2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Vacaville

License number: 550001207

Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit

CHNA Report for KFH-Vacaville

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 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 includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of 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, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

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

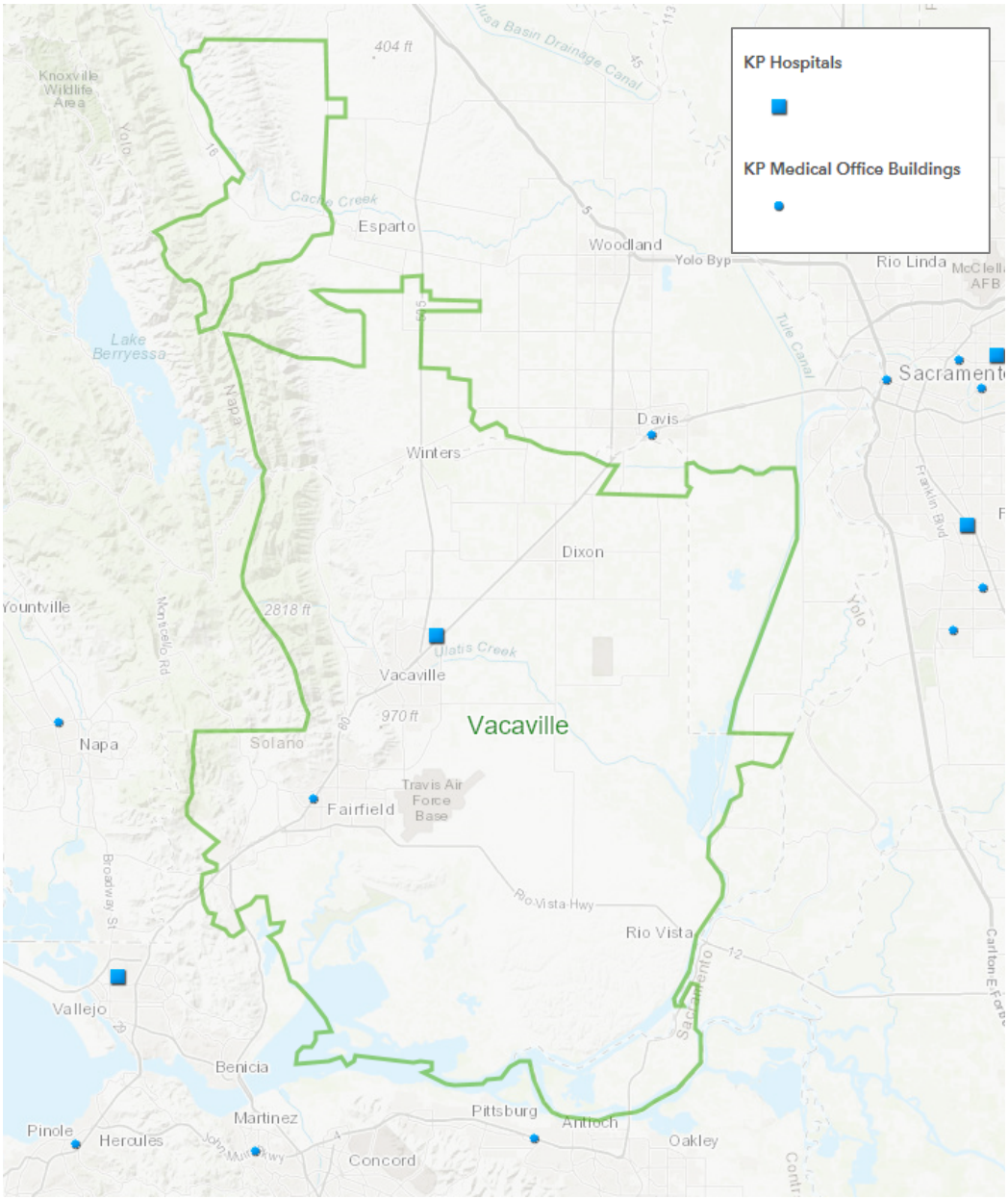
II. Community served

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-Vacaville Service Area

ii. Geographic description of the community served

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

iii. Demographic profile of the community served

Demographic profile: KFH-Vacaville

Race/ethnicity		**Socioeconomic Data**	
Total Population	287,540	Living in poverty (<100% federal poverty level)	11.3%
Asian	11.7%	Children in poverty	16.6%
Black	11.5%	Unemployment	3.9%
Native American/Alaska Native	0.6%	Uninsured population	8.5%
Pacific Islander/Native Hawaiian	0.8%	Adults with no high school diploma	13.5%
Some other race	11.6%		
Multiple races	7.3%		
White	56.7%		
Hispanic/Latino	27.4%		

III. Who was involved in the assessment?

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

KFH-Vacaville worked with both hospital and other partner organizations with similar service areas in Solano County at the onset of the CHNA to develop a coordinated approach to primary data collection. KFH-Vacaville then collaborated with the same group to determine the list of significant health needs based on both primary and secondary data.

Collaborative hospital partners:

1. Kaiser Foundation Hospital-Vacaville
2. NorthBay Healthcare
3. Sutter Health[1]

Additional partners:

1. Solano County Health and Social Services
2. Community Health Insights (CHI)*

[1] *Sutter Health and their consultant Community Health Insights (CHI) collaborated on the data collection and identification of health needs phases of the assessment, but had a separate process for health need prioritization and reporting.

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

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts—including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other Kaiser Foundation Hospital service areas in Roseville, Sacramento, San Bernardino, San Rafael, Santa Rosa, South Sacramento, and Vallejo.

IV. Process and methods used to conduct the CHNA

A. Secondary data

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

KFH-Vacaville used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources.

KFH-Vacaville also used additional data sources beyond those included in the CHNA Data Platform. Solano county health department partners shared additional data from their internal platforms and studies, and other online sources were referenced (e.g., kidsdata.org, California Healthy Places Index).

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

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-Vacaville also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners (e.g., county health departments, service providers, and other stakeholders) provided additional data (e.g., frequency tables, reports, etc.) to inform both the identification and prioritization of health needs across the service area (see Appendix A. Secondary data sources and dates for a list of additional data sources). This data provided additional context and, in some cases, more up-to-date statistics to the indicators included in the CHNA Data Platform. The Harder+Company team did not conduct additional analysis on secondary data shared by CHNA partners as the data was already disaggregated across several variables including region, race/ethnicity, and age. Each health need profile includes a reference section with a detailed list of all secondary data sources used in that profile to inform the prioritization of health needs (see Appendix C. Health Need Profiles).

B. Community input

i. Description of who was consulted

A broad range of community members provided input through key informant interviews, group interviews, and focus groups. We consulted individuals with knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, we gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., race/ethnic minorities and individuals experiencing homelessness). For a complete list of communities and organizations that provided input, see Appendix B. Community input tracking form.

ii. Methodology for collection and interpretation

In an effort to include a wide range of community voices from individuals with diverse perspectives and experiences and those who work with or represent underserved populations and geographic communities within the KFH-Vacaville service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries. (For a complete list of participating organizations, see Appendix B. Community input tracking form).

The consulting team developed interview and focus group protocols, which the CHNA Collaborative reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. The team also asked participants to describe any new or emerging health issues and to prioritize the top health concerns in their community.

We conducted key informant interviews over the phone by a single interviewer, while provider group interviews and community focus groups were in person and completed by both a facilitator and notetaker. When respondents granted permission, the team recorded and transcribed all interviews.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended healthcare solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the team finalized the codebook to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

In comparison to secondary (i.e., quantitative) data sources, primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

Harder+Company also coordinated with Sutter Health's CHNA consultant, Community Health Insights (CHI) for data collection in regions where service areas overlapped. CHI and Harder+Company conducted those activities independently and then shared transcripts (respondents were informed of this information sharing in the protocol). CHI recorded all data collection activities, which the Harder+Company team then had transcribed through an independent transcription service. In the case that participants did not give permission to record, CHI shared their notes from the interview with the Harder+Company team, who then coded the notes through the Atlas.ti platform. For the data collection activities that CHI conducted in Spanish, notes were documented in English by the interviewer and therefore no quotations were available from these notes.

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

D. Data limitations and information gaps

The KP CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that perform poorly compared to the state flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, the team made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, the team conducted focus groups in English and Spanish, future CHNA processes should

consider strategies to include data collection in additional languages that are prevalent in the service area.

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

Extensive secondary quantitative data (from the Kaiser CHNA Data Platform and other publically available data), as well as primary qualitative data collected from key informant interviews, provider group interviews, and focus groups, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews, see Section IV B ii for details). Part of the analysis included grouping individual qualitative themes (e.g., green spaces, safe spaces, food security, obesity, diabetes) into health need categories (e.g., healthy eating and active living) similar to those identified in the Kaiser CHNA Data Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as **high need based on secondary data** from the Kaiser CHNA Data Platform if it met *any* of the following conditions:

- *Overall severity:* at least one indicator Z-score within the health need was much worse or worse than benchmark.
- *Disparities:* at least one indicator Z-score within the health need was much worse or worse than benchmark for any defined racial/ethnic group.
- *External benchmark:* indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020).

2. A health need category was identified as **high need based on primary data** if it was identified as a theme in a majority of key informant interviews, group interview, *and* focus groups.
3. Classification of primary and secondary data was combined into the final health need category using the following criteria:
    - **Yes**: high need indicated in *both* secondary and across *all types* of primary data. Kaiser Permanente and CHNA partners then confirmed these health needs.
    - **Maybe**: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with Kaiser Permanente and CHNA partners to determine final status.
        - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
        - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
    - **No**: high need indicated in only one or fewer sources.

B. Process and criteria used for prioritization of health needs

For each identified community health need, Harder+Company developed a three- to four-page written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers, residents, and others) to prioritize the health needs. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity:** Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.

- **Clear Disparities or Inequities:** Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
- **Impact:** The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

During the small-group discussions, meeting participants referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-7 (*1=lowest priority*; *7=highest priority*). Ranking required that no two health needs were scored the same within each criterion. Harder+Company tallied the votes after the prioritization meeting and shared the final ranked list of health needs with participants via email.

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

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see B. Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to Appendix C. Health Need Profiles.

1. Economic Security: Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. Intrinsically related to all health issues, from housing to behavioral health, economic security is a strong determinant of an individual's health outcomes. While the Vacaville service area has a lower proportion of cost-burdened households when compared to the state average, large racial disparities in poverty exist. For instance, Native American/Alaska Native children in Vacaville experience poverty at 5 times the rate of Asian children. The three subpopulations by race/ethnicity with the highest percentage of children living below 100 percent of the Federal Poverty Line (FPL) are Native American/Alaska Native (35 percent), Black (28 percent), and Hispanic (20 percent).[2] Additionally, 17 percent of Black residents live in a household with incomes below the FPL—more than twice that of non-Hispanic White residents in the Vacaville service area.[3] Communities in and around Fairfield and Vacaville cities had high percentages of households with incomes below the FPL; notably, these same areas

[2] American Community Survey. (2012-2016).
[3] Same as above.

also indicate high percentages of adults with no high-school diploma.[4] Educational attainment is an important determinant of health and opportunity across a lifespan. In Rio Vista, a service provider noted that there are an increasing number of children using free and reduced priced lunch (FRPL), and that there is some stigma for those who are eligible for that benefit. Spanish-speaking residents in Fairfield expressed that many families have to choose between childcare and work, with one participant noting they spent $1,000 monthly last year for their three children. Residents and service providers identified many challenges related to maintaining economic security, such as unrealistic requirements for government assistance, and the need for better pay to be able to make ends meet.

2. Behavioral Health: Behavioral health is the foundation for healthy living and encompasses mental illness, substance use and overdoses, and access to service providers for preventive care and treatment. Vacaville service area residents face a range of behavioral health-related challenges, including a higher rate of excessive drinking, opioid prescription drug claims, and deaths by suicide, drug, or alcohol misuse, when compared to the state average. The non-Hispanic White population in the service area has the highest rate for suicide deaths at 17 per 100,000, nearly twice the state average.[5] Thirty-six percent of service area residents experience excessive drinking compared to 33 percent of residents across California[6]—and impaired driving deaths are also higher in the service area, with 32 percent of all motor vehicle crash deaths reporting that alcohol played a role compared to the state average of 29 percent.[7] Residents also smoke tobacco products at a higher rate and exhibit a higher incidence of lung cancer when compared to the state. Heart disease death rates are highest among non-Hispanic Blacks at a rate of 97 per 100,000 population compared to 74 per 100,000 for the Vacaville service area on average.[8] Interviewees described several barriers to achieving behavioral health, including early-age use of substances, decreased social connectedness in their communities, and strong peer pressure, especially among youth. Social associations including civic organizations, labor organizations, and recreational clubs and facilities were lowest in parts of Vacaville, Suisun City, and Esparto.[9] Community members also emphasized the need for increased access to mental health services. A service provider noted that in a recent study of students in Rio Vista, youth identified mental health and substance use as their top needs.

3. Access to Care: Access to quality health care includes affordable health insurance, use of preventive care, and ultimately reduced risk of unnecessary disability and

[4] Same as above.
[5] National Vital Statistics System. (2011-2015).
[6] California Health Interview Survey. (2015-2016).
[7] Fatality Analysis Reporting System. (2011-2015).
[8] National Vital Statistics System. (2011-2015).
[9] County Business Patterns. (2015).

premature death. Importantly, it is also one of the key drivers in achieving health equity. The Vacaville service area fares worse than the state across important access-related indicators, such as residents recently having a primary care visit and breast cancer incidence. For example, 61 percent of service area residents had a recent primary care visit compared to 73 percent of state residents.[10] While the Vacaville service area scores better than California on indicators such as total rate of uninsured residents, racial inequities persist. For example, Whites in the Vacaville service area are 2.5 times more likely to be insured compared to Native Hawaiian/Pacific Islanders. Native Alaskan/Native American and Hispanic/Latino populations also have higher percentages of individuals without health insurance at 15 and 14 percent respectively (compared to 9 percent for the service area overall).[11] Racial minority groups and lower income individuals also experience significant challenges in obtaining affordable care. Interviewees highlighted many barriers to accessing needed services, from a lack of culturally competent care, to not having sufficient time off work to go to the doctor.

4 (tie). HEAL: Healthy Eating and Active Living (HEAL) relates to Vacaville service area residents' ability to shape their health outcomes through nutrition and exercise. Regular physical activity can help control weight, reduce depression and anxiety, and reduce risks for chronic diseases. Similarly, healthy eating behaviors are associated with health benefits including lower risk for obesity and related chronic diseases. There is a high rate of obesity among adults and youth in Vacaville, especially among minority populations. For example, Hispanic and non-Hispanic Native Hawaiian/Pacific Islander youth reflect the highest incidence of obesity, both at 28 percent compared to the state average of 20 percent.[12] Community members highlighted the barriers to eating nutritiously, as well as the high costs and behavioral change needed to live an active lifestyle. Lack of access to healthy grocery stores and the prevalence of fast food options were another important barrier to healthful eating highlighted by interviewees. In the Vacaville service area, 23 percent of residents do not live close to a supermarket, compared to 13 percent of California residents overall.[13] A healthy lifestyle greatly influences the rates of chronic conditions like cardiovascular disease, stroke, and cancer, but is not equally attainable for all residents.

4 (tie). Violence and Injury Prevention: Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of the Vacaville Service Area have higher rates of domestic violence hospitalizations, injury deaths (intentional and unintentional), and violent crimes compared to the state. For example, there are 11.4 incidents of domestic violence hospitalization per 100,000 people in the Vacaville service area compared to

[10] Dartmouth Atlas of Health Care. (2014).
[11] American Community Survey. (2012 – 2016).
[12] FITNESSGRAM® Physical Fitness Testing. (2016-2017).
[13] USDA Food Access Research Atlas. (2014).

4.9 incidents in California.[14] Domestic violence hospitalizations are especially pronounced across the Solano County portion of the service area extending into the city of Vallejo. Violent crimes are also much higher than the state average, at a rate of 463 per 100,000 in the service area compared to 402 per 100,000 in California.[15] The incidence of violent crimes affects community safety in many ways. Through interviews and focus groups, local stakeholders identified several factors as contributing to the effects of violence and injury, including existing trauma in the community, stress from economic insecurity, competing priorities of families to meet basic needs and support youth, and a lack of safe spaces. Many of these barriers disproportionately affect low-income individuals and people of color.

6. Housing: Access to safe, secure, and affordable housing is an important social determinant of health. Families with fewer financial resources are more likely to experience substandard housing conditions and the associated risks. The Vacaville service area has a lower proportion of cost-burdened households and a less severe housing problem when compared to the state of California; however, the service area reflects clear disparities across race and ethnicity. For example, across Solano County, nearly two-thirds of both American Indian/Alaska Native and Black/African American renters spend 30 percent or more of their income on rent, which is considered a cost-burdened household.[16] Focus group and interview respondents provided additional insights; they identified that families of color, older adults, and single parents are most affected by housing issues. Many also noted that housing barriers are escalating within the community, and there is a lack of affordable options for everyone. At the extreme of housing issues, there is also a prevalence of individuals and households experiencing homelessness in the service area. One service provider noted that homelessness is prevalent in Fairfield and seems to be escalating. The number of individuals experiencing homelessness, in Solano County specifically, decreased from 2013 to 2015 (1,329 to 1,082 individuals respectively) but reflected an uptick to roughly 1,200 people as of 2017.[17] Service providers shared that the number of individuals who are situationally homeless is much higher (estimating anywhere from 5,000 to 9,000 individuals); this includes those who have lost a job, live in their car, or “couch surf” between relatives. Community members also shared that the closure of homeless shelters, which provide a much-needed safety net for many, and diminishing housing options for low-income families, as well as an influx of residents from other regions (e.g., East Bay), have created additional stressors to housing in the community.

7. Maternal & Infant Health: Mothers in the Vacaville service area face many barriers related to their own well-being and that of their children. Children born in the Vacaville

[14] California EpiCenter. (2013-2014).
[15] FBI Uniform Crime Reports. (2012-2014).
[16] American Community Survey 5-Year Estimates. (2012-2015).
[17] Point-In-Time, US Housing and Urban Development, Continuum of Care Assistance Programs, Homeless Populations and Subpopulations, CA-518 Vallejo/Solano County CoC. (2009-2017).

service area (specifically Solano County region) have slightly higher infant mortality rates compared to the state of California. When broken down by race/ethnicity, disparities in infant mortality are starker; children born to women of color are roughly 30 percent more likely to die as infants when compared to their White peers.[18] Additionally, a higher percentage of Black/African American infants (12 percent) are born at a low birth weight compared to other subpopulations by race/ethnicity across both Solano County and the state.[19] Mothers in the region struggle with many issues that relate to child health and development, including experiencing discrimination within the health system, providing a healthy home life for their young children, and facing a lack of options for reproductive health care. Solano County service providers noted that over the last ten years, health officials and community providers have made a concerted effort to increase prenatal care and have seen an increase in rates over time, especially for the Medi-Cal population. Preschool enrollment is also lower in the KFH-Vacaville service area at 43 percent compared to the state average of 49 percent.[20] Interviewees expressed a need for more services to support mothers of all ages and backgrounds.

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

The service area for KFH-Vacaville contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

Examples of community resources available to respond to each community-identified health need, as identified in qualitative data, are indicated in each health need brief found in Appendix C. Health Need Profiles. In addition, a list of community-based organizations and agencies that participated in the CHNA process can be found in Appendix B. Community input tracking form. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference https://www.211ca.org and enter the topic and/or city of interest.

VI. KFH-Vacaville 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Vacaville'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-Vacaville'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 www.kp.org/chna. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Vacaville in the 2016 Implementation Strategy Report.

[18] Area Health Resource File. (2006-2010).
[19] Kidsdata.org. (2013).
[20] American Community Survey. (2012-2016).

1. Healthy Eating/Active Living
2. Access to Care and Coverage
3. Behavioral Health
4. Community and Family Safety

KFH-Vacaville 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-Vacaville 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-Vacaville 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-Vacaville 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-Vacaville awarded 230 grants amounting to a total of $5,711,695.18 in service of 2016 health needs. Additionally, KFH 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-Vacaville service area. During 2017-2018, a portion of money managed by this foundation was used to award one grant totaling $4,761.90 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-Vacaville 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-Vacaville 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-Vacaville 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-Vacaville awarded 57 grants totaling $4,113,145.60 that address Access to Care in the KFH-Vacaville service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 15,527 and 15,458 Medi-Cal members respectively totaling $31,739,563.55 worth of care. KP also provided a total of $8,094,259.88 of Medical Financial Assistance (MFA) to 4,608 individuals in 2017 and 3,298 individuals in 2018.
		Navigation: KFH-Vacaville awarded a $25,000 grant to OLE Health to implement the Access and Care Coordination program. Care coordinators (CCs) will support patients, especially those who are least equipped to navigate the health care system, in effectively managing their medical and psychosocial conditions for improved health outcomes. CCs have assisted 2,869 patients thus far.
		Enrollment: KFH-Vacaville awarded a $50,000 grant to Solano Coalition for Better Health to strategically embed staff throughout Solano County to provide culturally sensitive outreach and enrollment services for those in need. A team of health access specialists provide education on the importance of staying linked to health coverage, avoiding disruption in services, and accessing preventive care. More than 700 families have been educated year to date.
		Operation Access: Operation Access received a $350,000 grant (evenly split between 15 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.
		PHASE: Over the course of three years (2017-2019), Community Medical Centers (CMC) is the recipient of a $150K grant (evenly split between KFH-Manteca and KFH-Vacaville) hospital service areas)to support the successful use of PHASE among clinic sites. Strategies include strengthening their team-based care approaches and implementing a QI coordinator model to support individual sites. CMC is reaching over 15,000 patients through PHASE. 77% of their patients with diabetes and 72% of their patients with hypertension have their blood pressure controlled.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Healthy Eating Active Living	*During 2017 and 2018, KFH-Vacaville awarded 42 grants totaling $486,371.43 that address Healthy Eating Active Living in the KFH-Vacaville service area*	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, Latinos, 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.
		Parks: Play 4 All Park, Inc. received a $125,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to support the creation of an inclusive park facility that serves children of all abilities and disabilities ensuring that children have a safe place to play. The park will include two dog parks, two baseball fields, a splash pad, and an 8,000 square-foot play structure. Once completed, it is expected that parents and families will travel to this park from all over Solano County because of the unique play facilities.
		Recreation programs: KFH-Vacaville awarded Fairfield Community Services Foundation a $15,000 grant for its Fun on the Run program, which brings quality recreation and enrichment programs directly into Fairfield's most isolated neighborhoods, annually serving more than 1,400 children 4 to 15. Three Fun on the Run vehicles staffed by youth development professionals visit 15 sites during the school year and 20 sites in the summer.
		Meals on Wheels: KFH-Vacaville awarded a $20,00 grant to Meals on Wheels of Solano County, supporting the provision of nutrition meals to seniors who are home-bound and at-risk throughout Solano County. For many seniors, this is their only daily meal and only interaction with another person. Providing a healthy, balanced meal reduces senior malnutrition and food insecurity, while promoting independence and socialization. Through this funding, more than 50,000 meals have been provided and a wait list of 125 people has been eliminated.
Mental Health & Wellness	*During 2017 and 2018, KFH-Vacaville awarded 39 grants totaling $607,389.15 that address Mental Health and Wellness in the KFH-Vacaville service area*	Stigma: County of Solano Office of Family Violence Prevention (OFVP) received a $90,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to increase its capacity to respond to individuals within the Latino and African American communities that are victims of intimate partner violence (IPV). OFVP expects to reach 120 domestic violence survivors through outreach, awareness, trainings and linkages to services. As a result of the program, participants will be empowered to seek out mental health care for IPV.
		Resilience: A Better Way – Berkeley received a $98,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to partner with Fairfield High School to promote student success and resilience by providing intervention/prevention services, training, and consultation on school policies. To date, a core group of 9-12 school staff have attended monthly trainings. Twenty students have received trauma-informed treatment through individual and group counseling.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Human trafficking: KFH-Vacaville provided a $20,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to 3Strands Global, Inc. to provide a trauma-informed education program to prevent human trafficking and to serve human trafficking victims. The program trained 1,100 educators, who support 25,000 students, in Solano County.
		Mental health services: Rio Vista Care received a $22,000 grant to provide free and low-cost culturally-appropriate mental health and family support services to 175 at-risk, underserved, uninsured, low-income children, adults, and families in Rio Vista. Clients will receive crisis and problem resolution services and learn positive, healthy coping skills for improved functioning.
Community & Family Safety	*During 2017 and 2018, KFH-Vacaville awarded 11 grants totaling $195,000.00 that address Community and Family Safety in the KFH-Vacaville service area*	Job readiness for youth: A $25,000 grant to Vacaville Neighborhood Boys & Girls Club supports the Junior Staff program, which will help 50 youth develop job readiness and leadership skills and provide them with coaching strategies to assist in setting and attaining academic and career goals.
		Vocational skills: The Robby Poblete Foundation received a $20,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to raise awareness about, and provide training in, vocational skills to equip young adults who don't have plans to go to college and reentry individuals in Solano County with skills that are in high demand in the workforce. This program will conduct outreach to 65,000 Solano County residents, focusing on public high school juniors and seniors, adult and alternative school students, and Solano County Superior Court’s parole reentry program participants.
		Financial literacy and workforce skills: Junior Achievement of Northern California received a $10,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to support 250 low- to moderate-income middle and high school youth in Solano County develop financial literacy and 21st century workforce skills.

VII. Appendices

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

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

	Source	Dates
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
43	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1	California Housing Consortium	2008-2014
2	American Community Survey 5-Year Estimates	2011-2015
3	American Community Survey 5-Year Estimates	2012-2016
4	American Community Survey PUMS data analyzed by Bay Area Regional Health Inequities Initiative (BARHII) and Alameda County Public Health	2016
5	Point-In-Time Survey, US Housing and Urban Development	2009-2017
6	Solano County Oral Health Needs Assessment (unpublished)	2018
7	Consolidated Planning/CHAS Data	2011-2015
8	Look InsideKP Northern California	2011-2017
9	California Department of Education	2016-2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Vacaville Family Resource Center (Senior Master Social Worker – FIRST)	1	Low-income	Service provider	8/28/18
2	Key Informant Interview	Winters Healthcare (Executive Director)	1	Health department representative	Service provider	8/23/18
3	Key Informant Interview	Solano County Board of Supervisors (Supervisor District 5)	1		Service provider	9/7/18
4	Key Informant Interview	Caminar (Executive Director and Director of Supported Housing for the Solano Region)	2	Medically-underserved, low-income	Service provider	8/8/18
5	Key Informant Interview	Solano County Department of Health and Social Services and Housing First Solano Board (Community Services Coordinator, mentally ill homeless outreach liaison)	1	Health department representative, medically-underserved, low-income	Service provider	8/21/18
6	Key Informant Interview	Solano County Public Health Department (Director of Public Health)	1	Health department representative, medically-underserved, low-income	Service provider	8/13/18
c7	Key Informant Interview	Partnership HealthPlan of California (Chief Executive Officer - Administration Department)	1	Health department representative, low-income	Service provider	8/24/18
8	Key Informant Interview	Solano County Department of Health and Social Services (Director)	1	Health department representative, medically-underserved, low-income	Service provider	9/07/18
9	Group Interview	First 5 Solano (Program Manager; Family Support and Program Manager) and partner organizations:	7	Medically-underserved, low-income, minority	Service providers	8/30/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		- Rio Vista CARE (Executive Director) - Child Start Inc. (Executive Director) - Solano Family and Children's Services (Executive Director) - Solano County Mental Health Services (Manager, Child Support Services) - Solano County Office of Education (Director of Early Learning)				
10	Group Interview	Workforce Development Board staff: -President/Executive Director -Planning and Industry Specialist -Industry and Community Engagement -Pathway to Success and Halfway to Employment Programs, Placement Coaches [6 staff] -Business Services Representative -Employability Specialist -Business Services Representative	12	Health department representative, medically-underserved, low-income, minority	Service providers	9/20/18
11	Group Interview	The Leaven (after-school mentoring and tutoring programs in low-income neighborhoods impacted by gangs and high dropout rates) staff: - Executive Director - Senior Site Director / Administrative Assistant - Regional Director (North Bay region) - Operations Director	4	Medically-underserved, low-income, minority	Service providers	9/20/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
12	Group Interview	Senior services providers: - Older and Disabled Adult Services (Social Services Supervisor) - Food Bank of Contra Costa and Solano (Program Director) - North Bay Regional Center (Physician) - North Bay Regional Center (Diversity and Equity Specialist) - Share the Care (Director)	5	Low-income, minority, medically-underserved, health department representative [21]	Service providers	9/28/18
Community residents						
13	Focus Group (split into two groups to accommodate high number of participants)	Vacaville Family Resource Center (program clients- youth)	9; 12	Low-income, minority	Community members	10/8/18
14	Focus Group	Black Infant Health clients (African-American/Black mothers, pregnant and post-partum)	12	Medically-underserved, minority, low-income	Service providers, community members	9/26/18
15	Focus Group	WIC (Vacaville) clients	9	Low-income, minority	Community members	10/1/18
16	Focus Group	Rio Vista residents	13	Low-income, minority	Service providers, community members	10/5/18
17	Focus Group (split into two groups to accommodate language differences)	The Leaven (after-school mentoring and tutoring programs in low-income neighborhoods impacted by gangs and high dropout rates) clients (English and Spanish-speaking parents, residents of Dana Dr. in Fairfield)	3 (Span.); 5 (Eng.)	Medically-underserved, low-income, minority	Community members	10/5/18

[21] No surveys were completed; the target group representative categories refer to those mentioned on organizations' respective websites.

*Focus group and group interview participants completed an optional survey These data were used to inform representation of the four target groups during data collection events using the criteria outlined below:

- **Medically-underserved:**
  Focus Groups: One or more participant indicated they have “No Insurance”
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.
- **Low-income:**
  Focus Groups: One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.
- **Minority:**
  Focus Groups: One or more participant indicated their race/ethnicity as non-White.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the minority community.
- **Health department representative:**
  Focus Groups: N/A
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.

Appendix C. Health Need Profiles

Health need profiles include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics), and were developed prior to the prioritization meeting. The profiles do not reflect additional knowledge shared by individual stakeholders during that meeting. Additionally, statistics presented in the health need profiles were not analyzed for statistical significance and should be interpreted in conjunction with qualitative findings.

Each health need profile also includes a “spotlight on equity” section which features community members’, including service providers, concerns in regard to inequities in their communities; examples provided in this section relate to complex and deeply rooted issues, and should be considered within a broader system-level context of historical disinvestment as well as discriminatory policies, practices, and discourse.

Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Access to Care

ACCESS TO CARE, CANCER, ORAL HEALTH, TRANSPORTATION, CLINICS

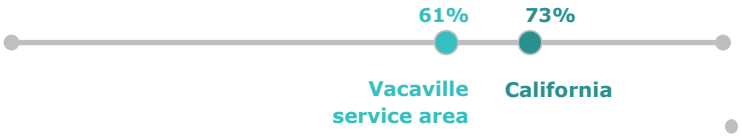
Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The Vacaville service area fares worse than the state across important access-related indicators, such as residents recently having a primary care visit and breast cancer incidence. While the Vacaville service area rates better than California on indicators such as total rate of uninsured residents, racial inequities persist; for example, Whites in the Vacaville service area are 2.5 times more likely to be insured when compared to Native Hawaiian and Pacific Islanders. Racial minority groups and lower income individuals also face significant challenges in obtaining affordable care. Interviewees highlighted many barriers to accessing needed services, from a lack of culturally competent care, to not having sufficient time off work to go to the doctor.

Key Data

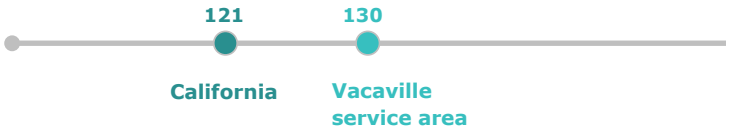
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Recent primary care visit (Medicare beneficiaries) (percent)[1]



Breast cancer incidence (rate per 100,000 population)[2]



Dentists (rate per 100,000 population)[3]

> We have people that are social workers, have been working with somebody, they're hospitalized and the hospital discharge planner sends them to another community, and all the work that everyone's been doing suddenly falls apart because they've been moved to another county.
> *- Service provider*

Community Identified Themes

Barriers to Access to Care

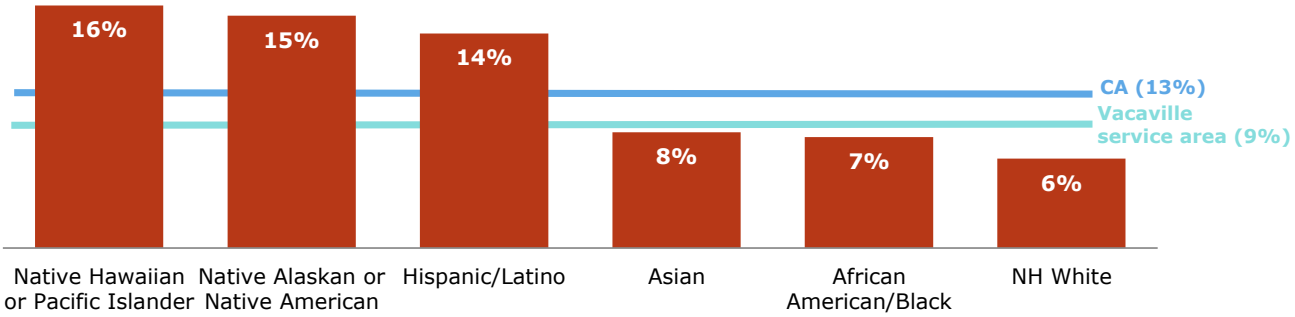
- Time-consuming public transportation
- Services not available locally
- Inconvenient hours of operation
- Communication gaps between service agencies (e.g., referrals and data systems not integrated)
- Lack of linguistically and culturally competent medical care
- Short appointments
- Lack of funding (state, private, etc.) and inability to pay providers a living wage (refers to smaller service providers)
- Impact of political climate

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Percentage of the population without health insurance[4]

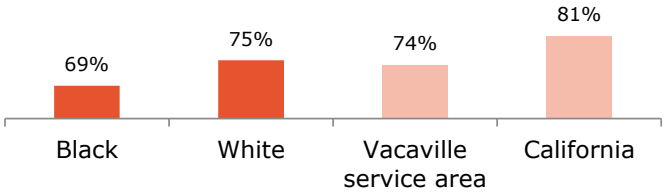


> The bus service runs three times a day in the town and out of town, so public transportation isn't adequate enough and a lot of the folks that we serve live in rural agrarian areas in and around town.
> *- Service provider*

- Service providers noted the **increasing senior population,** and common health needs including: **diabetes, COPD, heart issues, and cancer** (and some cases of dialysis).

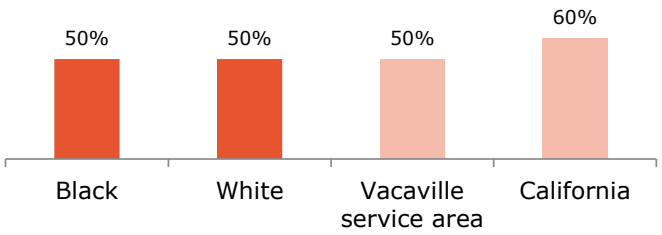
> I come from a family that's Haitian and east Indian, and I speak Farsi. So if I didn't grow up and learn English, how many people would be able to talk to me when I walked into a doctor's office. Where I used to work, it would take us up to seven to nine days to hire a translator.
> *- Focus group participant*

Diabetes Management (Hemoglobin A1c Test) administered in past year among Medicare patients[5]



> So many barriers to connecting with agencies, because of policies, procedures, climate, the culture of the agency, a lot of restraints put on the staff members of agencies.
> *- Service provider*

Breast Cancer Screening (Mammogram) in past two years among Medicare patients[5]



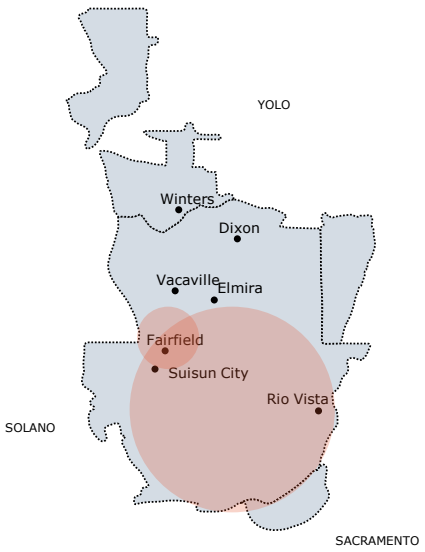
53% of Blacks who are Medicare beneficiaries had visited a primary care clinician at least once within the past year, compared to **62%** of their White peers with Medicare.[5]

Cancer death rate per 100,000 population [6]

Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Hispanic/ Latino	Native American Alaskan Native	Vacaville service area	California
192.1	190.6	113.4	108.2	101.5	168.6	147.3

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



As community members identified, transportation is a significant barrier that impacts access to care. Access varies by geographic communities within the Vacaville service area. (Circle size indicates the regional extent of disparities.)

While there is some data missing for the northern region of the service area, the available data for **Public Transit Stops** (percentage of the population living within 0.5 miles of a transit stop) reflects clear disparities**.** Community members living in the most southern region of the service area, extending from **Fairfield to Rio Vista, have extremely low access** (less than one percent) to transit stops (indicated by larger circle).

In Fairfield specifically, access varies greatly by census tract between **less than one percent to over 80 percent** (indicated by smaller circle).[7]

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Older adults living at home need additional support and may not have a social network to support needs.
- Solano County has a large Hispanic/Latino population that requires culturally competent and language appropriate care.
- Many families cannot afford to take off work for health care appointments and need extended evening hours to access services.
- In Rio Vista, providers conduct home visiting for families in most need and mentioned that it's an important option but not cost-effective.

> Private for-profit nursing homes are shutting out Medicare patients.
> *- Service provider*

> When English is their second language, it makes it even more difficult because people—also, based on the political climate [changes in policies and discourse impacting immigrants] right now—are really backing away and not coming to us for help.
> *- Service provider*

Assets and Ideas

Examples of Existing Community Assets

In-home support services, boarding care, nursing homes (for older adults)

Whole-person care approach (e.g., cross-sector communication and partnerships)

Health sector partnering with school districts

Continuum of Care, integrated services in one place

New community clinics, and extended hours for current services (e.g., dental for kids)

Community health fairs

Ideas from Focus Groups and Interview Participants

- Increase wages to address staff shortages and retain staff (e.g., caregivers for older adults)
- Increase co-locating and coordination of services (e.g., schools, health services, child care centers)
- More services for older adults, such as "day centers," crisis management, home-sharing
- Incorporate best practices from other counties working with older adults (e.g., Program of All-Inclusive Care for the Elderly or PACE)
- Educate providers on specific needs of different populations and improve bedside manner
- Provide primary care options for undocumented individuals (many use emergency room services)
- Integrate health service providers to accompany fire department (often called for medical needs)
- Improve public transit options
- Accessible and interactive health outreach and education in the community (e.g., web apps, health fairs with experts) about preventive care and social determinants of health
- More affordable and accessible clinics including dental care, and clear terms of eligibility
- Create a community center that promotes healthy living

1. Dartmouth Atlas of Health Care. (2014).
2. State Cancer Profiles. (2010-2014).
3. Area Health Resource File (Health Resources & Services Administration). (2015).
4. American Community Survey. (2012 – 2016).
5. Dartmouth Atlas of Health Care. (2014).
6. National Vital Statistics System. (2011- 2015).
7. EPA Smart Location Database. (2013).

Kaiser Foundation Hospital – Vacaville service area
Community Health Needs Assessment

Behavioral Health

MENTAL HEALTH, SUBSTANCE USE/TOBACCO

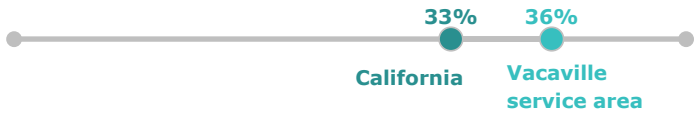
Behavioral health is the foundation for healthy living, and encompasses mental illness, substance use and overdoses, and access to service providers for preventive care and treatment. Vacaville service area residents face a range of behavioral health-related challenges, from a higher rate of excessive drinking, opioid prescription drug claims, and deaths by suicide, drug, or alcohol misuse, when compared to the state average. Residents also smoke tobacco products at a higher rate and exhibit a higher incidence of lung cancer when compared to the state. Interviewees described several barriers to achieving behavioral health, including early-age use of substances, decreased social connectedness in their communities, and strong peer pressure, especially among youth. The need for increased access to mental health services was also highlighted by community members.

Key Data

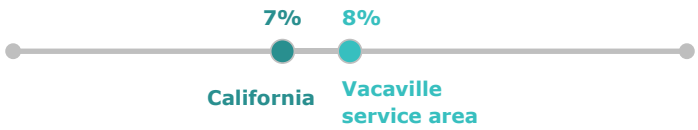
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

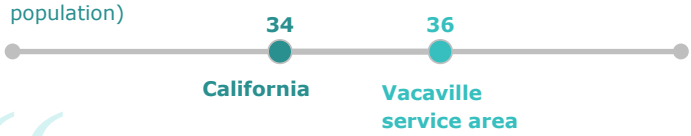
Excessive Drinking[1] (percent)



Opioid Prescription Drug Claims[2] (percent)



Deaths by Suicide, Drug or Alcohol Misuse[3] (rate per 100,000 population)



> Access to a provider that is bi-lingual is a huge barrier often. We see some of our families sit on wait lists , particularly for mental health services, for months on end, and when you have a kid in crisis, that just exacerbates it.
>
> *- Service provider*

> There's the chicken or the egg, but usually it's the mental health issue, substance abuse issue that leads to criminal activity, that often leads to homelessness.
>
> *- Service provider*

Community Identified Themes

Barriers to Behavioral Health

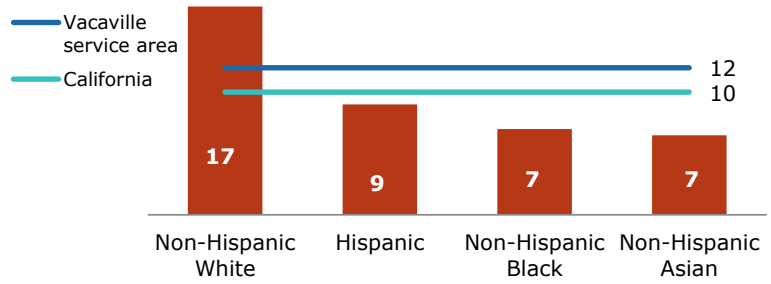
- Lack of buy-in in hospital systems to support crisis stabilization units
- Lack of financial partnerships addressing mental health
- Early-age use and abuse of substances (e.g., marijuana, alcohol, vaping)
- Increase in cyberbullying
- Less privacy and reduced in-person social connections due to social media use
- Anti-depressants don't provide immediate relief, need better options

Updated March 2019

Populations Disproportionately Affected

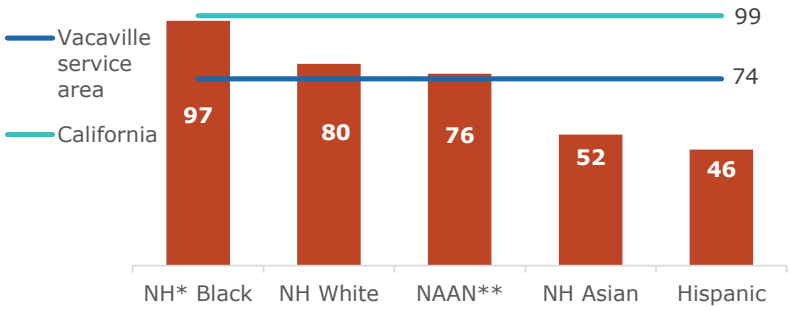
Populations with Greatest Risk

Suicide Deaths (rate per 100,0000 population)[4]



- In a focus group which included some service providers, a participant noted that in a recent study of students in Rio Vista, **youth identified mental health and substance use as their top needs.**

Heart Disease Death Rates (rate per 100,0000 population)[5]

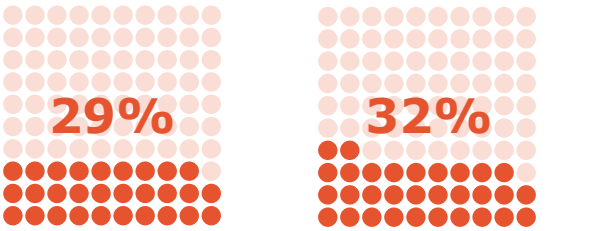


**NH refers to non-Hispanic. ** NAAN refers to Native American / Alaska Native*

A lot of grandparents are now raising their grandchildren because their sons and daughters have become addicted to some kind of substance; be it methamphetamine, or opiates.
- Service provider

It used to be do you smoke [marijuana]? Now it's, do you not smoke? Even before legalization it was already increasing.
- Youth Focus Group participant

Impaired driving deaths [6]



Current Smokers (rate per 100,000 population) [7]

Vacaville service area : California

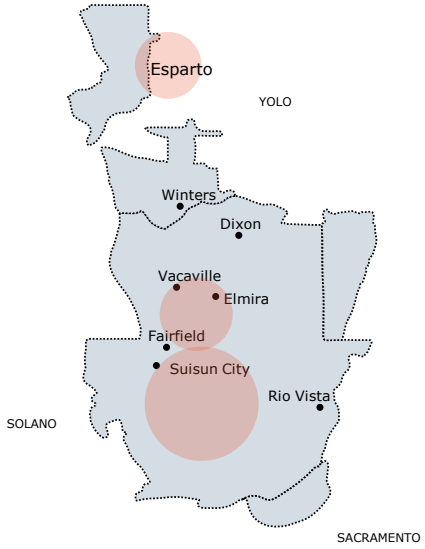
14.4 : 13.7

Lung Cancer Incidence
(rate per 100,000 population) [8]

Vacaville service area has a rate of **56 persons** compared to **California's 45 persons**

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Several common barriers to behavioral health varied by geographic communities within the Vacaville Service Area. (Circle size indicates the regional extent of disparities).

Deaths by suicide, alcohol, or dug misuse were moderate across the region around 34-43 per 100,000 population. (Data not shown on map).[9]

Social associations including civic organizations, labor organizations, recreational clubs and facilities, etc. were lowest in parts of Vacaville, Fairfield, Suisun City, and Esparto.[10]

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Youth respondents mentioned peer pressure that encourages young people to engage in drugs and violence.
- There is a gap in county mental health services for seniors over age 65.
- Solano County service providers noted that a culture shift is needed to create holistic care that underscores the impact of risk factors (e.g., Adverse Childhood Experiences) and how they affect mental and physical health.

> Solano is a few years behind some other counties in terms of how they roll out both addressing health inequities and programming. - *Service provider*

Assets and Ideas

Examples of Existing Community Assets

Diversion programs (e.g., drug courts, Prop 47 funds)

Grants through Mental Health Services Act (MHSA)

Extended hours for mental health services

Ideas from Focus Groups and Interview Participants

- Improve mental health services for youth and families through individualized treatment (vs. group), and increased access points to therapy
- Increase focus on preventive measures, particularly for youth (e.g., mentorship, community centers)
- Increase financial support for mental health services across sectors beyond county resources
- Identify and support smoking cessation opportunities
- More mental health providers and staff trained in behavior change
- Provide free, confidential drug testing, and more education on drug use
- Integrate behavioral and physical health care

1. California Health Interview Survey. (2015-2016).
2. Centers for Medicare and Medicaid Services. (2015).
3. National Vital Statistics System. (2011-2015).
4. Same as above.
5. Same as above.
6. Fatality Analysis Reporting System. (2011-2015).
7. California Health Interview Survey. (2014).
8. State Cancer Profiles. (2010-2014).
9. National Vital Statistics System. (2011-2015).
10. County Business Patterns. (2015).

Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Economic Security

ECONOMIC SECURITY, EMPLOYMENT, TRANSPORTATION

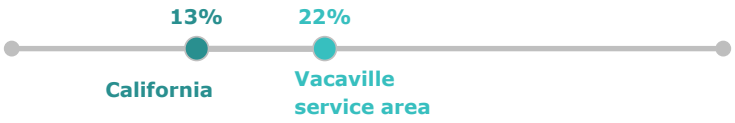
Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. Intrinsically related to all health issues from housing to behavioral health, economic security is a strong determinant of an individual's health outcomes. Residents of the Vacaville service area encounter many challenges when compared to California residents on the whole, such as decreased access to healthy foods stores and a lack of walkable destinations. Notably, the Vacaville service area has a lower proportion of cost-burdened households when compared to the state average, but large racial disparities in poverty incidence; for example, Native American/Alaska Native children in Vacaville experience poverty at 5 times the rate of Asian children. Residents and service providers identified many challenges related to maintaining economic security, such as unrealistic requirements for government assistance, and the need for better pay to be able to make ends meet.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Healthy Foods Stores, Low Access (percent)[1]



Walkable Destinations (percent)[2]

Cost Burdened Households (percent)[3]

> It's juggling or dropping your classes to make sure that your child is taken care of. It's really hard…it puts stress on you as well as your family when you're trying to juggle that, which also ties in with mental health.
> *- Focus Group participant*

> It's not a luxury to have a vehicle, it's a necessity at this point. So certain things really need to be counted as an expense when it comes to determining a person's eligibility for resources.
> *- Focus Group participant*

Community Identified Themes

Barriers to Economic Security

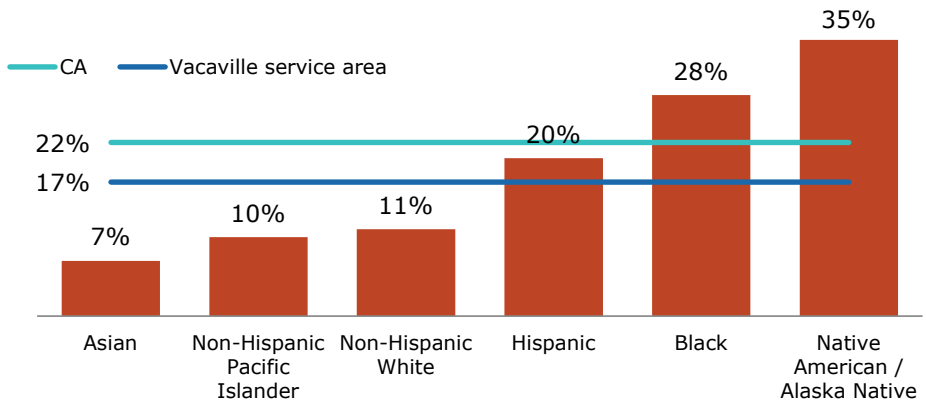
- Income requirements too low, unrealistic for gov't assistance (e.g., WIC)
- Poor public transportation infrastructure (e.g., wait times, bus transfers)
- Services are not linked
- Lack of private funding to support nonprofits
- Long-term impacts of high school students more motivated to work than continue school
- Difficulty to manage work, household, and education
- Salaries below living wage (e.g., health, education sectors)
- Lack of affordable child care

Updated March 2019

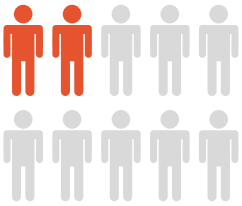
Populations Disproportionately Affected

Populations with Greatest Risk

Children Below 100% Federal Poverty Line [4]



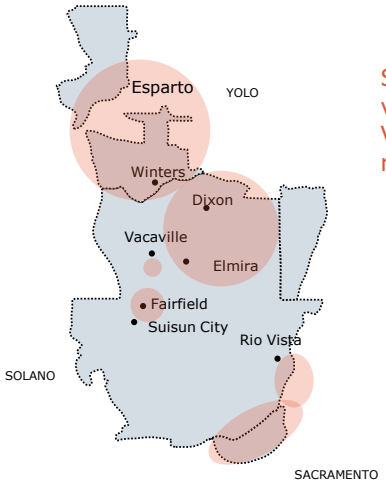
- Spanish-speaking residents in Fairfield expressed that many families have to choose between **childcare** and work, with one participant noting they spent **$1,000 monthly** last year for their three children.



17%
Of **Black residents** live in a household with incomes below the FPL[5]

8%
Of **non-Hispanic White residents** live in a household with incomes below the FPL[5]

Geographic Areas with Greatest Risk



- Solano County service providers mentioned **concentrations of poverty in Fairfield and Dixon.**

Several common barriers to economic security varied by geographic communities within the Vacaville Service Area. (Circle size indicates the regional extent of disparities).

Pockets of areas within Vacaville, Fairfield, and Rio Vista contained households with incomes **below the Federal Poverty Level.[6]**

Parts of Esparto, Winters, Dixon, Vacaville, and Fairfield had **high percentages of adults with no high school diploma.[7]**

Populations Disproportionately Affected

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- In Rio Vista, there are an increasing number of children using free and reduced priced lunch (FRPL)—there is some stigma for those who are eligible for that benefit.
- Teachers are particularly feeling the pressure of not earning a living wage (unable to afford classroom materials, and manage home responsibilities).
- Many first-generation Hispanic/Latino immigrants in the region do not have a high school education, and as a social determinant of health this puts this population at risk.
- In Fairfield, Hispanic/Latino community members noted that more cultural activities could bring currently segregated community members together.
- Youth identified how even with both parents working, they are still struggling with rent and food.
- Lack of affordable childcare is a barrier to many who otherwise could be working.

> People in the community are so segregated and in competition with the next person.
> *- Focus Group participant*

> We need to consider seriously economic mechanisms for minimizing the harm to poorer families during gentrification, otherwise, all they do is face displacement.
> *- Service provider*

Emerging Needs

Although the unemployment rate is currently low in the Vacaville service area, service providers emphasized the need for a greater focus on economic security *within* the region such as availability of jobs and more local investment for support services.

> In the case of Solano, I think we have to work to diversify our economic opportunities within the county. I think there's too heavy a reliance on people commuting to the Bay Area and to Sacramento, so that when the next recession hits, large, large numbers of people are going to be out of work, and that will be problematic. And they're not going to have alternate jobs within the county to try to focus on. I do think that we need to consider economic incentive programs to try to diversify the available range of job types within the county.
> *- Service provider*

Unemployment [8]

3.9% in Vacaville service area

4.0% in California

> I think Solano county sometimes gets forgotten as the area between the Bay Area and Sacramento, and so for that reason there's not a lot of foundations that focus their giving on Solano county, and so that just leaves a lot of nonprofits…with less funding than most other nonprofits.
> *- Service provider*

Assets and Ideas

Examples of Existing Community Assets

Grants that support education pathway for teachers

Partnerships across systems (e.g., workforce development, education sector, and WIC)

Natural resources and untapped physical space for new infrastructure

Ideas from Focus Groups and Interview Participants

- Identify and legalize an appropriate minimum wage for teachers that meets costs of time and resources, and value of work
- Build more personal connections between service providers and clients
- Continue and increase integrated services models across sectors (e.g., food vouchers and immunizations through WIC)
- More funding for nonprofit organizations, and more partnerships among community groups
- More affordable products at thrift stores
- Connecting youth and older adults (e.g., career mentorship, etc.), and more after-school resources
- Create safe and healthy community spaces (e.g., bowling alley, Boys & Girls Club, and YMCA)
- Improve efficiency of public transportation systems (e.g., train, more bus transfers, better sidewalks)
- Increase support provided from corporate organizations in the community
- Review standards that qualify people for public assistance to reduce barriers (e.g., for married couples, based on expenses)
- Raise Supplemental Security Income (SSI)
- Conduct outreach in schools to inform students of available services

1. USDA Food Access Research Atlas. (2014).
2. Center for Applied Research and Environmental Systems. (2012-2015).
3. American Community Survey. (2012-2016).
4. Same as above.
5. Same as above.
6. Same as above.
7. Same as above.
8. Bureau of Labor Statistics. (2017).

Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Healthy Eating and Active Living (HEAL)

OBESITY, DIABETES, CVD, STROKE, FOOD SECURITY

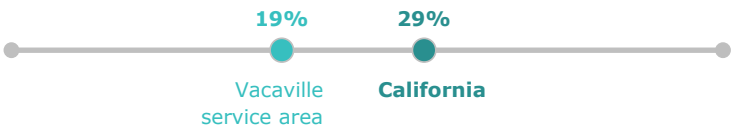
Healthy Eating and Active Living (HEAL) relates to Vacaville service area residents' ability to shape their health outcomes through nutrition and physical activity. There is a high rate of obesity among adults and youth in Vacaville, especially among minority populations. Community members highlighted the barriers to eating healthy, as well as the high costs and behavioral change needed to live an active lifestyle. Lack of access to healthy grocery stores and the prevalence of fast food options were another important barrier to healthy eating highlighted by interviewees. A healthy lifestyle greatly impacts the rates of chronic conditions like cardiovascular disease, stroke, and cancer, but is not equally attainable for all residents.

Key Data

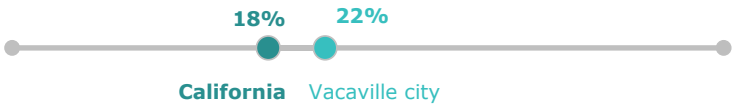
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

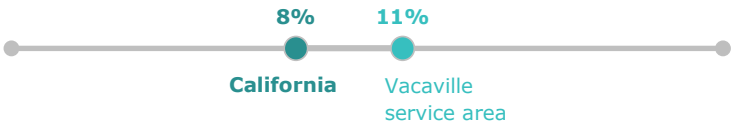
Walkable Destinations (percent) [1]



Soft Drink Consumption (percent) [2]



Diabetes Prevalence (percent) [3]



Community Identified Themes

Barriers to HEAL

- Requires behavior change for whole family
- May not align with cultural food practices
- Lack of affordable healthy food options
- Cost of other basic needs such as housing
- Play centers with fees are unaffordable for large families

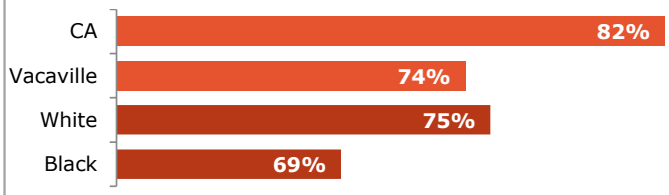
> Ultimately I think raising people's ability to purchase food is the better way to go about it. We always talk at the food bank about wanting to put ourselves out of business because we would prefer people be empowered to make their own purchasing decisions than need food from us.
> *- Service provider*

> When Michelle Obama was in the office, we were seein' her and she was gettin' us up and out and active and showin' us in commercials and through ads and all that other stuff, but now...
> *- Focus Group participant*

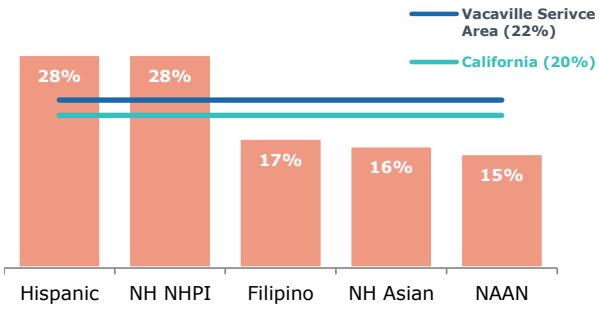
Populations Disproportionately Affected

Populations with Greatest Risk

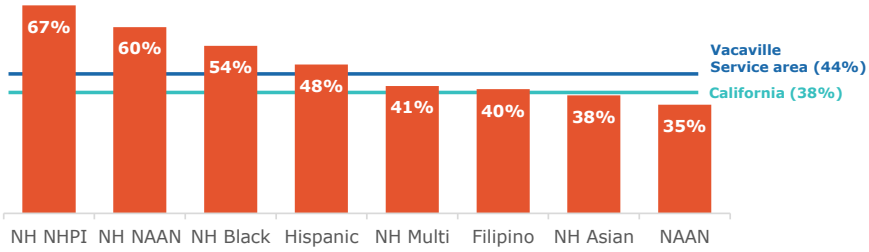
Diabetes Management [4]



Obesity among Youth [6]



Physical Inactivity among Youth [5]



They've had [housing] developments [in Fairfield] where lower income folks had no grocery stores, no supermarkets in the community and they have to find a way to get to the supermarket to purchase fresh vegetables and fruits.
- Service provider

30% of adults are obese in **Vacaville (City)** [7]

I think that we need to increase the exercise options for people, but that has to be accompanied by better safety, so we have to address crime at the same time.
- Service provider

Kids are walking to and from school and there's no sidewalk. They're walking on the shoulder of a road. They're crossing over train tracks. There have been so many pedestrian collisions with trains in Solano County, it just blows my mind when I hear about them.
- Service provider

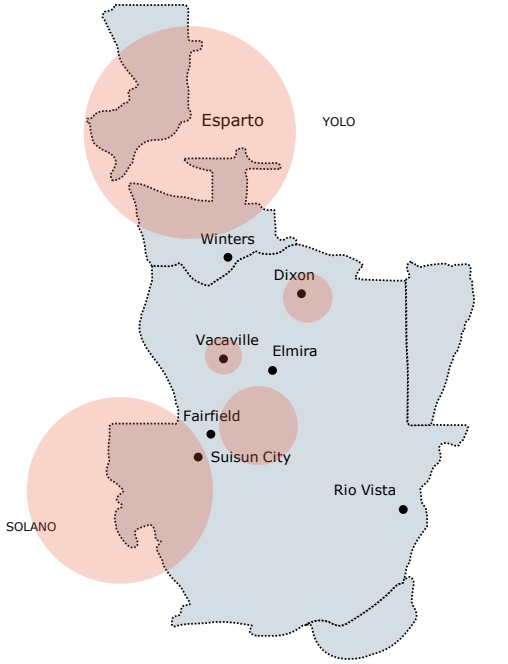
23% of **Vacaville** service area residents do not live close to a supermarket, compared to **13%** of **California** residents [8]

Percent of population who **experience food insecurity** [9]

Vacaville service area : CA
15% : 13%

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Healthy Food Stores (Low Access)[10]

Several communities within the Vacaville service area of Solano County do not have good access to healthy food retailers (large grocery store or supermarket) including the following census tracts (circle size indicates the regional extent of disparities):

- **Dixon:** 2534.02 (33.6%)
- **Solano** (Fairfield and Vacaville)**:** 2523.10 (91.8%), 2522.02 (98.2%), 2532.06 (99.8%)
- **Yolo** (Esparto and Winters): 115 (83.8%), 113 (39.4%)

When I'm in **Suisun,** there's the four corners that are all fast food, and you've got Walmart and yeah, they've got some healthy stuff, but most people are not going there for their healthy items.
- Focus Group participant

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- In Rio Vista, there are an increasing number of kids using free and reduced priced lunch (FRPL)—and there is some stigma associated with that between those who are or are not eligible for that benefit.
- Spanish-speaking residents noted that maintenance of parks differs between higher and lower income regions, and are less clean and safe (e.g., drug use, trash) in poor communities.
- Solano county senior service providers noted the importance of giving residents choice in food selections (through pantries, food stamps, etc.) so individuals can choose food aligned with their culture.

Wouldn't it be great if we linked with the bus transport services and identified maybe the senior centers that do noon meals or restaurants that want to participate in low senior cost meals and have the bus run around in the neighborhood and pick people up.
- Service provider

Assets and Ideas

Examples of Existing Community Assets

Cross-sector partnerships (e.g., county and health care organizations)

Community health promoters (e.g., provide nutrition education)

Youth Reach Coalition improved local trails

Senior food program sites converted to "choice pantries"

Public officials working to address food dessert issues (e.g., food pharmacy programs through grants and in collaboration with local Indian tribes)

Convenience store "food makeovers" promoting fruits and veggies up front, food banks

Ideas from Focus Groups and Interview Participants

- Offer low-cost meals for seniors at restaurants in the community
- Allow clients to have more choice in food selections through food pantries
- Continue to cultivate youth-led initiatives and civic engagement
- More role models that promote healthy eating and active living (e.g., Michelle Obama)
- Engage the whole family in simple and nutritional meal planning, and eating well within budget
- Diminish economic incentives driving the existence of unhealthy food
- Places to exercise and finding local champions to give the classes, and with options for those with kids (i.e., offer child care), more diverse exercise options (e.g., dance)

1. Center for Applied Research and Environmental Systems. (2012-2015).
2. California Health Interview Survey. (2014).
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4. Dartmouth Atlas of Health Care. (2014).
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Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Housing

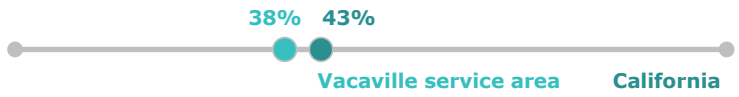
Access to safe, secure, and affordable housing is an important social determinant of health. Families with fewer financial resources are more likely to experience sub-standard housing conditions and the associated risks. The Vacaville service area has a lower proportion of cost-burdened households and a less severe housing problem when compared to the state of California. However, the region reflects clear disparities across race and ethnicity, and a prevalence of individuals and households experiencing homelessness. Focus group and interview respondents provided additional insights; they identified that families of color, older adults, and single parents are most affected by housing issues. Many also noted that housing barriers are escalating within the community, and there is a lack of affordable options across demographics and ages. The closure of shelters, which provide a much needed safety net for many, and diminishing options for low-income families as well as an influx of residents from other regions (e.g., East Bay) have created additional stressors to housing in the community.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Cost-burdened Households (percent) [1]



Severe Housing Problem (percent) [2]

Community Identified Themes

Barriers to Housing

- Affordable housing options below health standards (e.g., multi-family homes)
- Less affordable and Section 8 housing available due to influx of East Bay residents to the region
- Unaffordable and increasing rents
- Lack of sustainable funding streams for local shelters, and recent closure of some shelters

> One of the more negative points, unfortunately, is that while there's a lot of nice places to live in Vacaville, there can also be some really unhealthy places to live. And I think that's something that really needs to be brought to the attention of people who are in authority to make changes.
> *- Focus Group participant*

> Our county's very committed to the Housing First model that even if people have mental health issues, substance abuse issues, homelessness, you have to get them into some aspect of housing.
> *- Service provider*

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

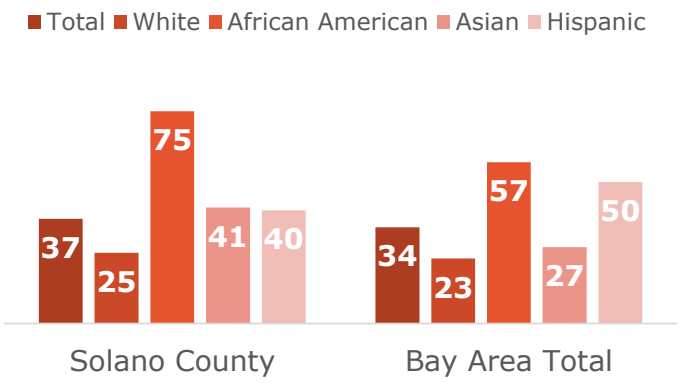
Percentage of individuals by race/ethnicity that spend 30% or more of their income on rent, Solano County [3]

69% Black/African American

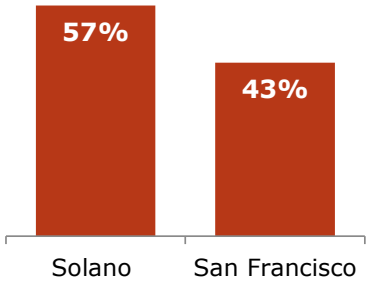
70% American Indian/Alaska Native

> Usually, it is our families of color and our seniors. We did take a look at, statistically, who is being affected by this housing situation, and it is our lower income families, our single parents with children, single moms and children, and our senior citizens; they are the most vulnerable of our community.
> *- Service provider*

Percentage of families with children under 5 years old, paying more than 30% income on housing[4]

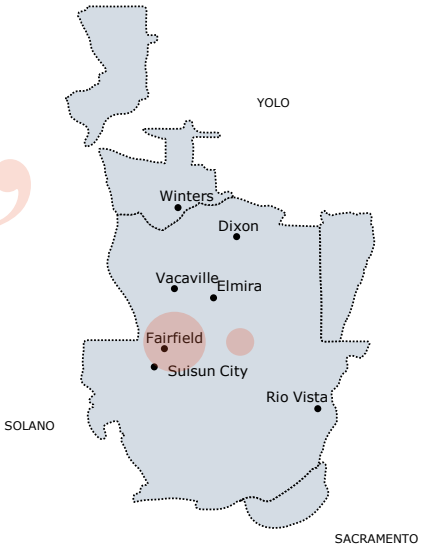


Percent of renters pay 30% or more of their income on rent comparison [3]



Geographic Areas with Greatest Risk

> Homelessness is a big problem in Fairfield. I would say it's escalating,
> *- Service provider*



Cost-burdened households[5]

Roughly a third of Vacaville service area residents spend thirty percent or more of their total household income on housing costs. While this actually fairs better than the state average of 43%—there are several communities in which the **housing cost burden is much worse than the state**. Those communities are largely concentrated **in and around Fairfield** and extending to the **north of the Travis Air Force Base.** Over half of residents are cost-burdened in the following census tracts (circle size indicates the regional extent of disparities):

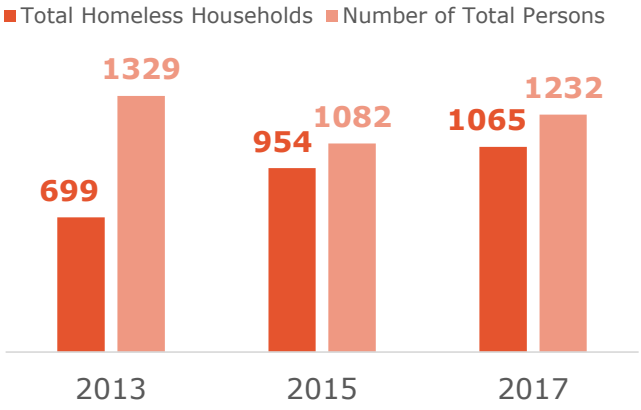
- **Fairfield region: 2526.04, 2526.07, and 2526.11** (Fifty-four to fifty-eight percent of households)
- **North of Travis Air Force Base: 2528.01, 2528.02** (Sixty-four to seventy-five percent* of households)

* Note that Travis Air Force Base region figures may be skewed due to unique income structures of military residents.

Populations Disproportionately Affected

Emerging Needs

Number of households and persons [experiencing homelessness], Solano County [6]



Age at first experience of homelessness (percent), Solano County [7]

58% were 25 years or older

29% were 18-24 years old

13% were 17 years or younger

"We have probably anywhere between **5,000 and 9,000** what I would consider, what our public health officer considers, **situationally homeless.** Meaning they have lost a job, living in a car, couch surfing with relatives, but to me they're still homeless and if you don't tackle *that* population, that chronically homeless population is just **going to grow over the next few years.** Even our staff, we do a lot to assist in terms of rental assistance, finding apartments, or whatever the case may be. Sometimes we have the money, but we don't have units." – Service provider

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- In a focus group with WIC recipients, a community member noted the stark differences in housing standards between high and low income housing.
- Influx of East Bay population to Solano county for more affordable housing opportunities has led to many landlords providing less Section 8 vouchers to pursue fair market rates. Families experiencing homelessness are more likely to live in cars and less likely to accept shelter possibly for fear the family would be separated.
- Increasing rent impacts many residents, including older adults living off of social security benefits.
- Fairfield residents noting that increasing rents have led to the breaking up of their "cute little neighborhood" and impacted their social connections.

"There should be a main [housing] standard for people's health no matter if you have a million dollars, or if you have a hundred.
- Focus Group participant

I came across a 76 year old, African-American female who had lived in her apartment for 25 years and had just been evicted because they went for a market. And then I've come across plenty of other individuals for the same reason."
- Service provider

Assets and Ideas

Examples of Existing Community Assets

Commitment of public officials to "Housing First" model (e.g., tiny home/tough shed initiative, shelters accepting pets, women and children only housing)

Grants dedicated to housing initiatives (e.g., Prop 47)

Opening of medical detox center, and sober living units

Ideas from Focus Groups and Interview Participants

- Rent control, especially in low-income communities
- Continue moving toward a "continuum of housing" model that incorporates housing options for those experiencing mental health or substance abuse issues
- Increase partnerships (corporations, community, local leaders) to create housing options that consider building in social connectedness through large common areas, aesthetically beautiful, comfortable, safe, etc.
- City partnerships with developers to provide affordable or moderate housing, offer tax credits, etc.
- Increase and facilitate opportunities for more civic engagement

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2. Consolidated Planning/CHAS Data. (2011-2015).
3. American Community Survey 5-Year Estimates. (2012-2015).
4. Housing Stability and Family Health: An Issue Brief; Bay Area Regional Health Inequities Initiative (BARHII), Federal Reserve Bank of San Francisco; extra analysis by BARHII and Alameda County Public Health of the American Community Survey PUMS data, (2016).
5. American Community Survey. (2012-2016).
6. Point-In-Time, US Housing and Urban Development, Continuum of Care Assistance Programs, Homeless Populations and Subpopulations, CA-518 Vallejo/Solano County CoC. (2009-2017).
7. Solano County Homeless Point in Time Census & Survey. (2017).

Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Maternal and Infant Health

Mothers in the Vacaville service area face many barriers related to their own well-being and that of their children. Children born in the Vacaville service area (specifically Solano County region) have slightly higher infant mortality rates compared to the state of California. When broken down by race/ethnicity, disparities in infant mortality are starker; children born to women of color are nearly 30 percent more likely to die as infants when compared to their White peers. Mothers in the region struggle with many issues relating to child health and development, including experiencing discrimination within the health system, providing a healthy home life for their young children, and experiencing a lack of options for reproductive health care. Interviewees expressed a need for more services to support mothers. Solano County service providers noted that over the last ten years, health officials and community providers have made a concerted effort to increase prenatal care and have seen an increase in rates over time, especially for the Medi-Cal population.

Key Data

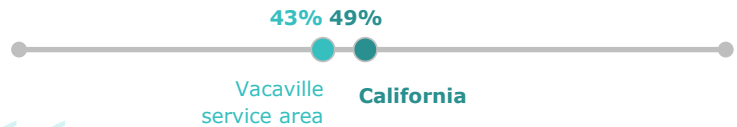
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Life Expectancy at Birth (years of age) [1]

Low Birth Weight (percent) [2]

Preschool Enrollment (percent) [3]



> If children are happy and children are adjusted and they seem like they're doing okay, that to me is a good indicator that they are from a healthy environment and things are going okay.
> *- Service provider*

> Teaching [pregnant women] about good oral health, mental health as well, so that they are taking care of themselves physically and emotionally. And serving the family when they're pregnant so they can continue that when their baby is born.
> *- Service provider*

Community Identified Themes

Barriers to Maternal and Infant Health

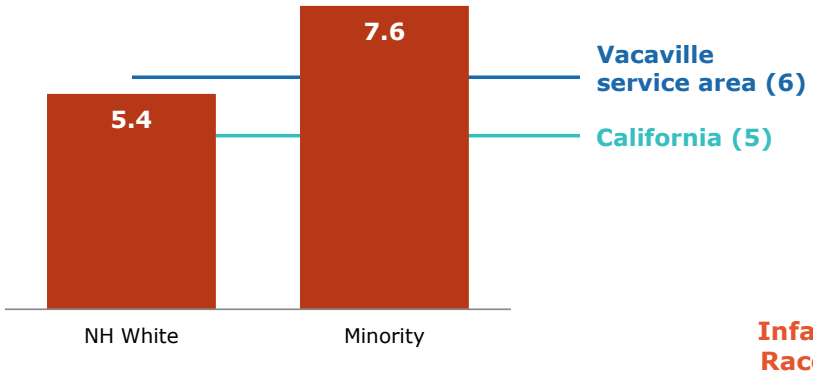
- Unhealthy home life (e.g., drugs, abuse)
- Lack of self-sufficiency of parent
- Discrimination of pregnant women (e.g., low-income, history of past drug use) in health settings
- Lack of reproductive health care services including family planning such as Planned Parenthood (esp. for youth)
- Prevalence of teen pregnancy in high school
- Lack of affordable health care and child care
- Need to commute for work

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Infant Deaths (rate of death per 1,000 births)[4]

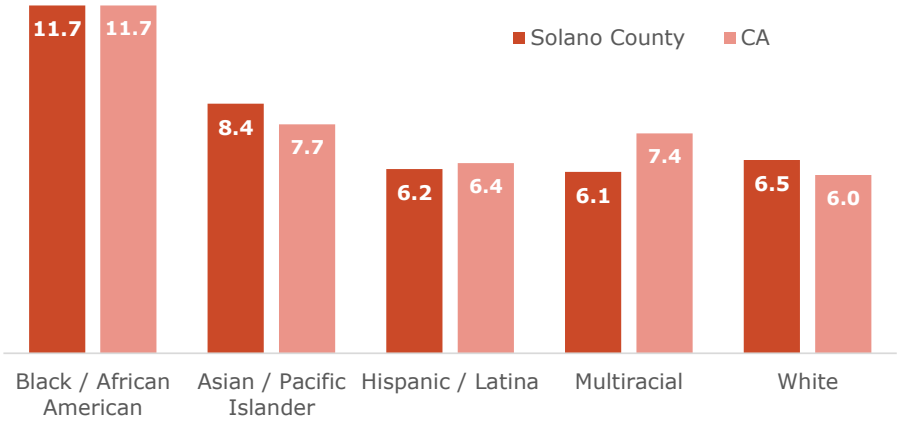


In 2013, infants whose mothers received Prenatal Care in the first trimester [5]

Solano County : CA

79.9% : 83.6%

Infants Born at low Birthweight, by Race/Ethnicity of mother (percent)[6]

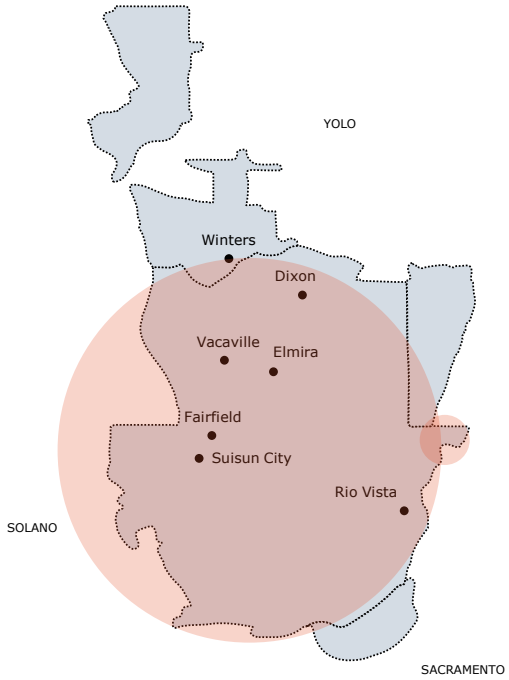


High blood pressure, diabetes ... I think obesity is a health issue, however, we're [as Black women] on a spectrum. We're shaped different. We carry different. But what does that look like in terms of obesity [and when pregnant]?
- Focus Group participant

So the cost of living is becoming more like the rest of the Bay Area and it's really creating issues for people, and we are always concerned that one of the things families struggle with is to pay for child care, and if they don't qualify for one of our programs, there's always that concern that they're going to leave a child home, or leave them with someone who's not safe.
- Service provider

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Rate of death among infants less than 1 year of age per 1,000 births[7]

Solano County's rate of death among infants, **6.1 deaths per 1,000 births**, trails the state average by nearly twenty percent. In close-by Yolo County, also in the Vacaville service area, rates are better than average though still suffer with 3.8 deaths per 1,000 births. (Circle size indicates the regional extent of disparities.)

Infant mortality is a proxy measure for community health status, poverty and socioeconomic status, and access to care.

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Families with children with developmental needs (e.g., autism) face many barriers including funds for medication, access to services, access to schools with inclusion teachers, etc. Many schools have a shortage of trained staff to address these needs.
- Black Infant Health Solano clients mentioned that Black women have different context of health issues (obesity, diabetes, etc.) and often don't find health providers culturally competent to address their health needs.
- Spanish-speaking residents in Fairfield mentioned the high costs of child care, and the need for more affordable options or government support. Other community members added that without affordable child care, kids can be out in adverse situations if staying at other people's homes.
- Throughout Solano County, including Rio Vista, service providers mentioned grandparents raising kids whose parents are incarcerated or abusing drugs—as well as a perceived increase in single parents (both women and men).
- Focus group participants noted that there is some stigma towards those using public assistance, by other community members.

> A nurse came to her [pregnant woman] and said, 'Oh you didn't eat your food. We assumed you came so often because you were homeless and wanted to eat.' So we have comments like that. It just reinforces the idea that I don't wanna seek medical treatment or that you avoid actual medical emergencies based on experiencing conversations like that.
> *- Focus Group participant*

Assets and Ideas

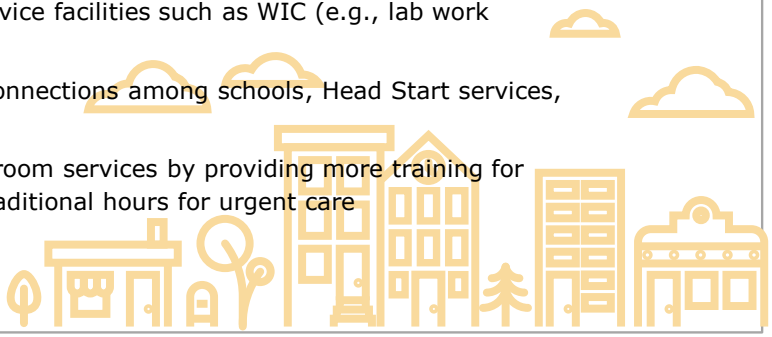
Examples of Existing Community Assets

The California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Public assistance for parents (e.g., CalWORKs)

Ideas from Focus Groups and Interview Participants

- Improve culturally competent care, bedside manner, and recognition of unique context and health needs of different populations
- Increase preventive services such as pre-natal and maternal health supports (e.g., education of mothers early on in pregnancy)
- Increase availability and affordability of reproductive health resources (e.g., free condoms, community clinics, school-based initiatives)
- Better integration of child development services and primary care services to be more convenient for families
- Need after school support systems for low income families
- Integrate more resources into central service facilities such as WIC (e.g., lab work capability to check for anemia)
- More co-location of services and better connections among schools, Head Start services, child care centers
- Prevent inappropriate use of emergency room services by providing more training for young mothers as well as offering non-traditional hours for urgent care



References

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3. American Community Survey. (2012-2016).
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5. Kidsdata.org. (2013).
6. Same as above.
7. Area Health Resource File. (2006-2010).

Kaiser Foundation Hospital – Vacaville service area Community Health Needs Assessment

Violence and Injury Prevention

Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of the Vacaville Service Area have higher rates of domestic violence hospitalizations, injury deaths (intentional and unintentional), and violent crimes compared to the state. Domestic violence hospitalizations are especially pronounced across the Solano County portion of the service area extending into the city of Vallejo. The incidence of violent crimes impacts community safety in many ways. Through interviews and focus groups with local stakeholders, several factors were identified as contributing to the effects of violence and injury, including existing trauma in the community, stress from economic insecurity, competing priorities of families to meet basic needs and support youth, and a lack of safe spaces. Many of these barriers disproportionally affect low-income individuals and people of color. Restorative justice programs are one approach that community leaders are implementing to address these and other disparities.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Violent Crimes (rate per 100,000 population) [1]

Injury Deaths (rate per 100,000 population) [2]

> I've watched these health initiatives for a long time and I think that a lot of it is linked to criminal activity and crime. Particularly when it gets down to how many people are coming to the trauma centers.
> *- Service provider*

> I have to walk all through that shitty neighborhood at the cost of ... fightin' to come to these resources, coming to these groups. I keep tryin' to push myself, to better myself so I can make a change for my children.
> *- Focus Group participant*

Community Identified Themes

Barriers to Violence/Injury Prevention

- Unsafe neighborhoods as a barrier to accessing services
- Lack of supervision of youth, living with a guardian rather than parents
- Gang-related crime
- Insufficient police protection
- Criminal activity continuing outside of trauma centers, and impact on hospital staff
- Service providers lack capacity to support clients who speak non-English languages

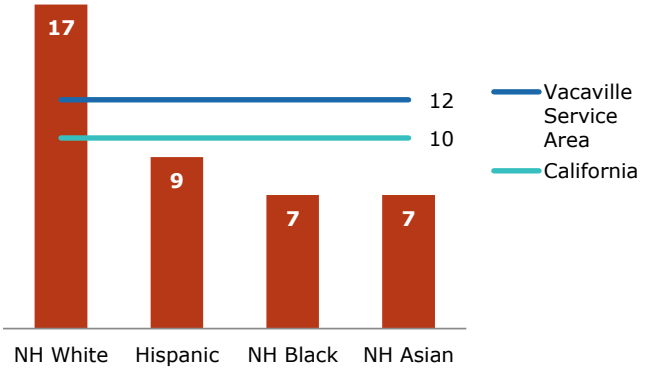
Populations Disproportionately Affected

Populations with Greatest Risk

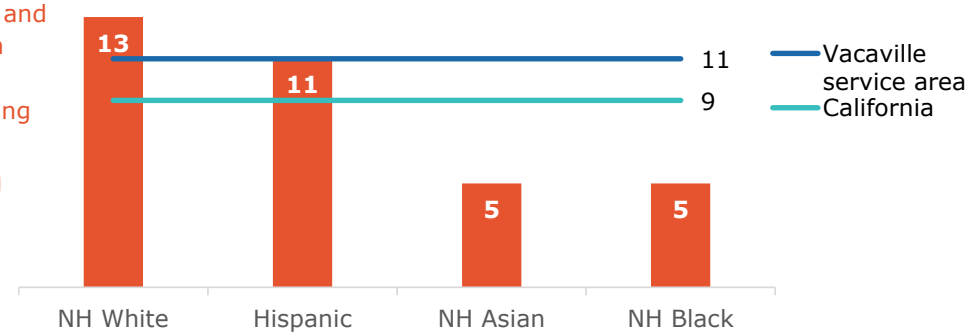
Both parents work at least one or two jobs so that they can maintain, pay their rent, which is really sad. Then, that affects the children. I don't want to blame the parents because they have to survive. Lots of times they're not supervising, especially their teens, effectively; and in the area that they live in, they tend to associate with other teens in the same predicament where they don't have supervision, and many times that's when problems start with substance abuse, or being involved in gangs, etc.

- Service provider

Suicide Deaths (rate per 100,000 population) [3]



Motor Vehicle Crash Deaths (rate per 100,000 population) [4]



Domestic Violence Hospitalization rates (per 100,000 population)[6]

11.4 incidents in **Vacaville service area**

4.9 incidents in **California**

I'd say crime, crime and crime again [as a top health issue]. When a community is unraveled by that, it is unraveled. I've seen that just time and time again that it takes a lot of money and a lot of resource to pull back together.
- Service provider

Percent of Motor Vehicle Crash deaths with alcohol playing a role [7]

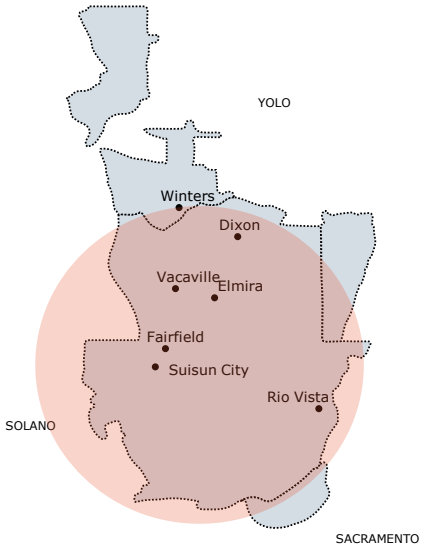
32% **in Vacaville service area**

29% **in California**

[From conversations with inmates] it's who they surround themselves with at a very, very young age that seems to have made a big impact.
- Service provider

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Domestic Violence Hospitalizations[7]

The rate of non-fatal emergency department visits for domestic violence incidents—among females aged 10 years and older—is **most prevalent in the Solano County region** of the Vacaville service area **and extending into the city of Vallejo** at a rate of **11.6 per 100,000 population**. (Circle size indicates the regional extent of disparities.)

This indicator is relevant as a proxy measure of intimate partner and domestic violence, and may signal broader issues in the community, such as economic insecurity and substance misuse.

- Service providers noted that crime has reduced according to police dept. data across the region such as in **Sunset Ave. and Dana Dr.—**however, community members still spoke of feeling unsafe in their communities.

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- A Solano County service provider noted that there is a disproportionately high number of youth of color in the region's juvenile hall. They shared that a greater focus on restorative justice programs for both youth and adults can prevent incarceration.*
- Service providers noted that many inmates are illiterate and have shared that damaging social connections in school led to them abandoning education which fueled their path toward crime.
- Both service providers and other community members emphasized the negative impacts of economic stress and unhealthy home environments on violence and crime. For example, if child care is unaffordable, children are more likely to be left in adverse environments.

> Just the overall vulnerabilities and risk factors of living in a neighborhood that has crime prevalent on some level.
> *- Service provider*

*Conditions that increase the likelihood of involvement with the juvenile justice system include **family poverty**, **separation from family members** including parental incarceration, a **history of maltreatment**, and **exposure to violence.** Youth who have contact with the juvenile justice system are at **increased risk** for a number of negative long-term outcomes, such as **injury, substance use** and dependency, **dropping out of school**, and **early pregnancy**. [8]

Assets and Ideas

Examples of Existing Community Assets

Family Violence Unit that addresses elder abuse, child abuse, sexual assault, and domestic violence—and individual officers that are helpful

Incorporation of restorative justice principles in services for youth and adults (e.g., Center for Positive Change)

Advocates and clinical staff that provide support to victims (e.g., legal aid, support groups, crisis counseling)

Ideas from Focus Groups and Interview Participants

- More economic and community stability, people taking initiative around creating change
- More programs and opportunities for men
- Stronger focus on preventive measures (e.g., education, support programs, mentorship, etc.)

References

1. FBI Uniform Crime Reports. (2012-2014).
2. National Vital Statistics System. (2011-2015).
3. Same as above.
4. Same as above.
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