2016 Community Health Needs Assessment

Kaiser Foundation Hospital Vacaville
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Approved by KFH Board of Directors
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Acknowledgements

This report was prepared by Valley Vision on behalf of Kaiser Foundation Hospital Vacaville. We are deeply grateful for all those who contributed to the community health needs assessment. Through the course of the CHNA project, many organizations and individuals on the health issues and conditions impacting their communities or the communities they serve. We gratefully acknowledge the contributions of these participants, many of whom shared deeply personal challenges and experiences with us. We hope that the contents of this report serve to accurately represent their voices.

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

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

B. Summary of Prioritized Needs

The following significant health needs were identified through the CHNA Process and are presented in order of priority according to a set of criteria detailed in Section VI-B.

1. **Healthy eating and active living** (HEAL) is a significant health need in the Kaiser Foundation Hospital (KFH) – Vacaville Hospital Service Area (HSA). Eighteen of 29 (62%) indicators pertaining to healthy eating and regular physical activity perform poorly compared to state benchmarks, including indicators that have significant disparities by race/ethnicity. Service providers and community members expressed concern about accessing affordable and healthy food options in their communities. Participants shared that unhealthy food and beverage products are easily accessible and cost less than a bag of fruit or vegetables. Particular issues included concerns that people have to go outside their communities to access healthy foods and that healthy food options are particularly limited for those with a lower socio-economic status.
2. **Safe, crime, and violence-free communities** is a significant health need in the KFH-Vacaville HSA. Twelve of 17 (71%) indicators pertaining to safe, crime and violence-free communities compare unfavorably to state benchmarks, including indicators that have significant disparities by race/ethnicity. Service providers and community members expressed concern about crime and violence in their communities, and that these communities often feel unsafe and non-walkable. Particular issues included gang violence, domestic violence and drug use. Participants also shared concerns about safety of parks in their communities, including drug and gang activity within parks, even during the day.
3. **Affordable and accessible transportation** is a significant health need in the KFH-Vacaville HSA. Four of eight (50%) indicators pertaining to affordable and accessible transportation compare unfavorably to state benchmarks. Service providers and community members expressed concern over the lack of transportation to get to doctors' appointments as well as other resources like healthy food options and employment opportunities.
4. **Access to behavioral health services** (mental health & substance abuse) is a significant health need in the KFH-Vacaville HSA. Two of six indicators (33%) pertaining to mental health perform poorly compared to state benchmarks, and one of five indicators (20%) pertaining to substance abuse and tobacco also exceeds the state benchmark. Service providers and community members expressed that the need for mental health and substance abuse services far outweighs the current amount of resources available in the service area. Community members talked about barriers to mental health treatment including stigma and lack of resources or places to go when you're having a mental health

crisis. Participants also mentioned concerns with the amount of substance abuse in their communities. Substances mentioned most often included crack, crystal meth, alcohol and tobacco.

5. **Economic security** (food, housing, employment, education) is a significant health need in the KFH-Vacaville HSA. Eight of 23 (35%) indicators pertaining to economic security compare unfavorably to state benchmarks, particularly for racial/ethnic minority groups in the HSA. Upstream health determinants (e.g., housing, employment and education) have the potential to impact downstream health determinants such as diabetes, heart disease and mental health. Economic security was mentioned in 15 of the 15 interviews conducted for KFH-Vacaville's service area. Service provider and community member focus groups voiced concerns over the lack of resources for adults and youth experiencing homelessness. There was concern over the lack of economic opportunities throughout the service area. Community members talked about having to work multiple jobs just to feed their families, while others talked about the service area as a "bedroom community" and having to go outside of their communities to get well paying jobs to support their families. Safe, affordable housing was also mentioned as a priority for community members.
6. **Access to high quality health care and services** is a significant health need in the KFH-Vacaville HSA. Eleven of 29 (38%) indicators pertaining to access to high quality health care and services, including oral health and maternal and infant health, perform poorly compared to state benchmarks. Service provider interviews and community member focus groups voiced concerns over the shortage of health care providers to keep up with the current demand for care and specific concerns that there are not enough specialty care services in the region. Community members also expressed concerns about oral hygiene, especially with youth, including the need for more oral health education in schools.
7. **Disease prevention, management and treatment** is a significant health need in the KFH-Vacaville HSA. Twenty-five of 41 (61%) indicators pertaining to the health need compare unfavorably to state benchmark. The need for cancer prevention, detection and treatment is marked by high rates of cancer incidence including breast, colorectal, prostate, and lung cancers. Service provider interviews and community member focus groups noted cancer and cardiovascular diseases as being problematic in their communities. Participants also voiced concerns over the amount of asthma problems seen in children and the high rates of sexually transmitted diseases in Solano County.

C. Summary of Needs Assessment Methodology and Process

The Community Health Needs Assessment (CHNA) was completed as a collaboration of the three major hospital systems in Solano County (Kaiser Permanente, Sutter Health, NorthBay Healthcare) as well as Solano Coalition for Better Health and the Solano County Public Health Department. Together, the CHNA collaborative represented three hospitals in Solano County including two Kaiser Permanente hospitals: KFH-Vacaville and KFH-Vallejo.

The CHNA Collaborative served to collectively conduct the 2016 CHNA and to support a coordinated approach to community benefit planning and activities. Building on federal and state requirements, the objective of the 2016 CHNA was:

> *To identify and prioritize community health needs and identify resources available to address those health needs, with the goal of improving the health status of the community at large with a particular focus on specific locations and/or populations experiencing health disparities.*

From this objective the following research questions were used to guide the 2016 CHNA:

1. What is the community or hospital service area (HSA) served by each hospital in the CHNA Collaborative?
2. What specific geographic locations within the community are experiencing social inequities that may result in health disparities?
3. What is the health status of the community at large as well as of particular locations or populations experiencing health disparities?
4. What factors are driving the health of the community?

5. What are the significant and prioritized health needs of the community and requisites for the improvement or maintenance of health status?
6. What are the potential resources available in the community to address the significant health needs?

To meet the project objectives, a defined set of data collection and analytic stages were developed. Data collected and analyzed included both primary or qualitative data, and secondary or quantitative data. To determine the geographic locations affected by social inequities, the Vulnerable Populations Footprint (VPF) feature in the Kaiser Permanente Community Commons Data Platform (CHNA-DP) (www.chna.org/kp) was used to look at two indicators that are among the most predictive of identifying poor health outcomes: poverty and high school graduation. Through consideration of these indicators as well as an initial review of the primary data, Focus Communities were identified within the KFH-Vacaville service area. Focus Communities were important to the overall CHNA methodology because they allowed for a place based lens with which to consider health disparities in the HSA.

To assess overall health status and disparities in health outcomes, the CHNA-DP was used to review over 135 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For specific sources and dates of the data used, please see Appendix A.

Community input and primary data on health needs were obtained via interviews with service providers and community key informants and through focus groups with medically underserved, low-income, and minority populations. Transcripts and notes from interviews and focus groups were analyzed to look for themes and to determine if a health need was identified as significant and/or a priority to address. Primary data included 10 interviews with 23 key informants and five focus groups conducted with 60 participants including community members and service providers. A complete list of primary data sources is available in Appendix B.

The quantitative and qualitative data were synthesized and analyzed to identify the significant health needs for KFH-Vacaville according to the criteria outlined in Section VI.A. This included identifying eight potential health need categories based upon a) the needs identified in the 2013 CHNA, b) the grouping of indicators in the CHNA-DP, and c) a preliminary review of primary data. Indicators within these categories were flagged if they compared unfavorably to the state benchmark or demonstrated racial/ethnic disparities according to a set of established criteria. Of the eight potential health needs, seven (7) were identified as significant for the KFH-Vacaville service area (Appendix C). The data validating and prioritizing these significant health needs are included in section VI.B. and Appendix D. Resources available to address the significant health needs were compiled by using the community assets listed in the KFH-Vacaville 2013 CHNA report as a foundation. This list was then verified and expanded upon to include those referenced through community input.

In order to assess the health needs of the community, eight potential health need categories were identified based upon a) the needs identified in the 2013 CHNA, b) the grouping of indicators in the Kaiser Permanente CHNA data platform (CHNA-DP), and c) a preliminary review of primary data. The quantitative and qualitative data were then organized by these eight categories and then analyzed to identify the significant health needs for each hospital according to the following criteria: 1) indicators that performed poorly compared to the State benchmark and/or demonstrated racial/ethnic disparities and 2) health needs identified as significant in key informant interviews and focus groups. Of the eight potential health needs, seven health needs were validated as significant for the KFH-Vacaville service area (Appendix C). As a final step, the resources available to address the significant health needs were compiled by using the community assets listed in the KFH-Vacaville 2013 CHNA report as a foundation. This list was then verified and expanded upon to include those referenced through community input.

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 10.2 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

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

B. About Kaiser Permanente Community Benefit

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

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

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

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

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the

subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

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

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

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

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

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

In conjunction with this report, KFH-Vacaville 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 the KFH-Vacaville Hospital Service Area

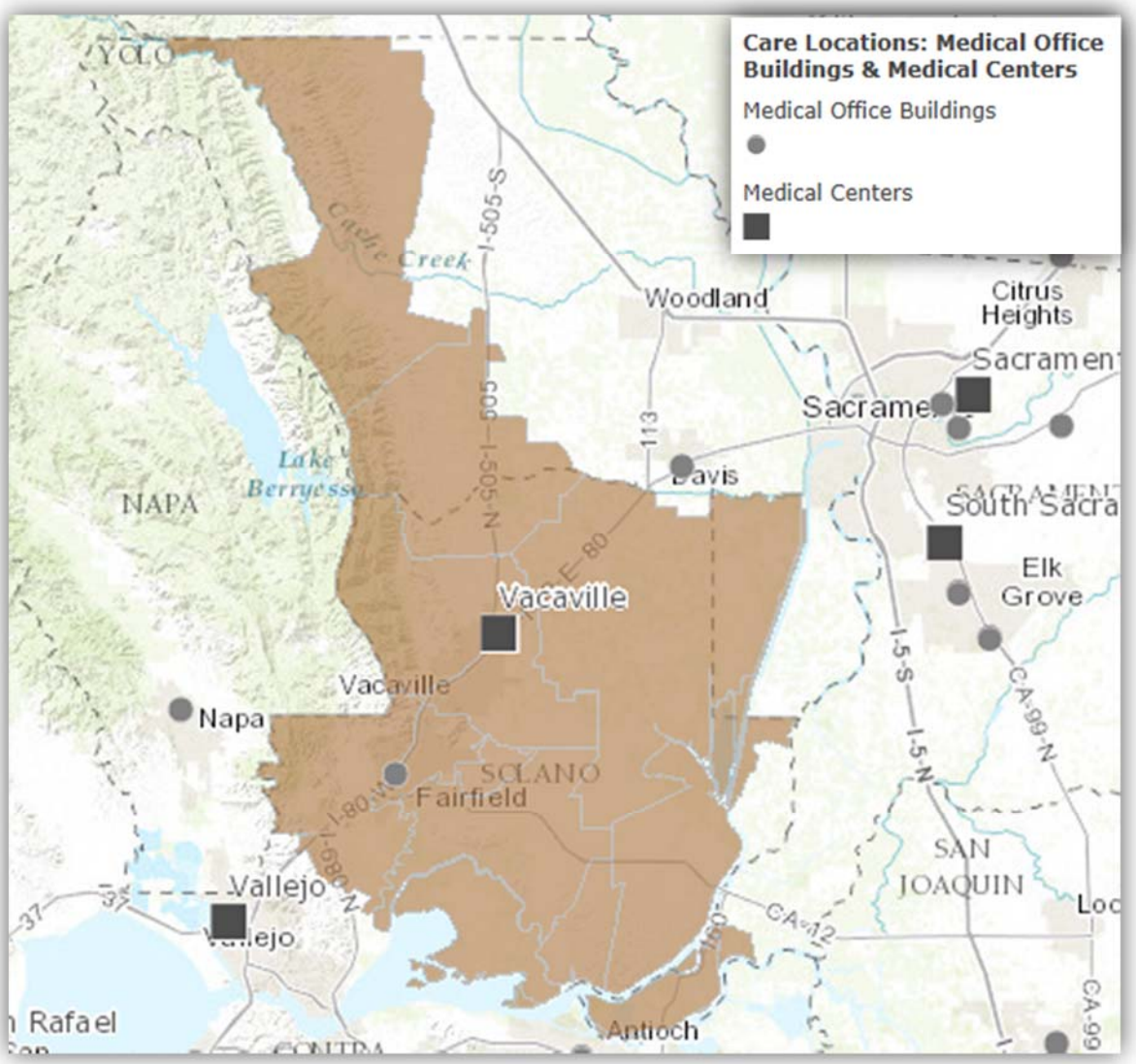


Figure 1. Map of KFH-Vacaville Hospital Service Area

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

The KFH-Vacaville service area includes the Solano County communities of Dixon, Elmira, Fairfield, Rio Vista, Suisun City, Vacaville, and Winters. The KFH-Vacaville hospital is centrally located along the Interstate 80 corridor in Solano County and intersects with Interstate 505.

iii. Demographic profile of community served

One quarter (25%) of the population served by KFH-Vacaville is under the age of 18, while 38% is between the ages of 18-44, and a little over one-third (38%) of residents are 45 or older. Over half (57.32%) of the population is White, while a quarter (25.95%) of the population is of Hispanic/Latino decent. The population is also made up of 11.89% Black, 10.98% Asian, 0.84% Pacific Islander/Native Hawaiian, 0.55% Native American/Alaskan Native, and 11.32% from another race. A little over a quarter (26.12%) of the population falls below 200% Federal Poverty

Level. There are large parts of KFH-Vacaville's service area that are rural farming communities; other parts are suburban and/or bedroom communities for the Bay Area and Central Valley.

A greater percentage of the population (11.94%) commutes over 60 minutes in each direction to work, compared to the national benchmark (8.12%). A little less than one-sixth (13.48%) of the population over age 25 does not have a high school diploma. Demographic and socio-economic data for KFH-Vacaville can be found in Table 1 and 2.

Table 1. KFH Vacaville Demographic Data	
Total Population	281,865
White	57.29%
Black	11.57%
Asian	11.17%
Native American/ Alaskan Native	0.53%
Pacific Islander/ Native Hawaiian	0.91%
Some Other Race	11.63%
Multiple Races	6.91%
Hispanic/Latino	26.69%

Table 2. KFH Vacaville Socio-economic Data	
Living in Poverty (<200% FPL)	26.04%
Children in Poverty (<100% FPL)	16.74%
Unemployed	8.6 %
Uninsured	10.88%
No High School Diploma	13.3%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

The Solano County Community Health Needs Assessment Collaborative (Solano CHNA Collaborative) included three health systems that represent three hospitals in Solano County. The CHNA Collaborative served to collectively conduct the 2016 CHNA and to support a coordinated approach to community benefit planning and activities. Solano CHNA Collaborative participants included the following hospitals:

- **Kaiser Permanente**: Kaiser Permanente Vacaville Medical Center
- **NorthBay Healthcare**: NorthBay Medical Center
- **Sutter Health Sacramento Sierra Region**: Sutter Solano Medical Center

B. Other partner organizations that collaborated on the assessment

The Solano Coalition for Better Health and the Solano County Public Health Department were both active contributors to the CHNA Collaborative. In addition, numerous partner organizations contributed to the CHNA. Over 15 organizations assisted the KFH-Vacaville CHNA process through participation in key informant interviews or focus groups, as outlined in Appendix B.

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

The 2016 CHNA was facilitated by Valley Vision, a regional leadership organization committed to making the Sacramento region a great place to live, work and recreate. The Solano CHNA Collaborative contracted with Valley Vision in 2016 and 2013 to conduct their CHNA process and reports. The collaborative process has built and strengthened partnerships between hospitals and other stakeholders, providing a coordinated approach to identifying priority health needs as well as developing plans to improve the health of Solano County.

Valley Vision was selected to conduct the 2016 CHNA in Solano County given its history of working with the Solano CHNA Collaborative, mixed methods research skills and strong commitment to drawing

attention to critical unmet health needs. Valley Vision has been a leading social enterprise and nonprofit consultancy for the Sacramento region since 1994 with the ability to deliver trusted research, design and drive multi-stakeholder initiatives and access a set of powerful leadership networks across the region.

The Valley Vision team conducted primary or qualitative data collection, analyzed primary and secondary data, synthesized these data to determine the significant and prioritized health needs, documented findings and wrote the draft and final CHNA reports. The CHNA report was primarily completed by Katie Strautman, MSW, lead for the Solano CHNA Collaborative project. The team that participated in the CHNA work – Amelia Lawless, CHES, ASW, Alan Lange, MPA, Anna Rosenbaum, MSW, MPH, Giovanna Forno, BS, and Sarah Underwood, MPH. The CHNA team brought a rich skill-set from years of experience working in public health, health care, social service and other public sectors. Valley Vision contracted with Dr. Heather Diaz and Dr. Mathew C. Schmidtlein, who assisted with project design, research methodology, data processing and GIS mapping for the CHNA.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

CHNA PROCESS MODEL

The CHNA collaborative project was conducted over a period of ten months, beginning in April 2015 and concluding in March 2016. The overall process to conduct the CHNA is outlined below in Figure 2, the CHNA Process Model. Additional details are provided in subsequent sections of the report.

The project began with confirming the HSA for KFH-Vacaville according to the geographic area defined by Kaiser Permanente. Once the broader HSA was identified, initial key informant interviews of area public health experts and social service representatives were conducted as part of the first phase of the CHNA process to identify preliminary vulnerable populations and locations where additional primary data collection was needed. Concurrently, secondary data collection began with using Kaiser Permanente's Vulnerable Populations Footprint (VPF) feature on the CHNA-DP to look at two key drivers of health; 1) poverty and 2) high school graduation, which are among the most predictive of identifying poor health outcomes. This information, including initial input from the key informant interviews, were analyzed to identify geographic areas within the HSA that were facing the greatest risk of both social and health inequities. These identified Focus Communities were used to target additional primary data collection in order to understand the specific health issues facing those particular high risk communities.

The second round of data collection and analysis included additional community input from high risk populations within the Focus Communities as well as a review of morbidity, mortality, health behavior and living conditions data on the CHNA-DP platform. Based on the analysis of the second round of primary and secondary data, a list of significant community health needs were identified for KFH-Vacaville service area. Finally, resources available to address the significant health needs were compiled and the final report was written.

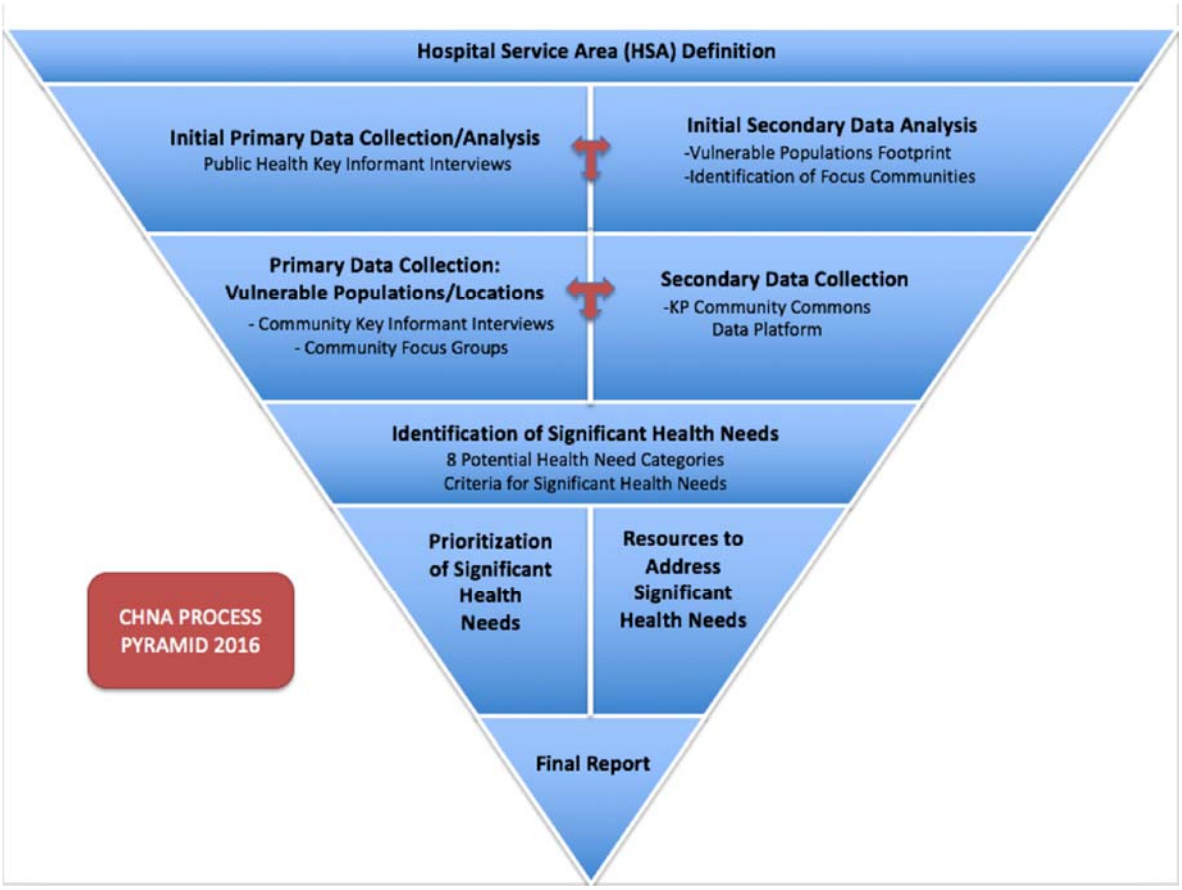


Figure 2. CHNA Process Model

The Focus Communities determined for KFH-Vacaville are noted in Table 3, followed by a map of the Focus Communities (Figure 5). Detailed methodology and socio-demographic information for these communities can be found in Appendix E.

Table 3. Vulnerable Populations Footprint (VPF) to Identify Focus Communities			
ZIP	City	100% Below Federal Poverty Level (>=20%)	Less Than High School Diploma (>=25%)
95620	Dixon	8.07%	**25.42%**
95688	Vacaville	**21.17%**	18.69%
94533	Fairfield	**27.52%**	**28.01%**
94534	Fairfield	**23.64%**	19.36%

**Zip code values where a majority of the census tracts exceeded one or both indicator thresholds.*
**Values in bold exceed the indicator threshold.*

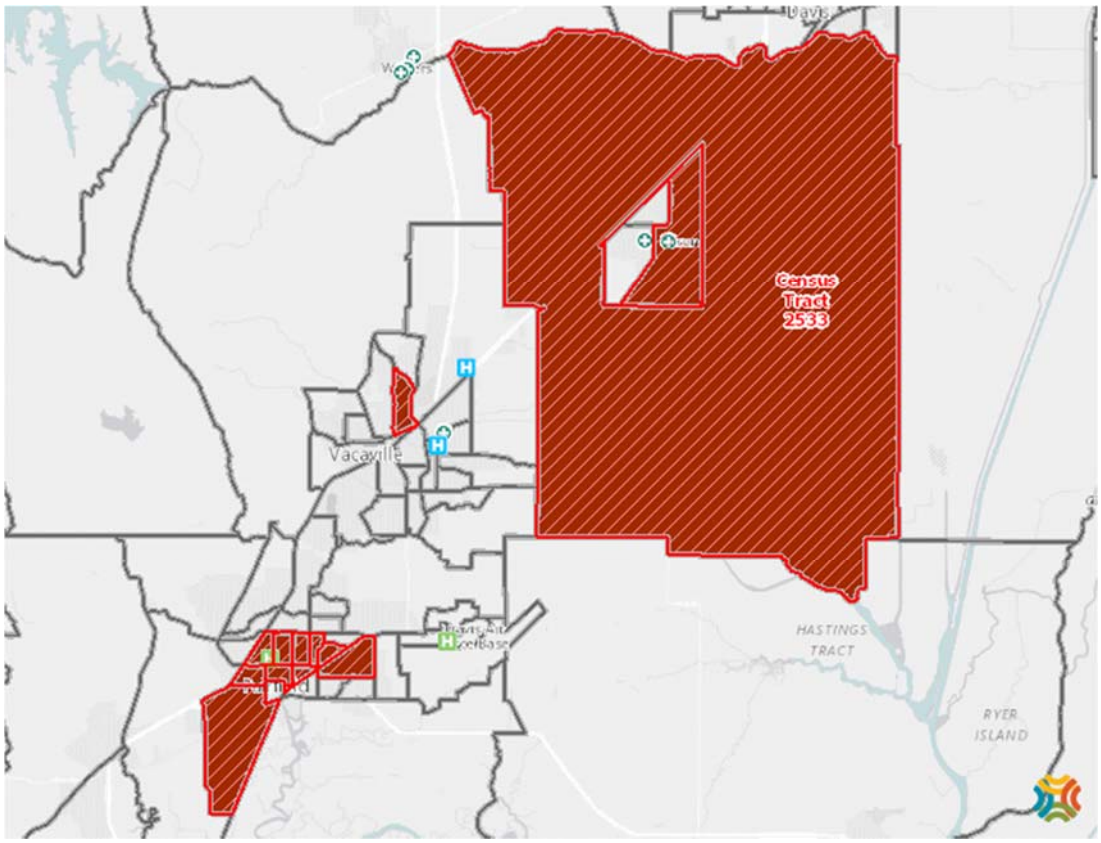


Figure 3. Vulnerable Populations Footprint (VPF) Map for KFH-Vacaville

A. Secondary data

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

KFH-Vacaville used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review 135 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For a list of indicators used in the KFH-Vacaville report, please see Appendix A.

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

The Vulnerable Populations Footprint (VPF), used to identify Focus Communities, looked at two key drivers of health; 1) poverty and 2) high school graduation rate, which are among the most predictive of identifying poor health outcomes. The thresholds for these two indicators were set to flag census tracts where 20% or more of the population was below the 100% Federal Poverty Level (FPL) and/or 25% or more of the population had less than a high school diploma. ZIP codes within the HSA where a majority of the census tracts exceeded one or both indicator thresholds were identified as Focus Communities.

Additional secondary indicators in the CHNA-DP were collected and organized using the following categories – demographics, health outcomes, social and economic factors, health behaviors, physical environment and clinical care. With the exception of the demographic variables, these categories closely mirror common themes found in other models of population health, including the County Health Rankings Model (Figure 4).

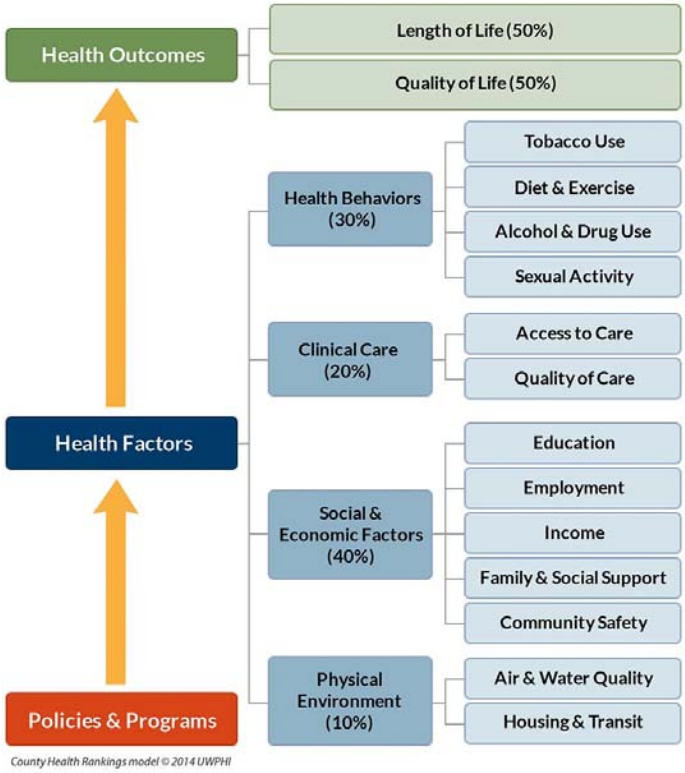


Figure 4. County Health Rankings Model

All indicators in the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) were organized by potential health needs categories, which are the 14 most commonly identified health needs from the 2013 CHNA cycle. For a detailed list of the KP subcategories, please refer to Table 4, Overview of Potential Health Need Categories and Subcategories. Indicators within these potential health need categories were analyzed and flagged if they performed poorly compared to the state benchmark. The results were ultimately used as an input into the health need identification process.

For the secondary (quantitative) data, indicators were considered if they compared unfavorably to state benchmarks or had evident racial/ethnic disparities. Indicators from the CHNA-DP were flagged if the HSA value performed (a) poorly (>2% or 2 percentage point difference) or (b) moderately (between 1-2% or 1-2 percentage point difference) compared to the state benchmark.

B. Community input

i. Description of the community input process

Primary data were collected from May 2015-November 2015. Community input was provided by a broad range of community members through the use of key informant interviews, focus groups, and surveys. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from the local public health department as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

ii. Methodology of collection and interpretation

Instruments used in primary data collection included a participant informed consent, a demographic questionnaire, the interview question guide and a project summary sheet. All participants were

given an informed consent form prior to their participation that provided information about the project, asked for permission to record the interview, and listed the potential benefits and risks for involvement in the interview (Appendix F). Participants were also asked to complete a voluntary questionnaire to compile the demographics of all key informant and focus group participants (Appendix G). The same interview guide was used for key informant interviews and community focus groups with slight modifications for focus groups conducted in Spanish and focus groups with youth or low-literacy populations. In brief, the guide prompted participants to share: (1) the quality of life in their communities; (2) the health issues they see and experience in their communities; (3) the most urgent or priority health needs of their communities; and (4) the resources available to help address health needs (see Appendix J for full interview guide). A project summary sheet (Appendix I) was also given to all participants to provide them with information about the project as well as contact information for the CHNA staff leading the interviews.

Key Informant Interviews

Primary data collection began with a key informant interview of the county Public Health Officer and additional interviews with other public health and social service experts within the KFH-Vacaville service area. These initial interviews were used to identify locations and populations that were most vulnerable to poor health outcomes and to identify place-based locations where additional data collection should be conducted. Following this information, a second phase of key informant interviews representing vulnerable locations and populations were conducted within the KFH-Vacaville service area. A total of 10 key informant interviews were completed with a cumulative total of 23 service providers participating in these interviews, which are listed in Appendix B.

Key informant interviewees represented the following sectors: community based organizations (38%), health care (6%), public health (31%), social services (13%) and other (19%), with some interviewees representing multiple sectors. These 23 key informants reported working with the following populations: low-income (94%), medically underserved (81%), and racial or ethnic minorities (88%). The racial and ethnic minority groups specified by interviewees included: Latino/Hispanic, Indigenous Mixtec, African American, Southeast Asian, Asian Pacific Islander, Native American, Russian, and multi-racial. In addition, key informants specified working with the following vulnerable sub-populations: adults and youth experiencing homelessness, youth in the foster care system, children with special needs, individuals experiencing mental health issues, pregnant and parenting teens, individuals who are undocumented, and people living with HIV.

Community Focus Groups

Focus group interviews were conducted with community members representing vulnerable populations and locations identified through the initial analysis of key informant input. Recruitment consisted of referrals from designated service providers as well as direct outreach from the Valley Vision CHNA Team to acquire input from special population groups. The identification of Focus Communities (see Focus Communities below) was another input that was considered when identifying vulnerable populations and locations to conduct community focus groups.

Within the KFH Vacaville HSA, five focus groups were conducted with 60 participants representing medically underserved, minority and low-income populations and/or community members living in vulnerable locations. Of the approximately 59 participants who completed demographic data cards, the median age was 30, 78% identified as female, 20% as male, and 3% as other. In addition, 14% indicated they were not covered by health insurance and 56% received some form of public assistance. Although 46% indicated they were not high school graduates, approximately 22 of the focus group participants were still in high school and therefore had not received their high school diploma. The racial breakdown of focus group participants was as follows:

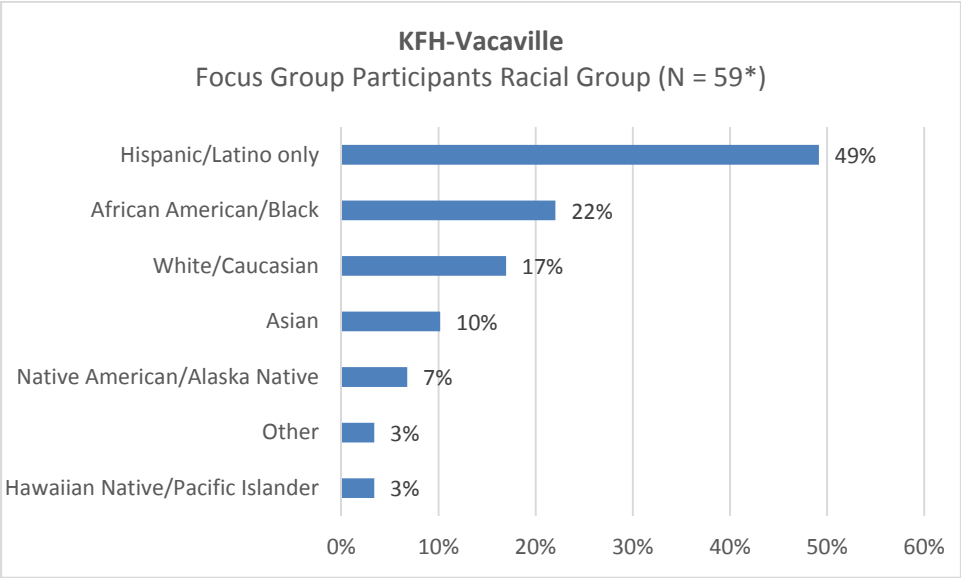


Figure 5. Participant Race/Ethnicity
*Demographic surveys were not completed by all participants

Processing Primary Data

After each interview or focus group was completed, the recording and any notes were uploaded to a secure server for future analysis. A significant portion of key informant interviews and focus group recordings were sent to a transcription service, with a smaller portion transcribed by Valley Vision staff or converted into notes corresponding to the order of questions in the interview guides. A small portion of the key informant interviews and focus groups were conducted in Spanish only.

Content analysis was done on the key informant and focus group transcripts utilizing NVivo 10 Qualitative Analytical Software. This analysis was completed in a two phase approach. In the first phase of analysis the qualitative data were coded into organically arising thematic areas. Further analysis was then conducted with thematic coding to the 8 potential health needs categories detailed later in this report and in Appendix D, with additional nodes for vulnerable populations and locations and resource identification. Results were aggregated to inform the determination of prioritized significant health needs as further detailed in Section VI of this report.

Focus Communities

The Kaiser Permanente's VPF feature on the CHNA-DP was used to look at two key drivers of health; 1) poverty and 2) high school graduation, which are among the most predictive of identifying poor health outcomes. The purpose of the Focus Communities is to provide a place-based lens within the HSA that show poor health outcomes. This information was used as one of the inputs to identify vulnerable locations and populations where additional primary or qualitative data collection was needed.

Outcomes from the VPF, as well as information collected from the first phase of primary data collection, were used to identify Focus Communities within KFH-Vacaville. The thresholds for these two indicators were set to flag census tracts where 20% or more of the population was below the 100% Federal Poverty Level (FPL) and/or 25% or more of the population had less than a high school diploma. ZIP codes within the HSA where a majority of the census tracts exceeded one or both indicator thresholds were identified as Focus Communities.

The Focus Communities determined for KFH-Vacaville are noted in Table 3, followed by a map of the Focus Communities (Figure 5). A demographic report of the Focus Communities can be found in Appendix E.

C. Written comments

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

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

D. Data limitations and information gaps

The CHNA-DP includes approximately 135 secondary data 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.

For primary data collection, it often proved to be a challenge to gain access to participants in communities that disproportionately experience health disparities. Measures were taken to reach out to vulnerable populations and locations through the process design and based on the recommendations of early key informants. However, recruitment was variable and several key contacts expressed the issue of research fatigue from repeated needs assessments. Community members also frequently mentioned distrust of the research process or concerns that their input would lead to change in their communities. As best as possible, the research team attempted to address these concerns and to be open and transparent about the full CHNA process. All participants were given contact information of the staff that conducted their interviews and were encouraged to reach out with any additional questions; key informants were also assured that they would receive notification once the CHNA reports become available.

Another challenge was reconciling the primary and secondary data. A large share of the primary or qualitative data was deliberately sourced from low-income, minority and medically underserved populations and locations within the KFH-Vacaville service area. Alternately, the secondary or quantitative data was collected for all populations within the service area. At times, this caused for there to be significant disparities between the primary and secondary data for the health need. Owing to this discrepancy, significant health need categories were validated by either the quantitative or qualitative data, rather than by both of these data sources.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying community health needs

i. Definition of "health need"

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

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

Significant health needs were identified through an integration of both qualitative and quantitative data. The process began with generating a list of 8 broad potential health needs (PHN categories)

that could exist within the HSA as well as subcategories of these broad needs as applicable. The PHN categories and subcategories were identified through consideration of the following inputs: the health needs identified in the 2013 CHNA process; the 14 health need categories in the KP CHNA data platform (CHNA-DP); and a preliminary review of primary data. Once the PHN categories were created, quantitative and qualitative indicators associated with each category and subcategory were identified in a crosswalk table. The potential health need categories, subcategories and associated indicators were then vetted and finalized by members of the Solano CHNA Collaborative prior to identification of the significant health needs. The PHN categories and subcategories are listed in Table 4; a full list of the indicators associated with each PHN category is available in Appendix A.

Table 4. Overview of Potential Health Need (PHN) Categories and Subcategories

Potential Health Need Category	Subcategories	Abbreviation
Access to High Quality Health Care and Services	Access to Care (General); Oral Health; Maternal/Infant Health	Access to Care
Access to Behavioral Health Services	Mental Health; Substance Abuse	Behavioral Health
Affordable and Accessible Transportation	N/A	Transportation
Economic Security	Food, Housing, Employment, Education	Economic Security
Disease Prevention, Management and Treatment	Cancer; Asthma; CVD/Stroke; HIV/AIDS/STIs	Disease Prevention
Healthy Eating and Active Living	N/A	HEAL
Pollution Free Living and Work Environments	N/A	Pollutant Free
Safe, Crime and Violence-Free Communities	N/A	Safe Communities

While all of these needs exist within the HSA to a greater or lesser extent, the purpose was to identify those that were most significant. The results from the primary and secondary data analyses were then merged to create a final set of significant health needs. The full results of these analyses are available in Appendix D.

A health need was determined to be significant if:

(1) At least 50% of secondary data (quantitative) indicators within a PHN category compared unfavorably to benchmarks or demonstrated racial/ethnic group disparities, or
(2) At least 75% of primary data (qualitative) sources mentioned a health outcome or related condition associated with the potential health need category (primary data was mainly sourced from Focus Communities).

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

Once significant health needs were identified, they were prioritized through the following process. First, health needs were given a score based upon the degree to which they met the criteria outlined above. Health needs that met or exceeded the thresholds for both the primary and secondary data categories were given a score of two (2 points); health needs that met or exceeded the thresholds for only one of the categories were given a score of one (1 point). The health needs were then ranked so that those with two points were put into a higher tier for prioritization than those with one point.

Secondly, health needs were further ranked within their tiers based upon further analysis of the primary data. As previously mentioned, the interview guide for primary data collection prompted participants to identify the health issues in their communities that were most urgent or important to address. Thematic analysis was conducted on the responses to this question and matched with the significant health need categories. The percentage of sources referring to each health need as a priority was calculated from this analysis, and then used for further prioritization of the health needs within tiers. Health needs with a higher percentage of sources identifying the need as important were ranked above those with a lower percentage of sources identifying that health need as a priority. The full results of these analyses are available in Appendix D.

Table 5. Prioritization of significant health needs within tiers by percentage of importance from community input

PRIORITIZED SIGNIFICANT HEALTH NEEDS				
PHN Category	**QUANT**	**QUAL**	**SCORE**	**IMPORTANCE**
	50%	75%		25%
1. HEAL	62%	100%	**2**	**67%**
2. Safe Communities	71%	87%	**2**	**20%**
3. Transportation	50%	93%	**2**	**13%**
4. Behavioral Health	27%	100%	**1**	**87%**
5. Economic Security	35%	100%	**1**	**27%**
6. Access to Care	38%	93%	**1**	**20%**
7. Disease Prevention	61%	73%	**1**	**13%**

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

The following are summarized descriptions of the prioritized significant health needs that were identified through the CHNA process. The data supporting these health needs are available in the Health Need Profiles in Appendix C.

1. Healthy Eating and Active Living

Healthy eating and active living (HEAL) is a significant health need in the Kaiser Foundation Hospital (KFH) – Vacaville Hospital Service Area (HSA). Eighteen of 29 (62%) indicators pertaining to healthy eating and regular physical activity perform poorly compared to state benchmarks, including indicators that have significant disparities by race/ethnicity. The need for healthy eating and active living is indicated by higher rates of overweight and obesity in both adults and youth, as well as higher rates of diabetes prevalence in adults over the age of 20. Overweight and obesity in youth are particularly high for the Hispanic/Latino population compared with other racial/ethnic groups and the rate for the HSA. Other related issues include high rates of low fruit and vegetable consumption among adults, limited access to grocery stores and WIC-authorized grocery stores in the service area.

Physical activity is low among both adults and youth when compared to the state benchmarks. In particular, non-Hispanic Black and Hispanic/Latino youth have higher rates of physical inactivity compared with other racial/ethnic groups in the HSA. In addition, a high percentage of the population within the HSA lives in a food desert and commute over 60 minutes to work by vehicle in each direction when compared to the state benchmark. There's also a low percentage of youth who walk, bike or skate to school within the HSA, especially among the Non-Hispanic Black population.

Service providers and community members expressed concern about accessing affordable, healthy food options in their communities. Participants shared that unhealthy food and beverage products are easily accessible and cost less than a bag of fruit or vegetables. Particular issues included concerns that people have to go outside their community to access healthy food options and that healthy food options are particularly limited for those with a lower socio-economic status. Faith-based and community-based organizations were often mentioned as resources in the community to access food, especially within food deserts. Community members shared concerns that obesity is a result of unhealthy eating options, lack of physical activity and the lack of knowledge about nutrition. Providers and community members noted the need to increase awareness around the importance of nutrition and physical activity to remain healthy.

2. Safe, Crime and Violence-Free Communities

Safe, crime, and violence-free communities is a significant health need in the KFH-Vacaville HSA. Twelve of 17 (71%) indicators pertaining to safe, crime and violence-free communities compare unfavorably to state benchmarks, including indicators that have significant disparities by race/ethnicity. The need for safe, crime and violence-free communities is marked by high rates of mortality due to homicide, suicide, and pedestrian and motor vehicle accidents. There is a higher rate of death due to motor vehicle accidents among the Native Hawaiian/Pacific Islander population as well as a higher rate of pedestrian-involved deaths due to motor vehicles in the Native Hawaiian/Pacific Islander population compared with other racial/ethnic groups. There are also high rates of crimes associated with unsafe communities, including assault, robbery, domestic violence and rape. Other related issues include high rates of school suspensions and a high percentage of adult excessive alcohol consumption based on a self-reported survey.

Service providers and community members expressed concern about violence in their communities, and that these communities feel unsafe and non-walkable. Particular issues included gang violence, domestic violence, and drug use in communities. Participants also shared concerns about the safety of parks in Solano County and the perception that there are a lot of active drug users and gang activity within parks, even during the day. Gun violence was also mentioned as an issue; specifically, Fairfield was mentioned as an area of concern when it comes to gun violence. Community members also expressed concern over the lack of resources for domestic violence.

3. **Access to Affordable and Accessible Transportation**

Access to affordable and accessible transportation is a significant health need in the KFH-Vacaville HSA. Four of eight (50%) indicators pertaining to affordable and accessible transportation compare unfavorably to state benchmarks. The issue of transportation is marked by a high percentage of the population who commute to work on a daily basis by car and/or commute alone in their car. There is also a high percentage of the population that commutes over 60 minutes to work in each direction and a low percentage of youth who walk, bike or skate to school, particularly for the Non-Hispanic Black population. In addition, a high percentage of Black and Native American/Alaskan Native populations have some form of physical disability and may require safe and effective transportation options.

Community input frequently referenced that Vacaville and Fairfield are the primary hubs for health and human services within KFH-Vacaville's HSA. Service providers and community members expressed concern over the lack of transportation to get to doctors' appointments as well as other resources like healthy food options and employment opportunities. Transportation was mentioned as a top priority for community members. More specifically, community members suggested transportation as a significant issue for the Dixon and Rio Vista areas of Solano County. It was shared that the bus schedules are not frequent enough for residents to keep up with their doctors' appointments; many community members expressed frustrations that taking public transportation to a doctor's appointment is an all-day process. Service providers and community members

mentioned that the current infrastructure of Solano County is designed for cars with a large highway running through it. There was concern that transportation can be economically challenging.

4. Access to Behavioral Health Services (Mental Health and Substance Abuse)

Access to behavioral health services (mental health & substance abuse) is a significant health need in the KFH-Vacaville HSA. Two of six indicators (33%) pertaining to mental health perform poorly compared to state benchmarks, and one of five indicators (20%) pertaining to substance abuse and tobacco also exceeds the state benchmark. The issue of mental health is marked by a high rate of suicide, particularly for Non-Hispanic White and the Native Hawaiian/Pacific Islander populations. A high percentage of Non-Hispanic White and Hispanic/Latino adults also report the need to see a mental health professional because of problems with their mental health, emotions, nerves or use of alcohol or other drugs. Substance abuse issues are also evident based on the high percentage of heavy alcohol consumption in adults over the age of 18.

Service providers and community members expressed that the need for mental health and substance abuse services far outweighs the current amount of resources available in the service area. Mental health was mentioned in 14 of 15 service provider and community member focus group interviews, with a sense of importance and urgency from the community to address this issue. Community members talked about barriers to mental health treatment including stigma and lack of resources or places to go when you're having a mental health crisis. It was also shared that there are a lot of youth experiencing homelessness and adults with both substance abuse and mental health conditions. Substance abuse was mentioned in 13 out of 15 service provider and community member focus group interviews. The substances that were mentioned most often included crack, crystal meth, alcohol and tobacco. Participants mentioned that there's a lot of drug dealing in parks in Solano County, with people doing drugs during the day and items such as needles found in public places.

5. Economic Security (Food, Housing, Employment, Education)

Economic Security (food, housing, employment, education) is a significant health need in the KFH-Vacaville HSA. Eight of 23 (35%) indicators pertaining to economic security compare unfavorably to state benchmarks, particularly for racial/ethnic minority groups in the HSA. Lack of economic security and access to basic needs such as food, housing and educational and job opportunities may lead to serious health problems and poor quality of life. People with a quality education, secure employment and stable housing tend to be healthier throughout their lives. The issue of economic security in the KFH-Vacaville HSA is marked by a particularly high percentage of Blacks and Hispanic/Latinos living in households that fall below 100% of the Federal Poverty Level (FPL). The same racial/ethnic groups also have a higher percentage of children (0-17) who fall below 100% FPL. A contributing factor to economic insecurity in the HSA may include the low high school graduation rate for Non-Hispanic Black and Hispanic/Latino populations. The percentage of the population age 25 and older without a high school diploma (or equivalency) is also lower in the Native American/Alaskan Native and Hispanic/Latino populations compared to other racial/ethnic groups. Among children in the Fourth Grade, reading proficiency for Black, Non-Hispanic, Native Hawaiian/Pacific Islander and Hispanic/Latino children is lower than that for other racial/ethnic groups. There is also a high percentage of Native Hawaiian/Pacific Islander and Hispanic/Latino populations that are uninsured within the hospital service area.

Economic security was mentioned in 15 of the 15 interviews conducted for KFH Vacaville's service area. Service provider interviews and community member focus groups voiced concerns over the lack of resources for adults and youth experiencing homelessness. Particularly, the closing of the homeless shelter in Vallejo was mentioned as having greatly impacted the other homeless shelters in the region. There was concern over the lack of economic opportunities throughout the service area. It was discussed that people are still recovering from the recession, when people lost their jobs and homes. Community members talked about the impact of financial stress on health, and

how this may impact healthy food options or exercising regularly. There was concern that it is challenging to make financial ends meet working just one job. Many participants talked about having to work multiple jobs just to feed their families, while others talked about the service area as being a “bedroom community” and having to go outside of their communities to get well paying jobs to support their families. Community members discussed the tremendous need for affordable housing and the waiting lists for public housing (some over two years). Safe, affordable housing was also mentioned as a priority for community members.

6. Access to High Quality Health Care and Services

Access to high quality health care and services is a significant health need in the KFH-Vacaville HSA. Eleven of 29 (38%) indicators pertaining to access to high quality health care and services, including oral health and maternal and infant health, perform poorly compared to state benchmarks. The issue of access to care is marked by the lack of a consistent source of primary care for Non-Hispanic Black and Hispanic/Latino populations. Oral health issues include a high percentage of Non-Hispanic White youth (ages 2 – 14) who report they have not been to a dentist or received an oral exam within the last year. The absence of dental insurance is also higher in the Hispanic/Latino population compared to other racial/ethnic groups. The need for access to maternal and infant health services is marked by a high rate of infant mortality and lack of prenatal care during the first and second trimester of pregnancies. The percentage of mothers who breastfeed their infants at birth is also low for Non-Hispanic Black and Non-Hispanic Native American/Alaskan Native populations. Additional issues related to the need for access to care include a high rate of preventable hospital days for ambulatory case sensitive (ACS) conditions and a low rate of mammogram cancer screenings in women. There are also noticeable disparities in the uninsured population: Native Hawaiian/Pacific Islander and Hispanic/Latinos are less likely to have health insurance compared to other racial/ethnic groups.

Service provider interviews and community member focus groups voiced concerns over the shortage of health care providers to keep up with the current demand for care and specific concerns that there are not enough specialty care services in the region. Barriers to accessing health care included the lack of access for older adults with health issues, long wait times to see a doctors, not enough medical providers who accept MediCal, and challenges with navigating the current health care system including understanding health care insurance and when to access primary and/or specialty care. Community members voiced concern over the need for more culturally component health care, suggesting the need for cultural competency education for health care providers to better understand communities’ diverse cultural, linguistic and social needs. The community expressed concerns about oral hygiene, including the need for more oral health education in schools. It was also expressed that many people don’t access the dentist owing to lack of dental insurance and because it’s too expensive to pay out of pocket.

7. Disease Prevention, Management and Treatment

Disease prevention, management and treatment is a significant health need in the KFH-Vacaville HSA. Twenty-five of 41 (61%) indicators pertaining to the health need compare unfavorably to state benchmark. The need for cancer prevention, detection and treatment is marked by high rates of cancer incidence including breast, colorectal, prostate, and lung cancers. Rates of cervical cancer are particularly high for Hispanic/Latino women and the incidence of colorectal, prostate and lung cancers is disproportionally high in the Black population. The mortality rate due to cancer exceeds the state and Healthy People 2020 benchmark, with disparities among the Non-Hispanic White and Black populations in the service area. The need for chronic disease prevention and management is marked by a high percentage of heart disease prevalence, particularly among Hispanic/Latino populations, and high rates of death due to heart disease for Non-Hispanic White, Black, and Native Hawaiian/Pacific Islander populations. Contributing factors include high rates of overweight and obesity in adults, high rates of physical inactivity in adults and youth, and low rates of fruit and vegetable consumption in adults.

Asthma prevalence also exceeds the state benchmark, with poor air quality in the HSA as a possible contributor. The particulate matter score levels are above the National Ambient Air Quality Standard per year compared to the state and national benchmarks. The need for infectious disease prevention, management and treatment is also evidenced by, disproportionately high rates of chlamydia, and high HIV prevalence among Non-Hispanic Blacks compared to other racial/ethnic groups.

Service provider interviews and community member focus groups noted cancer and cardiovascular diseases as being problematic in their communities. Community members also mentioned the connection between smoking and cancer. Upstream factors were mentioned as playing a role in these health issues, including smoking, obesity, physical inactivity and poor quality nutrition. It was suggested that there should be additional health education programs to address the onset of preventable cancers and heart disease. Community members voiced concern over the amount of asthma problems seen in children. Sexually transmitted disease rates were mentioned as being higher in the African American community and notably among teens. The STIs most frequently mentioned were chlamydia, gonorrhea and HIV. There was concern over the lack of sex education and health education in schools, communities and especially among youth. Community members mentioned the LGBTQ and African American female population as being at higher risk for STIs, including HIV.

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

An extensive process was used to identify the resources available to address the significant health needs and catalog them for inclusion in the final CHNA report. First, all resources identified in the 2013 CHNA report were included for consideration in a working comprehensive list of resources. Secondly, qualitative data from key informant interviews and focus groups were analyzed to include the resources identified by community input. Resources from community input were added to the list and all resources were then verified to assure that they were current and actively available. Once all resources on the list had been confirmed, each resource was considered in relation to the significant health needs for the HSA. As best as possible, each resource was assessed to determine which of the health needs it most closely addressed.

VII. KFH-VACAVILLE 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

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

- Access to culturally appropriate, affordable health care
- Access to affordable healthy food
- Lack of employment and vocational training
- Lack of safe places to walk, bike, exercise and play
- Broader Health Care System Needs in Our Communities (Research)

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

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

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

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

1. 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.

2. 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.

3. 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.

4. 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.

5. 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-Vacaville awarded 122 grants totaling $1,694,480 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 Vacaville service area. During 2014-2015, a portion of money managed by this foundation was used to award 32 grants totaling $349,374 in service of 2013 health needs.

In-Kind Resources: Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH Facility Name donated several in-kind resources in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

Collaborations and Partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH Facility Name engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: ACCESS TO CULTURALLY APPROPRIATE, AFFORDABLE HEALTH SERVICES

Long Term Goal:

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

Intermediate Goal:

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

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 12,278 Medi-Cal members* • *2015: 12,219 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $1,886,684* • *2014: 1,945 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $1,788,123* • *2015: 3 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: 1,129 members receiving CHC* • *2015: 953 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 49 active KFH grants totaling $1,126,220 addressing Access to Culturally Appropriate, Affordable Health Services in the KFH-Vacaville service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 15 grants totaling $165,800 that address this need. These grants are denoted by asterisks (*) in the table below.

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

		1. maintain and access service provider networks to preserve the basic needs safety net in each Solano County city 2. help families access programs that provide health care access, food assistance, and other essential services 3. offer one-time-only, last-resort financial assistance for emergency basic needs	As of Dec.31, 2015, the FRCs assisted 240 low-income families. Of the 69 families that completed FDMs, 53 remained stable or showed improvement in the four outcome indicators.
*Children's Nurturing Project (CNP)	$135,000 over 2 years $40,000 in 2014 $95,000 in 2015 (even split with KFH-Vallejo)	CNP, primary provider of trauma-related services in Fairfield Suisun Unified School District, will build additional capacity in 12 existing trauma-informed schools, by training school-based staff, providing staff wellness and self-care activities, enhancing CNP treatment facilities, and providing trauma treatment for students 12 to 18.	Expected outcomes include: • 11,223 students and 451 staff reached • increased staff understanding of trauma • increased staff competency in helping students who show signs of trauma-reactive behavior, including the initial approach, asking questions, and facilitating provision of additional support • CNP clinicians and managers receive targeted training in evidence-based, trauma informed modalities • CNP clinicians provide trauma-focused psycho-therapy interventions to trauma-impacted youth
Redwood Community Health Coalition (RCHC)	$400,000 over 2 years $209,501.15 in 2014 $190,498.85 in 2015 This grant impacts five KFH hospital service areas in Northern California Region.	This grant will strengthen core infrastructure to increase access to high-quality care for underserved patients and communities served by health centers; support health centers to continually improve operational capabilities, coordination of care, and workforce development; and support the Triple Aim infrastructure and management of the health center Accountable Care Organization (ACO).	RCHC has 6,685 PHASE patients and outcomes include: • increased health coaching skills among consortia/clinic staff using a comprehensive training/coaching program; 40 people were trained and three were trained as trainers • participated in a county-wide committee with leaders from the county's major health care delivery systems to develop an approach to reduce heart attacks and strokes; all leaders agreed to base the county-wide strategy on the PHASE clinical guidelines • worked with other delivery systems to create data sharing agreements and identify which data sets can be shared across systems

			• improved parts of a learning community to share promising practices with clinics; added PHASE resources to program website
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.	• improved Medi-Cal managed care patient assignment rates by creating quarterly reports shared with member health centers. • Improved/streamlined Medi-Cal application process to expedite eligibility determinations for patients • develop, secure funding for, and implement Contra Costa CARES, a local primary care access program for approximately 3,000 of the county's low-income, undocumented adults • increased long-term financial viability of CHCs • produced FY 15 financial dashboard and began efforts to use future dashboards to monitor financial reserves. Dashboards inform strategic the organization's financial decisions and have prompted CCCCCS staff to pursue opportunities to diversify revenue streams and increase sources of earned income
Dixon Family Services (DFS)	$30,000 over 2 years $15,000 in 2014 & 2015	Supports an aspect of DFS's Mental Health Continuum of Care (MMCC) program, which aims to reduce risky teen activities, including smoking, substance abuse, and sexual behavior.	Over two years of funding MMCC case managers offered basic needs supportive services and life skills education to teens at Dixon High and the alternative high school; 62 took part in healthy activities and 223 reported improvement in one or more FDM categories.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
Solano County Senior Coalition – Health and Social Services	Napa-Solano Area Physician-In-Chief played a key role in supporting the county's Older and Disabled Adults program, Solano County Mini-Medical School: Aging with Vitality, which aims to normalize the aging process and inspire participants to be proactive by making healthy lifestyle choices. Modeled after UC Davis' Mini-Medical School, the program received a California State Association of Counties merit award and brought statewide recognition to healthy living.		
Multiple community-based organizations in Solano County	KFH Vacaville and KFH Vallejo support Kaiser Permanente Volunteers-In-Public-Service (KP VIPS), a program that allows clinicians to volunteer and provide high-quality clinical and educational assistance to community-based organizations and clinics. KP VIPS currently supports 10 projects at Solano County agencies, including Opportunity House, La Clínica de la Raza, and Vallejo Unified School District's school-based clinics (Jesse Bethel High). In 2015,		

	nearly 30 clinicians donated more than 680 hours, providing consultations, health screenings, health education, and other clinical services for more than 1,000 patients.
All PHASE Grantees	To increase clinical expertise in the safety net, Quality and Operations Support (QOS), a Kaiser Permanente Northern California Region TPMG (The Permanente Medical Group) department, helped develop a PHASE data collection tool. QOS staff provided expert consultation on complex clinical data issues, such as reviewing national reporting standards, defining meaningful data, and understanding data collection methodology. This included: • conducting clinical training webinars • wireside/webinar on PHASE clinical guidelines • presentation at convening on Kaiser Permanente's approach to PHASE • presentation to various clinical peer groups through CHCN, SFCCC, etc. • individual consultation to staff at PHASE grantee organizations • individual consultation to Community Benefit Programs staff Kaiser Permanente Northern California Region's Regional Health Education (RHE) also provided assistance to PHASE grantees: • conducted two seven-hour Motivating Change trainings (24 participants each) to enable clinical staff who implement (or will) PHASE to increase their skills with regard to enhancing patients' internal motivations to make health behavior changes • provided access to patient education documents related to PHASE
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.

Impact of Regional Initiatives

PHASE:

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

PRIORITY HEALTH NEED II: ACCESS TO AFFORDABLE, HEALTHY FOODS

Long Term Goals:

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

Intermediate Goals:

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

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 34 active KFH grants totaling $239,734 addressing Access to Affordable, Healthy Food in the KFH-Vacaville service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling $53,095 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
American Heart Association (AHA)	$105,000 over 2 years $45,000 in 2014 $60,000 in 2015 (even split with KFH-Vallejo)	Supports AHA's Kids Cook with Heart, hands-on culinary programs led by trained professional chefs. The curriculum, which aims to address childhood obesity, will teach children 11 to 18 at three Vallejo schools (20-week program) and four Fairfield schools (10-week program) how to cook and eat in healthier ways.	As a result of 2014 and 2015 funding nearly 200 students 11 to 18 from two schools Fairfield and two in Vallejo, participated and learned how to prepare meals using fresh ingredients and less fat, sugar, and salt. In addition, they share the information with their parents, beginning a cycle of change.
Food Bank of Contra Costa and Solano	$50,000 over 2 years $25,000 in 2014 & 2015 (even split with KFH-Vallejo)	Supports the Food Bank's Farm 2 Kids program, which provides fresh produce for children attending afterschool programs in low-income neighborhoods. This project is supported by KFH Vacaville and KFH Vallejo hospitals.	For the 2014-2015 school year, 2,477 children were enrolled in Farm 2 Kids at 28 schools throughout Solano County. For the 2015-2016 school year, 2,643 children at 28 Solano County schools are enrolled in Farm 2 Kids. As part of the program, they take home a 3 to 5 pound bag of fresh produce each week and receive lessons about the benefits of eating fresh produce and the importance of healthy diet choices.
Meals On Wheels of Solano County (MOWSC)	$40,000 over 2 years $20,000 in 2014 & 2015 (even split with KFH-Vallejo)	The only program of its kind in the area for people 60 and older, MOWSC's elder nutrition program delivers healthy and nutritious meals to homebound seniors and provides meals for other elderly individuals who dine at senior and community centers.	As of November 2015, over 90,000 healthy and nutritious meals were home-delivered to over 1,000 clients and over 17,000 meals were served to over 800 clients at congregate dining sites.

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

Long Term Goal:

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

Intermediate Goals:

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

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 20 active KFH grants totaling $232,537 addressing Lack of Safe Places to Walk, Bike, Exercise, or Play in the KFH-Vacaville service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 4 grants totaling $88,661 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
The Leaven	$95,000 over 2 years $45,000 in 2014 $50,000 in 2015 (even split with KFH-Vallejo)	With nine Solano County sites, The Leaven works primarily with at-risk first through fifth graders, providing extra support to help them avoid gangs, dropping out, etc. Many participants live in extremely low-income households and more than 8 in 10 are racial/ethnic minorities.	The Leaven has provided afterschool tutoring and mentoring programs as well as healthy living programs that encourage daily physical activity and consumption of fresh fruit and vegetables to more than 140 students at three new sites. The Leaven plans to open two new afterschool tutoring centers, one in Vallejo and another in Napa, by Spring 2016.
Girls On The Run (GOTR) Napa & Solano	$20,000 in 2015 (even split with KFH-Vallejo)	GOTR is a transformational learning program for girls 8 to 13 that teaches life skills through dynamic, conversation-based lessons and running.	From July-Dec 2015, GOTR served 414 girls in schools throughout Napa and Solano counties, including American Canyon, Napa, St. Helena, Calistoga, Angwin, Benicia, Fairfield, Suisun, Vallejo and Vacaville.
*Golden Gate National Parks Conservancy	$300,000 over 2 years $150,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region.	Golden Gate National Parks Conservancy and Institute at the Golden Gate will coordinate the Healthy Parks Healthy People (HPHP) Bay Area program, a collaborative of park and health agencies designed to increase the accessibility and use of parks for activities that promote health.	Expected reach is 10,000 people and expected outcomes include: • 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**
Girls On The Run (GOTR) Napa & Solano	GOTR, a fun, healthy empowerment program that inspires girls 8 to 13 to believe in themselves and their dreams, participated in the Kaiser Permanente Community Giving Campaign kickoff at the KFH-Vacaville medical office. The event is designed to educate employees about the campaign.	GOTR was able to promote new services offered in the Fairfield /Suisun area and recruit KP volunteers to support the program. Girls, ages, complete a ten-week program that is led by two volunteer healthy women role models (life coaches) who creatively weave engaging discussions, experiential activities and running or moving it to inspire the girls to be confident, joyful, healthy and caring.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Dixon High School	KFH-Vacaville hosted Every 15 Minutes, a simulated, educational experience ("The crash is staged, the emotions are real.") that illustrates the dangers associated with texting and driving while impaired.
Fairfield-Suisun Unified School District (FSUSD)	KPET shared various resources in the district with the PEACE signs performance at Cleo Gordon Elementary in Fairfield which addresses anti-bullying, conflict resolution, violence prevention, and positive behaviors – at a school assembly, student and teacher workshops, and a family night performance. Nightmare on Puberty Street at Crystal Middle, Grange Middle, and David Weir Preparatory Academy. KPET led educational workshops that addressed anti-bullying, safe environments and prevention topics.

Impact of Regional Initiatives

Parks Initiative:

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

PRIORITY HEALTH NEED IV: LACK OF EMPLOYMENT AND VOCATIONAL TRAINING

Long Term Goal:

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

Intermediate Goals:

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

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 19 active KFH grants totaling $95,989 addressing Lack of Employment and Vocational Training in the KFH-Vacaville service area. In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 3 grants totaling $10,476 that address this need. These grants are denoted by asterisks (*) in the table below. In addition, KFH Vacaville provided trainings and education for 15 residents in their Graduate Medical Education program in 2014 and 11 residents in 2015, 12 nurse practitioners or other nursing beneficiaries in 2014, and 20 other health (non-MD) beneficiaries as well as internships for 5 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grantee	Grant Amount	Project Description	Results to Date
Vacaville Boys and Girls Club	$55,000 over 2 years $30,000 in 2014 $25,000 in 2015	Supports three Club programs: • the Healthy Habits nutrition curriculum portion of Triple Play, which emphasizes good nutrition, regular physical activity, and improving overall well-being; • SMART (Skills Mastery and Resistance Training) Moves, a prevention and education program for children 6 to 15 that addresses topics such as drug and alcohol use and premature sexual activity • Junior Staff Career Development, offered to teens every summer, combines summer school, summer camp, and job internships	With funding from the 2014 grant, Healthy Habits served 150 children who learned about soil-less geoponics gardening, adding nutrient tonic to the water, and testing the PH level. They also helped plant garden beds and had a bountiful harvest for cooking lessons. Junior Staff provides teens soft skills and training. In 2015, 202 students were served through the SMART Moves curriculum and two documentaries that allowed participants to explore topics such as self-confidence and abstinence. 52 junior staff volunteers received soft skills training, a place to be during the summer, and a meaningful experience while helping Club staff manage the increased number of school-age participants
Mission Solano	$20,000 over 2years $10,000 in 2014 & 2015	Mission Solano's auto donation car lot receives, processes, and sells used cars to benefit the county's low-income community and its auto donation job skills training program for underserved people (homeless vets, DV victims, etc.) who need jobs.	With the help of this funding the program served 15 homeless Solano County veterans 18 and older. The grant also helped Mission Solano reevaluate and restructure its auto donation program to develop a curriculum that incorporates all California-specific laws and regulations and adequately meets job skills (such as filling out DMV forms accurately) training needs.
2B Successful	$30,000 over 2 years	Supports an academic enrichment program that uses creative, focused techniques and	• Over 800 Fairfield-Suisun Unified School District students participated in 2B Successful

	$15,000 in 2014 & 2015	aligns its curriculum with students' regular classes to help them meet the challenges of STAR, ACT (American College Testing), and other exams. Specialized tutors help youth who are not in school prepare for and pass the GED.	• 32 students participated in the CSU Algebra institute, with a 99% retention rate and an overall program score of 75% or higher

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Rise Together Solano	Supports United Way of the Bay Area's goal to reduce poverty by 50% in six bay area counties, including Solano, by creating pathways out of poverty. Primary focus areas are housing, access to healthy food, workforce development for youth and young adults, full service community schools, and supporting seniors.	The CB Manager co-leads the Workforce Development workgroup, which has evolved, added new members, and hosted a kickoff launch for a Solano County youth employment program in January 2016. The group works closely with United Way of the Bay Area, Workforce Investment Board of Solano County, Solano Community College, the Fairfield-Suisun and Vallejo City school districts, Solano County Office of Education, Fairfield-Suisun Chamber of Commerce, Andrew Young Foundation, Fairfield City Councilmember, and Job Squad.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Anna Kyle Elementary FSUSD	A college and career fair, which took place on a fun, casual April afternoon allowed students and their families to learn about various career professions. Students received a list of suggested questions to ask parents and faculty, and resources on a variety of topics were shared.
Kaiser Permanente Summer Youth Employment Program (SYEP)	SYEP interns toured the Kaiser Permanente School of Allied Health Sciences and enjoyed a presentation by the admissions director on the school's commitment and programs offered. Interns also visited Kaiser Permanente Educational Theatre's offices to learn about its program and services, which are provided free to school districts throughout Northern California, and were excited to hear that KP has employment opportunities in theatre arts.
Willie B. Adkins Project	Willie B. Adkins is a college preparatory program under Vallejo City and Fairfield-Suisun unified school districts' special projects department. It aims to provide high school students with life skills, tutoring and mentoring services, and a strong network of positive, successful peers/individuals. Napa-Solano Area CB staff hosted Adkins' 5th annual career fair. Close to 100 high school students attended the fair. Senior leadership team members and physicians from Napa-Solano Area sat on a panel and talked about their career path; staff from various departments (clinical, administration, physical therapy, HR, and IT) provided career information and took part in Q&A sessions for breakout groups; and the Director of Leadership and Training spoke about career development, college and trade-school opportunities, and the importance of internships and mentors.
STEPS (Soroptimists Teaching and	Napa-Solano Area hosted a career information session and facility tour for program participants.

Empowering for Personal Success)	KFH-Vacaville hosted the event for students and six chaperones. The KFH-Vacaville and KFH-Vallejo chief operating officers talked about their career paths. The tour that followed allowed the students to learn more about entry level health care positions in the EVS, materials management, medical secretaries and health education departments.

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

KFH Research Highlights

Long Term Goal:

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

Intermediate Goal:

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

Grant Highlights

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

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations.

Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

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

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

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

RPGEH Project Title	Alignment with CB Priorities
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity
RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

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

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

	5. *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	

VIII. APPENDIX

A. **Secondary Data Sources and Dates**

B. **Community Input Tracking Form**

C. **Health Need Profiles**

D. **Detailed Methodology for Identifying Significant Health Needs**

E. **Focus Communities Demographic Report**

F. **Informed Consent**

G. **Demographic Forms**

H. **Interview Guides**

I. **Project Summary Sheet**

J. **Resources**

Appendix A: Secondary Data Dictionary

Indicator Details			
Indicator	**Indicator Variable**	**Data source**	**Source Geography**
Absence of Dental Insurance Coverage	Percent Adults Without Dental Insurance	University of California Center for Health Policy Research, California Health Interview Survey. 2009.	County (Grouping)
Access to Dentists	Dentists, Rate per 100,000 Pop.	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.	County
Access to Mental Health Providers	Mental Health Care Provider Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2014.	County
Access to Primary Care	Primary Care Physicians, Rate per 100,000 Pop.	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.	County
Air Quality - Ozone (O3)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.	Tract
Air Quality - Particulate Matter 2.5	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.	Tract
Alcohol - Excessive Consumption	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.	County
Alcohol - Expenditures	Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.	Tract
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.	ZIP Code
Asthma - Prevalence	Percent Adults with Asthma	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.	County
Breastfeeding (Any)	Percentage of Mothers Breastfeeding (Any)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.	County
Breastfeeding (Exclusive)	Percentage of Mothers Breastfeeding (Exclusively)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.	County

Cancer Incidence - Breast	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. 2008-12.	County
Cancer Incidence - Cervical	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. 2008-12.	County
Cancer Incidence - Colon and Rectum	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. 2008-12.	County
Cancer Incidence - Lung	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. 2008-12.	County
Cancer Incidence - Prostate	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. 2008-12.	County
Cancer Screening - Mammogram	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.	County
Cancer Screening - Pap Test	Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	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.	County
Cancer Screening - Sigmoid/Colonoscopy	Percent Adults Screened for Colon Cancer (Age-Adjusted)	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.	County
Change in Total Population	Percent Population Change, 2000-2010	US Census Bureau, Decennial Census. 2000 - 2010.	Tract
Children Eligible for Free/Reduced Price Lunch	Percent Students Eligible for Free or Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.	Address
Climate & Health - Canopy Cover	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.	Tract
Climate & Health - Drought Severity	Percentage of Weeks in Drought (Any)	US, Drought,Monitor.,2012-14.	County

Climate & Health - Heat Index Days	Percentage of Weather Observations with High Heat Index Values:%	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.	County
Climate & Health - Heat Stress Events	Heat-related Emergency Department Visits, Rate per 100,000 Population	California Department of Public Health, CDPH - Tracking. 2005-12.	County
Climate & Health - No Access to Air Conditioning	Percentage of Housing Units with No Air Conditioning	US Census Bureau, American Housing Survey. 2011, 2013.	
Commute to Work - Alone in Car	Percentage of Workers Commuting by Car, Alone	US Census Bureau, American Community Survey. 2009-13.	Tract
Commute to Work - Walking/Biking	Percentage Walking or Biking to Work	US Census Bureau, American Community Survey. 2009-13.	Tract
Dental Care - Lack of Affordability (Youth)	Percent Population Age 5-17 Unable to Afford Dental Care	University of California Center for Health Policy Research, California Health Interview Survey. 2009.	County (Grouping)
Dental Care - No Recent Exam (Adult)	Percent Adults Without Recent Dental Exam	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.	County
Dental Care - No Recent Exam (Youth)	Percent Youth Without Recent Dental Exam	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.	County (Grouping)
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.	ZIP Code
Diabetes Management (Hemoglobin A1c Test)	Percent Medicare Enrollees with Diabetes with Annual Exam	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.	County
Diabetes Prevalence	Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.	County
Drinking Water Safety	Percentage of Population Potentially Exposed to Unsafe Drinking Water	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.	County
Economic Security - Commute Over 60 Minutes	Percentage of Workers Commuting More than 60 Minutes	US Census Bureau, American Community Survey. 2009-13.	Tract

Economic Security - Households with No Vehicle	Percentage of Households with No Motor Vehicle	US Census Bureau, American Community Survey. 2009-13.	Tract
Economic Security - Unemployment Rate	Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2015 - November.	County
Education - Head Start Program Facilities	Head Start Programs Rate (Per 10,000 Children Under Age 5)	US Department of Health & Human Services, Administration for Children and Families. 2014.	Point
Education - High School Graduation Rate	Cohort Graduation Rate	California, Department of Education.,2013.	School District
Education - Less than High School Diploma (or Equivalent)	Percent Population Age 25+ with No High School Diploma	US Census Bureau, American Community Survey. 2009-13.	Tract
Education - Reading Below Proficiency	Percentage of Grade 4 ELA Test Score Not Proficient	California, Department of Education.,2012-13.	School District
Education - School Enrollment Age 3-4	Percentage of Population Age 3-4 Enrolled in School	US Census Bureau, American Community Survey. 2009-13.	Tract
Federally Qualified Health Centers	Federally Qualified Health Centers, Rate per 100,000 Population	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. Sept. 2015.	Address
Female Population	Percent Female Population	US Census Bureau, American Community Survey. 2009-13.	Tract
Food Environment - Fast Food Restaurants	Fast Food Restaurants, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.	Tract
Food Environment - Grocery Stores	Grocery Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.	Tract
Food Environment - WIC-Authorized Food Stores	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.	County
Food Security - Food Desert Population	Percent Population with Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.	Tract
Food Security - Food Insecurity Rate	Percentage of the Population with Food Insecurity	Feeding, America.,2013.	County
Food Security - Population Receiving SNAP	Percent Population Receiving SNAP Benefits	US Census Bureau, Small Area Income & Poverty Estimates. 2011.	County

Food Security - School Breakfast Program	Average Daily School Breakfast Program Participation Rate	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program. 2013.	State
Fruit/Vegetable Expenditures	Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.	Tract
Health Professional Shortage Area - Dental	Percentage of Population Living in a HPSA	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.	HPSA
Health Professional Shortage Area - Primary Care	Percentage of Population Living in a HPSA	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.	HPSA
Heart Disease Prevalence	Percent Adults with Heart Disease	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.	County (Grouping)
High Blood Pressure - Unmanaged	Percent Adults with High Blood Pressure Not Taking Medication	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.	County
Hispanic Population	Percent Population Hispanic or Latino	US Census Bureau, American Community Survey. 2009-13.	Tract
Housing - Assisted Housing	HUD-Assisted Units, Rate per 10,000 Housing Units	US, Department of Housing And Urban Development. 2013	County
Housing - Cost Burdened Households	Percentage of Households where Housing Costs Exceed 30% of Income	US Census Bureau, American Community Survey. 2009-13.	Tract
Housing - Substandard Housing	Percent Occupied Housing Units with One or More Substandard Conditions	US Census Bureau, American Community Survey. 2009-13.	Tract
Housing - Vacant Housing	Vacant Housing Units, Percent	US Census Bureau, American Community Survey. 2009-13.	Tract
Income Inequality	Gini Index Value	US Census Bureau, American Community Survey. 2009-13.	Tract
Infant Mortality	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	County

		and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.	
Insurance - Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid	US Census Bureau, American Community Survey. 2009-13.	Tract
Insurance - Uninsured Population	Percent Uninsured Population	US Census Bureau, American Community Survey. 2009-13.	Tract
Lack of a Consistent Source of Primary Care	Percentage Without Regular Doctor	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.	County (Grouping)
Lack of Prenatal Care	Percent Mothers with Late or No Prenatal Care	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.	ZIP Code
Lack of Social or Emotional Support	Percent Adults Without Adequate Social / Emotional Support (Age-Adjusted)	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.	County
Linguistically Isolated Households	Percent Linguistically Isolated Population	US Census Bureau, American Community Survey. 2009-13.	Tract
Liquor Store Access	Liquor Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.	ZCTA
Low Birth Weight	Percent Low Birth Weight Births	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.	ZIP Code
Low Fruit/Vegetable Consumption (Adult)	Percent Adults with Inadequate Fruit / Vegetable Consumption	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.	County
Low Fruit/Vegetable Consumption (Youth)	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.	County (Grouping)
Male Population	Percent Male Population	US Census Bureau, American Community Survey. 2009-13.	Tract
Median Age	Median Age	US Census Bureau, American Community Survey. 2009-13.	Tract
Mental Health - Depression Among Medicare Beneficiaries	Percentage of Medicare Beneficiaries with Depression	Centers for Medicare, And,Medicaid,Services.,2012.	County

Mental Health - Needing Mental Health Care	Percentage with Poor Mental Health	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.	County (Grouping)
Mental Health - Poor Mental Health Days	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.	County
Mortality - Cancer	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.	ZIP Code
Mortality - Homicide	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.	ZIP Code
Mortality - Ischaemic Heart Disease	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.	ZIP Code
Mortality - Motor Vehicle Accident	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.	ZIP Code
Mortality - Pedestrian Accident	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.	ZIP Code
Mortality - Premature Death	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.	County
Mortality - Stroke	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.	ZIP Code
Mortality - Suicide	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.	ZIP Code
Obesity (Adult)	Percent Adults with BMI > 30.0 (Obese)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.	County
Obesity (Youth)	Percent Obese	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.	School District

Overweight (Adult)	Percent Adults Overweight	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.	County
Overweight (Youth)	Percent Overweight	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.	School District
Park Access	Percent Population Within 1/2 Mile of a Park	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.	Block Group
Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.	County
Physical Inactivity (Youth)	Percent Physically Inactive	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.	School District
Pneumonia Vaccinations (Age 65+)	Percent Population Age 65+ with Pneumonia Vaccination (Age-Adjusted)	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.	County
Poor Dental Health	Percent Adults with Poor Dental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.	County
Poor General Health	Percent Adults with Poor or Fair Health (Age-Adjusted)	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.	County
Population Age 0-4	Percent Population Age 0-4	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 18-24	Percent Population Age 18-24	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 25-34	Percent Population Age 25-34	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 35-44	Percent Population Age 35-44	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 45-54	Percent Population Age 45-54	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 5-17	Percent Population Age 5-17	US Census Bureau, American Community Survey. 2009-13.	Tract

Population Age 55-64	Percent Population Age 55-64	US Census Bureau, American Community Survey. 2009-13.	Tract
Population Age 65+	Percent Population Age 65+	US Census Bureau, American Community Survey. 2009-13.	Tract
Population with Any Disability	Percent Population with a Disability	US Census Bureau, American Community Survey. 2009-13.	Tract
Population with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency	US Census Bureau, American Community Survey. 2009-13.	Tract
Poverty - Children Below 100% FPL	Percent Population Under Age 18 in Poverty	US Census Bureau, American Community Survey. 2009-13.	Tract
Poverty - Population Below 100% FPL	Percent Population in Poverty	US Census Bureau, American Community Survey. 2009-13.	Tract
Poverty - Population Below 200% FPL	Percent Population with Income at or Below 200% FPL	US Census Bureau, American Community Survey. 2009-13.	Tract
Preventable Hospital Events	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	ZIP Code
Recreation and Fitness Facility Access	Recreation and Fitness Facilities, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.	ZCTA
Soft Drink Expenditures	Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.	Tract
STD - Chlamydia	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.	County
STD - HIV Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	ZIP Code
STD - HIV Prevalence	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.	County
STD - No HIV Screening	Percent Adults Never Screened for HIV / AIDS	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.	County

Teen Births (Under Age 20)	Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.	ZIP Code
Tobacco Expenditures	Cigarette Expenditures, Percentage of Total Household Expenditures	Nielsen, Nielsen SiteReports. 2014.	Tract
Tobacco Usage	Percent Population Smoking Cigarettes(Age-Adjusted)	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.	County
Total Population	Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2009-13.	Tract
Transit - Public Transit within 0.5 Miles	Percentage of Population within Half Mile of Public Transit	Environmental Protection Agency, EPA Smart Location Database. 2011.	Tract
Transit - Road Network Density	Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.	Tract
Transit - Walkability	Percent Population Living in Car Dependent (Almost Exclusively) Cities	Walk,Score®.,2012.	City
Violence - All Violent Crimes	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.	County
Violence - Assault (Crime)	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.	County
Violence - Assault (Injury)	Assault Injuries, Rate per 100,000 Population	California Department of Public Health, California EpiCenter. 2011-13.	County
Violence - Domestic Violence	Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	California Department of Public Health, California EpiCenter. 2011-13.	County

Violence - Rape (Crime)	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.	County
Violence - Robbery (Crime)	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.	County
Violence - School Expulsions	Expulsion Rate	California, Department of Education.,	Tract
Violence - School Suspensions	Suspension Rate	California, Department of Education.,	Tract
Violence - Youth Intentional Injury	Intentional Injuries, Rate per 100,000 Population (Youth Age 13 - 20)	California Department of Public Health, California EpiCenter. 2011-13.	County
Walking/Biking/Skating to School	Percentage Walking/Skating/Biking to School	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.	County (Grouping)

Appendix B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Key Informant Interview/Focus Group Interview	**Respondent's title/role and organization or focus group name**	**Number of participants**	**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1	Key Informant Interview	Public Health Officer, Solano County Health and Human Services	1	County health department representative	Leader	7/7/15
2	Key Informant Interview	Executive Director, Children's Network of Solano County	1	Represents minority, underserved, and low-income children, parents and families	Leader	7/7/15
3	Key Informant Interview	Executive Director, Circle of Friends	1	Represents minority, medically underserved, low income homeless and mental health population	Leader	7/13/15
4	Key Informant Interview	Director of Behavioral Health, Solano County Health and Human Services	1	County behavioral health department representative	Leader	7/28/15
5	Group Key Informant Interview	Director of Community Services and Senior Health Educator, Planned Parenthood of Northern California	2	Represents minority, underserved, and low income women of all ages	Leader; Representative	8/7/15
6	Group Key Informant Interview	Deputy Health Officer and Senior Health Services Manager, Solano County Health and Human Services	2	County health department representative	Leader	8/11/15

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
7	Group Key Informant Interview	La Clinica de la Raza; Benecia Community Action Council; Partnership Health Plan	5	Represents low-income, minority and medically undeserved people in Solano County	Representative	8/14/15
8	Group Key Informant Interview	Executive Director, Mission Solano	1	Represents low income and medically underserved homeless population in Solano County	Leader	8/14/15
9	Group Key Informant Interview	Vacaville Family Resource Center (FRC); Fairfield/Suisun City FRC; Vallejo FRC; Rio Vista FRC; Benecia FRC; Children's Network of Solano County	8	Represents low-income, minority and medically underserved families in Solano County	Leader; Representative	8/19/15
10	Key Informant Interview	Health Education Manager	1	County health department representative	Leader	10/1/15
11	Focus Group	KP Youth Internship Program	22	Youth from multiple school districts in Solano County; minority; 16 – 18 years old	Member	7/31/15
12	Focus Group	Circle of Friends	10	Homeless, mental heath minority, and medically underserved population	Member	8/28/15
13	Focus Group	Parent Leadership Training Institute (PLTI) Leadership Program	2	Parents, minority, low-income and medically underserved population	Member	8/27/15
14	Focus Group	Migrant Community	22	Migrant, minority, medically underserved adults in the Dixon community	Member	10/7/15

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
15	Focus Group	LGBTQ community	4	LGBTQ, transgender, adults, medically	Member	11/23/15

Appendix C: Health Need Profiles

KFH-Vacaville Service Area Health Needs (in order of priority)	Health Need Criteria
1. Healthy Eating and Active Living 2. Safe, Crime and Violence Free Communities 3. Access to Affordable and Accessible Transportation 4. Access to Behavioral Health Services (Mental Health and Substance Abuse) 5. Economic Security (Food, Housing, Employment, Education) 6. Access to High Quality Health Care and Services 7. Disease Prevention, Management and Treatment	1. At least 50% of secondary data (quantitative) indicators within a health need category compared unfavorably to benchmarks or demonstrated racial/ethnic group disparities, or 2. At least 75% of primary data (qualitative) sources mentioned a health outcome or related condition associated with the health need category. ***Note**: California state benchmarks are included for reference. Differences between Solano County and California benchmarks are not necessarily statistically significant. Red color coding is used to highlight indicators that have a higher rate or percentage that is an undesirable difference from the KFH-Vacaville service area and green color coding is used to signify desirable differences.* * 1-2% undesirable difference from benchmark for service area overall ** > 2% undesirable difference from benchmark for service area overall

HEALTHY EATING AND ACTIVE LIVING		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
A lifestyle that includes **eating healthy** and **physical activity** improves overall health, mental health and cardiovascular health. A healthful diet and regular physical activity help individuals to maintain a healthy weight and reduce the risk for many health conditions including obesity, type 2 diabetes, heart disease, osteoporosis and some cancers. Access to and availability of healthier foods can help people follow healthful diets and may also have an impact on weight. Access to recreational opportunities and a physical environment conducive to exercise can encourage physical activity that improves health and quality of life.	**Overweight (Adult)** • HSA 39.50%** // CA 35.80% **Obesity (Adult)** • HSA 28.80%** // CA 22.30% **Overweight (Youth)** • HSA 19.51% // CA 19.30% • Hispanic/Latino 22.25%** // HSA 19.51% **Obesity (Youth)** • HSA 20.26%* // CA 18.99%	Low Fruit/Vegetable Consumption (Adult) • HSA 77.30%** // CA 71.50% Low Fruit/Vegetable Consumption (Youth) • HSA 43.90% // CA 47.40% • Non-Hispanic Other 69.80%** // HSA 43.90% • Hispanic/Latino 46.50%** // HSA 43.90% Food Environment – Grocery Stores • HSA 16.69** // CA 21.51 Food Environment – WIC-Authorized Food Stores • HSA 11.5** // CA 15.8 Food Security – Food Desert Population • HSA 25.46%** // CA 14.31% Physical Inactivity (Adult) • HSA 18.10%* // CA 16.60%

Sources: http://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status http://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity	• Hispanic/Latino 26.08%** // HSA 20.26% **Diabetes Prevalence (Adults – Age 20+)** • HSA 9.40%* // CA 8.05%	Physical Inactivity (Youth) • HSA 40.39%** // CA 35.92% • Non-Hispanic Black 48.86%** // HSA 40.39% • Hispanic/Latino 43.63%** // HSA 40.39% Economic Security – Commute Over 60 Minutes • HSA 11.94%* // CA 10.10% Diabetes Management (Hemoglobin A1c Test) • HSA 73.00%** // CA 81.50% Commute to Work – Alone in Car • HSA 77.74%** // CA 73.16% Walking/Biking/Skating to School • HSA 31.90%** // CA 43.00% • Non-Hispanic Black 14.73%** // HSA 31.90% Breastfeeding (Any) • HSA 94.50% // CA 93.00% • Non-Hispanic Black 87.15%** // HSA 94.50% • Non-Hispanic Native American/Alaskan Native 92.31%** // HSA 94.50% Breastfeeding (Exclusive) • HSA 78.90% // CA 64.90% • Non-Hispanic Black 68.57%** // HSA 78.90% • Non-Hispanic Native American/Alaskan Native 73.08%** // HSA 78.90%

Primary Data: 15 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to healthy eating and active living as a health need. Themes related to this health need were as follows:

- Community members voiced concerns about accessing affordable and healthy food options in their communities.
- Unhealthy food and beverage products are easily accessible and cost less according to many community participants. It was shared by participants that there is a lack of access to stores that provide healthy food options while there are a lot of fast food restaurants that are walkable and easily accessible.
- Community members shared frustrations that a fast food meal costs less than a bag of fresh fruits or vegetables.
- There was a sense from community members that only certain foods can be purchased with food stamps and EBT, which are not always the healthier options.
- Obesity was mentioned as an issue in Solano County as a result of unhealthy eating options, lack of physical exercise, and lack of knowledge about nutrition.
- Residents expressed concern about the high rates of obesity and diabetes in their community.
- Community members discussed the connection between obesity and diabetes and the importance of addressing obesity as a way of decreasing diabetes in their community.

- Community members describe Solano County as an agriculture community, however they say they have to go outside their communities in order to get affordable, healthy food options. It was also shared that a lot of the produce grown in Solano County is not available in local stores.
- Residents shared that the majority of the community that has trouble accessing healthy food options are from a lower socio-economic status.
- It was shared that children and adults are consuming a lot of sodas which are high in sugar content. A lot of vending machines provide unhealthy food and drink options, even in hospitals.
- Community members expressed concern about the lack of safe recreational places for physical activity.
- The community suggested more awareness and education on the importance of quality nutrition and physical activity.
- It was stated that food banks, faith-based organizations and other community-based organizations are resources in the community for accessing food, especially in food deserts and among lower socio-economic classes.

Geographic Impact:
Census tracts within ZIP codes 94533, 94534, 94535 (Fairfield), 94585 (Suisun City), and 95687, 95688 (Vacaville), and 95694 (Winters) had more than 50% of the population living in a designated food desert.

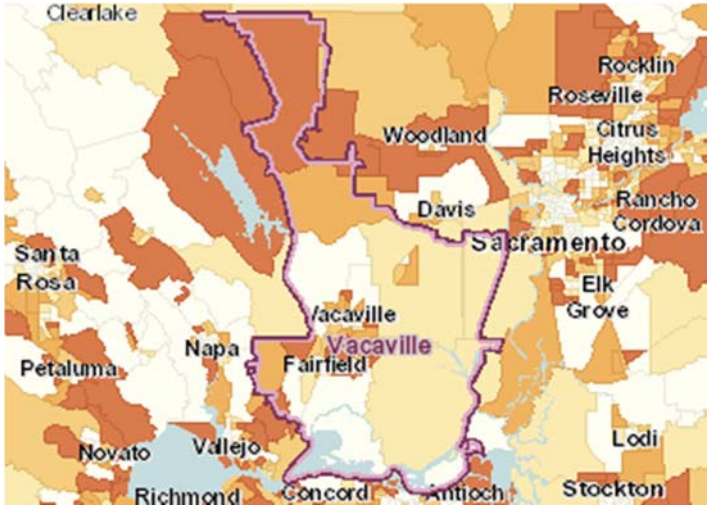


Figure 6. Population with Limited Food Access, Percent by Tract, FARA 2010

SAFE, CRIME AND VIOLENCE-FREE COMMUNITIES		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Safe, crime and violence-free communities contribute to overall health and well-being. Injuries and violence contribute to premature death, disability, poor mental health, high medical costs and loss of productivity. Individual behaviors such as substance use and aspects of the social environment such as peer group associations can affect the risk of injury and violence. The physical environment may also affect the rate of injuries related to falls, motor vehicle accidents and violent crime. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention	**Mortality – Homicide (per 100,000)** • HSA 6.6* // CA 5.15 • Black Alone 25.77** // HSA 6.6 **Mortality – Suicide (per 100,000)** • HSA 12.55** // CA 9.8 • Non-Hispanic White 15.61** // HSA 12.55 • Native Hawaiian/Pacific Islander Alone 16.85** // HSA 12.55 **Mortality – Motor Vehicle Accident (per 100,000)** • HSA 2.89 // CA 5.18 • Native Hawaiian/Pacific Islander Alone 15.95** // HSA 2.89 **Mortality – Pedestrian Accident (per 100,000)** • HSA 0.45 // CA 1.97 • Native Hawaiian/Pacific Islander Alone 7.24** // HSA 0.45 **Violence – Youth Intentional Injury (per 100,000)** • HSA 1110.3** // CA 738.7 **Violence – Assault (Injury) (per 100,000)** • HSA 418.9** // CA 290.3 **Violence – Domestic Violence (per 100,000)** • HSA 16.6** // CA 9.5 **Violence – Robbery (Crime) (per 100,000)**	Alcohol – Excessive Consumption • HSA 18.60%* // CA 17.20% Violence – School Suspensions • HSA 15.24%** // CA 4.04

	• HSA 169.3** // CA 149.5 **Violence (All Violent Crimes) (per 100,000)** • HSA 440.1** // CA 425 **Violence – Rape (Crime) (per 100,000)** • HSA 29.9** // CA 21	

Primary Data:

11 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to safe, crime and violence-free communities as a health need. Themes related to this health need are as follows:

- Community members expressed concerns about the safety of the parks in Solano County – perception that there are lots of persons experiencing homelessness, active drug users and gang activity, even during the day.
- There are pockets throughout Solano County where it was reported that there is a lot of gang violence, domestic violence and drug use making these communities unsafe and non-walkable. Community members suggest that pockets in Vacaville and Fairfield experience the most violence in the KFH-Vacaville Service Area.
- Community input on vulnerable locations include pockets around Vacaville and Fairfield; residents in these communities express a sense of feeling unsafe, preventing people from being outdoors and feeling safe in their own neighborhoods.
- Community members expressed concerns about gang activity, murders and gun violence in Fairfield.
- Residents reported a lot of gun violence in Solano County.
- Residents reported a cycle of poverty in their communities – people growing up with few resources and turning to drugs and gang violence.
- Community members are concerned with the lack of resources for people experiencing domestic violence.

Geographic Impact:

The following ZIP codes had high rates of homicides (12+) per 100,000 population from 2010 – 2012: 94533 (Fairfield) and 94585 (Suisun City).

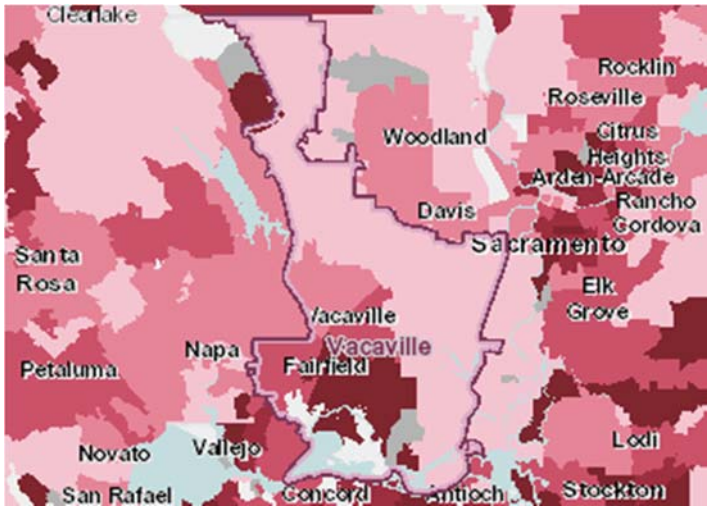


Figure 7. Homicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH 2010-2012

- Over 12.0
- 6.1 - 12.0
- 3.1 - 6.0
- Under 3.1
- No Homicide Deaths
- No Data or Data Suppressed
- Report Area

AFFORDABLE AND ACCESSIBLE TRANSPORTATION		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Affordable and accessible transportation options help people to live safely in their communities, reach essential destinations, and lead more rewarding and productive lives. This is especially important for people who may have difficulty with transportation to health care services including older adults, people with disabilities, and people with low incomes. Increasing access to a wide variety of transportation options helps people to maintain active lifestyles and can also lead to reductions in traffic congestion and air pollution, resulting in a healthier environment. Transportation options such as mass transit, paratransit and walking and biking helps to reduce dependency on automobiles and improve air quality and health. *Sources:* http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf	**Commute to Work – Alone in Car** • HSA 77.74%** // CA 73.16% **Economic Security – Commute Over 60 Minutes** • HSA 11.94%* // CA 10.10%	Population with Any Disability • HSA 12.13% // CA 10.13% • Black Alone 14.65%** // HSA 10.49% • Native American/Alaskan Native Alone 17.47%** // HSA 10.49% Walking/Biking/Skating to School • HSA 31.90%** // CA 43.00% • Non-Hispanic Black 14.73%** // HSA 31.90%
Primary Data: 14 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to access to affordable and reliable transportation as a health need. Themes related to this health need are as follows: • Transportation was mentioned as a top priority for community members. • Community members expressed concern about the lack of transportation to get to doctors' appointments in the KFH Vacaville service area. • More specifically, it was mentioned that transportation is an issue for residents of the Dixon area. Many are seasonal workers; working at the cannery, and when it's off-season, there are no more buses that go into town so they have to find a ride. • Community members expressed concern that bus schedules are too infrequent to support residents in keeping their doctors' appointments. In order to make an appointment at a clinic in Vacaville or Fairfield in the afternoon, many residents need to leave in the morning making the appointment an all-day process. • Community members voiced concerns about the transportation infrastructure in the area. Some saying the region was designed for cars with a large highway running through it. • It was shared that transportation is needed to get almost anywhere, which can be economically challenging.		
Geographic Impact: Less than 0.1% of workers travel to work by walking or biking in the census tracts within the following ZIP codes 95687, 95688 (Vacaville), 94533 and 94534 (Fairfield).		

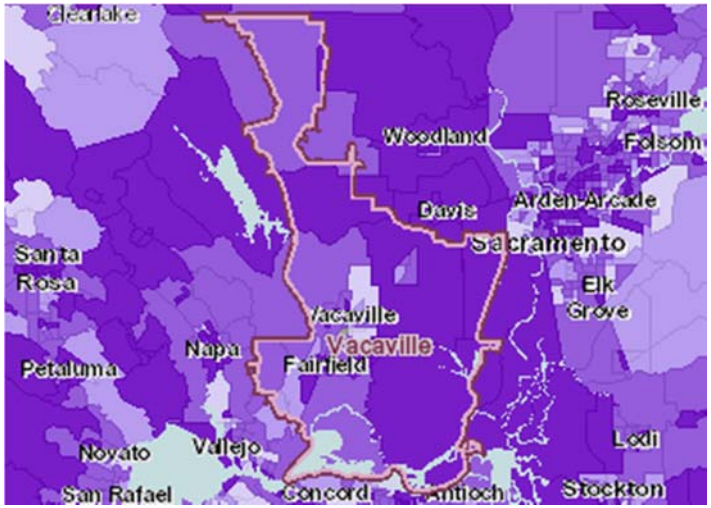


Figure 8. Workers Traveling to Work by Walking/Biking, Percent by Tract, ACS 2009-2013

ACCESS TO BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH AND SUBSTANCE ABUSE)		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Mental Health - Mental health and well-being is essential to living a meaningful and productive life. The burden of mental illness in the United States is among the highest of all diseases, and people with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including substance abuse and suicide. People with severe mental disorders on average tend to die earlier (10 to 25 years) as compared to the general population. Mental health disorders are also associated with chronic diseases including diabetes, heart disease, and cancer. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Social engagement opportunities are particularly important for youth and seniors that may be experiencing isolation or depression. **Substance Abuse/Tobacco -** Reducing tobacco use and treating/reducing substance abuse improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. For some individuals, substance abuse will develop into a chronic illness that will require lifelong monitoring and care. Access to treatment for substance abuse and co-occurring disorders will improve the health, safety and quality of life of individuals with substance use disorders as well as their children and families. *Sources:* http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health	**Mental Health** **Mortality – Suicide (per 100,000)** • HSA 12.55** // CA 9.8 • Non-Hispanic White 15.61** // HSA 12.55 • Native Hawaiian/Pacific Islander Alone 16.85** // HSA 12.55 **Mental Health – Needing Mental Health Care** • HSA 14.20% // CA 15.90% • Non-Hispanic White 19.34%** // HSA 14.20% • Hispanic/Latino 20.08%** // HSA 14.20% **Substance Abuse** **Alcohol – Excessive Consumption** • HSA 18.60%* // CA 17.20%	

http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse http://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use http://www.who.int/mental_health/management/info_sheet.pdf		

Primary Data:

15 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to behavioral health services as a health need. Themes related to this health need are as follows:

Mental Health

- Community members expressed concerns in accessing mental health services in Solano County. Some saying there are no services in their community.
- Mental health was identified in 14 out of the 15 interviews for the KFH Vacaville Service Area. Community members also expressed the importance and urgency in addressing mental health issues in Solano County.
- It was shared that there are many people who are economically challenged in the region, which produces unhealthy stress.
- Community members voiced concerns about high rates of depression in both youth and adults.
- The need for LGBTQ friendly counselors and cultural-competency training for health care professionals were mentioned in the interviews.
- It was expressed that a lot of people with mental health issues also have substance abuse issues (co-morbidity).
- It was shared that a lot of homeless youth and adults have substance abuse and mental health conditions.
- Community members suggest providing more education to city police on dealing with people who have mental health issues – providing an intervention rather than always taking them to jail.

Substance Abuse

- Lack of substance abuse treatment and services in Solano County; provider networks are weak.
- There's a perception that there is a lot of drug activity in the parks, including drug dealing, people doing drugs and items such as needles have been found in public places.
- Community residents expressed concern that people self-medicate instead of visiting the doctor to obtain treatment for their condition(s).
- It was noted that people will walk the streets at night to find and do drugs, making specific neighborhoods feel unsafe.
- It was shared that youth have easy access to drugs and alcohol at schools; there's a lot of peer pressure.
- Community members reported that crack, crystal meth, alcohol and tobacco are the drugs they see or hear about most often in Solano County.
- It was reported that there is a lot of advertisement and marketing of tobacco products in Solano County.

Geographic Impact:

- There are higher rates of suicide in Rio Vista (94571) than any other area in KFH-Vacaville's Service Area.
- There are higher rates of suicide in the Native Hawaiian/Pacific Islander and Non-Hispanic White population than Hispanic/Latino, Asian, Native American/Alaskan Native or Black population.

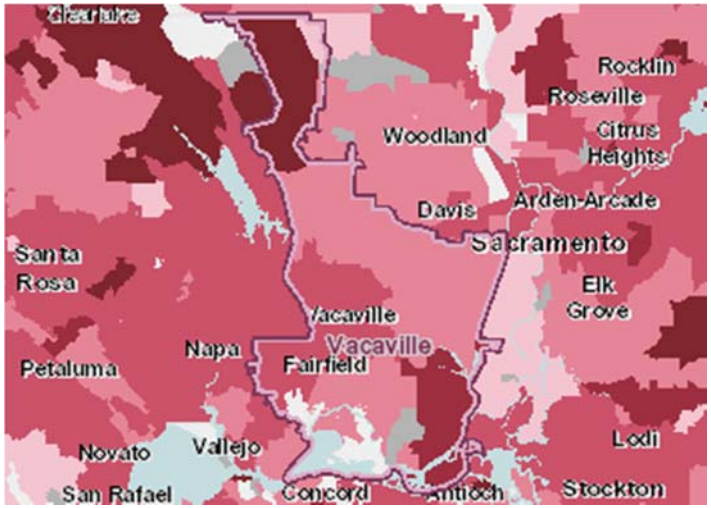


Figure 9. Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH 2010 - 2012

- Over 30.0
- 20.1 - 30.0
- 10.1 - 20.0
- Under 10.1
- No Suicide Deaths
- No Data or Data Suppressed
- Report Area

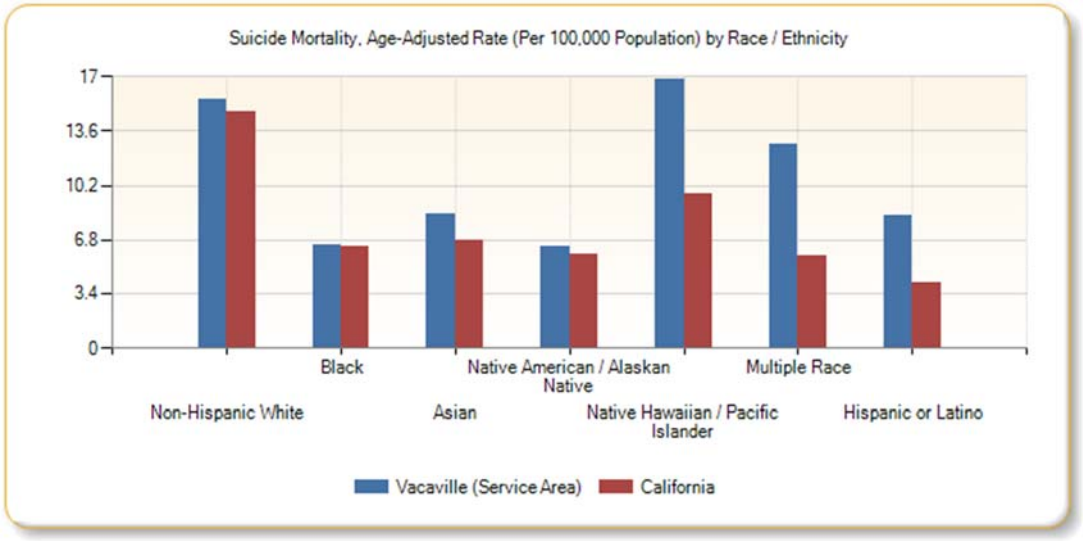


Figure 10. Suicide Mortality, Age-Adjusted Rate by Race/Ethnicity

ECONOMIC SECURITY (FOOD, HOUSING, EMPLOYMENT, EDUCATION)		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Lack of economic security and access to basic needs such as food, housing and educational and job opportunities may lead to serious health problems and poor quality of life. People with a quality education, secure employment and stable housing tend to be healthier throughout their lives. Education is associated with longer life expectancy and health-promoting behaviors such as going for routine checkups and recommended screenings. Without a good education, prospects for a stable job with good earnings also decrease. Secure employment that provides sufficient income allows people to obtain health coverage, medical care, food security and quality housing. Food security may improve access to and consumption of healthy foods and decrease the risk of being overweight or obese. Quality housing is associated with positive physical and mental well-being and helps to prevent disease and other health problems that may arise from unsafe living conditions. Homelessness also has a notable impact on health: people who are homeless have a mortality rate four to nine times higher compared to the general population and are at greater risk of infectious diseases and chronic illnesses, poor mental health, and substance abuse than those who are not homeless. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf http://www.cdc.gov/features/homelessness/	**Poverty - Population Below 100% FPL** • HSA 11.88% // CA 15.94% • Black 16.94%** // HSA 11.88% • Some Other Race 25.73%** // HSA 11.88% • Hispanic/Latino 19.31%** // HSA 11.88% **Poverty – Children Below 100% FPL** • HSA 17.48% // CA 22.15% • Black 29.39%** // HSA 17.48% • Some Other Race 34.12%** // HSA 17.48% • Hispanic/Latino 30.96%** // HSA 17.48% • Native American/Alaskan Native 21.12%** // HSA 17.48%	Education – School Enrollment Age 3-4 • HSA 46.24%** // CA 49.06% Education – High School Graduation Rate • HSA 87.54 // CA 80.44 • Non-Hispanic Black 84.16** // HSA 87.54 • Hispanic/Latino HSA 83** // HSA 87.54 Education – Reading Proficiency Level • HSA 35.00% // CA 36.00% • Non-Hispanic Black 48.66%** // HSA 35.00% • Non-Hispanic Native Hawaiian/Pacific Islander 44.12%** // HSA 35.00% • Hispanic/Latino 43.03%** // HSA 35.00% Education – Less than High School Diploma (or Equivalent) • HSA 13.48% // CA 18.76% • Native American/Alaska Native 16.75%** // HSA 13.48% • Some Other Race 39.18%** // HSA 13.48% • Hispanic/Latino 36.23%** // HSA 13.48% Insurance – Uninsured Population • HSA 11.56% // CA 17.78% • Native Hawaiian/Pacific Islander 20.71%** // HSA 11.56% • Some Other Race 21.93%** // HSA 11.56%

		• Hispanic/Latino 18.93%** // HSA 11.56% Economic Security – Commute Over 60 Minutes • HSA 11.94%* // CA 10.10%

Primary Data:

15 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to economic security as a health need. Themes related to this health need are as follows:

- Community members voiced concerns about the lack of resources for the homeless population. The homeless shelter in Vallejo closed, impacting the other shelters in the region.
- It was shared that animals can be a source of support for individuals experiencing homelessness and those with a serious mental illness, however animals are not allowed in most homeless shelters. Community members suggested a homeless shelter that accepts animals.
- Community members expressed concerns about trying to make financial ends meet working just one job. It was shared that some people work multiple jobs just to feed their families.
- Community members discussed concern that seasonal workers have a hard time applying for MediCal. Since their jobs are seasonal, their income fluctuates year-round. Most don't qualify, as they only work six months out of the year.
- It was shared that whether you have resources depends on your economic security.
- It was shared that there's vast income disparities throughout Solano County.
- Lack of affordable housing came up as a challenge in communities. It was shared that there is a long waiting list; some saying it can take years to receive affordable housing.
- Safe, affordable housing is a priority for community members.
- Financial stress was often mentioned by community members. It was shared that stress can in turn affect people's health as they are not eating healthy and regularly exercising.
- It was shared that there's a lack of jobs available in the region. People are still recovering from the recession where people lost their jobs and homes. There's a tremendous need for job creation in the region.
- Many residents described Solano County as a "bedroom community." People can't find jobs in the area, but it's cheaper to live in Solano than in the Bay area.
- There was a sense that most economic issues link back to poverty.

Geographic Impact:

- Census tracts within ZIP codes 95688 (Vacaville), 94533 and 94534 (Fairfield) have more than 20% of the population falling below the 100% Federal Poverty Level (FPL).
- In KFH-Vacaville Service Area, 19.31% of people falling below the 100% Federal Poverty Level (FPL) are of Hispanic/Latino decent, compared with 8.99% Non Hispanic/Latino.

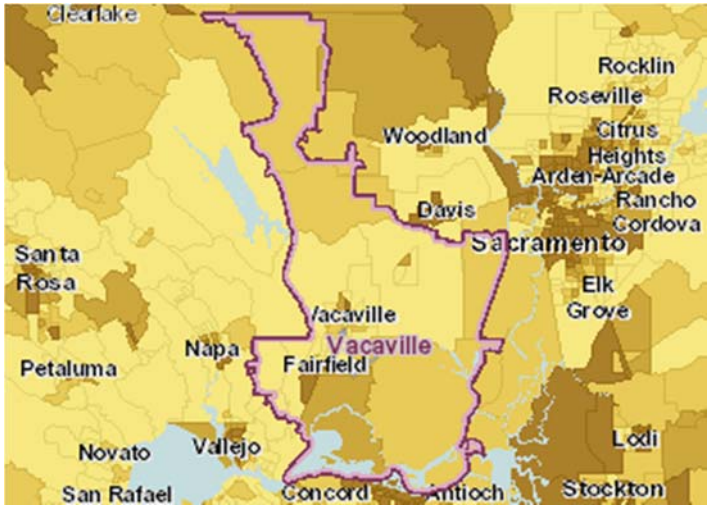


Figure 11. Population Below the Poverty Level, Percent by Tract, ACS 2009 - 2013

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Report Area

ACCESS TO HIGH QUALITY HEATLH CARE AND SERVICES		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Access to high quality, affordable health care and health services that provide a coordinated system of community care is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. Essential components of access to care include health insurance coverage, access to a primary care physician and clinical preventive services, timely access to and administration of health services, and a robust health care workforce. Culturally and linguistically appropriate health services are necessary to decrease disparities for diverse populations, including racial and ethnic minorities, LBGTQ populations and older adults. Health education/literacy and patient navigation services are also increasingly important following the passage of the Affordable Care Act of 2010, as the newly insured gain entry to the health care system. **Maternal and Infant Health -** Maternal and infant health are important for the health of future generations. Increasing access to quality preconception, prenatal, perinatal, and inter-conception care improves health outcomes for both the mom and the baby and is essential to addressing persistent disparities in maternal, infant, and child health. **Oral Health -** Oral health contributes to a person's overall health and well-being. Oral diseases contribute to the high costs of care and cause pain and disability for those who do not have access to preventative oral health services and dental	**Access to Care** **Lack of Consistent Source of Primary Care** • HSA 11.60% // CA 14.30% • Non-Hispanic Black 15.38%** // HSA 11.60% • Hispanic/Latino 19.27%** // HSA 11.60% **Oral Health** **Dental Care – No Recent Exam (Youth)** • HSA 5.70% // CA 18.50% • Non-Hispanic White 8.16%** // HSA 5.70% • Non-Hispanic Other 7.99%** // HSA 5.70% **Absence of Dental Insurance Coverage** • HSA 37.20% // CA 40.90% • Hispanic/Latino 48.06%** // HSA 37.20% **Maternal and Infant Health** **Infant Mortality (per 1,000)** • HSA 6* // CA 5 **Lack of Prenatal Care** • HSA 5.82%** // CA 3.14%	**Access to Care** Preventable Hospital Days • HSA 88.68** // CA 83.17 Cancer Screening – Mammogram • HSA 46.30%** // CA 59.30% Insurance – Uninsured Population • HSA 11.56% // CA 17.78% • Native Hawaiian/Pacific Islander 20.71%** // HSA 11.56% • Some Other Race Alone 21.93%** // HSA 11.56% • Hispanic/Latino 18.93%** // HSA 11.56% **Maternal and Infant Health** Education – School Enrollment Age 3-4 • HSA 46.24%** // CA 49.06% Breastfeeding (Any) • HSA 94.50% // CA 93.00% • Non-Hispanic Black 87.15%** // HSA 94.50% • Non-Hispanic Native American/Alaskan Native 92.31%** // HSA 94.50% Breastfeeding (Exclusive) • HSA 78.90% // CA 64.80% • Non-Hispanic Black 68.57%** // HSA 78.90% • Non-Hispanic Native American/Alaskan Native 73.08%** // HSA 78.90%

treatment. Dental care for low-income children is particularly important since tooth decay is the most common chronic childhood disease and may lead to problems in eating, speaking and learning if left untreated. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health http://www.healthypeople.gov/2020/topics-objectives/topic/oral-health http://www.gao.gov/new.items/d081121.pdf		

Primary Data:

14 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to high quality health care and services as a health need. Themes related to this health need are as follows:

Access to Care

- Participants from 14 of 15 interviews (93%) spoke about access to care as being problematic for the community.
- It was shared that health care for children is a lot easier to access than health care for adults.
- Community members expressed concern over the shortage of health care providers to keep up with the demand for care.
- It was shared that there is very limited access to health care services in Rio Vista. Some community members expressed concerns that there are no services in Rio Vista; you have to go outside of Rio Vista to obtain any health care services which often requires transportation.
- A lack of health care access for older adults with health issues was mentioned by community members.
- Residents expressed concern over the lack of access to health care providers who accept MediCal.
- Community members voiced concerns over long waiting periods to see a doctor.
- It was shared that navigating the health care system can be challenging. This includes understanding health care insurance and when to access primary and/or specialty care.
- A lack of access to specialty care services in Solano County was expressed as a concern by community members. This includes services for chronic conditions, mental health and the need for more psychiatrists.
- Community members expressed the need for more health care education including how to manage health care conditions and knowing when to access health care services.
- It was shared that there's a lack of culturally competent health care. Community members suggest cultural competency education for health care providers to better understand the communities' diverse cultural, linguistic and social needs.

Oral Health

- Participants from 10 of 15 interviews (67%) spoke about oral health as being problematic for their community.
- The community expressed concerns about oral hygiene; lack of access to dental care services to support oral hygiene, including oral health education in schools.
- It was shared that people are not going to the dentist because they don't have insurance and it's too expensive to pay out of pocket, resulting in poor oral hygiene.
- Community members expressed concern over the long waiting periods (up to a year) to get a dentist appointment.
- Community members suggest having a mobile van that provides dental care services.

Maternal and Infant Health

- It was shared that some parents don't know when to bring their babies in for baby well check ups and immunizations.

Geographic Impact:

- ZIP Code 95625 (Elmira) had more than 120 hospital discharges for conditions that were ambulatory care sensitive (ACS) compared with the rest of the hospital service area. ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions that could have been prevented if adequate primary care resources were available and accessed by those patients. (Figure 9).
- More than 5% of new mothers in the following ZIP codes had late or no prenatal care during pregnancy. ZIP codes include 94533, 94535 (Fairfield), 95620 (Dixon), 95687 (Vacaville)and 95688 (Vacaville). ZIP Codes 94571 (Rio Vista) and 95688 (Vacaville) had over 10% of new mothers with late or no prenatal care during pregnancy. (Figure 10).

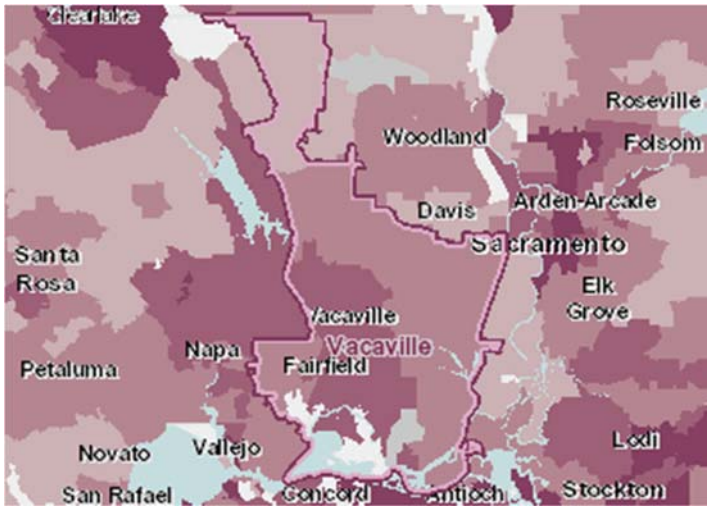


Figure 12. Preventable (ACS) Condition Hospital Discharges, Rate (Per 10,000 Pop.) by ZCTA, OSHPD 2011

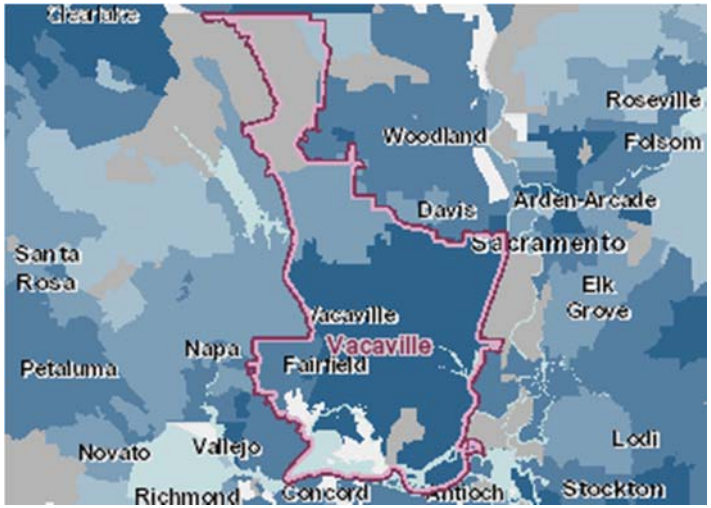


Figure 13. Mothers with Late or No Prenatal Care, Percent of New Mothers by ZCTA, CDPH 2011

Over 5.0%
3.1 - 5.0%
1.6 - 3.0%
Under 1.6%
No Data or Data Suppressed
Report Area

DISEASE PREVENTION AND MANAGEMENT		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark]**	**Contributing Factors (Related Indicators)**
Increasing the focus on **disease prevention and management** will improve health, quality of life and prosperity in communities. Chronic diseases such as heart disease, cancer and chronic lower respiratory diseases are the leading causes of death in the United States and approximately one out of every two adults is affected by chronic illness, many of which are preventable. There are also significant disparities among racial and ethnic minority groups as well as among children and seniors. Focusing on preventing disease and illness before they occur and better management of existing chronic diseases will create healthier places and decrease health care costs. http://www.cdc.gov/Features/PreventionStrategy **Asthma** Prevention, early-detection, treatment and management of asthma improves quality of life and productivity. Reducing exposures to triggers and risk factors such as tobacco smoke and poor air quality can decrease the burden of asthma and promote better health. http://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases **Cancer** Screening and early detection can help to reduce the illness, disability and death caused by cancer. Many cancers are preventable by reducing risk factors such as tobacco use, physical inactivity, poor nutrition, and obesity and promoting preventative behaviors such as vaccination against human papillomavirus and hepatitis B.	**Cancer** **Cancer Incidence – Breast (per 100,000)** • HSA 131.47** // CA 122.4 **Cancer Incidence – Cervical (per 100,000)** • HSA 7.1 // CA 7.7 • Hispanic/Latino 12.6** // HSA 7.1 **Cancer Incidence – Colon and Rectum (per 100,000)** • HSA 45.14** // CA 41.5 • Black 60.9**// HSA 45.14 **Cancer Incidence – Prostate (per 100,000)** • HSA 155.47** // CA 136.4 • Black 206.8** // HSA 155.47 **Cancer Incidence – Lung (per 100,000)** • HSA 60.19** // CA 49.5 • Black 64.1** // HSA 60.19 **Mortality – Cancer (per 100,000)** • HSA 194.24** // CA 157.1 • Non-Hispanic White 200.41** // HSA 194.24 • Black 208.34**// HSA 194.24 **CVD/Stroke** **Heart Disease – Prevalence** • HSA 7.70%* // CA 6.30% • Hispanic/Latino 12.79%** // HSA 7.70%	**Cancer** Overweight (Adult) • HSA 39.50%** // CA 35.80% Obesity (Adult) • HSA 28.80%** // CA 22.30% Physical Inactivity (Adult) • HSA 18.10%* // CA 16.60% Cancer Screening – Mammogram • HSA 46.30%** // CA 59.30% Alcohol – Excessive Consumption • HSA 18.60%* // CA 17.20% Low Fruit/Vegetable Consumption (Adult) • HSA 77.30%** // CA 71.50% Food Security – Food Desert Population • HSA 25.46%** // CA 14.31% Air Quality – Particulate Matter 2.5 • HSA 7.45%** // CA 4.17% **CVD/Stroke** Physical Inactivity (Youth) o HSA 40.39%** // CA 35.92% o Non-Hispanic Black 48.86%** // HSA 40.39% o Hispanic/Latino 43.63%** // HSA 40.39% Physical Inactivity (Adult) • HSA 18.10%* // CA 16.60% Alcohol – Excessive Consumption • HSA 18.60%* // CA 17.20% Overweight (Adult) • HSA 39.50%** // CA 35.80% Obesity (Adult) • HSA 28.80%** // CA 22.30%

http://www.healthypeople.gov/2020/topics-objectives/topic/cancer

CVD/Stroke

Cardiovascular disease is the leading cause of death and strokes are the third leading cause of death in the United States. Heart disease and stroke can result in serious illness and disability, a decreased quality of life and a significant financial burden on society. These diseases can be prevented and managed through behaviors such as engaging in regular physical activity, eating healthy foods and not smoking.
http://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke

HIV/AIDS/STDs

Preventing or reducing the transmission of HIV/AIDS and STDs leads to healthier, longer lives. There are approximately 19 million STD infections each year, almost half among the millennial population. HIV/AIDS/STDs are costly to treat and have long term health consequences, especially on reproductive health.
http://www.healthypeople.gov/2020/topics-objectives/topic/hiv
http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases

Mortality – Ischaemic Heart Disease (per 100,000)

- HSA 133.18 // CA 163.18
- Non-Hispanic White 151.7** // HSA 133.18
- Black 206.88** // HSA 133.18
- Native Hawaiian/Pacific Islander Alone 217.09** // HSA 133.18

Mortality – Stroke (per 100,000)

- HSA 37.58 // CA 37.38
- Black 40.72** // HSA 37.58
- Asian 64.89** // HSA 37.58
- Native American/Alaskan Native 41.78** // HSA 37.58

HIV/AIDS/STDs

STD – Chlamydia (per 100,000)

- HSA 506.4** // CA 444.9

STD – HIV Prevalence (per 100,000)

- HSA 337.6 // CA 363
- Non-Hispanic Black 970.43** // HSA 337.6

Asthma

Asthma - Prevalence

- HSA 30.30%** // CA 14.20%

Overweight (Youth)

- HSA 19.50% // CA 19.30%
- Hispanic/Latino 22.25%** // HSA 19.51%

Obesity (Youth)

- HSA 20.26%* // CA 18.99%
- Hispanic/Latino 26.08%** // HSA 20.26%

Diabetes Prevalence

- HSA 9.40%* // CA 8.05%

Diabetes Management (Hemoglobin A1c Test)

- HSA 73%** // CA 81.50%

Asthma

Air Quality – Particulate Matter

- HSA 7.45%** // CA 4.17%

Obesity (Adult)

- HSA 28.80%** // CA 22.30%

Overweight (Adult)

- HSA 39.50%** // CA 35.80%

Obesity (Youth)

- HSA 20.26%* // CA 18.99%
- Hispanic/Latino 26.08%** // HSA 20.26%

Overweight (Youth)

- HSA 19.50% // CA 19.30%
- Hispanic/Latino 22.25%** // HSA 19.51%

Primary Data:

11 of 15 sources (key informant and community member focus groups) mentioned health issues or drivers related to disease prevention and management as a health need. Themes related to this health need are as follows:

Cancer

- Participants from 4 of 15 interviews and focus groups spoke about cancer as being problematic for their community.
- It was suggested that there's a strong connection between smoking and cancer.

CVD/Stroke

- Participants from 4 of 15 interviews spoke about cardiovascular disease or stroke as being problematic for their community.
- According to participants, upstream factors that may play a role in this health issue include smoking, obesity, physical inactivity and poor quality nutrition.
- Community members suggested more health education and prevention programs to address the onset of preventable cancers and heart disease in Solano County.

HIV/AIDS/STDs

- Participants from 7 of 15 interviews spoke about HIV/AIDS/STIs as being problematic for their community.
- Community members expressed concern over the high Sexually Transmitted Infection (STI) rates in African Americans and teens.
- Chlamydia, Gonorrhea and HIV were mentioned as the most common sexually transmitted diseases mentioned by interview sources.
- Community members voiced concern over the lack of sex education in schools.
- It was often shared that patients with HIV are needing dental work.
- The LGBTQ community is at high risk of STDs according to community members.
- It was shared that there are higher rates of HIV positive women in the African American community.
- The community expressed concern over the lack of health education, especially in youth.

Asthma

- Participants from 6 of 15 interviews spoke about asthma as being problematic for their community.
- The community voiced concern over the amount of asthma problems seen in children.
- It was suggested that Rio Vista and Fairfield are communities that experience high rates of asthma, especially among youth.

Geographic Impact:

- ZIP codes 94535 (Travis AFB, Fairfield) and 95687 (Vacaville) have the highest rates of mortality due to cancer per 100,000 population compared with other ZIP codes within KFH-Vacaville's service area
- ZIP code 94535 (Travis AFB, Fairfield) has the highest rate of mortality due to stroke per 100,000 population compared with other ZIP codes within KFH-Vacaville's service area.
- There are significantly higher rates of mortality due to stroke in the Asian population within the KFH-Vacaville service area.
- All ZIP codes in the KFH-Vacaville service area have a high percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard per year compared to the state and national benchmarks. This indicator is relevant to poor air quality which can contribute to asthma.

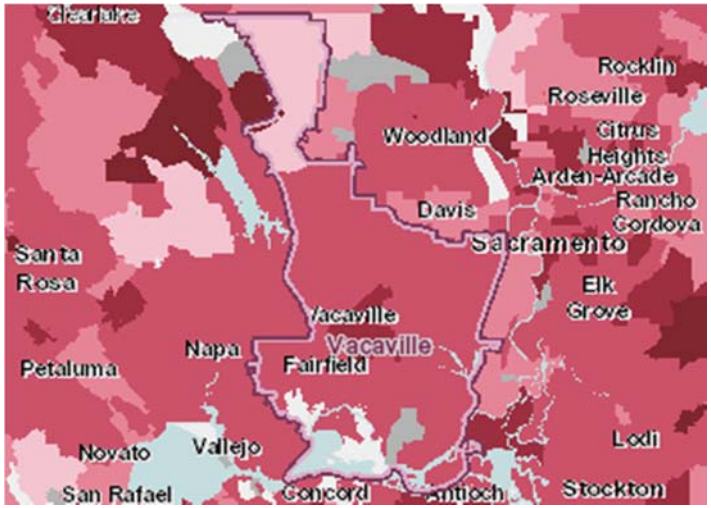


Figure 14. Cancer Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH 2010-2012

- Over 250.0
- 200.1 - 250.0
- 150.1 - 200.0
- 100.1 - 150.0
- Under 100.1
- No Data or Data Suppressed
- Report Area

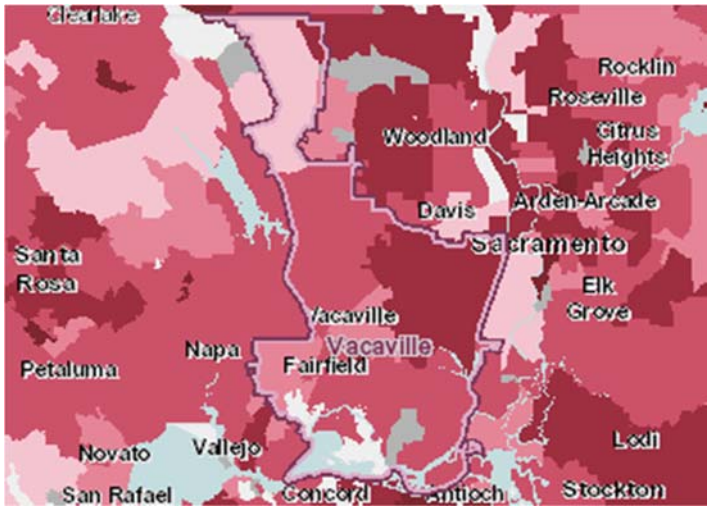


Figure 15. Stroke Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by ZCTA, CDPH 2010-2012

- **Over 60.0**
- **45.1 - 60.0**
- **30.1 - 45.0**
- **15.1 - 30.0**
- **Under 15.1**
- **No Data or Data Suppressed**
- **Report Area**

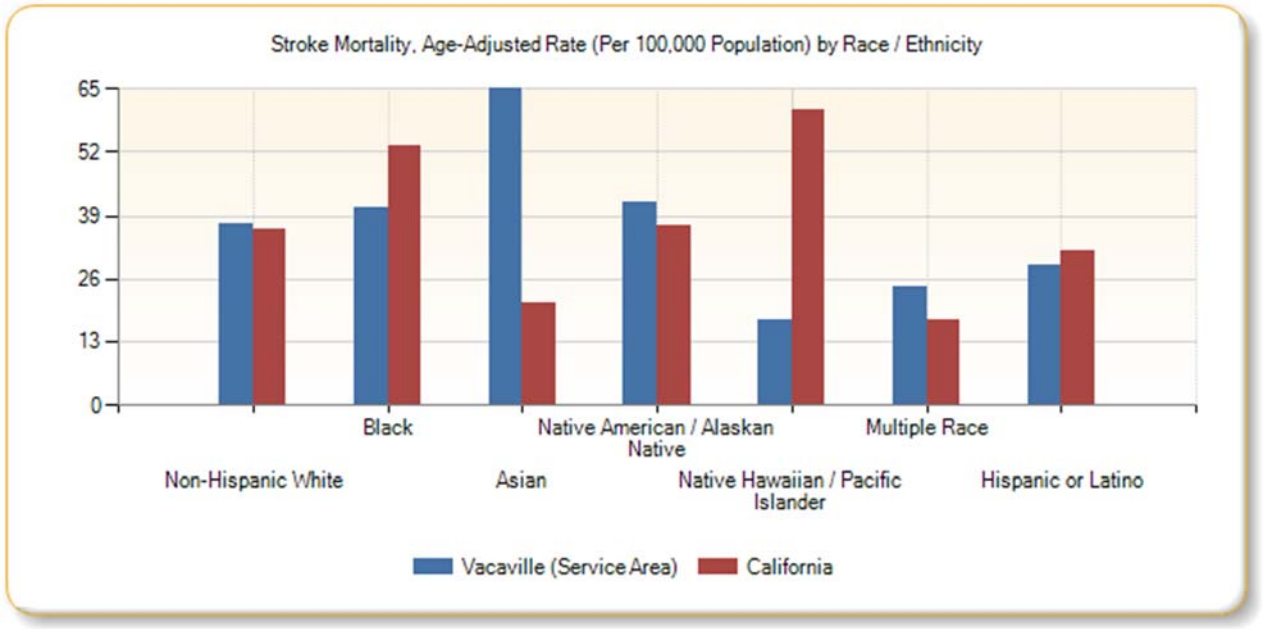


Figure 16. Stroke Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race/Ethnicity

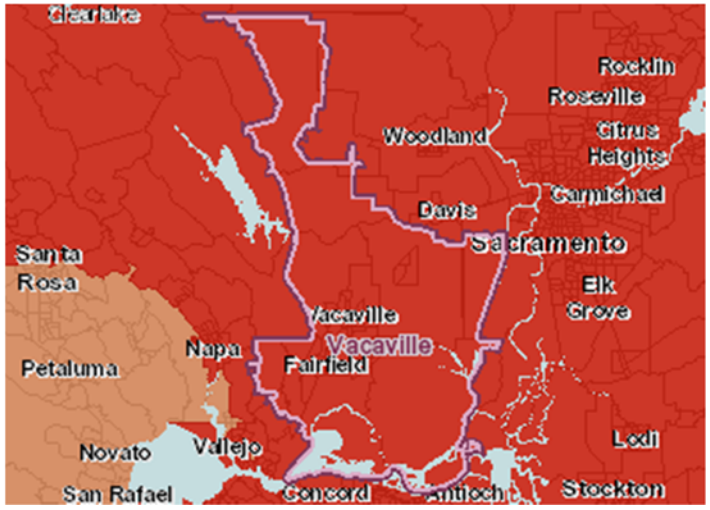


Figure 17. Fine Particular Matter Levels (PM 2.5), Percent Days Above NAAQ Standards by Tract, NEPHTN 2008

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

Appendix D: Detailed Methodology for Identifying Significant Health Needs

Potential Health Needs

Significant health needs were identified through an integration of both qualitative and quantitative data process began with generating a list of eight broad potential health needs (PHN categories) that could within the HSA as well as subcategories of these broad needs as applicable. The PHN categories and subcategories were identified through consideration of the following inputs: 1) the health needs identif 2013 CHNA process; 2) the categories in the Kaiser CHNA data platform (CHNA-DP), and 3) a prelim review of primary data. For a detailed list of the PHN categories, please see Table 6.

Table 6. Full Description of Potential Health Need (PHN) Categories and Subcategories

Potential Health Need Category	Subcategory	Components/Description
Access to High Quality Health Care and Services	Access to Care; Maternal and Child Health; Oral Health	This category encompasses the following needs related to acc to care: • Access to Primary and Specialty Care • Access to Dental Care • Access to Maternal and Infant Care • Health Education & Literacy • Continuity of Care, Care Coordination & Patient Navigation • Linguistically & Culturally Competent Services This category includes health behaviors that are associated w access to care (e.g. cancer screening), health outcomes that ar associated with access to care/lack of access to care (e.g. low birth weight) and aspects of the service environment (e.g. hea professional shortage area).
Access to Behavioral Health Services	Mental Health; Substance Abuse; Tobacco	This category encompasses the following needs related to behavioral health: • Access to mental health and substance abuse preventi and treatment services • Tobacco education, prevention and cessation services • Social engagement opportunities (especially for youth and seniors) • Suicide prevention This category includes health behaviors (e.g. substance abuse associated health outcomes (e.g. COPD) and aspects of the soc and physical environment (e.g. social support and access to liquor stores). In addition, this category includes life expectan since persons with severe mental health issues may have a lower life expectancy.
Affordable and Accessible	N/A	Includes the need for public or person transportation options transportation to health services and options for persons with disabilities.

Transportation		
Economic Security	Food Security, Housing; Economic Security; Education	This category encompasses the following basic needs: • Economic security (income, employment, benefits) • Food security/insecurity • Housing (affordable housing, substandard housing) • Education (reading proficiency, high school graduation rates) • Homelessness
Disease Prevention, Management and Treatment	Cancer; CVD/Stroke; Asthma; HIV/STIs	This category encompasses the following health outcomes that require disease prevention and/or management measures as a requisite to improve health status: • Cancer: Breast, Cervical, Colorectal, Lung, Prostate • CVD/Stroke: Heart Disease, Hypertension, Renal Disease, Stroke • HIV/AIDS/STDS: Chlamydia, Gonorrhea; HIV/AIDS • Asthma This category includes health behaviors that are associated with chronic and communicable disease (e.g., fruit/vegetable consumption, screening), health outcomes that are associated with these diseases or conditions (e.g. overweight/obesity), and associated aspects of the physical environment (e.g. food deserts).
Healthy Eating and Active Living (HEAL)	N/A	This category includes all components of healthy eating and active living including health behaviors (e.g. fruit and vegetable consumption), associated health outcomes (e.g. diabetes) and aspects of the physical environment/living conditions (e.g. food deserts).
Pollution-Free Living and Work Environments	Climate and Health	This category includes measures of pollution such as air and water pollution levels. This category includes health behaviors associated with pollution in communities (e.g. physical inactivity), associated health outcomes (e.g. COPD) and aspects of the physical environment (e.g. road network density). In addition, this category includes tobacco usage as a pollutant.
Safe, Crime and Violent Free Communities	Violence/ Injury Prevention	This category includes safety from violence and crime including violent crime, property crimes and domestic violence. This category includes health behaviors (e.g. assault), associated health outcomes (e.g. mortality - homicide) and aspects of the physical environment (e.g. access to liquor stores). In addition, this category includes factors associated with unsafe communities such as substance abuse and lack of physical activity opportunities, and unintentional injury such as motor vehicle accidents.

Significant Health Needs

While all of these potential health needs exist within the HSA to a greater or lesser extent, the purpose was to identify those that were most significant. A health need was determined to be significant through extensive

analysis of the secondary and primary data for the HSA.

For the secondary (quantitative) data, indicators were flagged that compared unfavorably to state benchmarks or had evident racial/ethnic group disparities. Indicators from the CHNA-DP were flagged if: (a) the HSA value performed poorly (>2% or 2 percentage point difference) or moderately (between 1-2% or 1-2 percentage point difference) compared to the state benchmark; or (b) a given indicator had one or more racial/ethnic group disparities where a given racial/ethnic group preformed poorly (>2% or 2 percentage point difference) compared to the value for the HSA.

For the primary (qualitative) data, the number of sources referring to each potential health need was totaled to generate a percentage for each category. A source (e.g., key informant or community member focus group interview) was considered to refer to a heath need if either a health outcome or related condition pertaining to the health need was mentioned by the source. In some cases, a reference could be applied to more than one PHN category.

A potential health need was identified as significant if it met or exceeded the thresholds determined by:

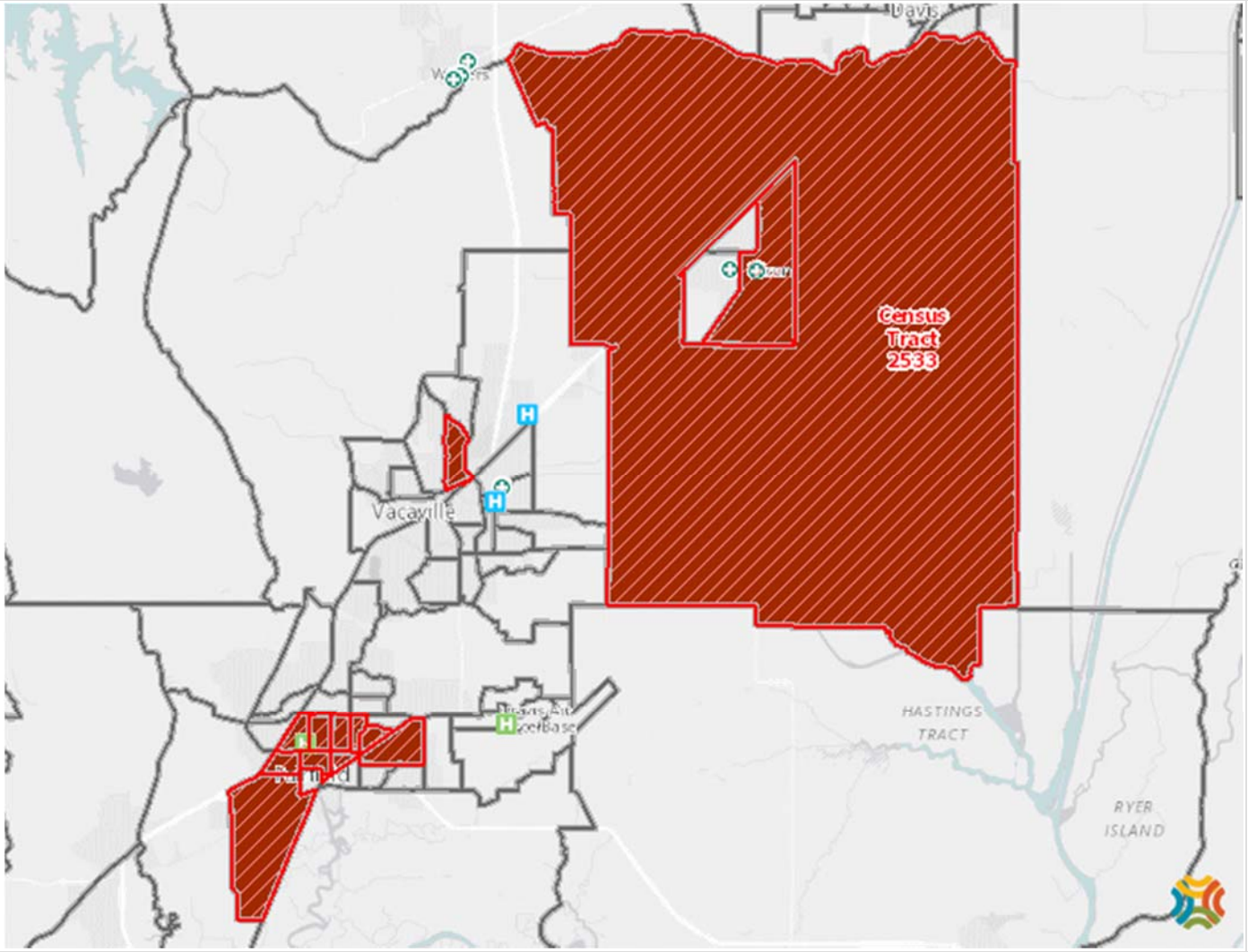
1. 50% of secondary data indicators compared unfavorably to benchmarks; and/or
2. 75% of sources referring to the health need);
3. 25% of primary data sources identified the health need as having a high level of priority/importance.

Health needs that met or exceeded the thresholds for both the primary and secondary data categories were given a score of two (2 points); health needs that met or exceeded the thresholds for only one of the categories were given a score of one (1 point). The health needs were then ranked so that those with two points were put into a higher tier for prioritization than those with one point. Finally, the percentage of importance was used as a way to prioritize the significant health needs. The prioritized significant health needs are displayed in Table 9.

Table 7. Prioritization of significant health needs within tiers by percentage of importance from community input

PRIORITIZED SIGNIFICANT HEALTH NEEDS				
PHN Category	**QUANT**	**QUAL**	**SCORE**	**IMPORTANCE**
	50%	75%		25%
1. HEAL	62%	100%	**2**	**67%**
2. Safe Communities	71%	87%	**2**	**20%**
3. Transportation	50%	93%	**2**	**13%**
4. Behavioral Health	27%	100%	**1**	**87%**
5. Economic Security	35%	100%	**1**	**27%**
6. Access to Care	38%	93%	**1**	**20%**
7. Disease Prevention	61%	73%	**1**	**13%**

Appendix E: Focus Communities Demographic Report



Map Legend

- Vulnerable Populations Footprint, ACS 2009-13
- Community Health Care Centers, HRSA 2013
- Hospitals, POS 2015
  - Public
  - Private
  - Other
- Priority Intervention Area - Kaiser Vacaville_2.4.16
- Tract Boundaries

Footprint Definition

Population Below Poverty >= 20%
Population Less Than High School >= 25%

Data Source

Health Resources and Services Administration: 2013
American Community Survey: 2009-13
Provider of Services File: 2015
TIGER 2013, U.S. Census Bureau

Priority Intervention Area - Kaiser Vacaville_2.4.16

ensus Tract 2524.01, Solano, California
ensus Tract 2524.02, Solano, California
ensus Tract 2525.01, Solano, California
ensus Tract 2526.04, Solano, California
ensus Tract 2526.05, Solano, California
ensus Tract 2526.06, Solano, California
ensus Tract 2526.07, Solano, California
ensus Tract 2526.08, Solano, California
ensus Tract 2526.11, Solano, California
ensus Tract 2527.07, Solano, California
ensus Tract 2532.05, Solano, California
ensus Tract 2533, Solano, California
ensus Tract 2534.02, Solano, California

Vulnerable Population in Priority Intervention Area

Below 100% of Federal Poverty Level	Total	Percent*
Total Population in Poverty	12,615	23.18
Children Age 0-17 in Poverty	5,224	33.77

Below 200% of Federal Poverty Level	Total	Percent*
Total Population in Poverty	24,950	45.85

Educational Attainment	Total	Percent**
Population with No High School Diploma	7,759	23.33

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates.

** Percentage of the population for whom poverty has been determined.*
*** Percentage of the population age 25 and over.*

Demographics in Priority Intervention Area

Total Population	55,100
Total Area in Square Miles	189.34
Persons Per Square Mile	291

Population by Gender	Total	Percent
Male	26,680	48.42
Female	28,420	51.58

Population by Age Groups	Total	Percent
Age 0 to 17	15,796	28.67
Age 18 to 64	33,941	61.60
Age 65 and Up	5,363	9.73

Population by Race/Ethnicity	Total	Percent
Non-Hispanic White	17,153	31.13
Black or African American	8,010	14.54
Asian	4,690	8.51
Native American / Alaska Native	126	0.23
Native Hawaiian / Pacific Islander	582	1.06
Some Other Race	65	0.12
Multiple Race	2,875	5.22
Hispanic or Latino	21,599	39.20

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates.

Report prepared by Community Commons.

Appendix F: Informed Consent

Key Informant Informed Consent Form

Gathering Information for a Community Health Needs Assessment (CHNA)

Purpose:
You have been invited to participate in a community health assessment. This assessment will help to inform area leaders on the specific needs of the communities which they serve. We will focus our questions on two main topics: 1) the health status of the community at large, and 2) the factors that help or prevent community members from living a healthy life. The information we gather from you will be combined with that of other interviews and focus groups. We will summarize these findings and report these to local leaders in your area.

Procedures:
The interview will capture your own experiences and opinions about community health issues. Completion of the questionnaire and the interview will take about 1 hour. We will also record and later transcribe the session. All identifying information will be removed from the transcripts and at the end of the project the recording will be destroyed.

Potential Risks or Benefits:
Some of the interview questions may be emotionally charged; otherwise there are no risks that we are aware of to answering the questions presented. There are no direct benefits to participating in this interview.

Participant's Rights:
Both completion of a short questionnaire and participation in this interview are completely voluntary; you may choose to not participate and terminate your involvement at any time.

Confidentiality and Anonymity:
Should you choose to participate, you will receive a copy of this consent form. The information you provide will only be shared with the project sponsors and associated vendors for the purpose of the CHNA and Public Health Accreditation Board (PHAB) processes. We will list your organization and or job title in the final report and may use quotes from the transcript of your interview; however, these *will not* be associated with your name directly. These forms and any information you provide will be kept in a secure location and there will be no link between the information we collect and this document.

How to obtain Additional Information:
If you have any questions or comments regarding this document, interview or final report please contact: **Anna Rosenbaum,** Senior Project Manager at **Valley Vision (**www.valleyvision.org) 916-325-1630.

I hereby agree to participate in this interview, understand that I will be provided a copy of this consent form for my own records, and acknowledge that my responses will be recorded.

_____	_____
Participant Name (Print)	Interviewer Name (Print)
_____	_____
Participant Signature Date	Interviewer Signature Date

Focus Group Informed Consent Form

Gathering Information for a Community Health Assessment

Purpose:

You have been invited to participate in a focus group for a community health needs assessment. This assessment will help to inform area leaders on the specific needs of the communities which they serve. We will focus our questions on two main topics: 1) the general health of the community, and 2) the factors that help or prevent community members from living a healthy life. The information we gather from you will be combined with that of other interviews and focus groups. We will summarize these findings and report these to local leaders in your area.

Procedures:

The focus group will capture your own experiences and opinions about community health issues. Completion of the questionnaire and the focus group will take about 90 minutes. We will also record and later transcribe the session. All identifying information will be removed from the transcripts and at the end of the project the recording will be destroyed.

Potential Risks or Benefits:

Some of the focus group questions may be emotionally charged otherwise there are no risks that we are aware of to answering the questions presented. Benefits include contributing to an important health assessment, along with compensation outlined below.

Participant's Rights:

Both completion of a short questionnaire and participation in this focus group are completely voluntary; you may choose to not participate and terminate your involvement at any time.

Compensation:

For your participation in the focus group you will be given a $10 gift card to a local retail outlet. Gifts cards will be distributed after completion of the focus group. If you are not able to complete the focus group you will not receive a gift card.

Confidentiality and Anonymity:

Should you choose to participate, you will receive a copy of this consent form. The information you provide and anything you share with us will only be shared with the project sponsors and associate vendors for the purpose of the CHNA and Public Health Accreditation Board (PHAB) processes. We may use quotes from the focus group transcript; however they will not be associated with your name directly. These forms and any information you provide will be in a secure location and there will be no link between the information we collect and this document.

How to obtain Additional Information:

If you have any questions or comments regarding this document, the questionnaire, focus group, or final report please contact: **Anna Rosenbaum,** Senior Project Manager at **Valley Vision (**www.valleyvision.org) 916-325-1630 (office).

I hereby agree to participate in this focus group, understand that I will be provided a copy of this consent form for my own records, and acknowledge that my responses will be recorded.

_____	_____
Participant Name Print	Interviewer Name Print
_____	_____
Participant Signature Date	Interviewer Signature Date

Focus Group Informed Consent – Parent/Guardian

Gathering Information for a Community Health Needs Assessment

Purpose:

Your son/daughter has been invited to participate in a focus group for a community health needs assessment (CHNA). This assessment will help to inform area leaders on the specific needs of the communities which they serve. We will focus our questions on two main topics: 1) the general health of the community, and 2) the factors that help or prevent community members from living a healthy life. The information we gather from your son/daughter will be combined with that of other interviews and focus groups. We will summarize these findings and report these to local leaders in your area.

Procedures:

The focus group will capture their experiences and opinions about community health issues. Completion of the questionnaire and the focus group will take about 90 minutes. We will also record and later transcribe the session. All identifying information will be removed from the transcripts and at the end of the project the recording will be destroyed.

Potential Risks or Benefits:

Some of the focus group questions may be emotionally charged otherwise there are no risks that we are aware of to answering the questions presented. Benefits include contributing to an important health assessment, along with compensation outlined below.

Participant's Rights:

Both completion of a short questionnaire and participation in this focus group are completely voluntary; your son/daughter may choose to not participate and terminate their involvement at any time.

Compensation:

For their participation in the focus group, your son/daughter will be given a $10 gift card to a local retail outlet. Gift cards will be distributed after completion of the focus group. If your son/daughter is not able to complete the focus group they will not receive a gift card.

Confidentiality and Anonymity:

Should your son/daughter choose to participate, they will receive a copy of this consent form. The information they provide and anything they share with us will only be shared with the project sponsors and associated vendors for the purposes of the CHNA and Public Health Accreditation Board (PHAB) processes. We may use quotes from the focus group transcript, however they will not be associated with your son/daughter directly. These forms and any information they provide will be in a secure location and there will be no link between the information we collect and this document.

How to obtain Additional Information:

If you have any questions or comments regarding this document, the questionnaire, focus group, or final report please contact: **Anna Rosenbaum,** Senior Project Manager at **Valley Vision (**www.valleyvision.org) 916-325-1630 (office).

I hereby agree to allow my son/daughter to participate in this focus group and understand that they will be provided a copy of this consent form for their own records, and acknowledge that their responses will be recorded.

_____	_____
Parent/Guardian Name Print	Interviewer Name Print
_____	_____
Parent/Guardian Signature Date	Interviewer Signature Date

Consentimiento Informado

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

Objetivo:
Usted ha sido invitado a participar en un grupo de enfoque para la evaluación de las necesidades de la salud de la comunidad. Esta evaluación le ayudará a informar a los líderes de la zona en las necesidades específicas de las comunidades a las que sirven. Nuestras preguntas se concentraran en dos temas principales: 1) la salud general de la comunidad, y 2) los factores que ayudan o que impiden a los miembros de la comunidad vivir una vida saludable. La información que juntamos de usted será combinada con los resultados de otras entrevistas y grupos de enfoque. Vamos a resumir estas conclusiones y reportar éstos resultados a los líderes de su área.

Procedimientos:
El grupo de enfoque captura tus propias experiencias y opiniones sobre temas de la salud de la comunidad Realización de un cuestionario y el grupo de enfoque tomara aproximada mente un hora y media (1 ½). Nos gustaría grabar la sesión y luego transcribir la. Toda la información de identificación será borrada de las transcripciones y al final del proyecto, la grabación será destruida.

Riesgos Potenciales o Beneficios:
Algunas preguntas pueden ser emocionalmente cargadas, a lo contrario, no hay ningún riesgo que estemos consciente al contestar las preguntas presentadas. Los beneficios por su participación en este grupo de enfoque incluye la oportunidad de participar en una evaluación importante y una tarjeta de regalo de 10 dólares (más detalles abajo).

Los Derechos del Participante:
La participación en este grupo de enfoque y en el cuestionario es completamente voluntaria, usted puede decidir a no participar y puede terminar su participación en cualquier momento que usted desea.

Compensación
Recibirá una tarjeta de regalo de $10 para una tienda local por participar en el grupo de enfoque. Después de completar el grupo de enfoque, le daremos la tarjeta de regalo. Si no eres capaz de completar el grupo de enfoque no recibirá tarjeta de regalo.

Confidencialidad y Anonimato
Si usted decide participar, usted recibirá una copia de esta forma de consentimiento. La información que usted nos dará solo será compartida con los patrocinadores del proyecto y vendedores asociados para el propósito de la evaluación y para el proceso de la junta de acreditación de la Salud Publica. Usted no será identificado en ninguna manera, su nombre no aparecerá en ningún documento y sólo el investigador tendrá el acceso a estos documentos. Estas formas y cualquier información coleccionada serán guardadas en una ubicación segura y no habrá ningún enlace entre la información que coleccionamos y este documento.

Como obtener Información Adicional:
Si tienes preguntas en par de esta forma, el cuestionario, el grupo de enfoque o el reporte final, póngase en contacto con **Giovanna Forno,** de **Valley Vision** (www.valleyvision.org) 916-325-1630 (oficina).

Por este medio consiento en participar en el grupo de enfoque y reconozco que mis repuestas serán grabadas. También entiendo que me van a dar una copia de esta forma de consentimiento para mis propios archivos.

Nombre del Participante	Nombre del Entrevistador
Firma del Participante Fecha	Firma del Entrevistador Fecha

Appendix G: Demographic Forms

Key Informant Questionnaire

Please complete this short questionnaire, which will give us more information about your professional experience, role and expertise working with special populations. Your answers to these questions will be combined with that of other key informants and cannot be used to identify you individually.

1. What sector do you work in? (Choose only one)

- ☐ Academic/Research
- ☐ Community Based Organization
- ☐ Health Care - Department/Division: _____
- ☐ Public Health - Department/Division: _____
- ☐ Social Services - Department/Division: _____
- ☐ Other (define): _____

2. What is your primary job classification? (Choose all that apply)

- ☐ Administrative or clerical personnel
- ☐ Community Health Worker/Promotora
- ☐ Community Organizer/Advocate
- ☐ Epidemiologist
- ☐ Environmental health worker
- ☐ Health Educator
- ☐ Medical Assistant
- ☐ Nurse
- ☐ Nutritionist
- ☐ Patient Navigator
- ☐ Physician
- ☐ Program Manager/Coordinator
- ☐ Senior Leadership/Upper Management
- ☐ Social Worker/Case Manager
- ☐ Other (define): _____

3. How would you define the geographic area served by your organization?

_____

_____

4. Do you work with any of the following vulnerable populations? (Choose all that apply)

- ☐ Low-Income
- ☐ Medically underserved
- ☐ Racial or ethnic minority (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____

Thank you for your participation!

VALLEY VISION
Connect. Partner. Impact.

Self-Report Demographic Data Card
Gathering Information for a Community Health Assessment

Please share…
Tell us a little about you….

This questionnaire helps us to gain more information about our community participants. Your answers to the following questions will be confidential and anonymous and cannot be used to identify you personally. Please note completion of this questionnaire is completely voluntary.

For each of the following, please choose <u>ONE</u> that describes you best:

1. **What is your gender identity (example: male, female, transman, transwoman, please specify)?**

   _____

2. **What is your ethnicity?**

   ☐Hispanic/Latino ☐Not Hispanic/Latino

3. **Please check <u>ONE or MORE</u> racial group(s) that describe you:**

   ☐African American/Black
   ☐Asian
   ☐Hawaiian Native/Pacific Islander
   ☐Hispanic/Latino only
   ☐Native American/Alaska Native
   ☐White/Caucasian
   ☐Other (Specify):_____

4. **What year were you born? _____**

5. **Please check the highest level of school you have completed.**

   ☐ High school graduate (diploma or the equivalent, for example, GED)
   ☐ NOT a high school graduate (diploma or the equivalent, for example, GED)

6. **What is your ZIP code of residence (where you live)? _____**

7. **Do you currently participate in any of the following programs? Choose <u>ALL</u> that apply.**

   ☐ CalFresh (Food Stamps, SNAP, EBT)
   ☐ CalWORKS (TANF)
   ☐ Head Start
   ☐ Medi-Cal
   ☐ Reduced Price School Meal
   ☐ Section 8 Public Housing
   ☐ Supplemental Security Income (SSI)
   ☐ Women, Infants, & Children (WIC Program)

8. **Are you <u>CURRENTLY</u> covered by any type of health insurance?**

☐Yes ☐No

Thank you for your participation!

Tarjeta de Datos Demográficos

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

Cuéntanos un poco acerca de usted…

Este cuestionario nos ayudará a obtener más información acerca de nuestros participantes de la comunidad. Tus respuestas serán confidenciales y anónimas y no se pueden utilizar para identificarte. Tu participación en este cuestionario es voluntaria.

Por cada pregunta, por favor elije UNO que te describe mejor:

3. ¿Con cuál genero identificas? (ejemplo: femenina, masculino, transexual, otro)

_____

2. ¿Cuál es tu raza?

☐ Latino/Hispano ☐ No Latino/ Hispano

3. Por favor marca <u>UNO o MÁS</u> grupos raciales que te describe:

☐Afroamericano/Negro
☐Asiático
☐Nativo de Hawái/Isleño del Pacifico
☐Solamente Latino/Hispano
☐Nativo Americano/Nativo de Alaska
☐ Caucásico/Blanco
☐ Otro (especifica):_____

4. ¿En qué año naciste? _____

5. Por favor marca el nivel más alto de la escuela que haya completado:

☐ Graduado de la escuela segundaria, (diploma o el equivalente, por ejemplo, el GED)

☐ No un graduado de la escuela secundaria, (diploma o el equivalente, por ejemplo, el GED)

6. ¿Cuál es tu código postal de residencia (donde usted vive)?_____

7. ¿Participa en alguno de los siguientes programas? Elija <u>TODOS</u> que correspondan:

☐ CalFresh (Cupones De Alimentos, SNAP, EBT)
☐ CalWORKS (TANF)
☐ Head Start
☐ Medi-Cal
☐ Comidas escolares gratis y reducido de precio
☐ Vivienda interés social
☐ Seguridad de ingreso suplementario (SSI)
☐ Programa Mujeres, bebes y niños (WIC)

8. ¿Está usted cubierto por algún tipo de seguranza de salud?

☐Sí ☐No

¡Gracias por participar!

Appendix H: Interview Guides

Key Informant Interview Guide

Gathering Information for a Community Health Assessment

Good [morning, afternoon, evening]!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Focus Group Guide

Gathering Information for a Community Health Assessment

Good [morning, afternoon, evening]!

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

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

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

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

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

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

14. Please, tell us generally about the community you live in.

- Follow Up: What are the specific neighborhoods?
- Follow Up: What types of people live there (race, age, legal status)?
    - Probe: How would you describe your neighborhood to someone who has never been there?
    - Probe: How would you describe the physical environment? (e.g urban, rural, large/small?)

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

- Probe: What does everyday life look like for most people?
- Probe: Is life easy or difficult for most people?

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

16. How would you describe the health of the community where you live?

- Probe: What are the biggest health issues that people struggle with?
- Probe: What health issues do you see or hear about from friends and family?

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

- Follow up: How would you rank these health issues in terms of importance?
    - Probe: These are the health issues I heard you mention earlier…which ones would you say are the most important?

18. What specific neighborhoods or places in your community struggle with health issues the most?

- **Follow up**: What specific groups in the community struggle with these health issues the most?
    - Probe: Do you see any differences in health by age, race, gender, sexual orientation, legal status?
    - Probe: Where do these groups live?

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

19. What are the challenges to being healthy in your community?

Individual Behaviors

- Probe: Do people engage in healthy or unhealthy behavior where you live?

- Probe: Are there any social norms or cultural beliefs that make it challenging for people to make healthy choices?

Physical/Social Environment

- Probe: Is it easy or hard to make healthy choices in your neighborhood? (E.g. access to healthy foods, places to exercise, access to health care)
- Probe: Is your neighborhood supportive of health? (E.g. sidewalks, safe streets, safe places to exercise, social supports)

20. What rules or laws prevent your community from being healthy?

- Probe: What types of rules or policies at your school or work, or in your neighborhood make it challenging to be healthy?
- Probe: What rules or laws keep people from being healthy at the local level? The state level? The federal level?

21. Are there changes happening in your community that could affect your health?

- Probe: What about any upcoming trends, factors, or events that may affect your health?

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

22. What resources exist in your community to help people live healthy lives?

- Probe: What are the barriers to accessing these resources?
- Probe: What are gaps in these resources? What resources are missing?

23. What would you say has been the impact of universal health care coverage [may also be known as Covered California, Obamacare, ACA] **on your community?**

- Probe: Has this made a difference for you, your family or your friends?
- Probe: Is it easier to get health care? Why or why not?
- Probe: Has this influenced how you use the health care system?

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

24. What is needed to improve the health of your community?

- Probe: Is there a particular person that could help improve the health of your community?

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

- Any other questions that you might have?

VALLEY VISION

Connect. Partner. Impact.

Guía de Grupo de Enfoque

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

[¡Buenos Días, Buenas Tarde o Buenas Noche!]

Somos _____ (nombre) y _____ (nombre), de Valley Vision, una firma de consulta local sin fines de lucro. Hoy, nos gustaría acumular información, pensamientos y opiniones suyas como parte de una evaluación de las necesidades de salud de tu comunidad que le ayudará a informar a los líderes de la zona en que tú vives en las necesidades de salud específicas.

Como parte del Affordable Care Act, el gobierno requiere evaluaciones cada tres años de las necesidades de salud de los hospitales sin fines de lucro y que utilizan los resultados de estas evaluaciones para implementar planes para mejorar la salud de la comunidad. Valley Vision es la organización que está llevando a cabo las evaluaciones para los hospitales sin fines de lucro en su área.

Usted ha sido identificado como una fuente de conocimiento significativo sobre la salud de su comunidad. Tenemos varias preguntas importantes que nos gustaría preguntarle- por favor responde abiertamente y honestamente a todas las preguntas. Usted también puede rechazar a responder cualquier pregunta o dejar el grupo de enfoque en cualquier momento.

Estaremos grabando durante este grupo de enfoque para asegurarnos que capturamos todo lo que dices. Nuestro grupo luego transcribiría la grabación y analizaría las transcripciones para pintar una imagen completa de las necesidades de salud de tu comunidad. Aunque esta entrevista es confidencial, podemos usar citas de la transcripción cunado escribimos nuestro informe final. Sin embargo, las cotizaciones no serán atribuidas directamente a usted.

Antes de empezar quiero pedirle que firme el documento de consentimiento informado y llenen el cuestionario. Al firmar, usted está de acuerdo de participar en este grupo de enfoque y nos da permiso para grabar y utilizar la grabación para nuestro informe final.

Date: Organization/Location: Number of Participants: HSA represented:

Objective 1: To understand the community served by the provider or resident
Objetivo 1: para entender la comunidad servido por el proveedor o residente

1. **Por favor, díganme de su comunidad.**
    - Seguimiento: ¿Cuáles son los barrios específicamente
    - Seguimiento: ¿Qué tipos de personas viven allí? (edad, raza, genero, estatus legal)
        - Prueba para: ¿Cómo describieran su comunidad a alguien que nunca ha estado aquí?
        - Prueba para: ¿Cómo describieran la ambiente física de su comunidad? *(¿es urbano/ rural, grande/pequeño?)*

2. **¿Cómo describen la calidad de vida en su comunidad?**
        - Prueba para: ¿Es la vida fácil o difícil para la mayoría de personas?
        - Prueba para: ¿Cómo experiencias la vida cada día en tu comunidad?

3. **Por favor, describen la salud de la comunidad adonde ustedes viven**
        - Prueba para: ¿Cuáles son los problemas de salud más grande?
        - Prueba para: ¿Qué problemas de salud oyes o ves en el trabajo, en la casa, en las escuelas, entre tus amigos/amigas, en tu familia?
4. **¿De los problemas de salud que ya han comentado, cuales son los más importantes de resolver?**
    - Seguimiento: **¿Estos son los problemas de salud que han dijeron… cuales son los más importantes/urgentes de resolver?**

5. **¿Qué grupos específicos (*tipos de gente por edad, raza, genero, estatus legal*) en la comunidad luchan con estos problemas de salud más?**
    - Seguimiento: **¿Qué áreas específicos luchan con problemas de salud lo más?**

        - Prueba para: Composición socio-demográfica (raza/etnicidad, edad, género, orientación sexual)
        - Prueba para: Las desigualdades/inequidades
        - Prueba para:¿Dónde viven estos grupos (concentración)?

Objective 3: To determine the drivers which influence the health status of the community.
Objetivo 3: Para determinar los controladores que influyen la salud de la comunidad**.**

6. ¿Cuáles son las dificultades para ser saludable en la comunidad adonde ustedes viven?

- Pruebe para dificultades/barreras a vivir saludable en varios niveles**:**
- *Comportamiento individual:*
  - ¿Actividades o comportamientos de grupos específicos?
  - ¿Actitudes y creencias de grupos específicos?
  - ¿normas o creencias culturales de la comunidad en torno a lo que es estar "saludable"?
    - ¿Estrés, ansiedad y estrategias de afrontamiento de grupos especifico?
- *Ambiente físico (estructura física y las condiciones del ambiente):*
  - Aceras, estructuras de construcción, luces de la calle
  - Rutas de transporte
  - Lugares para participar en actividades/deportes
  - Acceso a alimentos saludables
  - Acceso a servicios preventivos y servicios de salud
  - Percepción de seguridad

7. ¿Qué tipos de leyes, reglas, o prácticas impiden su comunidad de vivir saludable?

- Prueba para: ¿Qué tipos de leyes, políticas, o prácticas en sus trabajos, barrios o en las escuelas, lo hace difícil vivir saludable?

8. ¿Vienen cambios en la comunidad adonde usted vive que podría afectar tu salud?

- Prueba: ¿Hay modas, factores o eventos que vienen a la comunidad que podría afectar tu salud?

Objective 4: To determine opportunities and resources for living healthy in the community.
Objetivo 4: Para determinar oportunidades y recursos para un vida saludable en la comunidad.

9. ¿Qué recursos existen en la comunidad para ayudar las personas vivir saludable?

- Prueba para: ¿Cuáles son las dificultades/barreras para participar en estos recursos?
- Prueba para: ¿Qué se falta en estos recursos?
- Prueba para: ¿Qué recursos faltan?

10. ¿La Affordable Care Act ha impactado la comunidad adonde ustedes viven? [también se conoce como Covered California, Obamacare]

- Prueba para: ¿Cómo ha impactado la comunidad?
- ¿Si no, porque no impacto la comunidad?

Objective 5: To determine the requisites needed to improve the health of the community.
Objetivo 5: Para determinar los recursos necesarios para mejorar la salud de la comunidad

11. ¿Qué es necesario para mejorar la salud de tu comunidad?

- Seguimiento**: ¿Hay algún tipo de persona que podría ayudar mejorar la salud de la comunidad?**

12. ¿Hay algo más que les gustaría compartir con nosotros la salud de su comunidad?

- **Seguimiento: ¿Hay preguntas?**

Appendix I: Project Summary Sheet

2016 Community Health Needs Assessment (CHNA)

About the CHNA Project

About the CHNA

The 2016 Community Health Needs Assessment (CHNA) is a collaborative project that looks at the health of Solano County. The three nonprofit hospital systems in the region (Kaiser Permanente, NorthBay Healthcare and Sutter Health) and Solano County Public Health, in partnership with the Solano Coalition for Better Health, are working together to conduct a health assessment of the communities they serve. The assessments are then used by the hospital systems to develop plans to improve the health of these communities.

The CHNA Reports

Each CHNA report includes:

- A description of the health of the community served by a hospital facility;
- The health issues within the community and the factors contributing to those health issues;
- The areas and communities that are most affected by these health issues;
- The health needs that are most important to improve overall health for the community;
- Potential resources and services that are available to improve community health.

Previous CHNA reports are available online at http://www.healthylivingmap.com (see 2013 CHNA Reports), and the 2016 reports will be available in the Fall of 2016.

How the Project Works

To get information about the health of the community, we talk to many different groups of people including medical providers, public health workers, community organizations, and residents. We ask people to share information with us about: (1) the health issues they see and experience in their communities; (2) the challenges and opportunities to be healthy in their communities; and (3) the resources that may or may not be available to help people live healthy lives. We then look for patterns or themes in what we hear from the community and identify the priority health needs to be included in the CHNA reports. The reports are then used to help the hospital systems decide which community services and programs to support.

About Us

Valley Vision is an organization that works on economic, environmental and social issues. Our vision is to help create a healthy region for all generations through learning about the community, working with other organizations and helping to lead teams of people. We have worked on CHNA reports for the Sacramento region since 2007.

The Team

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- **Giovanna Forno**, Project Fellow: giovanna.forno@valleyvision.org

Project Sponsors

Kaiser Permanente
NorthBay Healthcare
Sutter Health
Solano Co. Public Health
Solano Coalition for Better Health

Appendix J: Resources Available to Address Significant Health Needs for KFH-Vacaville

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
AA, Al-Anon, Al-Ateen - Solano North	Vacaville	Yes		X					
AIDS Prevention & Care - Solano County AIDS Community Education Program	Fairfield	Yes			X				
Aldea Children and Family Services	Fairfield	Yes		X		X			
American Cancer Society	Suisun City	Yes	X					X	
Archway Recovery Services	Fairfield	Yes		X					
Bay Area Services Network (BASN) - Solano County Department of Mental Health	Fairfield	Yes		X					
Boys and Girls Clubs	Travis AFB, Vacaville	Yes		X		X	X		X
Casa of Solano County	Fairfield	Yes				X			X
Child Haven, Inc.	Fairfield	Yes		X					X
Children in Need of Hugs	Suisun City	Yes	X			X			
Children's Nurturing project	Fairfield	Yes		X					X

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Circle of Friends	Fairfield	Yes		X		X		X	
City of Fairfield Housing Authority	Fairfield	Yes				X			
City of Vacaville - Youth Services	Vacaville	Yes		X					
Community Action North Bay (CAN-B)	Fairfield	Yes				X			
Community Medical Centers	Vacaville	Yes	X		X				
Crossroads Christian Church	Vacaville	Yes		X					
DART Paratransit- Fairfield-Suisun Transit (FAST)	Fairfield	Yes						X	
Delta Intergroup of Alcoholics Anonymous - Serving Rio Vista	Rio Vista	Yes		X					
Dixon Family Resource Center	Dixon	Yes		X		X			X
Dixon Migrant Farm Labor Camp	Dixon	Yes				X			
Dungarvin California	Vacaville	Yes		X				X	
Emergency Medical Services - Solano County	Fairfield	Yes	X						

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Fairfield Adult Recreation Center - City of Fairfield	Fairfield	Yes				X	X		
Fairfield Christian Reformed Church	Fairfield	Yes				X			
Fairfield Family Resource Center	Fairfield	Yes		X		X			
Fairfield Health Center - Planned Parenthood	Fairfield	Yes	X	X	X				
Fairfield WIC Clinic	Fairfield	Yes	X			X	X		
Fairfield Youth Coalition	Fairfield	Yes		X			X		
Fairfield-Suisun Community Action Council, Inc.	Fairfield	Yes				X			
Faith PAC (Partners Against Crime)	Fairfield	Yes				X			X
Family Health Services- Solano County	Vacaville	Yes	X						
First 5 Solano - Children & Families Commission	Fairfield	Yes	X			X			
First Baptist Church	Fairfield	Yes				X			
Food Bank of Contra Costa and Solano County	Fairfield	Yes				X	X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Head Start Programs	Dixon, Fairfield, Vacaville	Yes		X		X	X		
Healthy Partnerships	Fairfield, Vacaville	Yes		X					
Heather House	Fairfield	Yes		X		X			
Heritage Home	Fairfield	Yes	X			X			
Kaiser Permanente Educational Theatre Program (ETP)	Vacaville	Yes			X		X		
Kaiser Permanente Fairfield Medical Offices	Fairfield	Yes	X		X				
Kaiser Permanente L.A.U.N.C.H.	Dixon, Fairfield, Vacaville	Yes				X			
Kaiser Permanente Vacaville Medical Offices	Vacaville	Yes	X	X			X		
Meals on Wheels of Solano County	Suisun City	Yes				X			
MedMark Treatment Centers	Fairfield	Yes		X					
Mission Solano	Fairfield	Yes	X			X			
Mission Solano: Bridge to Life Center	Fairfield	Yes		X		X			

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Mission Solano: Community Outreach Center	Fairfield	Yes	X			X			
Mission Solano: Social Enterprises	Fairfield	Yes				X			
Narcotics Anonymous - Solano County	Fairfield	Yes		X					
National Alliance on Mental Illness (NAMI) of Solano County	Fairfield	Yes		X					
NorthBay Cancer Center	Fairfield	Yes	X		X	X	X		
NorthBay Medical Center	Fairfield	Yes	X	X	X		X		
Opportunity House	Vacaville	Yes				X			
Pharmatox, Inc.	Fairfield	Yes		X					
Rio Vista CARE	Rio Vista	Yes		X					
Rio Vista Family Resource Center	Rio Vista	Yes		X		X			
Rio Vista Food Pantry	Rio Vista	Yes				X			
SafeQuest Solano	Fairfield	Yes		X		X			X
Solano Asthma Coalition	Fairfield	Yes			X				

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Solano Coalition for Better Health	Suisun City	Yes	X			X			
Solano Coalition for Better Health- SKIP (Solano Kids Insurance Program)	Suisun City	Yes	X			X			
Solano Community College	Fairfield, Vacaville	Yes				X			
Solano County Dental Clinic- Mobile Dental Van	Vacaville	Yes	X						
Solano County Department of Parks and Recreation	Fairfield	Yes			X		X		
Solano County Department of Public Health- Communicable Disease Control Program	Fairfield	Yes	X		X				
Solano County Department of Public Health- Emergency Medical Services	Fairfield	Yes	X	X		X			
Solano County Department of Public Health - Health Education & Community Resources	Fairfield	Yes			X		X		
Solano County Department of Public Health - Health Promotion & Community Wellness - Safe Routes to School Solano	Fairfield	Yes			X		X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Solano County Department of Public Health- Maternal, Child & Adolescent Health	Fairfield	Yes	X						
Solano County Department of Public Health- Maternal, Child & Adolescent Health - Baby First Solano- Healthy Families America Program	Fairfield	Yes	X						
Solano County Department of Public Health- Maternal, Child & Adolescent Health - Nurse - Family Partnership Program	Fairfield	Yes	X			X			
Solano County Department of Public Health - Nutrition Services Program	Fairfield	Yes	X		X		X		X
Solano County Department of Public Health- Nutrition Services Program - Nutrition Education & Obesity Prevention	Fairfield	Yes	X		X		X		
Solano County Family Health Services	Fairfield, Vacaville	Yes	X		X				
Solano County Health and Social Services Department- CalFresh Food Stamps	Fairfield	Yes				X	X		
Solano County Mental Health Services	Fairfield	Yes		X					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Solano Hearts United	Fairfield	Yes				X			
Solano Pride Center	Fairfield	Yes		X					
Solano/Napa Habitat for Humanity	Fairfield	Yes				X			
Sparkpoint Fairfield	Fairfield	Yes				X			
St. Mark's Lutheran Church	Fairfield	Yes				X			
St. Mary's Catholic Church	Vacaville	Yes				X			
St. Paul's United Methodist Church	Vacaville	Yes		X					
Suisun Family Resource Center	Suisun City	Yes		X		X			
Sutter Fairfield Medical Campus	Fairfield	Yes	X		X				
Sutter Medical Plaza	Vacaville	Yes	X		X				
The Children's Network of Solano County	Fairfield	Yes	X	X			X		
The Children's Network of Solano County- Earn it! Keep It! Save It! Solano	Fairfield	Yes				X			

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
The Children's Network of Solano County- Parent Leadership Training Institute (PLTI)	Fairfield	Yes				X			
The Father's House	Vacaville	Yes		X					
Vaca FISH - Bethany Lutheran Church	Vacaville	Yes				X			
Vacaville Community Services Department	Vacaville	Yes					X		
Vacaville Family Resource Center	Vacaville	Yes		X		X			
Vacaville Unified School District- After-School Enrichment	Vacaville	Yes				X	X		
Women, Infant and Children (WIC)	Dixon, Fairfield, Vacaville	Yes	X	X	X		X		
Vacaville Youth Roundtable	Vacaville	Yes							X
Voces Unidas Solano	Fairfield	Yes				X			
Workforce Investment Board of Solano County	Fairfield	Yes				X			
Youth & Family Services	Fairfield	Yes		X					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Behavioral Health	Disease Prevention	Economic Security	HEAL	Transportation	Safe Communities
Youth Takin' On Tobacco (YTOT)	Vacaville	Yes		X	X				

Additional Assets	Resource Guides
	211 Solano http://211bayarea.org/solano/
	Solano Network of Care http://solano.networkofcare.org/

Additional Assets	Community Assets *Reported in Key Informant Interviews and Focus Groups*
	After school programs
	Churches and faith-based organizations
	Farmer's markets

Sources: Primary data from community input (key informant and community member focus group interviews), the CHNA 2013 Resource Section, and organizations that contributed to the 2016 CHNA process.