in 2014	High touch perinatal education for low-income African American women in East Contra Costa.	Brighter Beginnings provided the pre- and postnatal Bright Start (Centering Pregnancy-like program) program for pregnant African American women and established a satellite community health clinic in Antioch. Brighter Beginnings participated in two outreach events, identified 54 likely participants, developed the curriculum, obtained its satellite license, and helped 12 people apply for Medi-Cal.
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**Collaboration/Partnership Highlights**

<b>Organization/ Collaborative Name</b>	<b>Collaborative/ Partnership Goal</b>	<b>Results to Date</b>
Healthy and Active Before 5 (HAB45)	HAB45, a large community collaborative serving Contra Costa County, aims to prevent obesity in children 0 to 5 by building partnerships and environments for healthy eating and active play. With a multi-agency steering committee and a leadership council, HAB45 encourages organizations to pass and implement healthy policies and has developed a model policy library that it actively promotes.	KFH-Antioch, KFH-Walnut Creek, and KFH-Richmond are represented on HAB45. In 2014 HAB45 made an active and innovative attempt at perinatal health by training 20 health promoters to provide breastfeeding peer support. As of Dec. 1, HAB45 and its community partners supported development of a breastfeeding accommodation policy at an East Contra Costa County agency and hosted a leadership meeting about lessons learned from the Berkeley Soda tax, reaching 53 individuals from 31 organizations.
Contra Costa Health Services Maternal & Child Health Community Advisory Board	Quarterly multi-sector meeting to discuss programs and issues related to maternal and child health in Contra Costa County.	Diablo Area CB staff participated as a stakeholder in the needs assessment conducted by Contra Costa Health Services and continues to attend quarterly meetings to look for opportunities to offer support.

**In-Kind Resources Highlights**

<b>Recipient</b>	<b>Description of Contribution and Purpose/Goals</b>
Planned Parenthood clients	Over 2014-2015 KFH-Antioch opened its newborn care, childbirth, and breastfeeding classes to 154 Planned Parenthood clients who participated in free perinatal health education classes at its East County facilities.
Contra Costa County, WIC Program	KFH Antioch provided 25 water bottles with infusers to participants of a WIC breastfeeding promotion event.



**PRIORITY HEALTH NEED II: HEALTHY EATING AND INCREASED EXERCISE AND ACTIVITY**

**Long Term Goals:**

- Decrease the number of individuals who suffer from negative health conditions related to poor eating habits, including overweight and obesity, diabetes, heart disease, and stroke.
- Decrease the number of individuals who suffer from negative health conditions related to limited exercise and activity, including overweight and obesity, diabetes, heart disease, and stroke.

**Intermediate Goals:**

- Increase the availability of fruits and vegetables in low-income neighborhoods.
- Increase the proportion of people, particularly low-income individuals, who consistently choose healthy food and beverage options.
- Increase access to and availability of options for safe exercise and physical activity.
- Increase the number of low-income people who engage in an active lifestyle.

**Grant Highlights**

**Summary of Impact:** During 2014 and 2015, there were 91 active KFH grants totaling \$530,157 addressing Healthy Eating and Increased Exercise and Activity in the KFH-Antioch service area.<sup>8</sup> In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 10 grants totaling \$75,262 that address this need. These grants are denoted by asterisks (\*) in the table below.

<b>Grantee</b>	<b>Grant Amount</b>	<b>Project Description</b>	<b>Results to Date</b>
Food Bank of Contra Costa and Solano	\$43,000 over two years  \$23,000 in 2014 \$20,000 in 2015  (this grant serves the Antioch and Walnut Creek communities)	In 2014 the grant supported the Food Bank’s Farm to Kids program, which provides free fresh produce and nutrition education to students in after-school programs in low-income areas. In 2015 the grant supported the Community Produce Program (CPP) which provides nutrition education and free, fresh produce to low-income families throughout east and central Contra Costa County.	As of Dec.1, 2015 the two rounds of funding had distributed 1,188,748 pounds of produce to 16,680 individuals.
Antioch Unified School District	\$30,000 over 2 years  \$15,000 in 2014 & 2015	Supports Get Fit Antioch, which provides school and afterschool fitness programs focused on walking and running that targets students, teachers, and administrators.	As of November 2015, Get Fit Antioch had engaged 3,369 students as well as 122 parents and staff attending several elementary schools and one middle school in Antioch Unified School District, in weekly walking and running programs. The students and adults walked a total of 23,961 miles.
Contra Costa Child Care Council	\$18,000 in 2014	Together with 4C’s of Alameda County, the Child Care Council, is developing two resource kits and a child care Facebook page to promote nutrition	The Child Care Council worked with eight child care sites in the Pittsburg/Bay Point area. The project reached 115 children and 86 parents.

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

		and physical activity best practices in child care settings. Providers receive child care training and support to use these tools to promote communication and interaction with the parents of children in their care.	
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**Collaboration/Partnership Highlights**

<b>Organization/ Collaborative Name</b>	<b>Collaborative/ Partnership Goal</b>	<b>Results to Date</b>
Healthy and Active Before 5 (HAB45)	KFH Antioch, KFH Walnut Creek and KFH Richmond are represented on HAB45, a large community collaborative serving Contra Costa County, aims to prevent obesity in children 0 to 5 by building partnerships and environments for healthy eating and active play. With a multi-agency steering committee and a leadership council, HAB45 encourages organizations to pass and implement healthy policies and has developed a model policy library that it actively promotes. The CB Manager has served on the Executive Committee	2014 and 2015 accomplishments include: <ul style="list-style-type: none"> <li>• Helped 11 Contra Costa organizations pass healthy policies.</li> <li>• Developed and distributed three park maps to 3,000 child care providers and low-income families and evaluated 60 Contra Costa parks with a goal of enhancing their suitability for families with young children.</li> <li>• Trained 20 promotoras in breastfeeding peer support.</li> <li>• Developed two new model worksite policies on tap water promotion and marketing to children.</li> <li>• advocated for considerations for children 0-5 in Healthy &amp; Livable Pittsburg</li> <li>• advocated for and secured \$187,000 for play equipment improvements at parks in Antioch and Pittsburg.</li> </ul>
Healthy & Livable Pittsburg (HLPC)	The KP Diablo CB Manager is an advisor to HLPC, a place-based initiative promoting healthy eating and active living through development and capacity building for a multisector collaborative in Pittsburg.	As of Dec. 1, HLPC finalized and adopted a community action plan, invited other Pittsburg resident and service organization leaders to participate, and sought funding to implement elements of the plan.
Pittsburg Unified School District (PUSD) Wellness Committee	KFH Antioch staff serve on the PUSD Wellness Committee, which has a focus on improving the school environment and student and staff health in all 11 PUSD schools, the committee develops and promotes healthy policies and practices.	The Wellness Committee drafted a comprehensive wellness policy for PUSD in 2014 that was approved in 2015.
Bay Point Partnership (BPP)	KFH Antioch staff participate in monthly BPP meetings. In existence for more than 15 years, BPP fosters collaboration and unity between Bay Point residents and service providers. KFH Antioch staff also participate on the planning	KFH Antioch staff bring a healthy eating/active living perspective and contributed to BPP's successful efforts to change the food served at meetings and events. They provided health education, farm stand produce, and KP volunteers who cooked and served a healthy lunch to all participants of the Unity in the Community event.

	committee for the annual Unity in the Community celebration.	
<b>In-Kind Resources Highlights</b>		
<b>Recipient</b>	<b>Description of Contribution and Purpose/Goals</b>	
Center for Human Development	Kaiser Permanente health educator speakers address topics related to healthy eating and active living at a bimonthly Mind, Body, and Soul support group for approximately 20 East County African-American residents.	
Pittsburg Unified School District	Kaiser Permanente health educators lead “Rethink Your Drink” presentations for all students at MLK Jr. and Pittsburg high schools.	
Pittsburg High School	Over two days, a Kaiser Permanente health educator provided nutrition education to Pittsburg’s entire student body, approximately 2,900 students.	

**PRIORITY HEALTH NEED III: PRIMARY CARE SERVICES AND INFORMATION (HEALTH LITERACY), INCLUDING ADEQUATE SPANISH CAPACITY**

- Long Term Goal:**
- Increase the proportion of individuals in the KFH-Antioch service area who have access to and receive primary care services.
- Intermediate Goal:**
- Reduce barriers to enrollment
  - Increase health care coverage.
  - Increase the proportion of low-income individuals who have access to and receive appropriate and culturally competent primary care services.

**KFH-Administered Program Highlights**

<b>KFH Program Name</b>	<b>KFH Program Description</b>	<b>Results to Date</b>
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.	<ul style="list-style-type: none"> <li>• 2014: 10,850 Medi-Cal members</li> <li>• 2015: 10,252 Medi-Cal members</li> </ul>
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.	<ul style="list-style-type: none"> <li>• 2014: KFH - Dollars Awarded By Hospital 2,327,953</li> <li>• 2014: 1,709 Applications approved</li> <li>• 2015: KFH - Dollars Awarded By Hospital \$1,698,159</li> <li>• 2015: 2 Applications approved</li> </ul>
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.	<ul style="list-style-type: none"> <li>• 2014: 1,512 members receiving CHC</li> <li>• 2015: 1,389 members receiving CHC</li> </ul>

### Grant Highlights

**Summary of Impact:** During 2014 and 2015, there were 38 active KFH grants totaling \$1,160,370 addressing Primary Care Services and Information in the KFH-Antioch service area.<sup>9</sup> In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 16 grants totaling \$183,544 that address this need. These grants are denoted by asterisks (\*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
St. Vincent de Paul	\$53,000 over 2 years	Supports free primary care services for underserved and uninsured adults in Pittsburg.	As of Dec. 1, 2015, Pittsburg RotaCare Clinic delivered primary and specialty care services to 1,633 adults and children. They expect to serve over 650 more patients before the funding is over.
La Clínica de la Raza	\$50,000 over 2 years  \$20,000 in 2014 \$30,000 in 2015 (even split with KFH-Walnut Creek)	This Connecting Families to Health Coverage/Care grant supports outreach and education to increase access to health care services for low-income and uninsured individuals and families in east and central Contra Costa County.	As of Dec 1, 2015 La Clínica trained 6 community health education staff and 20 promotores on health coverage options, reaching 1,854 community members at 72 community events, and screened 784 individuals for low and no cost health care services eligibility.
Planned Parenthood Northern California (PPNorCal)	\$25,000 over 2 years  \$10,000 in 2014 \$15,000 in 2015 (even split with KFH-Walnut Creek)	Support for expanded primary care services at Planned Parenthood health centers in Antioch and Concord.	As of Dec 1, 2015, Planned Parenthood Northern California served 24,033 adults and 2,472 children with expanded primary care services at its Antioch and Concord clinic sites.
Operation Access (OA)	\$300,000 in 2015  This grant impacts 14 KFH hospital service areas in Northern California Region.	This grant provides OA core support to organize a network of 41 medical centers and 1,400 medical professionals who donate surgical, specialty, and diagnostic services to 1,500 low income, uninsured people residing in nine Bay Area counties.	With 1,274 staff/physician volunteers providing more than 700 services at 14 hospitals in 2015, Kaiser Permanente is the largest health system participant. In total, 95 procedures were performed on 81 low-income and uninsured patients at OA events at KFH Antioch in 2014 & 2015.
Community Clinic Consortia of Contra Costa and Solano (CCCCCS)	\$250,000 over 2 years  \$125,000 in 2014 \$ 2015	Grant will provide core support for CCCCCS's continued operations designed to meet the needs of community health center (CHC) members, and the review, modification,	By grant end CCCCCS expects to reach 300,000 individuals and achieve the following outcomes: <ul style="list-style-type: none"> <li>• CCCCCS/CHCs will have ability to monitor patient assignment trends and assess the</li> </ul>

<sup>9</sup> 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.

	<p>This grant impacts five KFH hospital service areas in Northern California Region.</p>	<p>and implementation of their existing organizational strategic plan.</p>	<p>equity of Medi-Cal managed care patient assignment</p> <ul style="list-style-type: none"> <li>• Improved internal CHC systems and coordination with external stakeholders</li> <li>• Improved coordination between CHCs and other health systems</li> <li>• Produce financial dashboards to strengthen financial monitoring to inform business planning</li> </ul> <p>Continued coordination with regional consortia to share resources, develop trainings, and support sustainability efforts</p>
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**Collaboration/Partnership Highlights**

<b>Organization/ Collaborative Name</b>	<b>Collaborative/ Partnership Goal</b>	<b>Results to Date</b>
<p>Access to Care Stakeholders</p>	<p>Convened by the Contra Costa Health Services Director, this group has met quarterly since 2008. Membership includes representation from KFH Antioch as well as the Hospital Council, Contra Costa Board of Supervisors, Alameda-Contra Costa Medical Association, and most Contra Costa hospitals, and community clinics.</p>	<p>The Stakeholders' most recent focus has been to CB Manager represent Kaiser Permanente in the group and monitor community needs. The Stakeholders most recent focus is Contra Costa Cares, a county-wide coverage initiative to serve up to 3,000 uninsured Contra Costa residents.</p>
<p>East and Central Contra Costa County Access Team (ECCAAT)</p>	<p>ECCAAT includes representatives of clinics and hospitals serving east and central Contra Costa: KFH-Antioch, KFH-Walnut Creek, John Muir Health, Sutter Delta, Contra Costa Health Services, La Clínica de la Raza, and Planned Parenthood. It is key to information sharing and advocacy around health care access and coverage in the county, and its members have access to senior leaders in their organization.</p>	<p>In 2015, ECCAAT focused on the coverage options for the remaining uninsured in Contra Costa County.</p>

**In-Kind Resources Highlights**

<b>Recipient</b>	<b>Description of Contribution and Purpose/Goals</b>
<p>Operation Access</p>	<p>KFH Antioch physicians and staff donated a total of 1247.5 hours of time serving low-income and uninsured patients at OA events in 2014 and 2015.</p>

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

**KFH Workforce Development Highlights**

**Long Term Goal:**

- To address health care workforce shortages and cultural and linguistic disparities in the health care workforce

**Intermediate Goal:**

- Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care

**Summary of Impact:** During 2014 and 2015, Kaiser Foundation Hospital awarded 14 Workforce Development grants totaling \$51,963 that served the KFH-Antioch service area.<sup>10</sup> In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling \$45,210 that address this need. In addition, KFH Antioch provided trainings and education for 27 residents in their Graduate Medical Education program in 2014 and 26 residents in 2015, 15 nurse practitioners or other nursing beneficiaries in 2014 and none in 2015, and 22 other health (non-MD) beneficiaries for 2014-2015.

**Grant Highlights**

Grantee	Grant Amount	Project Description	Results to Date
*The Regents of the University of California	<p>\$75,000 in 2015</p> <p>This grant impacts all 21 KFH hospital service areas in Northern California Region</p>	<p>University of California Berkeley’s (UCB) Health Careers Opportunity Program (HCOP) aims to diversify the health professions workforce by working directly with students from underrepresented groups through direct student counseling at UCB, visits and outreach to local community colleges, and the Public Health and Primary Care, a UCB class taught by HCOP staff.</p>	<ul style="list-style-type: none"> <li>• HCOP supported programs and workshops throughout Northern California that reached more than 600 underrepresented students through mentoring, classes on biostatistics and public health research analytical concepts, professional development on oral and written communication, and business professionalism</li> <li>• HCOP served nine Summer Scholars (underrepresented students)</li> <li>• eight other students enrolled in and completed the Kaplan Course for GRE preparation</li> </ul>
*Vision Y Compromiso	<p>\$98,093 in 2015</p> <p>This grant impacts 15 KFH hospital service areas in Northern California Region</p>	<p>The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.</p>	<p>By grants end Vision y Compromiso expects to achieve the following outcomes:</p> <ul style="list-style-type: none"> <li>• increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities</li> <li>• increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities</li> <li>• increased knowledge of community resources, increased networking, and social support as</li> </ul>

<sup>10</sup> 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.



			measured by an increased number of agencies involved in the regional Networks
*San Francisco State University (SFSU) Health Equity Initiative	\$99,211 in 2015  This grant impacts 13 KFH hospital service areas in Northern California Region	SFSU's Metro College Success, a school within a school, has increased graduation rates of low-income, underrepresented and/or first-generation students by redesigning the first two years of college. Initiative will develop new health equity and career readiness content for the Metro Health Academy curriculum to diversify the health care workforce in the greater Bay Area.	By grant's end Metro College Success plans to achieve the following outcomes: <ul style="list-style-type: none"> <li>design/implement new curricula for three core courses (health equity, social determinants of health, and history of health) for 350 Metro Health Academy students</li> <li>develop/disseminate video modules to train Metro faculty in the new curricula</li> <li>develop a webpage to share curricula with faculty from other institutions in the region</li> </ul>

**PRIORITY HEALTH NEED IV: 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:**

- Increase access to, and the availability of, relevant public health and clinical care data and research

**Grant Highlights**

<b>Grantee</b>	<b>Grant Amount</b>	<b>Project Description</b>	<b>Results to Date</b>
UCLA Center for Health Policy Research	\$2,100,000 over 4 years  1,158,200 over 2014 & 2015  This grant impacts all KFH hospital service areas in Northern California Region.	Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic	CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews.  In addition, funding has supported the AskCHIS NE tool which has allowed the Center to: <ul style="list-style-type: none"> <li>Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology.</li> <li>Develop and deploy AskCHIS NE.</li> <li>Launch and market AskCHIS NE.</li> </ul>



	levels, allowing users to visualize the data at a sub-county level.	<ul style="list-style-type: none"> <li>• Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.</li> </ul>
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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: <a href="http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx">http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx</a>
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
<i>Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention</i> – Susan Brown	Access to care

<i>Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young</i> – Steven Sidney	Access to care
<i>Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes</i> – Monique Hedderson	Access to care
<i>Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs</i> – Susan Brown	HEAL
<i>The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization</i> – Kelly Young-Wolff	HEAL
<i>Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention</i> – Cynthia Campbell	Mental/Behavioral Health
<i>Integrating Addiction Research in Health Systems: The Addiction Research Network</i> – Cynthia Campbell	Mental/Behavioral Health
<b>RPGEH Project Title</b>	<b>Alignment with CB Priorities</b>
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>.

<b>Alignment with CB Priorities</b>	<b>Project Title</b>	<b>Principal Investigator</b>
Serve low-income, underrepresented, vulnerable populations located in the Northern California Region service area	<ol style="list-style-type: none"> <li>1. <i>A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.</i></li> <li>2. <i>Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.</i></li> </ol>	<ol style="list-style-type: none"> <li>1. Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing</li> <li>2. Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University</li> </ol>
Reduce health disparities.	<ol style="list-style-type: none"> <li>1. <i>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.</i></li> <li>2. <i>MIDAS data on elder abuse reporting in KP NCAL.</i></li> <li>3. <i>Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.</i></li> <li>4. <i>Transforming health care through improving care transitions: A duty to embrace.</i></li> <li>5. <i>New trends in global childhood mortality rates.</i></li> </ol>	<ol style="list-style-type: none"> <li>1. Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City</li> <li>2. Jennifer Burroughs, Skilled Nursing Facility, Oakland CA</li> <li>3. Tracy Trail-Mahan, et al., KFH-Santa Clara Clara</li> <li>4. Michelle Camicia, KFH-Vallejo Rehabilitation Center</li> <li>5. Deborah McBride, KFH-Oakland</li> </ol>
Promote equity in health care and the health professions.	<ol style="list-style-type: none"> <li>1. <i>Family needs at the bedside.</i></li> <li>2. <i>Grounded theory qualitative study to answer the question, "What behaviors and environmental factors contribute to</i></li> </ol>	<ol style="list-style-type: none"> <li>1. Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center</li> <li>2. Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED.</li> </ol>

	<p><i>emergency department nurse job fatigue/burnout and how pervasive is it?"</i></p> <p><b>3.</b> <i>A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.</i></p> <p><b>4.</b> <i>Electronic and social media: The legal and ethical issues for health care.</i></p> <p><b>5.</b> <i>Academic practice partnerships for unemployed new graduates in California.</i></p> <p><b>6.</b> <i>Over half of U.S. infants sleep in potentially hazardous bedding.</i></p>	<p><b>3.</b> Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL</p> <p><b>4.</b> Elizabeth Scruth, et al.</p> <p><b>5.</b> Van et al.</p> <p><b>6.</b> Deborah McBride, KFH-Oakland</p>
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## **VIII. CONCLUSION**

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

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

## **IX. APPENDICES**

- A. Secondary Data Sources and Dates
- B. List of Indicators on Which Data Were Gathered
- C. Persons Representing the Broad Interests of the Community
- D. Glossary
- E. 2016 Health Needs Prioritization Scores: Breakdown by Criteria
- F. CHNA Qualitative Data Collection Protocols
- G. Community Assets and Resources
- H. Health Needs Profiles

## APPENDIX A: SECONDARY DATA SOURCES AND DATES

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

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

**APPENDIX B: LIST OF INDICATORS ON WHICH DATA WERE GATHERED**

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



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

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

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

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

<b>Indicator Variable</b>	<b>Data Source</b>
(Percentage)	
Overweight (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Ozone (O3) - Days Exceeding Standards, Pop. Adjusted Average (Percentage)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Particulate Matter 2.5 - Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
People Delayed or had Difficulty Obtaining Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
People with a Usual Source of Health Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Physically Inactive Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccination (Age-Adjusted) (Percentage, Population Age 65+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Poor Dental Health (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor Mental Health (Percentage, Adults 18+)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Poor or Fair Health (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Population Change, 2000-2010 (Percentage)	US Census Bureau, Decennial Census. 2000 - 2010.
Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2009-13.
Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Population with HIV / AIDS, Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2010.
Potentially Exposed to Unsafe Drinking Water (Percentage, Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Poverty (Percentage, Population)	US Census Bureau, American Community Survey.



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

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



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

**APPENDIX C: PERSONS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY**

<b>Sector</b>	<b>Organization</b>	<b>Title</b>	<b>Focus Population/ Topic/ Expertise</b>	<b>Target Group Role (Leader/ Representative/ Member)</b>	<b>Target Group Represented*</b>	<b>Consultation Method</b>	<b>Date Consulted (2015)</b>
County Health	Behavioral Health Services, Contra Costa County	Director	Behavioral health, mental health, homeless	Leader	1, 2, 3	Interview	09/22/15
County Health	Contra Costa Health Services	Assistant Director	Health services, public health	Leader	1, 2, 3	Interview	07/30/15
County Health/Public Health	Contra Costa County Public Health	Epidemiologist	Public health	Leader	1, 2, 3	Interview	06/24/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	Lead African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member)	Target Group Represented*	Consultation Method	Date Consulted (2015)
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Non-Profit	Meals-on-Wheels Senior Outreach	Executive Director	Low-income, underserved, older adults	Leader	3	Interview	08/12/15
N/A	Pittsburg High School African American Parent Group (PAAACT)	N/A	Low-income, minority (Black/ African American)	Members (7)	3	Focus group	08/27/2015
N/A	First 5 Contra Costa County	N/A	Low-income, Spanish-speaking minority (Latino)	Members (11)	3	Focus group	09/03/2015

## APPENDIX D: GLOSSARY

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

**APPENDIX E: 2016 HEALTH NEEDS PRIORITIZATION SCORES: BREAKDOWN BY CRITERIA**

Health Need	Rank (1=Highest Priority)	Overall Average Score	Average Scores of Prioritization Criteria Used by Group			
			Severity	Magnitude	Disparities	Community Priority
Economic security	1	2.80	2.40	2.80	3.00	3.00
Healthcare access & delivery, including primary & specialty care	3	2.45	2.40	2.20	2.20	3.00
Mental health	5	2.25	1.80	1.80	2.40	3.00
Obesity, diabetes, & healthy eating/active living	2	2.75	2.80	2.80	2.40	3.00
Oral/dental health	4	2.35	2.20	2.00	2.20	3.00
Substance abuse, including alcohol, tobacco, and other drugs	8	1.85	2.00	2.00	2.40	1.00
Unintentional injuries	6	2.00	1.80	1.40	1.80	3.00
Violence/injury prevention	7	1.90	2.20	1.60	2.80	1.00

**Definitions:**

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

## APPENDIX F: CHNA QUALITATIVE DATA COLLECTION PROTOCOLS

### Professionals (Providers) Focus Group Protocol

#### Introductory remarks

- Welcome and thanks
- What the project is about:
  - We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
  - Identifying unmet health needs in your community, extending beyond patients.
  - Ultimately, to invest in community health strategies that will lead to better health outcomes.
- Why we're here (**put on flipchart page**):
  - Learn about health needs in your community
  - Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment
  - Talk about impact of various other things that influence health
  - Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed

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

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

#### Focus Group Questions

##### 1. Community Health Needs & Prioritization

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

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

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

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

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

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

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

## 2. Access to Care

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

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

## 3. Drivers/Barriers

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

**Prompts if they are having trouble thinking of anything:**

- Transportation
- Housing
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms



- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

#### 4. Suggestions/Improvements/Solutions

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

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

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

<ul style="list-style-type: none"> <li>▪ Specific new/expanded programs or services?</li> <li>▪ Increase knowledge/understanding?</li> <li>▪ Address underlying drivers like poverty, crime, education?</li> <li>▪ Facilities (incl. hospitals/clinics)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Infrastructure (transportation, technology, equipment)</li> <li>▪ Staffing (incl. medical professionals)</li> <li>▪ Information/educational materials</li> <li>▪ Funding</li> <li>▪ Collaborations and partnerships</li> <li>▪ Expertise</li> </ul>
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**Concluding Remarks**

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

## **Residents (Non-Professionals) Focus Group Protocol**

### Introductory remarks

- Welcome and thanks
- What the project is about:
  - We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
  - Identifying unmet health needs in your community, extending beyond patients.
  - Ultimately, to invest in community health strategies that will lead to better health outcomes.
- Why we're here (**put on flipchart page**):
  - Learn about health needs in your community
  - Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment
  - Talk about impact of various other things that influence health
  - Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed

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

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

### Focus Group Questions

#### 1. Community Health Needs & Prioritization

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

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

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

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

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

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

## 2. Access to Care

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

- a) First, a little about health insurance:
  - i. Have any of you enrolled in health insurance in the last two years...
    - For the first time?
    - After a lapse in insurance?
  - ii. What has kept you from enrolling, or from getting better coverage?
- b) Now, some questions about the “coverage” (benefits) that you do have:
  - i. Do you have more or better insurance “coverage” than you had two years ago, or is it the same, or worse?
  - ii. Are you more likely now, than you were two years ago, to visit a primary care doctor instead of ER or urgent care; or are you just as likely as before; or less likely?
- c) What prevents you from getting the health care you need?
- d) Now thinking about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

## 3. Drivers/Barriers

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

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

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

## 4. Suggestions/Improvements/Solutions

Now that we have identified the most challenging health needs impacting your community, as well as your experiences in accessing health services, we would like to ask you about some possible solutions. **For the needs you prioritized earlier...**

- a) Are there existing assets or resources available to address these needs that people are not using? Why?
- b) What other assets or resources are needed?

**Resource question prompts if they are having trouble coming up with anything:**

<ul style="list-style-type: none"> <li>▪ Specific new/expanded programs or services?</li> <li>▪ Increase knowledge/understanding?</li> <li>▪ Address underlying drivers like poverty, crime, education?</li> <li>▪ Facilities (incl. hospitals/clinics)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Infrastructure (transportation, technology, equipment)</li> <li>▪ Staffing (incl. medical professionals)</li> <li>▪ Information/educational materials</li> <li>▪ Funding</li> <li>▪ Collaborations and partnerships</li> <li>▪ Expertise</li> </ul>
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Concluding Remarks

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

## **Key Informant Interview Protocol**

### Introduction

What the project is about:

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

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

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

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

### Preamble

Our questions mainly relate to:

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

### Interview questions

#### 1. Background

First, please tell me a little about your current role and the organization you work for.

#### 2. Health needs

Next, we would like to get your opinion on the top health needs among those you serve.

- a) In your opinion, which health needs do you believe are the most important to address among those you serve/your constituency?
- b) In your opinion, what are the health needs that are not being met very well right now among those you serve/your constituency?
- c) Are there any specific groups that have greater health needs, or special health needs?
  - i. Differences by gender
  - ii. Within specific ethnic groups
  - iii. Among different age groups like seniors or children
  - iv. Within different parts of the county
  - v. Any other specific groups

**If they identified more than three health needs, ask question d; if not, go on to section 3.**

- d) Which would you say are the most urgent or pressing of all the health needs that you’ve named?

### 3. Challenges: Access to healthcare – post-ACA

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

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

### 4. Other Challenges

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

**Prompts if they are having trouble thinking of anything:**

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

### 5. Suggestions/Improvements/Solutions

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

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

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

<ul style="list-style-type: none"><li>▪ Specific new/expanded programs or services?</li><li>▪ Increase knowledge/understanding?</li><li>▪ Address underlying drivers like poverty, crime, education?</li><li>▪ Facilities (incl. hospitals/clinics)</li></ul>	<ul style="list-style-type: none"><li>▪ Infrastructure (transportation, technology, equipment)</li><li>▪ Staffing (incl. medical professionals)</li><li>▪ Information/educational materials</li><li>▪ Funding</li><li>▪ Collaborations and partnerships</li><li>▪ Expertise</li></ul>
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**Concluding Remarks**

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



## APPENDIX G: COMMUNITY ASSETS AND RESOURCES

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

### Overall:

#### Existing Health Care Facilities

Alta Bates Summit Medical Center

- Oakland
- Berkeley

Contra Costa Regional Medical Center

Eden Medical Center

Ernest Cowell Memorial Hospital

Fern Lodge

Fremont Hospital

Gilmore Hospital

Highland Hospital

John Muir Medical Center

- Concord
- Walnut Creek

John Muir Behavioral Health Center

Kaiser Permanente – Diablo (Antioch and Walnut Creek)

Kaiser Permanente – East Bay (Oakland and Richmond)

Kaiser Permanente – Greater Southern Alameda (Fremont and San Leandro)

Kindred Hospital San Francisco Bay Area

San Leandro Hospital

St. Rose Hospital

San Ramon Regional Medical Center

Stanford Health Care – ValleyCare Medical Center

Sutter Delta Medical Center

Telecare Heritage Psychiatric Health Facility

UCSF Benioff Children's Hospital – Oakland

U.S. Naval Hospital

Veteran's Administration Hospital

- Livermore
- Martinez

Washington Hospital

Willow Rock Center (psychiatric)

## Existing Federally Qualified Health Centers

Alameda County Health Care Services

- Mobile Van #2 (San Leandro)

Albert J. Thomas Medical Clinic

Alcatraz Avenue Medical Group

Asian Health Services

- 8th Street Satellite
- Webster Street

Axis Community Health

- Livermore
- Pleasanton

Berkeley Primary Care Access Clinic

Casa del Sol

East Oakland Health Center

Frank Kiang Medical Center

La Clinica

- Monument (Concord)
- Pittsburg-Medical
- Oakley

La Clinica de la Raza

- 9<sup>th</sup> Street, Oakland
- 12<sup>th</sup> Street, Oakland

Lifelong Ashby Health Center

Lifelong Brookside Community Health Center

- Richmond
- San Pablo

Lifelong Dental Care

Lifelong Dr. William M. Jenkins Pediatric Center

Lifelong Medical Care

- Albany
- East Oakland
- Eastmont
- Howard Daniel Clinic
- Oakland (Supportive Housing Program)
- Richmond

Native American Health Center

Over 60 Health

San Antonio Neighborhood Health Center

Tiburcio Vasquez Health Center

- Union City
- Hayward
- San Leandro

Tri-City Health Center

- Main Street Village, Fremont

West Oakland Health Council

William Byron Rumford Medical Clinic

Other Existing Community Resources and Programs for Each Health Need

**Health Need: Economic Security**

- Abode Services
- HOPE Project Mobile Health Clinic
- Project Independence
- Alameda County Community Food Bank
- Alameda County Early Head Start and Head Start
- Alameda County Homeless Project- Hayward (incl. Special Needs Housing)
- Alameda County Housing and Community Development Shelter and Care
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Alameda County Social Services Department
- America Works (ex-convicts)
- Antioch/East Contra Costa Health and Wealth Initiative
- Berkeley City College CalWORKS program
- Berkeley Public Library Adult Literacy Program
- Brighter Beginnings
- Building Blocks for Kids Collaborative
- Building Opportunities for Self-Sufficiency (BOSS)- Short-term Special Needs Housing
- Catholic Charities of the East Bay
- Center for Independent Living Employment Academy
- Centro de Servicios
- Child, Family and Community Services (CFCS)- Southern Alameda County Early Head Start and Head Start
- City of Berkeley Health, Housing and Community Services Department
- City of Dublin Senior Center
- City of Oakland Department of Human Services
- Community Resources for Independent Living (CRIL)
- Computer Technologies Program
- Contra Costa County Employment & Human Services
- Contra Costa County Early Head Start and Head Start
- EBALDC – East Bay Asian Local Development Corporation
- Economic Opportunity Council

## Health Need: Economic Security

- East Bay Community Foundation
- East Bay Community Law Center
- East Bay Green Jobs Corps
- East Oakland Youth Development Center
- East Richmond Youth Development Center
- Eden I&R, Inc.
- Emergency Shelter Program, Inc.
- Ensuring Opportunity Contra Costa
- Fremont Healthy Start (A Program of East Bay Agency for Children)
- Fremont Resource Center
- Friends of Alameda County Court Appointed Special Advocates
- Hope for the Heart- Food Distribution
- Inter-City Services (Veterans Employment Related Assistance, and Workforce Training Program)
- Monument Community Partnership & Michael Chavez Center for Economic Opportunity
- Monument Impact
- One Stop Center
- Operation Dignity (veterans)
- Opportunity Junction
- Richmond Health Equity Partnership
- Richmond Works
- San Lorenzo Family Help Center- Ecumenical Food Pantry
- Safe Alternative to Violent Environments (SAVE)
- Salvation Army Hayward:
  - Corps- Food, Clothing, and Donation Services
- USDA Commodity and Food Programs
- South Hayward Parish:
  - Emergency Food Pantry
- Hayward Community Action Network
- SparkPoint Bay Point
- The Stride Center
- Tri-City One-Stop Career Center (Employment Development Department)
- Tri-City Volunteers Food Bank & Thrift Store
- Tri-Valley Community Foundation
- Youth Employment Partnership

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

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

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

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

## Health Need: Mental Health

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

## Health Need: Mental Health

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



## Health Need: Mental Health

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

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

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

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

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

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

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

### Health Need: Oral/Dental health

- Axis Community Health
- Chabot- Las Positas Community College District- Dental Hygiene Clinic
- La Clinica de la Raza
- Ronald McDonald Dental Care Mobile
- Tiburcio Vasquez Health Center- Dental Department
- Tri-City Health Center, Dental Care
- University of the Pacific- Arthur A. Dugoni School of Dentistry- Union City Dental Care Center

## Health Need: Substance Abuse (including tobacco and alcohol)

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

**Health Need: Substance Abuse (including tobacco and alcohol)**

- PC 1000 Drug Division
- Terra Firma Diversion/Educational Services:
  - Court Ordered Adult Diversion Programs
  - Drug Relapse Prevention, Drug Testing, and Youth Services
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- Ujima:
  - East
  - West
- Victory Outreach - Prison Counseling and Services; Residential Rehab Program - Hayward
- West Oakland Health Council
- Women on the Way Recovery Center

**Health Need: Unintentional Injuries**

- Contra Costa Health Services
- Child Passenger Safety Program
- Fall Prevention Program of Contra Costa County

## Health Need: Violence and Injury Prevention

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



## **APPENDIX H: HEALTH NEEDS PROFILES**

- Economic Security
- Healthcare Access & Delivery, Including Primary & Specialty Care
- Mental Health
- Obesity, Diabetes, Healthy Eating/Active Living
- Oral/Dental Health
- Substance Abuse (Alcohol, Tobacco, and Other Drugs)
- Unintentional Injuries
- Violence/Injury Prevention



# Profile of KFH-Antioch Service Area Health Needs

## ECONOMIC SECURITY

### Why Is It Important?

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

### CHILDREN LIVING IN POVERTY TOO COMMON

Nearly 1 in 5 children in the KFH-Antioch service area lives in poverty, and ethnic disparities exist.

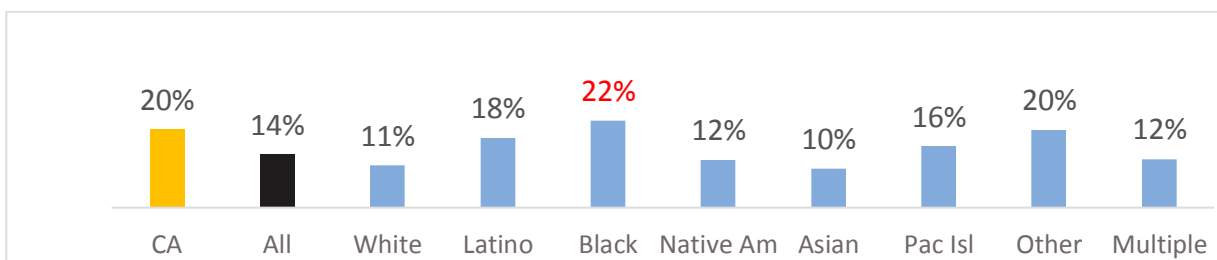
### Why Is It a Community Health Need?

In the KFH-Antioch service area, residents experience food insecurity, and some ethnic groups have higher proportions that are living in poverty than others. Regarding education, the rate of students graduating from high school is lower than both the Healthy People 2020 (HP2020) target and the Contra Costa County overall rate. Community members felt that many people must choose either to buy medicine or pay their rents and eat.

### What Do the Data Show?

- A larger proportion of Latino residents, Black residents, and those of "other" races were living in poverty compared to all county residents (see chart).

PERCENT LIVING AT OR BELOW 100% OF FEDERAL POVERTY LEVEL, KFH-ANTIOCH SERVICE AREA, 2009-13



<sup>1</sup> *Social Determinants of Health: How Social and Economic Factors Affect Health*. County of Los Angeles Public Health. 2013.

<sup>2</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- In the KFH-Antioch service area, 18% of children were living in poverty compared to 14% of county children, and many children of color fare worse: Black (31%), Latino (26%), and those of “other” races (26%).
- 13% of KFH-Antioch service area residents and Contra Costa County residents experience food insecurity at some point during the year, which is higher than the HP 2020 target of 6%.
- The high school graduation rate (4-year cohort) is 79%, falling just below both the state average (80%) and the HP 2020 goal (82%).
- 45% of the KFH-Antioch service area population (ages 3-4) were enrolled in school, which was lower than the state average (49%).
- Thirty-eight percent (38%) of KFH-Antioch service area 4<sup>th</sup> grade students were reading *below* proficiency, slightly worse than the state average (36%) and the HP 2020 goal (36%).

## What Does the Community Say?

- People are not able to afford or lack time to take care of themselves, which causes physical and mental health issues.
- Living in a poor neighborhood has an impact on your overall wellbeing even if you are not poor yourself.
- People are faced with the choice to either buy medicine, pay rent, or eat.
- Families have to work and do not have the time to obtain health care information.
- There is not enough job training, particularly for those between 18-25 years old.
- There are too few full-time jobs, and people are working two or more jobs and still not making ends meet. Low-income jobs are not stable and are more susceptible to the ups and downs of the economy.
- Seniors are on a fixed income which is often not enough to live on.
- There is too little affordable housing available in the community.



# Profile of KFH-Antioch Service Area Health Needs

## HEALTHCARE ACCESS & DELIVERY

### Why Is It Important?

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.<sup>1</sup>

Components of access to care include: coverage, services, and timeliness. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. As reflected in the community comments, barriers to services include: lack of availability, high cost, and lack of insurance coverage. As illustrated in the data below, these barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventative services, and hospitalizations that could have been prevented.

### LACK OF INSURANCE STILL AN ISSUE

More than 1 in 10 residents were uninsured in 2013 and most non-whites are much more likely to be uninsured.

### Why Is It a Community Health Need?

Wide racial/ethnic disparities exist in the uninsured population. Also, the KFH-Antioch service area falls short of the target in the rate of Federally Qualified Health Centers. The downstream indicator of preventable hospital events show that the service area residents are far more likely to be hospitalized for preventable issues than Californians overall.

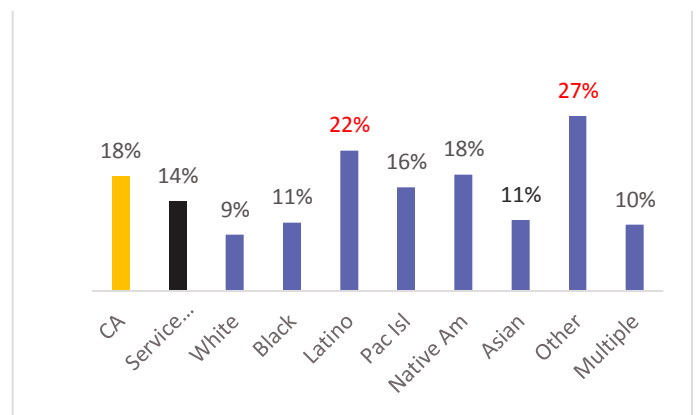
### What Do the Data Show?

- 22% of Latinos, 16% of Native Hawaiian/Pacific

Islanders, and 27% of those of an "other" race are uninsured as compared to 9% of Whites. In the KFH-Antioch service area overall 14% are uninsured.

- The rate of Federally Qualified Health Centers in the Antioch service area is 1.65 per 100,000, worse than the state average of 1.97.
- The age-adjusted discharge rate for preventable hospitable events in the KFH-Antioch service area 135.26 per 10,000 residents, which is worse than the state average of 83.2.

PERCENT UNINSURED, KFH-ANTIOCH SERVICE AREA, 2009-13



<sup>1</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

- Male patients have a slightly higher percentage of patient discharges for preventable conditions than female patients (13% as compared to 11% respectively).

## What Does the Community Say?

- Cost of insurance, co-payments, and deductibles are too high.
- Insurance does not cover the care that is needed.
- Lack of insurance and access to care cause stress that affects mental health.
- There is a lack of information about where and how to obtain health insurance.
- Getting to and from appointments is difficult when patients are relying on public transportation. The cost of transportation is also difficult.
- It is difficult to obtain a timely appointment and wait times in the office are too long.
- Emergency rooms are still being used when people can't get timely appointments or when the doctors' hours don't align with their schedules.
- Patients fear accessing care because of previous bad experiences.
- It is difficult for those who lack safe shelter to focus on other aspects of their health.



# MENTAL HEALTH

## Why Is It Important?

Mental health is a state of successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges.<sup>1</sup> Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.<sup>1</sup>

## Why Is It a Community Health Need?

In the KFH-Antioch service area, more than 10% of residents in each ethnic group expressed a need for mental health care, and suicide rates are higher than the state rate and the Healthy People 2020 (HP2020) HP2020 objective. Youth in the service area also have higher rates of non-fatal, intentional injuries as compared to the state. Community input indicates that cultural barriers make it harder to access mental health care. Community members also felt that primary care physicians are not educating patients about the link between well-being and disease prevention, and that primary care physicians are not making mental health referrals.

## What Do the Data Show?

- The age-adjusted rate of death due to intentional self-harm (suicide) per 100,000 population in the KFH-Antioch service area (11.5) was higher than the state benchmark (9.8) and the HP2020 objective (10.2). The suicide rate for Whites (13.6) was the highest among racial and ethnic groups, while the rates were lowest among Latinos and Asians (both 5.8).
- In the KFH-Antioch service area, Latino adults are much more likely to report a need for mental health care as compared to other racial and ethnic groups (see chart).
- The youth intentional injury rate (non-fatal ER visits)<sup>2</sup> in the KFH-Antioch service area is higher than the state average (779.3 per 100,000 population age 13-20 as compared to 738.7).

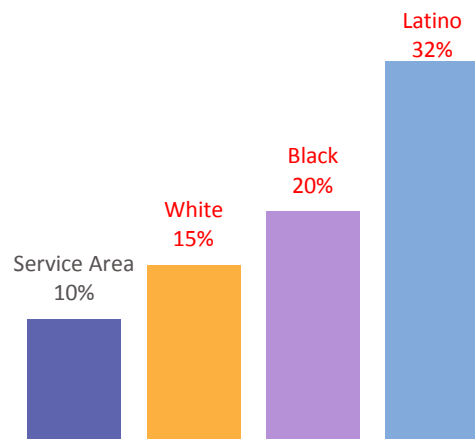
<sup>1</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

<sup>2</sup> *Public Safety and Self-Harm*.

## NEEDS FOR MENTAL HEALTH CARE COMMON

1 in 10 KFH-Antioch residents expressed a need for mental health care, and Latinos are most likely to express this need.

PERCENT NEEDING MENTAL HEALTH CARE, KFH-ANTIOCH SERVICE AREA, 2006-2012



## What Does the Community Say?

- Cultural barriers and stigma keep people from seeking mental health services; some think, “If you need a counselor, it’s because you’re crazy.” On the other hand, some people do not consider mental health an illness.
- Parents pressure children to be high-achieving students, which leads to poor mental health.
- Seniors are isolated and lonely, which sometimes leads to depression.
- Lack of insurance, high cost of insurance, and high cost of co-payments are keeping people from seeking mental health services.
- Primary care physicians are not educating patients about the link between well-being and disease prevention and are not making mental health referrals. Residents suspect that it is due to a perceived lack of coverage or affordability for the patient.
- There is no place to go and talk to someone and receive help. Also, specialty mental health care is hard to access.
- There are not enough physical spaces for mental health hospitals/treatment facilities, particularly for infants and children.





## Profile of KFH-Antioch Service Area Health Needs OBESITY/DIABETES/HEAL (HEALTHY EATING ACTIVE LIVING)

### Why Is It Important?

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

### MANY ARE LIVING IN A FOOD DESERT

In the KFH-Antioch service area, more residents are living in areas designated as food deserts compared to the state average.

### Why Is It a Community Health Need?

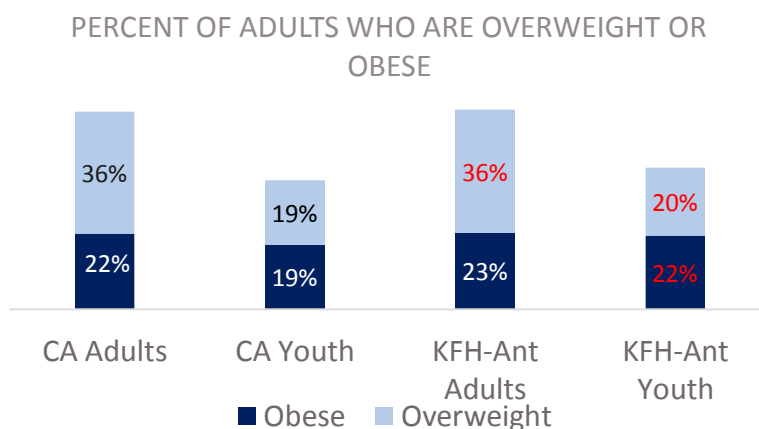
Compared to the state, data show that in KFH-Antioch service area there are higher rates of overweight among adults and youth, and higher rates of diabetes prevalence. Also, lower percentages of Medicare enrollees with diabetes who have an annual diabetes test. Also, in the KFH-Antioch service area, ethnic disparities are evident. Community input about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity. Community input indicates that there is a lack of education around linking mental health and healthy living, and that healthy food is often less affordable than the unhealthy food options.

### What Do the Data Show?

- Approximately 22% of adults and youth are obese in the KFH-Antioch service area.
- Latino and Black youth are much more likely to be obese than White or Asian youth. For instance, in the service area, 26% of Latino youth are obese as compared to 14% of Asian youth.
- In the KFH-Antioch service area, eight in ten (80%) Medicare enrollees with diabetes had an annual exam (Hemoglobin A1c Test), slightly lower than the state average of 81%.
- There are 13.2 grocery stores per 100,000 residents in the service area, below the county rate of 18.6 and state average of 21.5.

<sup>1</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

<sup>2</sup> *Healthy Food Environments*. Centers for Disease Control and Prevention. Web. December 2015.



- A food desert is defined as a low-income census tract where a substantial share of residents has low access to a supermarket or large grocery store. In the KFH-Antioch service area, 20% of residents live in areas designated as a food desert, which is well above the state proportion (14%).
- In the KFH-Antioch service area, 34% of students walk/bike/or skate to school, below the state average of 43%.
- Over a quarter (27%) of the population in the KFH-Antioch service area have a commute of over 60 minutes, compared to 18% for Contra Costa County and 10% for the state.

## What Does the Community Say?

- It is more expensive to eat healthy/organic; fast food is cheaper.
- Families are buying cheaper items to make money last, even if the items are not healthy (e.g., fast food).
- There is a lack of full access to supermarkets in low-income areas. However, farmers' markets are accepting CAL-Fresh.
- People qualify for CAL-Fresh but are not applying.
- Too many places sell products with high sugar content.
- There is a lack of education around linking mental health and healthy living/healthy eating.
- Many seniors are on dialysis, not eating well, and lacking physical activity.
- There are not enough affordable sports or recreational activities for youth and adults.
- Safe places are needed where people can get physical exercise.



# ORAL HEALTH

## Why Is It Important?

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.<sup>1</sup> However, oral diseases, from cavities to oral cancer, cause pain and disability. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health.<sup>1</sup> Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures. There are also social determinants that affect oral health. People with lower levels of education and incomes and people from specific racial/ethnic groups have higher rates of oral diseases. Additionally, people with disabilities are more likely to have poor oral health.

## ORAL HEALTH A COMMUNITY CONCERN

Two out of four focus groups prioritized oral health as a community health need.

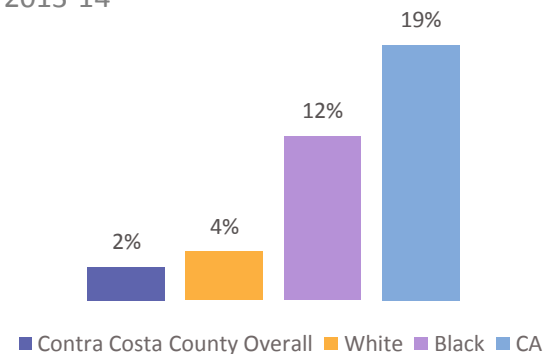
## Why Is It a Community Health Need?

County data indicates that many residents have low access to dental health care professionals, and Black youth in the county are less likely to have had a recent dental exam. In addition, the community is concerned about oral/dental health. In the KFH-Antioch service area, one out of three focus groups prioritized oral health as a health need, and it was a top priority of a key informant.

## What Do the Data Say?

- 9.3% of the county population is living in a Dental Health Professional Shortage Area (HPSA), which is higher than the state (4.9%).
- As shown in the chart, Black youth in the county are more likely to have had no recent dental exam than county youth overall.

PERCENT OF YOUTH WITHOUT A RECENT DENTAL EXAM, CONTRA COSTA COUNTY, 2013-14



<sup>1</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

## What Does the Community Say?

- Dental specialty care is hard to obtain. Many providers don't take Medi-Cal/Denti-Cal; reimbursement "just doesn't economically work" for dentists. Source: CHNS, 2013-14.
- Cost of dental care is too high for low-income people.
- Insurance often does not cover dental care, especially for adults. Coverage is often not sufficient (e.g., often root canals and porcelain fillings are not covered).
- There are long wait times for dental appointments.
- The community perception is that residents are receiving poor quality dental care with few treatment options. For example, healthcare facilities may resort to just pulling teeth because replacing a pulled tooth is expensive.
- The community feels preventative dental care is lacking. Parents may not take kids to the dentist for preventative care; they wait until there is a problem.
- The community has no mobile dental clinic.
- Transportation is difficult and expensive, especially when some have to go to Oakland for services.



# SUBSTANCE ABUSE

## Why Is It Important?

The abuse of substances, including alcohol, tobacco, and other drugs, has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases such as cancer, heart disease, and respiratory diseases.<sup>1</sup> The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to, teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide.<sup>2</sup>

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have shifted the research community's perspective on substance abuse. Substance abuse is now understood as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.<sup>2</sup>

## Why Is It a Community Health Need?

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

## What Do the Data Show?

- The rate of binge drinking in the KFH-Antioch Service Area is 19%, higher than the state average of 17%.
- Over 13% of KFH-Antioch Service Area residents' total household expenditures are towards alcohol, no better than the state average (13%).

## What Does the Community Say?

- In the community, people are generally using opiates, methamphetamines, and alcohol.
- Methamphetamine users are experiencing drug-induced heart failure.

<sup>1</sup> *Smoking and Tobacco Use, Health Effects*. Centers for Disease Control and Prevention. Web. December 2015.

<sup>2</sup> *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.

## ALCOHOL USE A CONCERN

Indicators of alcohol use show that KFH-Antioch service area residents may use alcohol more frequently than Californians overall.

- Residents use substances to help them sleep.
- Substances are also being used by those experiencing homelessness to cope with being on the street.
- The community lacks alcohol and drug services.
- There is a need for more beds in wet homeless shelters (i.e., shelters that do not require sobriety/abstinence for entry).
- People don't know where they may safely dispose of their unused prescription medications which could be misused by others.



# UNINTENTIONAL INJURIES

## Why Is It Important?

Unintentional injuries are defined as those that are not purposely inflicted. The most common unintentional injuries result from falls, motor vehicle crashes, poisonings, and drownings. Although most unintentional injuries are predictable and preventable, they are a major cause of premature death and lifelong disability. More individuals ages 1-44 die as a result of unintentional injuries than from any other cause.<sup>1</sup> Unintentional injury is the sixth leading cause of death for people of all ages in California.<sup>2</sup>

## ACCIDENTS MORE COMMON FOR SOME

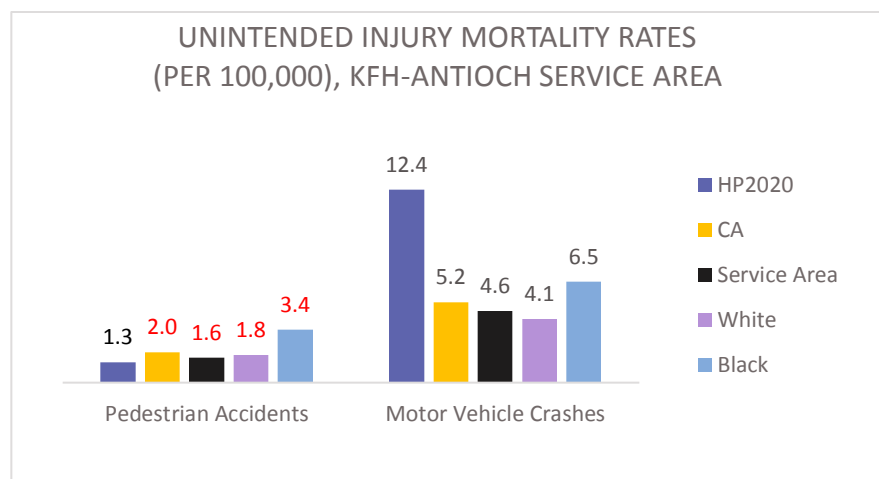
Data show ethnic disparities for unintentional injuries, including motor vehicle crashes and pedestrian accidents.

## Why Is It a Community Health Need?

Rates of unintentional injuries in the county and the KFH-Antioch service area show that in some cases residents are more likely to suffer an unintentional injury than Californians generally. Ethnic disparities are also evident in the data. The community is concerned about the impacts of older adult falls in the area.

## What Do the Data Show?

- The mortality rate for pedestrian accidents in the KFH-Antioch service area (1.6 per 100,000) was higher than the HP2020 goal (1.3).
- Ethnic disparities: Blacks in the KFH-Antioch service area have higher rates of motor vehicle crash mortality (see chart below).



<sup>1</sup> Society for Public Health Education (SOPHE) Unintentional Injury and Violence Prevention, <http://www.sophe.org/ui/injury-unintentional.shtml>

<sup>2</sup> California Department of Public Health. <https://www.cdph.ca.gov/programs/ohir/Pages/UnInjury2010Background.aspx>



- In Contra Costa County, Blacks have higher rates of death due to unintentional injuries (43.2 per 100,000) than all county residents (26.7) and Californians (36.4).
- In Contra Costa County, Whites have higher rates of hospitalizations due to unintentional injuries (723.7 per 100,000) than all county residents (537.1) and Californians (552.1).

## What Does the Community Say?

Community feedback mainly focused on falls:

- Seniors do not go to the doctor very often because of financial barriers.
- Some seniors are afraid to say they have fallen, because they don't want to be removed from their homes; often, seniors can never live alone again after being hospitalized for a fall.



# Profile of KFH-Antioch Service Area Health Needs **VIOLENCE/INJURY PREVENTION**

## Why Is It Important?

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

## HIGH RATES OF VIOLENT DEATHS & INJURIES

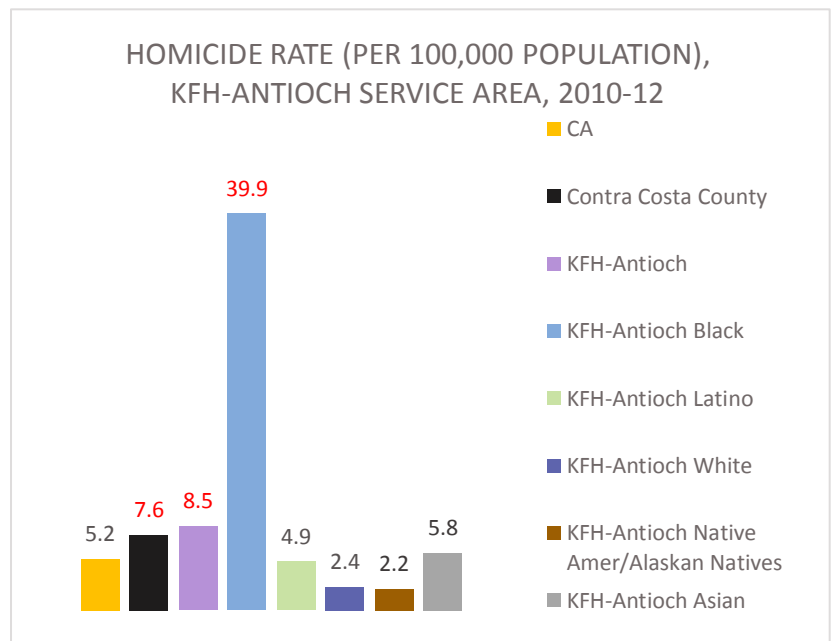
Service area rates of homicides, assault injuries, and domestic violence injuries are higher than those in the state overall.

## Why Is It a Community Health Need?

In the KFH-Antioch service area, rates of homicide are above the state benchmark and the Healthy People 2020 (HP2020) target. Also, non-fatal emergency room (ER) visits for injury due to assault and domestic violence are all much higher than state averages. Community input indicates that gang violence is a major issue, and that there are a lack of domestic violence shelters in the community.

## What Do the Data Show?

- The age-adjusted homicide mortality rate in the KFH-Antioch service area is above the state average and the HP2020 objective. Racial and ethnic disparities are stark, with Blacks having a homicide mortality rate 17 times higher than Whites and 18 times higher than Native Americans/Alaskan Natives, who have lowest rates (see chart).
- The rate of domestic violence (non-fatal ER visits) per 100,000 females age 10 and over in the KFH-Antioch service area (12.2) is higher than the state average (9.5).



- The rate (per 100,000) of emergency room visits for non-fatal assault injuries in Alameda and Contra Costa Counties was 316, much higher than in California (290).

School suspensions and expulsions are a relevant indicator because exclusionary school discipline policies are associated with engagement with the juvenile justice system and incarceration as an adult, as well as poor economic security and mental health outcomes.

- The KFH-Antioch service area has a rate of school suspensions well above the state average (17.7 per 100 enrolled students compared to 4.0 for the state).
- The rate of school expulsions per 100 enrolled students is above the state average in the KFH-Antioch service area (0.13 compared to 0.05).

## What Does the Community Say?

- The community lacks trust in the police.
- There are higher homicide rates amongst Black gangs than Latino gangs, even when there are more Latino gangs.
- There is a lack of domestic violence shelters in the community.
- Elder neglect is a problem, especially of those with mental health issues.

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3 Perez-Smith, A.M., Albus, K.E., & Weist, M.D. (2001). Exposure to violence and neighborhood affiliation among inner-city youth. Journal of Clinical Child Psychology, 30(4):464-472;

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[http://www.humanimpact.org/evidencebase/category/violent\\_crime\\_in\\_a\\_community\\_impacts\\_physical\\_and\\_mental\\_health](http://www.humanimpact.org/evidencebase/category/violent_crime_in_a_community_impacts_physical_and_mental_health)