2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Antioch

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Approved by Kaiser Foundation Hospital Board of Directors' Community Health Committee

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KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit

CHNA Report for KFH-Antioch

Contents

I. 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 12 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

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

B. About Kaiser Permanente Community Health

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. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. 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. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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 https://www.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 130 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, the KFH facility, with a collaborative, collected primary data

through key informant interviews and focus groups. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

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

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

II. Community served

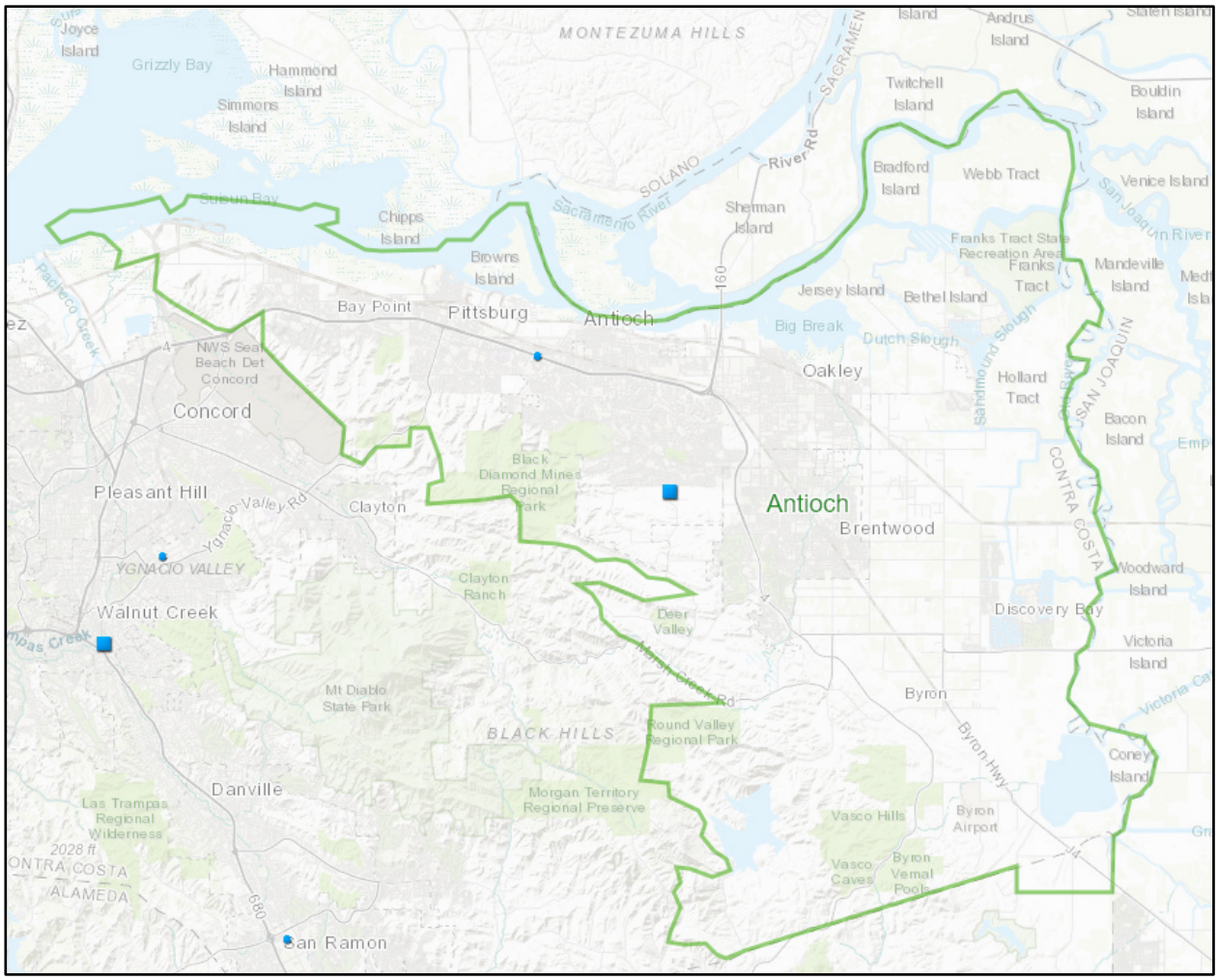
A. Kaiser Permanente's definition of community served

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

KFH-Antioch Service Area



ii. Geographic description of the community served

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

iii. Demographic profile of the community served

The KFH-Antioch service area is highly diverse. A total of 8% of the population is of two or more races. About half of the population is White alone. Approximately 35% of residents have Latinx heritage. Close to 13% of residents in KFH-Antioch lives in poverty, a higher proportion than in

Contra Costa County overall. In addition, 18% of children in the KFH-Antioch service area live below the poverty line, again exceeding the county statistic.[1]

Demographic profile: KFH-Antioch

Race/ethnicity		Socioeconomic Data	
Total Population	318,900	Living in poverty (<100% federal poverty level)	12.7%
Asian	10.4%	Children in poverty	18.0%
Black	13.6%	Unemployment	3.1%
Native American/Alaska Native	0.8%	Uninsured population	9.6%
Pacific Islander/Native Hawaiian	0.7%	Adults with no high school diploma	15.0%
Some other race	13.6%		
Multiple races	8.0%		
White	52.7%		
Hispanic/Latinx	34.6%		

Genetics have long been known to play a role in a person's risk of disease, but in the past several years, it has become more broadly accepted that a person's surroundings—or neighborhood—also influence their health.[2] That neighborhood comprises the natural, social (e.g., cultural traditions and support networks), and built environments (e.g., roads, workplaces, grocery stores, and health care services). Additionally, income and educational attainment, key components of socioeconomic status, also play a role in determining one's health.

The map that follows identifies where high concentrations of the population living in poverty and populations living without a high school diploma overlap. The orange shading shows where the percentage of the population living at or below 100% of the Federal Poverty Level exceeds 25%. The purple shading shows where the percentage of the population with no high school diploma exceeds 25%. Educational attainment is determined for all non-institutionalized persons aged 25 and older. Dark red areas indicate where the census tract is above these thresholds (worse) for both educational attainment and poverty.

[1] U.S. Census Bureau. (2017). American Community Survey, 5-Year Estimates, 2013-17.
[2] The California Endowment. (2015). *Zipcode or Genetic Code: Which is a Better Predictor of Health?*

Vulnerability Footprint: KFH-Antioch Service Area

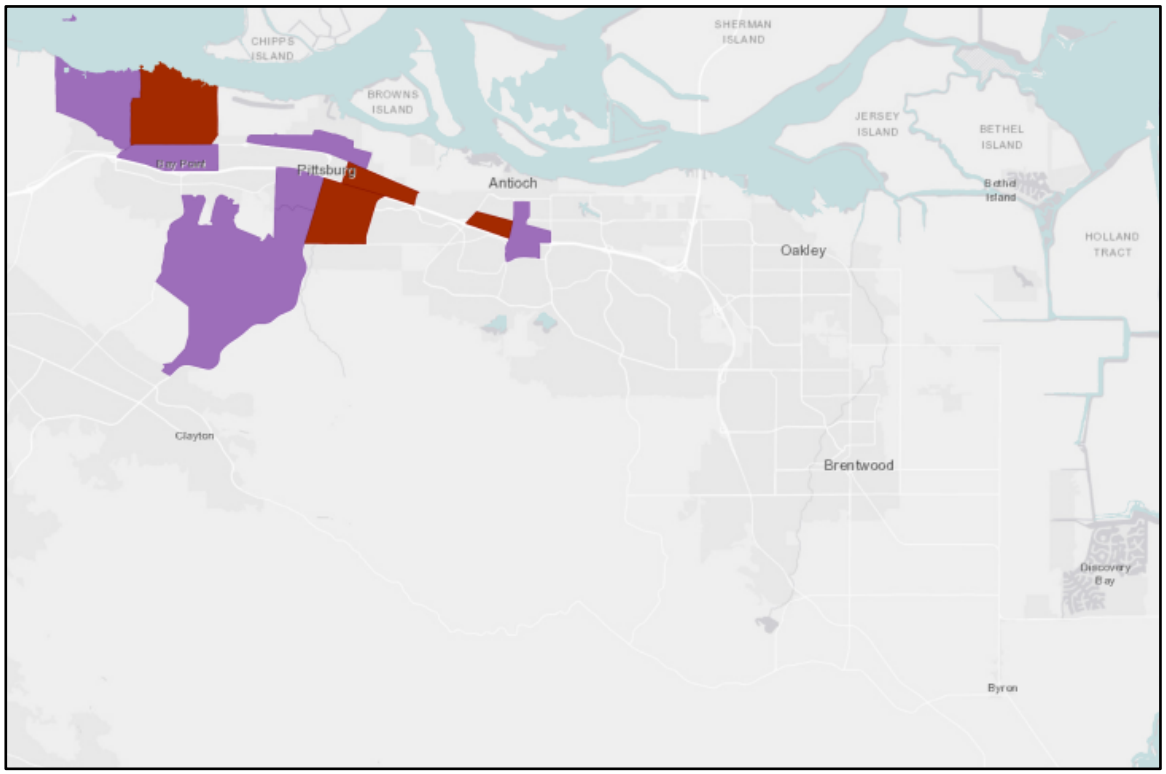
Legend

More than 25% of the population lives at or below 100% of FPL

More than 25% of the population age 25+ does not have a high school diploma

More than 25% of the population both lacks a high school diploma and lives at or below 100% of FPL

Mean income for the highest fifth of earners is double the county mean income



Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012-16.

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

Community benefit managers from 14 local hospitals in Alameda and Contra Costa counties contracted with Actionable Insights in 2018 to conduct the Community Health Needs Assessment in 2019. Three of these hospitals collaborated on the assessment in the KFH-Antioch service area; they were:

- John Muir Health
- Kaiser Foundation Hospital - Antioch
- Sutter Health Bay Area

KFH-Antioch also wishes to recognize Contra Costa Health Services for their contributions to this project.

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

Actionable Insights, LLC (AI), an independent, local research firm, completed the CHNA. For this assessment, AI assisted with CHNA planning, conducted primary research in conjunction with Contra Costa Health Services, collected secondary data, synthesized primary and secondary data, facilitated the process of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for over 25 hospitals during the 2018-19 CHNA cycle. More information about Actionable Insights is available at http://actionablellc.com.

IV. Process and methods used to conduct the CHNA

KFH-Antioch and its partners worked collaboratively on the primary and secondary data requirements of the 2019 CHNA. The CHNA data collection process took place over seven months and culminated in a report written for the hospital in the first half of 2019.

A. Secondary data

Actionable Insights (AI) analyzed over 180 quantitative health indicators to assist KFH-Antioch and its partners in understanding the health needs and assessing their priority in the community. AI collected sub-county data where available.

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

KFH-Antioch used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review over 130 indicators from publicly available data sources. KFH-Antioch also used additional data sources beyond those included in the CHNA Data Platform that included another 50-plus indicators. For details on specific sources and dates of the data used, please see Appendix A.

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

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform

provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KFH-Antioch also leveraged additional data sources beyond those included in the CHNA Data Platform. The decision to include these additional data was made, and these data were collected, in collaboration with KFH-Antioch's hospital partners. The hospitals as a group determined that these additional data would bring greater depth to the CHNA in their community. The secondary data that were gathered were compared to state benchmarks or Healthy People 2020 targets,[3] whichever were more stringent. When trend data, data by race/ethnicity, and/or data by age were available, they were reviewed to enhance understanding of the issue(s).

B. Community input

i. Description of who was consulted

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

ii. Methodology for collection and interpretation

Hospital community benefit managers planned qualitative data collection to better understand health needs and the drivers of health needs. The hospitals identified topics and populations which are less well understood than others (including emerging needs) and then identified experts on those topics and populations or groups of residents or stakeholders who could be convened to discuss them. AI used best practices to determine whether resident group feedback could be gathered in a sensitive and culturally appropriate way. Also, the hospitals sought out the input of sectors that had not been included in previous CHNAs. For example, in the KFH-Antioch service area, an interview was conducted with an elected official about the health of constituents in the local area, which had not been done before. Including local electeds in the CHNA allows for a broader understanding of the community and its needs.

Interviews with professionals were conducted in person or by telephone. For approximately one hour, AI interviewed professionals who are knowledgeable about health issues and/or drivers of health, including social determinants of health. Interviews often focused on understanding specific health conditions, or on target populations (low-income, minority, and undeserved). AI asked informants to identify and discuss the top needs of their constituencies, including barriers to health; give their perceptions of access to health care and mental health needs; and share which solutions may improve health (including services and policies).

[3] Healthy People (http://www.healthypeople.gov) is an endeavor of the U.S. Department of Health and Human Services, which has provided 10-year national objectives for improving the health of Americans based on scientific data for 30 years. Healthy People sets national objectives or targets for improvement. The most recent set of objectives are for the year 2020 (HP2020). Year 2030 objectives are currently under development.

Focus groups were conducted in person and lasted 60-90 minutes. Nonprofit hosts, such as Stoneman Village, recruited participants for the groups. The discussions centered around five topics, which AI modified appropriately for each audience:

- What are the most important health needs that you see in your community?
- What drivers or barriers are impacting the top health needs?
- To what extent is health care access a need in the community?
- To what extent is mental health a need in the community?
- What policies or resources are needed to address the top health needs?

Each interview and focus group was recorded as a stand-alone piece of data. Recordings were transcribed, and then the team used qualitative research software tools to analyze the transcripts for common themes. AI also tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. KFH-Antioch and its hospital partners used this tabulation to help assess community health priorities. Note that community resident input was treated the same way and given the same standing as the input from community leaders, service providers, and public health experts.

In the KFH-Antioch service area, community input surfaced health issues that cannot be understood with extant data. Often feedback related to inequities in health outcomes and health care access based on social determinants of health and immigration status. For example, service providers consistently described instances where individuals who are not legal residents are no longer seeking health care services and other social supports such as food from food banks because they fear being identified by U.S. Immigration and Customs Enforcement and deported. Some community input clearly connected the housing crisis and high cost of living with stress, while other feedback involved descriptions of the impact of discrimination and institutionalized racism, which has contributed to inequitable health outcomes.

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 email 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-Antioch had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

The KP CHNA data platform includes over 130 secondary indicators, and AI collected an additional 50-plus secondary indicators, all of which 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.

The consultants and hospital partners together noted the following additional data limitations/information gaps:

- Adequacy of community infrastructure (sewerage, electrical grid, etc.)
- Adult use of illegal drugs and misuse/abuse of prescription medications (e.g., opioids)
- Alzheimer's disease and dementia diagnoses
- Breastfeeding practices at home
- Cannabis use
- Data broken out by Asian sub-groups
- Diabetes among children
- Experiences of discrimination among vulnerable populations
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in data)
- Hepatitis C
- Mental health disorders
- Oral/dental health
- Suicide among LGBTQ youth
- Vaping

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

i. Definition of "health need"

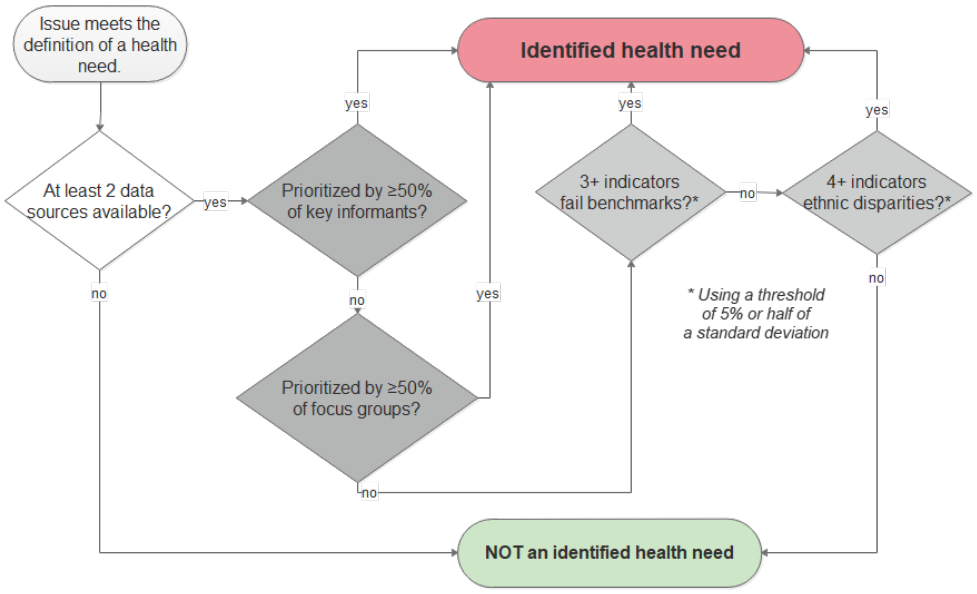
For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

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

Actionable Insights began with the set of health needs that were identified in the community in 2016. It also took into consideration the health need categories provided by Kaiser Permanente's data platform,[4] and the social determinants of health categories provided by Healthy People 2020.[5]

[4] http://www.chna.org/kp
[5] https://www.healthypeople.gov

What goes on the list?
Health needs list decision tree



In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria (depicted in the diagram above).

- A "data source" is either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from the interviews and focus groups that were conducted for the hospitals.
- A "benchmark" is either the California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

Criteria details:

1. Meets the definition of a "health need."
2. At least two data sources were consulted.
3. a. Prioritized by at least half of key informants or focus groups.
   b. If not (a), three or more direct indicators fail the benchmark by ≥5% or ≥0.5 standard deviations.
   c. If not (b), four or more indicators must show ethnic disparities of ≥5% or ≥ 0.5 standard deviations.

In 2014, final IRS regulations clarified the definition of a health need, which includes social determinants of health. Social determinants of health affect entire families and communities; they explain, in part, why some individuals thrive and experience good health, while other individuals are not as healthy as they could be. In addition to health behaviors such as eating nutritious foods and avoiding health risks such as smoking, our health is determined in large

part by: our economic opportunities; whether we receive a quality education; the availability of resources and support in our homes, neighborhoods, and communities; our workplaces; environmental factors such as access to clean water, healthy food, and air; community safety; and the nature of our social interactions and relationships. In 2019, given this broader definition, the KFH-Antioch identified nine health needs that fit all criteria.

B. Process and criteria used for prioritization of health needs

The IRS CHNA requirements state that hospital facilities must identify and prioritize significant health needs of the community. As described previously, Actionable Insights solicited qualitative input from focus group and interview participants about which needs they thought were the highest priority (most pressing). The hospital used this input as well as additional input described below to identify the significant health needs listed in this report.

Hospital Prioritization Process & Results

John Muir Health, Kaiser Permanente, and Sutter Health collaboratively convened a meeting with key leaders in Contra Costa County on January 25, 2019, including representatives from the county's Public Health Department, Office of Education, Clinic Consortium, the East Bay Community Foundation, and the Bay Area Regional Health Inequities Initiative (BARHII). At the meeting with these representatives, Actionable Insights presented the results of the CHNA to the attendees and facilitated the prioritization of the health needs by the participants. Participants considered a set of criteria in prioritizing the list of health needs. The criteria, which were chosen by KFH-Antioch and the other hospitals before beginning the prioritization process, were:

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

Participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs. Summary descriptions of each health need appear in the following pages.

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

1. BEHAVIORAL HEALTH

Behavioral health, including mental health and substance use, is one of the needs about which the KFH-Antioch service area community expressed the strongest concern. The community emphasized depression and stress, as well as the co-occurrence of mental health and substance use. These issues may be partially driven by social isolation. Statistical data suggest that there are significantly[6] fewer social associations (e.g., civic organizations, recreational clubs, and the like) per capita in the service area (3.9 per 10,000 people) compared to the state average (6.5); social associations contribute to personal well-being.[7]

KFH-Antioch community members also identified trauma and adverse childhood experiences (ACEs) as other drivers of behavioral health problems. Moreover, the community described the impact of discrimination and institutionalized racism as generational trauma, which has contributed to health disparities. These disparities are evident among multiple county-level behavioral health indicators for youth, including depression-related feelings (the highest proportion of youth experiencing such feelings are Latinx and Black), school connectedness (Black youth feel the least connected), and suicidal ideation (Black youth also fare the worst). Marijuana, alcohol, and other drug use is highest among Latinx youth.

2. (TIE) ECONOMIC SECURITY

Economic security was one of the top priorities of the KFH-Antioch community. Concerning this need, community members discussed food insecurity, risk of homelessness, and employment. Residents emphasized that while there may be plenty of jobs in the service area, they do not pay enough considering the high cost of living. This high cost of living may contribute to the high levels of enrollment in government assistance programs such as SNAP (i.e., food stamps) and Medicaid or other public insurance in the KFH-Antioch service area; quantitative data indicate that in the service area, a higher percentage of the population receive government assistance than the state average. Other factors may exacerbate the financial instability participants described in the service area. For example, there are only 1.9 banking institutions per 10,000 people in the service area, 30% fewer than the 2.7 per 10,000 in the state overall. Sufficient financial institutions in the community represent a measure of financial inclusion; limited access to these institutions' tools and resources contribute to economic instability. Community members also suggested that individuals with lower incomes may have a harder time accessing care, and cited the stress of economic instability as one of the most pressing drivers of poor mental health. Ethnic disparities in economic security also exist among service area residents. For various age groups (children, older adults, overall), the highest proportion of residents in poverty in the service area is Black.

[6] Community Commons. https://www.communitycommons.org/chna
[7] Putnam, R. (2000.) *Bowling Alone.*

2. (TIE) HOUSING AND HOMELESSNESS

Housing and homelessness together was a top priority for the KFH-Antioch community. Recent increases in housing costs especially affect renters and those with low and/or fixed incomes as well as single parents. Community members strongly linked housing and mental health, indicating that the stress of maintaining housing is negatively impacting families, including children. The community also recognized the connection between housing and physical health, stating that households have spent less on food and medical care due to the increased cost of housing in recent years. The health of those experiencing homelessness was of concern to a wide variety of experts and resident groups as homeless individuals are at greater risk of poor health outcomes. Statistical data on housing and homelessness in the service area are somewhat lacking; however, Contra Costa County data indicate that the median rent for a 2-bedroom apartment in the county is 11% higher than the state average, $2,390 compared to $2,150, and has been increasing. Possibly due to high rents, the proportion of children living in crowded housing has also been rising in the county. Professionals and residents described concerns about the increasing number of unstably-housed individuals and the displacement of families in the East Bay, including families with children. Experts cited a lack of strong tenant protections (and a lack of knowledge about protections that may exist) in the community.

4. HEALTH CARE ACCESS AND DELIVERY

Health care access and delivery was a high priority of the KFH-Antioch community. Access to comprehensive, quality health care is important for health and for increasing the quality of life for everyone.[8] Too often, common medical conditions that could be controlled through preventive care and proper management—such as asthma, cancer, and heart disease/stroke—are instead exacerbated by barriers to access, which can lead to premature death.

Good access to primary care can forestall the need for avoidable ER visits and hospitalizations for asthma, oral health, cancer, heart disease/stroke, and STIs. For example, research has found that health disparities related to cancer contribute to higher, avoidable death rates among low-income and ethnic minority populations nationwide. These disproportionalities are exacerbated by delivery issues in cancer screening and follow-up, as is reflected in the KFH-Antioch service area. While incidence rates for certain cancers (breast, colorectal, lung, and prostate) are worse than in the state, cancer mortality is much higher than the state average (147.3 per 100,000) among the local area's Black population (199.5). This increased mortality may be influenced by screening issues, as the Black population is less likely to have been screened for breast cancer (i.e., have had a mammogram) than the benchmark. Further with regard to inequitable health outcomes, the index of premature death based on ethnicity (i.e., premature death for non-Whites versus Whites) was 46.6, 27% worse than the measure for California of 36.8. Preventable hospital events were highest for the service area's Black population.

[8] Office of Disease Prevention and Health Promotion. (2015). http://www.healthypeople.gov.

With regard to health care delivery, many community members in the KFH-Antioch service area expressed alarm about barriers faced by immigrants who are either ineligible for Medi-Cal due to their immigration status, or fearful of being deported if they should access services for which they are eligible. The community often identified the need for greater language support, culturally-appropriate health care services, and whole-person care. In addition to immigrants, the community discussed how this need for sensitive, whole-person care also applied to LGBTQ community members; experts described the difficulty LGBTQ community members, especially transgender individuals, experience in finding medical professionals sensitive to their needs.

5. Education and Literacy

The relationship among literacy, educational attainment, employment, wages, and health has been well documented. Individuals with at least a high school diploma do better on a number of measures than high school drop-outs, including income, health outcomes, life satisfaction, and self-esteem.[9] Education and academic achievement were discussed by a wide variety of experts and community members in the KFH-Antioch service area; academic achievement was discussed most often as a driver of economic security, related to stable employment and sufficient wages. The county public health officer described educational attainment as a gateway to self-sufficiency, and a major contributing factor to homeownership. Statistical data for the KFH-Antioch service area reflect the community's concern regarding educational attainment in the region. For example, only 40% of local 4th-graders are reading at or above proficiency, compared with the state average of 44%. Moreover, there are 12 student suspensions per 100 students in the service area, two standard deviations above the state average of 5.9 per 100 students. Ethnic disparities are evident in education and literacy-related indicators. Black and Latina females have significantly[10] higher rates of teen pregnancy than females of other ethnicities, which can interrupt or end their educational trajectory. Black youth are also over-represented among high school drop-outs, while passing high school exit exams in lower proportions than youth of other ethnicities.

6. Community and Family Safety

Community and family safety is a need about which the KFH-Antioch service area community expressed concern. Crime, violence, and intentional injury are related to poorer physical and mental health for the victims, perpetrators, and community at large.[11] Community members most frequently discussed domestic violence; the hospitalization rate for domestic violence is 29% higher in the service area (6.3 per 100,000 females aged 10+) than the state average (4.9). Human trafficking was also mentioned as a community concern. Mental health, trauma, discrimination, and racially-motivated violence were often discussed in relation to crime and intentional injury. Children and youth were populations about which community members expressed the most concern, with issues including bullying and being victims of violence. The

[9] Insight Center for Community Economic Development. (2014). http://www.insightcced.org.
[10] "Significantly" worse = at least 5% or 0.5 standard deviations worse.
[11] Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (2002). The World Report on Violence and Health. *The Lancet*, 360(9339), 1083-1088.

data reflect these concerns, demonstrating significant ethnic disparities across multiple crime and intentional injury indicators for children and youth, including in-person bullying at school (Black youth fare the worst) and school climate (Latinx and Black youth are most likely to attend schools they perceive as unsafe), juvenile felony arrests (Black youth are arrested in much higher proportion than others), and substantiated child abuse and neglect (Black children and youth fare the worst). In addition to intentional injury, community members also worried about unintentional injuries among children and youth. Most community input about unintentional injuries came from experts who cited it as the leading cause of death for both children and older adults. These experts emphasized the need for prevention of falls among seniors (often occurring in the home) and children (specifically, from open windows). Motor vehicle crashes were also noted, with related mention of the use of car seats to prevent injuries to young children if collisions should occur.

7. HEALTHY EATING/ACTIVE LIVING

Healthy eating/active living was identified as a top health need by the KFH-Antioch service area community. This need includes concerns about access to food and recreation, diabetes, nutrition, diet, fitness, and obesity. With regard to the food supply, residents described the difficulty of accessing grocery stores that carry fresh food, the preponderance of fast food restaurants, and their dismay with the unhealthy food served at schools and provided by food banks. The community connected healthy eating and active living to good mental health. Residents, however, noted that the relatively lower cost of unhealthy grocery items and fast food, together with their convenience, makes buying and preparing fresh food less likely for busy families. Among adults, 58% of workers from the service area have long commutes (driving over 60 minutes each direction), compared to 39% in the rest of the state; this can affect the time individuals have available for engaging in healthy cooking/eating, as well as physical activity. For example, KFH-Antioch experts shared how few people walk or bike to work because they have long commutes. The Latinx population was mentioned frequently as a population of particular concern for HEAL-related conditions. Residents talked about the lack of motivation and lack of time to exercise, the expense of gym memberships and sports or exercise programs, and the inconvenient timing of exercise classes. Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living in order to lose weight. Indeed, the quantitative data indicate how a greater proportion of the KFH-Antioch service area youth are physically inactive compared to the state average. The community identified the increased use of screens (including video games) among youth as a driver of sedentary lifestyles, and lack of free exercise and sports programs as a barrier to children's physical activity.

8. TRANSPORTATION AND TRAFFIC

Community members in the KFH-Antioch service area discussed transportation as a barrier to seeing the doctor and getting to work. The community talked about the difficulty of using public transportation to get to East Bay locations because of poor reliability, limited bus and BART lines, long public transit travel times, and the high expense (especially for BART). The

community indicated that Eastern Contra Costa County is not widely accessible via BART despite the extension of the Pittsburg line. Quantitative data indicate only 13% of KFH-Antioch service area residents live within half a mile of a public transit stop, compared to 17% in the rest of the state. With respect to BART, participants also described the fear of becoming the victim of a crime at BART stations, while others stated that access for the disabled (i.e., elevators) is unreliable at BART stations. Finally, compared to the state average, a significantly greater proportion of KFH-Antioch service area commuters drive alone to work over long distances (more than 60 minutes in each direction), contributing to the traffic load on the roads.

9. CLIMATE/NATURAL ENVIRONMENT

Living in a healthy environment is critical to quality of life and physical health. Environmental issues can include air, water, food, and soil contamination, as well as natural and technological disasters.[12] Feedback from the KFH-Antioch service area community about the environment primarily concerned poor air quality, which was attributed to pollution caused by local refinery fires as well as motor vehicle traffic. Air pollution is often exacerbated by increased traffic and road density.[13] The KFH-Antioch service area has a significantly higher density of roads compared to the state average, which may contribute to community members' concerns regarding reduced air quality. Community members in the service area identified this reduced air quality as a driver of asthma; indeed, asthma prevalence among adults is worse in the service area (17%) compared to the state (15%). The community also expressed concern that local mobile home parks are using water from potentially contaminated wells. Lack of access to clean drinking water affects physical health in a variety of ways, including the potential for acquiring communicable diseases and the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay. Finally, the KFH-Antioch community discussed climate change as the cause of recent severe weather events and wildfires.

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

Contra Costa County contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations that are engaged in addressing many of the health needs identified by this assessment. Hospitals and clinics are listed below. Additional key resources available to respond to the identified health needs of the local community are listed in Appendix C.

Existing Health Care Facilities

- Kaiser Permanente Hospital, Antioch
- Sutter Delta Medical Center

[12] Office of Disease Prevention and Health Promotion. (2018). *Environmental Health*.
[13] Community Commons. https://www.communitycommons.org/chna

Existing Clinics & Health Centers

Federally Qualified Health Clinics

- Brighter Beginnings
- La Clínica de la Raza
- Pittsburg-Medical

County of Contra Costa Health Clinics

- Antioch Health Center
- Bay Point Family Health Center
- Brentwood Health Center
- Pittsburg Health Center

VI. KFH-Antioch 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Antioch's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Antioch's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit: kp.org/chna. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Antioch in the 2016 Implementation Strategy Report.

1. Health Care Access & Delivery
2. Obesity, Diabetes, Healthy Eating/Active Living
3. Behavioral Health

KFH-Antioch is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-Antioch tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive

community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-Antioch had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-Antioch will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 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 2017 and 2018, 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 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

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

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving 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 2017-2018, KFH-Antioch awarded 320 number of grants amounting to a total of $6,938,530.32 in service of 2016 health needs. Additionally, Kaiser Permanente Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Antioch service area. During 2017-2018, a portion of money managed by this foundation was used to award 2 grants totaling $9,449.40 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-Antioch leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report 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 2017-2018, KFH-Antioch engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Examples of collaborations and partnerships are included in the section of the report below.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-Antioch Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care and Coverage	*During 2017 and 2018, KFH-Antioch awarded 69 grants totaling $4,347,544.47 that address Access to Care in the KFH-Antioch service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 14,150 and 13,984 Medi-Cal members respectively totaling $44,542,878.19 worth of care. KP also provided a total of $8,086,406.41 of Medical Financial Assistance (MFA) to 4,984 individuals in 2017 and 2,684 individuals in 2018.
		Navigation: KFH-Antioch awarded a $40,000 grant (split with KFH-Walnut Creek) to La Clínica de la Raza to increase access to health care services for 1,950 low-income families in east and central Contra Costa County by providing one-on-one health care navigation support in utilizing health care services.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Operation Access: Operation Access received a $350,000 grant (evenly split between15 KFH hospital service areas) to coordinate donated medical care and expand access to care for low-income uninsured adults in the Bay Area through its volunteer and hospital network. 669 staff/physician volunteers provided 650 surgical and diagnostic services at 11 facilities, reaching 521 adults.
		211: Contra Costa Crisis Center (CCCC) received a $50,000 grant (evenly split between 3 KFH hospital service areas) to operate 211, which provides language specific, information and referral services to residents via voice and text lines. Through updates to the database, staff training and partnership with other organizations, CCCC expects to increase the number of calls and texts to the call center reaching at least 34,000 individuals.
Healthy Eating Active Living	*During 2017 and 2018, KFH-Antioch awarded 73 grants totaling $748,221.47 that address Health Eating Active Living in the KFH-Antioch service area*	Nutrition education: KFH-Antioch provided a $30,000 grant (split with KFH-Walnut Creek) to 18 Reasons to train lay educators to deliver Cooking Matters, a six-week cooking and nutrition education series, to low-income communities in east and central Contra Costa.18 Reasons will offer at least 28 six-week Cooking Matters cooking and nutrition series, and at least 40 Cooking Matters at the Store grocery store tours to more than 450 low-income Diablo area residents.
		Produce distribution: KFH-Antioch gave the Food Bank of Contra Costa & Solano a $30,000 grant (split with KFH-Walnut Creek) to support Farm2Kids, a program that distributes more than 320,000 pounds of fresh produce weekly to more than 3,800 children in after-school programs in Concord, Bay Point, Pittsburg, and Antioch neighborhoods. Participating after-school programs are in schools where more than 50% of the children are eligible for free and reduced-price meal programs.
		Parks: First 5 Contra Costa received a $75,000 grant (split with KFH-Walnut Creek) to implement park improvements and programming at Ambrose Park, a park primarily serving low-income families of color. The improvements will increase access to physical activity opportunities and improve social cohesion. 1,075 residents living near the park will benefit from the improvements.
		CalFresh: Food Bank of Contra Costa and Solano received a $95,000 grant (evenly split between 5 KFH hospital service areas) to increase CalFresh enrollment with a focus on Medi-Cal recipients, WIC clients, Latinxs, seniors, and families with children in low-income school districts. To date, the Food Bank has screened 194 individuals for CalFresh eligibility and submitted 133 applications. Of those, 47 were approved.
		Partnership: KFH-Antioch serves on the Executive Committee of Healthy & Active Before 5, a pediatric obesity prevention initiative focused on health equity for children 0 to 5 and their families in Contra Costa County.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Mental Health & Wellness	*During 2017 and 2018, KFH-Antioch awarded 50 grants totaling $1,231,441.93 that address Mental Health and Wellness in the KFH-Antioch service area*	Student mental health: KFH-Antioch provided a $20,000 grant to support Lincoln's School Engagement Program (SEP), which provides intensive case management to 40 students from east Contra Costa County schools who are struggling with chronic truancy/absenteeism. SEP reduces the anxiety and depression that leads to trauma and puts students on an academic and mental path to success.
		Stigma: La Clinical De La Raza and Antioch Unified School District received a total of $180,000 in grants to address mental health stigma. Stigma reduction efforts included outreach and education to parents and training for school staff. It is expected that participants will have increased knowledge about mental health's role in overall health and be more likely to access mental health services.
		Resilience: Lincoln received a $98,000 grant to develop a trauma-informed environment at Hillview Junior High School by providing trauma-informed mental health services to students, training teachers and staff, and support for overall school culture change. To date, 21 students have received mental health services and seen improvements in interpersonal skills, resilience, school classroom behavior and relationships with teachers.
		Partnership: KFH-Antioch's partnership with other health systems as part of the East & Central County Access Action Team (ECCAAT) supports the mental health pilot project at Antioch Unified School District through technical assistance and funding.

VII. Appendix

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
    ii. Other secondary data sources
B. Community Input Tracking Form
C. Community resources
D. Health Need Profiles

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014

	Source	Dates
43.	USDA - Food Access Research Atlas	2014

ii. Other secondary data sources

In addition to the sources in the KP CHNA Data Platform, the sources of data in the list below were consulted to compile the data tables that underlie this 2019 Community Health Needs Assessment.

	Source	Dates
1.	Annie E. Casey Foundation, KIDS COUNT Data Center	2015
2.	California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health	2016
3.	California Child Care Resource & Referral Network, California Child Care Portfolio	2014
4.	California Department of Education	2018
5.	California Department of Education, California Healthy Kids Survey (WestEd)	2011-2013, 2013-2015
6.	California Department of Finance	2016
7.	California Department of Justice	2014-2015
8.	California Department of Public Health	2010-2017
9.	California Office of Statewide Health Planning and Development (OSHPD)	2009-2016
10.	California State Highway Patrol	2015
11.	Centers for Disease Control and Prevention	2005-2016
12.	Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health	2008-2012
13.	Child Care Regional Market Rate Survey	2014
14.	Contra Costa Council on Homelessness, 2017 Point in Time Count: A Snapshot of Contra Costa County	2017
15.	Insight Center for Community Economic Development	2014
16.	Martin et al. (2015), Births	2013
17.	National Cancer Institute	2011-2015
18.	National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program	2009-2013
19.	Nielsen SiteReports	2014
20.	Population Reference Bureau	2014, 2016
21.	Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, Public Health Institute, Survey Research Group	2008, 2009, 2011, and 2013
22.	U.S. Cancer Statistics Working Group	2009-2013
23.	U.S. Census Bureau, American Community Survey	2012-2016
24.	U.S. Census Bureau, County Business Patterns	2016
25.	U.S. Department of Agriculture, Food Access Research Atlas	2015
26.	U.S. Department of Education, EDFacts	2014-2015, 2015-2016
27.	U.S. Dept. of Housing and Urban Development, PIT Estimates of Homelessness in the U.S.	2017
28.	UCLA Center for Health Policy Research, California Health Interview Survey	2009- 2016
29.	University of Wisconsin Population Health Institute, County Health Rankings.	2018
30.	Vera Institute of Justice, Incarceration Trends	2013, 2015

	Source	Dates
31.	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research	2013
32.	Zilpy.com, Rental Market Trends	2018

Appendix B. Community Input Tracking Form

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities, and the medically underserved. The group included leaders from the Contra Costa County Health & Hospital System, nonprofit hospital representatives, local government employees, and nonprofit organizations. For a description of members of the community who participated in focus groups, please see Section IVB, "Community Input."

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Interview	Supervisor, Contra Costa County, District III	1	Low-income, Minority	Leader	6/27/18
2	Interview	Director, Health, Housing, and Homeless Services, Contra Costa County Health Services	1	Low-income	Leader	7/13/18
3	Interview	Director of Public Health, Contra Costa County Health Services	1	Health department representative	Leader	7/23/18
4	Interview	Coordinator, Educational Services, Antioch Unified School District	1	Low-income, Minority	Leader	7/25/18
5	Interview	Director of Student Services, Antioch Unified School District	1	Low-income, Minority	Leader	7/25/18
6	Interview	Board Chair, John Muir Community Health Fund	1	Medically underserved	Leader	7/31/18
7	Interview	Acting Director of Behavioral Health, Medical Director, Contra Costa County Health Services	1	Medically underserved	Leader	7/31/18
8	Interview	Executive Director, Rainbow Community Center	1	Medically underserved, Minority	Leader	8/1/18
9	Interview	Assistant Director, Contra Costa County Employment & Human Services	1	Low-income, Medically underserved	Leader	8/2/18
10	Interview	Executive Director, Village Community Resource Center	1	Minority	Leader	8/14/18
11	Interview	Development Director, St. Vincent de Paul of Contra Costa County	1	Low-income, Medically underserved	Leader	8/16/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
12	Interview	Clinic Nurse Manager, Society of St. Vincent de Paul of Contra Costa County	1	Low-income, Medically underserved	Leader	8/16/18
13	Interview	Chief Program Officer, Lincoln	1	Medically underserved	Leader	8/17/18
14	Interview	Senior Planner, City of Pittsburg	1	Low-income	Leader	8/17/18
15	Interview	Chief Executive Officer, STAND! for Families Free of Violence	1	Low-income, Minority	Leader	8/17/18
16	Interview	President & Chief Executive Officer, East Bay Leadership Council	1	Low-income	Leader	8/21/18
17	Focus group	**Host:** Multifaith Action Coalition; attendees were professionals who advocate on behalf of the population in poverty in the service area	7	Low-income	Leaders	8/14/18
18	Focus group	**Host:** Kaiser Foundation Hospital-Walnut Creek; attendees were leaders of local nonprofit organizations and government agencies	13	Low-income	Leaders	8/27/18
19	Focus group	**Host:** Kaiser Foundation Hospital-Antioch; attendees were leaders of local nonprofit organizations and government agencies	7	Low-income	Leaders	9/17/18
Community residents						
20	Focus group	**Host:** Loaves & Fishes; attendees were community members experiencing homelessness and/or food insecurity	9	Low-income, Medically underserved	Members	8/6/18
21	Focus group	**Host:** Rubicon Programs-Antioch; attendees were community members of the re-entry population (i.e., formerly incarcerated)	5	Low-income, Medically underserved, Minority	Members	8/29/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
22	Focus group	**Host:** Los Medanos College; attendees were young adults who were local community college students	14	Low-income	Members	8/30/18
23	Focus group	**Host:** Stoneman Village; attendees were older adults on fixed incomes living in affordable housing in the service area	9	Low-income	Members	9/17/18

Appendix C. Community resources

Health Care Facilities and Agencies

In addition to assets and resources available to address specific health needs, the following health care facilities are available in the service area. Many hospitals provide charity care and cover Medi-Cal shortfalls.

Existing Health Care Facilities

Hospitals	**City/Region**
Kaiser Permanente	Antioch
Sutter Delta Medical Center	Antioch

Existing Clinics & Health Centers

Federally Qualified Health Clinics

Brighter Beginnings	Antioch
La Clínica de la Raza	Oakley
Pittsburg-Medical	Pittsburg

County of Contra Costa Health Clinics

Antioch Health Center	Antioch
Bay Point Family Health Center	Bay Point
Brentwood Health Center	Brentwood
Pittsburg Health Center	Pittsburg

Behavioral Health

ASSET/RESOURCE	DESCRIPTION	LINK
Child Abuse Prevention Council of Contra Costa County	Programs to promote child safety and prevent child abuse and neglect.	https://www.capc-coco.org
Contra Costa Crisis Center	24/7 support and counseling for people in emotional or psychological distress.	https://www.crisis-center.org
Contra Costa Health Services	Provides health care to the public at many locations.	https://cchealth.org

ASSET/RESOURCE	DESCRIPTION	LINK
Healthy Hearts Institute	Promotes food education, physical fitness, and mindfulness via gardening, nutritional classes, cooking classes and demos, exercise classes, boot camps, strength training, meditation, yoga and stress management classes.	https://www.healthyhearts.co/Partners/contra-costa-health-services
Jewish Family & Community Services East Bay	Promotes the well-being of individuals and families of all ages, races and religions, by providing essential mental health and social services through every stage of life.	https://jfcs-eastbay.org
John Muir Health Adolescent, Adult & Children's Psychiatric Programs	Inpatient and outpatient treatment programs for children, adolescents, and adults who have psychiatric or behavioral problems.	https://www.johnmuirhealth.com/services/behavioral-health-services.html
Lincoln	Provides children with support and services as young as possible through to graduation from high school.	http://lincolnfamilies.org
NAMI (National Alliance on Mental Illness)	Grassroots organization dedicated to building better lives for the millions of Americans affected by mental illness.	https://www.nami.org
Putnam Clubhouse	A free program for adults coping with mental illness, emphasizing vocational and social skills.	https://www.putnamclubhouse.org
Shelter Inc.	Helps families and individuals who are homeless or in danger of becoming homeless by assisting with rental costs and providing emergency and permanent housing.	https://shelterinc.org

Community and Family Safety

ASSET/RESOURCE	DESCRIPTION	LINK
Beyond Violence	Services for youth victims of traumatic intentional injuries aged 14-25, including: help to cope with the injury, follow-up care, and community resources to promote healthy choices and avoid street violence.	https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/youth/beyond-violence.html
Center for Human Development	Empowers communities to adapt to adversities through reducing health disparities, inspiring healthier choices, and promoting violence	http://chd-prevention.org
Child Passenger Safety Program	Promotes proper use of child passenger safety restraints (cchealth.org/topics/child_safety/pdf/child_passenger_factsheet.pdf)	https://cchealth.org/topics/child_safety
Community Violence Solutions	Works in partnership with the community to end sexual assault and family violence through prevention, crisis services, and treatment.	https://cvsolutions.org
Contra Costa Health Services	Provides health care to the public at many locations.	https://cchealth.org
Fall Prevention Program of Contra Costa County	Program to reduce deaths, preventable injuries, and loss of independence associated with falls of seniors and persons with disabilities, through educational support and home safety repairs.	https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/seniors/fall-prevention-program-ccc.html
Family Justice Center	A one-stop center for families affected by domestic violence, sexual assault, elder abuse, child abuse, and human trafficking.	http://www.cocofamilyjustice.org

ASSET/RESOURCE	DESCRIPTION	LINK
First 5 Contra Costa County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children 0 to 5 and their families.	http://www.first5coco.org
One Day at a Time	Provides school-linked positive educational and personal growth opportunities to youth from elementary age to high school.	https://www.odatec.org
STAND! for Families Free of Domestic Violence	Provides a complete spectrum of domestic violence and child abuse prevention, intervention, and treatment programs.	http://www.standffov.org
Youth Intervention Network	A program to reduce the two leading indicators of violence, truancy and student disengagement.	no link found

Economic Security

ASSET/RESOURCE	DESCRIPTION	LINK
Catholic Charities of the East Bay	A wide variety of services to aid youth, children and families facing difficulties in the following areas: immigration, eviction, literacy, and surviving traumatic violence.	http://www.cceb.org
Contra Costa County Early Head Start and Head Start	Comprehensive services for children ages 0-5 and their families including education, health, disabilities and mental health services as well as nutrition and family support services and resources.	https://ehsd.org/headstart/childcare-preschool/head-start-early-head-start-and-state-preschool

ASSET/RESOURCE	DESCRIPTION	LINK
Contra Costa County Employment & Human Services	Provides a wide variety of services: children's services (foster care, adoption, temporary housing); financial benefits (CalFresh, CalWorks, Medi-Cal, etc.), programs for the aging and disabled, Head Start, workforce development, etc.	https://ehsd.org
East Bay Community Foundation	Supports social justice and equitable opportunities and outcomes by providing grants to ensure early childhood success to economic empowerment.	https://www.ebcf.org
Ensuring Opportunity Contra Costa	Collaborative effort to end poverty in Contra Costa County by addressing structural causes at the policy level.	https://endpovertycc.org
Food Bank of Contra Costa and Solano	Searchable by city for free produce and free groceries for low income children, families, individuals and seniors.	https://www.foodbankccs.org/get-help/foodbycity.html
Opportunity Junction	Offers a job training program, career counseling, and job placement.	https://www.opportunityjunction.org
SparkPoint Bay Point	Offers one-stop assistance for low-income families and individuals to help them become financially stable, including high wage job training, and debt and credit counseling.	https://uwba.org/sparkpoint

Education & Literacy

ASSET/RESOURCE	DESCRIPTION	LINK
Antioch Unified School District	K-12 school district	www.antioch.k12.ca.us
Brentwood Union School District	K-8 school district	www.brentwood.k12.ca.us
Byron Union School District	K-8 school district	www.byronunionschooldistrict.us

ASSET/RESOURCE	DESCRIPTION	LINK
First 5 Contra Costa County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children 0 to 5 and their families.	http://www.first5coco.org
Contra Costa County Office of Education	Provides support services to schools, including direct services to students who are incarcerated, homeless or in foster care, or have physical or emotional challenges.	https://www.cccoe.k12.ca.us
Knightsen Elementary School District	K-12 school district	www.knightsen.k12.ca.us
Liberty Union High School District	High school district	libertyunion.schoolwires.net/
Oakley Union Elementary School District	K-8 school district	www.ouesd.k12.ca.us
Pittsburg Unified School District	K-12 school district	www.pittsburg.k12.ca.us

Health Care Access & Delivery

ASSET/RESOURCE	DESCRIPTION	LINK
American Cancer Society - East Bay	Provides information, research, prevention, support and referrals for cancer patients	https://www.cancer.org/about-us/local/california.html
American Diabetes Association	Organization committed to educating Californians about ways they can live healthier lives and support friends and loved ones living with diabetes.	http://www.diabetes.org/in-my-community/local-offices/san-francisco-california
American Heart Association	Organization committed to preventing and curing heart disease.	https://www.heart.org/en/affiliates/california/greater-bay-area
American Lung Association	Works to improve lung health and prevent lung disease through education.	https://www.lung.org

ASSET/RESOURCE	DESCRIPTION	LINK
Brighter Beginnings	Supports healthy births and successful development of children by partnering with parents.	http://www.brighter-beginnings.org
Community Oral Health Program	Links children, youth and families to no or low-cost dental resources.	https://cchealth.org/dental
Contra Costa Dental Society	A partnership of over 800 dental professionals who promote oral health through education, communication, service and leadership.	https://www.ccdds.org
Contra Costa Health Services	Provides health care to the public at many locations.	https://cchealth.org
Dental Clinics:		
○ Bay Point Family Health Center	Offers children's dental care.	https://cchealth.org/centers/baypoint.php
○ Fremont Elementary (Antioch)	On-campus dental clinic.	https://cchealth.org/school-based-clinic
○ Hillview Junior High (Pittsburg)	On-campus dental clinic.	https://cchealth.org/school-based-clinic
○ La Clínica Pittsburg	Health center offering affordable, culturally sensitive primary medical care, and health education.	https://www.laclinica.org/pittsburgmedical/index.html
○ Pittsburg Dental Clinic	Dental clinic.	https://cchealth.org/dental/dental-ccc.php
○ Turner Elementary (Antioch)	School-based dental clinic.	https://cchealth.org/dental/dental-ccc.php
Every Woman Counts	Free breast and cervical cancer screening and diagnostic services to California's underserved populations.	https://www.dhcs.ca.gov/services/cancer/EWC/Pages/default.aspx

ASSET/RESOURCE	DESCRIPTION	LINK
HIV/AIDS Consortium	Advocates and provides support for people impacted by HIV/AIDS, plans prevention and care services, develops recommendations and advises governments and community leaders.	https://cchealth.org/hiv/consortium
The Leukemia-Lymphoma Society	Funds research to cure blood cancers (leukemia, lymphoma, Hodgkin's disease and myeloma); provides information, education and support for patients and their families.	https://www.lls.org/greater-bay-area
Planned Parenthood Antioch	Offers abortion services, birth control; HIV testing; LGBTQ services; men's health care; morning-after pill (emergency contraception); pregnancy testing and services; STD testing, treatment and vaccines; and women's health care.	https://www.plannedparenthood.org/health-center/california/antioch/94509/antioch-health-center-2573-90200
Planned Parenthood Walnut Creek	Offers abortion services, birth control; HIV testing; LGBTQ services; men's health care; morning-after pill (emergency contraception); pregnancy testing and services; STD testing, treatment and vaccines; and women's health care.	https://www.plannedparenthood.org/health-center/california/walnut-creek/94596/walnut-creek-health-center-2571-90200
Planned Parenthood Concord	Offers abortion services, birth control; HIV testing; LGBTQ services; men's health care; morning-after pill (emergency contraception); pregnancy testing and services; STD testing, treatment and vaccines; and women's health care.	https://www.plannedparenthood.org/health-center/california/concord/94520/concord-health-center-3269-90200?utm_campaign=concord-health-center

ASSET/RESOURCE	DESCRIPTION	LINK
Regional Asthma Management Program (RAMP)	A collaborative that promotes strategies for reducing asthma through a broad and comprehensive approach that includes clinical management and environmental protection.	http://www.rampasthma.org
Ronald McDonald Dental Care Mobile	Provides restorative and preventive dental care, connections to a family dentist for ongoing care, and help enrolling in an insurance program to low-income patients up to the age of 19.	https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-alliance/our-programs/youth/mobile-dental-clinic.html
Rubicon Programs	Equips people to break the cycle of poverty.	http://rubiconprograms.org
St. Vincent de Paul RotaCare Clinic	Volunteer alliance of medical professionals, organizations and community members providing free primary health care services to uninsured adults (17 and up) with acute or chronic medical conditions.	http://www.svdp-cc.org/programs-rotacare-clinic
Safer STD Testing	STI testing clinics directory.	www.saferstdtesting.com
Sutter Delta Community Clinic	Inpatient and outpatient acute care clinic.	https://www.sutterhealth.org/eden-sutter-delta
Women's Cancer Resource Center: Contra Costa Cancer Navigation Partnership	Bilingual support for Latinx patients undergoing cancer treatment.	https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-fund/what-we-do/supporting-lasting-health-improvements/womens-cancer-resource-center.html

Healthy Eating/Active Living

ASSET/RESOURCE	DESCRIPTION	LINK
18 Reasons	Community cooking school; offers free Cooking Matters classes in low - income communities.	https://18reasons.org
Bay Point All Stars	Cheerleading team for youth 5-18.	http://allstarcheerreaction.com/index.html

ASSET/RESOURCE	DESCRIPTION	LINK
Bike East Bay	Encourages bicycling in the East Bay through education, advocacy, and community engagement.	https://bikeeastbay.org
Center for Human Development	Empowers communities to adapt to adversities through reducing health disparities, inspiring healthier choices, and promoting violence	http://chd-prevention.org
City of Antioch Recreation Department	Manages a senior center, a marina, various public recreational facilities and open spaces, and all city parks in Antioch; also offers a variety of recreational activities.	https://www.antiochca.gov/recreation
CoCoKids	Provides resource links and direct services in order to advance quality child care and early education.	https://www.cocokids.org
Contra Costa Boys & Girls Club	After-school youth development and extended learning program for children and youth age 6-18.	https://bgccontracosta.org
Contra Costa Health Services	Provides health care to the public at many locations.	https://cchealth.org
East Bay Regional Parks	Regional parks district managing multiple parks in the East Bay, and offering outdoor activities.	https://www.ebparks.org
East County Kids N Motion	Dance classes for youth at Ambrose Recreation & Park District.	https://www.ambroserec.org
East County Midnight Basketball	Basketball league for youth and young adults.	https://playpass.com/east-county-midnight-basketball-league-program-o1828
First 5 Contra Costa County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children 0 to 5 and their families.	http://www.first5coco.org
Food Bank of Contra Costa and Solano County	Searchable by city for free produce and free groceries for low income children, families, individuals and seniors.	https://www.foodbankccs.org/get-help/foodbycity.html

ASSET/RESOURCE	DESCRIPTION	LINK
Fresh Approach	Improves healthy food access in the community via farmers markets, community garden, and cooking and nutrition classes,	https://www.freshapproach.org
Healthy and Active Before 5	Collaborative that advances health equity through local policy and environmental changes to support the health and well-being of children ages 0-5 and their families.	http://www.healthyandactivebefore5.org
Loaves and Fishes	Operates five dining rooms and a food pantry, offers culinary training.	http://www.loavesfishescc.org
Meals on Wheels Diablo Region	Delivers meals and provide safety checks (fall prevention) to seniors who are homebound.	https://www.mowdiabloregion.org
Shelter Inc.	Helps families and individuals who are homeless or in danger of becoming homeless by assisting with rental costs and providing emergency and permanent housing.	https://shelterinc.org
Village Community Resource Center	Serves disadvantaged children and their families, with an emphasis on education, health, summer programs and social programs.	http://www.vcrcbrentwoodca.org/about-us.html
White Pony Express	Combats hunger and poverty by redistributing excess food and other items such as adult and children's clothing, toys, and books.	https://www.whiteponyexpress.org

Housing & Homelessness

ASSET/RESOURCE	DESCRIPTION	LINK
Abode Services	Agency working with government, supporters, landlords and clients to provide housing for the homeless	https://www.abodeservices.org

ASSET/RESOURCE	DESCRIPTION	LINK
Contra Costa Health Services - H3 (Health, Housing and Homeless Services)	A variety of services and referrals for the homeless and those at risk of becoming homeless.	https://cchealth.org/h3
Contra Costa Interfaith Housing	Permanent, affordable housing and vital support services to homeless and at-risk families and individuals in Contra Costa County.	http://ccinterfaithhousing.org
Love-A-Child Missions Homeless Recovery Shelter	Serves homeless women and children of Contra Costa County by providing emergency shelter, food, clothing, and offering hope through substance recovery programs, job training, educational support, and many other programs.	https://loveachildmissions.org
Satellite Affordable Housing Associates (SAHA).	Provides affordable housing for low-income and special needs populations, including veterans, seniors, and the formerly chronically homeless.	https://www.sahahomes.org
Shelter Inc.	Helps families and individuals who are homeless or in danger of becoming homeless by assisting with rental costs and providing emergency and permanent housing.	https://shelterinc.org
Shepherd's Gate	Helps women and children escape cycles of addiction, homelessness, and abuse.	https://www.shepherdsgate.org

Transportation & Traffic

ASSET/RESOURCE	DESCRIPTION	LINK
Alameda-Contra Costa Transit District (AC Transit)	Public transit agency providing regional bus service.	http://www.actransit.org
Bay Area Rapid Transit (BART)	Rapid transit system providing elevated and subway rail travel connecting Bay Area counties.	https://www.bart.gov

ASSET/RESOURCE	DESCRIPTION	LINK
Alameda-Contra Costa Transit District (AC Transit)	Public transit agency providing regional bus service.	http://www.actransit.org
CountyConnection.com - trip planning	Fixed-route and paratransit bus service; on-line trip planner.	https://countyconnection.com
Mobility Matters	Provides mobility management services in Contra Costa County, including coordination with public and private transportation providers, and direct programs and services.	https://www.mobilitymatterscc.com
Paratransit	Public transit service for people who are unable to use regular buses or trains because of a disability or a disabling health condition.	https://www.eastbayparatransit.org
Tri Delta Transit	Operates local bus routes, door-to-door bus service for senior citizens and people with disabilities, and shuttle services for community events throughout Eastern Contra Costa County.	http://trideltatransit.com

Appendix D. Health Need Profiles

COMMUNITY HEALTH NEED

Health Care Access & Delivery

What's the issue?

Access to health care is important for everyone's well-being and quality of life.[1] "Access" generally means a patient has a sufficient number of health care providers available locally, reliable transportation to medical appointments, and adequate insurance (or can otherwise afford services and medications). "Delivery" refers to the timeliness, standards, transparency, and appropriateness with which providers render services. Too often, common medical conditions that could be controlled through preventive care and proper management—such as asthma, cancer, heart disease/stroke—are instead exacerbated by barriers to access and/or delivery, which can lead to premature death.

What does the data show?

In the KFH-Antioch service area, the rate of Federally Qualified Health Centers, community assets that provide health care to vulnerable populations, is 1 per 100,000 people, which is 60% lower than the state average of 2.5 per 100,000.[2]

Selected Access and Delivery Indicators: Adults

HEALTH NEED INDICATOR	STATE AVERAGE	CONTRA COSTA COUNTY
Delayed/Didn't Get Care	10%	**11%**
ER Visit in Past 12 Months	21%	**24%**
ER Visit in Past 12 Months (65 or older)	22%	**30%**

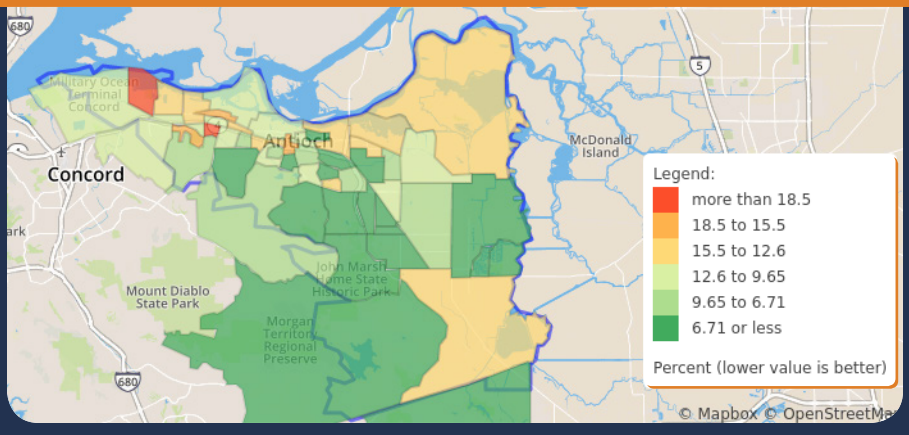
SOURCE: UCLA Center for Health Policy Research, California Health Interview Survey, 2016.

Data suggest that access is an issue across Contra Costa County, not just in the service area.

Communities experiencing economic challenges often also have higher rates of uninsured individuals. The map shows how census tracts in the KFH-Antioch service area compare with the state average of 12.6% uninsured.

continued >>

Uninsured Populations



SOURCE: American Community Survey, 2012–2016.

KEY DISCOVERY

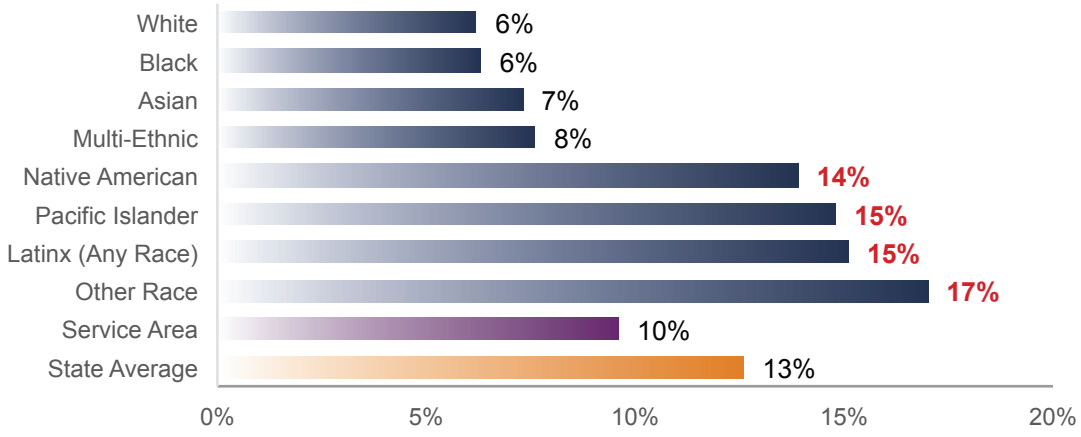
126.5

per 100,000 people

The incidence of prostate cancer among male residents of the KFH-Antioch service area is 16% worse than the state average of 109.2 per 100,000.[3]

The Latinx population has one of the highest rates of uninsured individuals compared with other ethnic groups in the KFH-Antioch service area. Black residents fare worse on most measures of access compared to Whites, including preventable hospital events.

Ethnic Disparities: Uninsured Populations



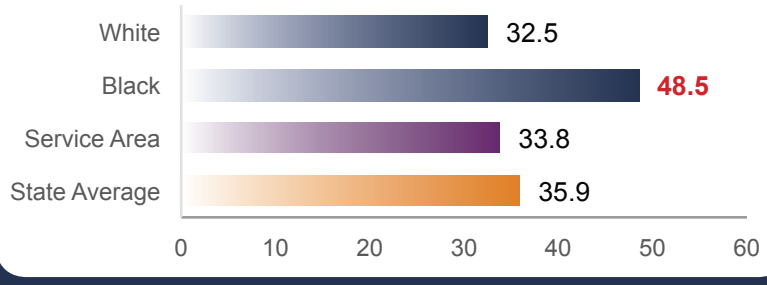
Percentage of total population without health insurance coverage. / SOURCE: American Community Survey, 2012–2016.

Ethnic Disparities: Preventive Care for Medicare Beneficiaries

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA	WHITE	BLACK
Breast Cancer Screening (Mammogram)	60%	64%	64%	**56%**
Diabetes Management (Hemoglobin A1c Test)	82%	82%	82%	**77%**

SOURCE: Dartmouth Atlas of Healthcare, 2014.

Ethnic Disparities: Preventable Hospital Events



Rates per 1,000 people. / SOURCE: Dartmouth Atlas of Healthcare, 2014.

"Particularly in East County, it's ... really hard to get a primary care physician, much less a specialist, because they don't live out here and they don't want to work out here. So there's a real challenge [to] access to all types of specialties."

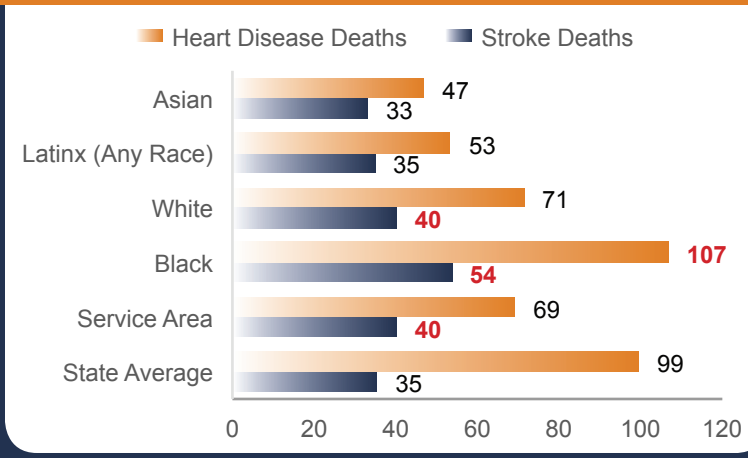
—COMMUNITY MEMBER

Impacts of Poor Health Care Access & Delivery

Barriers to health care access and delivery can affect medical outcomes for many conditions that could otherwise be controlled through preventive care and proper management. For example, various risk factors for **heart disease and stroke**—high blood pressure and cholesterol, obesity, excessive alcohol consumption, smoking, an unhealthy diet, physical inactivity—can be controlled.[4] Yet some of these risk factors are worse in the service area than state benchmarks. For example, 16% of

continued >>

Heart Disease and Stroke Mortality



Age-adjusted rates per 100,000 people. / SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, 2011–2015.

Cancer Incidence Rates

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Breast Cancer (females only)	120.7	**130.6**
Colon and Rectum Cancer	37.2	**40.0**
Lung Cancer	44.6	**47.4**
Prostate Cancer (males only)	109.2	**126.5**

Rates age-adjusted per 100,000 people. / SOURCE: State Cancer Profiles, 2010–2014.

residents have smoked, compared to the state average of less than 14%.[5]

With **asthma**, proper management requires avoidance of triggers, timely access to specialists and "quick-relief" medication, and regular use of "controller" medication.[6]

Timely, high-quality care is also crucial for people with **cancer** diagnoses. Certain cancer incidence rates are higher among service area residents than the state averages. Cancer deaths are highest among Black residents.[7] Delivery issues related to preventive screenings and follow-up appointments may make the inequities worse.

"You see it all the time in people not wanting to access schools or health care or anything, because they're afraid they're going to get deported or their husband is going to get deported."

—COMMUNITY MEMBER

What does the community say?

Residents and experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) expressed strong concerns about health insurance, the affordability of care, and a lack of specialists—especially those who serve Medi-Cal patients. Health experts noted that low reimbursement rates prevent clinicians from offering services to Medi-Cal patients. Discussions of delivery issues also touched on implicit bias, explicit discrimination, and the inequitable outcomes that can result from both. Health experts noted the difficulty that LGBTQ community members, especially transgender individuals, experience in finding medical service providers sensitive to their needs. The community called for greater non-English language support, culturally appropriate services, and whole-person care.

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2015). http://www.healthypeople.gov
[2]U.S. Centers for Medicare and Medicaid Services. (2016).
[3]State Cancer Profiles. (2010–2014).
[4]Centers for Disease Control and Prevention. (2017). *Heart Disease Facts.*
[5]Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. (2015).
[6]Asthma and Allergy Foundation of America, *Asthma Capitals 2018.*
[7]Centers for Disease Control and Prevention, National Vital Statistics System. (2011–2015).

Read the complete 2019 Community Health Needs Assessment report at **www.kp.org/chna**

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COMMUNITY HEALTH NEED

Behavioral Health

What's the issue?

Emotional and psychological well-being are important to every person's capacity to maintain healthy relationships and function in society.[1] "Well-being" generally means having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing satisfaction and fulfillment in life. Roughly one in five adults in the U.S. is coping with a mental illness.[2] Common disorders such as depression and anxiety can affect self-care. Likewise, chronic diseases can negatively affect mental health.[3] So too can substance use. Substance use can lead or contribute to other social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, car accidents, and HIV/AIDS.[4]

What does the data show?

In the KFH-Antioch service area, behavioral health concerns are prevalent in (see community section, next page). Most statistical data on behavioral health are available for Contra Costa County as a whole and not the service area. Various county indicators for adults and youth exceed state averages.

Behavioral Health: Adults

HEALTH NEED INDICATOR	STATE AVERAGE	COUNTY AVERAGE
Needing Help for a Behavioral Health Issue	16.4%	18.9%
Seeing a Health Care Provider for Behavioral Health Services	13.4%	16.5%
Taking Prescription Medicine Regularly for an Emotional/Mental Health Issue in Past 12 Months	11.1%	16.0%

Percentage of total population, self-reporting. / SOURCE: UCLA Center for Health Policy Research, California Health Interview Survey, 2016.

Behavioral Health: Youth

HEALTH NEED INDICATOR	STATE AVERAGE	COUNTY AVERAGE
Cyberbullied More than Once	12.4%	12.6%
Bullied at School	27.6%	28.8%
Low School Connectedness	12.5%	12.8%
Seriously Considered Suicide	18.1%	18.3%

Percentage of 11th graders in public schools. / SOURCE: California Dept. of Education, California Healthy Kids Survey (WestEd), 2013–2015

Social isolation may contribute to poor behavioral health among children and adults: The rate of access to civic organizations, recreational clubs, and other groups in the KFH-Antioch service area is 3.9 per 10,000 people, which is 40% worse than the state overall.[5]

Significant ethnic disparities around behavioral health exist in the community. Nearly one in three (30%) Black public high school students in Contra Costa County has seriously considered suicide, double the statistic for White students. The rate of suicide deaths for Whites (13.1 per 100,000 residents, age-adjusted) in the KFH-Antioch service area is higher than the state benchmark (12.6).[6]

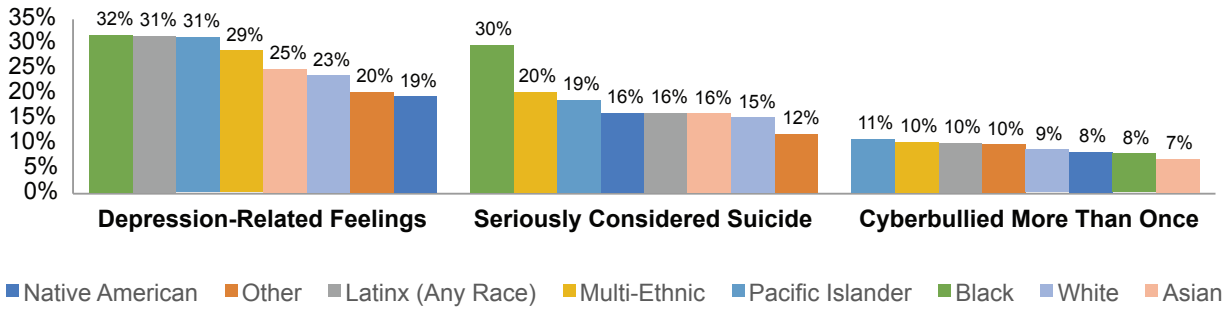
continued >>

KEY DISCOVERY

10%

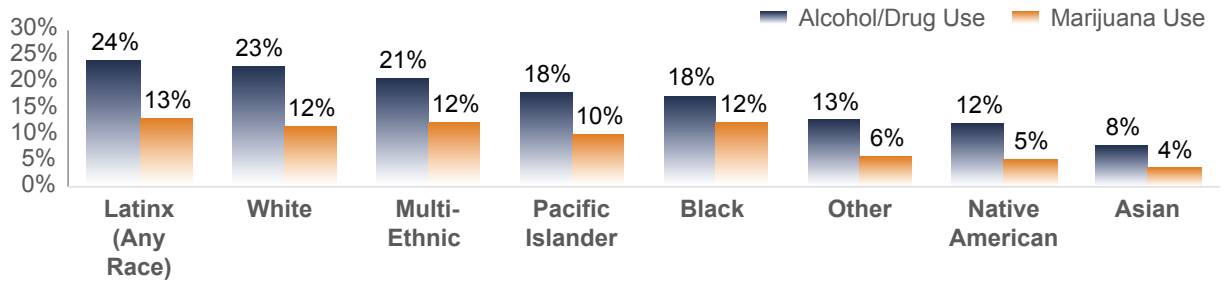
The amount by which KFH-Antioch service area surpasses the state average for Medicare Part D opioid prescription drug claims.[7]

Youth Self-Report: School Climate and Student Engagement, Mental Health Indicators



Surveyed public school students in 7th, 9th, and 11th grades, and nontraditional students, with the exception of suicidal ideation, which does not include 7th graders. SOURCE: California Department of Education, California Healthy Kids Survey, and California Student Survey (WestEd), 2013–2015.

Ethnic Disparities: Youth Substance Use



SOURCE: California Department of Education, California Healthy Kids Survey (WestEd), 2013–2015.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified behavioral health as a high priority. The most common issues raised in the service area were depression and stress. Participants in focus groups and interviews discussed the co-occurrence of mental health and substance use. Some called out trauma and adverse childhood experiences as drivers of behavioral health problems. Others described the impact of discrimination and institutionalized racism as generational trauma, which has contributed to disparities in health outcomes.

"I think there's definitely a stigma with mental health, and substance abuse, and also I don't think the general population knows a lot about that. So, you need to understand and accept someone for who they are, and give them a break."

—COMMUNITY MEMBER

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2018). *Mental Health and Mental Disorders.*
[2]Centers for Disease Control and Prevention. (2018). *Learn About Mental Health.*
[3]Lando, J. & Williams, S. (2006). A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion. *Preventing Chronic Disease.* 2006 Apr; *3*(2): A61.
[4]World Health Organization. (2018). *Management of Substance Abuse.*
[5] U.S. Census Bureau, County Business Patterns. (2015).
[6] Centers for Disease Control and Prevention, National Vital Statistics System. (2011–2015).
[7] U.S. Centers for Medicaid and Medicare Services. (2015).

Read the complete 2019 Community Health Needs Assessment report at **www.kp.org/chna**

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COMMUNITY HEALTH NEED

Climate & Natural Environment

What's the issue?

A healthy environment is critical to everyone's physical health and quality of life. Nearly 25% of all deaths and diseases worldwide can be attributed to environmental issues such as air, water, food, and soil contamination.[1, 2] Exposure to a poor environment can compound the problems of people whose health is already compromised.[2] Any effort to improve overall health must consider environmental factors that may increase the likelihood of illness and disease.This includes climate change, which is projected to have an increasing impact on the spread of infectious diseases, and the severity of fires, floods, droughts, and other natural disasters.[3] In 2017 and 2018, smoke from Northern California wildfires contributed significantly to the number of days where air quality reached unhealthy levels.[4] The long-term effects of prolonged exposure to poor air quality can be severe: pollution is linked to premature death from lung cancer, chronic obstructive pulmonary disorder, and child acute respiratory infections.[5]

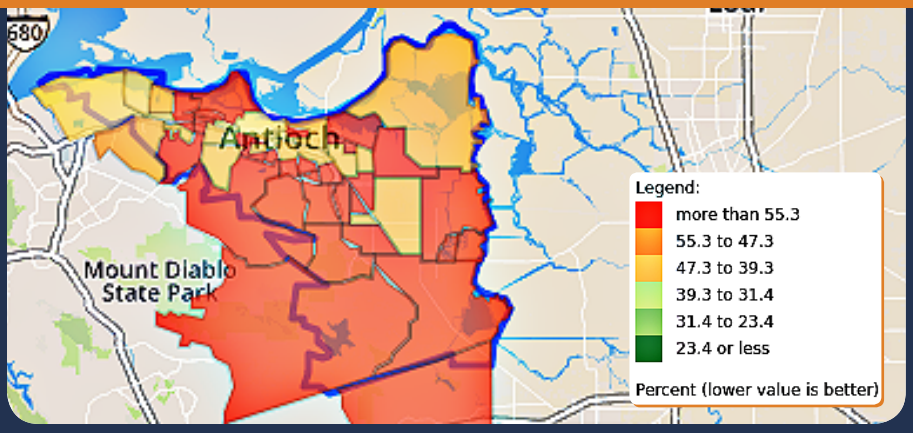
What does the data show?

Statistics for the KFH-Antioch service area suggest that climate and the natural environment are issues of concern. Driving alone (in a vehicle with standard gasoline or diesel internal combustion engines, still the vast majority in Contra Costa County) instead of carpooling or using public transit contributes to air pollution. The map below depicts how census tracts in the KFH-Antioch service area compare with the state average of commuters driving alone to work more than 60 minutes each way.

Poor outdoor air quality can exacerbate asthma. Asthma prevalence among adults in the service area is 17%, compared with the state average of 15%.[6]

continued >>

Drivers With Long Commute Times



Percentage of people who drive 60 or more minutes to work each way. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

KEY DISCOVERY

$45,784

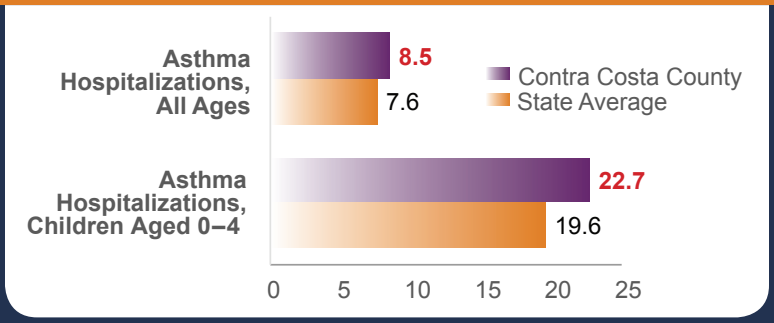
The average cost of asthma hospitalization in Contra Costa County is 15% higher than the average cost statewide.[7] The number of county asthma hospitalizations also exceeds the benchmark.

Environmental Hazards and Pollution

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Excessive Driving Alone to Work (60+ minutes each way)	39%	58%
Public Transit Access (living within a half mile of a public transit stop)	17%	13%
Road Network Density (miles of road per square mile of land)	2.0	4.6
Tree Canopy Cover (land area)	8%	7%

SOURCES: Driving: U.S. Census Bureau, American Community Survey, 2012–2016. Transit and road network: Environmental Protection Agency, Smart Location Database, 2013. Tree cover: Multi-Resolution Land Characteristics (MRLC) Consortium, U.S. Forest Service National Land Cover Database, 2011.

Asthma Hospitalizations



Rates per 10,000 people. / SOURCE: Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health, 2014.

"[Climate] is going to exacerbate heart conditions and many other chronic diseases, lethargy, lack of activity, lack of getting outside, because it's too darn hot. You're going to start to see this ripple effect of extreme heat. ... That's why it's a health issue."

—HEALTH EXPERT

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) attributed poor air quality to pollution from roadways and refinery fires as well as to climate change/severe weather. When asked how air pollution directly affects their health, asthma—particularly among children and youth—emerged as the biggest concern. Symptoms can be exacerbated by heat and pollution.

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2018). *Environmental Health.*
[2]Morris, G. & Saunders, P. (2017). The Environment in Health and Well-Being, *Oxford Research Encyclopedias.*
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[6]Counts for Medicare and Medicaid Services. (2015).
[7]Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health (2014).

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COMMUNITY HEALTH NEED

Economic Security

What's the issue?

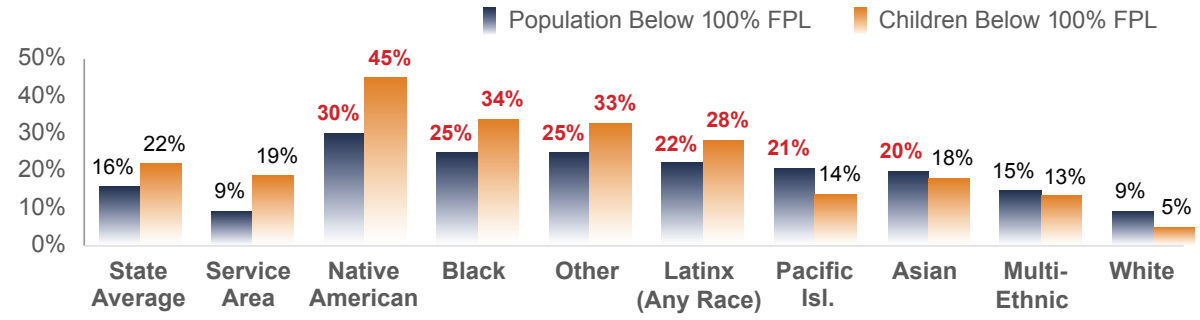
Economic security is one of the most widely recognized social determinants of health. Higher incomes and a secure social support system—families, friends, communities—play a significant role in people's overall well-being.[1] Access to economic security programs such as SNAP (Supplemental Nutrition Assistance Program, formerly referred to as food stamps) results in better long-term health outcomes.[2] Despite this, childhood poverty has lasting effects: Even after conditions improve, it results in poorer health outcomes over time.[3]

What does the data show?

The cost of living in Contra Costa County is high: The median rent for a two-bedroom apartment is $2,390, which is 11% above the state average of $2,150.[4] The annual cost of infant child care is $14,979, or 12% above average.[5] Ethnic disparities exist, as shown in the charts below.

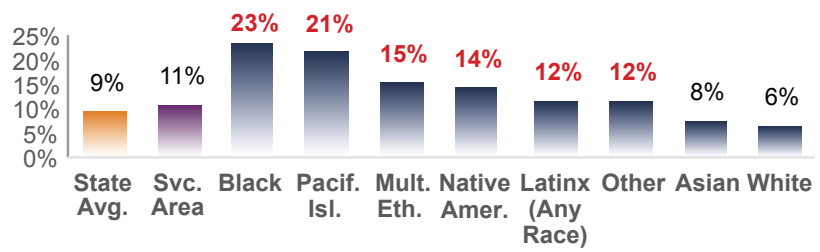
continued >>

Ethnic Disparities: Poverty



Percentage of households with incomes below Federal Poverty Level. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

Ethnic Disparities: SNAP Participation



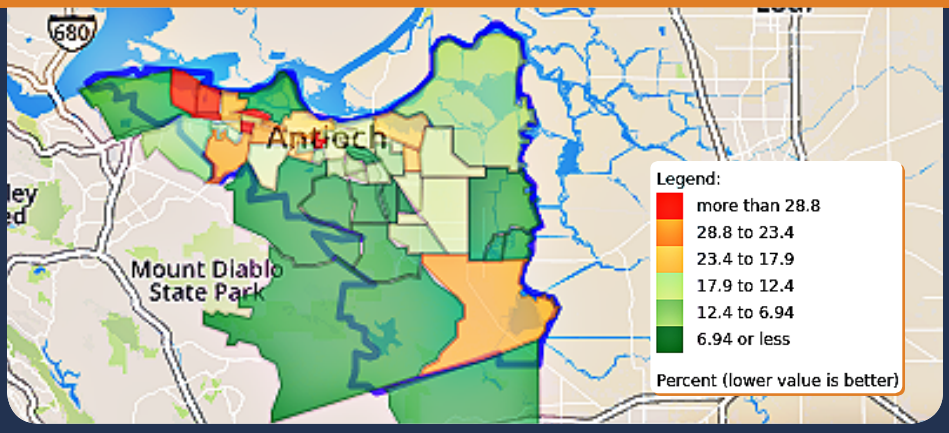
Estimated percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

KEY DISCOVERY

1 in 3

Latinx adults in the KFH-Antioch service area does not have a high school diploma, a number that falls significantly below the state benchmark.[6]

Adults With No High School Diploma (or Equivalent)



Percentage of residents aged 25 and older in the service area. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

Income and educational attainment are strongly associated.[7] Communities where educational attainment is lower tend to face economic challenges.

Far fewer banks serve the KFH-Antioch community (1.9 per 10,000 people) than the ratio serving California as a whole (2.7 per 10,000),[8] which suggests that local access to the tools and services needed to realize economic stability could be more inclusive.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) cited food insecurity, the risk of homelessness, and inadequate employment as Economic Security issues that need attention. Residents said that many local jobs do not pay enough to cover living expenses. The community linked poverty and poor health outcomes; some residents suggested that workers earning lower salaries or wages may have difficulty accessing health care. The stress caused by economic instability was cited as a strain on mental health.

"When low-income folks can never afford to own and are perpetually [stuck] being a renter, you've locked them into a life of poverty. So, we have to help folks [who] are on the lower end of this actually have a mechanism of homeownership and equity over time."

—HEALTH EXPERT

SOURCES

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[2]Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits.*
[3]Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The Impact of Poverty on the Current and Future Health Status of Children. *Pediatric Child Health. 12*(8): 667–672.
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COMMUNITY HEALTH NEED

Education & Literacy

What's the issue?

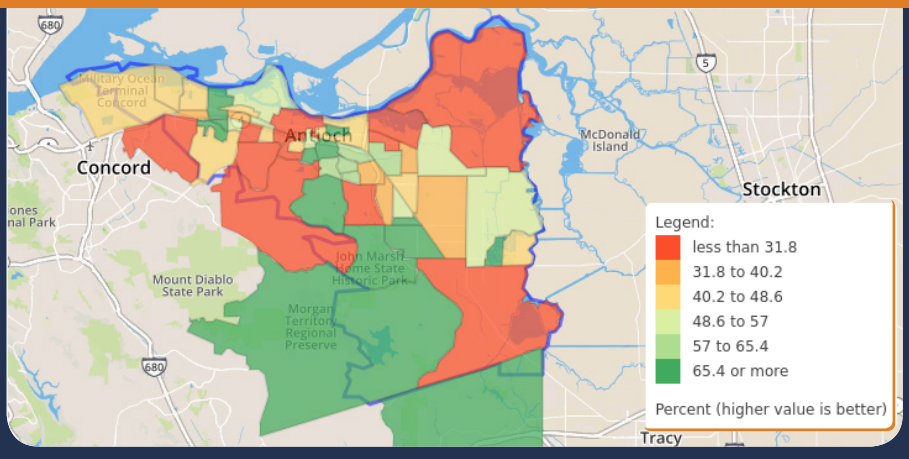
Literacy generally means "the ability to read and write," but it also involves skills related to listening, speaking, and working with numbers. Limited literacy reflects low levels of education, which is associated with poor health outcomes. People at risk for low English literacy include immigrants, people living in households where English is not spoken, and individuals with inadequate schooling.[1] Adults with at least a high school diploma do better than high school dropouts when it comes to health, income, life satisfaction, and self-esteem.[2] The National Poverty Center associates increased education with decreased rates of most acute and chronic diseases.[3] This may be because more-educated individuals are better able to afford health care: Research shows that families in which the head of household has a high school diploma are 10 times wealthier than those in which the head of household dropped out.[4] Many jobs in the U.S. require more than a high school education. Success starts early; attending preschool leads to learning and earning more.[5]

What does the data show?

Preschool enrollment and later reading proficiency appear to go hand-in-hand in the KFH-Antioch service area. Both indicators are lower than the respective state average. Geographic and ethnic disparities are apparent in educational indicators. The map below shows how census tracts in the KFH-Antioch service area compare with the state average (49%) in preschool enrollment (children aged 3–4). Meanwhile, high school suspensions in the service area are 103% higher than average (12.0 per 100 students compared to 5.9 statewide).[6]

continued >>

Preschool Enrollment



Percentage of 3- and 4-year-olds enrolled in preschool, by census tract. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

KEY DISCOVERY

1,014-to-1

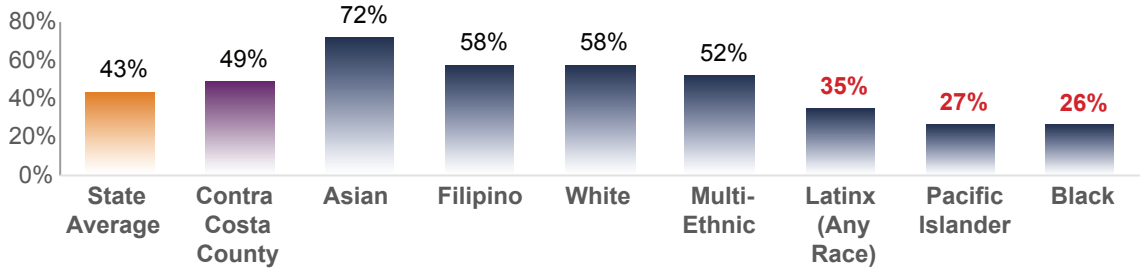
The average number of students per academic counselor in Contra Costa County compares to 792-to-1 statewide. The higher the ratio, the lower the ability of counselors to give students individual attention.[8]

Selected Educational Indicators

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Preschool Enrollment (3- and 4-year-olds)	49%	**44%**
Reading at or Above Proficiency (4th graders)	44%	**40%**

SOURCES: Preschool: U.S. Census Bureau, American Community Survey, 2012–2016. Reading: California Department of Education, California Assessment of Student Performance and Progress, 2015–2016.

Ethnic Disparities: High School Graduates Completing College Prep Courses



Percentage of total graduates. / SOURCE: California Department of Education, California Basic Educational Data System, 2015.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) expressed concerns about academic achievement, particularly as a means of enabling economic security through stable jobs and sufficient wages.

"Educational attainment in this nation is still one of the most important gateways to self-sufficiency."
—HEALTH EXPERT

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2018). *Language and Literacy.* www.healthypeople.gov
[2]Insight Center for Community Economic Development. (2014). www.insightcced.org
[3]Cutler, D.M. & Lleras-Muney, A. (2006). *Education and Health: Evaluating Theories and Evidence* (No. w12352). National Bureau of Economic Research.
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COMMUNITY HEALTH NEED

Healthy Eating & Active Living

What's the issue?

Nearly two in five adults and one in five children in the U.S. are obese.[1] Being obese or overweight raises the risk for diabetes, hypertension, stroke, and cardiovascular disease—some of the leading causes of preventable death.[2] Obesity also can contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Risk factors of obesity include an unhealthy diet, a sedentary lifestyle, underlying medical issues, family models, and social and economic factors. Obesity often co-exists with food insecurity (a lack of available financial resources for food at the household level)[3, 4] because "both are consequences of economic and social disadvantage."[5]

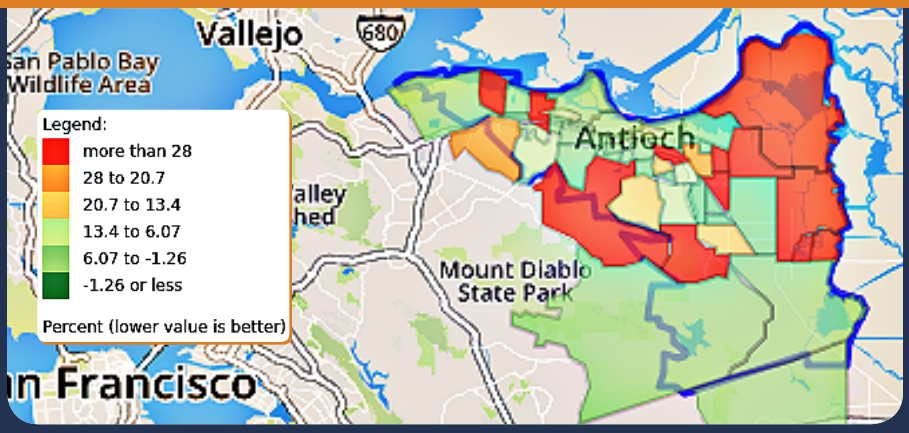
Getting regular exercise can help reduce the risk of obesity and Type 2 diabetes, as well as cardiovascular disease, some cancers, and other physical issues. It also can help strengthen bones and muscles, prevent falls for older adults, and promote a longer life.[6, 7] Similarly, maintaining a healthy diet can help prevent high cholesterol and high blood pressure and lower the risks of obesity, osteoporosis, and dental cavities.[8] For children and adolescents, a nutritious diet contributes to growth, bone development, and cognitive function.[9] Yet many people do not follow the recommended food and exercise guidelines.

What does the data say?

Concerns in the KFH-Antioch service area focused on food security/access and physical activity. Communities experiencing food insecurity also often have less access to healthy food. The map below shows how census tracts in the KFH-Antioch service area compare to the state average (13%) for low access (i.e., high relative distance) to supermarkets and large grocery stores. Physical inactivity among children and youth is a concern in the service area (see statistics on the last page).

continued >>

Low Access to Healthy Food Stores



Percentage of population that does not live in close proximity to a large grocery store or supermarket. / SOURCE: U.S. Department of Agriculture, Food Access Research Atlas, 2014.

KEY DISCOVERY

Fewer than 2

The frequency of grocery stores or produce vendors per 10,000 people in the KFH-Antioch service area is 38% lower than the state average.[10]

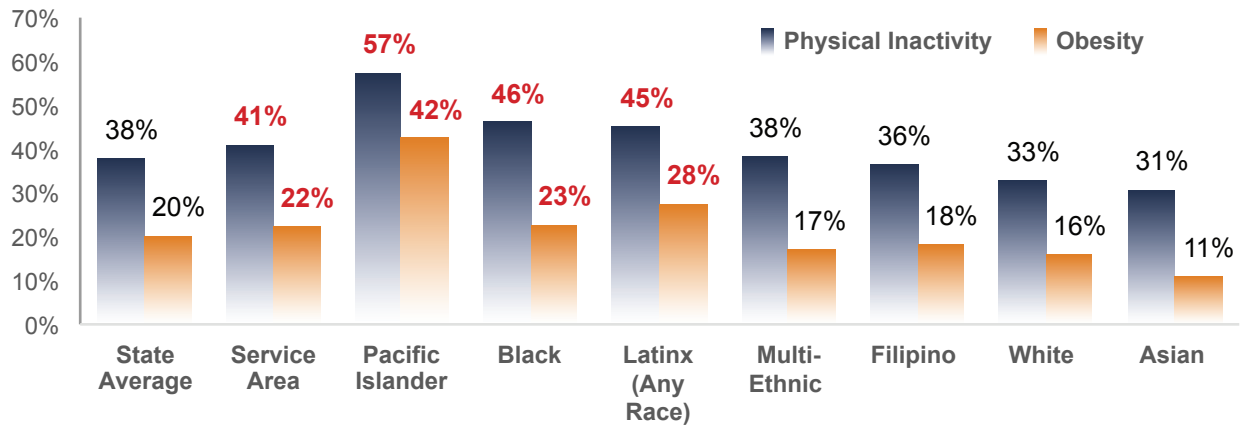
Food Access and Security

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Grocery Stores and Produce Vendors (per 10,000 people)	2.4	1.5
Low Access to Healthy Food Stores	13%	20%
Households Receiving SNAP Benefits (percent of total households)	9%	11%

SOURCES: Grocery/produce: U.S. Census Bureau, County Business Patterns, 2015. Healthy food: U.S. Department of Agriculture, Food Access Research Atlas, 2014. SNAP benefits: U.S. Census Bureau, American Community Survey, 2012–2016.

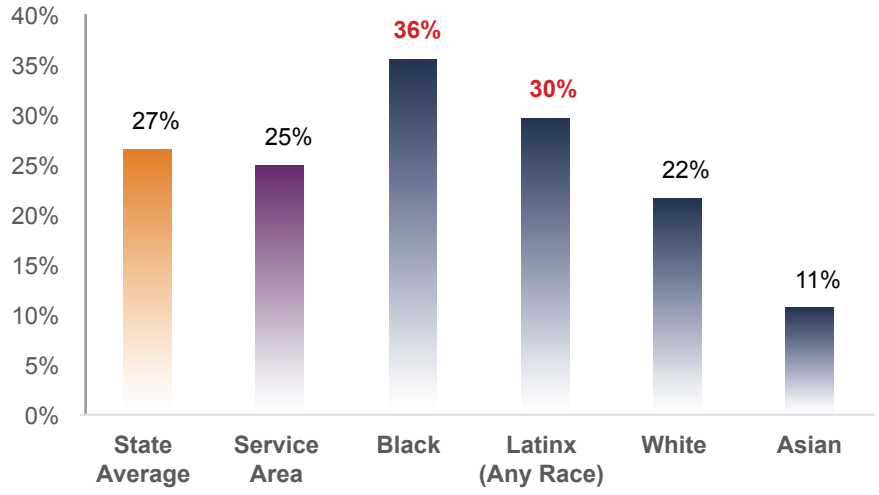
Youth and adult obesity and physical inactivity statistics show ethnic disparities in the KFH-Antioch service area.

Ethnic Diparities: Youth Obesity and Physical Inactivity



Percentage of 5th, 7th, and 9th graders categorized as "high risk" or "needs improvement" based on a test of aerobic capacity. / SOURCE: California Department of Education, FitnessGram Physical Fitness Testing, 2016–2017.

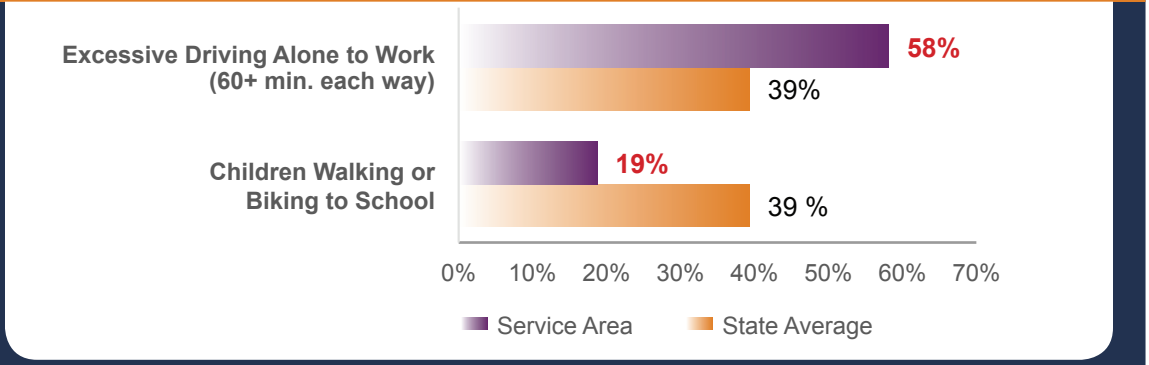
Ethnic Disparities: Adult Obesity



Percentage of adults who self-report a body mass index (BMI) greater than 30. / SOURCE: UCLA Center for Health Policy Research, California Health Interview Survey, 2014.

More than 1 in 5 youths in the KFH-Antioch service area is obese, which exceeds the state average.[11]

Physical Activity



SOURCES: Driving: U.S. Census Bureau, American Community Survey, 2012–2016; percentage of population driving alone to work. Walking/biking: UCLA Center for Health Policy Research, California Health Interview Survey, 2015–2016; the percentage of children whose parents or guardians reported that the child walks, bikes, or skates to school at least occasionally.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) prioritized healthy eating and active living. Participants called out food insecurity as a concern: The perception that healthy food costs more and is less convenient than packaged and fast food makes buying and cooking healthier meals less likely for many families. Busy schedules, a lack of motivation, and the expense of gym memberships and exercise programs make it tough to maintain a fitness routine, community members said. Parents also said they had difficulty encouraging their children to eat well and exercise to lose weight. Local experts pointed to long commutes as a barrier to preparing meals and to being physically active, including walking or biking to work. Participants stated that culturally appropriate health education is needed to help more people prevent chronic diseases and save on long-term health care costs.

"We have yet to tackle the food environment successfully in this nation. We still fundamentally think about food as a food safety issue, not as a food quality issue. So, that's a big issue."

—PUBLIC HEALTH EXPERT

SOURCES

[1]Centers for Disease Control and Prevention. (2018). *Overweight and Obesity.*
[2]Centers for Disease Control and Prevention. (2016). *Childhood Obesity Causes and Consequences.* See also: Centers for Disease Control and Prevention. (2018). *Adult Obesity Causes and Consequences.*
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COMMUNITY HEALTH NEED

Housing & Homelessness

What's the issue?

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30% of a household's annual income. Spending more than that makes household less able to afford other necessities, such as food, clothing, transportation, and medical care.[1] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.[2]

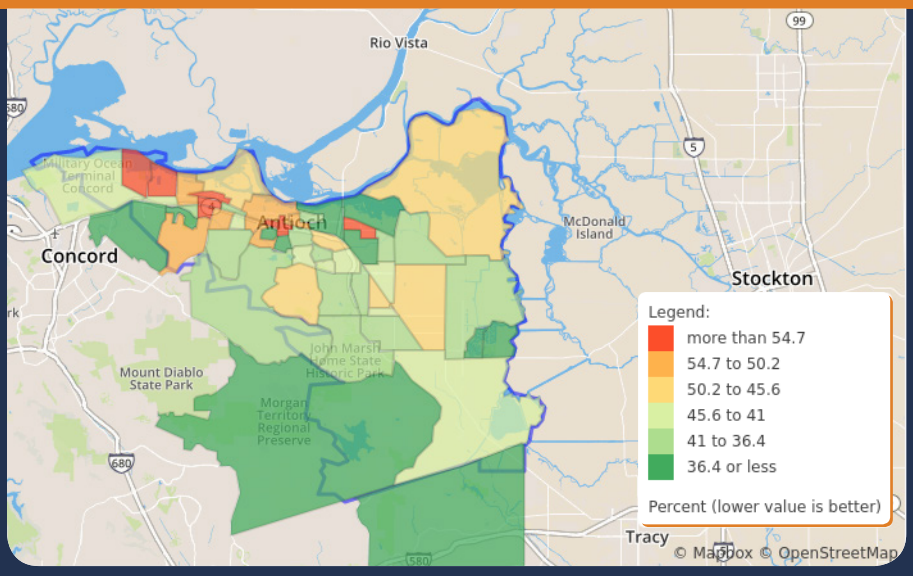
Poor health can lead to homelessness, and homelessness can lead to poor health.[3] People without a home experience more health care issues, suffer from preventable illnesses at a greater rate, require longer hospital stays, and have a greater risk of premature death than their peers with a home.[4] The average life expectancy for someone who lacks permanent housing is at least 25 years less than that of the average U.S. resident.[5]

What does the data show?

In the KFH-Antioch service area, housing concerns are prevalent (see community section, next page). Most statistical data on housing appear to meet state benchmarks, but two in five households here are cost-burdened.[6] Geographic and ethnicity data also suggest that certain neighborhoods and communities disproportionately experience challenges when it comes to housing.

continued >>

Households With Housing Problems



Housing problems include at least one of the following: Housing unit lacks complete kitchen facilities; housing unit lacks complete plumbing facilities; housing unit is overcrowded (>1 person per room); or household is cost-burdened (housing costs represent >30% of monthly income). / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

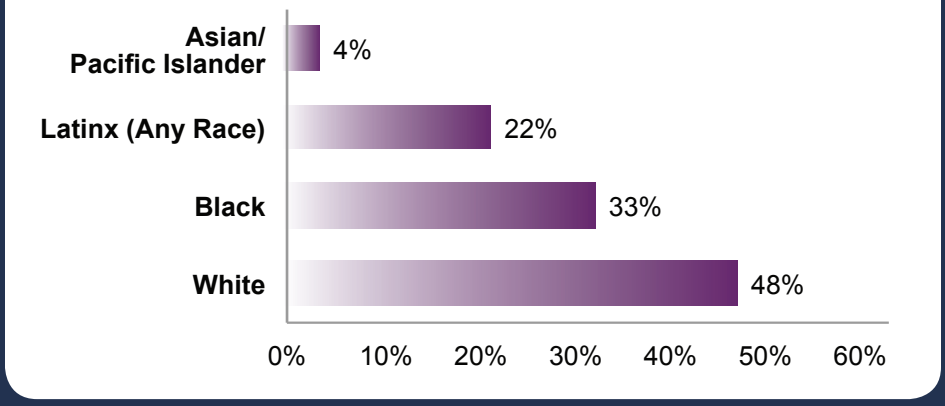
1,607 people experienced homelessness in Contra Costa County in 2017.[5]

KEY DISCOVERY

2 in 5

The number of cost-burdened households in the KFH-Antioch service area is slightly higher than the state average.[6]

Ethnic Disparities: Homelessness in Conta Costa County



Percentage total exceeds 100% due to people choosing multiple ethnicities. / SOURCE: Contra Costa Council on Homelessness, 2017 Point in Time Count: A Snapshot of Contra Costa County.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified safe, healthy housing as a top priority. Participants in focus groups and interviews strongly linked housing and mental health, indicating that the stress of maintaining housing is negatively affecting families. They also connected housing and physical health, noting that households have spent less on food and medical care in recent years because of increases in housing costs. Concerns were raised about the health of people experiencing homelessness, who are at greater risk of poor health outcomes.

Participants were troubled by the increasing number of unstably housed individuals and the displacement of families in the East Bay, including families with children. Experts cited a lack of strong tenant protections—and a lack of knowledge about protections that may exist—in the community. Focus group participants suggested that the imbalance of jobs and housing (many new jobs but few new residences) is a major driver of the housing crisis.

"When you have a permanent address, you create better, healthier, thriving communities, and your tenure in your community is longer. You're not having so much turnover or displacement."

—HOUSING EXPERT

SOURCES

[1]U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*
[2]Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis.* See also: The California Endowment (2015). *Zip Code or Genetic Code: Which Is a Better Predictor of Health?*
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COMMUNITY HEALTH NEED

Community & Family Safety

What's the issue?

Crime, violence, and intentional injury are related to poorer physical and mental health for victims, perpetrators, and communities.[1] Crime in a neighborhood causes fear, stress, and mental health issues.[2] Beyond physical injury, victims of violence have a higher risk of depression, substance use, anxiety, reproductive health problems, and suicidal behavior than other people.[3] Exposure to violence also has been linked to post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior oneself.[4]

Unintentional injury—accidents involving falls, traffic, overdoses of prescription medications, and more—was the #3 cause of death in the U.S. in 2016.[5, 6, 7] Unintentional injuries are the leading cause of death and hospitalization in California for children aged 16 and younger.[8] Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.[9]

Crime and Intentional Injury

What does the data show?

In the KFH-Antioch service area, safety concerns are prevalent (see community section, next page). Most statistical data on community and family safety are available for Contra Costa County as a whole

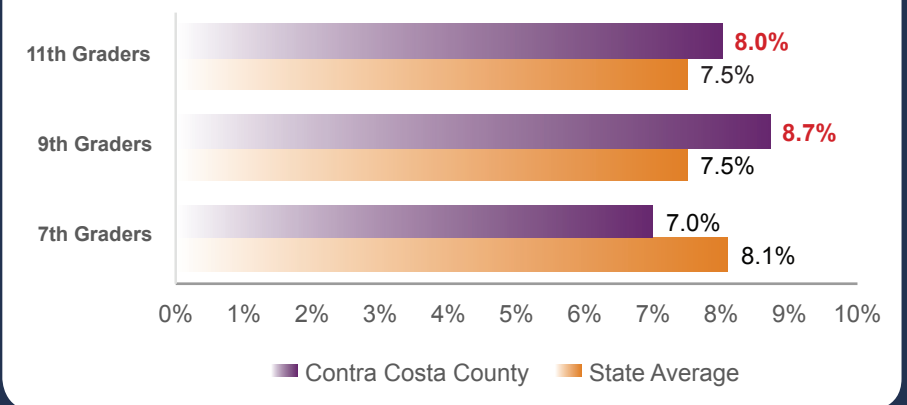
continued >>

Community Safety

HEALTH NEED INDICATOR	STATE AVERAGE	CONTRA COSTA COUNTY
Homicide Rate	5.0	**6.0**
Firearm Fatality Rate	8.0	**9.0**

Rates per 100,000 people. / SOURCES: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999–2017, CDC WONDER Online.

Youth Self-Report: Gang Membership



Surveyed 7th, 9th, and 11th graders (public schools) and nontraditional students. / SOURCE: California Department of Education, California Healthy Kids and California Student Surveys (WestEd), 2011–2013.

KEY DISCOVERY

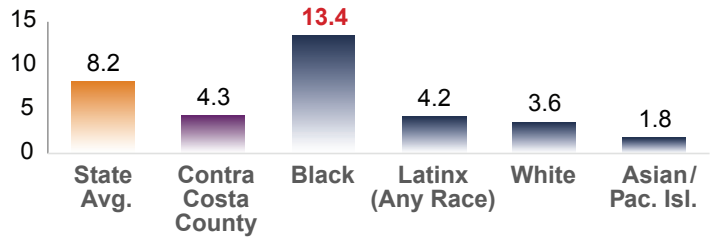
6.3

per 100,000 people

The domestic violence hospitalization rate for women and girls (aged 10 and older) in the KFH-Antioch service area is almost 30% higher than the state rate.[10]

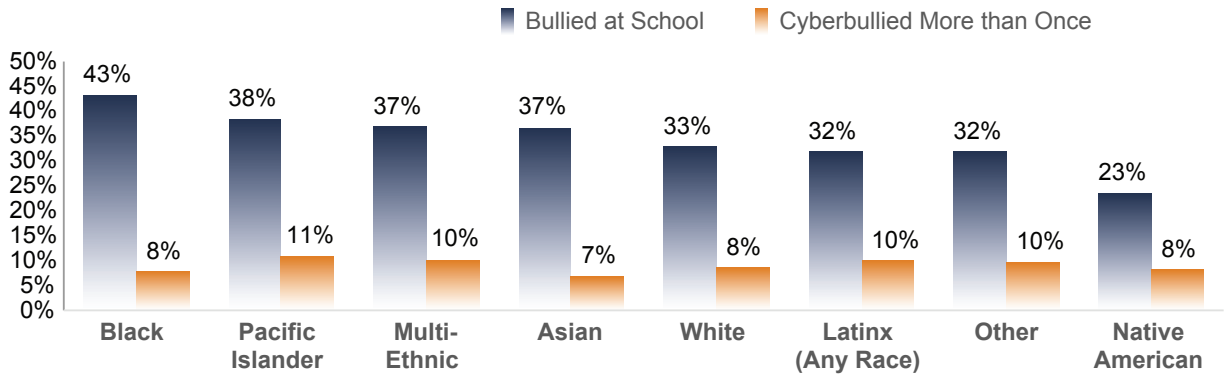
but not the service area. Various county indicators exceed state averages. The domestic violence hospitalization rate for women and girls (age 10 and older) in the KFH-Antioch service area—6.3 per 100,000 people—is almost 30% higher than the state rate.[10] Significant ethnic disparities around community and family safety exist in the community.

Ethnic Disparities: Child Abuse and Neglect



Number of substantiated cases per 1,000 people under age 18. / SOURCE: Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (2015) and Annie E. Casey Foundation, KIDS COUNT (2015).

Ethnic Disparities: Youth Bullied in the Past Year



Surveyed 7th, 9th, and 11th graders (public schools) and nontraditional students. / SOURCE: California Department of Education, California Healthy Kids and California Student Surveys (WestEd), 2011–2013.

What does the community say?

With regard to crime and intentional injury, KFH-Antioch service area residents and local experts (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) most frequently cited domestic violence as an issue in the community. They also worried about violent crime in general, reported an increase in violence, and called out human trafficking as a growing problem. Mental health, including trauma, came up often; various participants talked about the impact of discrimination and racially motivated violence on mental health. The group of greatest concern: children and youth, particularly online and in-person bullying, being victims of violence, and acting out (externalizing) trauma. The community also connected unsafe neighborhoods and the lack of outdoor play or other physical activities.

Accidents and Unintended Injuries

What does the data show?

Statistical data on unintended injuries and deaths indicate pedestrian accident mortality is higher in the KFH-Antioch service area than the California average. Additionally, Black service-area residents die in motor vehicle crashes at a rate of 10.2 per 100,000 people, which is disproportionately higher than residents of other ethnic groups.[11]

continued >>

Child hospitalizations for certain unintended injuries are also higher than state averages. Accidents are the #6 cause of death in Contra Costa County.[12]

What does the community say?

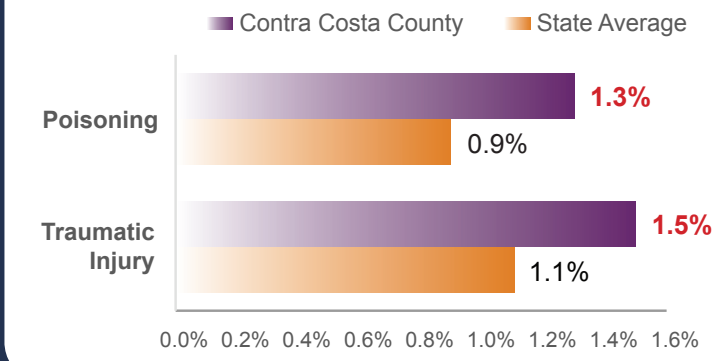
With regard to unintentional injury, key informants and focus group participants expressed the greatest concern about children and youth. Most community input came from experts, who cited unintentional injuries as a leading cause of death for both children and older adults. Experts emphasized the need for prevention of falls among seniors (often occurring in the home) and kids (specifically, from open windows). Motor vehicle crashes also were noted, along with the importance of using car seats to prevent injuries to young children when collisions occur.

Accident-Related Deaths

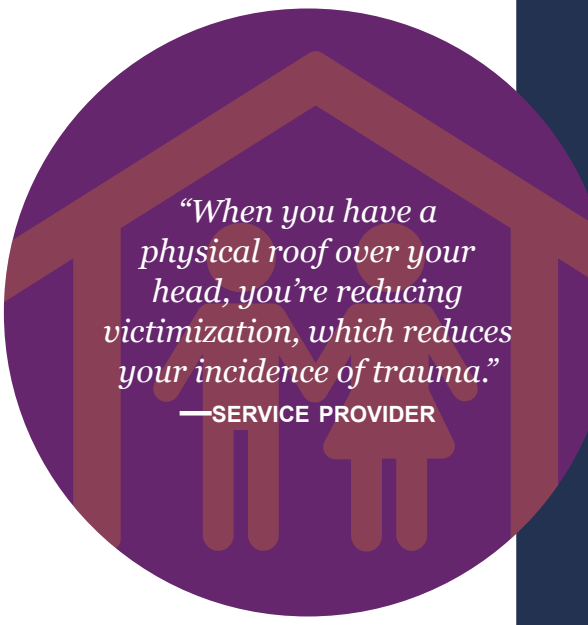
HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Pedestrian Accident Death Rate	2.3	2.6
Motor Vehicle Crash Death Rate	8.6	6.4
Unintentional Injury Death Rate	30.3	26.1

SOURCES: Pedestrian accident deaths: National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2011–2015. Other indicators: Centers for Disease Control and Prevention, National Vital Statistics System, 2011–2015.

Accident-Related Hospitalizations: Children and Youth



Percentage of children aged 0–17, excluding newborns. / SOURCE: Special tabulation by California Office of Statewide Health Planning and Development, 2015.



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COMMUNITY HEALTH NEED

Transportation & Traffic

What's the issue?

Motor vehicle crashes killed over 35,000 people and injured 2.5 million more across the U.S. in 2015. The major contributors to this type of bodily harm—drunken driving, distracted driving, speeding, and not using seat belts[1]—are preventable. Increases in road use and motor vehicle collisions go hand in hand.[2] Additionally, greater traffic congestion causes travel delays, more fuel consumption, and higher greenhouse gas emissions from vehicle exhaust.[1] Vehicle exhaust is a known risk factor for heart disease, stroke, asthma, and cancer. Thus, it is important to monitor the miles traveled by vehicles over time to understand the potentially adverse health consequences.[3]

The benefits of alternative transport such as walking or riding a bicycle include improving health, saving money by not purchasing or maintaining a car, and reducing impact on the environment. Combining alternative transport with traffic countermeasures can improve the community's health and reduce traffic-related injuries and deaths.

What does the data show?

Statistics suggest that traffic and transportation are concerns in the KFH-Antioch service area. Black residents in the service area are killed in motor vehicle crashes at a rate of 10.2 per 100,000 people. This rate exceeds the state average by 19%—and is much higher than the rates for residents of other ethnicities.[4]

Vehicle crashes resulting in traumatic injury in Contra Costa County that are trending up[5]:

- Auto vs. Pedestrian
- Bicycle
- Motorcycle

continued >>

Road Use and Mortality

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Motor Vehicle Crash Deaths	**8.6**	6.4
Pedestrian Accident Deaths	**2.3**	**2.6**
Road Network Density (miles of road per square mile)	**2.0**	**4.6**

Death rates per 100,000 people. SOURCES: Motor vehicles: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 2011-2015. Pedestrians: National Highway Transportation Safety Administration, Fatality Analysis Reporting System, 2011-2015. Roads: Environmental Protection Agency, Smart Location Database, 2013.

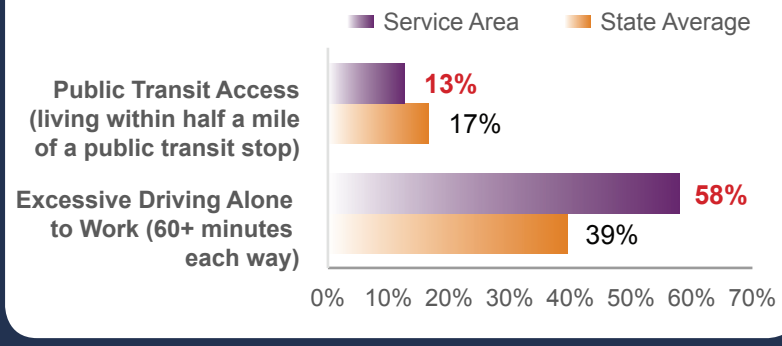
KEY DISCOVERY

4.6

miles of road per square mile

The road density in the KFH-Antioch service area is more than twice the state average (2.0),[6] making the potential for congestion and pollution higher.

Selected Transportation Indicators



SOURCES: Driving: U.S. Census Bureau, American Community Survey, 2012–2016. Transit: Environmental Protection Agency, Smart Location Database, 2013.

"We hear a lot of people say, 'I have to go to the doctor, but I can't get there.'"

—COMMUNITY RESIDENT

Six in 10 adults in the KFH-Antioch service area drive to work alone, 60 minutes or more in each direction, compared with only four in 10 statewide.[7] Driving alone rather than using more active transportation (e.g., walking or bicycling) contributes to sedentary lifestyles.

What does the community say?

Residents and local experts in the KFH-Antioch service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) discussed transportation as a barrier to accessing health care and getting to work. The community talked about the difficulty of using public transportation to get to East Bay locations because of poor reliability, limited bus and BART lines, long public transit travel times, and the high expense (especially for BART). Participants described the fear of becoming a victim of a crime at BART stations, while others stated that access for the disabled (i.e., elevators) is unreliable at BART stations. The community indicated that Eastern Contra Costa County is not widely accessible via BART despite the extension of the Pittsburg line.

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