2016 Community Health Needs Assessment

Kaiser Foundation Hospital Manteca and Modesto
License #030000393

Approved by KFH Board of Directors
September 21, 2016

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

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

Acknowledgements

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Community Medical Centers
Community Partnerships for Families
Dameron Hospital Association
First 5 San Joaquin
Health Net
Health Plan of San Joaquin
Kaiser Permanente
San Joaquin County Public Health Services
St. Joseph's Medical Center
Sutter Tracy Community Hospital

Research and report development by Harder+Company Community Research.

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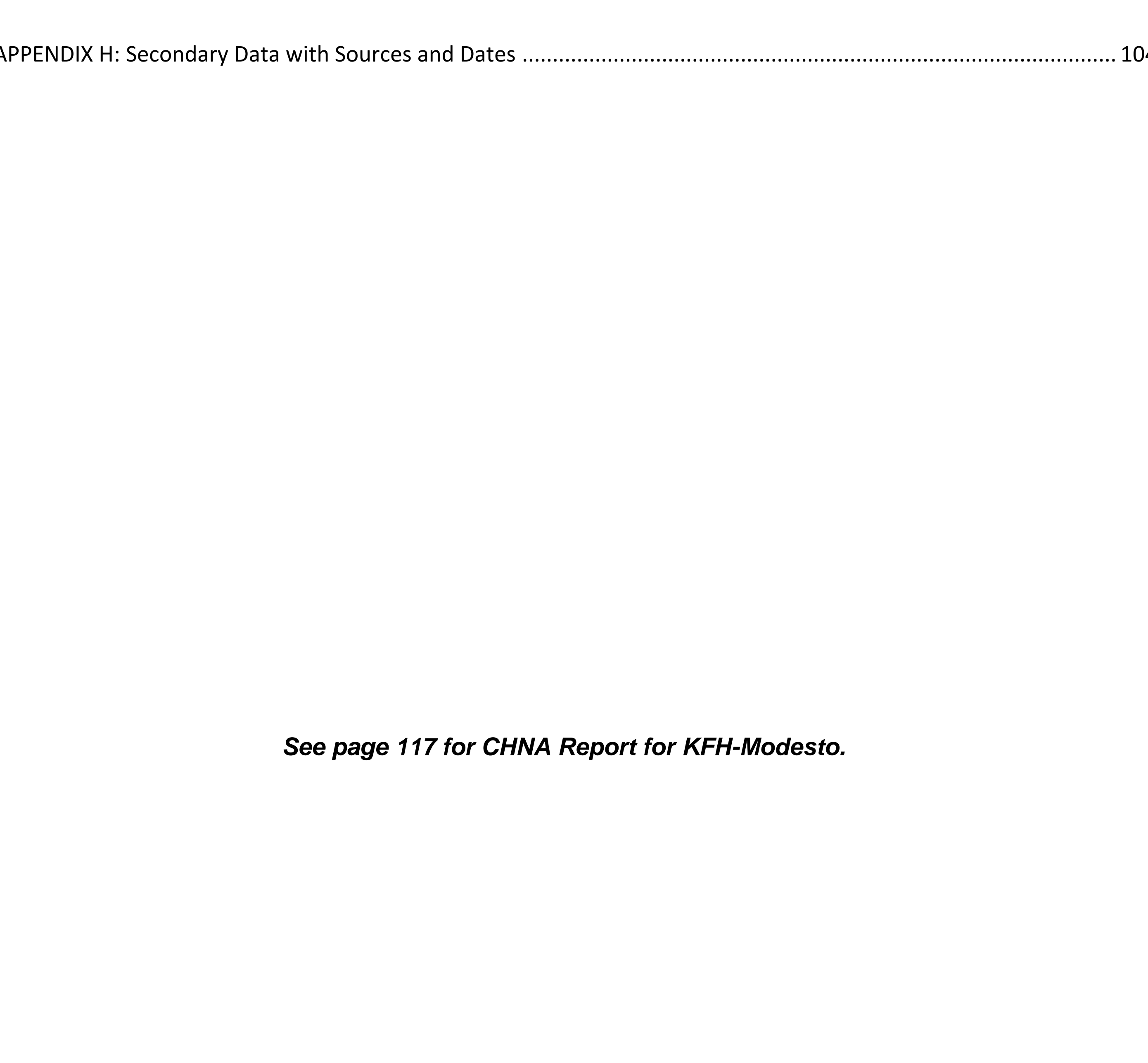


See page 117 for CHNA Report for KFH-Modesto.

I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

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

B. Summary of Prioritized Needs

The following health needs have been identified as priorities in San Joaquin County through a prioritization process that was informed by secondary data, primary data collection in the form of stakeholder interviews, community surveys, and community members participating in focus groups. The following eleven community health needs were ranked in the following numerical order:

1. Obesity and Diabetes
2. Education
3. Youth Growth and Development
4. Economic Security
5. Violence and Injury
6. Substance Use
7. Access to Housing
8. Access to Medical Care
9. Mental
10. Oral Health
11. Asthma/Air Quality

C. Summary of Needs Assessment Methodology and Process

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

- Analysis of over 150 health indicators from publicly available data sources such as the California Health Interview Survey, American Community Survey, and the California Healthy Kids Survey. Secondary data were organized by a framework of potential health needs, a broad list of needs relevant to San Joaquin County.
- A community survey administered to 2,927 residents, online or in person.
- Interviews with 34 key stakeholders from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted.
- 29 focus groups, reaching 348 residents, representing a breadth of geographic regions, racial/ethnic subpopulations, and age categories.

Data was used to score each health need. Potential health needs were included in the prioritization process if:

a. Multiple distinct indicators reviewed in secondary data demonstrated that the county estimate was poorer than the benchmark comparison estimate by at least 1%.
b. Health issue was identified as a key theme in at least five interviews.
c. Health issue was identified as one of the top three health issues, health behaviors, or social and economic issues by at least 20% of survey respondents.

The Core Planning Group with additional community partners were convened on November 12, 2015, to review the health needs identified, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the County. The group utilized the Criteria Weighting Method, which enabled consideration of each health issue using four criteria: severity, disparities, impact, and prevention. Based on the scoring, the health needs were ranked in order of priority.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

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

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

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

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

B. About Kaiser Permanente Community Benefit

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

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

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

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

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

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

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

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

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

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 Manteca will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and

resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

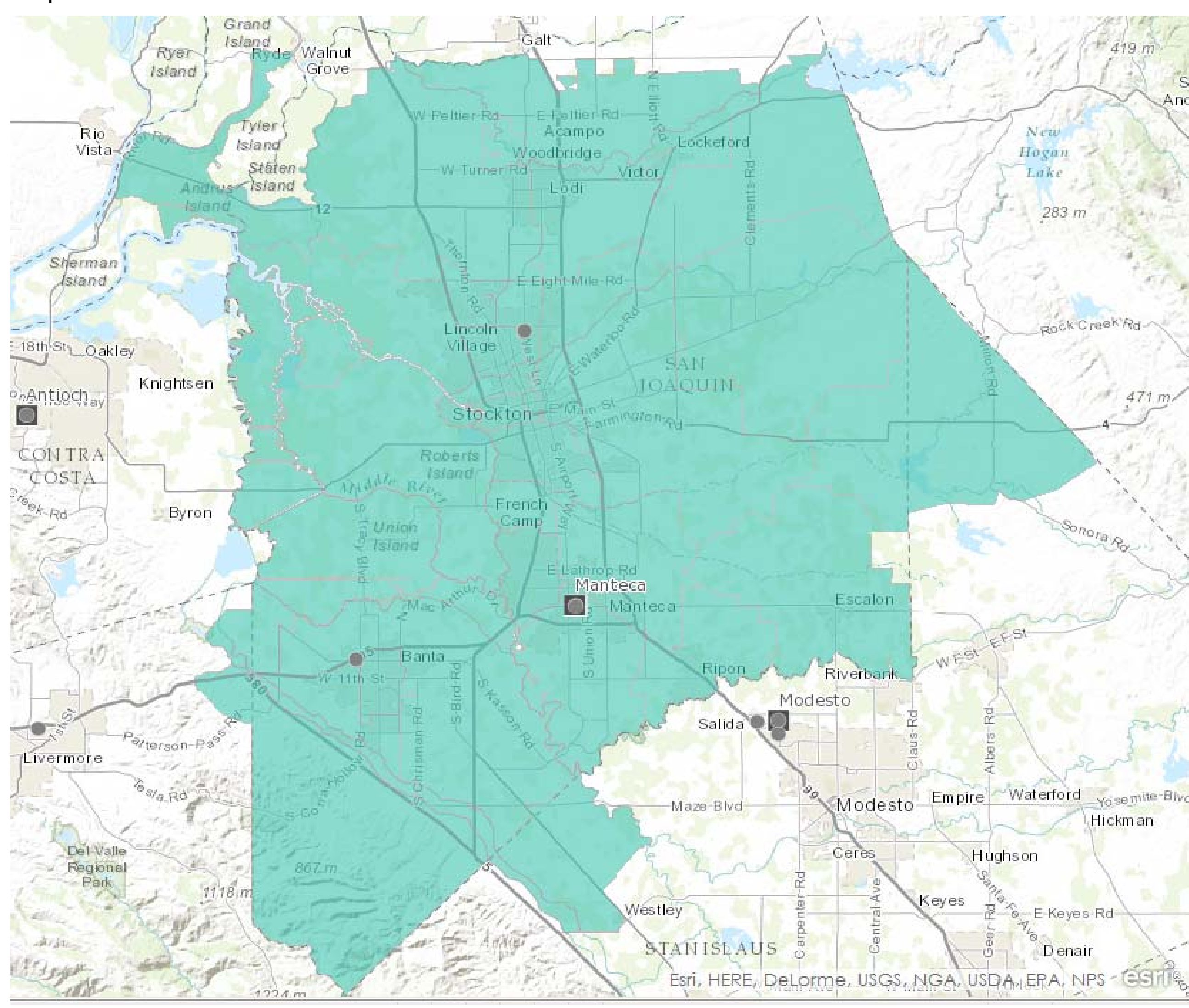
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

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

B. Map and Description of Community Served

i. Map



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

The KFH-Manteca service area includes Ceres, Escalon, Farmington, French Camp, Hughson, Lathrop, Lockeford, Lodi, Manteca, Oakdale, Patterson, Ripon, Riverbank, Stockton, Tracy, and Waterford.

iii. Demographic profile of community served

The KFH-Manteca service area faces an exacerbated set of many of the same challenges seen throughout the state, including unemployment, poverty, and lack of education. These key health drivers have upstream impacts for health outcomes. Overall, San Joaquin residents rate their health as poorer than the state overall, and there are notable disparities between the county and the state including obesity rates, asthma prevalence, and cancer mortality. All indicators include California comparison data as a benchmark to determine disparities between the KFH- Manteca service area (or San Joaquin County when service area data isn't available) and the state. Healthy People 2020 benchmarks are also included when available.

The following data provide an overall picture of the San Joaquin County population. Demographic and socioeconomic data present a general profile of residents, while overall health indicators present an assessment of the health of the county. Key drivers of health (e.g., healthcare insurance, education, and poverty) illuminate important upstream conditions that affect the health of San Joaquin today and into the future.

KFH-Manteca Demographic Data	
Total Population	701,631
White	57.86%
Black	7.19%
Asian	14.61%
Native American/ Alaskan Native	0.86%
Pacific Islander/ Native Hawaiian	0.57%
Some Other Race	11.47%
Multiple Races	7.45%
Hispanic/Latino	39.73%

KFH-Manteca Socio-economic Data	
Living in Poverty (<200% FPL)	42.18%
Children in Poverty	26.39%
Unemployed	12.4
Uninsured	16.11%
No High School Diploma	22.3%

San Joaquin County and California Health Profile Data[1]

[1] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2009-2013 American Community Survey 5-Year Estimate.

Indicator	SJ County	California	HP 2020[2]
Overall Health			
Diabetes Prevalence (Age Adjusted)[3]	10.4%	8.1%	--
Adult Asthma Prevalence[4]	17.4%	14.2%	--
Adult Heart Disease Prevalence[5]	6.2%	6.3%	--
Poor Mental Health[6]	18.2%	15.9%	--
Adults with Self-Reported Poor or Fair Health (Age Adjusted)[7]	22.0%	18.4%	--
Adult Obesity Prevalence (BMI > 30)[8]	29.1%	22.3%	≤ 30.5%
Child Obesity Prevalence (Grades 5, 7, 9) (BMI>30)[9]	21.0%	19.0%	≤ 16.1%
Adults with a Disability[10]	34.2%	29.9%	--
Infant Mortality Rate (per 1,000 births)[11]	5.8	5.0	≤ 6.0
Cancer Mortality Rate (Age Adjusted) (per 100,000 pop.)[12]	174.9	157.1	≤ 160.6
Key Drivers of Health			
Living in Poverty (<200% FPL)	41.3%	35.9%	--
Children in Poverty (<100% FPL)	24.5%	22.2%	--
Age 25+ with No High School Diploma	22.7%	18.8%	--
High School Graduation Rate[13]	80.3%	80.4%	≥ 82.4%
3rd Grade Reading Proficiency[14]	34.0%	45.0%	--
Percent of Population Uninsured	17.1%	17.8%	--
Percent of Population Receiving MediCal/Medicaid	29.4%	23.4%	--
Climate and Physical Environment			
Days Exceeding Particulate Matter 2.5 (Pop. Adjusted)[15]	10.1%	4.2%	--
Days Exceeding Ozone Standards (Pop. Adjusted)[16]	1.6%	2.5%	--
Weeks in Drought[17]	96.9%	92.8%	--
Total Road Network Density (Road Miles per Acre)[18]	2.73	4.3	--
Pounds of Pesticides Applied[19]	11,017,592	193,597,806	--
Population within Half Mile of Public Transit[20]	16.8%	15.5%	--

Leading Causes of Death in San Joaquin County, 2011-2013[21]		
Cause of Death	**San Joaquin County***	**California***
1. All cancers	171.3	151.0

[2] Whenever available, Healthy People 2020 Benchmarks are provided. Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
[3] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional analysis by CARES. 2011-2012.
[5] California Health Interview Survey. 2011-2012.
[6] California Health Interview Survey. 2013-2014.
[7] 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. 2006-2012.
[8] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[9] California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-2014.
[10] California Health Interview Survey. 2011-2012.
[11] 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, 2006-2010.
[12] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-2012.
[13] California Department of Education. 2013.
[14] Standardized Testing and Reporting (STAR) Results, 2010-11 and 2012-13, from California Department of Education, Accessed via kidsdata.org. 2013.
[15] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
[16] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
[17] US Drought Monitor. 2012-2014.
[18] Environmental Protection Agency, EPA Smart Location Database. 2011.
[19] California Department of Pesticide Regulation (CDPR). 2013.
[20] Environmental Protection Agency, EPA Smart Location Database. 2011.
[21] California Department of Public Health, OHIR San Joaquin County's Health Status Profile for 2015, 2011-2013.

2. Coronary heart disease	107.8	103.8
3. Cerebrovascular disease (stroke)	45.5	35.9
4. Chronic lower respiratory disease	44.4	35.9
5. Alzheimer's disease	44.1	30.8

* Age-Adjusted Mortality Rate (Per 100,000 Residents)

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

The San Joaquin County Community Health Needs Assessment was a collaborative effort that included San Joaquin's hospitals as well as many partner organizations and individuals throughout the community. San Joaquin County Community Health Assessment Committee (SJC2HAC) formed a Steering Committee who supported and provided input in this process, and was led by a Core Planning Group who assisted in data collection and was responsible for planning and key decision-making. The collaborative group worked alongside consultants to collect and analyze data and ultimately produce this report.

The core Planning group consisted of the following organizations: Community Medical Centers, Community Partnership for Families of San Joaquin, Dameron Hospital Association, Dignity Health—St. Joseph's Medical Center, First 5 San Joaquin, Health Net, Health Plan of San Joaquin, Kaiser Permanente, San Joaquin County Public Health Services, and Sutter Tracy Community Hospital

B. Other partner organizations that collaborated on the assessment

The other partner organizations that are members of the San Joaquin County Community Health Assessment Committee and participated in the assessment include: Community Partnership for Families, First 5 San Joaquin, Community Medical Centers, Inc., San Joaquin County Public Health Services, Health Net of California, Health Plan of San Joaquin, Scan Health Plan, San Joaquin County Office of Education, National Alliance on Mental Illness (NAMI), Catholic Charities, California Center for Public Health Advocacy, Lao Family Community Empowerment, Inc., St. Mary's Dining Room, Wallach & Associates, San Joaquin County Behavioral Health Services, Community Development, City of Stockton, Delta Health Care, El Concilio, City of Tracy Parks and Recreational Services, Tracy Unified School District, Counseling and More, Journey Christian Church, Reich's Pharmacy, City of Tracy City Council, Child Abuse Prevention Council, Stockton City Council, San Joaquin County Probation, Emergency Food Bank San Joaquin, Family Resource & Referral, San Joaquin County Data Co-Op, Regional Transit Division, County Office of Education, People and Congregations Together (PACT), University of the Pacific, Business Council of San Joaquin County, Asian-American Chamber of Commerce, San Joaquin Hispanic Chamber of Commerce, League of Women Voters of San Joaquin County, UC Cooperative Extension, San Joaquin County Housing Authority, Aging and Community Services, San Joaquin Council of Governments, and Business Forecasting Center.

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

- Harder+Company Community Research: Harder+Company Community Research is a comprehensive social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-based evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986,

Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts – including conducting needs assessments; developing and operationalizing strategic plans; engaging and gathering meaningful input from community members; and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation which is essential to both healthcare reform and the CHNA process in particular. Harder+Company is also the evaluation partner on several other CHNAs throughout the state including in Napa, Marin, and Sonoma County.

- MIG: Since it was founded in 1982, MIG has focused on planning, designing and sustaining environments that support human development. MIG embraces inclusivity and encourages community and stakeholder interaction in all of its projects. For each endeavor — in planning, design, management, communications or technology — MIG's approach is strategic, context-driven and holistic, addressing social, political, economic and physical factors to ensure clients achieve the results they want.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

The CHNA process used a mixed-methods approach to collect and compile data to provide a robust assessment of health in San Joaquin County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. The following section outlines the data collection and analysis methods used to conduct the CHNA.

A. Secondary data

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

Harder & Co. used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publicly available data sources. Additional secondary data were compiled and reviewed from existing sources including the California Health Interview Survey, American Community Survey, and California Healthy Kids Survey. In addition to statewide and national survey data, previous CHNAs and other relevant external reports were reviewed to identify existing data on additional indicators at the county level. (Appendix A)

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

Secondary data were organized by a framework of potential health needs, a broad list of needs relevant to San Joaquin County. The consulting team and Core Planning Group finalized this framework in advance of analysis.

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

B. Community input

i. Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews, focus groups, and/or surveys. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from local public health departments 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 D.

A community survey was administered to 2,927 residents of San Joaquin County in the participant's self-identified dominant language (English or Spanish) or verbally in other languages (Hmong or Cambodian). Approximately 10% of surveys were administered in Spanish. The survey was available online and in a paper version. Among all respondents, 19.2% were under age 25 and 7.2% were over age 60. Respondents were 71.7% female, 43.0% identified as Latino, and 26.6% spoke Spanish at home.

A total of 34 individuals identified by the Core Planning Group as having valuable knowledge, information, and expertise were interviewed. Interviewees included representatives from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted. To maximize resources and strengthen relationships, all interviews were conducted by members of the Core Planning Group. For a complete list of individuals who provided input, see Appendix D. For a summary of key themes related to health needs that arose from these interviews, see Appendix C.

Additionally, 29 focus groups were conducted throughout the County, reaching 348 residents. To maximize resources and leverage relationships with community groups and residents, these groups were facilitated by local volunteers who had been trained by MIG staff. Community partners provided invaluable assistance in recruiting and enrolling focus group participants. Individuals who participated in focus groups included leaders, representatives, or members of medically underserved, low-income, chronically diseased, and minority populations. Participants also represented a breadth of geographic regions, racial/ethnic subpopulations, and age categories. For more information about specific populations reached in focus groups, see Appendix D. For a summary of key themes related to health needs that arose from these focus groups, see Appendix C.

ii. Methodology for collection and interpretation

Survey and interview protocols were developed by the consulting team and reviewed by SJC2HAC, and were designed to inquire about top health needs in the community, as well as a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing drivers of each health need. Additionally, the community survey collected data about specific issues, including current insurance status and public opinion of alcohol, tobacco, and sugar-sweetened beverage advertisements. For more information about interview and survey protocols, see Appendix E. Focus groups were designed to be broader discussions to assess strengths and needs of the community.

All qualitative data was coded and analyzed using Excel. Because the Core Planning Group conducted all interviews and focus groups, the consulting team coded summaries rather than full transcripts. A codebook with robust definitions was developed to assign codes to each summary for information related to each potential health need, as well as to identify comments related to specific

drivers of health needs, subpopulations or geographic regions disproportionately affected, existing assets or resources, and community recommendations for change. At the onset of analysis, several interview and focus group summaries were coded by two members of the analysis team to ensure inter-coder reliability and minimize bias.

Transcripts were analyzed to examine the health needs identified by the interviewee or group participants. Health need identification in qualitative data was based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions of that particular health need within each transcript. Because only summary data was recorded, the consulting team was not able to assess the breadth or depth of conversation about particular health needs.

C. Written comments

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

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

D. Data limitations and information gaps

The 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.

Supplementary secondary data were obtained from reliable data platforms including U.S. Census American FactFinder, askCHIS, and others. However, as with any secondary data estimates, there are some limitations with regard to this information. With attention to these limitations, the process of identifying health needs was based on triangulating primary data and multiple indicators of secondary data estimates. The following considerations may result in unavoidable bias in the analysis.

- Some relevant drivers of health needs could not be explored in secondary data because information was not available.
- Many data were 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, limiting the ability to examine disparities of health within the community.
- In all cases where secondary data estimates by race/ethnicity are reported, the categories presented reflect those collected by the original data source, which yields inconsistencies in racial labels within this report.

- For some county level indicators, data are available but reported estimates are statistically unstable; in this case estimates are reported but instability is noted.
- Secondary data collection was subject to differences in rounding from different data sources; e.g., Kaiser Platform indicators are rounded to the nearest hundredth, whereas other data sources report only to the nearest tenth or whole number.
- Data are not always collected on a yearly basis, meaning that some data estimates are several years old and may not reflect the current health status of the population. In particular, data reported from prior to 2013 should be treated cautiously in planning and decision-making.
- California state averages and, where available, United States national averages and Healthy People 2020 goals are provided for context. No analysis of statistical significance was done to compare county data to a benchmark; thus, these benchmarks are intended to provide contextual guidance and do not intend to imply a statistically significant difference between county and benchmark data.

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

- Themes identified during interviews and focus groups were likely subject to the experience of individuals selected to provide input; the Collaborative sought to receive input from a robust and diverse group of stakeholders to minimize this bias.
- The final prioritized list of health needs is also subject to the affiliation and experience of the individuals who attended the Prioritization Day event, and to how those individuals voted on that particular day. The closeness in priority scores suggests that all identified health needs are of importance to stakeholders in San Joaquin County. While a priority order has been established during this needs assessment process, narrow differences in the results highlight the importance of directing attention and resources to each identified resource to the extent possible.

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.

The following 19 potential health needs were examined, as outlined in the Table below.

Health Need *(outcome or contributing condition)*	Definition
Access to Medical Care	Data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health
Access to Housing	Data related to cost, quality, availability, and access to housing
Asthma and COPD	Known drivers of asthma and other respiratory diseases,
Cancers	Known drivers of cancers, and other health outcomes related to cancers
Child Mental and Emotional Development	Data related to development of mental and emotional health in young children, particularly ages 0-5
Climate and Health	Data related to climate and environment, and related health impacts
CVD and Stroke	Known drivers of heart disease and stroke, and related cardiovascular health outcomes
Economic Security	Data related to economic well-being, food insecurity, and drivers of poverty
Education	Data related to educational attainment and academic success, from preschool through post-secondary education
HIV/AIDS/STD	Known drivers of sexually transmitted infections
Mental Health	Data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes
Obesity and Diabetes	Data related to healthy eating and food access, physical fitness and active living, overweight/obesity prevalence
Oral Health	Data related to access to oral health care, utilization of oral health preventative services, and oral disease prevalence
Overall Health	Data related to overall community health including self-rated health and all-cause mortality
Pregnancy and Birth Outcomes	Data related to behaviors, care, and outcomes occurring during gestation, birth, and infancy; includes health status of both mother and infant
Substance Abuse and Tobacco	Data related to all forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs
Vaccine-Preventable Infectious Disease	Data related to vaccination rates and prevalence of vaccine-preventable diseases
Violence and Injury	Data related to intended and unintended injury such as violent crime, motor vehicle accidents, domestic violence, and child abuse
Youth Growth and Development	Data related to supports and outcomes affecting youth ability to develop to their full potential as adults, particularly focused on adolescents

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

The secondary data were compared to a benchmark estimate, in most cases the California state estimate. It was considered to indicate concern if the San Joaquin County estimate was poorer by at least 1% when compared to the benchmark estimate. Additionally, content analysis was used to analyze key themes in both the Key Informant Interviews and Focus Groups.

Potential health needs were included in the prioritization process if:

a. Multiple distinct indicators reviewed in secondary data demonstrated that the county estimate was poorer by more than 1% when compared to the benchmark estimate (in most cases, California state average).
b. Health issue was identified as a key theme in at least five interviews.
c. Health issue was identified as one of the top three health issues, health behaviors, or social and economic issues by at least 20% of survey respondents.

If a health need was mentioned overwhelmingly in interviews but did not meet criteria related to secondary data, the analysis team conducted an additional search of secondary data to confirm that all valid and reliable data concurred with the initial secondary data finding and to examine whether indicators for the health need disproportionately impact specific geographic, age, or racial/ethnic subpopulations. However, no potential health need was identified to move forward for discussion and prioritization by the Steering Committee unless it was confirmed by both secondary and primary data.

Harder+Company summarized the results of this analysis in a matrix which was then reviewed and discussed by the Collaborative. (Appendix H)

Eighteen health needs were identified that met the first criterion of having a high secondary data score. Only 12 of these health needs met the additional criteria of being identified as a theme in key leader interviews or focus groups. Of these, the salient theme related to Climate and Health was poor air quality. For this reason, the Core Planning Group decided not to include Climate and Health as an identified health need, but rather to capture data about poor air quality data with data about Asthma and COPD. As such, the final prioritized list reflects 11 distinct health needs. Process and criteria used for prioritization of the health needs

The Criteria Weighting Method, a mathematical process whereby participants establish a relevant set of criteria and assign a priority ranking to issues based on how they measure against the criteria, was used to prioritize the eleven health needs. This method was selected as it enabled consideration of each health need from different facets, and allowed the Collaborative to weight certain criteria to use a multiplier effect in the final score.

Additionally, while the calculated values provide an overall priority score to help indicate which health needs are the highest priorities, the results are not intended to dictate the final policy decision, but offer a means by which choices can be ordered.[22]

To determine the scoring criteria, SJC2HAC reviewed a list of potential criteria and selected a total of four criteria:

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

[22] www.cdc.gov/od/ocphp/nphpsp/documents/Prioritization.pdf

	outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.

The Collaborative members also assigned a score to each criterion between 1 and 5. The scores were used to determine the weight for each criteria that would be used to rate the health need. Scores of 1 indicated the criterion is not that important in prioritizing health issues whereas scores of 5 indicated the criterion is extremely important in prioritizing health issues. The average score for each criterion was used to develop the formula below to provide a weight for each health need.

Overall Score = (1.5*Severity) + (1.5*Disparities) + (1.4*Impact) + (1.3*Prevention)

The Steering Committee with additional hospital representatives was convened on November 12, 2015, to review the health needs identified, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the County. A total of 45 participants attended this half-day session.

In order to prioritize the list of identified health needs, participants rated each one using the four criteria discussed above, after each health need was reviewed and discussed. The table below outlines the results average scores of the ratings on each of these.

Health Needs in Priority Order					
Final Results		Unweighted Scores by Criteria			
Health Need	Weighted Score	Severity	Disparities	Impact	Prevention
1. Obesity/Diabetes	34.72	6.22	5.62	6.18	6.39
2. Education	33.98	6.07	5.73	6.18	5.87
3. Youth Growth and Development	33.66	5.86	5.91	6.07	5.77
4. Economic Security	32.99	6.07	5.84	6.22	4.93
5. Violence and Injury	32.69	5.84	6.16	5.58	5.30
6. Substance Use	32.48	6.13	5.42	5.76	5.46
7. Access to Housing	31.75	5.87	5.51	5.76	5.09
8. Access to Medical Care	31.69	5.71	5.71	5.58	5.20
9. Mental Health	31.33	6.04	4.73	5.91	5.30
10. Oral Health	29.81	4.89	5.48	4.86	5.73
11. Asthma/Air Quality	29.66	5.42	5.27	4.89	5.22

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

1) **Obesity and Diabetes:** Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent leading causes of death nationwide, as well as among residents of San Joaquin County. Primary and secondary data indicate that there are many risk factors in common, such as unhealthy eating and lack of physical activity. Community concerns raised reflect this in that residents recognized that access to affordable healthy foods is limited in at-risk neighborhoods, and there are not enough safe places to enjoy every day physical activity. Diabetes is of particular concern as San Joaquin County has one of the highest rates in California for diabetes mortality.

2) **Education:** There is an important relationship between education and health. People with limited education tend to have much higher rates of disease and disability, whereas people with more education are likely to live longer, practice healthy behaviors, and experience better health outcomes for themselves and their children.[23] In San Joaquin County, graduation rates are lower than the California state average, as is reading proficiency among third graders. Community members and key stakeholders highlighted education as an important health need and suggested strategies such as affordable preschool and culturally responsive education to improve outcomes.

3) **Youth Growth and Development:** Youth growth and development refers to the healthy physical, social, and emotional development of young people. Promoting youth development is a deliberate process of providing support, relationships, experiences, and opportunities for young people—leading to happy, healthy, successful adulthood. Primary and secondary data indicate that youth development tends to be undermined by trauma and violence, unhealthy family functioning, exposure to negative institutional environments and practices, and insufficient access to positive youth activities, among other things. In San Joaquin County, the disparate levels of exposure to these risk factors contribute to outcome disparities during youth and throughout adulthood. This includes disparities by race, ethnicity, gender, sexual orientation, and income, with respect to outcomes such as juvenile justice involvement, foster placement, adult incarceration, educational attainment, and chronic disease.

4) **Economic Security:** Economic security is very strongly linked to health; it can impact access to healthy food, medical care, education and safe environments.[24] Poverty and unemployment are higher in San Joaquin County than California as a whole. Concerns surrounding economic security were particularly important to community members, who highlighted the need for jobs that pay a living wage and the ability to afford descent and safe housing.

5) **Violence and Injury**: Injury is a broad topic that includes both unintentional injuries, as a result of motor vehicle crashes, drowning, falls or accidental poisoning (overdoses), etc., and intentional violent injuries such as assault and abuse, as well as homicide and suicide. San Joaquin County's injury rates remain substantially higher that the California averages. Among unintentional injuries, the leading causes of death in San Joaquin County are poisoning, motor vehicle crashes, falls, and drowning/submersion. Among intentional injuries, core concerns are often associated with family and community violence. In particular, the homicide rate is much higher than California as a whole, particularly among men of color. Survey respondents identified violence as a core issue in their communities and cited concerns such as gun violence, gang activity among youth, and domestic violence as key themes.

6) **Substance Use**: Substance abuse, including abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences, including increased risk of liver disease, cancer, and death from overdose.[25] San Joaquin County's rate of drug-induced deaths is 56% higher than average rate across California (17.3 per 100,000 compared to 11.1 per 100,000). Primary data collection from surveys, focus group discussions and interviews highlighted the importance of this issue for the county; 41.1% of community survey respondents report that drug abuse is among the most concerning health behaviors in their community.

7) **Access to Housing:** Access to stable, affordable housing is a foundation for good health. A family that pays more than 30 percent for housing is considered "cost-burdened" and may have difficulty affording food, clothing, transportation, and medical care.[26] Substandard housing and

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[23] "Exploring the Social Determinants of Health: Education and Health," Robert Wood Johnson Foundation, Accessed October 19, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447.
[24] "Health & Poverty," Institute for Research on Poverty, Accessed October 19, 2015, http://www.irp.wisc.edu/research/health.htm.
[25] http://www.cdc.gov/drugoverdose/epidemic/index.html; http://www.cdc.gov/alcohol/fact-sheets/womens-health.htm; http://www.cdc.gov/alcohol/fact-sheets/mens-health.htm
[26] US Department of Housing and Urban Development, accessed via http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/.

homelessness can exacerbate health concerns, ranging from physical and mental health to substance abuse. Poor housing also makes it difficult to maintain education and employment, which are associated with being healthy. Primary and secondary data indicate that access to safe and affordable housing is an important health concern in San Joaquin County, reflective of the rapid rise of housing costs occurring in California overall in recent years. In San Joaquin County, the foreclosure crisis, limited subsidized housing, rising rents, absentee landlords, and deteriorating housing stock are all significant contributing factors to the lack of safe and affordable housing. Moreover, a recent point-in-time count found that at least 2,641 individuals in the county are homeless. Interview participants noted disparities in access to housing among foster youth, low-income populations, older adults, and seasonal workers.

8) **Access to Medical Care**: Access to comprehensive, affordable, quality medical care is critical to the prevention, early intervention, and treatment of health conditions. San Joaquin County has been successful in enrolling residents in Expanded Medi-Cal under the ACA; however, learning how to use services, retention of coverage, and the shortage of primary care providers that will accept new Medi-Cal patients remain challenges. The fact that the County's many undocumented adult residents are without insurance also remains a barrier to care.

9) **Mental Health**: In addition to severe mental health disorders, mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder (PTSD), has profound consequences on health behavior choices and physical health.[27,28] While some mental health outcomes in San Joaquin County are similar to California benchmarks, mental health was a key concern among surveyed community members. Interviewees noted that the psychology of poverty, including living day-to-day and struggling to provide basic needs, can negatively impact one's ability to make long-term plans, and can interfere with parenting abilities. In addition, poor mental health frequently co-occurs with substance use disorders. Youth, notably foster youth and lesbian, gay, bisexual, transgender and queer and/or questioning (LGBTQ) youth, and residents experiencing homelessness, were noted as particularly high risk populations for mental health concerns.

10) **Oral Health**: Tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.[29] Secondary data indicate that oral health outcomes are worse in San Joaquin County than in other parts of California, particularly among children. Access to oral health services is a concern in all age groups, marked by limited dental visits and difficulty finding affordable and nearby care. Factors that may contribute to oral health needs include poverty, as well as an unhealthy diet that includes sugar-sweetened beverages.

11) **Asthma/Air Quality**: Asthma is a disease that affects the lungs, and is often triggered by environmental conditions such as poor outdoor air quality as well as mold, dust, and cleaning solutions in the home. Asthma and breathing problems are a health need in San Joaquin County, as marked by high prevalence of asthma in adults and youth. In particular, asthma disproportionately impacts non-Hispanic Blacks. Poor outdoor air quality not only exacerbates asthma, but it is also an issue that affects all residents, and ranges from second-hand cigarette smoke to greenhouse gas emissions (vehicle exhaust) and other elements that lead to high particulate matter (mixture of solid particles and liquid droplets found in the air such as dust, dirt, or

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[27] Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. Prev Chronic Dis 2005; 2(1):A14.

[28] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) Study, American Journal of Preventive Medicine 1998; 14:245–258.

[29] "Healthy Smile, Healthy You: The Importance of Oral Health," Delta Dental Insurance, accessed October 28, 2015, https://www.deltadentalins.com/oral_health/dentalhealth.html.

soot). The percentage of days exceeding Fine Particulate Matter (PM 2.5) standards is high throughout the county and affects breathing and lung health for all residents.

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

San Joaquin County has a rich network of community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of community resources available to respond to each community identified health need are highlighted in each Health Need Profile in Section VI. For a more comprehensive list of community assets and resources, please call 2-1-1 or (800) 436-9997, or reference http://www.211sj.org/

VII. KFH MANTECA 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH Manteca'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 Manteca's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH Manteca in the 2013 Implementation Strategy Report.

1. Limited Access to Primary and Preventive Care
2. Healthy Food/Physical Activity
3. Broader Health Care System Needs in Our Communities (Workforce and Research)

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

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

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

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

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

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

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

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

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH Manteca awarded 68 grants totaling $1,072,542 in service of 2013 health needs. Additionally, Kaiser Permanente 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 Manteca service area. During 2014-2015, a portion of money managed by this foundation was used to award 30 grants totaling $348,467 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 Facility Name 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 Facility Name engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: LIMITED ACCESS TO PRIMARY AND PREVENTIVE CARE

Long Term Goal:

- Increase the number of people who have access to health care and preventive services, particularly underinsured children, youth, and families

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

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 6,045 Medi-Cal members* • *2015: 2,138 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $3,388,430* • *2014: 4,049 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $3,604,659* • *2015: 5,413 applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 4,763 members receiving CHC* • *2015: 1,641 members receiving CHC*

Grant Highlights

Summary of Impact: During 2004 and 2015, there were 25 active KFH grants totaling $584,220 addressing Access to Care in the KFH-Manteca service area.[30] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 14 grants totaling $122,467 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Catholic Charities of the Diocese of Stockton	$80,000 over 2 years $40,000 in 2014 $40,000 in 2015	The program aims to increase health care access by reducing enrollment barriers and increasing health care coverage for underinsured children, youth, and families through outreach and application assistance.	Nearly 10,000 contacts (Hispanic families and homeless women and children) were made through outreach and 1,500 coverage applications were submitted. Case managers helped reduce utilization barriers for a minimum of 300 families.

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

Family Resource and Referral Center	$90,000 over 2 years $50,000 in 2014 $40,000 in 2015	Grants funds will be used to promote, launch, and operate a 2-1-1 program in San Joaquin County.	A 2-1-1 system was established to enhance access to available health and social services for county residents; priority given to connecting high-need individuals and families to public hospitals and community health clinics. 1,469 individuals have called the system.
Gospel Center Rescue Mission, Inc.	$100,000 over 2 years $60,000 in 2015 $40,000 in 2014	Provide post-hospital respite and recovery services for homeless individuals.	The "Respite and Obesity Prevention Program" served a total of 28 unduplicated homeless individuals with medical respite care and a total of 53 unduplicated homeless adults and 20 homeless children in the first phase of residential treatment were provided with nutrition education, exercise demonstrations and one-on-one personal care management plans.
Planned Parenthood Mar Monte-Sacramento	$80,000 over 2 years $40,000 in 2014 $40,000 in 2015	Planned Parenthood's Improving Women's Health project will increase the number of San Joaquin County people, particularly underinsured children, youth, and families, who have access to health care and preventive services.	Project aims to reduce barriers to health insurance enrollment and increase health care coverage. Two Community peer educators were trained to assist in outreach efforts; 710 women increased knowledge of and access to preventive health care services, especially women's reproductive health care through Family PACT program.
St. Mary's Interfaith Community Services	$80,000 over 2 years $40,000 in 2014 $40,000 in 2015	St. Mary's Virgil Gianelli M.D. Medical Clinic treats the uninsured. Eye exams are also performed and prescription glasses are provided for those who need them. Health classes, including Diabetes Education, are provided in both English and Spanish.	5,644 patients were seen by a medical doctor, 355 individuals participated in our diabetes education classes, and 395 patients received an eye exam with over 500 receiving eyeglasses.
University of the Pacific	$90,000 over 2 years $60,000 in 2015 (2 grants) $30,000 in 2014	Funding supported Pacific's Mobile Medicare Clinics to increase the number of people who have access to health care and preventive services, while providing volunteer opportunities for pharmacy students. Funding also supported a project to replicate Pacific's successful Virtual Dental Home system within San Joaquin County and support development of a self-sustaining source of care for underserved groups.	The nine mobile clinics served 1,492 patients. In addition, they provided 3,521 immunizations and preventive screenings and 888 comprehensive medication reviews. The project will also train and support development of a Virtual Dental Home system in conjunction with Community Medical Centers and YMCA of San Joaquin County After School Program that will target low-income children in San Joaquin County.
Collaboration/Partnership Highlights			

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
San Joaquin Healthier Community Coalition	Inform and engage local stakeholders and community members to promote joint efforts based on data, community input, and group consensus to improve the health of local residents.	As a committee vice chair, KFH-Manteca helped implement a collaborative approach to creating a community health worker program that will partner with the local safety net to increase access to health care for migrant populations and ESL (English as a second language) speakers and create increased access to dental health services through the virtual dental home program.
Gospel Rescue Mission Respite Care Committee	The committee's charge is to inform and assess respite care needs and resources within San Joaquin County.	The committee has contributed to the identification of efficient workflows and needs for respite care services in San Joaquin county.

PRIORITY HEALTH NEED II: HEALTHY FOOD/PHYSICAL ACTIVITY

Long Term Goal:

- Reduce obesity/diabetes among at-risk populations, particularly low-income youth and families

Intermediate Goals:

- Increase food security and access to healthy food and decrease access to unhealthy food
- Increase nutrition awareness and knowledge and adoption of healthy eating practices
- Increase access to physical activity environments and opportunities in schools
- Increase knowledge and adoption of physical activity

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 34 active KFH grants totaling $454,959 addressing Healthy Food/Physical Activity in the KFH-Manteca service area.[31] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 10 grants totaling $172,976 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Boys & Girls Club of Tracy Inc.	$74,000 over 2 years $34,000 in 2015 $40,000 in 2014	The Club's Triple Play program will reduce obesity and diabetes among at-risk youth by increasing nutrition awareness and access to physical activity.	The program served 1,116 youth during the grant cycle including youth with disabilities. 72% engaged in physical activity 5 or more times/week; 70% consumed two or more servings of fruit/day and 38% consumed 3 or more servings of vegetables/day. 76% consumed 1 soda or less/day.
Boys and Girls Club of Manteca	$74,200 over 2 years	The Club is piloting Dancersize and Positive Sprouts to reduce obesity and diabetes in at-risk youth by increasing physical activity and	419 students participated in the Positive Sprouts community garden program and 377 actively participated in the Dancersize program on a daily

[31] 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.

	$29,000 in 2015 $45,200 in 2014	nutrition awareness. Funding also supports a basketball program.	basis. 250 youth participated in the basketball program.
San Joaquin County Office of Education (SJCOE)	$167,121 over 2 years $82,000 in 2015 (2 grants) $85,121 in 2014 (2 grants)	SJCOE's Exercise Across California will increase nutrition awareness and access to physical activity for students attending 12 low-income schools. In addition SJCOE will offer opportunities for afterschool programs within San Joaquin County to participate in the Mini Mermaids and Young Trojans running clubs, which meet biweekly for six weeks. Finally, by encouraging participation in the San Joaquin County and California Fire Up Your Feet (FUYF) challenges, SJCOE will support workforce and student health by promoting physical activity and healthy eating and by including parents in program components so that school wellness efforts can be implemented and reinforced at home.	Nearly 2,000 third through six graders at the 12 schools improved their California PFT (physical fitness test) results on the Aerobic Capacity component by 9%, and increased their knowledge of fitness and nutrition by at least 11%. A total of 2,657 students from 12 schools located throughout San Joaquin County participated in the Spring Fire Up Your Feet CA Activity Challenge. Third to eighth graders who participated in the clubs during afterschool programs completed a 5-kilometer run, gained confidence in their ability to accomplish goals, and were able to effectively voice their fears as they worked through them. FUYF expects to reach 1,000 individuals with at least one classroom from each EAC participating school participating. School staff and parent fitness knowledge will increase by 5% and student, staff, and parent knowledge of healthy eating and nutrition information will increase by 5%.
Second Harvest Food Bank	$55,000 over two years $25,000 in 2015 (2 grants) $30,000 in 2014 (2 grants)	The food bank's Food for Thought program seeks to increase food security and access to healthy food for low-income youth. Increase nutrition awareness and healthy eating practices while meeting basic food needs.	The Food 4 Thought Program is provided at 39 after-school program sites in San Joaquin and Stanislaus Counties and has reached 5,809 children with supplemental groceries and weekly after-school physical activity programs.
*KaBoom	$500,000 in 2015	KaBOOM! will partner with Kaiser Permanente and a community partner to create kid-designed, community-built playgrounds in three KP service areas. Each site will incorporate the unique KaBOOM! community build process to ensure community engagement and support.	Expected reach is 8,100 children and family members, and expected outcomes include: • three playgrounds designed by community residents and built by volunteers at organizations or in community settings serving high-need youth. • high need communities have increased access to safe public spaces for recreation and physical activity

$90,000 in 2015	CCS will implement its nationally recognized Healthy Behaviors Initiative (HBI) at five multi-site afterschool programs in targeted school districts in San Joaquin and Stanislaus counties. HBI fundamentally changes afterschool programs by intentionally changing their program policies and design so that children and families learn and practice healthy eating and physical activity behaviors	Expected reach is 2,500 people and expected outcomes include: • five after-school programs in targeted Thriving Schools districts adopt Exemplary Practices designed to increase quality physical activity and nutrition education programs/practices • afterschool program staff are trained as role models to promote healthy behaviors • students' food security needs are met through increased participation in school meal programs and referring families\' to food security resources • regional learning centers are established to ensure sustainability of these practices

In-Kind Resources Highlights
Description of Contribution and Purpose/Goals
aiser Permanente Educational Theater offered a *Best Me* performance to encourage healthy eating and an active estyle at the North, Central, and Louis A. Bohn elementary schools.
aiser Permanente Educational Theater offered a *Best Me* performance to encourage healthy eating and an active estyle at Lincoln and Sequoia elementary schools and provided a "Teddy Bear" clinic, which included a physician ho encouraged healthy eating and active lifestyles for more than 250 kindergarten through second grade students at rock Elliot Elementary School.
upported employee wellness initiatives in Manteca Unified School District by providing a Sports Medicine physician ho presented basic exercise techniques that teachers can implement within the school setting.
ealthy lunches and physical activity items, including hula hoops and pedometers were given to the 350 parents and 00 children who attended a community forum in Stockton focused on taking action and making changes to improve heir and their families' health. Event was part of a statewide Champions for Change movement.

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

KFH Workforce Development Highlights
vorkforce shortages and cultural and linguistic disparities in the health care workforce
killed, culturally competent, diverse professionals working in and entering the health care workforce to provide access

Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 9 Workforce Development grants totaling $33,363 that served the KFH-Manteca service area.[32] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 4 grants totaling $21,682 that address this need. In addition, KFH Manteca provided trainings and education 1 nurse practitioner or other nursing beneficiaries in 2014, and 16 other health (non-MD) beneficiaries as well as internships for 11 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
*The Regents of the University of California	$75,000 in 2015	UC Berkeley's Health Careers Opportunity Program (HCOP) aims to diversify the health professions workforce by working directly with 600 students from underrepresented groups through direct student counseling at UC Berkeley, through visits and outreach to local community colleges, and through the Public Health and Primary Care, a UC Berkeley class taught by HCOP staff.	• 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, HCOP served nine Summer Scholars (underrepresented students) • eight other students enrolled in and completed Kaplan's GRE preparation course
*Vision Y Compromiso	$98,093 in 2015	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities • increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks

[32] 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.

UCSF Fresno Health Careers Opportunity Program	$50,000 in 2015 This grant impacts three KFH hospital service areas in Northern California Region.	This Kaiser Permanente Northern California Region grant supports HCOP (Healthy Careers Opportunity Program), which addresses the shortage of health professionals in the Central Valley by providing an educational pipeline for qualified disadvantaged California State University, Fresno students who are interested in pursuing a health professional career.	It is expected that 95 HCOP students will receive at least two individual advising sessions per semester to help them select the required health professions courses and to assess their academic performance. They will have access to tutoring services for core courses in math and science. Upper division HCOP students will visit UCSF's Medicine, Dentistry, and Pharmacy schools to learn about admissions and financial aid and gain a better understanding of program requirements.

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:

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

Grant Highlights

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

		levels, allowing users to visualize the data at a sub-county level.	• Develop and deploy AskCHIS NE. • Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

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

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

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

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

Research Project Title	Alignment with CB Priorities
Risk of Cancer among Asian Americans (2014)	Research and Scholarly Activity
Racial and Ethnic Disparities in Breastfeeding and Child Overweight and Obesity (2014)	Healthy Eating, Active Living

Transition from Healthy Families to Medi-Cal: The Behavioral Health Carve-Out and Implications for Disparities in Care (2014)	Access to Care Mental/Behavioral Health
Health Impact of Matching Latino Patients with Spanish-Speaking Primary Care Providers (2014)	Access to Care
Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention – Susan Brown	Access to care
Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young – Steven Sidney	Access to care
Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes – Monique Hedderson	Access to care
Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs – Susan Brown	HEAL
The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization – Kelly Young-Wolff	HEAL
Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention – Cynthia Campbell	Mental/Behavioral Health
Integrating Addiction Research in Health Systems: The Addiction Research Network – Cynthia Campbell	Mental/Behavioral Health
RPGEH Project Title	**Alignment with CB Priorities**
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity
RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

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

Alignment with CB Priorities	Project Title	Principal Investigator
Serve low-income, underrepresented, vulnerable populations located in the Northern California Region service area	**1.** *A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.* **2.** *Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.*	**1.** Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing **2.** Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University
Reduce health disparities.	**1.** *Making sense of dementia: exploring the use of the markers of assimilation of problematic experiences in dementia scale to understand how couples process a diagnosis of dementia.* **2.** *MIDAS data on elder abuse reporting in KP NCAL.* **3.** *Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.* **4.** *Transforming health care through improving care transitions: A duty to embrace.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA **3.** Tracy Trail-Mahan, et al., KFH-Santa Clara **4.** Michelle Camicia, KFH-Vallejo Rehabilitation Center

	5. *New trends in global childhood mortality rates.*	**5.** Deborah McBride, KFH-Oakland
Promote equity in health care and the health professions.	**1.** *Family needs at the bedside.* **2.** *Grounded theory qualitative study to answer the question, "What behaviors and environmental factors contribute to emergency department nurse job fatigue/burnout and how pervasive is it?"* **3.** *A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.* **4.** *Electronic and social media: The legal and ethical issues for health care.* **5.** *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center **2.** Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED. **3.** Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL **4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. APPENDIX

A. Secondary Data, Sources, and Years
B. Summary of Community Survey Results
C. Summary of Focus Group and Key Informant Interview Results
D. Community Input Tracking Form
E. Primary Data Collection Tools
F. Prioritization Scoring Matrix
G. Health Need Profiles
H. Secondary Data with Sources and Dates

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. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
26. Environmental Protection Agency, EPA Smart Location Database. 2011.
27. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
28. Feeding America. 2012.
29. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
30. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
31. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
32. New America Foundation, Federal Education Budget Project. 2011.
33. Nielsen, Nielsen Site Reports. 2014.
34. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.

35. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
36. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
37. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
38. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
39. US Census Bureau, American Community Survey. 2009-2013.
40. US Census Bureau, American Housing Survey. 2011, 2013.
41. US Census Bureau, County Business Patterns. 2011.
42. US Census Bureau, County Business Patterns. 2012.
43. US Census Bureau, County Business Patterns. 2013.
44. US Census Bureau, Decennial Census. 2000-2010.
45. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
46. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
47. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
48. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
49. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
50. US Department of Education, EDFacts. 2011-2012.
51. US Department of Health & Human Services, Administration for Children and Families. 2014.
52. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
53. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
54. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
55. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
56. US Department of Housing and Urban Development. 2013.
57. US Department of Labor, Bureau of Labor Statistics. June 2015.
58. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
59. US Drought Monitor. 2012-2014

APPENDIX B: Summary of Community Survey Results

Biggest health problems	Valid Percent
Youth violence (like gang fights, murders)	**30.3**
Diabetes	**30.0**
Breathing problems/asthma	**27.7**
Mental health issues (e.g., depression)	**26.7**
Obesity	**26.6**
Tooth problems	20.3
Age-related health problems (like arthritis)	19.6
Alcoholism	19.3
Cancer	17.7
Heart disease	13.3
Domestic violence	13.2
Teens getting pregnant	11.2
Motor vehicle injuries (including pedestrian and bicycle accidents)	9.1
Other (please specify)	7.3
Child abuse or neglect	6.7
Sexually transmitted disease	4.5
Poor birth outcomes (e.g., baby underweight)	4.4
Stroke	3.7
Infectious diseases (e.g., hepatitis or TB)	3.6
Suicide	2.4

Behaviors affecting health	Valid Percent
Drug abuse	**41.4**
Alcohol abuse (drinking too much)	**38.0**
Poor eating habits	**35.2**
Lack of exercise	**34.6**
Life stress/not able to deal with life stresses	**27.5**
Smoking/tobacco use	24.8
Not getting regular check-ups by the doctor	21.7
Driving while drunk/on drugs	21.3
Using weapons/guns	19.2
Talking/texting and driving	16.4
Not getting "shots" (vaccines) to prevent disease	8.0
Unsafe sex (e.g., not using condom or birth control)	6.7
Teenage sex	6.5
Other (please specify)	3.5

Store window advertising (tobacoo, alcohol)	Valid Percent
A big problem	42.5
I don’t know	15.7
Not a problem	14.9
A medium problem	14.8
A small problem	10.7
Other (please specify)	1.4

Have health insurance	Valid Percent
Yes	79.7
No	17.9
Don’t know	2.4

Obstacles to health care	Valid Percent
Waiting time to see the doctor is too long	**34.2**
High co-pays and deductibles	**28.8**
Can't afford medicine	**28.2**
It is not hard to get health care	**20.8**
No health insurance	**20.1**
ER only option	16.8
Medi-Cal is too hard to get	16.1
Can't get off work to see a doctor	15.7
No night/weekend health care	15.5
Not enough doctors here	13.7
No transportation	12.7
Other (please specify)	12.3
Covered California/Obama Care is too hard to get	9.3
Doctors and staff don’t speak my language	7.7
Medi-Cal is too hard to use	7.2
Covered California/Obama Care is too hard to use	6.3

Social and economic problems	Valid Percent
Not enough local jobs	**61.3**
Homelessness	**39.5**
Poverty	**34.6**
Not enough interesting activities for youth	**31.7**
Fear of crime	**28.8**
Not enough education/high school drop-outs	20.1
No health insurance	19.4
Racism and discrimination	15.2
Not enough healthy food	12.9
Overcrowded housing	10.8
Schools	6.7

No police and firefighters	6.6
Can’t pay for transportation	6.4
Other (please specify)	4.6

Biggest problems to having a healthy environment	Valid Percent
Air pollution (dirty air)	**39.0**
Not enough safe places to be physically active	**34.3**
Poor housing conditions	**29.3**
Cigarette smoke	**28.6**
Trash on streets and sidewalks	**27.3**
Not enough places nearby to buy healthy and	22.9
Speeding/traffic	18.2
Pesticide use	18.0
Not enough public transportation	14.7
Home is too far from shops, work, school	14.5
Not enough sidewalks and bike paths	12.6
Too many hot days	11.3
Unsafe drinking water	10.2
Other (please specify)	4.9
Flooding problems	2.7

Parts of thriving community	Valid Percent
Safe place to raise kids	**51.3**
Jobs	**49.8**
Good air quality	**12.5**
Access to health care	**18.2**
Access to healthy food	**13.4**
Parks and recreation facilities	14.5
Affordable housing	26.4
Low crime and violence	36.3
Good schools	27.4
Green/open spaces	5.3
People know how to stay healthy	6.2
Support agencies	9.8
Community involvement	11.2
Time for family	14.0
Services for elders	6.4
Inexpensive childcare	6.8
Diversity is respected	5.4
Other (please specify)	2.4

APPENDIX C: Summary of Focus Group and Key Informant Interview Results

San Joaquin County Community Health Needs Assessment

Summary of and Focus Group and Key Informant Interview Results

Qualitative Data Supporting Identified Health Needs				
	Key Informant In terviews (n=34)		Focus Groups (n=29)	
Health Need	Number	Key Themes	Number	Key Themes
1. Obesity and Diabetes	24	- Lack of safe physical activity - Easy access to unhealthy food leads to overeating and obesity	9	- Safe areas for kids to be active - Access to healthy food - More local farmers markets to walk to
2. Education	6	- Absence of skilled and educated workforce - Education is not preparing our students for the global marketplace	7	- Literacy programs - College workshops - More relevant courses
3. Youth Growth and Development	9	- Notion that young men of color have no future in our society - Teen pregnancy	7	- More after school programs free of charge - Teen centers to help teens stay out of trouble - Affordable summer programs
4. Economic Security	6	- Lack of jobs that pay a living wage - Poverty	5	- Poverty - More jobs - Increase transportation at night
5. Violence and Injury	14	- Family violence - Community violence	16	- Community partnership with law enforcement for neighborhood watch - Stronger police presence - Talk about issues as a community - Shootings, drugs, racism
6. Substance Use	21	- Limited resources for substance abuse treatment - No detox program for drugs or alcoholism	2	- Excessive liquor stores - Drugs on school campuses
7. Access to Housing	11	- Not enough affordable housing in safe locations - Homelessness	6	- Affordable housing - Homeless population - Senior Facilities - Lack of jobs and housing resources
8. Access to Care	8	- Lack of health insurance - Lack of access to mental health services and knowledge about services	8	- Culturally competent care - Shorter wait times - More organizations to help with addiction - Longer appointment hours for doctors - More access to dentists and eye doctors
9. Mental Health	24	-Stressors in life - Trauma - Not enough mental health access for students - Behavioral issues - PTSD - Postpartum depression	2	- Bullying - Less drugs - More community support - More suicide prevention
10. Oral Health	5	- No dental care - No dental health education	0	
11. Asthma/Air Quality	16	- Poor air quality	0	

APPENDIX D: Community Input Tracking Form

San Joaquin County
Community Health Needs Assessment

Primary Data Collection Tracking Form

Data Collection Method	Title/Name	Number	Target Group(s) Represented (interviewee or at least one participant in the focus group self-identified as a leader, member, or representative of the following populations)					Date Input Was Gathered
Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Jose Rodriguez, President and CEO of El Concilio Council for the Spanish Speaking	1		X	X	X	X	8/20/2015
Interview	Bill Mitchell, Retired Director of San Joaquin County Public Health	1						8/27/2015
Interview	David Jomaoas, Director of San Joaquin General Hospital Clinics and Ambulatory Care Services	1		X	X	X	X	8/10/2015
Interview	Vic Singh, Director of San Joaquin County Behavioral Health Services	1						8/27/2015
Interview	Tori Verber Salazar, District Attorney of San Joaquin County	1						8/20/2015
Interview	Robina Asghar, Director of Community Partnership for Families	1			X	X	X	8/31/2015
Interview	John Solis, Executive Director of San Joaquin County Worknet	1						8/25/15
Interview	Edward Figueroa, CEO of St. Mary's Dining Hall	1		X		X	X	8/25/2015

San Joaquin County
Community Health Needs Assessment
Primary Data Collection Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Fred Schneil, Administrator for Stocktonians Taking Action to Neutralize Drugs	1			X		X	8/20/2015
Interview	LaCresia Hawkins, REACH Program Manager for the California Center of Public Health Advocacy	1			X			8/19/2015
Interview	Marvin Rothschild, President of the Tracy Community Connections Center	1		X	X	X	X	8/20/2015
Interview	Joel Wurgler Executive Director and Gino Avala Early Intervention Specialist for San Joaquin Valley Youth for Christ	2						8/19/2015
Interview	Stephanie James, Chief Probation Officer for San Joaquin County Probation	1			X		X	8/21/2015
Interview	Kay Ruhstaller, Executive Director of Family Resource and Referral Center	1						9/2/2015
Interview	Lani Schiff Ross, Executive Director for First 5 San Joaquin	1		X	X	X	X	8/31/2015
Interview	Robert Reinarts, Representative for the San Joaquin County Commission on Aging Long Term Care Services	1				X	X	8/20/2015

San Joaquin County
Community Health Needs Assessment
Primary Data Collection Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Jolene Jauregui Recreation Services Supervisor and Amanda Jensen Recreation Leader III of Tracy Senior Center	2		X	X		X	8/27/2015
Interview	Lori Souza, Social Worker for Environmental Alternatives Foster Family Agency	1		X	X	X	X	8/26/2015
Interview	Sheri Tidwell, CASA Program Coordinator for the Child Abuse Prevention Council	1		X		X	X	9/2/2015
Interview	Ger Vang, CEO for Lao Family Community Empowerment	1		X	X	X	X	8/18/2015
Interview	Joelle Gomez, CEO for Women's Center Youth & Family Services	1		X				9/10/2015
Interview	Dean Fujimoto, Deputy Director for Aging & Community Services, Health Services Agency.	1		X	X	X	X	
Interview	Nicholas Hatten, Executive Director of San Joaquin Pride Center	1			X	X	X	8/26/2015
Interview	Carol Ornela, Director of Visionary Homebuilders	1			X		X	8/10/2015

San Joaquin County
Community Health Needs Assessment
Primary Data Collection Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Focus Groups	County-wide; Adult population	12						3/16/2015
Focus Groups	Stockton; Adult population	17		X		X	X	3/13/2015
Focus Groups	Stockton; Adult population	25		X		X	X	3/25/2015
Focus Groups	County-wide; Adult population	8						3/19/2015
Focus Groups	County-wide; Adult population	12			X			3/19/2015
Focus Groups	County-wide; Women experiencing homelessness	16		X	X	X	X	3/24/2015
Focus Groups	Unknown population	8						3/24/2015
Focus Groups	Tracy; Adult population	8						3/31/2015
Focus Groups	County-wide; Older adult population	4						4/2/2015
Focus Groups	Stockton; Latino population	4			X		X	4/7/2015
Focus Groups	County-wide; Adult population	4			X		X	4/8/2015
Focus Groups	County-wide; Adult population	12			X	X	X	3/26/2015
Focus Groups	County-wide; Youth population;	26			X		X	3/28/2015
Focus Groups	County-wide; Women	12			X		X	4/3/2015
Focus Groups	County-wide; Homeless population	7				X	X	4/9/2015
Focus Groups	County-wide; Older adult population	21						4/14/2015
Focus Groups	County-wide; Adult population	5			X		X	4/17/2015
Focus Groups	Stockton; Youth population	15			X		X	4/16/2015
Focus Groups	Stockton; Youth and adult population	23			X			4/25/2015
Focus Groups	County-wide; Adult population	14		X	X	X	X	4/8/2015
Focus Groups	Stockton; Youth and adult population	13			X		X	4/9/2015
Focus Groups	Stockton; Older adult population	8		X	X		X	3/10/2015
Focus Groups	County-wide; Adult population	8			X			3/31/2015
Focus Groups	County-wide; Adult population	17		X	X	X	X	4/16/2015
Focus Groups	Unknown population	10			X			4/13/2015
Focus Groups	Thornton; Adult population	9		X		X	X	3/30/2015

San Joaquin County
Community Health Needs Assessment
Primary Data Collection Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Focus Groups	County-wide; Older adult population	6						4/8/2015
Focus Groups	Unknown population	10						4/13/2015
Focus Groups	County-wide; Adult population	14					X	4/13/2015

APPENDIX E: Primary Data Collection Tools

E.1 Instructions for Key Stakeholder Interviews

San Joaquin County
Community Health Needs Assessment
Key Stakeholder Interview Instructions

1. Prepare for the interview:
   a. Review relevant information about the participant and his/her organization.
   b. Thoroughly review the interview protocol.
   c. Review Interviewing Tips document.
   d. Schedule adequate time for the interview and additional questions that might be asked from the interviewee. Plan time additional time afterwards to clean up your notes and write an interview summary.

2. Complete the interview, using attached protocol:
   a. Begin the interview by reminding the interviewee about the intended purpose of the interview, confidentiality, and how long the interview will take, and by asking whether they have any questions.
   b. As the interviewee responds to each question, write notes directly in the saved protocol document under that question if possible. If handwritten notes are easier, print out the protocol in advance to write directly below each question and type the summary notes at the end. Take notes and focus on key words and key concepts. Try to write down a few key quotes verbatim when possible. Abbreviating common words used during the interview can help keep up with typing.
   c. Use probes (provided in italics after the question) as needed to get more in-depth answers or to focus to interviewee's response on the desired topic.

3. After the interview:
   a. As soon as possible, review your notes from the interview. Fill in any main ideas that you missed, and clarify any words that were abbreviated during the interview.
   b. Using your notes, fill out the Key Points summary box provided at the end of the interview protocol. Be sure to include any key concepts or key quotes that you wrote down.
   c. Enter the interviewee's information and the date of the interview on the Primary Data Collection Tracking Form.

E.2 Key Stakeholder Interview Protocol Page 1 of 8

Community Health Needs Assessment
Key Stakeholder Interview Protocol

Interviewee: ________________________ Date: __________

Organization: ________________________

Interviewer: ________________________

Introduction

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

I have several important questions I'd like to ask over the next 45 minutes or so. Please feel free to respond openly and candidly. We may use a few quotes in the writing of the final report. If anything you share with me should be kept confidential, please let me know.

Questions

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

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

- ☐ Escalon
- ☐ Lathrop
- ☐ Lodi
- ☐ Manteca
- ☐ Ripon
- ☐ Stockton
- ☐ Tracy
- ☐ All of San Joaquin County
- ☐ Other: ______________

E.2 Key Stakeholder Interview Protocol Page 2 of 8

2. What are the biggest <u>health issues</u> that face your clients? (or "your community" if not service provider) *{Probes: diabetes, alcoholism, mental health issues such as depression, youth violence}*

3. a) What are the <u>specific populations</u> adversely affected by these health problems? *(e.g., Latinos, postpartum women, seniors)*

   b) The following data are from preliminary community survey findings:
      i. Most Important Health Issues *[insert data from preliminary analysis here]*:
         1. Youth violence (29%)
         2. Diabetes (29%)
         3. Breathing problems/asthma (27%)
         4. Mental health issues (26%)
         5. Obesity (25%)

   Can you tell me your thoughts on this?

   c) What existing community resources could be used to address these health issues and inequities? (Resources could include community organizations, religious and cultural organizations, characteristics of the community such as community cohesiveness, physical or built community characteristics such as parks, markets, or health centers, or other resources.)

E.2 Key Stakeholder Interview Protocol Page 3 of 8

4. a) What <u>health behaviors</u> do you think have the biggest influence on these issues for your clients/your community? *{Probes: substance abuse, life stress, unsafe sex, poor eating habits}*

   b) The following data are from preliminary community survey findings:
      i. Most Important Health Behaviors *[insert data from preliminary analysis here]*:
         1. Drug abuse (40%)
         2. Alcohol abuse (38%)
         3. Poor eating habits (34%)
         4. Lack of exercise (33%)
         5. Life stress/not able to deal with life stresses (26%)

   Can you tell me your thoughts on this?

   c) What existing community resources could be used to address these health issues and inequities? (Resources could include community organizations, religious and cultural organizations, characteristics of the community such as community cohesiveness, physical or built community characteristics such as parks, markets, or health centers, or other resources.)

E.2 Key Stakeholder Interview Protocol Page 4 of 8

5. a) What social factors do you think have the biggest influence on these issues for your clients/your community? *{Probes: How are residents affected by mainstream values? Is there a strong sense of community? Perceived or real fear of violence?}*

   b) What economic factors do you think have the biggest influence on these issues for your clients/your community? *{Probes: no good jobs available, residents don't have needed skills, jobs not near where residents live}*

   c) The following data are from preliminary community survey findings:
      i. Biggest Social and Economic Problems *[insert data from preliminary analysis here]*:
         1. Not enough local jobs (58%)
         2. Homelessness (37%)
         3. Poverty (33%)
         4. Not enough interesting activities for youth (30%)
         5. Fear of crime (27%)

   Can you tell me your thoughts on this?

E.2 Key Stakeholder Interview Protocol Page 5 of 8

   d) What existing community resources could be used to address these health issues and inequities? (Resources could include community organizations, religious and cultural organizations, characteristics of the community such as community cohesiveness, physical or built community characteristics such as parks, markets, or health centers, or other resources.)

6. a) What environmental factors do you think have the biggest influence on these issues for your clients/your community? *{Probes: poor air quality, unsafe to walk, no nearby parks}*

   b) The following data are from preliminary community survey findings:
      i. Biggest Environmental Problems *[insert data from preliminary analysis here]*:
         1. Air pollution (36%)
         2. Not enough safe places to be physically active (32%)
         3. Poor housing (27%)
         4. Cigarette smoke (27%)
         5. Trash on streets and sidewalks (25%)

   Can you tell me your thoughts on this?

E.2 Key Stakeholder Interview Protocol Page 6 of 8

c) What existing community resources could be used to address these health issues and inequities? (Resources could include community organizations, religious and cultural organizations, characteristics of the community such as community cohesiveness, physical or built community characteristics such as parks, markets, or health centers, or other resources.)

7. a) Do you have suggestions for changes that could help to address the inequities that exist because of these influences?

b) Looking across all sectors, who are some current or potential community partners that we have not yet engaged who could help to impact these issues? (These partners may overlap with resources you have listed previously, but are not limited to these. Partners could refer to individuals or organizations that are presently engaged in this work, or potential partners.)

E.2 Key Stakeholder Interview Protocol Page 7 of 8

8. Are there any specific health issues or needs that you foresee emerging in the near future, but that you have not listed as an immediate concern today?

9. Imagine a future five years from now. What would success look like to you?

10. What race do you most identify with?
    - ☐ Black/African American
    - ☐ White/Caucasian
    - ☐ Hispanic/Latino
    - ☐ Native American
    - ☐ Asian (if checked, please select a choice below):
        - o Cambodian
        - o Hmong
        - o Vietnamese
        - o Filipino
        - o Other:
        - o Chinese
        - o Pakistani
        - o Japanese
        - o Thai
        - o Korean
        - o Laotian
        - o East Indian
        - o Native Hawaiian or Pacific Islander

E.2 Key Stakeholder Interview Protocol Page 8 of 8

11. What is your current gender identity? (Check one that best describes your current gender identity.)
    - ☐ Male
    - ☐ Female
    - ☐ Trans man
    - ☐ Trans woman
    - ☐ Genderqueer / Gender non-conforming
    - ☐ Another gender identity (Fill in the blank) ____________
    - ☐ Declined to answer

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

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

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

E.3 Key Stakeholder Interview Summary Page 1 of 3

San Joaquin County
Community Health Needs Assessment
Key Stakeholder Interview Summary (page 1 of 3)

Please complete the following summary box (using your notes for reference) after the conclusion of the interview:

Key Points

Area of expertise: *(e.g. homeless, youth, county-wide perspective)*

Top health issues identified:

Top health behaviors identified:

Top social problems identified:

Top economic problems identified:

Top environmental problems identified:

E.3 Key Stakeholder Interview Summary Page 2 of 3

San Joaquin County
Community Health Needs Assessment
Key Stakeholder Interview Summary (page 2 of 3)

Please complete the following summary box (using your notes for reference) after the conclusion of the interview:

sKey Points

Suggestions for change:

Potential community partners:

Key quotes:

E.3 Key Stakeholder Interview Summary Page 2 of 3

San Joaquin County
Community Health Needs Assessment
Key Stakeholder Interview Summary (page 3 of 3)

Tracking Information

(Q10.) What race do you most identify with?

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Asian (if checked, please select a choice below):
  - o Cambodian
  - o Hmong
  - o Vietnamese
  - o Filipino
  - o Other: ______
  - o Chinese
  - o Pakistani
  - o Japanese
  - o Thai
  - o Korean
  - o Laotian
  - o East Indian
  - o Native Hawaiian or Pacific Islander

(Q11.) What is your current gender identity? (Check one that best describes your current gender identity.)

- ☐ Male
- ☐ Female
- ☐ Trans man
- ☐ Trans woman
- ☐ Genderqueer / Gender non-conforming
- ☐ Another gender identity (Fill in the blank) ______
- ☐ Declined to answer

(Q12.) Do you identify as a leader, representative, or member of any of the following communities? Please select all that apply.

- ☐ Individuals with chronic conditions
- ☐ Minorities
- ☐ Medically underserved
- ☐ Low-income

E.4 Community Health Survey Page 1 of 6

San Joaquin County MAPP Community Health Survey

San Joaquin County MAPP Community Health Survey

Make your voice heard! **We would like to hear your opinions about health issues in San Joaquin County. The San Joaquin County "*Mobilizing for Action through Planning and Partnerships*" (MAPP)** project will use this survey and other information to work with the community to help make the county a healthier place to live, work, and play.

Your opinion is important! If you have already completed a survey, please don't fill out another one but ask your family and friends to do so. Thank you for your participation!

***1. In what city do you live? Choose one:**

- Escalon
- Lathrop
- Lodi
- Manteca
- Ripon
- Stockton
- Tracy
- Unincorporated San Joaquin County (please specify):
- Other (please specify)

***2. What is your home Zip Code?**

3. Would you say your health in general is excellent, very good, good, fair, or poor? Choose one.

Excellent	Very Good	Good	Fair	Poor	Don't know
○	○	○	○	○	○

E.4 Community Health Survey Page 2 of 6

San Joaquin County MAPP Community Health Survey

4. What are the three biggest health problems in your community? Choose three:

- Age-related health problems (like arthritis)
- Cancer
- Tooth problems
- Heart disease
- Infectious diseases (e.g., hepatitis or TB)
- Mental health issues (e.g., depression)
- Motor vehicle injuries (including pedestrian and bicycle accidents)
- Poor birth outcomes (e.g., baby underweight)
- Breathing problems/asthma
- Sexually transmitted disease
- Youth violence (like gang fights, murders)
- Domestic violence
- Stroke
- Teens getting pregnant
- Suicide
- Alcoholism
- Diabetes
- Child abuse or neglect
- Obesity
- Other (please specify)

5. What are the three behaviors that most affect health in your community? Choose three:

- Alcohol abuse (drinking too much)
- Driving while drunk/on drugs
- Drug abuse
- Lack of exercise
- Poor eating habits
- Not getting "shots" (vaccines) to prevent disease
- Smoking/tobacco use
- Using weapons/guns
- Not getting regular check-ups by the doctor
- Life stress/not able to deal with life stresses
- Unsafe sex (e.g., not using condom or birth control)
- Teenage sex
- Talk/texting and driving
- Other (please specify)

E.4 Community Health Survey Page 3 of 6

San Joaquin County MAPP Community Health Survey

6. What are the three biggest social and economic problems in your community? Choose three:

- ☐ Not enough local jobs
- ☐ Poverty
- ☐ Overcrowded housing
- ☐ Homelessness
- ☐ Not enough education/high school drop-outs
- ☐ Schools
- ☐ Racism and discrimination
- ☐ No health insurance
- ☐ Not enough interesting activities for youth
- ☐ Fear of crime
- ☐ Not enough healthy food
- ☐ Can't pay for transportation
- ☐ No police and firefighters
- ☐ Other (please specify)

7. What are the three biggest problems to having a healthy environment in your community? Choose three:

- ☐ Air pollution (dirty air)
- ☐ Pesticide use
- ☐ Poor housing conditions
- ☐ Home is too far from shops, work, school
- ☐ Too many hot days
- ☐ Cigarette smoke
- ☐ Not enough sidewalks and bike paths
- ☐ Trash on streets and sidewalks
- ☐ Flooding problems
- ☐ Unsafe drinking water
- ☐ Not enough safe places to be physically active
- ☐ Not enough places nearby to buy healthy and affordable foods
- ☐ Not enough public transportation
- ☐ Speeding/Traffic
- ☐ Other (please specify)

8. In your opinion, is store window advertising of tobacco, alcohol, and sugary beverages a problem in San Joaquin County? Choose one:

- ◯ Not a problem
- ◯ A medium problem
- ◯ A small problem
- ◯ A big problem
- ◯ I don't know
- ◯ Other (please specify)

E.4 Community Health Survey Page 4 of 6

San Joaquin County MAPP Community Health Survey

9. Do you have health insurance?

- ◯ Yes
- ◯ No
- ◯ Don't know

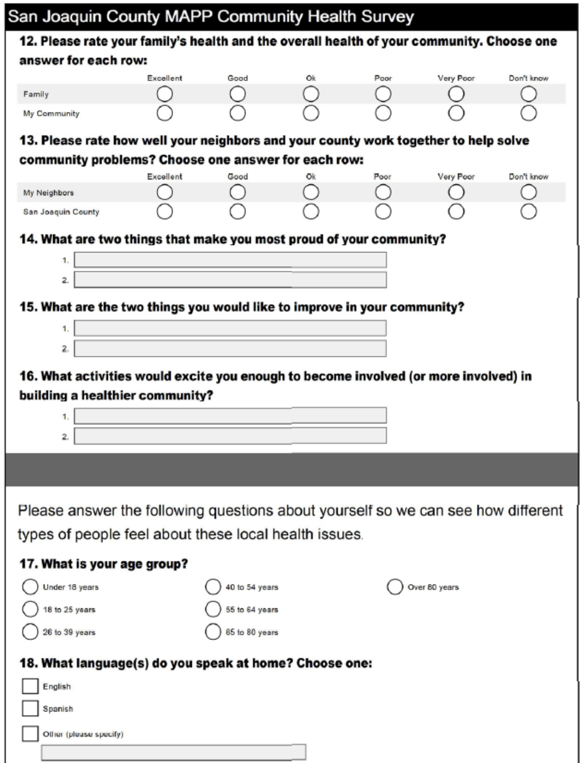
10. What three things make it hard to get health care in your community? Choose three:

- ☐ It is not hard to get health care
- ☐ No health insurance
- ☐ Medi-Cal is too hard to get
- ☐ Medi-Cal is too hard to use
- ☐ No health care available at night or weekends
- ☐ Can't get off work to see a doctor
- ☐ The only place to go is the emergency room
- ☐ Can't afford medicine
- ☐ Covered California/Obama Care is too hard to get
- ☐ Covered California/Obama Care is too hard to use
- ☐ No transportation
- ☐ Not enough doctors here
- ☐ Waiting time to see the doctor is too long
- ☐ Doctors and staff don't speak my language
- ☐ High co-pays and deductibles
- ☐ Other (please specify)

11. What are the three most important parts of a healthy, thriving community? Choose three:

- ☐ Safe place to raise kids
- ☐ Jobs
- ☐ Good air quality
- ☐ Access to health care
- ☐ Access to healthy food
- ☐ Parks and recreation facilities
- ☐ Affordable housing
- ☐ Low crime and violence
- ☐ Good schools
- ☐ Green/open spaces
- ☐ People know how to stay healthy
- ☐ Support agencies (e.g., social workers, churches and temples)
- ☐ Community involvement
- ☐ Time for family
- ☐ Services for elders
- ☐ Inexpensive childcare
- ☐ Diversity is respected
- ☐ Other (please specify)

E.4 Community Health Survey Page 5 of 6



San Joaquin County MAPP Community Health Survey

12. Please rate your family's health and the overall health of your community. Choose one answer for each row:

	Excellent	Good	Ok	Poor	Very Poor	Don't know
Family	◯	◯	◯	◯	◯	◯
My Community	◯	◯	◯	◯	◯	◯

13. Please rate how well your neighbors and your county work together to help solve community problems? Choose one answer for each row:

	Excellent	Good	Ok	Poor	Very Poor	Don't know
My Neighbors	◯	◯	◯	◯	◯	◯
San Joaquin County	◯	◯	◯	◯	◯	◯

14. What are two things that make you most proud of your community?

1.
2.

15. What are the two things you would like to improve in your community?

1.
2.

16. What activities would excite you enough to become involved (or more involved) in building a healthier community?

1.
2.

Please answer the following questions about yourself so we can see how different types of people feel about these local health issues.

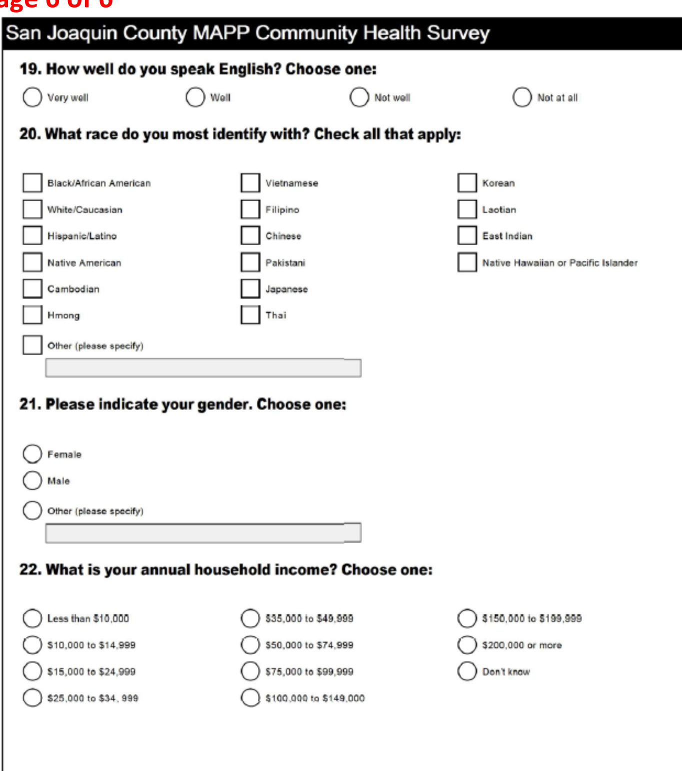
17. What is your age group?

◯ Under 18 years
◯ 18 to 25 years
◯ 26 to 39 years
◯ 40 to 54 years
◯ 55 to 64 years
◯ 65 to 80 years
◯ Over 80 years

18. What language(s) do you speak at home? Choose one:

☐ English
☐ Spanish
☐ Other (please specify)

E.4 Community Health Survey Page 6 of 6



San Joaquin County MAPP Community Health Survey

19. How well do you speak English? Choose one:

◯ Very well
◯ Well
◯ Not well
◯ Not at all

20. What race do you most identify with? Check all that apply:

☐ Black/African American
☐ White/Caucasian
☐ Hispanic/Latino
☐ Native American
☐ Cambodian
☐ Hmong
☐ Vietnamese
☐ Filipino
☐ Chinese
☐ Pakistani
☐ Japanese
☐ Thai
☐ Korean
☐ Laotian
☐ East Indian
☐ Native Hawaiian or Pacific Islander
☐ Other (please specify)

21. Please indicate your gender. Choose one:

◯ Female
◯ Male
◯ Other (please specify)

22. What is your annual household income? Choose one:

◯ Less than $10,000
◯ $10,000 to $14,999
◯ $15,000 to $24,999
◯ $25,000 to $34, 999
◯ $35,000 to $49,999
◯ $50,000 to $74,999
◯ $75,000 to $99,999
◯ $100,000 to $149,000
◯ $150,000 to $199,999
◯ $200,000 or more
◯ Don't know

E.4 Community Health Survey Page 7 of 7

San Joaquin County MAPP Community Health Survey

23. How many people live in your household? Choose one:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ Other (please specify)

24. What is your educational level? Choose one:

- ◯ Less than high school
- ◯ High school diploma
- ◯ GED
- ◯ Some college
- ◯ College degree
- ◯ Graduate/professional degree
- ◯ Other (please specify)

APPENDIX F: Prioritization Scoring Matrix

San Joaquin County
Community Health Needs Assessment

Prioritization Scoring Matrix

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

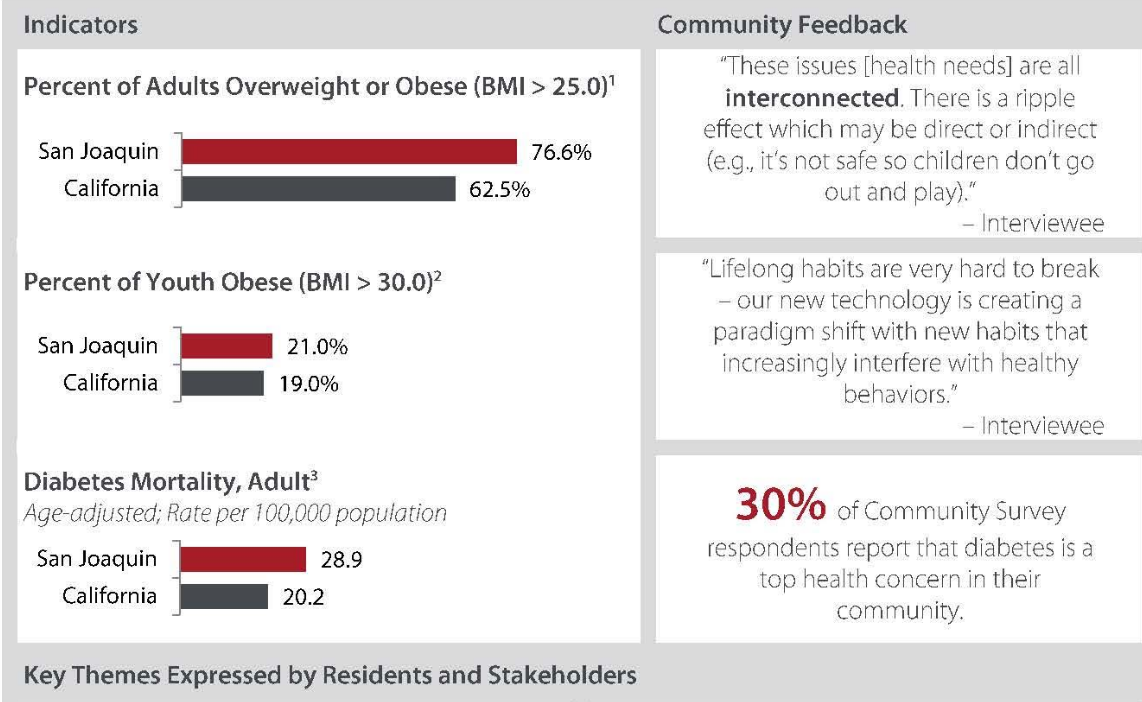
Health Need	Severity	Disparities	Impact	Prevention
	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.	There is an opportunity to intervene at the prevention level and impact overall health outcomes.
Weighting	*1.*	*1.*	*1.*	*1.*
Access to				
Access to Housing				
Economic				
Security				
Education				
Injury and Violence				
Prevention Mental Health				
Substance Use				
Youth				
Development				

APPENDIX G: Health Need Profiles

Obesity & Diabetes

Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent leading causes of death nationwide, as well as among residents of San Joaquin County. Primary and secondary data indicate that there are many risk factors in common, such as unhealthy eating and lack of physical activity. Community concerns raised reflect this in that residents recognized that access to affordable healthy foods is limited in at-risk neighborhoods, and there are not enough safe places to enjoy every day physical activity. Diabetes is of particular concern as San Joaquin County has one of the highest rates in California for diabetes mortality.

Key Data



Key Themes Expressed by Residents and Stakeholders

Poor nutrition

- Healthy foods are too expensive
- Education needed about healthy foods and the effects of nutrition
- Too busy to eat healthy

Lack of physical activity

- Not enough safe, green space
- Lack of safe places to bike, walk, or hike
- Lack of affordable exercise options
- Community violence and traffic safety constraints inhibit playing outside

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Obesity & Diabetes (continued)

Additional Data

Related Health Outcomes

Indicator	San Joaquin	California
Adult Diabetes Prevalence — *Age adjusted*[4]	10.4	8.1
Adult Prediabetes Prevalence — *Estimate*[†,5]	47	46
Stroke Mortality, Adult — *Age-adjusted mortality rate per 100,000 pop.*[6]	45.8	37.4
Ischaemic Heart Disease Prevalence (Medicare enrollees) — *% of Medicare fee for service pop*[7]	29.3	26.1
Overweight Youth — *% of 5,7,9 grade with "Needs Improvement" for body composition*[8]	20.9	19.3
Overweight Adults — *% of adults with BMI Between 25.0 and 30.0*[9]	31.0	35.8

Nutrition

Indicator	San Joaquin	California
Low Fruit and Vegetable Consumption — *% adults consuming <5 servings of fruit and vegetables*[10]	65.6	71.5
Sweetened Beverages — *% children age 2-11 consuming1+ sugar-sweetened beverages on previous day*[12]	38.3	27.0
Fast Food — *Fast food establishments per 100,000 pop.*[13]	59.1	74.5
Grocery Stores — *Grocery stores per 100,000 pop.*[13]	23.2	21.5

35.2% of Community Survey respondents indicated poor eating habits is a high concern in their community.

Social and Economic Risks

Indicator	San Joaquin	California
Food Insecurity — *% population experiencing food insecurity*[14]	18.0	16.2
Poverty and Food Access — *% of low income pop. with low food access*[15]	4.6	3.4

† The estimate of prediabetes is based on predictive models developed using 2009-2012 NHANES data and applied to CHIS 2013-14 data. Prediabetes estimates include adults with undiagnosed diabetes (approximately 3.9% of adults nationally).

Obesity & Diabetes (continued)

Additional Data and Trends

Physical Activity

Health Behaviors
% adults with no leisure time activity[16]

18.6 | 16.6
San Joaquin | California

% youth in grades 5,7,9 with "high risk" or "needs improvement" aerobic capacity[18]

42.5 | 35.9
San Joaquin | California

Safe Active Places

34.3%
of Community Survey respondents indicated that there are not enough safe active places in their community.

Physical Environment
% pop. living ½ mile from a park[17]

45.6 | 58.6
San Joaquin | California

Recreation and fitness centers per 100,000 pop.[19]

5.0 | 8.7
San Joaquin | California

Clinical Care

Diabetes Management
% diabetic Medicare patients with HbA1c test[20]

83.9 | 81.5
San Joaquin | California

Percent of Adults with Diabetes in San Joaquin County[21]

Year	Percent
2007	8.7%
2009	11.6%
2011	8.5%
2012	15.5%

Obesity & Diabetes (continued)

Salient Disparities

Percent of Adults Obese in San Joaquin County by Race/Ethnicity, Gender, and Income[22]

Group	Percent
Latino	57.1
White	43.1
African American	12.0*
American Indian/Alaska Native	DS
Asian	38.8*
Native Hawaiian/Pacific Islander	DS
Two or More Races	DS
Male	52.0
Female	35.5
0-99% FPL	30.0*
100-299% FPL	50.4%
300%+ FPL	42.9

DS = Data Suppressed

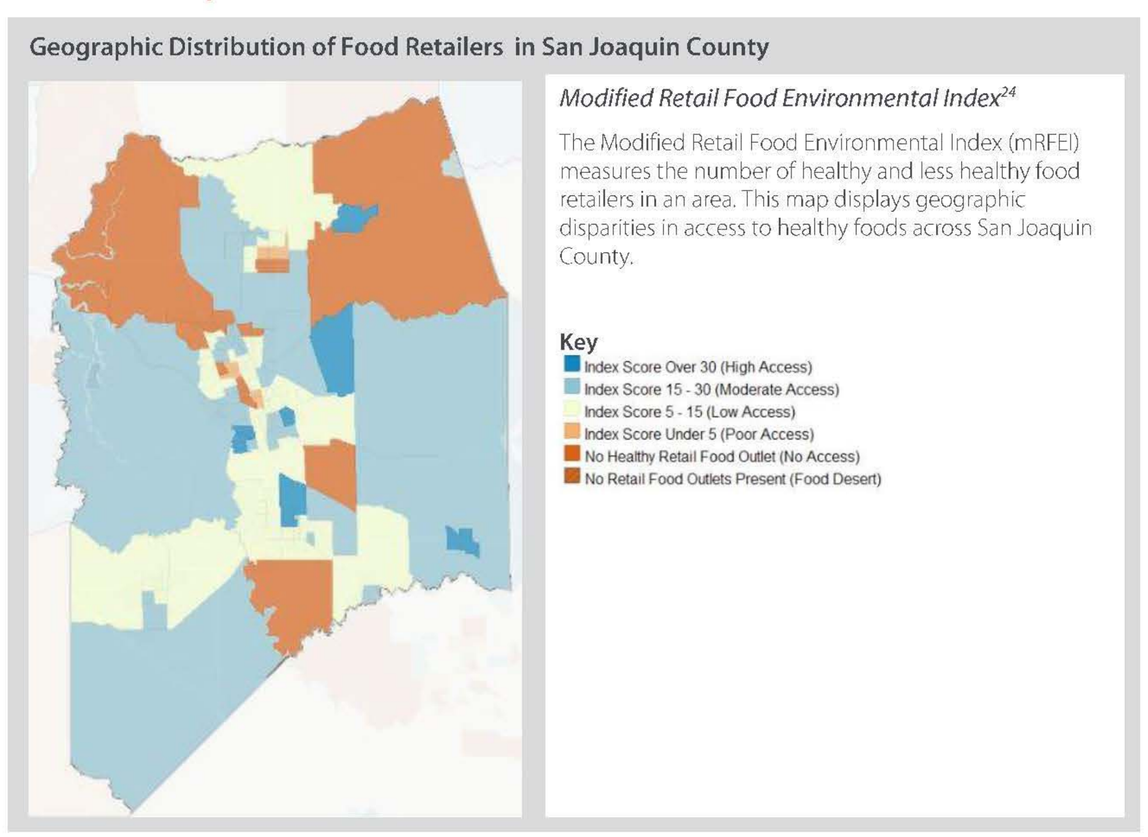
*Unstable county estimate; findings should be interpreted with caution.

Percent of Youth Overweight and Obese in San Joaquin County by Race/Ethnicity[23]

Group	Percent
Latino	44.2
White	35.0
African American	40.6
American Indian/Alaska Native	46.3
Asian	26.8
Native Hawaiian/Pacific Islander	51.3
Two or More Races	36.0

Obesity & Diabetes (continued)

Salient Disparities



Obesity & Diabetes (continued)

Examples of Existing Community Assets†

Food Banks

Health Education/Youth Athletics Departments

Parks and Recreations

Ideas from Focus Group and Interview Participants†

- Increase safe areas for children to play
- Create urban community gardens
- Offer healthy cooking classes and support groups for overeaters
- Offer daily Meals on Wheels service, not frozen food for the week
- Support walkable communities in the city's General Plan
- Provide alternative recreation options during poor air quality days

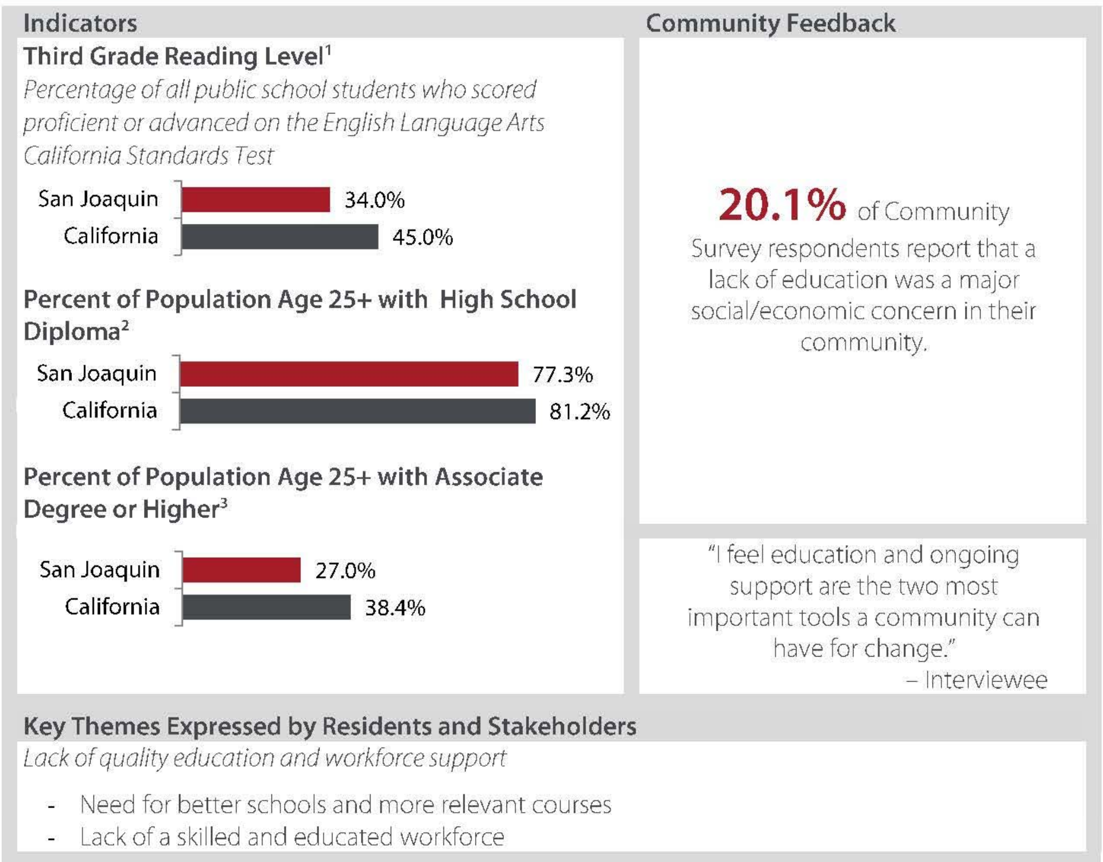
† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

[1] California Health Interview Survey, 2014.
[2] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[3] California Department of Public Health, 2009-11.
[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[5] University of California Los Angeles Center for Health Policy Research, Prediabetes Rates by County, 2016.
[6] University of Missouri, Center for Applied Research and Environmental Systems., California Department of Public Health (CDPH), Death Public Use Data, 2010-12.
[7] Centers for Medicare and Medicaid Services, 2012.
[8] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[10] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2005-09.
[11] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[12] California Health Interview Survey, 2011-12.
[13] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[14] Feeding America, Child Food Insecurity Data, 2012.
[15] U.S. Department of Agriculture, Economic Research Service, 2010.
[16] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[17] US Census Bureau, Decennial Census. ESRI Map Gallery, 2010.
[18] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[19] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[20] Dartmouth College Institute for Health Policy and Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[21] California Health Interview Survey, 2007-12.
[22] California Health Interview Survey, 2014.
[23] California Department of Education, Physical Fitness Testing Research Files (Dec. 2015).
[24] Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity (DNPAO), 2011.

Education

There is an important relationship between education and health. People with limited education tend to have much higher rates of disease and disability, whereas people with more education are likely to live longer, practice healthy behaviors, and experience better health outcomes for themselves and their children. In San Joaquin County, graduation rates are lower than the California state average, as is reading proficiency among third graders. Community members and key stakeholders highlighted education as an important health need and suggested strategies such as affordable preschool and culturally responsive education to improve outcomes.

Key Data



Key Themes Expressed by Residents and Stakeholders

Lack of quality education and workforce support

- Need for better schools and more relevant courses
- Lack of a skilled and educated workforce

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Education (continued)

Additional Data

Early Childhood Education

Preschool Enrollment
% of children age 3-4 enrolled in Head Start, licensed child care, nurseries, Pre K, registered child care, and other cares[4]

38.6 | 47.8
San Joaquin | California

Head Start Programs Rate
Rate per 10,000 children under age 5[5]

10.1 | 6.3
San Joaquin | California

English Language Learners

English Performance among English Language Learners (Grade 10)
% of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts[6]

33.0 | 38.0
San Joaquin | California

Math Performance among English Language Learners (Grade 10)
of English language learners (grade 10) who passed the California High School Exit Exam in Math[7]

56.0 | 54.0
San Joaquin | California

English Performance among English Language Learners (Grade K-12)
% of English language learners (K-12) who met California English Language Development Test (CELDT) criteria for proficiency[8]

38.0 | 39.0
San Joaquin | California

Retention

Expulsion
Rate of expulsion per 100 enrolled K 12 public school students[9]

0.2 | 0.1
San Joaquin | California

Suspension
Rate of suspension per 100 enrolled K 12 public school students[10]

7.9 | 3.8
San Joaquin | California

Post-Secondary Education

College Preparation
% of students meeting UC or CSU course requirements[11]

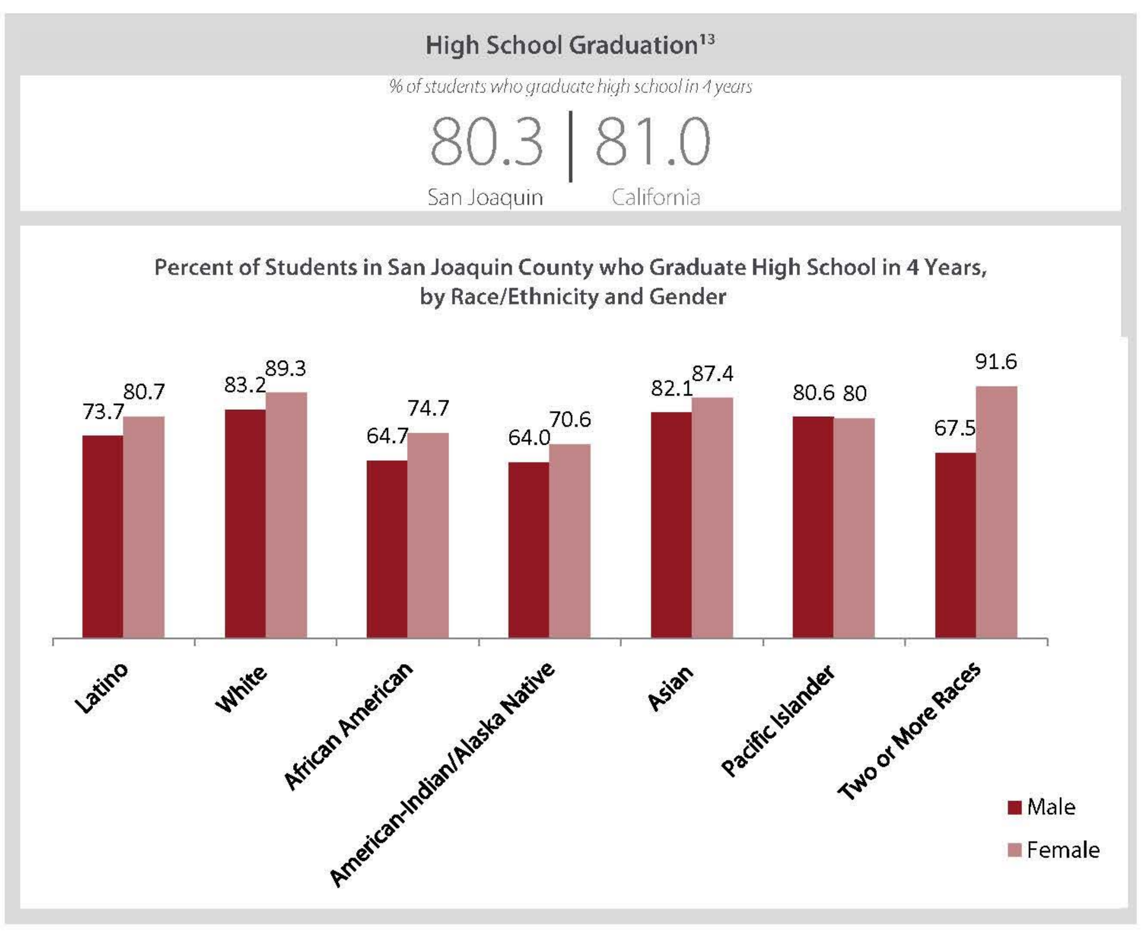
27.0 | 41.9
San Joaquin | California

Postsecondary Enrollment in U.S.
% of high school graduates enrolled in a postsecondary institution in the U.S. within 16 months after graduation[12]

71.7 | 74.4
San Joaquin | California

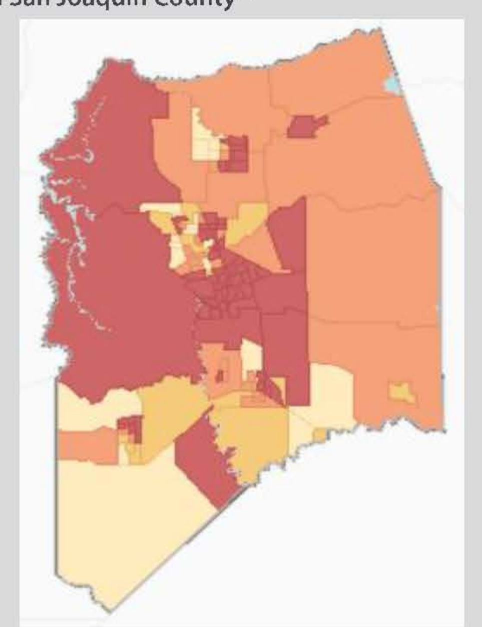
Education (continued)

Salient Disparities



Education (continued)

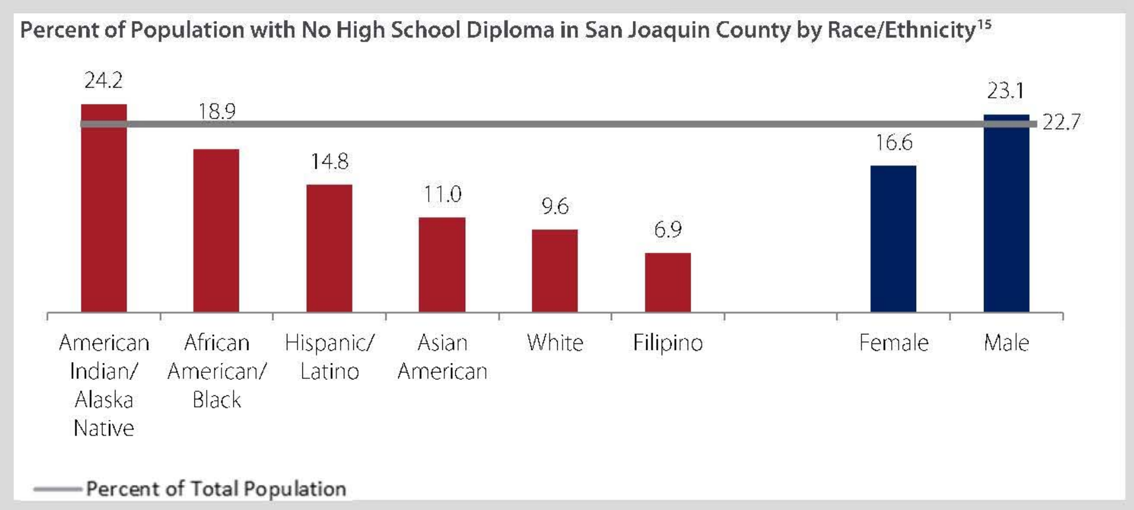
Salient Disparities



Percent with No High School Diploma

- Over 21%
- 16.1-21%
- 11.1-16%
- Under 11.1%

The map displays geographic disparities in high school educational attainment across San Joaquin County. Areas where more than one in five residents do not have high school diploma include **Lockeford, Lodi, areas of Stockton, Tracy,** and the **eastern area of the county**.



Education (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

School Readiness Programs

Youth Enrichment Programs

School Districts

Ideas from Focus Group and Interview Participants†

- Provide multicultural education
- Prepare students for the global workforce
- Provide affordable preschool
- Support tutoring and after-school programs
- Host college preparation workshops
- Partner with business and private sector to support appropriate educational training

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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[1] California Dept. of Education, Standardized Testing and Reporting (STAR) Results, 2013.
[2] US Census Bureau, American Community Survey, 2009-13.
[3] Ibid.
[4] US Census Bureau, American Community Survey, 2014.
[5] US Department of Health & Human Services, Administration for Children and Families, 2014.
[6] California Department of Education, 2014.
[7] Ibid.
[8] California Department of Education, 2014-15.
[9] Ibid.
[10] Ibid.
[11] California Department of Education, California Basic Educational Data System (CBEDS), 2014.
[12] California Department of Education, 2008-09.
[13] California Department of Education, 2013-14.
[14] US Census Bureau, American Community Survey, 2009-13.
[15] Ibid.

Youth Growth and Development

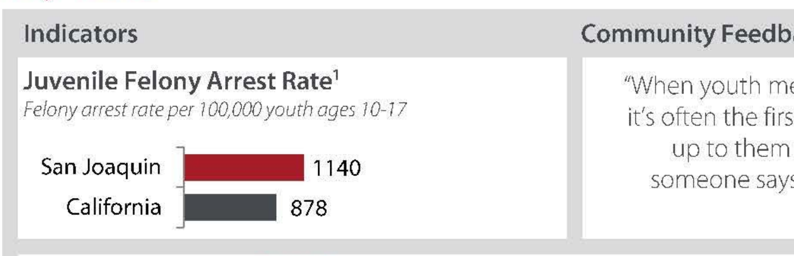
Youth growth and development refers to the healthy physical, social, and emotional development of young people. Promoting youth development is a deliberate process of providing support, relationships, experiences, and opportunities for young people—leading to happy, healthy, successful adulthood. Primary and secondary data indicate that youth development tends to be undermined by trauma and violence, unhealthy family functioning, exposure to negative institutional environments and practices, and insufficient access to positive youth activities, among other things. In San Joaquin County, the disparate levels of exposure to these risk factors contribute to outcome disparities during youth and throughout adulthood. This includes disparities by race, ethnicity, gender, sexual orientation, and income, with respect to outcomes such as juvenile justice involvement, foster placement, adult incarceration, educational attainment, and chronic disease.

Key Data

Indicators

Juvenile Felony Arrest Rate[1]

Felony arrest rate per 100,000 youth ages 10-17



Community Feedback

"When youth meet with their case manager, it's often the first time that the world opens up to them with opportunities and someone says to them, 'You can do it'."
– Interviewee

Over one-third **(36%)** of all San Joaquin County youth arrests occur at school; of these arrests **85%** were youth of color.[2]

Link between violence and health outcomes

Youth exposed to abuse or violence in the home, or violence in their community, are at greater risk of poor mental and physical health outcomes in adulthood, including increased risk for heart disease, depression, suicide attempts, and alcoholism, among others.[3,4]

Poverty during childhood can also have a strong impact on later outcomes, including healthy brain development and success in school.[5]

Key Themes Expressed by Residents and Stakeholders

Trauma, stress, and mental health/substance abuse
- Exposure to violence
- Improper diagnoses and insufficient treatment
- Substance use as a coping mechanism
- Suicide

Education and economic opportunities
- Poverty as a root cause
- Education not preparing students for workforce
- Lack of employment opportunities and low wages

Social activity and support
- Lack of social skills and healthy peers
- Lack of free and affordable activities for youth
- Lack of family and community support

Engagement with the criminal justice system
- Violence
- Early and consistent law enforcement interaction
- Probation and/or criminal record limits work opportunities

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Youth Growth and Development

(continued)

Additional Data

Education

School Suspension Rate
Rate of suspension per 100 enrolled students[6]

7.9 | 3.8
San Joaquin | California

Expulsion
Rate of expulsion per 100 enrolled K-12 public school students[7]

0.2 | 0.1
San Joaquin | California

English Performance among English Language Learners (Grade 10)
% of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts[8]

33.0 | 38.0
San Joaquin | California

Foster Care

Foster Care Placement Stability
% of children in foster care system for more than 8 days but less than 12 months with 2 or less placements[9]

84.7 | 86.6
San Joaquin | California

Youth Activities

31.7% of Community Survey respondents indicated that a lack of activities for youth is a high concern in their community.

"There are a lot of youth activities, but there is often a cost to participate and many families cannot afford it. There needs to be innovative strategies to deal with this."

– Interviewee

Violence and Crime

"Reducing racial disparities is important. There is a disproportionate amount of bookings, suspensions, and expulsions with the school to prison pipeline."

– Interviewee

30.3% of Community Survey respondents reported that youth violence is an important health concern in their community.

Gang Involvement, Youth
% of 11th grade students reporting current gang involvement[10]

15.0 | 8.0
San Joaquin | California

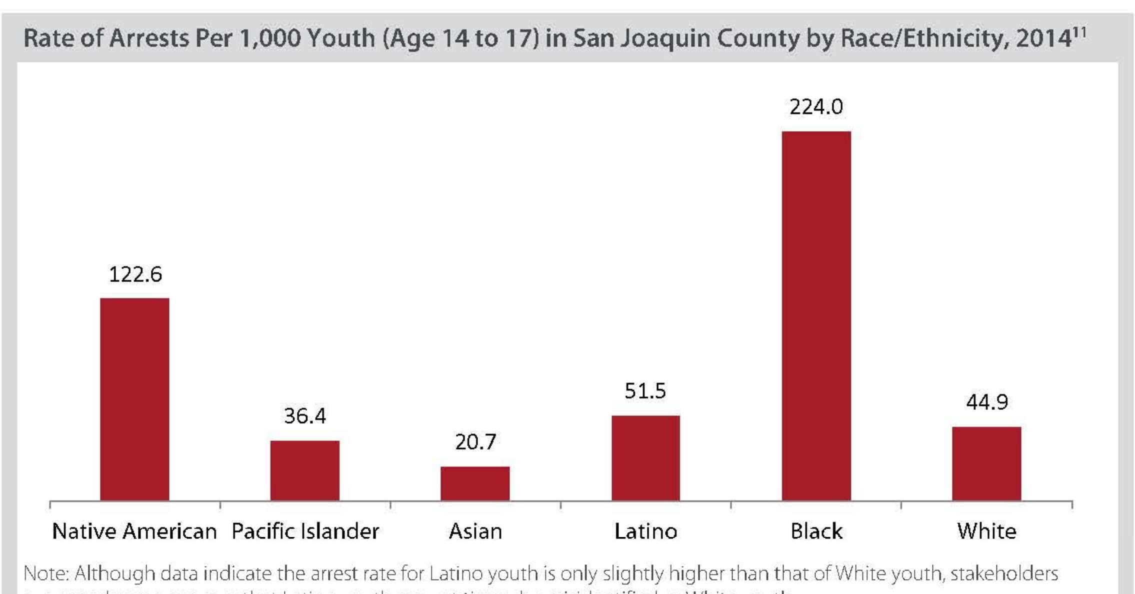
"Youth crime has dropped dramatically over last 10 years. However, those who do enter the system are at very high risk. More youth cases are being tried as adults even though they don't have previous experiences with the criminal system."

– Interviewee

Youth Growth and Development
(continued)

Salient Disparities

Rate of Arrests Per 1,000 Youth (Age 14 to 17) in San Joaquin County by Race/Ethnicity, 2014[11]

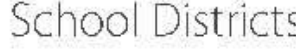


Note: Although data indicate the arrest rate for Latino youth is only slightly higher than that of White youth, stakeholders expressed some concern that Latino youth may, at times, be misidentified as White youth.

Youth Growth and Development (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

Youth Service Providers	School Districts	Community Mentors and Foster Care Systems
		

Ideas from Focus Group and Interview Participants†

- Partner with San Joaquin Pride Center and implement early interventions in school to address LGBTQ concerns, bullying, and feelings of isolation
- Decriminalize general youth behavior
- Provide counselors for kids and families (e.g., at school-based health centers)
- Connect youth to role models
- Provide trainings about trauma-based care
- Provide more opportunities for parenting classes; teach motivational interviewing techniques for parents of teens who are asking for help
- Address substance abuse among teens
- Provide education, internship, entertainment, recreation, sports, and mentoring opportunities to youth
- Provide youth-friendly nutrition information

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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[1] Center on Juvenile and Criminal Justice, 2012.
[2] 2015 San Joaquin County Racial and Ethnic Disparities Technical Assistance Project, Phase One Assessment, Youth Justice Data 2014.
[3] Jack P. Shonkoff and Deborah A. Phillips, eds.,"From Neurons to Neighborhoods: The Science of Early Childhood Development," National Research Council and Institute of Medicine, Committee on Integrating the Science of Early Childhood Development, National Academy Press, 2000.
[4] "Adverse Childhood Experiences: Major Findings," Centers for Disease Control and Prevention, accessed November 2015, http://www.cdc.gov/violenceprevention/acestudy/findings.html.
[5] 2016 California Children's Report Card, Ch1ldren Now.
[6] California Department of Education, 2014-15.
[7] Ibid.
[8] California Department of Education, 2014.
[9] California Child Welfare Indicators Project (CCWIP), 2014.
[10] Healthy Kids Survey, 2009-11.
[11] 2015 San Joaquin County Racial and Ethnic Disparities Technical Assistance Project, Phase One Assessment, Youth Justice Data 2014.

Economic Security

Economic security is very strongly linked to health; it can impact access to healthy food, medical care, education and safe environments. Poverty and unemployment are higher in San Joaquin County than California as a whole. Concerns surrounding economic security were particularly important to community members, who highlighted the need for jobs that pay a living wage and the ability to afford descent and safe housing.

Key Data

Indicators

Percent Population With Income at or Below 200% Federal Poverty Level[1]

San Joaquin	41.3%
California	35.9%

Percent of Children Under Age 18 Living Below 200% of Federal Poverty Level[2]

San Joaquin	52.0%
California	46.0%

Percent of Population Unemployed[3]

San Joaquin	10.6%
California	7.9%

Percent of Households Receiving Public Assistance Income[4]

San Joaquin	6.6%
California	4.0%

Community Feedback

34.6% of Community Survey respondents report poverty is a significant social/economic problem in their community.

61.3% of Community Survey respondents report the lack of local jobs is a significant social/economic problem in their community.

Key Themes Expressed by Residents and Stakeholders

- Trapped in poverty; no upward mobility
- Struggle to survive causes chronic stress
- Lack of job opportunities and affordable housing
- Hard to find a job with limited skills or education or criminal record

"The social diseases and ills have transferred into chronic diseases and ills such as cancer, diabetes and heart disease."
-Interviewee

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Economic Security (continued)

Additional Data and Key Drivers

Economic Security

Female Headed Households
Percent single female headed households in poverty[5]

15.4 San Joaquin | 13.5 California

Percent Population Insured by Medi-Cal
% of total population receiving Medi Cal[6]

30.9† San Joaquin | 23.2 California

Supplemental Nutrition Assistance Program (SNAP) Benefits
Percent population receiving SNAP benefits[7]

15.2 San Joaquin | 10.6 California

Education

Percent Population Age 25+ with No High School Diploma[8]

22.7 San Joaquin | 18.8 California

Free and Reduced Meal Programs
% of students in county eligible for free or reduced price lunch[9]

64.3 San Joaquin | 58.1 California

3rd Grade Reading Proficiency
% of all public school students tested in 3rd grade who scored proficient or advanced on the English Language Arts California Standards Test[10]

34.0 San Joaquin | 45.0 California

Outcomes of Poverty

Access to Healthy Food
Percentage of the population with food insecurity[11]

18.0 San Joaquin | 16.2 California

Income and Living Wage

Median Household Income[12]

$53k San Joaquin | $61k California

Living Wage
Annual income required to support one adult and one child[13]

$42k† San Joaquin | $47k California

Disparities in Median Household Income by Race/Ethnicity in San Joaquin County[14]

Race/Ethnicity	Median Household Income
Native Hawaiian/Pacific Islander	$79,971
Asian	$61,734
White	$57,016
American Indian/Alaska Native	$46,981
Latino	$42,584
Two or more races	$41,559
Some other race	$39,963
Black	$25,697

† This value is not color-coded because directionality does not apply.

Economic Security (continued)

Salient Disparities

Percent of Subpopulations Living below Federal Poverty Level by Race/Ethnicity in San Joaquin County[15]

Percent of Total Population: 7.8%

Black	White	Hispanic/Latino (any race)	Native American/ Alaska Native	Native Hawaiian/ Pacific Islander
24.7%	6.3%	17.5%	34.1%	9.4%

Percent of Population Living below 200% Federal Poverty Level in San Joaquin County by Geographic Area[16]

Population below 200% Federal Poverty Level, Percent by Tract

This map demonstrates particularly high risk of poverty in the central part of the county near **Stockton**, as well as throughout areas surrounding **Holt** and **Lodi**.

A greater percentage of community survey participants in **Thornton, Ripon**, and **Tracy** indicated that a **lack of local jobs** was among the top three social/economic problems in their community (77.6%, 76.5%, and 66.9%, respectively, compared to 61.3% of all respondents).

Key
- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Economic Security (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

Apprenticeship Programs, Job Trainings

County and City Governments

Community Based Organizations

Ideas from Focus Group and Interview Participants†

- Increase communication and collaboration among county, city, and social service agencies to serve communities and ensure individuals are aware of the resources available
- Include partners from all sectors, including businesses, diverse ethnic groups, schools, faith based organizations, community-based organizations, legislators, and employers
- Involve groups that engage residents as advocates and youth development
- Explore opportunities to increase equity in policies
- Provide courses to help families in need gain life skills
- Expand support for single mothers with children
- Increase job training

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

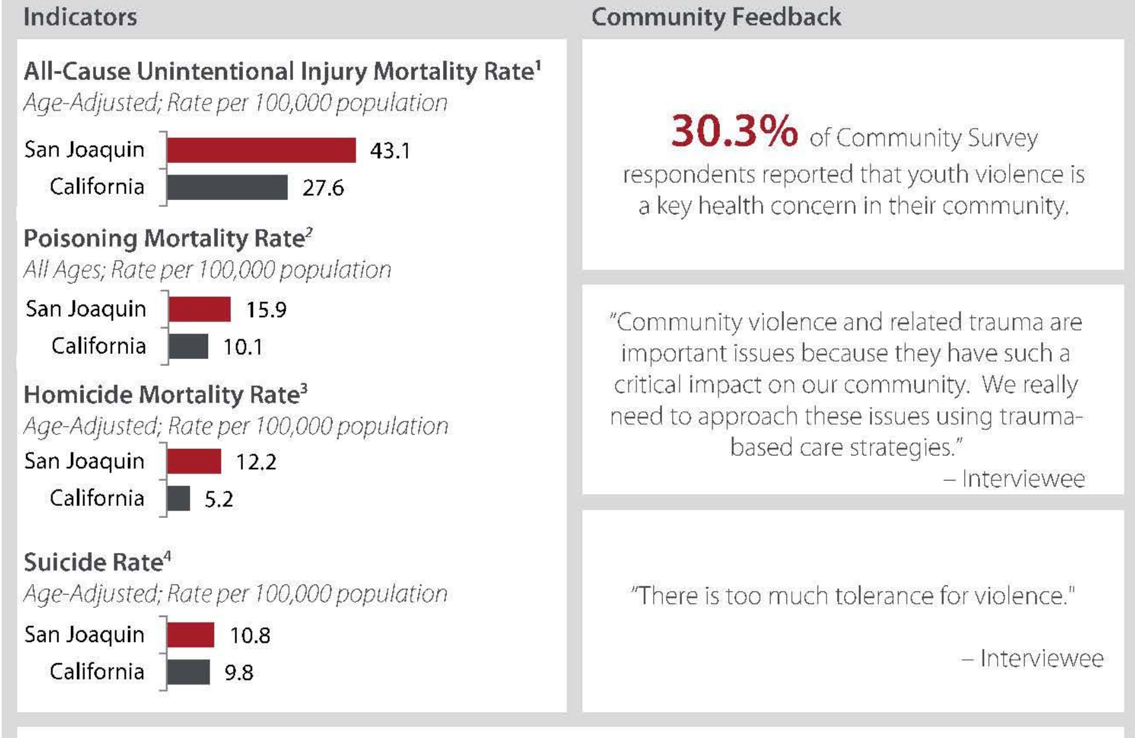
[1] US Census Bureau, American Community Survey, 2009-13.
[2] Ibid.
[3] US Department of Labor, Bureau of Labor Statistics, 2015.
[4] US Census Bureau, American Community Survey, 2009-13.
[5] Ibid.
[6] US Census Bureau, American Community Survey, 2014.
[7] US Census Bureau, Small Area Income & Poverty Estimates, 2011.
[8] US Census Bureau, American Community Survey, 2009-13.
[9] National Center for Education Statistics, NCES- Common Core of Data, 2013-14.
[10] California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013.
[11] Feeding America, Child Food Insecurity Data, 2012.
[12] US Census Bureau, American Community Survey, 2010-14.
[13] Calculated from livingwage.mit.edu, 2015.
[14] US Census Bureau, American Community Survey, 2014.
[15] US Census Bureau, American Community Survey, 2009-13.
[16] Ibid.

San Joaquin County Community Health Needs Assessment

Violence and Injury

Injury is a broad topic that includes both unintentional injuries, as a result of motor vehicle crashes, drowning, falls or accidental poisoning (overdoses), and intentional violent injuries such as assault and abuse, as well as homicide and suicide. San Joaquin County's injury rates remain substantially higher than the California averages. Among unintentional injuries, the leading causes of death in San Joaquin County are poisoning, motor vehicle crashes, falls, and drowning/submersion. Among intentional injuries, core concerns are often associated with family and community violence. In particular, the homicide rate is much higher than in California as a whole, particularly among men of color. Survey respondents identified violence as a core issue in their communities and cited concerns such as gun violence, gang activity among youth, and domestic violence as key themes.

Key Data



1 in 4 11th grade students in San Joaquin County report **driving after drinking** *(respondent or friend)*.[5]

Key Themes Expressed by Residents and Stakeholders

- Violence in schools and among youth
- Chronic exposure to violence and/or abuse

Among Community Survey respondents, **Youth** were more likely to report that **youth violence** (44.4% compared to 30.6% of all respondents) and **use of weapons** (24.7% compared to 19.6% of all respondents) were significant health concerns.

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Violence and Injury (continued)

Additional Data

Additional Causes of Unintentional Death

Drowning/Submersion Mortality Rate
All Ages; Rate per 100,000 population[6]

1.8 | 1.0
San Joaquin | California

Fall Mortality Rate
All Ages; Rate per 100,000 population[7]

4.6 | 5.7
San Joaquin | California

Pedestrian Injury Mortality Rate
Age-Adjusted; Rate per 100,000 population[8]

2.3 | 2.0
San Joaquin | California

Motor Vehicle Crash Mortality Rate
Age-Adjusted; Rate per 100,000 population[9]

11.4 | 7.5
San Joaquin | California

Domestic Violence and Child Maltreatment

Domestic Violence Injuries
Rate per 100,000 population (Females Age 10+)[10]

7.6 | 9.5
San Joaquin | California

Rate of Domestic Violence Calls for Assistance
Rate per 1,000 population[11]

8.2 | 6.0
San Joaquin | California

Substantiated Allegations of Child Maltreatment
(per 100,000 children ages 0-17)[12]

7.3 | 8.7
San Joaquin | California

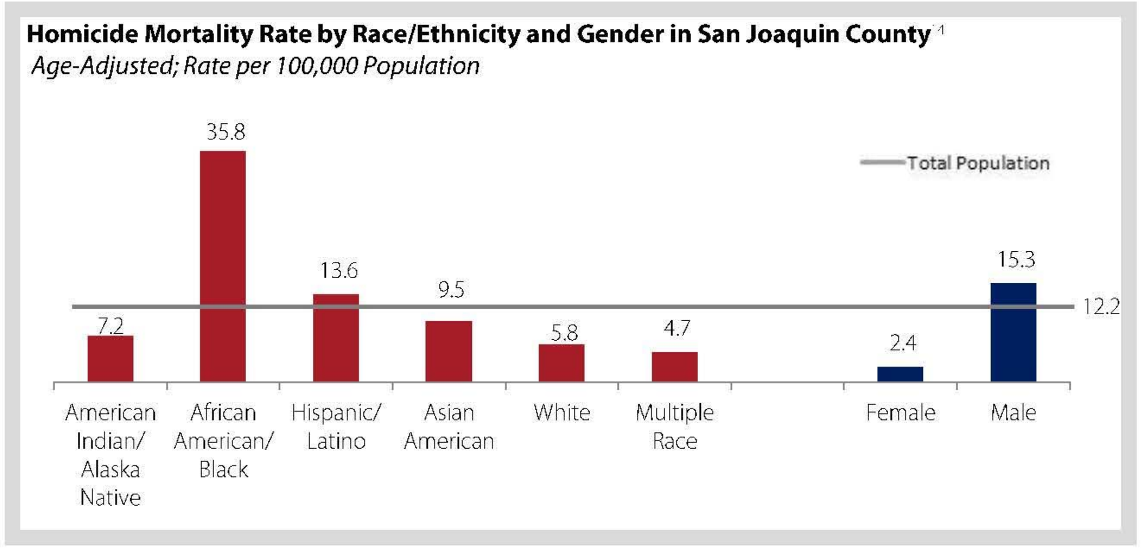
Gang Involvement

Gang Involvement, Youth
Percentage of 11th grade students reporting current gang involvement[13]

15.0 | 8.0
San Joaquin | California

Violence and Injury (continued)

Populations Disproportionately Affected



Violence and Injury (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

Domestic Violence Services

Efforts Against Gang Violence, Community-level Violence Prevention Activities

Ideas from Focus Group and Interview Participants†

- Expand support in the schools
- Involve businesses, faith-based communities
- Increase after-school programs, especially after 6th grade
- Strengthen socio-cultural connection with law enforcement to ensure "Community Policing"
- Improve community resource centers
- Interrupt cycle of abuse and substance abuse
- Bring our community together across diversity and races to have the hard conversation
- Do not accept the violence that is happening in other parts of the city or county

"**We need everyone saying, 'This is our issue' because we live here.** Most people are happy that the violence happens in pockets that you can avoid."
–Interviewee

"Success would be kids being able to walk to school without their parents; kids being able to play in their backyards. Being able to drive slowly in the streets to avoid the kids out playing versus avoiding wandering addicts and gang violence."
–Interviewee

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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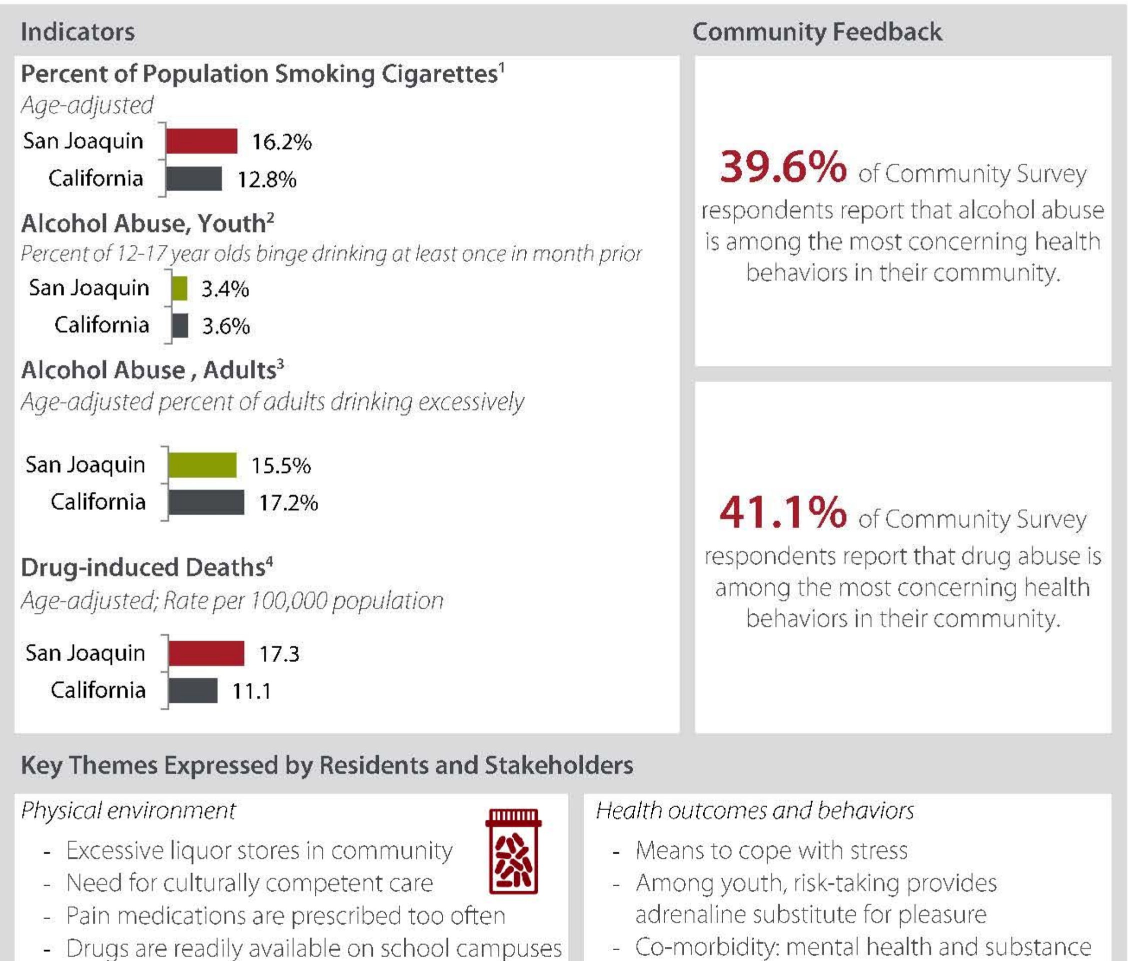
[1] "2013 County Health Status Profiles," California Department of Public Health, 2009-11.
[2] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[4] Ibid.
[5] California Healthy Kids Survey, 2013-14.
[6] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.
[7] Ibid.
[8] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[9] "2013 County Health Status Profiles," California Department of Public Health, 2009-11.
[10] California Department of Public Health, EpiCenter Overall Injury Surveillance, 2011-13.
[11] California Department of Justice, Criminal Justice Statistics Center, 2014.
[12] California Child Welfare Indicators Project, 2014.
[13] California Healthy Kids Survey, 2009-11.
[14] California, Department of Public Health, 2013 Death Records. Population denominator from State of California, Department of Finance, Race/Ethnic Population with Age and SeN/A Detail, 2010-2060. Sacramento, CA, December 2014.

Substance Abuse

Substance abuse, including abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences, including increased risk of liver disease, cancer, and death from overdose. San Joaquin County's rate of drug-induced deaths is 56% higher than average rate across California (17.3 per 100,000 compared to 11.1 per 100,000). Primary data collection from surveys, focus group discussions and interviews highlighted the importance of this issue for the county; 41.1% of community survey respondents report that drug abuse is among the most concerning health behaviors in their community.

Key Data



Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Substance Abuse (continued)

Additional Data

Tobacco Use

Use Among Youth
% of 11th graders using cigarettes any time within last 30 days[5]

5.0 | 12.0
San Joaquin | California

24.6% of Community Survey respondents report that smoking/tobacco use is a significant health concern in their community.

Attempt to Quit
% of adult smokers who attempted to quit for at least one day in the past year[6]

55.4 | 57.7
San Joaquin | California

42.5% of Community Survey respondents report that store window advertising of tobacco and alcohol products is a big problem in their community.

Alcohol Use

Use Among Youth
% of 12-17 year olds binge drinking at least once in month prior[7]

3.4 | 3.6
San Joaquin | California

Arrests
Rate of arrests for alcohol related offenses per 100,000 population; ages 10-69[8]

1,569 | 1,203
San Joaquin | California

Health Outcomes
Chronic liver disease and cirrhosis mortality rate (Per 100,000 population)[9]

17.1 | 11.7
San Joaquin | California

21.3% of Community Survey respondents report that drunk driving is a significant health concern in their community.

Drug Use

Use Among Youth
% of 11th grade students who report they've been "high" from using drugs[10]

49.0 | 36.0
San Joaquin | California

Health Outcomes
Drug induced deaths (age adjusted rate; per 100,000 population)[11]

17.3 | 11.1
San Joaquin | California

Link to Homelessness and Mental Health

Homelessness

2,641
people in San Joaquin County are experiencing homelessness.[12]

Adults Needing Mental Health or Substance Abuse Treatment
% of adults reporting need for treatment for mental health, or use of alcohol/drug[13]

14.0 | 14.3
San Joaquin | California

Substance Abuse (continued)

Salient Disparities

Percent of Adults Drinking Excessively in San Joaquin County, by Race/Ethnicity and Gender[14]

Group	Percent
Latino	35.4
White	35.7
African American	20.7
American Indian/Alaska Native	37.1
Asian	20.3
Native Hawaiian/Pacific Islander	DS
Two or More Races	DS
Male	39.8
Female	25.8

DS = Data Suppressed

Substance Abuse Treatment Facilities in San Joaquin County[15]

Key

Substance Abuse Treatment Facility, including outpatient, residential, hospital inpatient, and partial hospitalization/day treatment facilities and programs, as well as halfway houses. It includes facilities that provide detoxification, treatment, and treatment with methadone or buprenorphine.

The map (pictured left) corroborates primary data themes related to substance abuse treatment options, including that resources are limited and more options are needed **outside of Stockton**.

Substance Abuse (continued)

Salient Disparities

Community Respondents' View of Disparities

Gender disparities

Among Community Survey respondents, **men were more likely to report alcohol abuse** (45.9% compared to 39.5% of all respondents) and smoking (29.3% compared to 24.7% of all respondents) as health concerns.

Age disparities

Among Community Survey respondents, **youth were much more likely to report drunk driving** (32.3% compared to 21.3% of all respondents) and **alcohol abuse** (46.1% compared to 39.6% of all respondents) as significant health concerns, and slightly more likely to report **drug abuse** (46.3% compared to 41.4% of all respondents).

Among Community Survey respondents, **older adults** were much more likely to indicate that **smoking** was a behavior that most affects health in their community (34.8% compared to 24.7% of all respondents).

Other disparities

Interviewees noted other populations with a high risk of substance abuse. Among others, **foster youth** and **LGBTQ youth** were named as populations of high concern. Community members **experiencing domestic violence** were also noted as a population with high risk. One interviewee elaborated, "90% of our clients [people experiencing domestic violence] have substance abuse as a concern. It is a way to numb what is happening."

Substance Abuse (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

Behavioral Health Services

Support Groups

Treatment Facilities/Programs

Ideas from Focus Group and Interview Participants†

Increase access to substance abuse treatment

- Start support groups at schools for those influenced by drug/alcohol abuse
- Utilize mandated DUI classes to enroll alcohol abusers in appropriate services
- Increase in-patient drug rehabilitation facilities
- Create quality rehab programs to address adolescent prescription drug use
- Organize resources to improve awareness of options and access

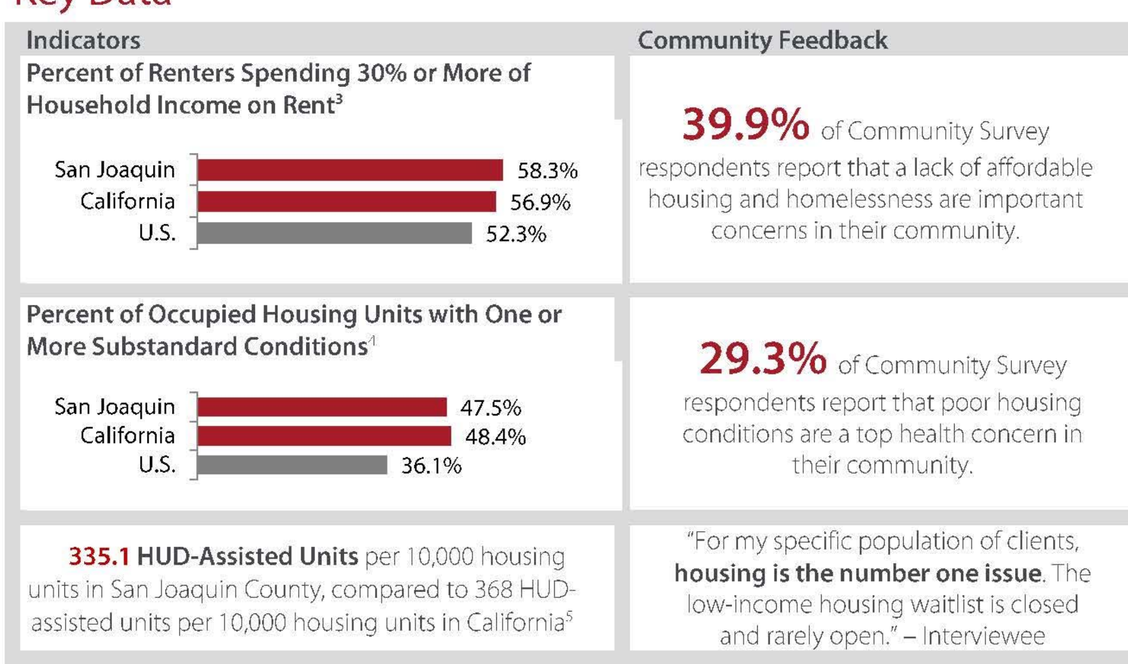
† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

[1] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[2] California Health Interview Survey, 2011-12.
[3] 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.
[4] California Public Health Department, 2011-13.
[5] California Healthy Kids Survey, 2011-2013.
[6] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12.
[7] California Health Interview Survey, 2011-12.
[8] CA-Community Prevention Initiative (CPI), 2009.
[9] California Department of Public Health, 2011-13.
[10] California Healthy Kids Survey, 2009-11.
[11] California Department of Public Health, 2011-13.
[12] "San Joaquin County Point-In-Time Homeless Count," Head Start Report: Assessing the Needs of Children & Families in San Joaquin County 2014. San Joaquin County Community Development Department, 2011.
[13] California Health Interview Survey, 2013-14.
[14] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[15] Substance Abuse and Mental Health Services Administration, 2014.

Access to Housing

Access to stable, affordable housing is a foundation for good health. A family that pays more than 30 percent for housing is considered "cost-burdened" and may have difficulty affording food, clothing, transportation, and medical care.[1] Substandard housing and homelessness can exacerbate health concerns, ranging from physical and mental health to substance abuse. Poor housing also makes it difficult to maintain education and employment, which are associated with being healthy. Primary and secondary data indicate that access to safe and affordable housing is an important health concern in San Joaquin County, reflective of the rapid rise of housing costs occurring in California overall in recent years. In San Joaquin County, the foreclosure crisis, limited subsidized housing, rising rents, absentee landlords, and deteriorating housing stock are all significant contributing factors to the lack of safe and affordable housing. Moreover, a recent point-in-time count found that at least 2,641 individuals in the county are homeless.[2] Interview participants noted disparities in access to housing among foster youth, low-income populations, older adults, and seasonal workers.

Key Data



2,641 people in San Joaquin County are experiencing homelessness.[6]

Key Themes Expressed by Residents and Stakeholders

Lack of safe and affordable housing

- High foreclosure rates
- Migrants often live in substandard conditions
- Leads to health concerns such as TB, colds, lice, bed bugs, flu and poor nutrition
- Linked to parents losing custody of children
- Section 8 vouchers are challenging to use and waitlist is extremely long

Homelessness

- Homeless shelters are at capacity
- Link between homelessness, mental illness, and substance abuse
- Homeless people face stigmatization

Link to unemployment

- High unemployment rates
- Lack of jobs with living wages

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

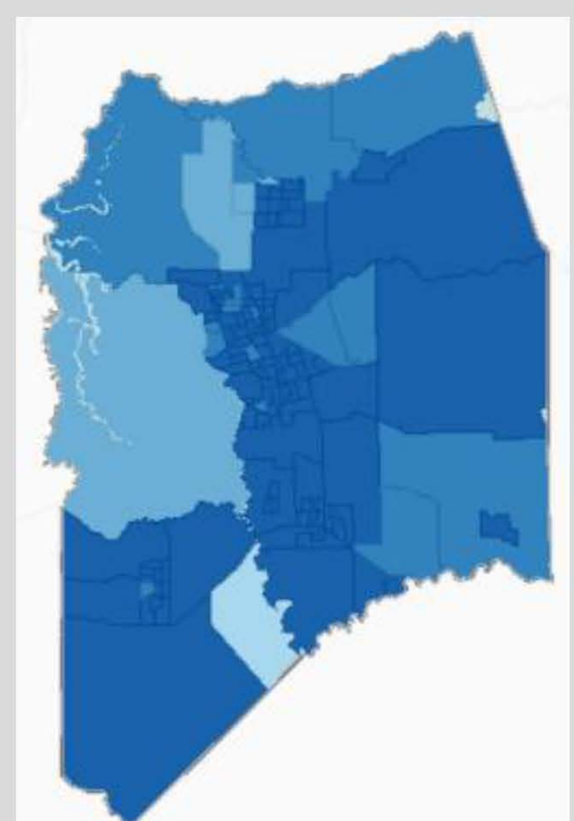
Access to Housing (continued)

Salient Disparities

Geographic Areas with Greatest Cost Burden

Percent of households where housing costs exceeds thirty percent of income[7]

44.9	45.9	35.5
San Joaquin	California	United States



Geographic disparities exist among residents experiencing high cost burden of housing. The map displays geographic disparities in cost-burdened households across San Joaquin County. The percentage of households spending more than a third of household income on housing is high across the county; the Central and North Eastern areas of the county, along with the South Eastern corner, face the highest percentages of cost burdened households.

KEY

- Over 35.1%
- 28.1 - 35.0%
- 21.1 - 28.0%
- Under 21.1%
- No Data or Data Suppressed

The San Joaquin County Grand Jury recently reported that South Stockton is disproportionately affected by issues of poor housing.[8] South Stockton has notably low levels of home-ownership, which can have implications for community cohesion by fostering more transient resident populations. Additionally, building code violations or blight often go unreported because tenants fear reprisals from their landlord.

Community Respondents' View of Disparities

Age disparities

Among Community Survey respondents, youth were more likely to report homelessness as a top health concern (45.1% of youth compared to 39.3% of all respondents).

Residents and stakeholders cited a need for more affordable housing for seniors.

Other disparities

Interview respondents noted that people who have engaged with the foster care system are more likely to experience homelessness.

Interviewees and focus group participants noted a high burden of housing costs on seasonal workers.

Access to Housing (continued)

Assets and Suggestions for Change

Examples of Existing Community Assets†

Faith Organizations

Ideas from Focus Group and Interview Participants†

- Provide outreach to the homeless, and consider implementing programs to house the homeless, based on existing successful models in similar communities
- Support programs that provide housing, education, and employment services
- Redirect funding for homeless encampment clearance toward long-term solutions to the homelessness

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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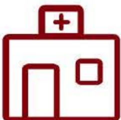
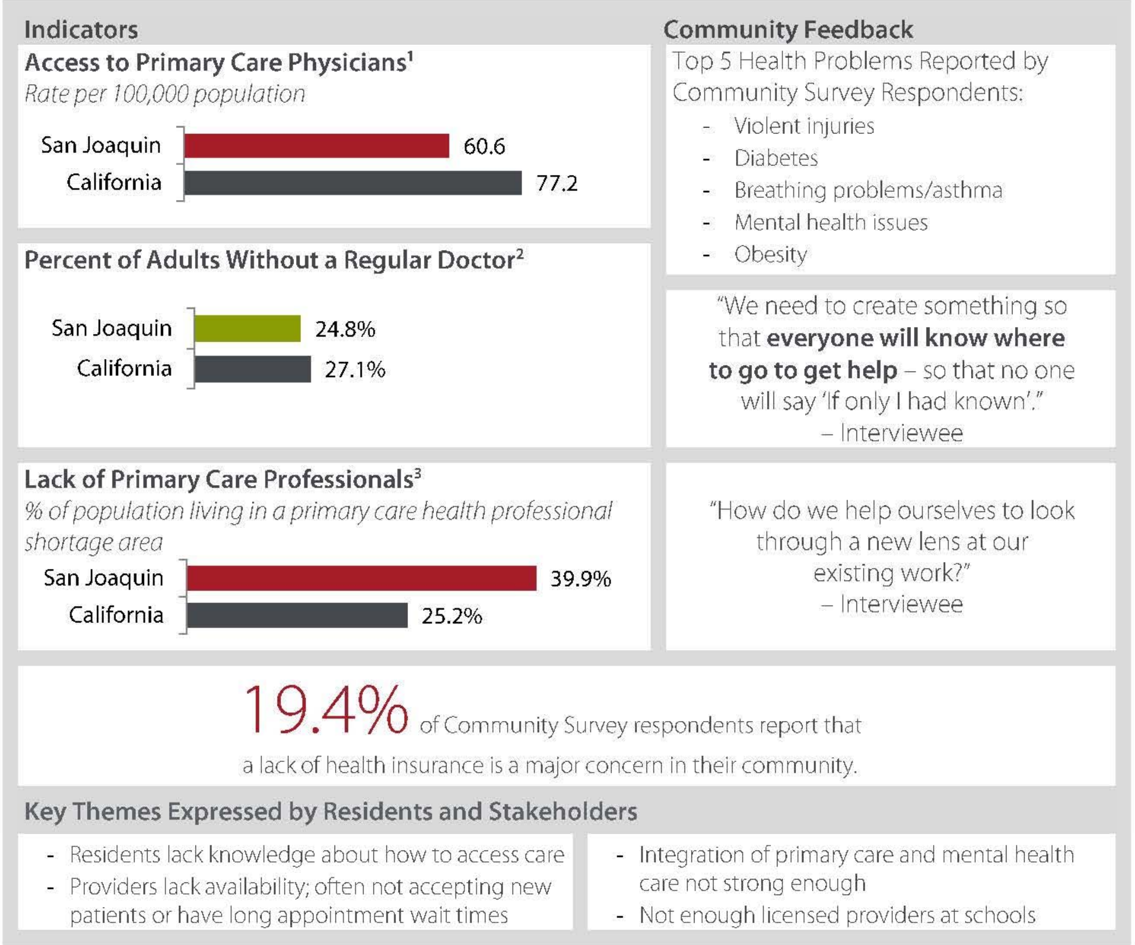
[1] US Department of Housing and Urban Development, accessed via http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/.
[2] "San Joaquin County Point-In-Time Homeless Count," Head Start Report: Assessing the Needs of Children & Families in San Joaquin County 2014. San Joaquin County Community Development Department, 2011.
[3] US Census Bureau, American Community Survey, 2009-13.
[4] Ibid.
[5] US Department of Housing and Urban Development, 2013.
[6] "San Joaquin County Point-In-Time Homeless Count," Head Start Report: Assessing the Needs of Children & Families in San Joaquin County 2014. San Joaquin County Community Development Department, 2011.
[7] US Census Bureau, American Community Survey, 2009-13.
[8] San Joaquin County Grand Jury Report, accessed via https://www.sjcourts.org/grandjury/2015/1414%20report%20approved.pdf.

Access to Medical Care



Access to comprehensive, affordable, quality medical care is critical to the prevention, early intervention, and treatment of health conditions. San Joaquin County has been successful in enrolling residents in Expanded Medi-Cal under the Affordable Care Act (ACA); however, learning how to use services, retention of coverage, and the shortage of primary care providers that will accept new Medi-Cal patients remain challenges. The fact that the County's many undocumented adult residents are without insurance also remains a barrier to care.

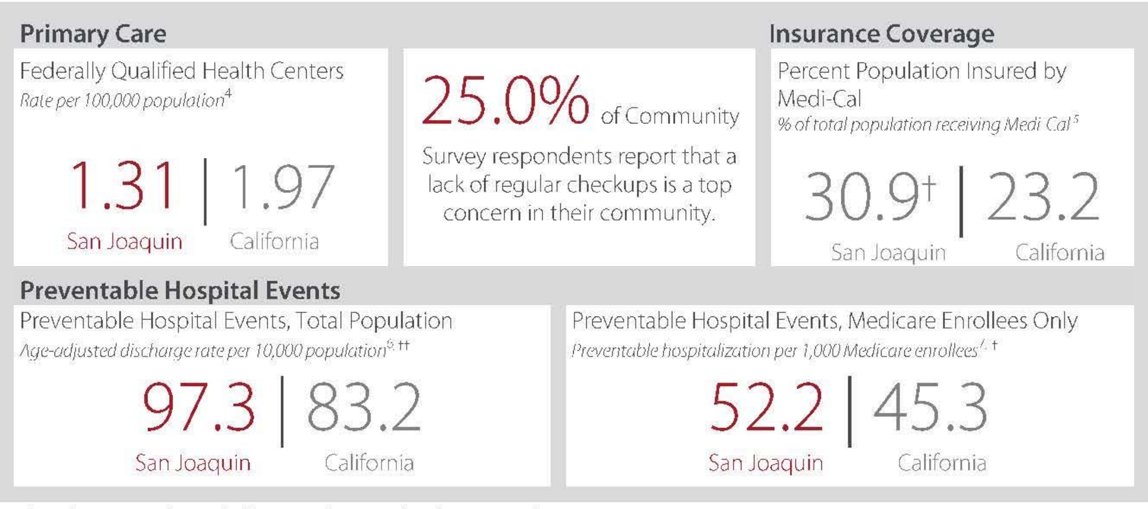
Key Data



Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Access to Medical Care (continued)

Additional Data and Drivers



This value is not color-coded because directionality does not apply.

†† This indicator reports the patient discharge rate for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients.

Access to Medical Care (continued)

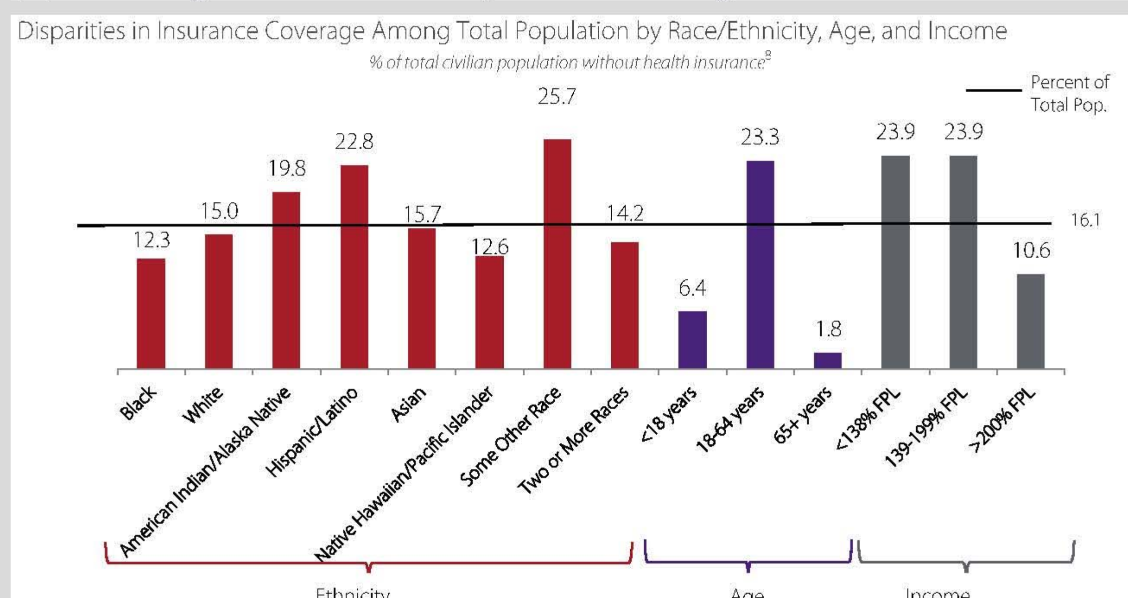
Salient Disparities

Geographic Disparities

Although existing data is limited as to geographic disparities in health insurance status, the San Joaquin Community Survey provided some information about insurance status and care access in different regions of the county. Issues described included **scarcity of services in rural areas, and the fact that the undocumented population and agricultural workers face unique barriers in accessing health insurance and care**.

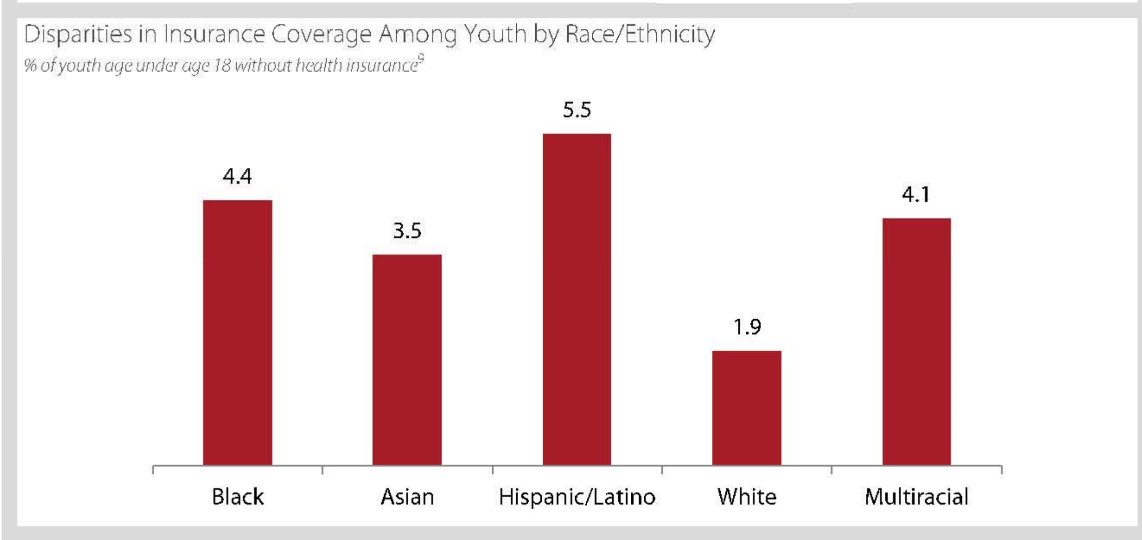
Disparities in Insurance Coverage Among Total Population by Race/Ethnicity, Age, and Income

% of total civilian population without health insurance[9]



Disparities in Insurance Coverage Among Youth by Race/Ethnicity

% of youth age under age 18 without health insurance[9]



Access to Medical Care (continued)

Assets and Residents' Suggestions for Change

Examples of Existing Community Assets†

Health Insurance Agencies

Hospitals and Health Organizations

Community Resource Centers

Ideas from Focus Group and Interview Participants†

- Promote existing services
- Strengthen collaboration and service coordination/referrals among county, city, and social service agencies
- Provide multiple services in one location when possible
- Utilize technology to provide remote access to health screenings and services
- Ensure community members are aware of resources and are encouraged to access them (e.g., via health navigator)
- Integrate primary and mental health care services

† Assets and recommendations excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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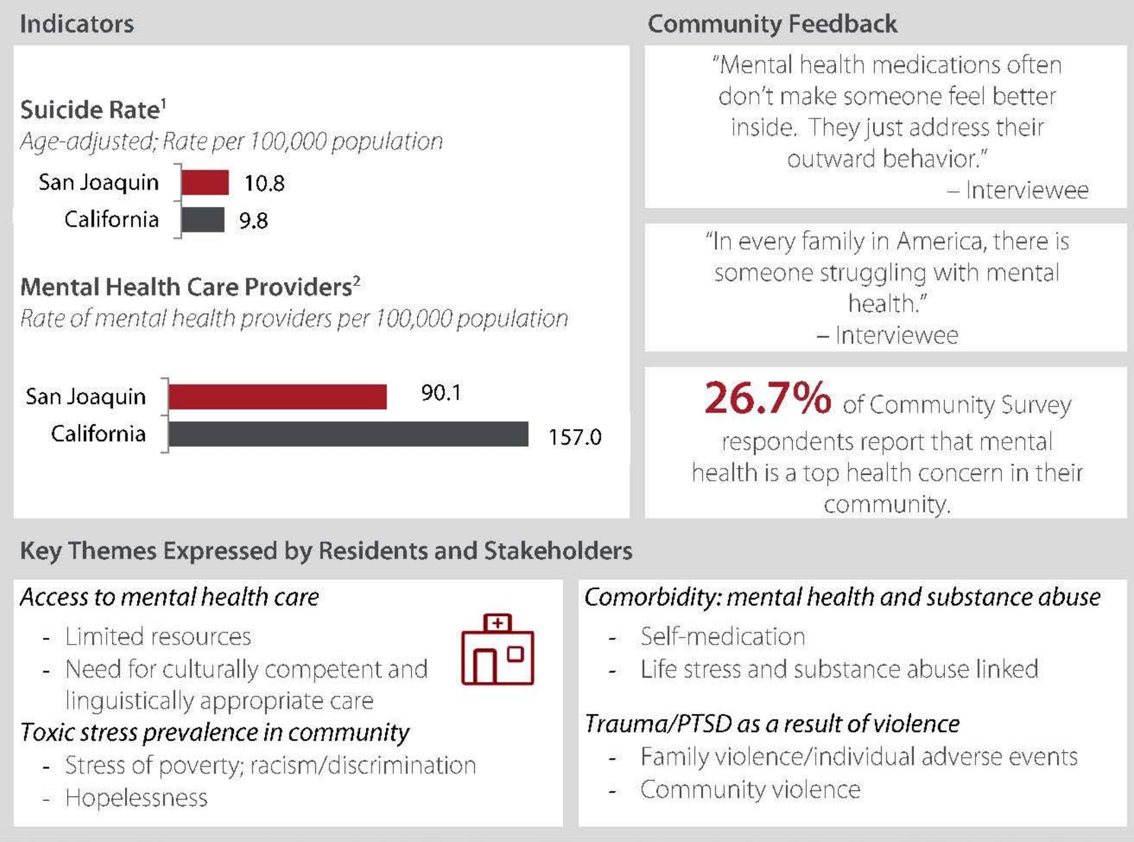
[1] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2012.
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12.
[3] US Department of Health & Human Services, Health Resources and Services Administration, March 2015.
[4] US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, June 2014.
[5] US Census Bureau, American Community Survey, 2014.
[6] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011.
[7] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[8] US Census Bureau, American Community Survey, 2010-14.
[9] US Census Bureau, American Community Survey, 2014.

Mental Health

In addition to severe mental health disorders, mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder (PTSD), has profound consequences on health behavior choices and physical health. , While some mental health outcomes in San Joaquin County are similar to California benchmarks, mental health was a key concern among surveyed community members. Interviewees noted that the psychology of poverty, including living day-to-day and struggling to provide basic needs, can negatively impact one's ability to make long-term plans, and can interfere with parenting abilities. In addition, poor mental health frequently co-occurs with substance use disorders. Youth, notably foster youth and lesbian, gay, bisexual, transgender and queer and/or questioning (LGBTQ) youth, and residents experiencing homelessness, were noted as particularly high risk populations for mental health concerns.

Key Data



Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Mental Health (continued)

Additional Data

Related Health Outcomes

Depression, Older Adults
% of Medicare beneficiaries with depression[3]

13.0 | 13.4
San Joaquin | California

Depression, New Mothers
% of new mothers experiencing post partum depression[4]

17.7 | 16.0
San Joaquin | California

Depression, Youth
% of 11th grade students who felt sad or hopeless almost every day for 2 weeks or more[5]

32.0 | 32.0
San Joaquin | California

Access to Mental Health Care

Adults Needing Treatment
% of adults reporting need for treatment for mental health, or use of alcohol /drug[6]

18.2 | 15.9
San Joaquin | California

"People with mental illness live **25 years less than the general population and die from the same causes** as the general population."
–Interviewee

Social Support and Stress

Social Support, Adult
% adults without adequate social / emotional support (age-adjusted)[7]

29.1 | 24.6
San Joaquin | California

"Society says, 'Pull yourself up by your bootstraps.' This is not very empathetic."
–Interviewee

27.5% of Community Survey respondents indicated that life stress is a high concern in their community.

Bullying, Youth
% of 11th grade students reporting harassment or bullying on school property within the past 12 months for any reason[8]

34.0 | 28.0
San Joaquin | California

"Families do not provide the support that they used to. When this support is missing it is very hard to compensate for that through service providers."
–Interviewee

Exposure to Violence
Age adjusted homicide mortality rate; per 100,000 population)[9, †]

12.2 | 5.2
San Joaquin | California

Exposure to Poverty
% population with income at or below 200% Federal Poverty Line[10, †]

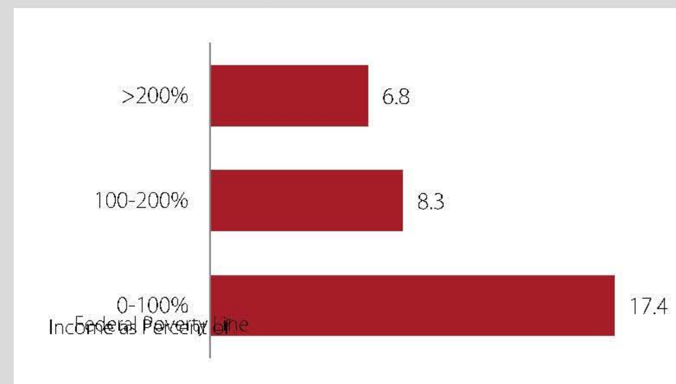
52.0 | 46.0
San Joaquin | California

† Exposure to violence and poverty increases risk of poor mental health outcomes, including increased risk of depression. *("Adverse Childhood Experiences: Major Findings," Centers for Disease Control and Prevention, accessed November 2015, http://www.cdc.gov/violenceprevention/acestudy/findings.html.)*

Mental Health (continued)

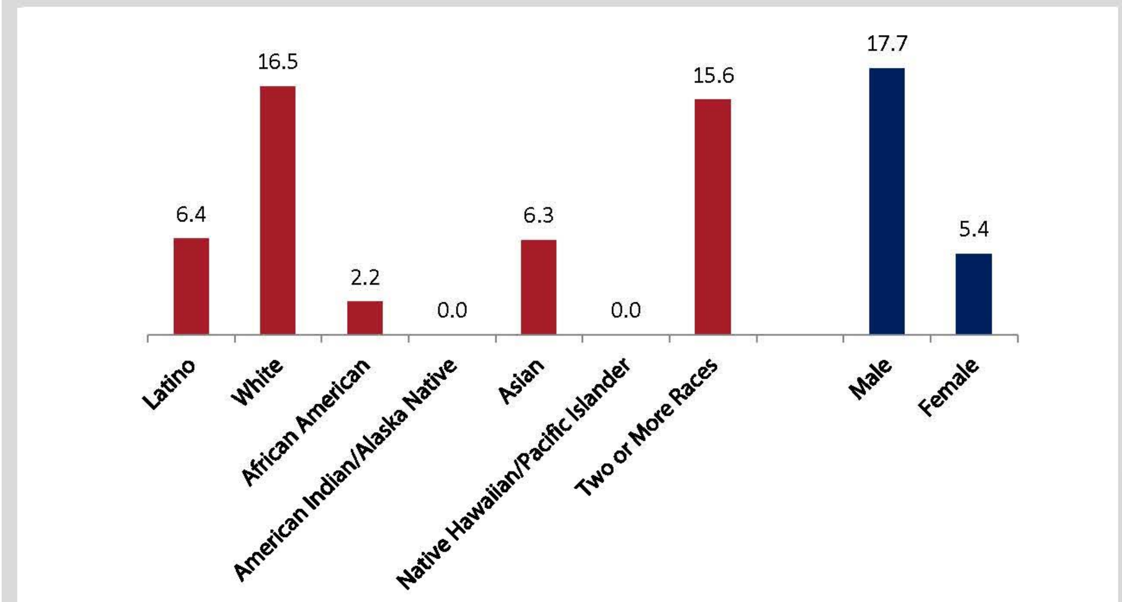
Salient Disparities

Percent of Adult Population in San Joaquin County Likely Experiencing Serious Psychological Distress in Past Year, by Income[11]



Poverty was identified across interviews as a source of stress in San Joaquin County. Toxic stress, often induced by individual adverse events or chronic stressful life conditions, can have permanent and profound effects on physical and emotional health. The graph to the left demonstrates that lower income level is correlated with a higher risk of poor mental health. Struggling to meet basic needs on a daily basis may increase risk of chronic toxic stress exposure, and decrease mental health.

Suicide Rate Per 100,000 Residents in San Joaquin County, by Race/Ethnicity and Gender[12]



Mental Health (continued)

Assets

† Assets excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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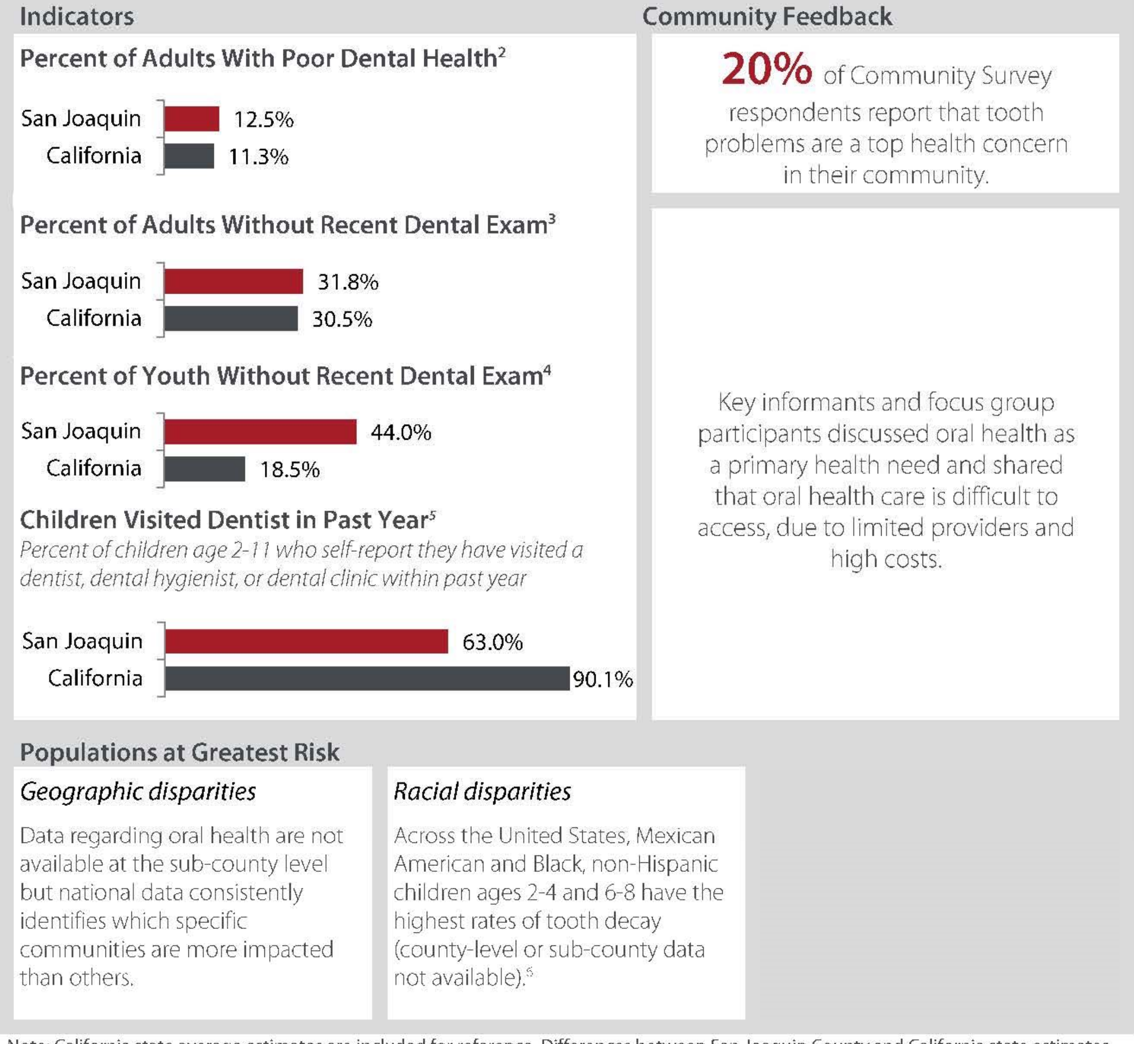
[1] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[2] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[3] Centers for Medicare and Medicaid Services, 2012.
[4] Maternal and Infant Health Assessment, 2012.
[5] California Healthy Kids Survey, 2009-11.
[6] California Health Interview Survey, 2014.
[7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the U.S. Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[8] California Healthy Kids Survey, 2009-11.
[9] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[10] US Census Bureau, American Community Survey, 2009-13.
[11] California Health Interview Survey, 2012-14.
[12] State of California, Department of Public Health, 2013 Death Records. Population denominator from State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2010-60. Sacramento, CA, December 2014.

Oral Health

Tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.[1] Secondary data indicate that oral health outcomes are worse in San Joaquin County than in other parts of California, particularly among children. Access to oral health services is a concern in all age groups, marked by limited dental visits and difficulty finding affordable and nearby care. Factors that may contribute to oral health needs include poverty, as well as an unhealthy diet that includes sugar-sweetened beverages.

Key Data



Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Oral Health (continued)

Additional Data

Access to Dental Care

Access to Dental Care Providers
Dentists, Rate per 100,000 population[7]

55.4 | 77.5
San Joaquin | California

While parts of San Joaquin County are designated as Health Professional Shortage Areas for primary care, they are not designated as shortage areas for dental care.[8] There is, however, a shortage of providers that serve Denti-Cal members.

Access to Dental – Adults

Adult Dental Insurance Coverage
% adults without dental insurance.[9]

41.7 | 40.9
San Joaquin | California

Senior Dental Insurance
% of adults age 65+ without dental insurance for all or part of past year[10]

58.1 | 47.3
San Joaquin | California

Access to Care – Youth

Children Unable to Afford Dental Care
% of population age 5-17 unable to afford dental care[11]

4.2 | 6.3
San Joaquin | California

Health Behaviors – Youth

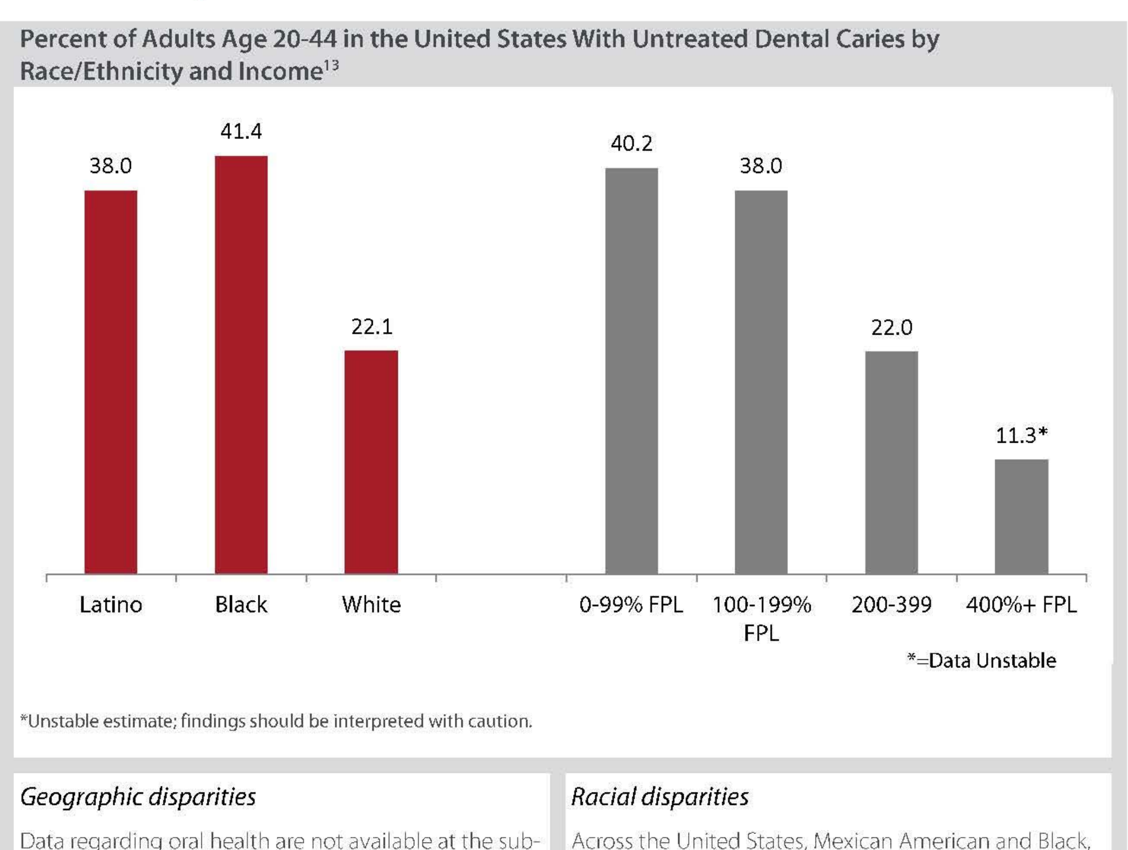
Sweetened Beverage Consumption
% children age 2-11 consuming 2+ sugar sweetened beverages on previous day[12]

38.3 | 27.0
San Joaquin | California

Oral Health (continued)

Salient Disparities

Percent of Adults Age 20-44 in the United States With Untreated Dental Caries by Race/Ethnicity and Income[13]



*Unstable estimate; findings should be interpreted with caution.

Geographic disparities

Data regarding oral health are not available at the sub-county level to identify whether specific communities are more impacted than others.

Racial disparities

Across the United States, Mexican American and Black, non-Hispanic children ages 2-4 and 6-8 have the highest rates of tooth decay (county-level or sub-county data not available).[14]

Oral Health (continued)

Assets

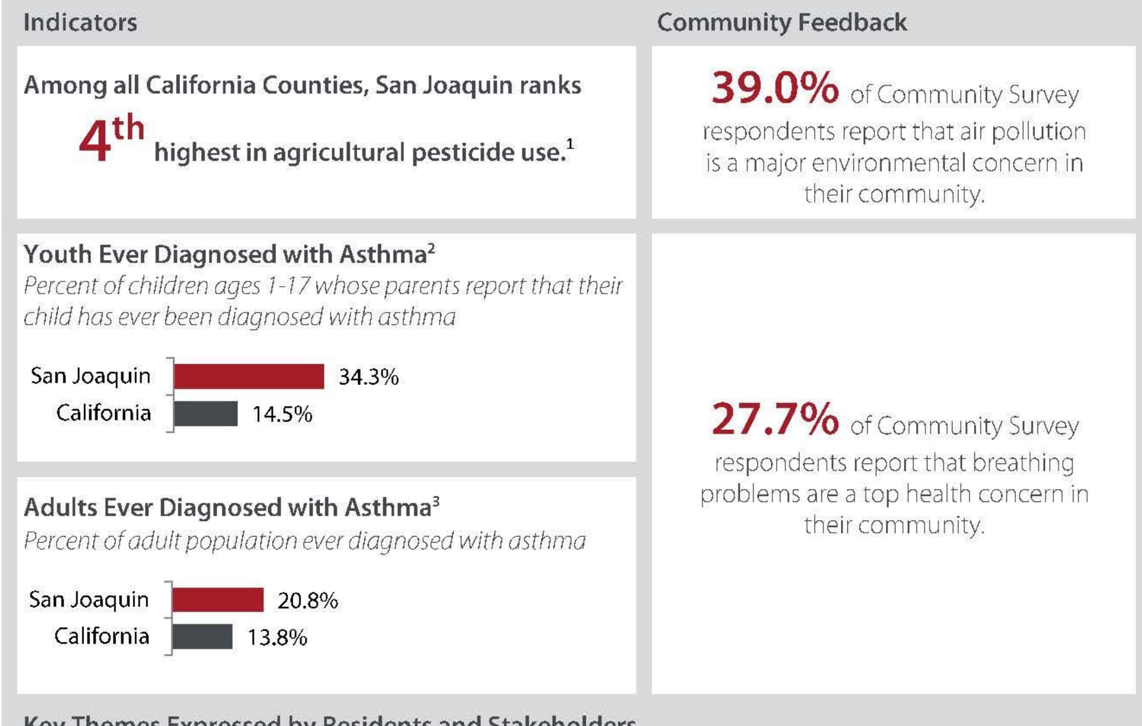
† Assets excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

[1] "Healthy Smile, Healthy You: The Importance of Oral Health," Delta Dental Insurance, accessed October 28, 2015, https://www.deltadentalins.com/oral_health/dentalhealth.html.
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2006-10.
[3] Ibid.
[4] California Health Interview Survey, 2013-14.
[5] California Health Interview Survey, 2014.
[6] Centers for Disease Control and Prevention, Oral Health Disparities, accessed October 28, 2015, http://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.
[7] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2013.
[8] US Department of Health & Human Services, Health Resources and Services Administration, March 2015.
[9] California Health Interview Survey, 2009.
[10] California Health Interview Survey, 2007.
[11] California Health Interview Survey, 2009.
[12] California Health Interview Survey, 2011-12.
[13] CDC/NCHS, National Health and Nutrition Examination Survey, 2011-12.
[14] Centers for Disease Control and Prevention, Oral Health Disparities, accessed October 28, 2015, http://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.

Asthma/Air Quality

Asthma is a disease that affects the lungs, and is often triggered by environmental conditions such as poor outdoor air quality as well as mold, dust, and cleaning solutions in the home. Asthma and breathing problems are a health need in San Joaquin County, as marked by high prevalence of asthma in adults and youth. In particular, asthma disproportionately impacts non-Hispanic Blacks. Poor outdoor air quality not only exacerbates asthma, but it is also an issue that affects all residents, and ranges from second-hand cigarette smoke to greenhouse gas emissions (vehicle exhaust) and other elements that lead to high particulate matter (mixture of solid particles and liquid droplets found in the air such as dust, dirt, or soot). The percentage of days exceeding Fine Particulate Matter (PM 2.5) standards is high throughout the county and affects breathing and lung health for all residents.

Key Data

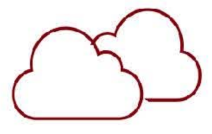


Key Themes Expressed by Residents and Stakeholders

- Heavy cigarette smoke
- Air pollution / heavy carbon footprint
- Poor living conditions (e.g., housing quality)
- Traffic congestion
- High pesticide exposure in agricultural community
- Breathing problems are particularly high among agricultural workers.

Note: California state average estimates are included for reference. Differences between San Joaquin County and California state estimates are not necessarily statistically significant.

Asthma/Air Quality (continued)



Additional Data and Key Drivers

Related Health Outcomes

Chronic Lower Respiratory Disease Mortality Rate
Age-adjusted morality rate per 100,000 pop.[4]

44.4 | 37.5
San Joaquin | California

Cigarette Smoke

Cigarette Smoking
% population smoking cigarettes; age adjusted[5]

16.2 | 12.8
San Joaquin | California

Community Feedback

28.6% of Community Survey respondents report that cigarette smoke is a major environmental concern in their community.

Pesticide Use

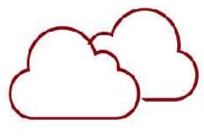
Pounds of Pesticides Used[6]

11,017,592

Pounds of pesticides applied in San Joaquin County

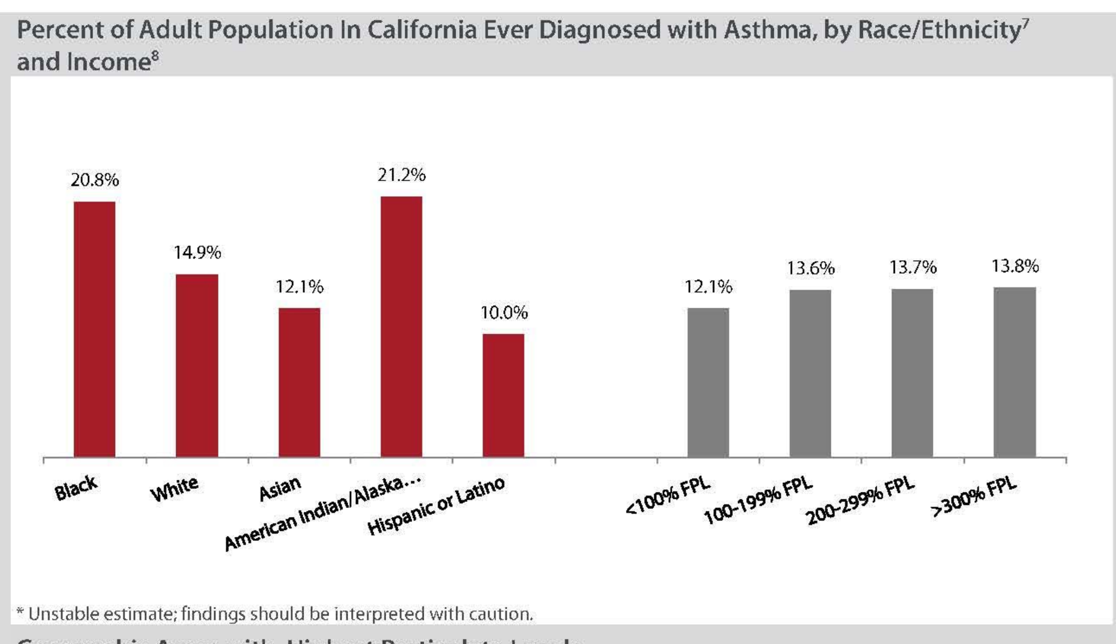
(Compared to 193,597,806 total pounds applied across California State.)

Asthma/Air Quality (continued)



Salient Disparities

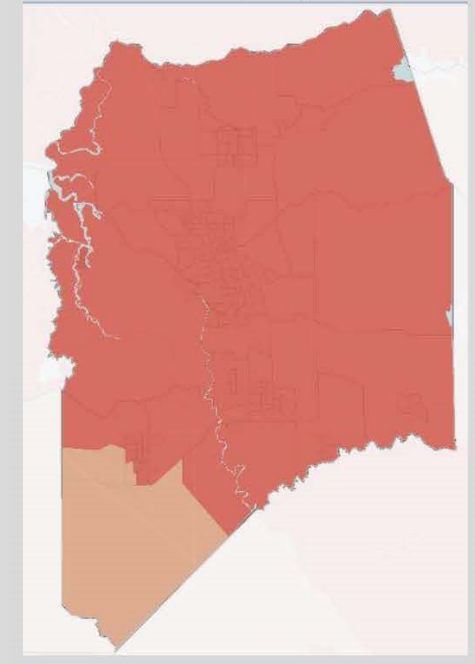
Percent of Adult Population In California Ever Diagnosed with Asthma, by Race/Ethnicity[7] and Income[8]



* Unstable estimate; findings should be interpreted with caution.

Geographic Areas with Highest Particulate Levels

Fine Particulate Matter (PM 2.5) Levels[5]



Key: Percent of Days PM 2.5 above National Ambient Air Quality Standards

- Over 6.0%
- 1.1 - 6.0%
- 0.51 - 1.0%
- Under 0.51%
- No Days Above NAAQS Standards
- No Data or Data Suppressed

This map demonstrates that the percentage of days exceeding Fine Particulate Matter (PM 2.5) standards is high throughout the county, with the most affected areas in the northern and central part of the county. Within the red, census tracts concentrated near **Lodi** and **Stockton** exhibit the highest percentages of days with levels above PM 2.5 standards.

Community survey respondents in **Tracy, Manteca**, and **Thornton** were more likely to report breathing problems among the top three health problems in their community (38%, 37%, and 36%, respectively, compared to 27.7% of all respondents). A greater percentage of respondents in **Tracy** reported air pollution as a major environmental concern compared to respondents county-wide (49.8% compared to 39% of all respondents).

Asthma/Air Quality (continued)

Assets

† Assets excerpted from qualitative data and San Joaquin CHNA Core Planning Group. For a comprehensive list of county assets and resources, reference http://www.211sj.org/.

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[1] California Department of Pesticide Regulation, 2013.
[2] California Health Interview Survey, 2014.
[3] Ibid.
[4] California Department of Public Health, 2009-2011.
[5] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-12. Accessed via the Health Indicators Warehouse.
[6] California Department of Pesticide Regulation, 2013.
[7] California Health Interview Survey, 2007-09.
[8] California Health Interview Survey, 2009.
[9] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2008. Additional data analysis by CARES.

APPENDIX H: Secondary Data with Sources and Dates

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Access to Care	Core	Primary Care Physicians, Rate per 100,000 population	Access to Primary Care	Clinical Care	Rate	702,612	n/a	77.2	74.5	State	Above benchmark	60.6	-16.6	2			US Department of Health & Human Services,Health Resources and Services Administration,Area Health Resource File	2012	2012	2012
		Percent of adults without any regular doctor	n/a	Clinical Care	Percentage	no data	n/a	27.1%	22.1%	State	Below benchmark	24.8%	-2.30%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2011-12	2011-12	2011-12
		Mental Health Care Provider Rate Per 100,000 population	Access to Mental Health Providers	Clinical Care	Rate	716,369	n/a	157	134.1	State	Above benchmark	90.1	-66.9	2			University of Wisconsin Population Health Institute, County Health Rankings	2014	2014	2014
	Related	Percent of child population without health insurance (<age 19)	n/a	Social and Economic Factors	Percentage	no data	n/a	8.4%	7.5%	State	Below benchmark	8.2%	-0.20%	0	1.00		U.S. Census Bureau, Small Area Health Insurance Estimates	2012	2012	2012
		Percent of adult population without health insurance (age 18-64)	n/a	Social and Economic Factors	Percentage	no data	n/a	24.7%	20.8%	State	Below benchmark	25.2%	0.50%	0			U.S. Census Bureau, Small Area Health Insurance Estimates	2012	2012	2012
		Percent of population receiving MediCal/Medicaid	n/a	Social and Economic Factors	Percentage	no data	n/a	23.4%	20.2%	State	Below benchmark	29.4%	5.99%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of women late to prenatal care (past first trimester)	n/a	Health Behaviors	Percentage	no data	<=22.1%	16.5%	39.2%	State	Below benchmark	22.5%	6.00%	2			California Department of Public Health / Centers for Disease Control and Prevention, National Vital Statistics System / HP2020	2011	2007	2011
		Percent of kindergartenеrs with all required immunizations	n/a	Clinical Care	Percentage	no data	n/a	90.4%	no data	State	Above benchmark	95.6%	5.20%	0			California Department of Public Health Immunization Branch (data accessed through kidsdata.org)	2014-15		2014-15
		Percent of adults age 65+ who have ever received a pneumonia vaccination	n/a	Clinical Care	Percentage	no data	n/a	63.4%	67.5%	State	Above benchmark	63.9%	0.50%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2006-12	2006-12	2006-12
		Percent Uninsured Population	Insurance - Uninsured Population	Social & Economic Factors	Percentage	684,141	n/a	17.8%	14.9%	State	Below benchmark	17.1%	-0.68%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Federally Qualified Health Centers, Rate per 100,000 Population	Federally Qualified Health Centers	Clinical Care	Rate	685,306	n/a	1.97	1.92	State	Above benchmark	1.31	-0.66	2			US Department of Health & Human Services,Center for Medicare & Medicaid Services,Provider of Services File, June 2014.	2014	2014	2014
		Percentage of Population Living in a Primary Care HPSA	Health Professional Shortage Area - Primary Care	Clinical Care	Percentage	685,306	n/a	25.2%	34.1%	State	Below benchmark	39.9%	14.75%	2			US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration	2015	2015	2015
		Age-Adjusted Discharge Rate (Per 10,000 population)	Preventable Hospital Events	Clinical Care	Rate	no data	n/a	83.17	no data	State	Below benchmark	97.33	14.16	2			California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
		Preventable hospitalization rate among Medicare enrollees / preventable hospital events per 1,000 population	n/a	Clinical Care	Rate	no data	n/a	45.30	59.30	State	Below benchmark	52.2	6.9	2			Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care	2012	2012	2012
		Percent of Insured Population Receiving Medicaid	Insurance - Population Receiving Medicaid	Social & Economic Factors	Percentage	684,141	n/a	23.4%	20.2%	State	Below benchmark	29.4%	5.99%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percentage of Population Living in a Dental HPSA	Health Professional Shortage Area - Dental	Clinical Care	Percentage	685,306	n/a	4.9%	32.0%	State	Below benchmark	0.0%	-4.93%	0			US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration	2015	2015	2015
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Cancer Screening - Mammogram	Clinical Care	Percentage	3,518	n/a	59.3%	63.0%	State	Above benchmark	59.3%	0.00%	0			Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care	2012	2012	2012
		Percent Adults Females Age 18+ with Regular Pap Test (Age-Adjusted)	Cancer Screening - Pap Test	Clinical Care	Percentage	295,609	n/a	78.3%	78.5%	State	Above benchmark	78.9%	0.60%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Percent decrease in uninsurance rate among non-elderly adults from 2013 to 2014 (ACA implementation)	n/a	Clinical Care	Percentage	no data	n/a	no data	no data	State	Above benchmark	8.0%	n/a				Enroll America (www.enrollamerica.org)			2013-14
		Percent Adults Screened for Colon Cancer (Age-Adjusted)	Cancer Screening - Sigmoid/Colonoscopy	Clinical Care	Percentage	136,365	n/a	57.9%	61.3%	State	Above benchmark	54.7%	-3.20%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
Access to Housing	Core	Vacant Housing Units, Percent	Housing - Vacant Housing	Physical Environment	Percentage	234,622	n/a	8.6%	12.5%	State	Below benchmark	8.1%	-0.51%	0	0.60	0.43	US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percentage of Households where Housing Costs Exceed 30% of Income	Housing - Cost Burdened Households	Physical Environment	Percentage	215,563	n/a	45.0%	35.5%	State	Below benchmark	44.3%	-0.67%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Proportion of renters spending 30% or more of household income on rent	n/a	Social and Economic Factors	Percentage	no data	n/a	56.9%	52.3%	State	Below benchmark	58.3%	1.40%	1			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard Housing	Physical Environment	Percentage	215,563	n/a	48.4%	36.1%	State	Below benchmark	47.5%	-0.88%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		HUD-Assisted Units, Rate per 10,000 Housing Units	Housing - Assisted Housing	Physical Environment	Rate	233,755	n/a	1399.0	1468.2	State	Above benchmark	335.1	-1063.9	2			US Department of Housing and Urban Development	2015	2015	2015
	Related	Total number of homeless individuals	n/a	Social and Economic Factors	Number	no data	n/a	no data	no data	n/a	n/a	2,641	n/a	n/a	0.00		Head Start Report: ASSESSING THE NEEDS OF CHILDREN & FAMILIES IN SAN JOAQUIN COUNTY 2014. San Joaquin County Community Development Department, "San Joaquin			2011
		Percent renter occupied households	n/a	Social and Economic Factors	Percentage	no data	n/a	44.7%	35.1%	State	Below benchmark	41.7%	-3.00%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Proportion of renter occupied households living in overcrowded environments (>1 persons/room)	n/a	Physical Environment	Percentage	no data	n/a	12.2%	4.2%	State	Below benchmark	11.4%	-0.80%	0			US Census Bureau,American Community Survey	2008-12	2008-12	2008-12
		Percent Adults Ever Diagnosed with Asthma	Asthma - Prevalence	Health Outcomes	Percentage	486,558	n/a	14.2%	13.4%	State	Below benchmark	17.4%	3.20%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2011-12	2011-12	2011-12
		Percent Children Ever Diagnosed with Asthma	n/a	Health Outcomes	Percentage	no data	n/a	15.4%	no data	State	Below benchmark	22.9%	7.50%	2			University of California Center for Health Policy Research, California Health Interview Survey	2011-12		2011-12

Health Indicators										Needs Score							Data Details			
Potential Health Needs	**Core/ Related**	**Indicator**	**Kaiser Indicator name**	**MATCH Category**	**Measure Type**	**Population Denominator**	**HP 2020 Value**	**State Benchmark**	**National Benchmark**	**Benchmark used in scoring**	**Desired Direction**	**Value for San Joaquin County**	**Difference from the Benchmark Value**	**Points**	**Core/ Related Score**	**Potential Health Need Score**	**Data Source**	**State Data Year**	**National Data Year**	**County Area Year**
	Core	Percent of children diagnosed and currently experiencing asthma	n/a	Health Outcomes	Percentage	no data	n/a	10.1%	8.3%	State	Below benchmark	15.1%	5.00%	2	1.60		California Health Interview Survey / NHIS 2013 (from CDC website)	2011-12	2013	2011-12
		Tuberculosis Incidence (per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=1.0	6.4	3.0	State	Below benchmark	8.1	1.7	2			California Department of Public Health / Centers for Disease Control and Prevention	2009-11	2013	2009-11
		Age-Adjusted Hospital Discharge Rate for Asthma (Per 10,000 population)	Asthma - Hospitalizations	Health Outcomes	Rate	no data	n/a	8.9	no data	State	Below benchmark	8.7	-0.16	0			California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
		Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard Housing	Physical Environment	Percentage	215,563	n/a	48.4%	36.1%	State	Below benchmark	47.5%	-0.88%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Chronic lower respiratory disease morality rate (age adjusted; per 100,000)	n/a	Health Outcomes	Rate	no data	n/a	37.5	no data	State	Below benchmark	44.4	6.9	2			California Department of Public Health	2009-11		2009-11
Asthma and COPD		Percentage of Days Exceeding Ozone Standards, population Adjusted Average	Air Quality - Ozone (O3)	Physical Environment	Percentage	685,306	n/a	2.5%	0.5%	State	Below benchmark	1.6%	-0.83%	0		1.29	Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network	2008	2008	2008
		Percent Population Smoking Cigarettes (Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	479,299	n/a	12.8%	18.1%	State	Below benchmark	16.2%	3.40%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
	Related	Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	State	Below benchmark	suppressed			1.11		Nielsen, Nielsen Site Reports	2014	2014	
		Percentage of Days Exceeding Particulate Matter Standards, population Adjusted Average	Air Quality - Particulate Matter 2.5	Physical Environment	Percentage	685,306	n/a	4.2%	1.2%	State	Below benchmark	10.1%	5.95%	2			Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network	2008	2008	2008
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	480,180	n/a	22.3%	27.1%	State	Below benchmark	29.1%	6.80%	2			Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	466,438	n/a	35.8%	35.8%	State	Below benchmark	31.0%	-4.80%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2011-12	2011-12	2011-12
		Percent Youth Obese	Obesity (Youth)	Health Outcomes	Percentage	30,138	n/a	19.0%	no data	State	Below benchmark	21.0%	1.96%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent Youth Overweight	Overweight (Youth)	Health Outcomes	Percentage	30,138	n/a	19.3%	no data	State	Below benchmark	20.9%	1.62%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Annual Breast Cancer Incidence Rate (Per 100,000 population)	Cancer Incidence - Breast	Health Outcomes	Rate	341,182	n/a	122.4	122.7	State	Below benchmark	111.3	-11.1	0			National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles	2007-11	2007-11	2007-11
		Colorectal cancer mortality rate (age-adjusted; per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=14.5	13.9	no data	State	Below benchmark	15.5	1.6	2			California Department of Public Health	2011-13		2011-13
		Breast cancer mortality rate (age-adjusted; per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=20.7	20.7	no data	State	Below benchmark	21.7	1	2			California Department of Public Health	2011-13		2011-13
		Lung cancer mortality rate (age-adjusted; per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	33.6	no data	State	Below benchmark	43.2	9.6	2			California Department of Public Health	2011-13		2011-13
	Core	Prostate cancer mortality rate (age-adjusted; per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=21.8	20.2	no data	State	Below benchmark	20.5	0.3	2	1.40		California Department of Public Health	2009-11		2009-11
		Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Cancer	Health Outcomes	Rate	685,306	<= 160.6	157.1	no data	State	Below benchmark	174.9	17.79	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Annual Cervical Cancer Incidence Rate (Per 100,000 population)	Cancer Incidence - Cervical	Health Outcomes	Rate	341,182	<= 7.1	7.8	7.8	State	Below benchmark	6.4	-1.4	0			National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles	2007-11	2007-11	2007-11
		Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 population)	Cancer Incidence - Colon and Rectum	Health Outcomes	Rate	680,277	<= 38.7	41.5	43.3	State	Below benchmark	41.2	-0.3	0			National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles	2007-11	2007-11	2007-11
		Annual Prostate Cancer Incidence Rate (Per 100,000 population)	Cancer Incidence - Prostate	Health Outcomes	Rate	338,095	n/a	136.4	142.3	State	Below benchmark	147.6	11.2	2			National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles	2007-11	2007-11	2007-11
		Annual Lung Cancer Incidence Rate (Per 100,000 population)	Cancer Incidence - Lung	Health Outcomes	Rate	680,277	n/a	49.5	64.9	State	Below benchmark	60.7	11.2	2			National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles	2007-11	2007-11	2007-11
		Estimated Percentage Adults Drinking Excessively Age-Adjusted	Alcohol - Excessive Consumption	Health Behaviors	Percentage	479,299	n/a	17.2%	16.9%	State	Below benchmark	15.5%	-1.70%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	685,306	n/a	10.0	10.4	State	Below benchmark	7.4	-2.58	0			US Census Bureau,County Business Patterns. Additional data analysis by CARES	2012	2012	2012
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	466,438	n/a	35.8%	35.8%	State	Below benchmark	31.0%	-4.80%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2011-12	2011-12	2011-12
Cancers		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	480,180	n/a	22.3%	27.1%	State	Below benchmark	29.1%	6.80%	2		1.17	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent of women age 55+ with mammogram in past 2 years	n/a	Clinical Care	Percentage	no data	>=81.1%	81.2%	no data	State	Above benchmark	78.6%	-2.60%	2			California Health Interview Survey	2007		2007
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Cancer Screening - Mammogram	Clinical Care	Percentage	3,518	n/a	59.3%	63.0%	State	Above benchmark	59.3%	0.00%	0			Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care	2012	2012	2012

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
	Related	Percent Adults with In/adequate Fruit / Vegetable Consumption	Low Fruit/Vegetable Consumption (Adult)	Health Behaviors	Percentage	462,248	n/a	71.5%	75.7%	State	Below benchmark	65.6%	-5.90%	0	1.00		Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2005-09	2005-09	2005-09
		Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Fruit/Vegetable Expenditures	Health Behaviors	Percentage	no data	n/a	14.1%	12.7%	State	Above benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Percent Population with Low Food Access	Food Security - Food Desert Population	Social & Economic Factors	Percentage	685,306	n/a	14.3%	23.6%	State	Below benchmark	15.1%	0.79%	0			US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas	2010	2010	2010
		Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	479,293	n/a	12.8%	18.1%	State	Below benchmark	16.2%	3.40%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Percent of adults currently or formerly using tobacco	n/a	Health Behaviors	Percentage	no data	n/a	37.0%	44.2%	State	Below benchmark	40.0%	3.00%	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2011-12	2008	2011-12
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	Cancer Screening - Pap Test	Clinical Care	Percentage	195,809	n/a	78.3%	78.5%	State	Above benchmark	78.9%	0.60%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Percent Population with no Leisure Time Physical Activity	Physical Inactivity (Adult)	Health Behaviors	Percentage	480,591	n/a	16.6%	22.6%	State	Below benchmark	18.6%	2.00%	2			Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent Adults Screened for Colon Cancer (Age-Adjusted)	Cancer Screening - Sigmoid/Colonoscopy	Clinical Care	Percentage	136,365	n/a	57.9%	61.3%	State	Above benchmark	54.7%	-3.20%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Pounds of pesticides applied	n/a	Physical Environment	Number	n/a	n/a	193,597,806	no data	n/a	n/a	11,017,592	n/a	n/a			California Department of Pesticide Regulation	2013		2013
		Rank of pesticides use among California counties	n/a	Physical Environment	Number	n/a	n/a	n/a	n/a	n/a	n/a	4	n/a	n/a			California Department of Pesticide Regulation			2013
		Percentage of Days Exceeding Particulate Matter Standards, Population Adjusted Average	Air Quality - Particulate Matter 2.5	Physical Environment	Percentage	685,306	n/a	4.2%	1.2%	State	Below benchmark	10.1%	5.85%	2			Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network	2008	2008	2008
Child Mental and Emotional Development	Core	Percent of children age 3-4 enrolled in school (includes Head Start, licensed child care, nurseries, Pre-K, registered child care, and other)	Education - School Enrollment Age 3-4	Social and Economic Factors	Percentage	no data	n/a	49.1%	47.7%	State	Above benchmark	40.7%	-8.40%	2	1.25	1.29	US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Head Start Programs Rate (Per 10,000 Children Under Age 5)	Education - Head Start Program Facilities	Social and Economic Factors	Rate	54,228	n/a	6.3	7.6	State	Above benchmark	10.1	3.8	0			US Department of Health & Human Services, Administration	2014	2014	2014
		3rd grade reading proficiency (Percentage of all public school students tested in 3rd grade who scored proficient or advanced on the English Language Arts California Standards Test)	n/a	Social and Economic Factors	Percentage	no data	n/a	45.0%	no data	State	Above benchmark	34.0%	-11.00%	2			California Dept. of Education, Standardized Testing and Reporting (STAR) Results	2013		2013
		Percent of children in foster care system for more than 8 days but less than 12 months with 2 or less placements (placement stability)	n/a	Social and Economic Factors	Percentage	no data	n/a	86.6%	no data	State	Above benchmark	84.7%	-1.90%	1			California Child Welfare Indicators Project (CCWIP)	2014		2014
	Related	Percent of children age 0-12 considered in excellent or very good health	n/a	Health Outcomes	Percentage	no data	n/a	77.8%	no data	State	Above benchmark	70.9%	-6.90%	2	1.33		California Health Interview Survey	2013-14		2013-14
		Percent of children 4 months-5 years at moderate or high risk of developmental delay	Percent of children 4 months-5 years at moderate or high risk	Health Outcomes	Percentage	no data	n/a	42.2%	no data	State	Below benchmark	43.1%	0.90%	0			California Health Interview Survey	2007-09		2007-09
		Rate of children in foster care (per 1,000 child population under age 18)	n/a	Social and Economic Factors	Rate	no data	n/a	6.0	no data	State	Below benchmark	7.1	1.1	2			California Child Welfare Indicators Project (CCWIP)	2014		2014
		Pounds of pesticides applied	n/a	Physical Environment	Number	no data	n/a	193,597,806	n/a	n/a	n/a	11,017,592	n/a				California Department of Pesticide Regulation	2013		2013
Climate and Health	Core	Percentage of Days Exceeding Particulate Matter Standards, Population Adjusted Average	Air Quality - Particulate Matter 2.5	Physical Environment	Percentage	685,306	n/a	4.2%	1.2%	State	Below benchmark	10.1%	5.85%	2	1.25		Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network	2008	2008	2008
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	443,414	n/a	2.7%	10.2%	State	Below benchmark	27.1%	24.40%	2			University of Wisconsin Population Health Institute, County Health Rankings	2012-13	2012-13	2012-13
		Percentage of Days Exceeding Ozone Standards, population Adjusted Average	Air Quality - Ozone (O3)	Physical Environment	Percentage	685,306	n/a	2.5%	0.5%	State	Below benchmark	1.8%	-0.63%	0			Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network	2008	2008	2008
		Percentage of Weather Observations with High Heat Index Values	Climate & Health - Heat Index Days	Physical Environment	Percentage	8,395	n/a	0.6%	4.7%	State	Below benchmark	0.3%	-0.33%	0			National Oceanic and Atmospheric Administration,North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. additional data analysis by CARES	2014	2014	2014
		Percentage of Weeks in Drought (Any)	Climate & Health - Drought Severity	Physical Environment	Percentage	no data	n/a	82.8%	45.9%	State	Below benchmark	86.9%	4.10%	2			US Drought Monitor	2012-14	2012-14	2012-14
		Heat-related Emergency Department Visits, Rate per 100,000 Population	Climate & Health - Heat Stress Events	Physical Environment	Rate	685	n/a	11.1	no data	State	Below benchmark	16.8	5.7	2			California Department of Public Health,CDPH - Tracking	2005-12		2005-12
		Age-Adjusted Asthma-related Discharge Rate (Per 10,000 population)	Asthma - Hospitalizations	Health Outcomes	Rate	no data	n/a	8.9	no data	State	Below benchmark	8.7	-0.16	0			California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
		Percent Adults with Asthma	Asthma - Prevalence	Health Outcomes	Percentage	486,558	n/a	14.2%	13.4%	State	Below benchmark	17.4%	3.20%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2011-12	2011-12	2011-12
	Related	Percent Low Birth Weight Births	Low Birth Weight	Health Outcomes	Percentage	685,306	n/a	6.8%	no data	State	Below benchmark	7.0%	0.24%	0			California Department of Public Health,CDPH - Birth Profiles by ZIP Code	2011		2011
		Total Road Network Density (Road Miles per Acre)	Transit - Road Network Density	Physical Environment	Rate	1,427	n/a	4.3	2.0	State	Below benchmark	2.7	-1.52	0			Environmental Protection Agency, EPA Smart Location Database	2011	2011	2011

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Climate and Health	Related	Percentage of Population within Half Mile of Public Transit	Transit - Public Transit within 0.5 Miles	Physical Environment	Percentage	685,306	n/a	15.5%	8.1%	State	Above benchmark	16.8%	1.27%	0	1.22		Environmental Protection Agency, EPA Smart Location Database	2011	2011	2011
		Population Weighted Percentage of Report Area Covered by Tree Canopy	Climate & Health - Canopy Cover	Physical Environment	Percentage	685,306	n/a	15.1%	34.7%	State	Above benchmark	9.2%	-5.93%	2			Multi-Resolution Land Characteristics Consortium,National Land Cover Database 2011. additional data analysis by CARES	2011	2011	2011
		Percentage of Housing Units with No Air Conditioning	Climate & Health - No Access to Air Conditioning	Physical Environment	Percentage	233,755	n/a	33.8%	11.4%	State	Below benchmark	no data					US Census Bureau,American Housing Survey	2011, 2013	2011, 2013	
		Pounds of pesticides applied	n/a	Physical Environment	Number	n/a	n/a	193,597,806	no data	n/a	n/a	11,017,592	n/a				California Department of Pesticide Regulation	2013		2013
		Rank of pesticide use among California counties	n/a	Physical Environment	Number	n/a	n/a	n/a	n/a	n/a	n/a	4	n/a				California Department of Pesticide Regulation			2013
		Age-Adjusted Diabetes-related Discharge Rate (Per 10,000 population)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a	10.4	no data	State	Below benchmark	12.0	1.55	2			California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
		Average Number of Mentally Unhealthy Days per Month	Mental Health - Poor Mental Health Days	Health Outcomes	Rate	479,299	n/a	3.6	3.5	State	Below benchmark	4.0	0.4	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse	2006-12	2006-12	2006-12
		Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Ischaemic Heart Disease	Health Outcomes	Rate	685,306	<= 100.8	163.2	no data	State	Below benchmark	179.9	16.67	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	480,180	n/a	22.3%	27.1%	State	Below benchmark	29.1%	6.80%	2			Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent Youth Obese	Obesity (Youth)	Health Outcomes	Percentage	30,139	n/a	19.0%	no data	State	Below benchmark	21.0%	1.96%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
CVD/Stroke	Core	Percent Adults with Heart Disease	Heart Disease Prevalence	Health Outcomes	Percentage	486,000	n/a	6.3%	no data	State	Below benchmark	6.2%	-0.10%	0	1.30	1.39	University of California Center for Health Policy Research,California Health Interview Survey	2011-12		2011-12
		Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Ischaemic Heart Disease	Health Outcomes	Rate	685,306	<= 100.8	163.2	no data	State	Below benchmark	179.9	16.67	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Percent of Medicare fee-for-service population with ischaemic heart disease	n/a	Health Outcomes	Percentage	no data	n/a	26.1%	28.6%	State	Below benchmark	29.3%	3.20%	2			Centers for Medicare and Medicaid Services	2012	2012	2012
		Percent of adults who have coronary heart disease (age 18+)	n/a	Health Outcomes	Percentage	no data	n/a	3.5%	4.4%	State	Below benchmark	3.6%	0.10%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2011-12	2005-08	2011-12
		Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Stroke	Health Outcomes	Rate	685,306	n/a	37.4	no data	State	Below benchmark	45.8	8.43	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
	Related	Percent Population with no Leisure Time Physical Activity	Physical Inactivity (Adult)	Health Behaviors	Percentage	480,591	n/a	16.6%	22.6%	State	Below benchmark	18.6%	2.00%	2	1.44		Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent of Youth Physically Inactive	Physical Inactivity (Youth)	Health Behaviors	Percentage	30,139	n/a	35.9%	no data	State	Below benchmark	42.5%	6.60%	2			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent Population Within 1/2 Mile of a Park	Park Access	Physical Environment	Percentage	685,306	n/a	58.6%	no data	State	Above benchmark	45.6%	-13.01%	2			US Census Bureau, Decennial Census. ESRI Map Gallery	2010		2010
		Percent Population Living in Car Dependent (Almost Exclusively) Cities	Transit - Walkability	Physical Environment	Percentage	no data	n/a	1.7%	2.0%	State	Below benchmark	no data					Walk Score®	2012	2012	
		Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Recreation and Fitness Facility Access	Physical Environment	Rate	685,306	n/a	8.7	9.44	State	Above benchmark	5.0	-3.69	2			US Census Bureau,County Business Patterns. Additional data analysis by CARES	2012	2012	2012
		Percent Population Smoking Cigarettes (Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	479,299	n/a	12.8%	18.1%	State	Below benchmark	16.2%	3.40%	2			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Alcohol - Excessive Consumption	Health Behaviors	Percentage	479,299	n/a	17.2%	16.9%	State	Below benchmark	15.5%	-1.70%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	685,306	n/a	10.0	10.35	State	Below benchmark	7.4	-2.58	0			US Census Bureau,County Business Patterns. Additional data analysis by CARES	2012	2012	2012
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	466,438	n/a	35.8%	35.8%	State	Below benchmark	31.0%	-4.80%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2011-12	2011-12	2011-12
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	480,180	n/a	22.3%	27.1%	State	Below benchmark	29.1%	6.80%	2			Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent Youth Overweight	Overweight (Youth)	Health Outcomes	Percentage	30,139	n/a	19.3%	no data	State	Below benchmark	20.9%	1.62%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent Youth Obese	Obesity (Youth)	Health Outcomes	Percentage	30,139	n/a	19.0%	no data	State	Below benchmark	21.0%	1.96%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent of adults (age 18+) who have ever been diagnosed with high blood pressure	n/a	Health Outcomes	Percentage	no data	n/a	26.2%	28.2%	State	Below benchmark	30.1%	3.90%	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2006-12	2006-12	2006-12

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
		Percent of Medicare fee-for-service population diagnosed with high blood pressure	n/a	Health Outcomes	Percentage	no data	n/a	51.5%	55.5%	State	Below benchmark	55.6%	4.10%	2			Centers for Medicare and Medicaid Services	2012	2012	2012
		Percent of adults (age 18+) who have ever been diagnosed with high cholesterol	n/a	Health Outcomes	Percentage	no data	n/a	36.0%	38.5%	State	Below benchmark	39.8%	3.80%	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2011-12	2011-12	2011-12
		Percent of Medicare fee-for-service population diagnosed with high cholesterol	n/a	Health Outcomes	Percentage	no data	n/a	42.1%	44.8%	State	Below benchmark	47.7%	5.60%	2			Centers for Medicare and Medicaid Services	2012	2012	2012
		Percent of adults not taking medication for their high blood pressure (self-report)	n/a	Clinical Care	Percentage	no data	n/a	30.3%	21.7%	State	Above benchmark	30.3%	0.00%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2006-10	2006-10	2006-10
		Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Diabetes Prevalence	Health Outcomes	Percentage	478,411	n/a	8.1%	9.1%	State	Below benchmark	10.4%	2.30%	2			Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Age-Adjusted Diabetes-related Discharge Rate (Per 10,000 population)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a	10.4	no data	State	Below benchmark	12.0	1.55	2			California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
Demographics	n/a	Total Population (density per square mile)	n/a	Demographics	Rate	no data	n/a	241.8	88.3	n/a	n/a	498.3	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Change in Total Population	n/a	Demographics	Percentage	no data	n/a	10.0%	9.7%	n/a	n/a	21.6%	n/a	n/a			U.S. Census Bureau	2000-10	2000-10	2000-10
		Families with Children (% of total households)	n/a	Demographics	Percentage	no data	n/a	36.5%	32.7%	n/a	n/a	43.4%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Male Population	n/a	Demographics	Percentage	no data	n/a	49.7%	49.2%	n/a	n/a	49.8%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Female Population	n/a	Demographics	Percentage	no data	n/a	50.3%	50.8%	n/a	n/a	50.2%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Population under Age 18	n/a	Demographics	Percentage	no data	n/a	24.5%	23.7%	n/a	n/a	28.9%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 0-4	n/a	Demographics	Percentage	no data	n/a	6.7%	6.4%	n/a	n/a	7.8%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 5-17	n/a	Demographics	Percentage	no data	n/a	17.8%	17.3%	n/a	n/a	21.1%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 18-24	n/a	Demographics	Percentage	no data	n/a	10.5%	10.0%	n/a	n/a	10.5%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 25-34	n/a	Demographics	Percentage	no data	n/a	14.4%	13.4%	n/a	n/a	13.3%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 35-44	n/a	Demographics	Percentage	no data	n/a	13.7%	13.1%	n/a	n/a	13.1%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 45-54	n/a	Demographics	Percentage	no data	n/a	13.9%	14.3%	n/a	n/a	13.2%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 55-64	n/a	Demographics	Percentage	no data	n/a	11.1%	12.1%	n/a	n/a	10.3%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 65+	n/a	Demographics	Percentage	no data	n/a	11.8%	13.4%	n/a	n/a	10.8%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of Population 75y+	n/a	Demographics	Percentage	no data	n/a	5.4%	6.0%	n/a	n/a	4.8%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Median Age in Years	n/a	Demographics	Number	no data	n/a	35.4	37.3	n/a	n/a	32.9	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Veteran Population (% of total population)	n/a	Demographics	Percentage	no data	n/a	6.7%	9.0%	n/a	n/a	7.2%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Rural	n/a	Demographics	Percentage	no data	n/a	5.1%	19.1%	n/a	n/a	8.5%	n/a	n/a			U.S. Census Bureau	2010	2010	2010
		Percent Population Urban	n/a	Demographics	Percentage	no data	n/a	95.0%	80.9%	n/a	n/a	91.5%	n/a	n/a			U.S. Census Bureau	2010	2010	2010
		Percent Population Hispanic	n/a	Demographics	Percentage	no data	n/a	37.9%	16.6%	n/a	n/a	39.3%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Foreign-Born	n/a	Demographics	Percentage	no data	n/a	27.0%	13.0%	n/a	n/a	23.1%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population not a U.S. Citizen	n/a	Demographics	Percentage	no data	n/a	14.5%	7.1%	n/a	n/a	12.7%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Population Geographic Mobility	n/a	Demographics	Percentage	no data	n/a	4.9%	6.0%	n/a	n/a	5.4%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of the population that speak English less than "very well"	n/a	Demographics	Percentage	no data	n/a	19.4%	8.6%	n/a	n/a	18.3%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13

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		Percent of linguistically isolated households	n/a	Demographics	Percentage	no data	n/a	10.5%	4.8%	n/a	n/a	9.7%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Age 5+ with Limited English Proficiency	n/a	Demographics	Percentage	no data	n/a	19.4%	8.6%	n/a	n/a	18.3%	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Median household income	n/a	Social and Economic Factors	Number	no data	n/a	$61,094	$53,046	n/a	n/a	$53,380	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Living Wage - Annual income required to support household with two adults*	n/a	Social and Economic Factors	Number	no data	n/a	$34,798.40	no data	n/a	n/a	$30,139.20	n/a	n/a			calculated from livingwage.mit.edu	2015		2015
		Living wage - Annual income required to support one adult and one child*	n/a	Social and Economic Factors	Number	no data	n/a	$47,216.00	no data	n/a	n/a	$41,724.80	n/a	n/a			calculated from livingwage.mit.edu	2015		2015
		Voter turnout rate as a percent of eligible voters	n/a	Social and Economic Factors	Percentage	no data	n/a	30.9%	no data	n/a	n/a	27.8%	n/a	n/a			California Secretary of State	2014		2014
		Percent of population living within 1/2 mile of public transit	n/a	Physical Environment	Percentage	no data	n/a	15.5%	8.1%	n/a	n/a	16.8%	n/a	n/a			US Census Bureau,American Community Survey	2011	2011	2011
		Median year housing units built	n/a	Physical Environment	Year	no data	n/a	1974	1976	n/a	n/a	1980	n/a	n/a			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of children under age 18 living below 200% of Federal Poverty Level	n/a	Social and Economic Factors	Percentage	no data	n/a	46.0%	43.8%	State	Below benchmark	52.0%	6.00%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population with Income at or Below 200% FPL	Poverty - Population Below 200% FPL	Social & Economic Factors	Percentage	678,214	n/a	35.9%	34.2%	State	Below benchmark	41.3%	5.38%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population in Poverty	Poverty - Population Below 100% FPL	Social & Economic Factors	Percentage	678,214	n/a	15.9%	15.4%	State	Below benchmark	18.2%	2.21%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Population Under Age 18 in Poverty	Poverty - Children Below 100% FPL	Social & Economic Factors	Percentage	678,214	n/a	22.2%	21.6%	State	Below benchmark	24.5%	2.34%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent People 65 years or Older in Poverty	n/a	Social and Economic Factors	Percentage	no data	n/a	9.9%	9.4%	State	Below benchmark	10.0%	0.10%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent Single Female Headed Households in Poverty	n/a	Social and Economic Factors	Percentage	no data	n/a	13.5%	13.0%	State	Below benchmark	15.4%	1.00%	1			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of people living below 50% of Federal Poverty Line	n/a	Social and Economic Factors	Percentage	no data	n/a	6.9%	6.8%	State	Below benchmark	7.2%	0.30%	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
	Core	Percent of Families Earning over $75,000/year	n/a	Social and Economic Factors	Percentage	no data	n/a	46.8%	42.8%	State	Below benchmark	39.8%	-7.00%	0	1.44		US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Median household income	n/a	Social and Economic Factors	Number	n/a	n/a	$61,094.00	$53,046.00	State	Above benchmark	$53,380.00	-$7,714.00	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Per capita income	n/a	Social and Economic Factors	Number	n/a	n/a	$29,527.00	$28,154.00	State	Above benchmark	$22,589.00	-$6,938.00	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Living wage - Annual income required to support one adult and one child*	n/a	Social and Economic Factors	Number	n/a	n/a	$47,216.00	no data	State	n/a	$41,724.80	-$5,491.20	2			calculated from livingwage.mit.edu	2015		2015
		Percent population receiving MediCal/Medicaid	n/a	Social and Economic Factors	Percentage	no data	n/a	23.4%	20.2%	State	Below benchmark	29.4%	5.99%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of households with public assistance income	n/a	Social and Economic Factors	Percentage	no data	n/a	4.0%	2.8%	State	Below benchmark	6.6%	2.60%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Unemployment Rate	Economic Security - Unemployment Rate	Social & Economic Factors	Percentage	311,771	n/a	7.9%	6.0%	State	Below benchmark	10.6%	2.70%	2			US Department of Labor,Bureau of Labor Statistics	2015	2015	2015
		Percentage of civilian non-institutionalized population age 16 or older unemployed	n/a	Social and Economic Factors	Percentage	no data	n/a	7.2%	5.9%	State	Below benchmark	10.7%	3.50%	2			U.S. Department of Labor, Bureau of Labor Statistics	2015	2015	2015
		Gini Index Value	Income Inequality	Social & Economic Factors	Proportion	215,563	n/a	0.48	0.47	State	Below benchmark	0.44	-0.04	0			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Cohort Graduation Rate	Education - High School Graduation Rate	Social & Economic Factors	Rate	10,389	>= 82.4	80.4	no data	State	Above benchmark	80.3	-0.14	2			California Department of Education	2013		2013
		Percent of children age 3-4 enrolled in school (includes Head Start, licensed child care, nurseries, Pre-K, registered child care, and other)	Education - School Enrollment Age 3-4	Social and Economic Factors	Percentage	no data	n/a	49.1%	47.7%	State	Above benchmark	40.7%	-8.40%	2			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
Economic Security		Percentage of Grade 4 ELA Test Score Not Proficient	Education - Reading Below Proficiency	Social & Economic Factors	Percentage	9,652	<= 36.3%	36.0%	n/a	State	Below benchmark	48.0%	12.00%	2		0.95	California Department of Education	2012-13		2012-13
		3rd grade reading proficiency (Percentage of all public school students tested in 3rd grade who scored proficient or advanced on the English Language Arts California Standards Test)	n/a	Social and Economic Factors	Percentage	no data	n/a	45.0%	no data	State	Above benchmark	34.0%	-11.00%	2			California Dept. of Education, Standardized Testing and Reporting (STAR) Results	2013		2013
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	685,306	n/a	10.0	10.4	State	Below benchmark	7.4	-2.58	0			US Census Bureau, County Business Patterns. Additional data analysis by CARES.	2012	2012	2012
		Percent Students Eligible for Free or Reduced Price Lunch	Children Eligible for Free/Reduced Price Lunch	Social & Economic Factors	Percentage	139,605	n/a	58.1%	52.4%	State	Below benchmark	64.3%	6.15%	2			National Center for Education Statistics, NCES - Common Core of Data	2013-14	2013-14	2013-14

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
		Percent Population Receiving SNAP Benefits	Food Security - Population Receiving SNAP	Social & Economic Factors	Percentage	682,863	n/a	10.6%	15.2%	State	Below benchmark	15.2%	4.60%	2			US Census Bureau, Small Area Income & Poverty Estimates	2011	2011	2011
		Dignity Community Need Index	n/a	Social and Economic Factors	Number	n/a	n/a	n/a	n/a	n/a	Below benchmark	4.2					Dignity Health Community Need Index			2015
		Percent of Insured Population Receiving Medicaid	Insurance - Population Receiving Medicaid	Social & Economic Factors	Percentage	684,141	n/a	23.4%	20.2%	State	Below benchmark	28.4%	5.00%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent Uninsured Population	Insurance - Uninsured Population	Social & Economic Factors	Percentage	684,141	n/a	17.8%	14.9%	State	Below benchmark	17.2%	-0.60%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
	Related	Average Daily School Breakfast Program Participation Rate	Food Security - School Breakfast Program	Social & Economic Factors	Percentage	no data	n/a	3.9%	4.2%	State	Below benchmark	no data	n/a		0.89		US Department of Agriculture, Food and Nutrition Service,USDA - Child Nutrition Program	2013	2013	
		Percentage of the Population with Food Insecurity	Food Security - Food Insecurity Rate	Social & Economic Factors	Percentage	687,056	n/a	16.2%	15.9%	State	Below benchmark	18.0%	1.71%	1			Feeding America	2012	2012	2012
		Vacant Housing Units, Percent	Housing - Vacant Housing	Physical Environment	Percentage	234,822	n/a	8.6%	12.5%	State	Below benchmark	8.1%	-0.51%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percentage of Households where Housing Costs Exceed 30% of Income	Housing - Cost Burdened Households	Physical Environment	Percentage	215,563	n/a	45.9%	35.5%	State	Below benchmark	44.9%	-0.97%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard Housing	Physical Environment	Percentage	215,563	n/a	48.4%	36.1%	State	Below benchmark	47.5%	-0.88%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
		HUD-Assisted Units, Rate per 10,000 Housing Units	Housing - Assisted Housing	Physical Environment	Rate	233,755	n/a	368.3	364.3	State	Below benchmark	335.1	-33.16	0			US Department of Housing and Urban Development	2013	2013	2013
		Proportion of renter occupied households living in overcrowded environments (>1 persons/room)	n/a	Physical Environment	Percentage	no data	n/a	12.2%	4.2%	State	Below benchmark	11.4%	-0.80%	0			American Community Survey, 5y	2008-12	2008-12	2008-12
		Percentage of Workers Commuting More than 60 Minutes	Economic Security - Commute Over 60 Minutes	Social & Economic Factors	Percentage	250,801	n/a	10.1%	8.1%	State	Below benchmark	15.2%	5.06%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent renter occupied households	n/a	Social and Economic Factors	Percentage	no data	n/a	44.7%	35.1%	State	Below benchmark	41.7%	-3.00%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
		Road network density (road miles per square mile)	n/a	Physical Environment	Rate	n/a	n/a	0.0	0.0	State	Below benchmark	0.0	-0.016	0			Environmental Protection Agency	2011	2011	2011
		Percentage of Households with No Motor Vehicle	Economic Security - Households with No Vehicle	Social & Economic Factors	Percentage	215,563	n/a	7.8%	9.1%	State	Below benchmark	6.9%	-0.86%	0			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent Population Age 25+ with No High School Diploma	Education - Less than High School Diploma (or Equivalent)	Social & Economic Factors	Percentage	420,689	n/a	18.8%	14.0%	State	Below benchmark	22.7%	3.88%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent of population age 25+ with Associate's degree or higher	n/a	Social and Economic Factors	Percentage	no data	n/a	38.4%	36.7%	State	Above benchmark	27.0%	-11.40%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
	Core	Percent of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts (ELA)	n/a	Social and Economic Factors	Percentage	no data	n/a	38.0%	n/a	State	Above benchmark	33.0%	-5.00%	2			California Department of Education	2014		2014
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	n/a	Social and Economic Factors	Percentage	no data	n/a	54.0%	n/a	State	Above benchmark	56.0%	2.00%	0			California Department of Education	2014		2014
		Percentage of Population Age 3-4 Enrolled in School	Education - School Enrollment Age 3-4	Social & Economic Factors	Percentage	22,915	n/a	49.1%	47.7%	State	Above benchmark	40.7%	-8.35%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
		Head Start Programs Rate (Per 10,000 Children Under Age 5)	Education - Head Start Program Facilities	Social & Economic Factors	Rate	54,228	n/a	6.3	7.6	State	Above benchmark	10.1	3.8	0			US Department of Health & Human Services, Administration for Children and Families	2014	2014	2014
Education		Percent of fourth grade children reading below the "proficient" level ("basic" or "worse")	Education - Reading Below Proficiency	Social and Economic Factors	Percentage	no data	<=36.3%	36.0%	n/a	State	Below benchmark	48.0%	12.00%	2	1.31	1.31	California Department of Education	2012-13		2012-13
		Percent of students meeting UC or CSU course requirements	n/a	Social and Economic Factors	Percentage	no data	n/a	41.9%	n/a	State	Above benchmark	27.0%	-14.90%	2			California Department of Education	2014		2014
		Percent of English language learners (K-12) who met California English Language Development Test (CELDT) criteria for proficiency	n/a	Social and Economic Factors	Percentage	28,282	n/a	39.0%	n/a	State	Above benchmark	38.0%	-1.00%	1			California Department of Education	2014-15		2014-15
		Expulsion Rate (per 100 enrolled students)	Violence - School Expulsions	Social and Economic Factors	Percentage	283,265	n/a	0.1%	n/a	State	Below benchmark	0.1%	0	0			California Department of Education, California Longitudinal Pupil Achievement Data System	2013-14		2013-14
		Percent of high school graduates enrolled in CA public postsecondary institution within 16 months after graduation	n/a	Social and Economic Factors	Percentage	no data	n/a	51.3%	n/a	State	Above benchmark	53.0%	1.70%	0			California Department of Education	2006-07		2006-07
		Percent of high school graduates who complete at least 1 year of credits at CA public postsecondary institution within 2 years of postsecondary enrollment	n/a	Social and Economic Factors	Percentage	no data	n/a	28.3%	n/a	State	Above benchmark	26.2%	-2.10%	2			California Department of Education	2006-07		2006-07
		Percent of high school graduates enrolled in a postsecondary institution in the U.S. within 16 months after graduation	n/a	Social and Economic Factors	Percentage	no data	n/a	74.4%	no data	State	Above benchmark	71.7%	-2.70%	2			California Department of Education	2008-09		2008-09
		Chlamydia Infection Rate (Per 100,000 population)	STD - Chlamydia	Health Outcomes	Rate	696,214	n/a	444.9	456.7	State	Below benchmark	528.1	83.2	2			US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral	2012	2012	2012
		Gonorrhea Incidence (rate of gonorrhea cases per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=251.9	152.8	no data	State	Below benchmark	264.8	112	2			California Department of Public Health	2011-13		2011-13

Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Health Indicators										**Needs Score**							**Data Details**			
HIV/AIDS/STDs	Core	AIDS Incidence (newly diagnosed cases; per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=12.4	8.1	no data	State	Below benchmark	5.1	-3	0	0.00	1.00	California Department of Public Health	2009-11		2011-13
		Population with HIV / AIDS, Rate (Per 100,000 population)	STD - HIV Prevalence	Health Outcomes	Rate	544,951	n/a	363.0	340.4	State	Below benchmark	217.0	-146	0			US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral	2010	2010	2010
		Age-Adjusted Discharge Rate (Per 10,000 population)	STD - HIV Hospitalizations	Health Outcomes	Rate	no data	n/a	2.0	no data	State	Below benchmark	1.7	-0.26	0			California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. additional data analysis by CARES. 2011.	2011		2011
	Related	Percent Adults Never Screened for HIV / AIDS	STD - No HIV Screening	Clinical Care	Percentage	403,397	n/a	60.8%	62.8%	State	Below benchmark	66.7%	5.82%	2	2.00		Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.	2011-12	2011-12	2011-12
Mental Health	Core	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Suicide	Health Outcomes	Rate	685,306	<= 10.2	9.8	no data	State	Below benchmark	10.8	1.03	2	1.33	1.18	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data	2010-12		2010-12
		Average Number of Mentally Unhealthy Days per Month	Mental Health - Poor Mental Health Days	Health Outcomes	Rate	479,299	n/a	3.6	3.5	State	Below benchmark	4.0	0.4	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.	2006-12	2006-12	2006-12
		Percentage likely having had serious psychological distress in past year	n/a	Health Outcomes	Percentage	no data	n/a	8.0%	n/a	State	Below benchmark	9.3%	1.30%	1			California Health Interview Survey	2012-14		2012-14
		Percentage of Medicare Beneficiaries with Depression	Mental Health - Depression Among Medicare	Health Outcomes	Percentage	55,640	n/a	13.4%	15.4%	State	Below benchmark	13.0%	-0.40%	0			Centers for Medicare and Medicaid Services	2012	2012	2012
		Mental Health Care Provider Rate (Per 100,000 Population)	Access to Mental Health Providers	Clinical Care	Rate	718,269	n/a	157.0	134.1	State	Above benchmark	90.1	-66.9	2			University of Wisconsin Population Health Institute, County Health Rankings	2014	2014	2014
		Percent of adults with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	no data	n/a	29.9%	n/a	State	Below benchmark	34.2%	4.30%	2			California Health Interview Survey	2011-12		2011-12
		Percent of adults age 65+ with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	no data	n/a	51.9%	n/a	State	Below benchmark	54.0%	2.10%	2			California Health Interview Survey	2011-12		2011-12
		Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	n/a	Health Outcomes	Percentage	no data	n/a	32.0%	n/a	State	Below benchmark	32.0%	0.00%	0			Healthy Kids Survey	2009-11		2009-11
		Suicide attempt rate (emergency room or hospitalization per 100,000 residents ages 13-24)	n/a	Health Outcomes	Rate	no data	n/a	7.7	no data	State	Below benchmark	6.0	-1.7	0			California Department of Public Health	2013		2013
		Percentage of mothers reporting postpartum depression	n/a	Health Outcomes	Percentage	no data	n/a	16.0%	n/a	State	Below benchmark	17.7%	1.70%	1			Maternal and Infant Health Assessment	2012		2012
		Drug induced deaths (age-adjusted rate; Per 100,000 population)	n/a	Health Outcomes	Rate	no data	<= 11.3	11.1	n/a	State	Below benchmark	17.3	6.20	2			California Public Health Department	2011-13		2011-13
		Percentage with Poor Mental Health	Mental Health - Needing Mental Health Care	Health Outcomes	Percentage	496,000	n/a	15.9%	no data	State	Below benchmark	18.2%	2.30%	2			California Health Interview Survey	2013-14		2013-14
	Related	Total number of homeless individuals	n/a	Social and Economic Factors	Number	no data	n/a	no data	no data	n/a	n/a	2,641	n/a		0.80		Head Start Report: Assessing The Needs Of Children & Families In San Joaquin County 2014. San Joaquin County Community Development Department, "San Joaquin County			2011
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	n/a	Health Outcomes	Rate	no data	<=8.5	8.7	n/a	State	Below benchmark	7.3	-1.4	0			California Child Welfare Indicators Project (CCWIP)	2014		2014
		Percent of 11th grade students who report they've been victims of cyber bullying in the past 12 months	n/a	Health Outcomes	Percentage	no data	n/a	24.0%	n/a	State	Below benchmark	15.0%	-9.00%	0			Healthy Kids Survey	2009-11		2009-11
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	n/a	Health Outcomes	Percentage	no data	n/a	8.0%	n/a	State	Below benchmark	6.0%	-2.00%	0			Healthy Kids Survey	2009-11		2009-11
		Percent of 11th grade students reporting harassment or bullying on school property within the past 12 months for any reason	n/a	Health Outcomes	Percentage	no data	n/a	28.0%	n/a	State	Below benchmark	34.0%	6.00%	2			Healthy Kids Survey	2009-11		2009-11
		Percent Adults Without Adequate Social / emotional Support (Age-Adjusted)	Lack of Social or emotional Support	Social & Economic Factors	Percentage	479,299	n/a	24.6%	20.7%	State	Below benchmark	29.1%	4.50%	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
	Core	Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	466,458	n/a	35.8%	35.8%	State	Below benchmark	31.0%	-4.80%	0	1.33		Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.	2011-12	2011-12	2011-12
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	480,180	n/a	22.3%	27.1%	State	Below benchmark	29.1%	6.80%	2			Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent Youth Overweight	Overweight (Youth)	Health Outcomes	Percentage	30,139	n/a	19.3%	no data	State	Below benchmark	20.9%	1.62%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent Youth Obese	Obesity (Youth)	Health Outcomes	Percentage	30,139	n/a	19.0%	no data	State	Below benchmark	21.0%	1.96%	1			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent of low income (<200% FPL) preschool children (age 2-4) who are obese	n/a	Health Outcomes	Percentage	no data	<=9.4	17.2%	no data	State	Below benchmark	16.8%	-0.40%	0			California Department of Public Health, Pediatric Nutrition Surveillance Survey	2010		2010
		Percent Adults with Diagnosed Diabetes (Age-Adjusted)	Diabetes Prevalence	Health Outcomes	Percentage	478,411	n/a	8.1%	9.1%	State	Below benchmark	10.4%	2.35%	2			Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent of Medicare fee-for-service population with diabetes	n/a	Health Outcomes	Percentage	no data	n/a	26.6%	27.0%	State	Below benchmark	28.8%	2.20%	2			Centers for Medicare and Medicaid Services	2012	2012	2012
		Diabetes mortality rate (age-adjusted; Per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	20.2	no data	State	Below benchmark	28.9	8.7	2			California Department of Public Health	2009-11		2009-11

Potential Health Needs	Core/ Related	Indicator	Kaiser indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Health Indicators										Needs Score							Data Details			
		Age-Adjusted Diabetes-related Discharge Rate (Per 10,000 population)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a	10.4	no data	State	Below benchmark	12.0	1.55	2			California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES.	2011		2011
		Percent Adults with Inadequate Fruit / Vegetable Consumption	Low Fruit/Vegetable Consumption (Adult)	Health Behaviors	Percentage	462,349	n/a	71.5%	75.7%	State	Below benchmark	65.6%	-5.90%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2005-09	2005-09	2005-09
		Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	Low Fruit/Vegetable Consumption (Youth)	Health Behaviors	Percentage	110,000	n/a	47.4%	no data	State	Below benchmark	46.4%	-1.00%	0			California Health Interview Survey	2011-12		2011-12
		Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Fruit/Vegetable Expenditures	Health Behaviors	Percentage	no data	n/a	14.1%	12.7%	State	Above benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Soft Drink Expenditures	Health Behaviors	Percentage	no data	n/a	3.6%	4.0%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Percent of children age 2-11 drinking one or more sugar sweetened beverages on previous day	n/a	Health Behaviors	Percentage	no data	n/a	27.0%	no data	State	Below benchmark	38.3%	11.30%	2			California Health Interview Survey	2011-12		2011-12
		Percent of low-income population with low food access	n/a	Physical Environment	Percentage	no data	n/a	3.4%	6.3%	State	Below benchmark	4.6%	1.20%	1			U.S. Department of Agriculture, Economic Research Service	2010	2010	2010
		SNAP-authorized retailers per 100,000 population	n/a	Physical Environment	Rate	no data	n/a	63.9	78.4	State	Above benchmark	69.3	5.35	0			U.S. Department of Agriculture, Food and Nutrition Service	2014	2014	2012
		Fast Food Restaurants, Rate (Per 100,000 Population)	Food Environment - Fast Food Restaurants	Physical Environment	Rate	685,306	n/a	74.5	72.0	State	Below benchmark	59.1	-15.41	0			US Census Bureau, County Business Patterns. Additional data analysis by CARES.	2011	2011	2011
		Grocery Stores, Rate (Per 100,000 Population)	Food Environment - Grocery Stores	Physical Environment	Rate	685,306	n/a	21.5	21.1	State	Above benchmark	23.2	1.69	0			American Community Survey, 5y	2011	2011	2011
		WIC-Authorized Food Stores, Rate (Per 100,000 Population)	Food Environment - WIC-Authorized Food Stores	Physical Environment	Rate	696,217	n/a	15.8	15.6	State	Above benchmark	16.4	0.60	0			US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas	2011	2011	2011
Obesity/HEAL/ Diabetes		Percent Population with Low Food Access	Food Security - Food Desert Population	Social & Economic Factors	Percentage	685,306	n/a	14.3%	23.6%	State	Below benchmark	15.1%	0.79%	0		1.20	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas	2010	2010	2010
		Percent Population with no Leisure Time Physical Activity	Physical Inactivity (Adult)	Health Behaviors	Percentage	480,591	n/a	16.6%	22.6%	State	Below benchmark	18.6%	2.00%	2			Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2012	2012	2012
		Percent youth in grades 5,7,9 with "high risk" or "needs improvement" aerobic capacity	Physical Inactivity (Youth)	Health Behaviors	Percentage	30,139	n/a	35.9%	no data	State	Below benchmark	42.5%	6.60%	2			California Department of Education, FITNESSGRAM® Physical Fitness Testing	2013-14		2013-14
		Percent of children under 18 consuming fast food at least once in past week	n/a	Health Behaviors	Percentage	no data	n/a	70.9%	n/a	State	Below benchmark	79.1%	8.20%	2			California Health Interview Survey	2011-12		2011-12
		Percent of 11th grade students who report eating breakfast on day of survey	n/a	Health Behaviors	Percentage	no data	n/a	60.0%	n/a	State	Above benchmark	53.0%	-7.00%	2			California Healthy Kids Survey	2011-13		2013-14
	Related	Percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test administered by a health care Professional in the past year	n/a	Clinical Care	Percentage	no data	n/a	81.5%	84.6%	State	Above benchmark	83.9%	2.40%	0	1.15		Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care	2012	2012	2012
		Percent Population Within 1/2 Mile of a Park	Park Access	Physical Environment	Percentage	685,306	n/a	58.6%	no data	State	Above benchmark	45.6%	-13.01%	2			US Census Bureau, Decennial Census. ESRI Map Gallery	2010		2010
		Percent Population Living in Car Dependent (Almost Exclusively) Cities	Transit - Walkability	Physical Environment	Percentage	no data	n/a	1.7%	2.0%	State	Below benchmark	no data					Walk Score®	2012	2012	
		Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Recreation and Fitness Facility Access	Physical Environment	Rate	685,306	n/a	8.7	9.4	State	Above benchmark	5.0	-3.69	2			US Census Bureau,County Business Patterns. Additional data analysis by CARES	2012	2012	2012
		Percentage of Mothers Breastfeeding (Any)	Breastfeeding (Any)	Health Behaviors	Percentage	8,392	n/a	93.0%	no data	State	Above benchmark	89.1%	-3.90%	2			California Department of Public Health,CDPH - Breastfeeding Statistics	2012		2012
		Percentage of Mothers Breastfeeding (Exclusively)	Breastfeeding (Exclusive)	Health Behaviors	Percentage	8,392	n/a	64.8%	no data	State	Above benchmark	60.4%	-4.40%	2			California Department of Public Health,CDPH - Breastfeeding Statistics	2012		2012
		Average Daily School Breakfast Program Participation Rate	Food Security - School Breakfast Program	Social & Economic Factors	Percentage	no data	n/a	3.9%	4.2%	State	Below benchmark	no data					US Department of Agriculture, Food and Nutrition Service,USDA - Child Nutrition Program	2013	2013	
		Percentage of Workers Commuting More than 60 Minutes	Economic Security - Commute Over 60 Minutes	Social & Economic Factors	Percentage	250,601	n/a	10.1%	8.1%	State	Below benchmark	15.2%	5.06%	2			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percentage of the Population with Food Insecurity	Food Security - Food Insecurity Rate	Social & Economic Factors	Percentage	687,036	n/a	16.2%	15.9%	State	Below benchmark	18.0%	1.71%	1			Feeding America	2012	2012	2012
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	443,414	n/a	2.7%	10.2%	State	Below benchmark	27.1%	24.40%	2			University of Wisconsin Population Health Institute, County Health Rankings	2012-13	2012-13	2012-13
		Percentage Walking or Biking to Work	Commute to Work - Walking/Biking	Health Behaviors	Percentage	261,485	n/a	3.8%	3.4%	State	Above benchmark	2.4%	-1.42%	1			American Community Survey, 5y	2009-13	2009-13	2009-13
		Percent of 5th graders who meet 6 of 6 fitness standards on physical fitness test	n/a	Health Behaviors	Percentage	no data	n/a	26.6%	n/a	State	Above benchmark	24.8%	-1.80%	1			California Department of Education	2013-14		2013-14
		Percent of 7th graders who meet 6 of 6 fitness standards on physical fitness test	n/a	Health Behaviors	Percentage	no data	n/a	33.0%	n/a	State	Above benchmark	30.0%	-3.00%	2			California Department of Education	2013-14		2013-14
		Percent of 9th graders who meet 6 of 6 fitness standards on physical fitness test	n/a	Health Behaviors	Percentage	no data	n/a	38.1%	n/a	State	Above benchmark	32.0%	-6.10%	2			California Department of Education	2013-14		2013-14

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
		Percentage of mothers obese at the beginning of pregnancy	n/a	Health Outcomes	Percentage	no data	n/a	no data	n/a	n/a	Below benchmark	44.6%					San Joaquin County Birth Statistical Master File (SJC PHS)			2009
		Percentage Walking/Skating/Biking to School	Walking/Biking/Skating to School	Health Behaviors	Percentage	162,353	n/a	43.0%	no data	State	Above benchmark	42.5%	-0.50%	0			California Health Interview Survey	2011-12		2011-12
Oral Health	Core	Percent Adults with Poor Dental Health	Poor Dental Health	Health Outcomes	Percentage	472,748	n/a	11.3%	15.7%	State	Below benchmark	12.5%	1.20%	1	1.00	1.27	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.	2006-10	2006-10	2006-10
		Percent Adults Without Recent Dental Exam	Dental Care - No Recent Exam (Adult)	Clinical Care	Percentage	472,748	n/a	30.5%	30.2%	State	Below benchmark	31.8%	1.30%	1			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. additional data analysis by CARES	2006-10	2006-10	2006-10
		Percent Youth Without Recent Dental Exam	Dental Care - No Recent Exam (Youth)	Clinical Care	Percentage	107,000	n/a	18.5%	no data	State	Below benchmark	44.0%	25.50%	2			California Health Interview Survey	2013-14		2013-14
		Percent Adults Without Dental Insurance	Absence of Dental Insurance Coverage	Clinical Care	Percentage	443,000	n/a	40.9%	no data	State	Below benchmark	41.7%	0.80%	0			California Health Interview Survey	2009		2009
		Dentists, Rate per 100,000 population	Access to Dentists	Clinical Care	Rate	704,379	n/a	77.5	63.2	State	Above benchmark	55.4	-22.10	2			US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File	2013	2013	2013
		Percentage of Population Living in a HPSA- Dental	Health Professional Shortage Area - Dental	Clinical Care	Percentage	685,306	n/a	4.9%	32.0%	State	Below benchmark	0.0%	-4.93%	0			US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration	2015	2015	2015
	Related	Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Soft Drink Expenditures	Health Behaviors	Percentage	no data	n/a	3.6%	4.0%	State	Below benchmark	suppressed			1.60		Nielsen, Nielsen Site Reports	2014	2014	
		Percent of adults with dental insurance for all or part of past year	n/a	Clinical Care	Percentage	no data	n/a	66.3%	n/a	State	Above benchmark	55.3%	-11.00%	2			California Health Interview Survey	2007		2007
		Percent of adults age 65+ with dental insurance for all or part of past year	n/a	Clinical Care	Percentage	no data	n/a	52.7%	n/a	State	Above benchmark	41.9%	-10.80%	2			California Health Interview Survey	2007		2007
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	443,414	n/a	2.7%	10.2%	State	Below benchmark	27.1%	24.40%	2			University of Wisconsin Population Health Institute, County Health Rankings	2012-13	2012-13	2012-13
		Percentage of children age 2-13 who self-report that they have visited a dentist, dental hygienist or dental clinic within the past year	n/a	Clinical Care	Percentage	no data	n/a	90.1%	n/a	State	Above benchmark	63.0%	-27.10%	2			California Health Interview Survey	2014		2014
		Percent Population Age 5-17 Unable to Afford Dental Care	Dental Care - Lack of Affordability (Youth)	Clinical Care	Percentage	202,000	n/a	6.3%	no data	State	Below benchmark	4.2%	-2.10%	0			California Health Interview Survey	2009		2009
Overall Health	Core	Percent Adults with Poor or Fair Health (Age-Adjusted)	Poor General Health	Health Outcomes	Percentage	479,293	n/a	18.4%	15.7%	State	Below benchmark	22.0%	3.60%	2	1.70	1.70	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Percent of adults with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	no data	n/a	29.9%	n/a	State	Below benchmark	34.2%	4.30%	2			California Health Interview Survey	2011-12		2011-12
		Percent of adults age 65+ with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	no data	n/a	51.9%	n/a	State	Below benchmark	54.0%	2.10%	2			California Health Interview Survey	2011-12		2011-12
		Years of Potential Life Lost, Rate per 100,000 Population	Mortality - Premature Death	Health Outcomes	Rate	636,214	n/a	5594.0	6851.0	State	Below benchmark	7087.0	1493.00	2			University of Wisconsin Population Health Institute,County Health Rankings. Centers for Disease Control and Prevention,National Vital Statistics System. Accessed via	2008-10	2008-10	2008-10
		Percent Population with a Disability	Population with Any Disability	Demographics	Percentage	684,141	n/a	10.1%	12.1%	State	Below benchmark	11.7%	1.58%	1			US Census Bureau,American Community Survey	2009-13	2009-13	2009-13
		Percent of children age 0-12 considered in excellent or very good health	n/a	Health Outcomes	Percentage	no data	n/a	77.8%	n/a	State	Above benchmark	70.9%	-6.90%	2			California Health Interview Survey	2013-14		2013-14
		Age adjusted death rate, all causes (Per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	654.3	821.5	State	Below benchmark	758.5	103.80	2			California Department of Public Health / US from CDC Deaths: final data for 2013	2013	2013	2013
		Child mortality, 1-4 years (Per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=25.7	21.4	n/a	State	Below benchmark	24.4	3.00	2			California Department of Public Health (via Kidsdata.org)	2010-12		2010-12
		Child mortality, 5-14 years (Per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	10.3	n/a	State	Below benchmark	9.0	-1.30	0			California Department of Public Health (via Kidsdata.org)	2010-12		2010-12
		Alzheimer's disease mortality rate (age-adjusted; Per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	30.5	n/a	State	Below benchmark	37.5	7.00	2			California Department of Public Health	2009-11		2009-11
	Core	Percent Low Birth Weight Births	Low Birth Weight	Health Outcomes	Percentage	685,306	n/a	6.8%	no data	State	Below benchmark	7.0%	0.24%	0	0.83		California Department of Public Health,CDPH - Birth Profiles by ZIP Code	2011		2011
		Infant Mortality Rate (Per 1,000 Births)	Infant Mortality	Health Outcomes	Rate	55,530	<= 6.0	5.0	6.5	State	Below benchmark	5.8	0.80	2			Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data	2006-10	2006-10	2006-10
		Percent Mothers with Late or No Prenatal Care	Lack of Prenatal Care	Clinical Care	Percentage	685,306	n/a	3.1%	no data	State	Below benchmark	no data					California Department of Public Health,CDPH - Birth Profiles by ZIP Code	2011		
		Percent of women late to prenatal care (past first trimester)	n/a	Health Behaviors	Percentage	no data	<=22.1%	16.5%	29.2%	State	Below benchmark	22.5%	6.00%	2			California Department of Public Health / Centers for Disease Control and Prevention, National Vital Statistics System / HP2020	2011	2007	2011
		Percent of pre-term births (< 37 weeks gestation)	n/a	Health Outcomes	Percentage	no data	<=11.4%	9.8%	12.7%	State	Below benchmark	10.0%	0.20%	0			California Department of Public Health/ Centers for Disease Control and Prevention, National Vital Statistics System / HP2020	2011	2007	2011
		Percent of newborns with very low birth rates	n/a	Health Outcomes	Percentage	no data	<=1.4%	1.1%	1.5%	State	Below benchmark	1.3%	0.20%	0			California Department of Public Health/ Centers for Disease Control and Prevention, National Vital Statistics System / HP2020	2011	2007	2011

Health Indicators										Needs Score							Data Details			
Potential Health Needs	**Core/ Related**	**Indicator**	**Kaiser Indicator name**	**MATCH Category**	**Measure Type**	**Population Denominator**	**HP 2020 Value**	**State Benchmark**	**National Benchmark**	**Benchmark used in scoring**	**Desired Direction**	**Value for San Joaquin County**	**Difference from the Benchmark Value**	**Points**	**Core/ Related Score**	**Potential Health Need Score**	**Data Source**	**State Data Year**	**National Data Year**	**County Area Year**
Pregnancy and Birth Outcomes		Percentage of mothers reporting postpartum depression	n/a	Health Outcomes	Percentage	no data	n/a	16.0%	n/a	State	Below benchmark	17.7%	1.70%	1		1.00	Maternal and Infant Health Assessment	2012		2012
	Related	Pounds of pesticides applied	n/a	Physical Environment	Number	n/a	n/a	193,597,806	no data	n/a	n/a	11,017,592	n/a		1.25		California Department of Pesticide Regulation	2013		2013
		Proportion of births by C-section to low risk women giving birth for the first time	n/a	Health Outcomes	Percentage	no data	<=23.9%	26.3%	26.5%	State	Below benchmark	25.2%	-1.10%	0			California Department of Public Health/ Centers for Disease Control and Prevention, National Vital Statistics System / HP2020	2011	2007	2011
		Percentage of Mothers Breastfeeding (Any)	Breastfeeding (Any)	Health Behaviors	Percentage	8,392	n/a	93.0%	no data	State	Above benchmark	89.1%	-3.90%	2			California Department of Public Health,CDPH - Breastfeeding Statistics	2012		2012
		Percentage of Mothers Breastfeeding (Exclusively)	Breastfeeding (Exclusive)	Health Behaviors	Percentage	8,392	n/a	64.8%	no data	State	Above benchmark	60.4%	-4.40%	2			California Department of Public Health,CDPH - Breastfeeding Statistics	2012		2012
		Percentage of mothers obese at the beginning of pregnancy	n/a	Health Outcomes	Percentage	no data	n/a	no data	no data	State	Below benchmark	44.6%					San Joaquin County Birth Statistical Master File (SJC PHS)			2009
		Percentage of the Population with Food Insecurity	Food Security - Food Insecurity Rate	Social & Economic Factors	Percentage	687,036	n/a	16.2%	15.9%	State	Below benchmark	18.0%	1.71%	1			Feeding America	2012	2012	2012
Substance Abuse/Tobacco	**Core**	Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	479,399	n/a	12.8%	18.1%	State	Below benchmark	16.2%	3.40%	2	0.75	1.00	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Percent of 12-17 year olds binge drinking at least once in month prior	n/a	Health Behaviors	Percentage	no data	<=8.6%	3.6%	9.5%	State	Below benchmark	3.4%	-0.20%	0			California Health Interview Survey / NSDUH 2008 / HP2020	2011-12	2008	2011-12
		Percent of 11th grade students reporting driving after drinking (respondent or by friend)	n/a	Health Behaviors	Percentage	no data	<=25.5%	25.0%	n/a	State	Below benchmark	18.0%	-7.00%	0			California Healthy Kids Survey	2011-13		2013-14
		Percent of 11th grade students using cigarettes any time within last 30 days	n/a	Health Behaviors	Percentage	no data	<=21%	12.0%	n/a	State	Below benchmark	5.0%	-7.00%	0			California Healthy Kids Survey	2011-13		2013-14
		Percent of 11th grade students reporting marijuana use within the last 30 days	n/a	Health Behaviors	Percentage	no data	<=10%	24.0%	n/a	State	Below benchmark	14.0%	-10.00%	0			California Healthy Kids Survey	2011-13		2013-14
		Percent of 11th grade students who report they've been "high" from using drugs	n/a	Health Behaviors	Percentage	no data	n/a	36.0%	n/a	State	Below benchmark	49.0%	13.00%	2			California Healthy Kids Survey	2009-11		2009-11
		Drug induced deaths (age-adjusted rate; Per 100,000 population)	n/a	Health Outcomes	Rate	no data	<= 11.3	11.1	n/a	State	Below benchmark	17.3	6.20	2			California Public Health Department	2011-13		2011-13
		Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Alcohol - Excessive Consumption	Health Behaviors	Percentage	479,399	n/a	17.2%	16.9%	State	Below benchmark	15.5%	-1.70%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
	Related	Rate of arrests for alcohol related offenses among persons age 10 to 69 years (Per 100,000 population)	n/a	Social and Economic Factors	Rate	no data	n/a	1,203	no data	State	Below benchmark	1,569	366.00	2	1.50		CA-Community Prevention Initiative (CPI)	2008		2008
		Percent of adult smokers who attempted to quit for at least one day in the past year	n/a	Health Behaviors	Percentage	no data	n/a	57.7%	60.0%	State	Above benchmark	55.4%	-2.30%	2			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2011-12	2008	2011-12
		Chronic liver disease and cirrhosis mortality rate (Per 100,000 population)	n/a	Health Outcomes	Rate	no data	<=8.2	11.7	no data	State	Below benchmark	17.1	5.40	2			California Department of Public Health	2011-13		2011-13
		Total number of homeless individuals	n/a	Social and Economic Factors	Number	no data	n/a	no data	no data	n/a	n/a	2,641	n/a	n/a			Head Start Report: ASSESSING THE NEEDS OF CHILDREN & FAMILIES IN SAN JOAQUIN COUNTY 2014. San Joaquin County Community Development Department, "San Joaquin			2011
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	685,306	n/a	10.0	10.4	State	Below benchmark	7.4	-2.58	0			US Census Bureau, County Business Patterns. Additional data analysis by CARES.	2012	2012	2012
Vaccine Preventable Infectious Disease	**Core**	Percent of kindergarteners with all required immunizations	n/a	Clinical Care	Percentage	no data	n/a	90.4%	n/a	State	Above benchmark	95.6%	5.20%	0	0.00	0.00	California Department of Public Health Immunization Branch (data accessed through kidsdata.org)	2014-15		2014-15
		Percentage of adults age 65+ who have ever received a pneumonia vaccination	n/a	Clinical Care	Percentage	no data	n/a	63.4%	67.5%	State	Above benchmark	63.9%	0.50%	0			Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2006-12	2006-12	2006-12
		Influenza and pneumonia incidence (per 100,000 population)	n/a	Health Outcomes	Rate	no data	n/a	17.3	n/a	State	Below benchmark	16.9	-0.40	0			California Department of Public Health	2009-11		2009-11
		Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Homicide	Health Outcomes	Rate	685,306	<= 5.5	5.2	no data	State	Below benchmark	12.2	7.01	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Suicide	Health Outcomes	Rate	685,306	<= 10.2	9.8	no data	State	Below benchmark	10.8	1.03	2			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Motor Vehicle Accident	Health Outcomes	Rate	685,306	<= 12.4	5.3	no data	State	Below benchmark	4.6	-0.57	0			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Motor vehicle crash death rate (age-adjusted; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	n/a	7.5	no data	State	Below benchmark	11.4	3.90	2			2013 County Health Status Profiles, California Department of Public Health	2009-11		2009-11
		Pedestrian motor vehicle death rate (per 100,000 Population)	n/a	Health Outcomes	Rate	no data	<=1.3	2.0	no data	State	Below benchmark	1.7	-0.30	0			University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12

Health Indicators										Needs Score							Data Details			
Potential Health Needs	Core/ Related	Indicator	Kaiser indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Violence and Injury	Core	Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Pedestrian Accident	Health Outcomes	Rate	685,306	<= 1.3	2.0	no data	State	Below benchmark	2.3	0.34	2	1.26	1.33	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data	2010-12		2010-12
		Intentional Injuries, Rate per 100,000 Population (Youth Age 13 - 20)	Violence - Youth Intentional Injury	Social & Economic Factors	Rate	93,936	n/a	738.7	no data	State	Below benchmark	891.7	153.00	2			California Department of Public Health, California EpiCenter for Overall Injury Surveillance	2011-13		2011-13
		Unintentional Injuries (accidents; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	<=36	no data	50.8	State	Below benchmark	46.3					California Department of Public Health / Centers for Disease Control and Prevention, National Vital Statistics System / HP2020		2005-11	2005-11
		Unintentional injury mortality rate (age-adjusted; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	<=36.0	27.6	no data	State	Below benchmark	43.1	15.50	2			2013 County Health Status Profiles, California Department of Public Health	2009-11		2009-11
		Assault Injuries (Rate per 100,000 Population)	Violence - Assault (Injury)	Social & Economic Factors	Rate	698,392	n/a	290.3	no data	State	Below benchmark	413.5	123.20	2			California Department of Public Health, California EpiCenter for Overall Injury Surveillance	2011-13		2011-13
		Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	Violence - Domestic Violence	Social & Economic Factors	Rate	298,347	n/a	9.5	no data	State	Below benchmark	7.6	-1.90	0			California Department of Public Health, California EpiCenter for Overall Injury Surveillance	2011-13		2011-13
		Assault Rate (Per 100,000 population)	Violence - Assault (Crime)	Social & Economic Factors	Rate	693,779	n/a	249.4	246.9	State	Below benchmark	538.5	289.10	2			Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium	2010-12	2010-12	2010-12
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	n/a	Health Outcomes	Rate	no data	<=8.5	8.7	n/a	State	Below benchmark	7.3	-1.40	0			California Child Welfare Indicators Project (CCWIP)	2014		2014
		Drowning/Submersion mortality rate (age-adjusted; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	n/a	1.0		State	Below benchmark	1.8	0.80	2			California Department of Public Health, EpiCenter Overall Injury Surveillance	2011-13		2011-13
		Fall mortality rate (age-adjusted; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	n/a	5.7		State	Below benchmark	4.6	-1.10	0			California Department of Public Health, EpiCenter Overall Injury Surveillance	2011-13		2011-13
		Poisoning mortality rate (age-adjusted; per 100,000 Population)	n/a	Health Outcomes	Rate	no data	n/a	10.1		State	Below benchmark	15.9	5.80	2			California Department of Public Health, EpiCenter Overall Injury Surveillance	2011-13		2011-13
		Non-fatal emergency department visits for intentional injuries among youth age 13-20 (Per 100,000)	n/a	Health Outcomes	Rate	no data	n/a	738.7	n/a	State	Below benchmark	891.7	153.00	2			California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data	2011-13		2011-13
		Percent of adults reporting experiencing physical or sexual violence by an intimate partner in past year	n/a	Social and Economic Factors	Percentage	no data	n/a	3.8%	n/a	State	Below benchmark	2.0%	-1.80%	0			California Health Interview Survey	2007, 2009		2007, 2009
		Percent of adults reporting ever experiencing physical or sexual violence by an intimate partner since age 18	n/a	Social and Economic Factors	Percentage	no data	n/a	14.8%	n/a	State	Below benchmark	13.1%	-1.70%	0			California Health Interview Survey	2009		2009
		Robbery Rate (Per 100,000 population)	Violence - Robbery (Crime)	Social & Economic Factors	Rate	693,779	n/a	149.5	116.4	State	Below benchmark	267.3	117.80	2			Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium	2010-12	2010-12	2010-12
	Related	Number of domestic violence calls for assistance and rate per 1,000 population	n/a	Social and Economic Factors	Rate	no data	n/a	5.9	n/a	State	Below benchmark	8.4	2.50	2	1.45		California Department of Justice, Criminal Justice Statistics Center (via Kidsdata.org)	2013		2013
		Violent Crime Rate (Per 100,000 population)	Violence - All Violent Crimes	Social & Economic Factors	Rate	693,779	n/a	425.0	395.5	State	Below benchmark	839.2	414.20	2			Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium	2010-12	2010-12	2010-12
		Percentage of 11th grade students reporting current gang involvement	n/a	Social and Economic Factors	Percentage	no data	n/a	8.0%	n/a	State	Below benchmark	15.0%	7.00%	2			Healthy Kids Survey	2009-11		2009-11
		Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	Alcohol - Excessive Consumption	Health Behaviors	Percentage	479,299	n/a	17.2%	16.9%	State	Below benchmark	15.5%	-1.70%	0			Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human	2006-12	2006-12	2006-12
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	State	Below benchmark	suppressed					Nielsen, Nielsen Site Reports	2014	2014	
		Percent of 11th grade students reporting driving after drinking (respondent or by friend)	n/a	Health Behaviors	Percentage	no data	<=25.5%	25.0%	n/a	State	Below benchmark	18.0%	-7.00%	0			California Healthy Kids Survey	2011-13		2013-14
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	685,306	n/a	10.0	10.4	State	Below benchmark	7.4	-2.58	0			US Census Bureau, County Business Patterns. Additional data analysis by CARES.	2012	2012	2012
		Percent Population Living in Car Dependent (Almost Exclusively) Cities	Transit - Walkability	Physical Environment	Percentage	no data	n/a	1.7%	2.0%	State	Below benchmark	no data					Walk Score®	2012	2012	
		Rape Rate (Per 100,000 population)	Violence - Rape (Crime)	Social & Economic Factors	Rate	693,779	n/a	21.0	27.3	State	Below benchmark	21.9	0.90	2			Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium	2010-12	2010-12	2010-12
		Suspension Rate (per 100 enrolled students)	Violence - School Suspensions	Social & Economic Factors	Rate	283,265	n/a	4.0	no data	State	Below benchmark	8.8	4.75	2			California Department of Education, California Longitudinal Pupil Achievement Data System	2013-14		2013-14
		Juvenile felony arrest rate per 100,000 youth ages 10-17	n/a	Social and Economic Factors	Rate	no data	n/a	878.0	n/a	State	Below benchmark	1140.0	262.00	2			Center on Juvenile and Criminal Justice	2012		2012
		Robbery rate (per 100,000 population)	n/a	Social and Economic Factors	Rate	no data	n/a	149.5	116.4	State	Below benchmark	267.3	117.83	2			Federal Bureau of Investigation, FBI Uniform Crime Reports	2010-12	2010-12	2010-12
		Expulsion Rate (per 100 enrolled students)	Violence - School Expulsions	Social & Economic Factors	Rate	283,265	n/a	0.1	no data	State	Below benchmark	0.1	0.05	2			California Department of Education, California Longitudinal Pupil Achievement Data System	2013-14		2013-14
	Core	Cohort Graduation Rate	Education - High School Graduation Rate	Social & Economic Factors	Percentage	10,389	>= 82.4	80.4%	no data	State	Above benchmark	80.3%	-0.14%	0	0.67		California Department of Education	2013		2013
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts (ELA)	n/a	Social and Economic Factors	Percentage	no data	n/a	38.0%	n/a	State	Above benchmark	33.0%	-5.00%	2			California Department of Education	2014		2014

Health Indicators										
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark
Youth Growth and Development		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	n/a	Social and Economic Factors	Percentage	no data	n/a	54.0%	n/a
	Related	Suspension Rate (per 100 enrolled students)	Violence - School Suspensions	Social & Economic Factors	Rate	283,265	n/a	4.0	no data
		Expulsion Rate (per 100 enrolled students)	Violence - School Expulsions	Social & Economic Factors	Rate	283,265	n/a	0.1	no data
		Teen Birth Rate (Per 1,000 Female population Under Age 20)	Teen Births (Under Age 20)	Social & Economic Factors	Rate	108,619	n/a	8.5	no data
		Percentage of 11th grade students reporting current gang involvement	n/a	Social and Economic Factors	Percentage	no data	n/a	8.0%	n/a
		Percent of children in foster care system for more than 8 days but less than 12 months with 2 or less placements (placement stability)	n/a	Social and Economic Factors	Percentage	no data	n/a	86.6%	n/a
		Juvenile felony arrest rate (per 100,000 youth ages 10-17)	n/a	Social and Economic Factors	Rate	no data	n/a	878.0	n/a

Indicator	Needs Score							Data Details			
	Benchmark used in scoring	Desired Direction	Value for San Joaquin County	Difference from the Benchmark Value	Points	Core/ Related Score	Potential Health Need Score	Data Source	State Data Year	National Data Year	County Area Year
Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	State	Above benchmark	56.0%	2.00%	0		1.44	California Department of Education	2014		2014
Suspension Rate (per 100 enrolled students)	State	Below benchmark	8.8	4.75	2	1.83		California Department of Education, California Longitudinal Pupil Achievement Data System	2013-14		2013-14
Expulsion Rate (per 100 enrolled students)	State	Below benchmark	0.1	0.05	2			California Department of Education, California Longitudinal Pupil Achievement Data System	2013-14		2013-14
Teen Birth Rate (Per 1,000 Female population Under Age 20)	State	Below benchmark	9.9	1.40	2			California Department of Public Health,CDPH - Birth Profiles by ZIP Code	2011		2011
Percentage of 11th grade students reporting current gang involvement	State	Below benchmark	15.0%	7.00%	2			Healthy Kids Survey	2009-11		2009-11
Percent of children in foster care system for more than 8 days but less than 12 months with 2 or less placements (placement stability)	State	Above benchmark	84.7%	-1.90%	1			California Child Welfare Indicators Project (CCWIP)	2014		2014
Juvenile felony arrest rate (per 100,000 youth ages 10-17)	State	Below benchmark	1140.0	262.00	2			Center on Juvenile and Criminal Justice	2012		2012

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

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

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

B. Summary of Prioritized Needs

This report provides an overview of the significant health needs in the Kaiser Foundation Hospital (KFH) Modesto service area. Through a prioritization process with Kaiser Permanente leadership that was informed by secondary data, Stanislaus County stakeholders, and community members participating in focus groups, nine identified health needs were prioritized into low, medium and high priority:

- High priority: Obesity/HEAL/Diabetes, Mental Health, Access to Care
- Medium priority: CVD/Stroke, Economic Security, Cancers
- Low priority: Asthma, Substance Abuse/Tobacco, Violence/Injury Prevention

C. Summary of Needs Assessment Methodology and Process

KFH Modesto partnered with Sutter Health Memorial Medical Center (SHMMC) to conduct this CHNA. All secondary data cited in this CHNA report comes from the Kaiser Permanente CHNA Data Platform, run by Community Commons. The Kaiser Permanente CHNA Data Platform contains over 150 publically available indicators mapped to one or more potential health needs. Indicators from the Kaiser Permanente CHNA platform were reviewed and potential health needs that benchmarked poorly compared to state averages were identified. Stakeholder interviews with those having special knowledge of health needs, health disparities, and vulnerable populations provided information that increased the understanding of the health needs in the KFH Modesto service area. Community residents who participated in focus groups provided additional insights on the priority health needs in the KFH Modesto service area. Once secondary and primary data were collected and analyzed, a prioritization process involving a group of Kaiser Permanente stakeholders ranked the health needs. The prioritization process was informed by the secondary and primary data. Each need received a numerical score, which was the average score from secondary data, primary data and disparities. The next step in this process will be to develop an implementation strategy for addressing selected health needs, which will build on Kaiser Permanente's assets and resources, as well as evidence based strategies.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health

plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

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

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

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

B. About Kaiser Permanente Community Benefit

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

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

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

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

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

written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

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

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

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

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

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

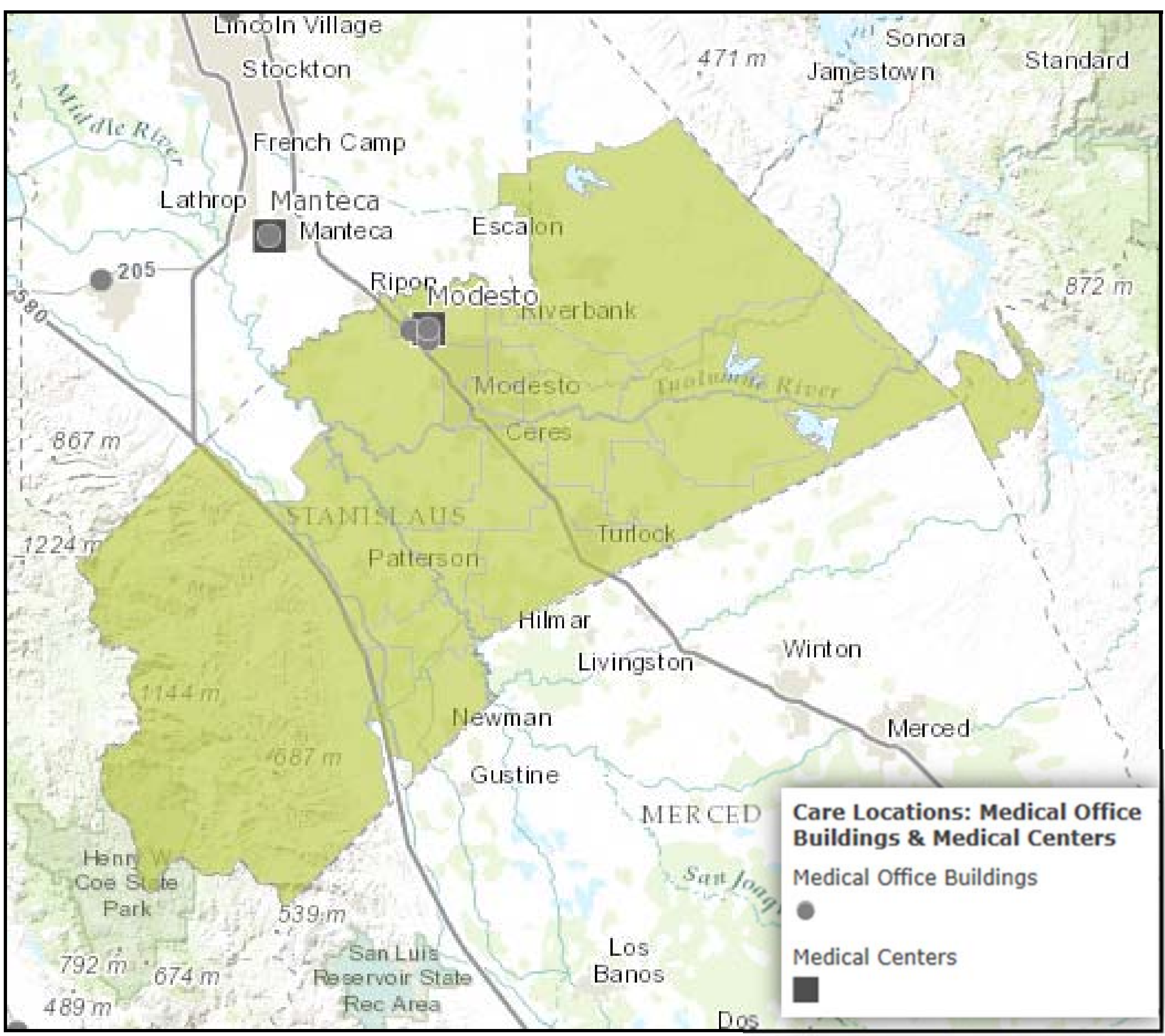
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

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

B. Map and Description of Community Served

i. Map



ii. Geographic description of the community served

KFH Modesto is located at 4601 Dale Road, Modesto, CA 95356 and its service area includes the cities of Ceres, Hughson, Modesto, Newman, Oakdale, Patterson, Riverbank, Turlock, and Waterford. The service area includes a large portion of Stanislaus County, making Stanislaus County data a good proxy for data for the KFH Modesto service Area.

iii. Demographic profile of community served

The demographics of a community significantly impact its health profile. Different ethnic, age, and socioeconomic groups may have unique needs and take varied approaches to health. This section provides an overview of the demographics of Stanislaus County, with comparisons to California and the United States for reference. All estimates are sourced from the U.S. Census Bureau's American Community Survey, 2009-13 unless otherwise indicated.

KFH Modesto Demographic Data	
Total Population	524,919
White	75.91%
Black	2.75%
Asian	5.26%
Native American/ Alaskan Native	0.81%
Pacific Islander/ Native Hawaiian	0.74%
Some Other Race	10.04%
Multiple Races	4.5%
Hispanic/Latino	42.93%

KFH Modesto Socio-economic Data	
Living in Poverty (<200% FPL)	44.15%
Children in Poverty	28.28%
Unemployed	13%
Uninsured	16.46%
No High School Diploma	22.8%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

KFH Modesto collaborated with Sutter Health Memorial Medical Center to complete the assessment.

B. Other partner organizations that collaborated on the assessment

No other partner organizations collaborated on the assessment.

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

KFH Modesto contracted with Ad Lucem Consulting, a public health consulting firm, to conduct the CHNA. Ad Lucem Consulting specializes in initiative design, strategic planning, grants management, and program evaluation, tailoring methods and strategies to each project and adapting to client needs and priorities, positioning clients for success. Ad Lucem Consulting works in close collaboration with clients, synthesizing complex information into easy-to-understand, usable formats, bringing a hands-on, down to earth approach to each project. Ad Lucem Consulting supports clients through a variety of services that can be applied to a range of issues.

Ad Lucem Consulting has developed CHNA reports and Implementation Plans for hospitals including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies.

To learn more about Ad Lucem Consulting please visit www.adlucemconsulting.com.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary data

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

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

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

All secondary data cited in this CHNA report comes from the KP CHNA Data Platform. The KFH Modesto service area includes a large portion of Stanislaus County, making Stanislaus County data a good proxy for data for the Service Area.

Kaiser Permanente National Program Office identified 14 major health needs in the KP CHNA Data Platform. For each need, the data platform includes core and related indicators. Core indicators are a direct measure of the health need. Related indicators are upstream "drivers" that influence the potential health need. For example, in the Obesity/HEAL/Diabetes health need, overweight and obesity are core indicators and fruit and vegetable consumption and physical inactivity are related indicators.

Using the scoring rubric developed by Kaiser Permanente, core and related indicators were assigned a score of 0-2 depending on how the indicator benchmarked to the state average. A potential health need score was then calculated as the average of all point values assigned to both core and related indicators within the health need. The 14 potential health needs were ranked according to health need score.

Race and ethnicity data was reviewed for all health needs and indicators (when available). The number of groups experiencing disparities for each indicator was noted in the secondary data review process.

B. Community input

i. Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews, focus groups, and/or surveys. 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 B.

ii. Methodology for collection and interpretation

To obtain community members' perspectives on the most pressing health issues facing their communities, in-depth stakeholder interviews with community leaders and focus groups with community residents were conducted in August and September 2015. The goal of the interviews and focus groups was to supplement the findings from the secondary data in order to identify the priority health needs for KFH Modesto, the populations most impacted, and the community assets and resources available to address the health needs.

Stakeholder Interview Methodology
Ad Lucem Consulting conducted stakeholder interviews with seven individuals representing a diversity of sectors including: public health, community based organizations, safety net, education and government. The stakeholders were identified by Kaiser Permanente and Sutter Health Memorial Medical Center staff.

All interviews were conducted by telephone in English and took approximately 30-45 minutes to complete. The interviews followed a standard set of interview questions and the interviewer took detailed notes during the call. At the beginning of the interview, confidentiality was assured and the respondents were invited to skip any questions which were not applicable to the respondent's experience.

Interview topics: Interview questions were developed by Ad Lucem Consulting with input from KFH Modesto and SHMMC. For the complete list of interview questions, see Appendix C. Questions addressed the following topics:

1. Top three health issues in Stanislaus County
2. Factors that contribute to the top health issues
3. Impacts on specific populations (e.g. low income, racial/ethnic subpopulations)
4. Successful strategies and community assets to address top health issues
5. Opportunities and role for community and Kaiser Permanente to address top health issues

Data Analysis: Upon completion of each interview, responses were grouped by question and analyzed for common themes across all respondents. Data was then coded and a set of relevant themes selected. The codes were subsequently quantified and tallied for their presence in response to each question. The number of times each theme occurred was tabulated. The most prominent themes were identified and included in each relevant topic area in the Health Needs Profiles (see Appendix E) and used to inform both the identification and prioritization of health needs.

Focus Group Methodology

Ad Lucem Consulting conducted eight community resident focus groups in five different geographic areas within the KFH Modesto service area, including Ceres, Patterson, Turlock, Hughson and Modesto. Four groups were conducted in Spanish, three were conducted in English and one was conducted in Spanish and English. Participants were male and female adults who represented underserved, low-income, and varied ethnic communities. Population groups represented included Promotores, community service agency clients, and older adults.

Participants were recruited from communities throughout the KFH Modesto service area. Kaiser Permanente Central Valley and Sutter Health Memorial Medical Center staff recruited participants and organized logistics for the focus groups, including providing incentives and refreshments. Each focus group session averaged 90 minutes and was facilitated by Ad Lucem Consulting. All focus groups were recorded and the moderator or co-moderator took notes. Community resident participants were provided with a meal or snack and received a gift card in appreciation of their participation.

Focus group question guide: A focus group guide was used to ensure consistency across groups. The focus group questions were developed by Ad Lucem with input from KFH Modesto and Sutter Memorial. Questions were open-ended and additional probing questions were used as needed to elicit more in-depth responses and richer details. The questions were translated into Spanish by a native Spanish-speaker experienced in translation; the guide was modified slightly to maintain question flow and intent in Spanish. At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses and identity. An overview of the discussion was provided as well as a review of discussion ground rules, such as "there are no right or wrong answers." For the complete list of focus group questions, see Appendix D. Questions addressed the following topics:

1. Vision for a healthy community
2. Top three health issues in Stanislaus County
3. Factors that contribute to the top health issues
4. Successful strategies and community assets to address top health issues and resources needed
5. Opportunities to engage community members in creating a healthy community

Data Analysis: Audio recordings of the focus groups were transcribed verbatim by a professional transcription company. Responses were analyzed by key questions and themes were identified and coded across focus groups in a systematic manner. In reporting the results, care was taken to ensure that the views of the participants were voiced. The most prominent themes were identified and included in each relevant topic area in the Health Needs Profiles and used to inform both the identification and prioritization of health needs.

C. Written comments

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

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

D. Data limitations and information gaps

The Kaiser Permanente CHNA Data Platform, run by Community Commons 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.

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.

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

The following criteria were used to identify the community health needs for KFH Modesto:

- The health need fits the Kaiser Permanente definition of a "health need" as described above.
- The health need was confirmed by multiple data sources (i.e., the health need was identified in both secondary and primary data).
- Indicator(s) related to the health need performed poorly against a defined benchmark (e.g. state average).
- The community prioritized the health need. A health need was prioritized based on the frequency with which stakeholders and focus groups mentioned the need. A need was only included in the final list of health needs if at least three stakeholders and focus groups identified it as a need.

The following methods were used to identify the community health needs for KFH Modesto:

- A health needs identification table was developed which included all core and related indicators that benchmarked poorly to the state. Race and ethnicity data was reviewed (when available) to identify all indicators for which disparities existed. The number of groups experiencing disparities for a given indicator was noted and addressed during prioritization. Primary data was reviewed and health needs that were not mentioned in primary data collection were not included as a health need.

- AIDS/HIV/STD, maternal child health, climate and health, and oral health indicators performed poorly against state averages in secondary data, however they were not mentioned in primary data collection and therefore were not included as health needs for the KFH Modesto service area in this CHNA.

Nine health needs met the above criteria:

- Obesity/HEAL/Diabetes
- CVD/Stroke
- Mental Health
- Access to Care
- Economic Security
- Violence/Injury Prevention
- Asthma
- Cancers
- Substance Abuse/Tobacco

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

The following steps were taken to determine the preliminary ranking for prioritizing health needs:

- Step 1: A prioritization matrix (Table H) was developed with rows for each health need and columns listing health need scores for secondary data, primary data, and ethnic/racial disparities (based on secondary data).
- Step 2: A scoring rubric was applied to each data type (see tables I, J and K below) to calculate a numerical score for the data type.
- Step 3: Scores were averaged across data types for each health need to calculate an overall health need score.
- Step 5: Health needs were rank ordered by score.

Table H: Prioritization Matrix

Health Need	Secondary Data Score	Primary Data Score	Disparities Score	Average
1. HEAL, Obesity, Diabetes	1.04	1.73	2	1.59
2. CVD/Stroke	1.25	0.66	2	1.30
3. Mental Health	0.67	1.13	2	1.27
4. Access to Care	1.17	1.2	1	1.12
5. Economic Security	1	0.33	2	1.11
6. Violence/Injury Prevention	1.07	0.2	2	1.09
7. Asthma	1.33	0.73	1	1.02
8. Cancers	0.83	0.4	1	0.74
9. Substance abuse/Tobacco	0.67	0.46	0	0.38

Secondary Data scoring

Secondary data scores were taken from the Kaiser Permanente CHNA data platform. The health need score is the average of all point values assigned to both core and related indicators within the potential health need.

Table I: Secondary Data scoring

Health Need	Health Needs Score
HEAL, Obesity, Diabetes	1.04
CVD/Stroke	1.25
Mental Health	0.67
Access to Care	1.17
Economic Security	1
Violence/Injury Prevention	1.07
Asthma	1.33
Cancers	0.83
Substance Abuse/Tobacco	0.67

Primary Data scoring

In order to determine the relative importance of health needs according to the community input, a high, medium or low designation was applied to each of the health needs. A health need received a "high" designation if the stakeholder or focus group (as a whole) identified it as one of the top three health needs for KFH Modesto. A health need received a medium designation if it was mentioned but not identified as one of the top three health needs. A health need received a low designation if it was not mentioned by a stakeholder or a focus group. There were a total of 15 primary data sessions (seven stakeholder interviews and eight focus groups).

To calculate a primary data score for each health need, a point value was assigned to each of the designations as follows:

- High 2 Points
- Medium 1 Point
- Low 0 Points

Low scores were excluded from Table J because they received 0 points and did not impact the overall score.

To get an average score for a health need, the point values for the high and medium designations were calculated and summed and then averaged over the total number of stakeholders/focus groups.

Table J: Primary Data scoring

Health Need	High		Medium		Total Score	Average score (total score/15)
	# of sessions assigning a "High" designation	Points	# of sessions assigning a "Medium" designation	Points		

HEAL, Obesity, Diabetes	12	24	2	2	26	1.73
Mental Health	8	16	1	1	17	1.13
Access to Care	7	14	4	4	18	1.20
Violence/Injury Prevention	2	2	1	1	3	0.20
Substance Abuse/Tobacco	3	6	1	1	7	0.46
Economic Security	2	4	1	1	5	0.33
Asthma	2	4	7	7	11	0.73
Cancer	2	4	2	2	6	0.40
CVD/Stroke	3	6	4	4	10	0.66

Disparities scoring

The secondary data revealed that certain ethnic/racial groups had worse health outcomes when compared to the county overall. With the exception of Substance Abuse/Tobacco, all health needs had a least one core or related indicator where ethnic/racial disparity data was available. Because there were no disparities data available for Substance Abuse/Tobacco, that health need received a disparities score of zero, which may not accurately reflect true disparities. Disparities scores were assigned based on the number of ethnic/racial groups that had disparities for core and related indicators for each health need. This data is limited by availability of disparities data but it is important to consider ethnic/racial disparities during health need scoring as disparities paint a more detailed picture of the need in a community and how specific groups of people may be disproportionately impacted by certain health needs

Point values were assigned as follows:

- 0 = No disparities and/or no disparity data among any groups in core or related indicators
- 1 = One-two groups had disparities in at least one core or related indicator
- 2 = 3 or more groups had disparities in at least one core or related indicator

Table K: Disparities scoring

Health Need	Disparities Score
HEAL, Obesity, Diabetes	2
CVD/Stroke	2
Mental Health	2
Access to Care	1
Economic Security	2
Violence/Injury Prevention	2
Asthma	1
Cancers	1
Substance Abuse/Tobacco	0

Prioritization Process

A multi-voting method was used to prioritize the nine identified health needs as high, medium or low priorities. In addition to the prioritization matrix, participants were asked to consider the following criteria when prioritizing health needs:

- Severity of the issue
- Opportunity to intervene at the prevention level
- Existing resources dedicated to the issue
- Effective and feasible interventions exist

Participants in this process included the Sr. Vice President/Area Manager, Executive Consultant, Chief Nursing Officer, Quality Leader, Public Affairs Director, Human Resources Director, Chief Financial Officer, Continuum Administrator, Support Services Administrator, Compliance Officer, IT Director, Pharmacy Director and Area Director of Account Management.

Participants took part in two rounds of voting to prioritize the nine health needs. For the first round, all nine health needs were listed and participants voted for their top three priority health needs. The three needs that received the most votes were identified as high priority health needs. The same voting process was used for round two: participants voted for their top three priority health needs among the remaining six health needs. The three health needs that received the most votes were identified as medium priority health needs. The remaining three needs were identified as low priority health needs.

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

As a result of this prioritization process, the health needs were grouped into high, medium, and low priority. (Detailed profiles of each health need are found in Appendix E.)

High priority

- **Obesity/HEAL/Diabetes**: A lifestyle that includes eating healthy and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly and life-threatening health outcomes such as obesity, diabetes, cardiovascular disease, and strokes. Obesity rates, diabetes prevalence and related hospitalizations were higher in Stanislaus County as compared to the state. Obesity was the most frequently cited health concern among stakeholders and focus groups. Lack of access to healthy food and safe places for physical activity were frequently mentioned as barriers in primary data and confirmed by secondary data.
- **Mental Health**: Mental health and well-being is essential to living a meaningful and productive life. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Access to mental health providers is limited in Stanislaus County. Compared to the state average of 157 mental health providers per 100,000 population, in Stanislaus County there are 61.9 providers per 100,000 population. Primary data described that low- income individuals are particularly impacted by high levels of stress due to lack of employment, education and housing opportunities. Non-Hispanic White, Asian, and Native Hawaiian/Pacific Islander populations in Stanislaus county are disproportionately affected by suicide.
- **Access to care:** Access to high quality, culturally competent, affordable healthcare and health services are essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. In Stanislaus County, residents have less access to dentists, primary care providers and mental health providers as compared to the

state. Secondary data revealed that health care access is a particular concern for low-income populations and those without health insurance. Lack of transportation, long wait times, difficulty scheduling appointments, language issues, and poor quality of care were frequently discussed by stakeholders and in the focus groups.

Medium priority

- **CVD/Stroke:** In the United States, cardiovascular disease is the leading cause of death and strokes are the third leading cause of death. These diseases can be prevented and managed through early adoption of healthy behaviors including physical activity, not smoking, and healthy eating. The rate of heart disease and stroke mortality in Stanislaus County is higher than the state average. Ethnic/racial groups are disproportionately affected by heart disease and stroke; non-Hispanic blacks have over twice the prevalence of heart disease as compared to the county. Lack of access to safe parks, low cost exercise opportunities, and high rates of obesity and overweight were frequently cited as contributing factors by stakeholders and in the focus groups.
- **Economic Security:** Economic security contributes to good health. It facilitates access to healthcare services, healthy eating, and other factors that play a role in overall wellbeing. Stanislaus County benchmarks poorly compared to the state on all economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black, Native American/Alaska Native and Hispanic/Latino populations are among those most impacted by poverty. Homelessness, lack of employment, food insecurity and poor educational attainment are connected with economic security and were mentioned as important issues by stakeholders and in the focus groups.
- **Cancers**: Screening and early treatment of cancers saves and prolongs lives. Additionally, preventive measures and reducing behavioral risk factors (e.g., obesity, physical inactivity, smoking, and UV light exposure) can be effective at reducing the incidence of cancer. Overall cancer mortality is greater in Stanislaus County, and colon/rectum and lung cancer incidence rates are greater in Stanislaus County as compared to the state. Whites are disproportionately impacted by lung cancer. Obesity, physical inactivity and poor air quality were identified by stakeholders and in the focus groups as contributors to cancer.

Low priority

- **Asthma:** Prevention and management of asthma by reducing exposures to triggers such as tobacco smoke and poor air quality, improves quality of life and productivity as well as reduces the cost of care. Asthma prevalence and the hospitalization rate are greater in Stanislaus County than in the state. Many stakeholders agreed that asthma was a major health concern.
- **Substance Abuse/Tobacco:** Reducing tobacco use and treating/reducing substance abuse improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Tobacco usage is higher in Stanislaus County than the state. The prevalence of drugs in local parks, particularly among the homeless population, was frequently mentioned in primary data, as was the intersection of substance abuse, poverty and mental illness.
- **Violence/Injury Prevention:** Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Ethnic/racial groups are disproportionately affected by violence/injury; the homicide rate for blacks is over three times the rate for the county. Unsafe parks, homelessness, drugs and stray dogs were frequently mentioned in primary data as barriers to safety.

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

i. Community resources

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
2-1-1	X	X	X	X	X	X	X	X	X
American Diabetes Association	X							X	
American Cancer Society									X
American Red Cross		X							
Behavioral Health and Recovery Services, Stanislaus County			X			X	X		
Boys and Girls Club	X		X			X	X		
CareMore exercise facilities	X							X	
Catholic Charities		X			X				
Center for Human Services	X		X					X	X
Church food banks	X				X			X	X
Community Hospice, Inc.			X						
Community Housing & Shelter Services	X	X	X		X				
Community Services Agency	X	X	X	X	X	X	X	X	
Disability Resource Agency for Independent Living		X	X						
El Concilio	X	X			X				
Family Resource Centers	X	X	X		X	X	X	X	X
The First Tee	X		X						

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Central Valley									
Food Banks	X				X			X	X
Haven's Women's Center of Stanislaus		X	X			X			
Healthy Aging Association	X	X		X				X	
Healthy Start Program	X	X	X	X	X	X	X		
Inter-Faith Ministries		X	X			X			
Mancini Senior Center	X		X					X	X
Parent Institute for Quality Education		X							
Parents United Inc.		X							
Salvation Army Modesto Corps		X	X			X			
Salvation Army Red Shield Center		X	X			X			
Salvation Army Turlock corps		X	X			X			
Second Harvest Food Bank	X				X				
Senior Citizens Center Modesto	X		X					X	X
Sierra Vista Child & Family Services	X	X	X			X			
STANCO Affordable Housing Corporation		X			X				
Stanislaus Literacy Center		X							

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
St. Vincent de Paul Society			X		X	X			
West Modesto King Kennedy Neighborhood collaborative	X	X	X		X				
United Samaritans Foundation	X	X							
United Way of Stanislaus County	X	X	X	X	X	X		X	X

ii. Health Care Facilities

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Doctor's Medical Center	X	X	X	X		X	X	X	X
Emanuel Medical Center, Inc.	X	X	X	X		X		X	X
Golden Valley Health Center – Corner of Hope	X	X	X	X		X		X	X
Golden Valley Health Center – Florida Suites	X	X	X	X	X	X		X	X
Golden Valley Health Center – Hanshaw School	X	X	X	X	X	X		X	X
Golden Valley Health Center – Robertson Road School	X	X	X	X	X	X		X	X
Golden Valley Health Center – Tenaya	X	X	X	X	X	X		X	X
Golden Valley Health Center – Patterson	X	X	X	X	X	X		X	X
Golden Valley Health Center – Riverbank	X	X	X	X	X	X		X	X
Golden Valley	X	X	X	X	X	X		X	X

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Health Center – Turlock									
Golden Valley Health Center – West Turlock	X	X	X	X	X	X		X	X
Golden Valley Health Center – Westley	X	X	X	X	X	X		X	X
Golden Valley Health Center - Ceres	X	X	X	X	X	X		X	X
Golden Valley Health Center - Newman	X	X	X	X	X	X		X	X
Golden Valley Health Center – West Modesto	X	X	X	X	X	X		X	X
Health Services Agency – Administrative Offices				X		X		X	
Health Services Agency - McHenry Medical Office		X							
Health Services Agency - Paradise Medical Office Urgent Care – Valley Family Medicine Residency of Modesto		X							
Health Services Agency - Pediatric		X							
Kaiser Permanente Modesto Medical Center	X	X	X	x		X		X	X
Memorial Medical Center	X	X	X	X		X	X	X	X
Oak Valley District Hospital	X	X	X	X		X		X	X
Stanislaus Surgical Hospital		X							

VII. KFH MODESTO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH Modesto'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 Modesto's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH Modesto in the 2013 Implementation Strategy Report.

1. Obesity/Diabetes
2. Health Access
3. Broader Health Care System Needs in Our Communities (Workforce & Research)

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

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

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

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:
    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

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

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

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH Modesto awarded 67 grants totaling $1,207,148 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 Modesto service area. During 2014-2015, a portion of money managed by this foundation was used to award 32 grants totaling $397,373 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 Modesto 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 Modesto engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: OBESITY/DIABETES

Long Term Goal:

- Reduce obesity/diabetes among at-risk population, particularly among low-income youth and families

Intermediate Goals:

- Increase food security and access to healthy food and decrease access to unhealthy food
- Increase nutrition awareness and knowledge and adoption of healthy eating practices
- Increase access to physical activity environments and opportunities in schools
- Increase knowledge and adoption of physical behavior

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 30 active KFH grants totaling $446,797 addressing Obesity/Diabetes in the KFH-Modesto service area.[1] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling $84,881 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Healthy Aging Association	$80,000 over 2 years $40,000 in 2014 & 2015	Young at Heart, a strength training, exercise, health, and nutrition education program, will increase knowledge and adoption of physical behavior.	To date, Young at Heart has served 1,477 individuals age 50+ in exercise classes 2-3 times/week, trained 37 seniors in fall prevention classes and provided 200 Green Bags – 10lbs of fresh fruits and vegetables to low-income seniors monthly. By improving Young at Heart's integrated nutrition education and fall prevention program, the goal is that 1,600 individuals age 50+ will reduce their chronic disease conditions.
Parent Resource Center	$61,476 $30,738 in 2014 & 2015	Heroes for Health focuses on nutrition education, healthy eating practices, hands-on activities, and physical activity to reduce obesity among at-risk populations.	345 low-income families with children will participate in this series, which focuses on nutrition education, healthy eating practices, hands-on activities, and physical activity.
Second Harvest Food Bank	$55,000 over 2 years $25,000 in 2015 (2 grants) $30,000 in 2014 (2 grants)	Grant will increase nutrition awareness and knowledge of healthy eating practices while meeting basic food needs. Food for Thought program aims to increase food security and healthy food access for low-income youth.	The Food 4 Thought Program is provided at 39 after-school program sites in San Joaquin and Stanislaus Counties and reached 3,887 children with supplemental groceries and weekly after-school physical activity programs. The goal for remaining funding is that an additional 3,860 low-income youth will participate in afterschool

[1] 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.

			programs and will receive healthy food, including fresh fruits and vegetables, on a weekly basis.
United Samaritans Foundation	$60,000 over 2 years $30,000	The agency’s food program will increase food security and access to healthy food and nutrition information.	Over 800,000 meals individuals will be served by their four mobile lunch trucks food boxes. 70% of meals will include fresh fruits and vegetables.
United Way of Stanislaus County	$65,000 over 2 years	Funding supported a United Way health initiative that encourages agencies to collaborate to leverage funding and resources to raise nutrition awareness and promote the adoption of healthy eating policies. It also supported efforts to reduce obesity and diabetes rates among at-risk populations, particularly low-income youth and families.	Over 1000 students have received bi-weekly food bags that had 50-75% fresh foods. Over 500 caregivers participated in cooking and nutrition classes.
West Modesto King Kennedy Neighborhood Collaborative	$35,000	Program will target low-income youth and families to reduce obesity and diabetes rates.	The goal is that 120 youth and families will participate in Boys & Girls Club West Modesto where they will increase their knowledge of healthy eating and active living.
*Center for Collaborative Solutions (CCS)	$90,000	CCS will implement its nationally recognized Healthy Behaviors Initiative (HBI) at five multi-site afterschool programs in targeted school districts in San Joaquin and Stanislaus counties. HBI fundamentally changes afterschool programs by intentionally changing their program policies and design so that children and families learn and practice healthy eating and physical activity behaviors	Expected reach is 2,500 people and expected outcomes include: • five after-school programs in targeted Thriving Schools districts adopt Exemplary Practices designed to increase quality physical activity and nutrition education programs/practices • afterschool program staff are trained as role models to promote healthy behaviors • students’ food security needs are met through increased participation in school meal programs and referring families\’ to food security resources • regional learning centers are established to ensure sustainability of these practices
Modesto City Schools	$250,000 over 2 years	Modesto City Schools will partner with Boys and Girls Club of Stanislaus and the West Modesto King Kennedy Neighborhood Collaborative to implement a Triple Play after-school program that promotes physical	Outcomes include: • Triple Play participants will increase consumption of fruits and vegetables and decrease consumption of foods with limited nutrition

		activity, healthy eating, and positive social interaction for West Modesto youth.	• Participants will increase physical activity to the federally recommended guideline of 60 minutes per day • Participants will understand the relationship between behaviors (choices) and health and increase their ability to interact positively with other youth and adults in school and at home.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Modesto City Schools	Support Healthy Behaviors Initiative launch running clubs at five school sites by providing 550 water bottles to help students increase their consumption of water. In addition, Kaiser Permanente Educational Theater offered a *The Best Me* performance to encourage healthy eating and active lifestyles at Catherine Everett, El Vista, and Orville Wright elementary schools.
Sylvan Union School District	Kaiser Permanente Educational Theater offered a *The Best Me* performance to encourage healthy eating and active lifestyles at Coleman F. Brown and Sylvan elementary schools.
Salida Union School District	Kaiser Permanente Educational Theater offered a *The Best Me* performance to encourage healthy eating and active lifestyles at Sisk Elementary School.

PRIORITY HEALTH NEED II: HEALTH ACCESS

Long Term Goal:
- Increase the number of people who have access to health care and preventive services, particularly underinsured children, youth, and families

Intermediate Goal:
- Reduce barriers to health insurance enrollment and increase health care coverage for underinsured children, youth, and families
- Develop systems that increase access to and utilization of available health care services
- Develop a trained and culturally competent workforce to provide preventive and primary care services

KFH-Administered Program Highlights		
KFH Program Name	**KFH Program Description**	**Results to Date**
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 34 Medi-Cal members* • *2015: 38 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is	• *2014: KFH - Dollars Awarded By Hospital -$1,867,178* • *2014: 976 applications approved*

	based on prescribed levels of income and expenses.	• *2015:KFH - Dollars Awarded By Hospital - $1,018,838* • *2015: 1,184 applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 4,347 members receiving CHC* • *2015: 4,047 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 28 active KFH grants totaling $726,988 addressing Access to Care in the KFH-Modesto service area.[2] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 16 grants totaling $250,780 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Planned Parenthood Mar Monte-Sacramento	$40,000 over 2 years	The Improving Women's Health project will increase the number of San Joaquin County residents, particularly underinsured children, youth, and families, who have access to health care and preventive services.	The project aims to reduce barriers to health insurance enrollment and increase health care coverage. Two Community peer educators were trained to assist in outreach efforts; 560 women increased knowledge of and access to preventive health care services, especially women's reproductive health care through Family PACT program.
The Salvation Army	$40,000 in 2014	Uninsured and homeless clients at The Salvation Army Berberian Homeless Shelter and Transitional Living Center will have access to free health services at The Salvation Army Collaborative Health Clinic.	44 clients received optical exams and 29 clients received dental exams, X-rays and services.
Sierra Vista Child & Family Services	$200,000 over 2 years (5 grants)	Funding has supported several programs including: • SierraWest Modesto Mental Health Services (MHS) program will increase the number of people who have access to direct mental health care services. • Bridge South-East Asian Outreach (BSEAO) will provide preventive health care information and wellness programs, including culturally competent consumer-	• The MHS program reached 160 individuals and provided mental health counseling and 400 individuals received case management services. • BSEAO reached 550 South East Asian immigrants who received outreach, medical interpreting, and case management services • NCSS reached 4,000 individuals who increased knowledge of mental health

[2] 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.

		centered case management services and mental health outreach. • Neighborhood Connections for Southeast Stanislaus (NCSS) increase the number of people who have access to direct mental health care services and participant in insurance enrollment program.	services, 160 received services, and 100 actively participated in individual counseling.
United Way of the Stanislaus Area	$130,000 over 2 years (3 grants)	Supports Stanislaus County 2-1-1, which makes referrals to health care and social services for Stanislaus County residents, to increase access.	20,048 callers had access to health and human services program information 24/7/365. Callers will learn how to get health care, preventive, and human services through information and referrals. 47.4 % of callers who were contacted through a follow-up reported having their needs met after calling Stanislaus County 2-1-1.
Golden Valley Health Centers	$40,000 in 2014	Program will increase access to health care and preventive services for uninsured children, youth, and families by reducing barriers to health insurance enrollment.	8,344 people were reached and informed of services and coverage options available to them to improve access to health care. From those, 635 applications were submitted to enroll 1,143 individuals in Medi-Cal and/or a Covered CA Qualified Health Plan.

PRIORITY HEALTH NEED III: 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 9 Workforce Development grants totaling $33,363 that served the KFH-Modesto service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $30,370 that address this need. In addition, KFH Modesto provided trainings and education for 34 residents in their Graduate Medical Education program in 2014 and 22 residents in 2015, 1 nurse practitioners or other nursing beneficiaries in 2014 and 5 in 2015, and 58 other health (non-MD) beneficiaries as well as internships for 33 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

[3] 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.

Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
*The Regents of the University of California	$75,000	UC Berkeley's Health Careers Opportunity Program (HCOP) aims to diversify the health professions workforce by working directly with 600 students from underrepresented groups through direct student counseling at UC Berkeley, through visits and outreach to local community colleges, and through the Public Health and Primary Care, a UC Berkeley class taught by HCOP staff.	• 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, HCOP served nine Summer Scholars (underrepresented students) • eight other students enrolled in and completed Kaplan's GRE preparation course
*Vision Y Compromiso	$98,093	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities • increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks
UCSF Fresno Health Careers Opportunity Program	$50,000 This grant impacts three KFH hospital service areas in Northern California Region.	This Kaiser Permanente Northern California Region grant supports HCOP (Healthy Careers Opportunity Program), which addresses the shortage of health professionals in the Central Valley by providing an educational pipeline for qualified disadvantaged California State University, Fresno students who are interested in pursuing a health professional career.	It is expected that 95 HCOP students will receive at least two individual advising sessions per semester to help them select the required health professions courses and to assess their academic performance. They will have access to tutoring services for core courses in math and science. Upper division HCOP students will visit UCSF's Medicine, Dentistry, and Pharmacy schools to learn about admissions and financial aid and gain a better understanding of program requirements.

<table>
<tr><th colspan="4">PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH</th></tr>
<tr><th colspan="4">KFH Research Highlights</th></tr>
<tr><td colspan="4">Long Term Goal:
• To increase awareness of the changing health needs of diverse communities</td></tr>
<tr><td colspan="4">Intermediate Goal:
• Increase access to, and the availability of, relevant public health and clinical care data and research</td></tr>
<tr><th colspan="4">Grant Highlights</th></tr>
<tr><th>Grantee</th><th>Grant Amount</th><th>Project Description</th><th>Results to Date</th></tr>
<tr><td>UCLA Center for Health Policy Research</td><td>$2,100,000 over 4 years

1,158,200 over 2014 & 2015

This grant impacts all KFH hospital service areas in Northern California Region.</td><td>Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.</td><td>CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews.

In addition, funding has supported the AskCHIS NE tool which has allowed the Center to:
• Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology.
• Develop and deploy AskCHIS NE.
• Launch and market AskCHIS NE.
• Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.</td></tr>
</table>

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

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and

public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

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

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

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

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

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

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

VIII. APPENDICES

A. Secondary Data Sources and Dates

B. Community Input Tracking Form

C. Stakeholder Interview Questions

D. Focus Group Interview Questions

E. Health Need Profiles

A. 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. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
26. Environmental Protection Agency, EPA Smart Location Database. 2011.
27. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
28. Feeding America. 2012.
29. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
30. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
31. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
32. New America Foundation, Federal Education Budget Project. 2011.
33. Nielsen, Nielsen Site Reports. 2014.
34. Public Policy Institute of California, Unauthorized Immigrants in California: Estimates for Counties. 2011.

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 Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
39. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
40. US Census Bureau, American Community Survey. 2009-2013.
41. US Census Bureau, American Housing Survey. 2011, 2013.
42. US Census Bureau, County Business Patterns. 2011.
43. US Census Bureau, County Business Patterns. 2012.
44. US Census Bureau, County Business Patterns. 2013.
45. US Census Bureau, Decennial Census. 2000-2010.
46. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
47. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
48. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
49. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
50. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
51. US Department of Education, EDFacts. 2011-2012.
52. US Department of Health & Human Services, Administration for Children and Families. 2014.
53. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
54. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
55. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
56. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
57. US Department of Housing and Urban Development. 2013.
58. US Department of Labor, Bureau of Labor Statistics. June 2015.
59. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
60. US Drought Monitor. 2012-2014

B. APPENDIX B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Number of participants**	**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1	*Key Informant Interview*	Public Health Officer, Stanislaus County Health Services Agency	*1*	*Health Department representative*	*Leader*	*8/25/15*
2	*Key Informant Interview*	Chief Executive Officer, United Way of Stanislaus County	*1*	*Community Based Organization representative*	*Leader*	*8/24/15*
3	*Key Informant Interview*	Director of Patient Education, Golden Valley Health Centers	*1*	Minority, Medically underserved, low income	Leader	9/3/15
4	*Key Informant Interview*	Executive Director, Center for Human Services	*1*	Minority, Medically underserved, low income	Leader	8/26/15
5	*Key Informant Interview*	Director of Student Support Services, Stanislaus County Office of Education	*1*	Education representative	Leader	8/24/15
6	*Key Informant Interview*	Community Development and Empowerment Manager, Stanislaus County	*1*	County representative	Leader	9/17/15
7	*Key Informant Interview*	Chief Executive Officer, Stanislaus County	*1*	County representative	Leader	9/17/15
8	*Key Informant Interview*	Clinical Director, Sierra Vista Child & Family Services	*1*	Medically underserved, low income	Leader	8/26/15
9	*Focus Group*	Ceres Promotores focus group in Spanish (all female)	16	Minority, medically underserved, low income	Members	8/25/15

10	Focus Group	Modesto/King Kennedy Center community advocates focus group in English	7	Minority, medically underserved, low income	Representatives and Members	8/28/15
11	Focus Group	Senior Health focus group in English	9	Minority, medically underserved, low income	Representatives and Members	8/28/15
12	Focus Group	Patterson Promotores focus group in Spanish	11	Minority, medically underserved, low income	Members	9/1/15
13	Focus Group	Turlock Promotores focus group in Spanish (all female)	10	Minority, medically underserved, low income	Members	9/9/15
14	Focus Group	Hughson Family Resource Center focus group in Spanish	9	Minority, medically underserved, low income	Members	9/10/15
15	Focus Group	Salvation Army focus group in English and Spanish	6	Minority, medically underserved, low income	Representatives and Members	9/11/15
16	Focus Group	Young at Heart Exercise older adult focus group in English	7	Medically underserved, low income	Representatives and Members	9/18/15

C. APPENDIX C: Stakeholder Interview Questions

1. What are Stanislaus County's 3 most critical health issues? Why are these the top priorities?
2. Starting with (health issue #1), what are the factors that contribute to making this a priority?
3. How do the health issues you've identified specifically impact low income, underserved/uninsured populations? Which populations do the issues impact most?
4. How do the health issues you've identified impact ethnic/racial subpopulations? Which populations do the issues impact most?
5. Based on your knowledge and expertise, what are the successful strategies that could be implemented to address the top 3 health issues you have identified? What are some of the challenges to addressing the health issues?
6. What assets and services are available in Stanislaus County to address the top health issues?
7. Beyond the 3 top health issues you've identified, are there any other health issues that you think are also important to address?
8. What are your suggestions for ways to engage community members, particularly low income, underserved/uninsured populations and ethnic/racial subpopulations, in addressing the health issues?
9. What role can Kaiser Permanente Central Valley and Sutter Health Memorial Medical Center play in addressing the health issues?
10. Is there anything else you would like to share about the top health issues in Stanislaus County and how to address the issues?

D. APPENDIX D: Focus Group Interview Questions

1. Please describe for me your idea of what a healthy community looks like.

2. Now think about how your community is right now. What is healthy about your community?
    i. What makes it easy to be healthy in your community?

3. What makes it difficult to be healthy in your community?

4. In 2013, we asked community members to describe the top health issues in the community. Asthma, obesity/overweight/diabetes and access to care came up as top health issues facing your community. How important do you think these issues are today?
    i. What other health issues are important?
    ii. Of all the health issues we've discussed what would you say are three most urgent ones?

5. What are the top three things that could be done to make your community healthier?
    i. For each of these, what are some successful ways to address them that you've seen either in your community or other communities you know about?
    ii. If you haven't seen or heard about things that have been successful, do you have any ideas for ways to make your community healthier?

6. What are some organizations, services or resources in your community that help people to be healthy?
    i. How do these organizations, services or resources help people to be healthy?
    ii. What does the County/your community need in terms of health (services, programs, etc.) that does not currently exist in the community?

7. What do you recommend as the best ways to get people in your community involved in making your community healthier? Please be specific.
    i. What are the challenges to engaging people in your community
    ii. How can these challenges be overcome?

8. We're just about ready to wrap up. Is there anything else you feel is important for us to know about health in your community?

E. APPENDIX E: Health Need Profiles

HEALTH NEEDS

Obesity/Healthy Eating Active Living/Diabetes
Access to Care
Economic Security
Mental Health
Asthma
Cardiovascular Disease/Stroke
Cancers
Substance Abuse/Tobacco
Violence/Injury Prevention

HEALTH NEED CRITERIA

1. Meets the KP definition of a health need (either a poor health outcome and its associated driver or a health driver that is associated with a poor health outcome that hasn't yet itself arisen as a need).
2. The health need is confirmed by multiple data sources.
3. Indicator(s) related to the health need perform(s) poorly against a state benchmark.

NOTES:
Disparities were drawn from core indicators that had race and ethnicity data available on CHNA.org/KP. Other disparities may exist but are not included due to data gaps.
Contributing factors were drawn from related indicators on CHNA.org/kp. Other evidence-based contributing factors may exist but are not included due to data gaps.
Racial/ethnic disparities are highlighted in red. Unlike the indicators, which benchmark to the state, the racial/ethnic disparities benchmark to the county.
Additional indicators for each health need can be found on CHNA.org/kp. The indicators listed below are only those that benchmark poorly to the state.

* 1-2% difference from benchmark for Stanislaus County
** > 2% difference from benchmark for Stanislaus County

Obesity/Healthy Eating Active Living (HEAL)/Diabetes

RATIONALE

A healthy lifestyle that includes eating healthy and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly health outcomes such as obesity, diabetes, cardiovascular disease, and strokes.

Rates of obesity are high in Stanislaus County when compared to state benchmarks. Adults have an obesity rate that is 10% greater than the state average. Diabetes prevalence and related hospitalizations in Stanislaus County are also greater than the State average. Stanislaus County benchmarks poorly on many of the related indicators contributing to high obesity rates, including fruit and vegetable consumption among youth, physical inactivity among youth and adults, breastfeeding, and access to parks. Many racial/ethnic groups including, non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic other and Hispanic/Latino have lower rates of exclusive breastfeeding when compared to the county. Additionally, stakeholders and focus group participants frequently identified Obesity/Healthy Eating Active Living (HEAL)/Diabetes as the top health issue in Stanislaus County.

HEALTH OUTCOMES

INDICATORS [STANISLAUS COUNTY// BENCHMARK]

Indicator	[Stanislaus County // Benchmark]
Overweight (Youth)*	[20.37% // 19.30%]
Multiple race**	[38.35% // 20.37%]
Obesity (Youth)**	[21.99% // 18.99%]
Obesity (Adult)**	[32.20% // 22.30%]
Diabetes Prevalence*	[9.10% // 8.05%]
Diabetes Hospitalizations**	[10.40 // 14.35]

CONTRIBUTING FACTORS

Fruit and Vegetable Consumption (Youth)**
Physical Inactivity (Adult)*
Physical Inactivity (Youth)**
Non-Hispanic Multiple Races, Hispanic/Latino
Park Access**
Recreation and Fitness Facility Access*
Breastfeeding (Any)**
Non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic Other
Breastfeeding (Exclusive)
Non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic Other, Hispanic/Latino
Food Insecurity*
Drinking water safety**
Walk/bike to work*
Commute alone in car**
Walk/bike to school**

PRIMARY DATA: Obesity/HEAL/Diabetes was the most frequently cited health concern, with 80% of stakeholders and focus groups identifying it as a top health need. Lack of accessible, affordable healthy food and safe places for physical activity were frequently cited as barriers. Many focus group participants indicated that the parks in the community are unsafe and not well maintained. Additionally, lack of sidewalks, poor lighting and stray dogs made walking outside feel unsafe. Respondents also cited a high prevalence of fast food restaurants.

ETHNIC/RACIAL DISPARITIES:	Overweight disproportionately affects youth of multiple races. Many racial/ethnic groups including, non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic other and Hispanic/Latino have lower rates of exclusive breastfeeding when compared to the county. Additionally, Hispanic/Latino youth and non-Hispanic multiple race youth are more physically inactive than youth in the rest of the county.

Access to Care

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]		CONTRIBUTING FACTORS
Access to high quality, culturally competent, affordable healthcare and health services that provide a coordinated system of community care is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable.			
Compared to State benchmarks, residents in Stanislaus County have less access to dentists, primary care providers and mental health providers. Stanislaus County residents are also less likely to have a consistent source of primary care when compared to the State. The lack of mental health providers is particularly acute with a rate of 61.9 per 100,000 population compared to the state average of 157 per 100,000 population. Stakeholders and focus groups consistently cited lack of access to services as a major need. Low income populations and those without insurance are disproportionately impacted. Accessibility of existing services is a major concern among residents.	Access to Dentists** Access to Primary Care** Lack of Consistent Source of Primary Care** Non-Hispanic Other* Hispanic/Latino** Access to Mental Health Providers**	[58 // 77.5] [67.9 // 77.2] [18.40% // 14.30%] [19.57% // 18.40%] [21.46% // 18.40%] [61.9 // 157]	Health Professional Shortage Area - Primary Care** Preventable Hospital Events** Insurance - Population Receiving Medicaid** Cancer Screening - Pap Test** Uninsured population Some Other Race, Hispanic/Latino
PRIMARY DATA:	Lack of access to health care services was frequently cited as a top health issue in stakeholder interviews and focus groups. Health access was perceived as a particular concern for low-income populations and those without health insurance. Lack of transportation was the most commonly cited factor. In addition to transportation barriers, long wait times, difficulty scheduling appointments and language barriers were also frequently mentioned. Many focus group respondents felt the quality of care was poor, especially for the uninsured and low-income.		
ETHNIC/RACIAL DISPARITIES:	The percent of Hispanic/Latino adults who lack a consistent source of primary care is greater than other ethnic/racial groups in Stanislaus County. Hispanic/Latino populations are also more likely to be uninsured than other ethnic/racial groups in the county.		

Economic Security

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Economic security contributes to good health. It facilitates access to healthcare services, eating healthier, and other necessities that play a role in overall wellbeing. Poverty impacts Stanislaus County residents as a whole, and certain ethnic/racial groups, in particular. As a whole, Stanislaus County has a greater percentage of adults living below 100% Federal Poverty Level (FPL) and 200% FPL. Stanislaus County also has more children living below 100% FPL and a greater unemployment rate as compared to the State. Many ethnic/racial groups are disproportionately impacted by poverty. Black, Native American/Alaska Native and Hispanic/Latino populations are among those most impacted by poverty. Economic Security was mentioned as both a health need and a driver of other health needs by stakeholders. Other drivers of health, including education and insurance are closely related to economic security and benchmark poorly compared to the state.	Economic Security - Unemployment Rate** [11.1 //7.9] Poverty - Population Below 100% FPL** [20.34%//15.94%] Black** [33.18%//20.34%] Native American/Alaskan Native** [31.88%//20.34%] Native Hawaiian/Pacific Islander** [28.98%//20.34%] Some other race ** [29.74%//20.34%] Hispanic/Latino** [27.98%//20.34%] Poverty - Population Below 200% FPL** [43.81% //35.91%] Poverty - Children Below 100% FPL** [28.40%//22.15%] Black** [46.18%//28.40%] Native American/Alaskan Native** [48.47%//28.40%] Native Hawaiian/Pacific Islander** [49.79%//28.40%] Some other race** [36.90%//28.40%] Hispanic/Latino** [35.84%//28.40%]	Education - Reading Below Proficiency** Children Eligible for Free/Reduced Price Lunch** Food Security - Population Receiving SNAP** Insurance - Population Receiving Medicaid** Education - Less than High School Diploma (or Equivalent)** Some other race, Hispanic/Latino Education - School Enrollment Age 3-4** Food Security - Food Insecurity Rate** Education - High School Graduation Rate Non-Hispanic Black, Hispanic/Latino Insurance - Uninsured Population Some other race, Hispanic/Latino

PRIMARY DATA:	Economic security was mentioned both as a health need and as a driver of other health needs in the stakeholder interviews. Homelessness, lack of employment opportunities, food insecurity and poor educational attainment are all factors connected with economic security. Respondents said that poverty primarily impacts Hispanic/Latino and African American populations. While no focus group participants identified economic security as a health need, it was frequently mentioned as a driver of other health needs, in particular around healthy food access and access to health services.
ETHNIC/RACIAL DISPARITIES:	Not only does Stanislaus County benchmark poorly on all economic security indicators, there are a significant number of ethnic/racial disparities within the county. Five ethnic/racial groups are disproportionately represented in the population living below 100% FPL and children living below 100% FPL. Black, Native American/Alaska Native and Hispanic/Latino populations are those most impacted by poverty.

Mental Health

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Mental health and well-being is essential to living a meaningful and productive life. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. In Stanislaus County, access to mental health providers is limited. Compared to the state average of 157 mental health providers per 100,000 population in Stanislaus County there are 61.9 providers per 100,000 population. Lack of mental health services was a common theme in stakeholder interviews and focus groups. Suicide rates are higher for non-Hispanic whites, Asians and Native Hawaiian/Pacific Islanders than the rest of the County. In particular, Native Hawaiian/Pacific Islanders are disproportionately impacted by suicide when compared to all other ethnic/racial groups in the county.	Access to Mental Health Providers** [61.9 // 157] Mental Health- Needing Mental Health Care** [26.50% // 15.90%] Non-Hispanic Black* [27.80% // 26.50%] Non-Hispanic Other** [43.10% // 26.50%] Suicide [10.7 // 9.8] Non-Hispanic white** [14.0 // 10.7] American Indian/Alaskan Native** [14.27 // 10.7] Native Hawaiian/Pacific Islander** [24.3 // 10.7]	
PRIMARY DATA:	Lack of access to mental health services was mentioned in stakeholder interviews and focus groups as a major barrier to well-being. Respondents also cited a lack of knowledge of existing mental health services and stigma in seeking care. Substance abuse and homelessness were frequently mentioned as co-occurring conditions. Respondents said that low income individuals experience more stress because of lack of employment, education and housing opportunities.	
ETHNIC/RACIAL DISPARITIES:	Non-Hispanic White, Asian and Native Hawaiian/Pacific Islander populations have a greater rate of suicide than the county as a whole. Native Hawaiian/Pacific Islanders are more than twice as likely to die by suicide than the general population in Stanislaus County. A greater percentage of Non-Hispanic Other population needs mental health care as compared to the other ethnic/racial groups in Stanislaus County.	

Asthma

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]		CONTRIBUTING FACTORS
Prevention and management of asthma by reducing exposures to triggers and other risk factors that increase the severity of asthma, such as tobacco smoke and poor air quality, improves quality of life and productivity as well as reduces the cost of care. Asthma is more prevalent in Stanislaus County than the state. 16.9% of adults reported having asthma in Stanislaus County as compared to 14.2% for the state. Poor air quality, tobacco usage and obesity and overweight are all related indicators that impact asthma prevalence and hospitalizations. Many stakeholders agreed that asthma was a major health concern in the county.	Asthma - Prevalence** Asthma - Hospitalizations*	[16.90% // 14.20%] [10.85 // 8.90]	Tobacco Usage** Air Quality - Particulate Matter 2.5** Obesity (Adult)** Obesity (Youth)** Overweight (Youth)* Multiple races
PRIMARY DATA:	When asked if asthma was a major health concern, many stakeholders agreed. Poor air quality, agricultural pollution, and allergies were commonly mentioned as factors contributing to asthma. Respondents mentioned that low income neighborhoods are more impacted by agricultural pollution and the impacts of dust.		
ETHNIC/RACIAL DISPARITIES:	Ethnic/racial disparity data was unavailable in the KP data platform for the core asthma indicators. Focus group participants indicated that low-income neighborhoods were particularly impacted by asthma triggers including agricultural pollution and dust.		

Cardiovascular Disease/Stroke

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]	CONTRIBUTING FACTORS
In the United States, cardiovascular disease is the leading cause of death and strokes are the third leading cause of death. These diseases can be prevented and managed through early adoption of preventative measures and a lifestyle that includes physical activity, not smoking, and healthy eating. There is a higher rate of heart disease and stroke mortality in Stanislaus County as compared to the state. Non-Hispanic whites and Non-Hispanic Blacks are disproportionately affected by heart disease. Non-Hispanic Blacks have over twice the prevalence of heart disease as compared to the county. Stanislaus County benchmarks poorly on many of the related indicators contributing to Cardiovascular Disease (CVD)/Stroke, including access to parks, and diabetes prevalence and related hospitalizations, obesity among adults and youth, and physical inactivity among youth and adults.	Heart Disease Prevalence [5.30% // 6.30%] Non-Hispanic White** [7.60% // 5.30%] Non-Hispanic Black** [10.60% // 5.30%] Mortality - Ischemic Heart Disease** [221.18 // 163.18] Non-Hispanic White** [245.32 // 221.18] Black** [240.71 // 221.18] Native Hawaiian/Pacific Islander** [273.12 // 221.18] Mortality - Stroke** [43.98 // 37.38] Black** [52.78 // 43.98] Native Hawaiian/Pacific Islander** [54.71 // 43.98]	Physical Inactivity (Adult)* Physical Inactivity (Youth)** Non-Hispanic Multiple Races, Hispanic/Latino Park Access** Recreation and Fitness Facility Access* Tobacco Usage** Obesity (Adult)** Overweight (Youth)* Multiple races Obesity (Youth)** Diabetes Prevalence* Diabetes Hospitalizations**
PRIMARY DATA:	Although cardiovascular disease was not a major concern, it was mentioned as a top health need in one stakeholder interview and in 2 focus groups. The contributing factors to CVD were frequently mentioned in both stakeholder interviews and focus groups. In particular, lack of access to safe parks and low cost exercise opportunities and high rates of obesity and overweight were frequently cited as top needs.	
ETHNIC/RACIAL DISPARITIES:	Several ethnic/racial groups are disproportionately affected by heart disease and stroke. Non-Hispanic Blacks are twice as likely to have heart disease as compared to the county as a whole. Heart Disease mortality is greater for Non-Hispanic White, Black and Native Hawaiian/Pacific Islander populations as compared to the county. Blacks and Native Hawaiian/Pacific Islanders also experience higher rates of mortality from stroke as compared to the county.	

Cancers

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Screening and early treatment of cancers saves and prolongs lives. Additionally, preventative measures and reducing behavioral risk factors (e.g., obesity, physical inactivity, smoking, and UV light exposure) can be effective at reducing the incidence of cancer. Overall, cancer mortality is greater in Stanislaus County as compared to the state. In particular, Non-Hispanic Whites are disproportionately affected by cancer mortality. Colon/rectum and lung cancer incidence rates are also greater in Stanislaus County than in the state. Whites are nearly three times more likely to have lung cancer as compared to the county as a whole. Many factors contributing to cancers such as obesity, physical inactivity and poor air quality were identified by stakeholders and focus groups as key areas of concern. The secondary data supports the primary data as those contributing factors mentioned above also benchmark poorly to the state.	Mortality - Cancer** [167.85 // 157.10] Non-Hispanic White** [189.77 // 167.85] Cancer Incidence - Colon and Rectum** [47.40 // 41.50] Black** [59 // 47.40] Cancer Incidence - Prostate [123.40 // 136.40] Black** [173 // 123.40] Cancer Incidence - Lung** [62.20 // 49.50] White** [173 // 62.20]	Tobacco Usage** Obesity (Adult)** Cancer Screening - Pap Test** Physical Inactivity (Adult)* Air Quality - Particulate Matter 2.5**
PRIMARY DATA:	Cancer did not come up as a health need in stakeholder interviews and although it came up in 4 focus groups, there was minimal discussion around it.	
ETHNIC/RACIAL DISPARITIES:	Non-Hispanic Whites are more likely to die from cancer than the other ethnic/racial groups in the County. Whites are almost three times as likely to have lung cancer than the county population as a whole. Blacks have greater incidence of colon/rectum cancer and prostate cancer than the rest of the county.	

Substance Abuse/Tobacco

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Reducing tobacco use and treating/reducing substance abuse improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Tobacco usage is higher in Stanislaus County than the state. Substance use emerged as a theme in the focus groups. The prevalence of drugs in local parks was commonly mentioned. Additionally, many respondents identified other health needs including economic security, mental health and violence as frequently co-occurring with substance abuse.	Tobacco Usage** [16.80% // 12.80%] Note: Tobacco usage is the only indicator from the KP data platform that benchmarks poorly to the State.	
PRIMARY DATA:	The prevalence of drugs in the parks, particularly among the homeless population was frequently mentioned in focus groups. Many respondents talked about the intersection of substance abuse, poverty and mental illness and how closely related these issues are in the population. Respondents described how mental illness is exacerbated by substance use and how poverty contributes to substance use. Respondents also indicated a need for more treatment centers.	
ETHNIC/RACIAL DISPARITIES:	Ethnic/racial disparity data were unavailable in the KP CHNA data platform for tobacco/substance abuse indicators. Primary data would suggest there are socioeconomic disparities related to tobacco/substance abuse. Substance abuse was frequently described as an issue among the homeless population.	

Violence/Injury Prevention

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]		CONTRIBUTING FACTORS
Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. In Stanislaus County, violence/injury prevention affects both certain ethnic/racial communities and the county overall. In particular, Blacks are disproportionately affected by homicide. The homicide rate for Blacks is over three times the rate for the county as a whole. Many focus group respondents felt their community was unsafe.	Mortality - Homicide*	[7.02 // 5.15]	Violence - All Violent Crimes** Violence - Rape (Crime)** Violence - School Suspensions**
	Black**	[24.28 // 7.02]	
	Native Hawaiian/Pacific Islander*	[8.31 // 7.02]	
	Hispanic/Latino*	[8.68 // 7.02]	
	Native American/Alaskan Native*	[7.22 // 7.02]	
	Mortality - Suicide	[10.70 // 9.8]	
	Non-Hispanic White**	[13.99 // 10.70]	
	Native American/Alaskan Native	[14.27 // 10.70]	
	Native Hawaiian/ Pacific Islander **	[24.30 // 10.70]	
	Mortality - Motor Vehicle Accidents*	[6.46 // 5.18]	
	Non-Hispanic White*	[8.39 // 6.46]	
	Asian	[6.67 // 6.46]	
	Violence - Youth Intentional Injury**	[921 // 738.7]	
	Violence - Assault (Injury)**	[388.40 // 290.3]	
	Violence - Domestic Violence**	[13.3 // 9.5]	
	Violence - Assault (Crime)**	[339.6 // 249.4]	

PRIMARY DATA:	Two stakeholders identified child abuse and domestic violence as major issues. Other stakeholders identified a lack of education on parenting and the bad economy as contributing to abuse. Focus group participants frequently mentioned unsafe parks, homeless people, drugs and stray dogs as factors in the environment that made them feel unsafe. Additionally, poor lighting and the need for built environment improvements were mentioned. A few respondents mentioned the need for more police officers.
ETHNIC/RACIAL DISPARITIES:	Many ethnic/racial groups are disproportionately affected by violence. The homicide rate for Blacks is over three times the rate for the county as a whole. Non-Hispanic White, Native American/Alaskan Native and Native Hawaiian/Pacific Islander populations have a greater rate of suicide than the county as a whole.