2016 Community Health Needs Assessment

Kaiser Foundation Hospital – Walnut Creek
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Approved by KFH Board of Directors
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To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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AUTHORS AND ACKNOWLEDGEMENTS

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

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- Debi Ford, **San Ramon Regional Medical Center**
- Susan Miranda, **Kaiser Permanente – Greater Southern Alameda Area**
- Dana Williamson, **Kaiser Permanente – Northern California Region**

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

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

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

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

B. SUMMARY OF PRIORITIZED NEEDS

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

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

Based on community input and secondary data, KFH-Walnut Creek worked with John Muir Health (JMH) to understand health needs in their shared service areas. KFH-Walnut Creek and JMH

then identified local community stakeholders to assist with prioritizing (ranking) the list of health needs via a multiple-criteria scoring system. These needs are listed below in priority order, from highest to lowest.

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

Community Health Needs Identified for KFH-Walnut Creek (KFH-WC), in Order of Priority

Health need	Why is it important?	What do the data say?
1. Obesity, diabetes, and healthy eating/ active living	Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives.	High rates of obesity are of concern in the KFH-WC service area. Although rates of adult diabetes are no worse than California overall (8%), the community perception is that childhood obesity is on the rise. Populations of color are much more likely to be overweight. The environment may play a factor; more than a quarter of residents live in a food desert, and there are fewer WIC-authorized food stores than in the state overall. In addition, fewer KFH-WC service area students walk, bike or skate to school than in the state overall. The community expressed a desire for more education and information about CAL-Fresh, Food Banks, and Farmer's Markets.
2. Oral/dental health	Oral health is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.	Contra Costa County has a higher percentage of children who missed school days due to a dental problem compared to the state average. KFH-WC's service area shows no shortage of dental professionals and rates of youth without recent dental exams which are better than the state but worse than Contra Costa County overall. Community input indicates that dental care is not always covered by insurance, benefits are not sufficient, and providers often don't accept the dental insurance residents do have or require payments be made in cash.

Health need	Why is it important?	What do the data say?
3. Substance abuse, including alcohol, tobacco, and other drugs	Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime and suicide.	Levels of excessive alcohol consumption ("binge drinking") among adults in the KFH-WC service area are higher than the state average. In addition, KFH-WC service area residents' total household expenditures towards alcohol are slightly higher than the state average. Community members feel that the area lacks alcohol and drug services and that treatment facilities are far away and hard to get to.
4. Economic security	Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve.	Residents in the KFH-WC service area experience food insecurity at rates which fail Healthy People 2020 targets. Ethnic disparities are seen in the proportions of people living in poverty; a greater proportion of Latino residents and Latino children in the KFH-WC service area were living in poverty compared to non-Latino residents and children. The community input indicates that insurance premiums and co-payments are too high. Community input suggests that affordable housing is a major issue, and homelessness is a concern as there are not enough services for basic needs. Community members also expressed that people can't afford or lack time to take care of themselves.

Health need	Why is it important?	What do the data say?
5. Healthcare access & delivery, including primary & specialty care	Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life.	In the KFH-WC service area, ethnic disparities are seen in the proportions of residents who are uninsured. In the KFH-WC service area, the number of federally qualified health centers and the rate of preventable hospital events look favorable compared to the state, but overall Contra Costa rates are worse than the state. Community members also expressed concern about a lack of cultural competence amongst health system staff.
6. Mental health	Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health.	While the rate of suicide in Contra Costa County is higher than the Healthy People 2020 target, in the KFH-WC service area the rate is slightly lower. However, KFH-WC service area Whites are more likely than KFH-WC service area residents in general to commit suicide and a report the need for mental health care. Latinos have the highest rates in the KFH-WC service area of needing mental health care. Community input indicates that a lack of education around mental health and available mental health services as well as difficulty navigating the healthcare system are barriers to accessing mental health care.
7. Violence and injury prevention	Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term	Rates of KFH-WC service area non-fatal ER visits for injury due to assault and domestic violence are both much higher than the state averages. In addition, the Contra Costa County age-adjusted homicide mortality rate is worse than the state, and racial and ethnic disparities are stark in the county and the service area. For example, in the service area, the homicide mortality rate for Blacks is 17 times higher than for Whites. Community input indicates that elder neglect is a problem and that there is a lack of domestic violence shelters in the community.

Health need	Why is it important?	What do the data say?
	behavioral and emotional problems in youth.	

C. SUMMARY OF NEEDS ASSESSMENT METHODOLOGY AND PROCESS

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

II. INTRODUCTION/BACKGROUND

A. ABOUT KAISER PERMANENTE (KP)

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

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

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

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

B. ABOUT KAISER PERMANENTE COMMUNITY BENEFIT

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

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grant making to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've

focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

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

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

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

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

D. IMPACT OF THE AFFORDABLE CARE ACT (ACA)

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

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

State and County Context

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

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

from subsidized premiums.[1]

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,[2] according to data cited by the California Healthcare Foundation. According to the California Health Interview Survey, in 2014, 18% of the population aged 18-64 in Contra Costa County was not insured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013 when 16% of that population was uninsured.[3]

Although some Costa County residents may have obtained health insurance for the first time, health insurance costs, the cost of care, and access to timely appointments, remains a concern. As discussed later in this report, residents (including those whose insurance plans did not change since ACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. Indeed, professionals who participated in this assessment also expressed concern about the lack of a sufficient number of doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance. This is supported by evidence that there was an increase in the proportion of people who said they had forgone care because they could not get an appointment (from 5% in 2013 to 8% in 2014).[4]

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

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

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

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

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

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

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

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

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

includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

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

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

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

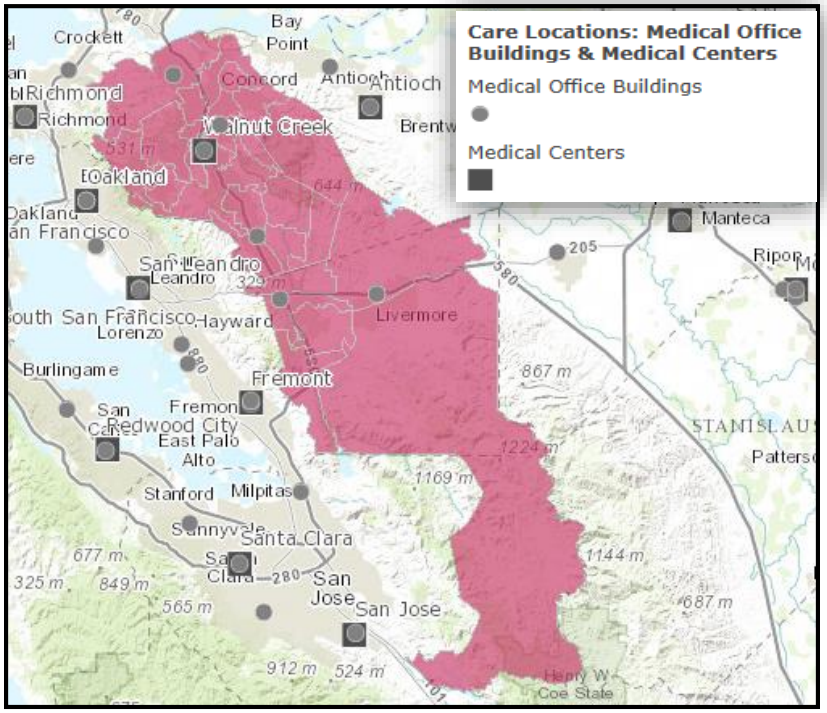
III. COMMUNITY SERVED

A. KAISER PERMANENTE'S DEFINITION OF COMMUNITY SERVED

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

B. MAP AND DESCRIPTION OF COMMUNITY SERVED

i. Map of KFH-Walnut Creek service area



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

The KFH-Walnut Creek service area includes communities in Contra Costa and Alameda counties. The major cities and communities are Dublin, Livermore, and Pleasanton in Alameda County and Alamo, Concord, Danville, Lafayette, Martinez, Moraga, Orinda, Pacheco, Pleasant Hill, San Ramon, and Walnut Creek in Contra Costa County. The map above shows the service area which also includes unincorporated areas.

iii. Demographic profile of community served

KFH Walnut Creek Demographic Data	
Total Population	727,995
White	71.54%
Black	2.77%
Asian	17.08%
Native American/ Alaskan Native	0.36%
Pacific Islander/ Native Hawaiian	0.33%
Some Other Race	3.01%
Multiple Races	4.91%
Hispanic/Latino	14.86%

KFH Walnut Creek Socio-economic Data	
Living in Poverty (<200% FPL)	15.49%
Children in Poverty	6.94%
Unemployed	6.8%
Uninsured	7.61%
No High School Diploma	6%

KFH-Walnut Creek Service Area

The KFH-Walnut Creek service area population is about 716,000. The two largest racial subpopulations are White (72%) and Asian (17%), and about 15% are Latino. Compared to Contra Costa and Alameda Counties, a larger proportion of the community is White and non-Latino. Data also indicate that 7% of residents are living in poverty, about half the proportions of both the state and the counties of Contra Costa and Alameda.

Demographic Data	KFH-Walnut Creek Service Area	Contra Costa County	Alameda County
Total Population	716,058	1,065,794	1,535,248
White	72.2%	63.1%	45.6%
Black	2.8%	9.1%	12.1%
Asian	16.7%	14.7%	26.8%
Native American/ Alaskan Native	<0.5%	0.5%	0.6%
Pacific Islander/ Native Hawaiian	<0.5%	0.5%	0.8%
Some Other Race	3.1%	6.7%	8.3%
Multiple Races	4.5%	5.4%	5.9%
Hispanic/Latino	14.5%	24.5%	22.5%

Note: Percentages may not add to 100% because they overlap.
Data source: U.S. Census Bureau, American Community Survey, 2009-2

Social Determinants of Health

Two key social determinants, poverty and education, have a significant impact on health outcomes.

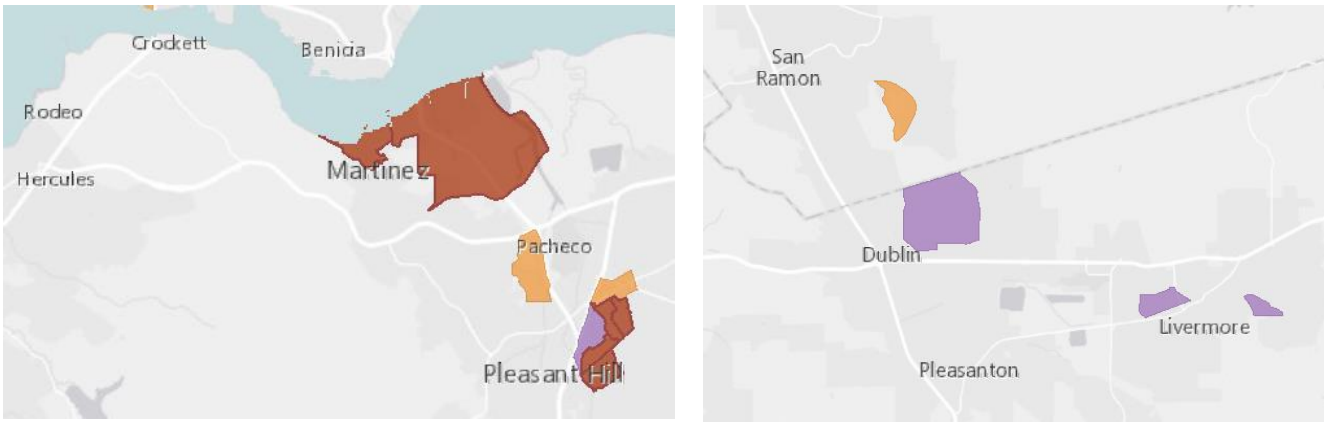
Socio-economic Data

Socio-economic Data	KFH-Walnut Creek Service Area	Contra Costa County	Alameda County
Living in Poverty (<200% FPL)	15.3%	24.6%	27.8%
Living in Poverty (<100% FPL)	6.5%	10.7%	12.9%
Children in Poverty (<100% FPL)	6.8%	13.8%	15.7%
Unemployed	6.0%	6.1%	5.8%
Uninsured	7.9%	11.9%	12.6%
No High School Diploma	5.9%	14.0%	13.6%

Data Source: All except unemployment are from: U.S. Census Bureau, American Community Survey. 2009-13. Unemployment is from: U.S. Department of Labor, Bureau of Labor Statistics. 2015 - June.

Nearly one in six KFH-Walnut Creek service area residents (15%) lives below 200% of the federal poverty level, and over two in five (41%) of households are overburdened by housing costs (i.e., housing costs exceed 30% of total household income). The map below displays where vulnerable populations live by identifying where high concentrations of population living in poverty and population living without a high school diploma overlap. Data are from the U.S. Census Bureau 2009-13 American Community Survey.

East/Central Contra Costa County & Tri-Valley Vulnerability Footprint



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

The orange shading shows areas where the percentage of population living at-or-below 100% of the Federal Poverty Level (FPL) exceeds 16% (the rate for California). The purple shading shows areas where the percentage of the population with no high school diploma exceeds the Healthy People 2020 target of 18% (i.e. 82% with a high school diploma or

higher). Educational attainment is determined for all non-institutionalized persons age 25 and older. Dark red areas indicate that the census tract is above these thresholds (worse) for both educational attainment and poverty.

More than one in six (17%) of the children in KFH-Walnut Creek are eligible for Free & Reduced-Price lunch (NCES Common Core of Data 2013-14), while less than one in ten children (7%) lives in a household with income below 100% of the Federal Poverty level (U.S. Census Bureau, American Community Survey, 2009-2013). Less than one in ten (8%) residents in the community are uninsured (U.S. Census Bureau, American Community Survey, 2009-2013.

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. IDENTITY OF HOSPITALS THAT COLLABORATED ON THE ASSESSMENT

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

Most of the Hospitals then collaborated with one or more of the Hospitals with similar service areas to decide on criteria for identifying significant health needs; KFH-Walnut Creek worked with John Muir Health. The Hospitals then used the primary and secondary data collected that pertained to their respective service areas for identification of needs. KFH-Walnut Creek also worked with John Muir Health to prioritize their shared health needs using an online survey (described in Section VI-B).

Collaborative Hospital Partners

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

B. OTHER PARTNER ORGANIZATIONS THAT COLLABORATED ON THE ASSESSMENT

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

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

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

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

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

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

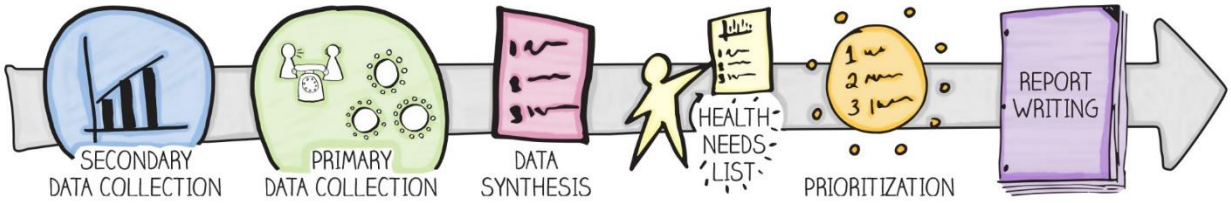
Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Alameda, Contra Costa, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties,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

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

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

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

CHNA Process



A. SECONDARY DATA

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

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

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

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

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

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

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

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

B. COMMUNITY INPUT

i. Description of the community input process

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

In all, ASR gathered community input from 55 individuals through focus groups and individual interviews.

In all, ASR consulted with 21 professional community representatives of various organizations and sectors through 15 key informant interviews and one focus group (which included six participants). These representatives either work in the health field or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- County Public Health (2)
- Other health centers or systems (7)
- Mental/Behavioral health or violence prevention providers (2)
- School system representatives (8)
- City or county government representatives (1)
- Other nonprofit agencies serving children, seniors, veterans, and/or families (1)

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

a. Key Informant Interviews

ASR conducted primary research via key informant interviews with 15 Alameda and Contra Costa Counties experts from various organizations. Between June and October 2015, experts including the public health officers, community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

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

b. Stakeholder Focus Groups

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

Details of Focus Group with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Community health workers from communities which are medically underserved, minority and/or low income	Pittsburg Health Center	09/08/15	6

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

c. Resident Input

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

In order to provide a voice to the community they serve in Alameda and Contra Costa counties, the Hospitals targeted participants who were medically underserved, in poverty, and/or socially or linguistically isolated. Three focus groups were held with community members.

These resident groups were planned in various geographic locations around the service area. Residents were recruited by nonprofit hosts, such as Monument Crisis Center, who serve medically underserved and low-income residents.

Details of Focus Groups with Residents

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Medically underserved, low-income	Monument Crisis Center	08/24/15	11
Medically underserved, low-income	Open Heart Kitchen	09/02/15	12
Spanish-speaking minority (Latino), low-income	First 5 Contra Costa County	09/03/15	11

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

- 97% of participants (33) completed a survey.
- 39% (13) of respondents were White, 36% were Latino, 12% were Black, and 12% reported another ethnicity (Asian, Native Hawaiian/Pacific Islander, or multiracial).
- 73% (24) were between the ages of 18 and 64 years old; of these, seven were younger than 40, and seventeen were 40 or older. 18% did not report their age, and the rest were age 65 or older.

- 12% (4) were uninsured, while 64% had benefits through Medi-Cal, Medicare, or another public health insurance program. Three did not report their insurance status, and the rest had private insurance.
- Residents lived in various areas of the counties: Concord (14), Livermore (9), Antioch (5), Pleasanton (2), and other unidentified parts of the counties (3).
- 79% (15) reported having an annual household income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for both Alameda County and Contra Costa County for two adults with no children (Alameda County $38,817; Contra Costa County $38,169). Almost two-thirds (64%) earned under $25,000 per year, which is below Federal Poverty Level for a family of four. This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California. Four respondents did not report their household income.

ii. Methodology for collection and interpretation

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

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

C. WRITTEN COMMENTS TO 2013 CHNA

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

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

D. DATA LIMITATIONS AND INFORMATION GAPS

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

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

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. IDENTIFYING COMMUNITY HEALTH NEEDS

i. Definition of "health need"

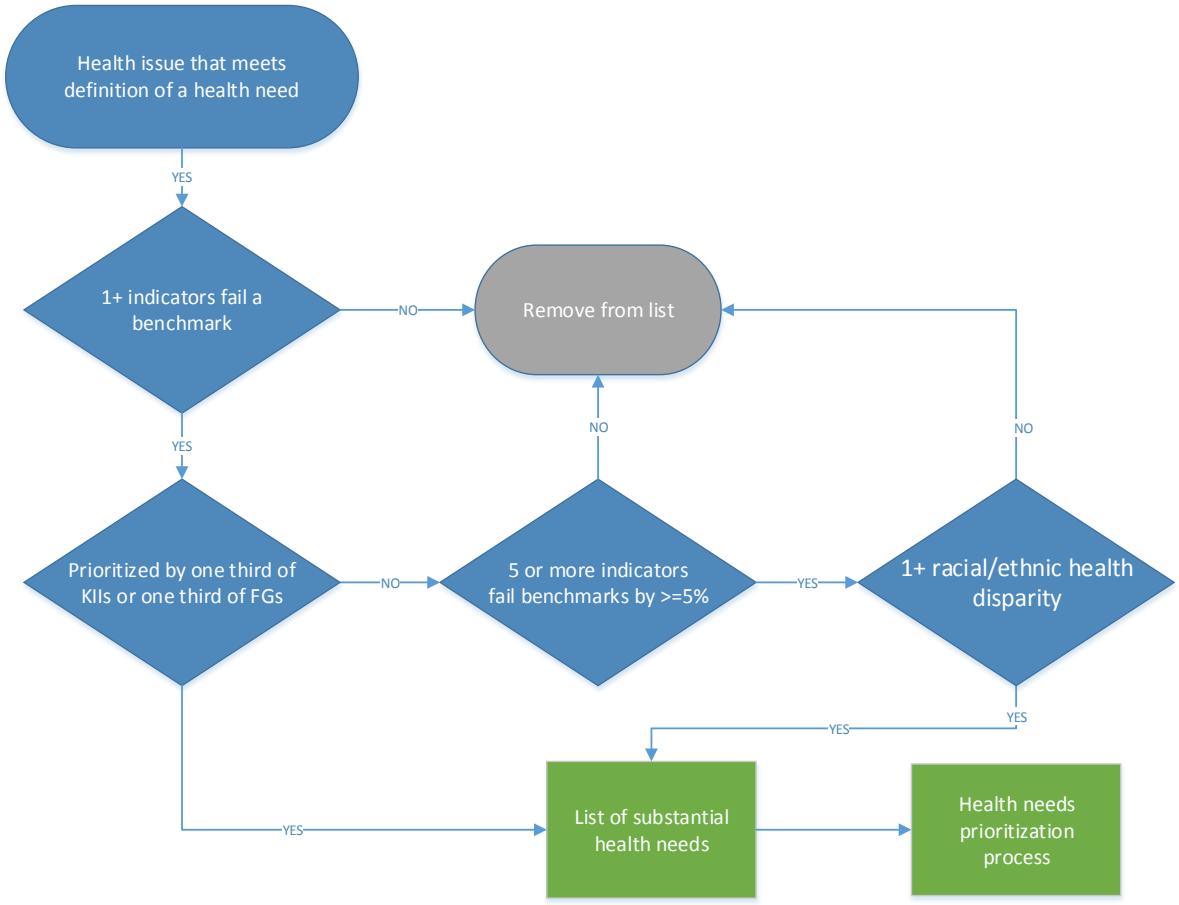
For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.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

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

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

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

KP-Walnut Creek Health Needs Identification Process



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

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

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

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

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

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

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

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

List of Prioritized Needs: The overall need scores ranged between 1.75 and 2.64 on a scale of 1-3 with 1 being the lowest priority possible and 3 being the highest priority possible. The needs are ranked by prioritization score in the table below. The specific scores for each of the four criteria used to generate the overall community health needs prioritization scores may be viewed in Appendix E.

Prioritized Needs and Average Priority Score

Rank	KFH-Walnut Creek Health Need	Overall Average Priority Score
1	Obesity, Diabetes, Healthy Eating/Active Living	2.64
2	Oral/Dental Health	2.46
3	Substance Abuse (Alcohol, Tobacco, and Other Drugs)	2.43
4	Economic Security	2.39
4	Healthcare Access & Delivery, Including Primary & Specialty Care	2.39
6	Mental Health	2.29
7	Violence/Injury Prevention	1.75

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

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

1: Obesity, diabetes, and healthy eating/active living are health needs locally as illustrated by high rates of overweight and obesity among adults. In addition, 44% of Latinos in Contra Costa County are overweight as compared to 32% of Whites, a more than ten percentage point difference. Community input about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity. Community members indicated that obesity among youth is of highest concern, and lack of access to affordable, healthy food is driving this health need. The community also wanted more education and information about CAL-Fresh, Food Banks, and Farmer's Markets. Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives.

2: Oral health is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use,

excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures. Oral/dental health is a health need as marked by a higher percentage of children in Contra Costa County who missed school days due to a dental problem compared to the state average. Community input indicates that dental care is not always covered by insurance, benefits are not sufficient, and providers often don't accept the dental insurance residents do have or require payments be made in cash. Community members also mentioned that reimbursement rates are not economically feasible for dentists.

3: Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide. Substance abuse (including tobacco and alcohol) is a health need in the KFH-Walnut Creek service area as demonstrated by levels of excessive alcohol consumption among adults, which are higher than the state average. In addition, close to 14% of the KFH-Walnut Creek service area residents' total household expenditures are towards alcohol, slightly higher than the state average (13%). Community feedback indicates that residents use substances to help them cope and sleep. Community members feel that the area lacks alcohol and drug services and that treatment facilities are far away and hard to get to. Some members also feel that the religious component of certain treatment options may drive people away.

4: Economic security is a health need in the KFH-Walnut Creek service area as marked by the percentage of residents who experienced food insecurity at some point during the year, which is higher than HP2020 target. In addition, a greater proportion of Latino residents (12%) and Latino children (26%), Black residents (18%) and children (22%), American Native residents and children (both 13%) Native Hawaiian residents (27%) and children (29%), and other race residents (16%) and children (21%) in the KFH-Walnut Creek service area were living in poverty compared to non-Hispanic White residents (6%) and children (5%). Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve. Community input suggests that affordable housing is a major issue, and homelessness is a concern as there are not enough services for basic needs. Community members also expressed that people can't afford or lack time to take care of themselves.

5: Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. **Healthcare access & delivery, including primary and specialty care,** is a health need in the KFH-Walnut Creek service area as demonstrated by ethnic disparities in the proportion of residents who are uninsured. In addition, Contra Costa County falls short of the benchmark in the rate of Federally Qualified Health Centers (FQHCs). The rate of FQHCs is 0.5 per 100,000, well below the state average of 2.0. The community input indicates that insurance premiums and co-payments are too high. Community members also expressed concern about a lack of cultural competence amongst health system staff.

6: Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope

with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health. Mental health is a health need in the KFH-Walnut Creek service area as evidenced by the rate of suicide in Contra Costa County, which is higher than the HP2020 target. Community input indicates that a lack of education around mental health and available mental health services as well as difficulty navigating the healthcare system are barriers to accessing mental health care.

7: Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. Violence and intentional injury prevention is a health need in the KFH-Walnut Creek service area as marked by the overall violent crime rate and rates of non-fatal ER visits for injury due to assaults and domestic violence that are all much higher than the state averages. In addition, Contra Costa County miss the state average in age-adjusted homicide mortality rates, and racial and ethnic disparities are stark. For example, Contra Costa County's age-adjusted homicide mortality rate is 7.6, which is higher than the state average of 5.2. The homicide mortality rate for Blacks is five times higher than for Whites. Community input indicates that elder neglect is a problem and that there is a lack of domestic violence shelters in the community.

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

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

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

VII. KFH-WALNUT CREEK 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. PURPOSE OF 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

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

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

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

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

B. 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT OVERVIEW

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

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

    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
    - Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
    - Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH Walnut Creek awarded 170 grants totaling $3,314,398 in service of 2013 health needs. Additionally, KFH in Northern California has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Walnut Creek service area. During 2014-2015, a portion of money managed by this foundation was used to award 42 grants totaling $625,253 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 Walnut Creek 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 Walnut Creek 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: HEALTHY EATING AND INCREASED EXERCISE AND ACTIVITY

Long Term Goals:

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

Intermediate Goals:

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

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 95 active KFH grants totaling $1,671,061 addressing Healthy Eating and Increased Exercise and Activity in the KFH-Walnut Creek service area.[7] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 10 grants totaling $107,033 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Livermore Area Recreation and Park District (LRPD)	$30,000 over 2 years $15,000 in 2014 & 2015	Supports a summer swim program that provides affordable swim lessons and subsidized recreational swim fees for low-income families in the Livermore area.	During the two years of funding, 2014 grant, 637 children enrolled in swim lessons through scholarships provided by the grant from KFH Walnut Creek and an additional 17,013 people participated in the afternoon recreational swim. LRPD reached three times the number of people projected in the grant application due to the contacts they made in the community and the trust they established. The addition of bilingual staff members were a huge help in being able to answer patron questions and provide information on the programs.
Food Bank of Contra Costa and Solano	$20,000 in 2015 (even split with KFH-Antioch)	Supports providing nutrition education and free, fresh produce to low-income families throughout east and central Contra Costa County.	Program proposed to deliver 1.3 million pounds of produce to 12,000 individuals. As of Dec.1, 12,851 individuals received 605,209 pounds of produce.
Loaves & Fishes	$20,000 in 2015	Supports free hot meals for low-income	Goal was to provide 150,000 meals at five dining

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

	(even split with KFH-Antioch)	clients served in dining rooms throughout east and central Contra Costa County.	rooms and three partner sites. Between July 1 and Oct. 31, 56,690 meals were provided at five dining rooms and three partner sites.
Monument Impact	$1.5M over 3 years $500,000 in 2014 & 2015	HEAL Zone grant to implement coordinated, high reach, high impact strategies focused on policy, systems, built environment, and program changes to support healthy eating and active living in Concord's Monument community.	2014: HEAL Zone 2.0 outcomes include: • Established a Junior Giants League and implemented a healthy beverage and snack policy that has been adopted for all Junior Giants affiliates. • Conducted a walk audit that led to sidewalk and traffic signal changes and leveraged $2.2 million in grant funding for other projects. • Conducted a community-driven park assessment with resident advocacy to the city to make park improvements. • 25 organizations serving the HEAL Zone adopted healthy food and physical activity policies. • Established a sustainable model for conducting community Zumba classes at local schools. Conducted six-week healthy cooking classes for more than 500 residents Expected reach is 10,000 people; expected outcomes include • food, beverage, and physical activity guidelines are adopted in community-based institutions and childcare settings • food and nutrition policies and activities implemented in schools • to increase access to physical activity resources, shared use agreements with schools, parks, and apartment complexes are established • cooking classes, walking groups, and bike promotion activities are provided for community residents
*Regional Parks Foundation	$85,000 in 2015	Regional Parks Foundation will connect underserved and vulnerable communities to	Expected reach is 2,550 people and expected outcomes include:

	This grant impacts six KFH hospital service areas in Northern California Region.	outdoor recreation opportunities within East Bay Regional Parks District (EBRPD). With a focus on increasing park access and engagement of at-risk youth, seniors, and communities of color that under-utilize parks, EBRPD staff will conduct targeted outreach, and offer transportation and programming tailored for the target populations. EBRPD staff will undergo cultural competency training to build capacity and to welcome and engage the intended communities.	• 450 individuals from multi-ethnic communities enjoy park programs designed to increase physical activity, social cohesion, and connections to nature • 960 seniors get free transportation to outdoor physical activities to increase healthy living, flexibility, sensory perceptions, and social connections • 840 low-income youth participate in summer day camp programs at various EBRPD parks • up to 300 EBRPD staff take part in cultural competency training to more effectively encourage all communities to feel safe engaging in outdoor activities in EBRPD
*Golden Gate National Parks Conservancy	$300,000 over 2 years $150,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region	Golden Gate National Parks Conservancy and Institute at the Golden Gate will coordinate the Healthy Parks Healthy People (HPHP) Bay Area program, a collaborative of park and health agencies designed to increase the accessibility and use of parks for activities that promote health.	Expected reach is 10,000 people and expected outcomes include: • train HPHP program leaders to run effective park programs to engage target populations, including low-income, ethnic minorities, high-risk youth, seniors, and those referred by health care and social service providers • to ensure long-term sustainability, train at least one person at each park agency as an HPHP programming trainer • all nine Bay Area public health departments/ health systems actively prescribe HPHP for at-risk youth, seniors, ethnic minorities, and low-income community residents • based on lessons learned in the Bay Area, create an HPHP blueprint model/toolkit for other parts of California and the U.S.

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Healthy and Active Before 5 (HAB45)	HAB45, a large community collaborative serving Contra Costa County, aims to prevent obesity in children 0 to 5 by building partnerships and environments for healthy eating and active play. With a multi-agency	KFH-Antioch, KFH-Walnut Creek, and KFH-Richmond are represented on HAB45. The KP North Bay CB Manager serves on the Executive Committee. As of Dec. 1, HAB45 and its community partners: • advocated for considerations for children 0-5 in Healthy & Livable

	steering committee and a leadership council, HAB45 encourages organizations to pass and implement healthy policies and has developed a model policy library that it actively promotes.	Pittsburg • advocated for and secured $187,000 for play equipment improvements at parks in Antioch and Pittsburg.

Impact of Regional Initiatives

HEAL Zones:

Kaiser Permanente's HEAL (Healthy Eating, Active Living) Zone initiative is a place-based approach that aims to lower the prevalence and risks of diseases associated with obesity in communities that have disproportionate rates of heart disease, type 2 diabetes, high blood pressure, stroke, depression, and some cancers. HEAL Zones focus on increasing access to fresh fruit, vegetables, and healthy beverages, as well as increasing safe places to be play and be physically active. HEAL Zones deploy robust coalitions of local public agencies, schools and school districts, community-based organizations, employers, local businesses, faith-based organizations, and health care providers, including Kaiser Permanente, to affect broad population-level behavior change that will ultimately lead to better health outcomes.

Parks Initiative:

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

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

Long Term Goal:

- Increase the proportion of individuals in the KFH-Walnut Creek service area who have access to and receive primary care services.

Intermediate Goal:

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

KFH-Administered Program Highlights

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	• *2014: 7,725 Medi-Cal members* • *2015: 7,004 Medi-Cal members*

	beneficiaries, both members and non-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 - $4,584,708* • *2014: 4,024 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $3,312,828* • *2015: 4,996 applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 1,662 members receiving CHC* • *2015: 1,450 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 44 active KFH grants totaling $1,488,184 addressing Primary Care Services and Information in the KFH-Walnut Creek service area.[8] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 17 grants totaling $194,211 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Axis Community Health	$25,000 in 2015	Supports primary care operations, with a focus on medication compliance.	Goals of the grant ares to improve health outcomes for 2,108 adult patients through better medication management. By Dec. 1, 1,215 adult patients received facilitated medication review services.
La Clínica de la Raza	$50,000 over 2 years $20,000 in 2014 $30,000 in 2015 (even split with KFH-Antioch)	This Connecting Families to Health Coverage/Care grant supports outreach and education to increase access to health care services for low-income and uninsured individuals and families in east and central Contra Costa County.	As a result of the 2014 grant, three Community Health Educators (CHE) and 13 *Promotores* completed refresher training "Access to Health Insurance Coverage."CHE Staff and Promotores disbursed culturally and linguistically appropriate materials to 1,045 community members at 66 community events/ presentations where health coverage options and eligibility were discussed with community members and served 287 individuals who were screened for health coverage eligibility. The goal of the 2015 grant is to train three community health education staff and 12 promotores on health coverage options, reach 900 individuals at nine community events, reach 120 community members at 12 presentations; and provide health care utilization support to 100 individuals. As of Dec 1, 2015

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

			three community health education staff and seven promotores were trained, six community events reached 809 people, 318 community members attended 12 presentations, and 497 individuals received one-on-one health care utilization support.
RotaCare Bay Area	$53,000 over 2 years $23,000 in 2014 $30,000 in 2015	Supports free primary care services for underserved and uninsured adults in Concord.	As a result of the 2014 grant RotaCare increased evenings of service by expanding to (2) clinics monthly at the Monument Crisis Center, providing 966 clinic visits. The goal of the 2015 grant is to provide an additional 900 client visits. As of Dec. 1, 2015 the program provided 389 client visits.
*Operation Access (OA)	$300,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region.	Core support to organize OA's network of 41 medical centers and 1,400 medical professionals who donate surgical, specialty, and diagnostic services to 1,500 low-income, uninsured people residing in nine Bay Area counties.	With 1,274 staff/physician volunteers providing more than 700 services at 14 hospitals in 2015, Kaiser Permanente is the largest health system participant. KP volunteers performed a total of 49 procedures in 2014 and 2015.
Community Clinic Consortia of Contra Costa and Solano (CCCCCS)	$250,000 over 2 years $125,000 in 2014 & 2015 This grant impacts five KFH hospital service areas in Northern California Region.	Core support for continued operations of CCCCCS's various activities to meet the needs of community health center (CHC) members, and the review, modification, and implementation of existing organizational strategic plan. CCCCC serves four health centers with 123,144 patients.	Expected outcomes for the grant include: • improved Medi-Cal managed care patient assignment rates by creating quarterly reports shared with member health centers. • Improved/streamlined Medi-Cal application process to expedite eligibility determinations for patients • develop, secure funding for, and implement Contra Costa CARES, a local primary care access program for approximately 3,000 of the county's low-income, undocumented adults • increased long-term financial viability of CHCs

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Access to Care Stakeholders	Convened by Contra Costa health services director, William Walker, MD, this group has met quarterly since 2008. Membership includes representation from the Hospital Council,	KP North Bay CB Manager represents Kaiser Permanente in the group and monitors community needs. The Stakeholders most recent focus is Contra Costa Cares, a county-wide coverage initiative to serve up to 3,000 uninsured Contra Costa residents.

	Contra Costa Board of Supervisors, Alameda-Contra Costa Medical Association, and most Contra Costa hospitals, community clinics.	
East and Central Contra Costa County Access Team (ECCAAT)	ECCAAT includes representatives of clinics and hospitals serving east and central Contra Costa: KFH-Antioch, KFH-Walnut Creek, John Muir Health, Sutter Delta, Contra Costa Health Services, La Clínica de la Raza, and Planned Parenthood. It is key to information sharing and advocacy around health care access and coverage in the county, and its members have access to senior leaders in their organization.	KP North Bay CB Manager participates in this group. In 2015, ECCAAT focused on the coverage options for the remaining uninsured in Contra Costa County.
In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.	

PRIORITY HEALTH NEED III: ASTHMA PREVENTION

Long Term Goal:

- Decrease the negative impacts of asthma on children and adults in the KFH-Walnut Creek service area

Intermediate Goals:

- Reduce the prevalence of asthma in low-income communities
- Decrease hospitalizations and days lost from school because of asthma and asthma-related emergencies

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 5 active KFH grants totaling $85,500 addressing Asthma Prevention in the KFH-Walnut Creek service area.[9]

Grantee	Grant Amount	Project Description	Results to Date
American Lung Association (ALA)	$25,000 in 2014	Tri-Valley Asthma Management and Prevention project focuses on Pleasanton, Livermore, and Dublin school districts and will provide asthma management training and resources for at-risk students, school personnel, and parents.	Fifty one (51) adults received Asthma 101: What You Need to Know instruction, 15 students received OAS classes, and 26 students received one-on-one asthma education at Firehouse Arts Center Health Fairs.

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

Community Child Care Council of Alameda County (4Cs)	$50,000 over 2 years $20,000 in 2014 $30,000 in 2015	Supports asthma prevention/management sessions to help Community Association for Preschool Education (CAPE) child care centers develop policies to make their environments asthma-friendly. Program also provides training to providers and parents on common asthma triggers, managing asthma attacks, and administering treatments.	4C's reached 20 child care programs, serving 400 providers, parents, and children. All child care programs and at least half of participating families reduced at least one environmental asthma trigger in their facility or home. The goal of the 2015 grant is to provide asthma training and support to three CAPE Head Start child care centers, and reach 120 children, 25 child care providers, and 175 family members. As of Dec. 1, 2015 4Cs had started recruiting Head Start centers to participate.

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

KFH Workforce Development Highlights

Long Term Goal:

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

Intermediate Goal:

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

Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 12 Workforce Development grants totaling $44,589 that served the KFH-Walnut Creek service area.[10] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $31,039 that address this need. In addition, KFH Walnut Creek provided trainings and education for 73 residents in their Graduate Medical Education program in 2014 and 50 residents in 2015, 19 nurse practitioners or other nursing beneficiaries in 2014 and 28 in 2015, and 64 other health (non-MD) beneficiaries as well as internships for 20 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grantee	Grant Amount	Project Description	Results to Date
*The Regents of the University of California	$75,000 This grant impacts all KFH hospital service areas in Northern California Region.	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	• 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

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

		Public Health and Primary Care, a UC Berkeley class taught by HCOP staff.	professionalism, HCOP served nine Summer Scholars (underrepresented students) • eight other students enrolled in and completed Kaplan's GRE preparation course
*Stiles Hall	$75,000 This grant impacts all KFH hospital service areas in Northern California Region.	Stiles' Experience Berkeley Program aims to promote admission of low-income, first-generation students of color, specifically Black, Latino, and Native American high school students, to University of California Berkeley (UCB) through mentorship by UCB students and admissions officers, academic counseling, and active recruitment of underrepresented high school and community college students.	Anticipated outcomes for the 260 mentored Experience Berkeley students include: • 100% of mentees apply for admission to UCB • 52% UCB admission rate for high school program participants • 87% UCB admission rate for community college program participants • 65% of those admitted from high school will attend UCB • 95% of those admitted from community college will attend UCB • 3.3 average GPA and maintained by program participants (vs. 2.9 GPA for underrepresented minority students not in program)
*Students Rising Above (SRA)	$50,000 This grant impacts 15 KFH hospital service areas in Northern California Region.	SRA's College2Careers program enables low-income, first-generation college students from the greater Bay Area to attain college degrees and enter careers in science, technology engineering and math (STEM) and health care through college preparation, college and financial aid application support, tutoring, health care, tuition assistance, career development, mentoring, internships, and college-to-workforce transition support.	Anticipated outcomes include • through College2Careers' tutoring workshops and webinars, 182 youth in SRA's College and Workforce Success Program gain the job readiness skills and knowledge needed for STEM and health care careers • via online webinars and informational interview videos with professionals from underserved socio-economic communities, more than 200 users of the web-based resource College2CareersHub are encouraged to consider majoring in STEM/health care fields
*Physicians Medical Forum (PMF)	$150,000 This grant impacts 16 KFH hospital service areas in Northern California Region.	PMF's Doctors On Board (DOB) Pipeline and Community Health Ambassadors (CHA) programs aim to increase the pipeline of African American and other under-represented minority medical students, residents, and physicians in Northern California who want to pursue careers in medicine. Through DOB, health care professionals mentor students and	Anticipated outcomes include: • 250 DOB students mentored annually by faculty, physicians, medical students, residents, and other health care professionals • 250 DOB students participate in workshops to prepare them for SAT/MCAT tests, essay/ writing skills, and interviewing/communication skills

		workshops help students prepare for the process of working towards a health care career. Through CHA, students work in teams with community-based organizations to design and help implement health education programs to improve the health of their communities and better prepare them for health care careers.	• 25 CHA students work with medical students, residents, and physicians to become prepared for medical school and with community-based organizations to develop multimedia community service/learning projects on a health-related topic

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

KFH Research Highlights

Long Term Goal:

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

Intermediate Goal:

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

Grant Highlights

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

			• Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

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

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- 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:
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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

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- 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

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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.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA

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

VIII. CONCLUSION

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

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

IX. APPENDICES

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

APPENDIX A: SECONDARY DATA SOURCES AND DATES

1. Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
2. Alameda County Public Health Department. http://www.healthyalamedacounty.org (various).
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61. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Healthy People 2020. http://www.healthypeople.gov/ . 2015.
62. US Department of Housing and Urban Development. 2013.
63. US Department of Labor, Bureau of Labor Statistics. June 2015.
64. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
65. US Drought Monitor. 2012-2014

APPENDIX B: LIST OF INDICATORS ON WHICH DATA WERE GATHERED

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

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

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

Indicator Variable	Data Source
(Percentage)	County Health Data Profile. 2014.
High School Cohort Graduation Rate	California, Department of Education. 2013.
Hispanic or Latino (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HIV Hospitalizations Age-Adjusted Discharge Rate (per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Households where Housing Costs Exceed 30% of Income (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HUD-Assisted Units, Rate (per 10,000 Housing Units)	US Department of Housing and Urban Development. 2013.
Inadequate Fruit / Vegetable Consumption (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09.
Inadequate Fruit/Vegetable Consumption (percentage, Population Age 2-13)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Income at or Below 200% FPL (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Infant Mortality Rate (Per 1, 000 Births)	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.
Insured Population Receiving Medicaid (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Intentional Injuries, Rate (per 100,000 Population (Youth Age 13 - 20))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Limited English Proficiency (Percentage, Population Age 5+)	US Census Bureau, American Community Survey. 2009-13.
Linguistically Isolated Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Liquor Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Live Within 1/2 Mile of a Park (Percentage, Population)	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.
Live within Half Mile of Public Transit (Percentage, Population)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Living in a HPSA-Dental (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.
Living in a HPSA-Primary Care (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.

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

Indicator Variable	Data Source
Students Tested)	Physical Fitness Testing. 2013-14.
Ozone (03) - Days Exceeding Standards, Pop. Adjusted Average (Percentage)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Particulate Matter 2.5 - Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
People Delayed or had Difficulty Obtaining Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
People with a Usual Source of Health Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Physically Inactive Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccination (Age-Adjusted) (Percentage, Population Age 65+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Poor Dental Health (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor Mental Health (Percentage, Adults 18+)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Poor or Fair Health (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Population Change, 2000-2010 (Percentage)	US Census Bureau, Decennial Census. 2000 - 2010.
Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2009-13.
Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Population with HIV / AIDS, Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2010.
Potentially Exposed to Unsafe Drinking Water (Percentage, Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Poverty (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Poverty, Children (Percentage, Population Under Age 18)	US Census Bureau, American Community Survey. 2009-13.
Pre-School Enrollment (Percentage, Population Age 3-4)	US Census Bureau, American Community Survey. 2009-13.
Preventable Hospital Events Age-	California Office of Statewide Health Planning and

Indicator Variable	Data Source
Adjusted Discharge Rate (Per 10,000 Pop.)	Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Primary Care Physicians, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
Rape Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Rate of Reported AIDS Cases (per 100,000)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Receiving SNAP Benefits (Percentage, Population)	US Census Bureau, Small Area Income & Poverty Estimates. 2011.
Recreation and Fitness Facilities, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Regular Pap Test (Age-Adjusted) (Percentage, Adults Females Age 18+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Robbery Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
School Expulsion Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
School Suspension Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
Screened for Colon Cancer (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Severe Mental Illness Related Emergency Department Visits (Rate per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Smoking Cigarettes (Age-Adjusted) (Percentage, Population)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Students Eligible for Free or Reduced Price Lunch (Percentage)	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.
Substance Use Emergency	Alameda County Public Health Department. Alameda

Indicator Variable	Data Source
Department Visit Rate (Rate per 100,000 (age-adjusted))	County Health Data Profile. 2014.
Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Teen Birth Rate (Per 1, 000 Female Pop. Under Age 20)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Teens Who Engage in Regular Physical Activity (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Tuberculosis Incidence Rate (per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Unable to Afford Dental Care, Youth (Percentage, Population Age 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2015 - June.
Uninsured Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Vacant Housing Units (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Walking or Biking to Work (Percentage, Aged 16+)	US Census Bureau, American Community Survey. 2009-13.
Walking/Skating/Biking to School (Percentage, Aged 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Weather Observations with High Heat Index Values (Percentage)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Without Adequate Social / Emotional Support (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Without Dental Insurance (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Without Recent Dental Exam (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Without Regular Doctor (Percentage, Total Population)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Workers Commuting by Car, Alone (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Workers Commuting More than 60 Minutes (Percentage)	US Census Bureau, American Community Survey. 2009-13.

Indicator Variable	Data Source
Years of Potential Life Lost, Rate (per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2008-10.
Youth Without Recent Dental Exam (Percentage)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.

APPENDIX C: PERSONS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member)	Target Group Represented*	Consultation Method	Date Consulted (2015)
County Government	Supervisor Haggerty's Office	Deputy Chief of Staff	Residents	Leader	3	Interview	08/21/15
County Health	Behavioral Health Services, Contra Costa County	Director	Behavioral health, mental health, homeless	Leader	1, 2, 3	Interview	09/22/15
County Health	Contra Costa Health Services	Assistant Director	Health services, public health	Leader	1, 2, 3	Interview	07/30/15
County Health/Public Health	Contra Costa County Public Health	Epidemiologist	Public health	Leader	1, 2, 3	Interview	06/24/15
Education	Dublin Unified School District	Director	Education	Leader	3	Interview	10/21/15
Education	Dublin Unified School District	District Nurse	Education, child health	Leader	1, 3	Interview	10/21/15
Education	Livermore Unified School District	Nurse	Education, child health	Representative	1, 3	Interview	09/30/15
Education	Livermore Unified School District	Director	Education	Leader	3	Interview	09/30/15
Education	Livermore Unified School District	Executive Secretary	Education	Leader	3	Interview	09/30/15

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

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member)	Target Group Represented*	Consultation Method	Date Consulted (2015)
Education	Pleasanton Unified School District	Director	Education	Leader	3	Interview	09/25/15
Education	Pleasanton Unified School District	Nurse	Education, child health	Leader	1, 3	Interview	09/25/15
Education	San Ramon Valley Unified School District	Student Services Coordinator	Education	Leader	3	Interview	09/15/15
Local Health	Axis Community Health	Sue Compton, Chief Executive Officer	Public health	Leader	1, 3	Interview	08/06/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	Lead African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15

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

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Rep-resentative/ Member)	Target Group Repre-sented*	Consul-tation Method	Date Consulted (2015)
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community health, minority	Representative, Member	1, 3	Focus group	09/08/15
Non-Profit	Meals-on-Wheels Senior Outreach	Executive Director	Low-income, underserved, older adults	Leader	3	Interview	08/12/15
Non-Profit	Tri-Valley Haven	Executive Director	Safety/violence	Leader	3	Interview	09/29/15

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

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Rep-resentative/ Member)	Target Group Repre-sented*	Consul-tation Method	Date Consulted (2015)
N/A	First 5 Contra Costa County	N/A	Spanish-speaking minority (Latino), low-income	Members (12)	3	Focus group	09/03/15
N/A	Monument Crisis Center	N/A	Medically underserved, low-income	Members (11)	3	Focus group	08/24/15
N/A	Open Heart Kitchen	N/A	Medically underserved, low-income	Members (11)	3	Focus group	09/02/15

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

APPENDIX D: GLOSSARY

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

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

Health Need	**Rank** (1=Highest Priority)	**Overall Average Score**	**Average Scores of Prioritization Criteria Used by Group**			
			Severity	Magnitude	Disparities	Community Priority
Economic security	**4**	**2.39**	2.00	1.86	2.71	3.00
Healthcare access & delivery, including primary & specialty care	**4**	**2.39**	2.14	2.00	2.43	3.00
Mental health	**6**	**2.29**	2.14	1.57	2.43	3.00
Obesity, diabetes, & healthy eating/active living	**1**	**2.64**	2.57	2.71	2.29	3.00
Oral/dental health	**2**	**2.46**	2.57	2.00	2.29	3.00
Substance abuse, including alcohol, tobacco, and other drugs	**3**	**2.43**	2.14	2.00	2.57	3.00
Violence/injury prevention	**7**	**1.75**	1.86	1.57	2.57	1.00

Definitions:

A. **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

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

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

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

APPENDIX F: CHNA QUALITATIVE DATA COLLECTION PROTOCOLS

Professionals (Providers) Focus Group Protocol

Introductory remarks

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

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

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

1. Community Health Needs & Prioritization

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

a. We'd like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on this list that should be added. **(Write them on the list.)**

i. Overall?

ii. Specific needs for groups by gender, age, ethnicity, geography, etc.?

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

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

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

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

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

2. Access to Care

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

a) Based on your observations and interactions with the clients you serve, to what extent are your clients aware of how to obtain health care? **(Explain if needed: Where to find a clinic, how to make an appointment, etc.)**

b) To what extent are your clients aware of how to obtain health insurance?

c) What barriers to access still exist? **(Focus on comparison pre- and post-ACA)**
   i. Is the same proportion still medically uninsured/under-insured; or is it a smaller proportion, or a larger proportion than before ACA?
   ii. Do more people, the same, or fewer people have a primary care physician than before ACA?
   iii. Are people using the ER as primary care to the same degree, less, or more than before ACA?
   iv. Is the same proportion of the community facing difficulties affording health care, or is it a smaller proportion, or a greater proportion than before ACA?

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

3. Drivers/Barriers

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

Prompts if they are having trouble thinking of anything:

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

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

4. Suggestions/Improvements/Solutions

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

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

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

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

Concluding Remarks

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

Residents (Non-Professionals) Focus Group Protocol

Introductory remarks

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

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

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

1. Community Health Needs & Prioritization

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

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

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

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

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

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

2. Access to Care

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

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

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

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

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

3. Drivers/Barriers

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

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

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

4. Suggestions/Improvements/Solutions

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

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

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

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

Concluding Remarks

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

Key Informant Interview Protocol

Introduction

What the project is about:

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

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

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

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

Preamble

Our questions mainly relate to:

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

1. Background

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

2. Health needs

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

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

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

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

3. Challenges: Access to healthcare – post-ACA

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

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

4. Other Challenges

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

Prompts if they are having trouble thinking of anything:

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

5. Suggestions/Improvements/Solutions

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

a) Are there any policy changes you would recommend that could address these issues? Consider those that are readily achievable and politically feasible.
b) Are there existing resources available to address these needs? If so, why aren't people using them?
c) What other resources are needed?

d) Of the resources/solutions to improve health, which do you feel is the most significant improvement needed, second, and third?

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

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

Concluding Remarks

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

APPENDIX G: COMMUNITY ASSETS AND RESOURCES

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

Existing Health Care Facilities

Alta Bates Summit Medical Center

- Oakland
- Berkeley

Contra Costa Regional Medical Center

Eden Medical Center

Ernest Cowell Memorial Hospital

Fern Lodge

Fremont Hospital

Gilmore Hospital

Highland Hospital

John Muir Medical Center

- Concord
- Walnut Creek

John Muir Behavioral Health Center

Kaiser Permanente – Diablo (Antioch and Walnut Creek)

Kaiser Permanente – East Bay (Oakland and Richmond)

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

Kindred Hospital San Francisco Bay Area

San Leandro Hospital

St. Rose Hospital

San Ramon Regional Medical Center

Stanford Health Care – ValleyCare Medical Center

Sutter Delta Medical Center

Telecare Heritage Psychiatric Health Facility

UCSF Benioff Children's Hospital – Oakland

U.S. Naval Hospital

Veteran's Administration Hospital

- Livermore
- Martinez

Washington Hospital

Willow Rock Center (psychiatric)

Existing Federally Qualified Health Centers

Alameda County Health Care Services
- Mobile Van #2 (San Leandro)

Albert J. Thomas Medical Clinic

Alcatraz Avenue Medical Group

Asian Health Services
- 8th Street Satellite
- Webster Street

Axis Community Health
- Livermore
- Pleasanton

Berkeley Primary Care Access Clinic

Casa del Sol

East Oakland Health Center

Frank Kiang Medical Center

La Clinica
- Monument (Concord)
- Pittsburg-Medical
- Oakley

La Clinica de la Raza
- 9th Street, Oakland
- 12th Street, Oakland

Lifelong Ashby Health Center

Lifelong Brookside Community Health Center
- Richmond
- San Pablo

Lifelong Dental Care

Lifelong Dr. William M. Jenkins Pediatric Center

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

Native American Health Center

Over 60 Health

San Antonio Neighborhood Health Center

Tiburcio Vasquez Health Center

- Union City
- Hayward
- San Leandro

Tri-City Health Center

- Main Street Village, Fremont

West Oakland Health Council

William Byron Rumford Medical Clinic

Other Existing Community Resources and Programs for Each Health Need

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

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

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

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

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

- La Clinica de La Raza
- La Familia – FRC - Fuller
- LIFE Eldercare, Inc. - VIP Rides Program
- LifeLong Medical Care
- Lighthouse Community Center
- Native American Health Center
- Operation Access
- Planned Parenthood:
    - Mar Monte
    - Shasta Pacific

- Pregnancy Choices Clinic
- Ronald McDonald Care Mobile Dental Clinic
- RotaCare Clinic
- Silva Pediatric Medical Clinic
- Second Chance Hayward Center
- Serra Center - Intermediate Care Facility for the Developmentally Disabled - Handicapped (ICF- DDH) and ILS/Supported Living Services
- South Hayward Parish- Hayward Community Action Network
- St. Rose Hospital:
    - Main
    - Silva Pediatric Medical Clinic
    - Women's Center
    - Women's Imaging Center

- St. Vincent de Paul RotaCare Clinic
- Sutter Delta Community Clinic
- The Latina Center
- Tiburcio Vasquez Health Center:
    - Family Support Services
    - Hayward Clinic
    - School Based Health Services- Logan Health Center
    - School Based Health Services- Tennyson Health Center
    - Union City Clinic
    - Union City Clinic
- Tri-City Health Center:
    - Harm Reduction
    - LGBT Services
    - Teen City Health Clinic

- United Seniors of Oakland and Alameda County
- Respite Care Shelter for the Homeless
- Washington on Wheels Mobile Health Clinic
- Washington Township Medical Foundation

Health Need: Mental Health

- Abode Services:
  - Greater HOPE (Homeless Outreach and People Empowerment)
  - HOPE Project Mobile Health Clinic
  - Project Independence
  - STAY (Supportive Housing for Transitional Aged Youth)

- ACBHCS:
  - Crisis Response Program
  - Eden Children's Services
  - Geriatric Assessment & Response Team
  - Tri-City Children's Outpatient Services
  - Tri-City Community Support Center

- ACMC:
  - John George Psych Pavilion
  - Outpatient Psychiatric Services
- Alameda County Health Care Services Agency
- Alameda County Housing and Community Development Shelter + Care
- Alameda County Tri-City Children and Youth Service

- Alzheimer's Services of the East Bay Adult Day Healthcare Center - Hayward Center
- Ashland Youth Center
- Axis Community Health Adult Behavioral Health Services
- Bay Area Community Services, Inc., including Adult Day Care Services
- Boldly Me
- Building Opportunities for Self-Sufficiency (BOSS):
  - Behavioral Health Care Transitional Housing
  - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward

- Cal-SAFE - Tri-City Cal-SAFE Program
- Centro de Servicios
- Chabot- Women in Transition
- Child Abuse Listening Interviewing Center - CASA
- Child Family and Community Services (CFCS):
  - Burke Cal-SAFE Program
  - Southern Alameda County Early Head Start and Head Start
- Christian Counseling Centers, Inc.:
  - Fremont Christian Counseling Center
  - Hayward Christian Counseling Center

- City of Berkeley Health, Housing and Community Services Department
- Community Health for Asian Americans
- Concord Family Services Center
- Contra Costa Crisis Center
- Contra Costa Health Services
- Crockett Counseling Center
- Davis Street Family Resource Center
- Deaf Counseling Advocacy and Referral Agency
- Early Childhood Mental Health Program

Health Need: Mental Health

- East Bay Agency for Children- Child Assault Prevention Training Center
- East Bay Services to the Developmentally Disabled- Evergreen Senior Center
- East Bay Community Recovery Project- Hayward Outpatient Division
- Eden I&R, Inc.
- Eden Youth and Family Service's Tattoo Removal Program
- Emergency Shelter Program, Inc.
- Familias Unidas
- Families Forward
- Family Education and Resource Center (FERC)
- Family Paths:
    - 24-hour Parent Support Hotline
    - Counseling Services

- FCHSD:
    - Fremont Senior Center
    - Youth and Family Services

- Fremont Hospital:
    - 23-Hour Behavioral Crisis Assessment
    - Acute Inpatient Care Program
    - Chemical Dependency Intensive Outpatient Program
- Filipino Advocates for Justice - Youth Development

- George Mark Children's Home
- Girls Inc.
- GOALS for Women (Oakland)
- HARPD – Matt Jimenez Community Center
- Horizons Family Counseling
    - Cronin House
    - Project Eden

- Jewish Family & Community Services East Bay
- JFK University – Concord Community Counseling Center
- John Muir Health Adolescent, Adult & Children's Psychiatric
- Programs
- Kidango, Inc.:
    - Early Head Start/Head Start Programs
    - Mental Health
    - Special Needs/Early Intervention Services

- La Cheim School, Inc
- La Clinica de la Raza, San Leandro
- La Familia Mental Health Services:
    - Outpatient Counseling Program

- Monument Impact – Mentes Positivas
- Multi Lingual Counseling Center, Inc.
- NAMI (National Alliance on Mental Illness):
    - Alameda County South
    - Contra Costa (National Alliance on Mental Illness)

Health Need: Mental Health

  - Tri-Valley

- Power Program
- Pregnancy Choices Clinic
- Putnam Clubhouse
- REACH Ashland Youth Center
- Safe Alternative to Violent Environments (SAVE) - 24-Hour Crisis Line
- SAVE:
  - Emergency Shelter
  - Individual Counseling and Support Group

- Schuman-Lilies Clinic Fremont
- Second Chance:
  - Anger Management
  - Hayward Center
  - Newark Center

- Seneca Center for Children and Families:
  - Public School-based Outpatient Counseling for HUSD
  - Willow Rock Center 23-hour Crisis Stabilization and Outpatient Services

- South Hayward Parish - Hayward Community Action Network
- St. Rose Hospital- Main
- Telecare Corp.:
  - Morton Bakar Center
  - Villa Fairmont Short Stay Program
  - Willow Rock Center Inpatient Services

- Terra Firma Diversion/Educational Services:
  - Court Ordered Adult Diversion Programs
  - Domestic Violence and Anger Management Classes

- The Latina Center (Richmond)
- Tiburcio Vasquez Health Center:
  - Behavioral Health Center
  - School based health services – Logan Health Center
  - School based health services – Tennyson Health Center

- Tri-City Health Center:
  - HIV/AIDS Care and Treatment Program
  - Women's Services

- Tri-Valley Axis Community Health Adult Behavioral Health Services
- Horizon Family Counseling
- USG – Department of Veterans Affairs (VA) - Fremont Outpatient Clinic
- Victory Outreach - Prison Counseling and Services; Residential Rehab Program - Hayward
- Washington Hospital Healthcare System - Health Connection
- Women on the Way Recovery Center

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

- 18 Reasons
- Abode Services
- ACPHD - WIC
- ACMC- Winton Wellness Center
- Alameda County Community Food Bank
- Alameda County Deputy Sheriffs' Activities League's- Dig Deep
- Alameda County Food Bank
- Alameda County Healthcare Services – School Health Services Coalition
- Alameda County Nutrition Services
- Alameda County Office of Education
- Alameda County Public Health Department

- Alzheimer's Services of the East Bay Adult Day Healthcare Center- Hayward Center
- Ambrose Recreation and Park District
- Ashland Free Medical Clinic
- BACS - Adult Day Care Services
- BOSS - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward
- Bay Point All Stars
- Bay Point Community Foundation
- Berkeley Food and Housing Project
- Boys & Girls Club of the Diablo Valley
- Building Blocks Collaborative
- Building Blocks for Kids Collaborative
- California State University, East Bay's Promise Neighborhood
- Center for Human Development
- Centro de Servicios
- CFCS - Southern Alameda County Early Head Start and Head Start
- Children's Emergency Food Bank
- City of Antioch
- City of Fremont Parks and Recreation Dept.
- City of Livermore
- City of Newark - Senior Center for Adults ages 55
- City of San Leandro Recreation and Human Services- Senior Community Center
- City Slicker Farms
- Commodity and Food Programs
- Community Child Care Council of Alameda County
- Contra Costa Health Services
- Cooking Matters/Three Squares
- East Bay Agency for Children
- East Bay Regional Parks
- East County Health and Wealth Initiative
- East County Kids N Motion
- East County Midnight Basketball

- Eden I&R, Inc.
- Eden Youth and Family Center:
    - Hayward Day Labor Center
    - New Start Tattoo Removal

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

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

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

  - Hayward Community Action Network
  - Senior Meal Site

- Spectrum Community Services, Inc.- Senior Nutrition and Activities Program
- St. Rose Hospital- Main
- Tri-City Free Breakfast Program
- Tri-City Health Center
- Tri-City Medical Services
- Tri-Valley Children's Emergency Food Bank
- Tri-Valley Open Heart Kitchen
- Senior Support Program of the Tri-Valley Children's Emergency Food Bank

- Tiburcio Vasquez Health Center (incl. WIC)
- United Seniors of Oakland and Alameda County
- Urban Tilth
- Village Community Resource Center
- Viola Blythe Community Service Center of Newark
- Washington Hospital and Health Care Services
- Washington Hospital Healthcare System:
  - Community Outreach
  - Diabetes Program
  - Outpatient Diabetes Center

- Washington on Wheels Mobile Health Clinic
- White Pony Express
- YMCA:
  - East Bay
  - Fremont/Newark

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

Health Need: Substance Abuse (including tobacco and alcohol)

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

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

Health Need: Violence and Injury Prevention

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

APPENDIX H: HEALTH NEEDS PROFILES

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

Profile of Walnut Creek Service Area Health Needs

ECONOMIC SECURITY

Why Is It Important?

MORE THAN 1 IN 10 LACK FOOD SECURITY

In the KFH-Walnut Creek service area 14% experienced food insecurity in the prior year.

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

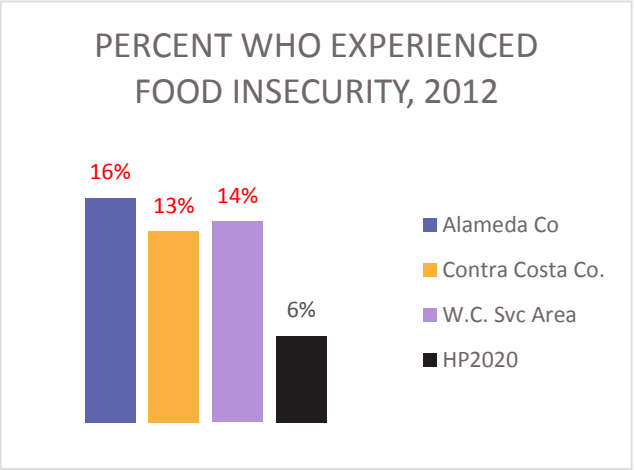
Why Is It a Community Health Need?

Residents in the KFH-Walnut Creek service area experience food insecurity at a rate which fail Healthy People 2020 (HP2020) target. Ethnic disparities are seen in the proportions of people living in poverty. Community input suggests that affordable housing is a major issue, and homelessness is a concern as there are not enough services for basic needs. Community members also expressed that people can't afford or lack time to take care of themselves.

What Do the Data Show?

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

- In the KFH-Walnut Creek service area a greater proportion of Latino residents (12%) and Latino children (26%), Black residents (18%) and children (22%), American Native residents and children (both 13%) Native Hawaiian residents (27%) and children (29%), and other race residents (16%) and children (21%) in the KFH-Walnut Creek service area were living in poverty compared to non-Hispanic White residents (6%) and children (5%).



- A higher percentage of adult Latinos (24%) Blacks (9%) Native Americans (13%) Native Hawai'ians (24%) and other race (30%) did not have a high school diploma compared to White adults (5%).
- KFH-Walnut Creek service area residents and Contra Costa County residents experience food insecurity at some point during the year in proportions which do not meet the HP2020 target. (See chart.)

What Does the Community Say?

- People cannot afford to or lack time to take care of themselves
- Living in a poor neighborhood has an impact on your overall wellbeing even if you are not poor yourself.
- People are faced with the choice to either buy medicine, pay rent, or eat. Seniors who are on a fixed income are particularly affected.
- Families have to work and do not have the time to obtain health care information.
- Not enough job training, particularly for those between 18-25 years old.
- There are too few full-time jobs; people are working two or more jobs and still not making ends meet.
- Available jobs do not pay enough. Low-income jobs are not stable and are more susceptible to the ups and downs of the economy.
- There is too little affordable housing available. Multiple families are living in single family homes.
- Homelessness is of concern:
  - ➥ Not enough services for basic needs (safe and dry places for homeless people to sleep; food banks).
  - ➥ Health issues are much harder to manage when you are homeless.
  - ➥ Homeless children miss school more often.

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

Profile of KFH-Walnut Creek Service Area Health Needs

HEALTHCARE ACCESS & DELIVERY

Why Is It Important?

ETHNIC DISPARITIES IN UNINSURED POPULATION

In the KFH-Walnut Creek service area, close to 1 in 5 residents in certain ethnic populations are uninsured.

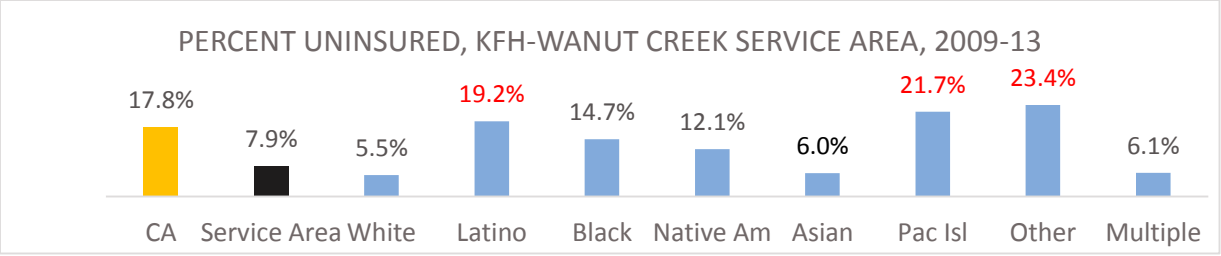
Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.[3] Components of access to care include: coverage, services, and timeliness. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. As reflected in the community comments, barriers to services include: lack of availability, high cost, and lack of insurance coverage. As illustrated in the data below, these barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented.

Why Is It a Community Health Need?

In the KFH-Walnut Creek service area, ethnic disparities are seen in the proportions of residents who are uninsured. Countywide, Alameda rates of those who have had difficulty obtaining care and those who are lacking a source of care do not meet Healthy People 2020 (HP2020) targets. In Contra Costa County, the number of federally qualified health centers is well below the state average and the rate of preventable hospital events exceeds the state average. The community input indicates that insurance premiums and co-payments are too high. Community members also expressed concern about a lack of cultural competence amongst health system staff.

What Does the Data Say?

- Stark ethnic disparities exist in the uninsured population of the KFH-Walnut Creek service area. (See chart.)



- Alameda County missed the HP2020 target for people with a usual source of care: 88% of Alameda County residents reported a usual source of care, below the HP2020 target of 95%.

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

- Contra Costa County falls short of the target rate for Federally Qualified Health Centers (FQHCs). The rate of FQHCs in 0.5 per 100,000, well below the state average of 2.0.
- Contra Costa County has an age-adjusted rate of 85.1 for preventable hospitable events per 10,000 residents (for conditions such as pneumonia, dehydration, asthma, and diabetes), which is higher than the state average of 83.2.

What Does the Community Say?

- The cost of insurance, co-payments, and deductibles are too high. The low-income population has less access and may delay care, which may result in a lack of diagnoses. The lack of insurance/access to care cause stress.
- Insurance does not always cover the care that is needed.
- Some find it difficult to navigate complex health systems, especially new immigrants, non-English speakers, low-income, and undocumented residents.
- There is a lack of providers overall (primary, specialty, and mental health professionals) and too few existing providers that accept Medi-Cal. Specialty care providers are also too few and too distant (including vision, dental, and mental health care).
- It is difficult to obtain a timely appointment and wait times in the office are too long. The emergency room is still being used as a source of care because it is faster than getting an appointment with a primary care physician and is available outside of working hours.
- Patients fear accessing care due to previous bad experiences with health system staff who lack cultural competence.
- Getting to and from appointments is difficult when patients are relying on public transportation. Cost of transportation is also an issue.
- The community lacks awareness about available, low-cost healthcare resources and how to obtain health insurance.
- For the homeless, it is difficult to think about health when you are busy thinking about where you are going to sleep at night.

Profile of KFH-Walnut Creek Service Area Health Needs

MENTAL HEALTH

Why Is It Important?

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges.[4] Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

SUICIDE HIGHEST FOR WHITE RESIDENTS

White KFH-Walnut Creek residents are ten times more likely than Pacific Islanders and twice as likely as Blacks to commit suicide.

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

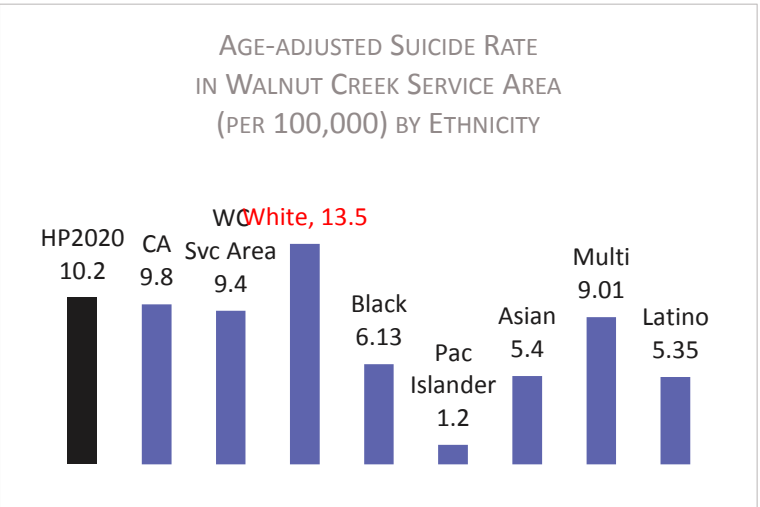
Why Is It a Community Health Need?

While the rate of suicide in Contra Costa County is higher than the Healthy People 2020 (HP2020) target, in the KFH-Walnut Creek service area the rate is slightly lower. Whites are disproportionately more likely to commit suicide and to report the need for mental health care than those of other ethnicities. Community input indicates that a lack of education around mental health and available mental health services as well as difficulty navigating the healthcare system are barriers to accessing mental health care.

What Do the Data Show?

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

- The age-adjusted rate of death due to intentional self-harm (suicide) per 100,000 population in the KFH-Walnut Creek service area was slightly lower than the state average and the HP2020 objective. (See chart.)



- As shown in the chart, the suicide rate in the KFH-Walnut Creek service area for Whites was the highest among racial and ethnic groups while the rates were lowest among Native Hawaiians/Pacific Islanders.
- White adults are much less likely to report a need for mental health care as compared to other racial and ethnic groups. For example, in the KFH-Walnut Creek service area, 16% of Whites reported a need for mental health care during the past 12 months, as compared to 21% of Blacks and 28% of Latinos.
- 26% of Alameda County residents felt a lack of social or emotional support, slightly above the state average of 25%.

What Does the Community Say?

- There is a lack of knowledge about mental health imparted by primary care providers and lack of referrals to obtain mental health services.
- Navigating the healthcare system is difficult.
- There is a need for more counselors for children/adolescents.
- There are not resources for people with high mental health needs who can't afford therapists.
- There is a lack of places for people to go with acute mental illness.
- Not enough physical spaces for mental health hospitals/treatment facilities.
- Lack of insurance and the cost of insurance is keeping people from obtaining services.
- Seniors are isolated and lonely leading to depression.
- Education is needed around the link between mental health and healthy living/healthy eating.
- Cultural norms stigmatize people who go to counseling (e.g., people who need mental health services are viewed as crazy).
- High-achieving students are being pressured by their parents to be faster, quicker, and better than previous generation. Parents are concerned about having their child "outed as anything but perfect".

Profile of KFH-Walnut Creek Service Area Health Needs

OBESITY/DIABETES/HEALTHY EATING/ACTIVE LIVING

Why Is It Important?

OBESITY A CONCERN FOR ADULTS AND YOUTH

In the KFH-Walnut Creek service area, nearly six in ten adults and one in four youth is overweight or obese.

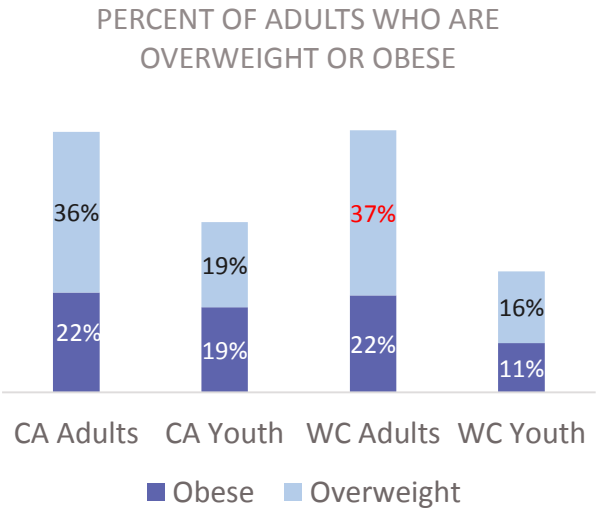
Healthy diets and achievement and maintenance of healthy body weight reduces the risk of chronic diseases and promotes health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.[5] For example, having healthy food available and affordable in food retail and food service settings allows people to make healthier food choices. When healthy foods are not available, people may settle for foods that are higher in calories and lower in nutritional value.[6] Creating and supporting healthy food environments allows people to make healthier choices and live healthier lives.

Why Is It a Community Health Need?

High rates of obesity are of concern in the KFH-Walnut Creek service area. Although rates of adult diabetes are no better than California (8%), the community perception is that childhood obesity is on the rise. Populations of color are much more likely to be overweight. The environment may play a factor; more than a quarter of residents live in a food desert,[7] and KFH-Walnut Creek service has a lower rate of WIC-authorized food stores than in the state. In addition, fewer KFH-Walnut Creek service area students walk, bike or skate to school than in the state. Community members indicated that obesity among youth is of highest concern, and lack of access to affordable, healthy food is driving this health need.

What Do the Data Show?

- Over half of service area residents are overweight or obese, which is similar to the state and Contra Costa County (59%). (See chart.)
- In Alameda and Contra Costa counties combined, half of Whites (51%) and Blacks (56%) are overweight or obese, compared to 22% for Latinos, and 45% overall.
- About 8% of service area adults have been diagnosed with diabetes, which is no better than the state.
- Six in ten youth in Alameda County have low fruit/vegetable consumption, missing the state average



[5] Healthy People 2020. Office of Disease Prevention and Health Promotion. Web. December 2015.
[6] Healthy Food Environments. Centers for Disease Control and Prevention. Web. December 2015.
[7] A low-income census tract where a substantial share of residents has low access to a supermarket or large grocery store.

of 47% in the county. White youth are much more likely to have low fruit/vegetable consumption as compared to Latino and Black youth.

- In the KFH-Walnut Creek service area, eight in ten (80%) Medicare enrollees with diabetes had an annual exam (Hemoglobin A1c Test), slightly lower than the state average of 81%.
- In the KFH-Walnut Creek service area, 27% of residents live in areas designated as a food desert, which is higher than Contra Costa County (25%) and the state average (14%).
- There are 12.5 WIC-authorized food stores per 100,000 residents in the KFH-Walnut Creek service area, missing the state average of 15.8.
- In the KFH-Walnut Creek service area, 37% of students walk/bike/or skate to school, below the state average of 43%.

What Does the Community Say?

- Diabetes is an epidemic at schools, injections must be provided by licensed nurses only and there isn't enough nurse power at the schools.
- The community needs more education and information about CAL-Fresh, Food Banks, and Farmer's Markers.
- Too many places sell products with high sugar content.
- It is more expensive to eat healthy and organic; fast food is cheaper.
- There is a lack of full access to supermarkets in low income areas.
- More sports and recreational activities for youth and adults that are affordable are needed.

Profile of KFH-Walnut Creek Service Area Health Needs

ORAL HEALTH

Why Is It Important?

KIDS WITH DENTAL PROBLEMS MISS SCHOOL

8% of Contra Costa County children have missed a day or more of school due to a dental problem.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, chew, swallow, and make facial expressions to show feelings and emotions.[8] However, oral diseases, from cavities to oral cancer, cause pain and disability. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health.[9] Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures. There are also social determinants that affect oral health. People with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of oral diseases. Additionally, people with disabilities and other health conditions are more likely to have poor oral health.

Why Is It a Community Health Need?

Statistical data show similar proportions and rates of poor oral health access, utilization, and dental problems compared with the state. However, the community expressed concern about the lack of access to oral and dental health services for the community.

What Do the Data Show?

- Seventeen percent (17%) of youth had *not* had a recent dental exam, which is similar the state average (18.5%).
- Eighty-two percent (82%) of children in Alameda County had visited the dentist within the past 12 months, lower than the state proportion of 85%.
- In Contra Costa County, 8% of children missed one or more school days due to a dental problem, slightly higher than in the state (7%).
- Nearly one in four (23%) KFH-Walnut Creek service area adults had *not* had a recent dental exam, which is better than in the state (31%).
- The KFH-Walnut Creek service area is *not* a Dental Health Professional Shortage Area.

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

What Does the Community Say?

- Health plans don't cover dental care.
- The cost of dental care is too high for low-income people. Many providers require cash for services.
- Many people don't have transportation to get to the dentist. Obtaining transportation is difficult and expensive, especially when some have to go to Oakland for services. Dental health specialty care services are too distant.
- There are an insufficient number of providers that accept Medi-Cal insurance.
- The community has no mobile dental clinic.
- There are long wait times for appointments, especially for specialty oral/dental care.
- Parents may not take kids to the dentist for preventative care, and instead wait until there is a problem.
- Benefits provided aren’t sufficient to meet all of the dental care demands.
- There is a perception that residents are receiving poor quality dental care with few treatment options. For example, healthcare facilities may resort to just pulling teeth, which are expensive to replace. For example, insurance often does not cover root canals.
- Reimbursement rates are not economically feasible for dentists.

Profile of KFH-Walnut Creek Service Area Health Needs

SUBSTANCE ABUSE

Why Is It Important?

The abuse of substances, including alcohol, tobacco, and other drugs, has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases.[10] The effects of substance abuse contribute to costly social, physical, mental and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime and suicide.[11]

BINGE DRINKING RATES HIGHER THAN STATE

Bing drinking rates in the KFH-Walnut Creek service area are higher than in California.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have shifted the research community's perspective on substance abuse. Substance abuse is now understood as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.[11]

Why Is It a Community Health Need

Substance abuse (including tobacco and alcohol) is a health need in the KFH-Walnut Creek service area as demonstrated by levels of excessive alcohol consumption among adults, which are higher than the state average. In addition, close to 14% of the KFH-Walnut Creek service area residents' total household expenditures are towards alcohol, slightly higher than the state average. Community feedback indicates that residents use substances to help them cope and sleep. Community members feel that the area lacks alcohol and drug services and that treatment facilities are far away and hard to get to. Some members also feel that the religious component of certain treatment options may drive people away.

What Do the Data Show?

- The rate of binge drinking in the KFH-Walnut Creek service area is 19%, higher than the state average of 17%.
- Close to 14% of KFH-Walnut Creek service area residents' total household expenditures are towards alcohol, slightly higher than the state average (13%).

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

- Tobacco usage in the KFH-Walnut Creek service area is 12%, similar to California (13%), Contra Costa County (12%), and Alameda County (11%).

What Does the Community Say?

- In the community, people are generally using opiates, methamphetamines, and alcohol. Marijuana is used more often now that it's legal; education is needed. Providers are seeing an increase in drug use.
- Methamphetamine users are experiencing drug-induced heart failure. Methamphetamine use also leads to tooth decay and other health issues.
- Residents use substances to help them cope and to sleep. For those experiencing homelessness, substances are also being used to cope with being on the street.
- Youth substance use is often not addressed "until it's too late."
- The community lacks alcohol and drug services. Treatment facilities are far away and hard to get to.
- Existing services to help people quit using substances aren't good and are expensive.
- Residential treatment facilities are not effective. They "just lock people up" and when they are out, they start using again.
- There should be no court mandates to go to residential treatment facilities. Twelve-step programs are available and easy to access.
- There is a need for more beds in wet homeless shelters (i.e., shelters that do not require sobriety/abstinence for entry). Some feel the religious component of certain treatment options may drive people away.
- People don't know where they may safely dispose of their unused prescription medications which could be misused by others.
- The community perceives that there is a connection between drug/alcohol abuse and domestic violence.

Profile of KFH-Walnut Creek Service Area Health Needs

VIOLENCE/INJURY PREVENTION

Why Is It Important?

VIOLENCE CRIME RATES ALARMING

Rates of homicide and domestic violence deaths are worse in KFH-Walnut Creek than in California.

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

Why Is It a Community Health Need?

The KFH-Walnut Creek service area and/or its surrounding counties have worse rates of violence compared to the state. Also, ethnic disparities are evident in homicide rates. Community input indicates that elder neglect is a problem and that there is a lack of domestic violence shelters in the community.

What Do the Data Show?

Indicator (per 100,000 except where noted)	KFH-Walnut Creek Service Area	California
Overall violent crime rate	490.0	425.0
School suspensions rate[12] (per 100 students)	4.1	4.0
School expulsion rate[1] (per 100 students)	0.03	0.05
Assault rate	259.4	249.4
Rape rate	20.4	21.0
Adult homicide mortality rate	1.8	5.2
Domestic violence rate (per 100,000 females aged 10+)	12.1	9.5

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

- As seen in the table above, the age-adjusted homicide rate in Contra Costa County is worse than the rates for California. They also are worse than the Healthy People 2020 objective of 5.5. Also, racial and ethnic disparities among homicide victims are stark: The age-adjusted homicide mortality rate for Blacks is 39.9 in Contra Costa County.

What Does the Community Say?

- Elder neglect is a problem, especially of those with mental health issues.
- There is a lack of domestic violence shelters in the community.
- There are higher homicide rates amongst African American gangs than Latino gangs even when there are more Latino gangs.
- The community may be underreporting violent crime or not cooperating with law enforcement because they lack trust of law enforcement.
- Community perceives a connection between domestic violence and drug/alcohol abuse.
- Youth service providers find that often people who need help with substance abuse and truancy have a history of abuse or domestic violence in their families.
- There are now fewer area facilities where rape assessments can be done.

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