2022 Community Health Needs Assessment










Kaiser Permanente Walnut Creek Medical Center

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

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Kaiser Permanente Walnut Creek Medical Center 2022 Community Health Needs Assessment

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Kaiser Permanente Walnut Creek Medical Center 2022 Community Health Needs Assessment

Summary

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. For 75 years, Kaiser Permanente has been committed to shaping the future of health and health care — and helping our members, patients, and communities experience more healthy years. We are recognized as one of America's leading health care providers and nonprofit health plans.

Every three years Kaiser Permanente Walnut Creek Medical Center conducts a community health needs assessment (CHNA). The CHNA process is driven by a commitment to improve health equity and is intended to be transparent, rigorous, and collaborative. Our Community Health team has identified and prioritized needs unique to our service area, based on community-level secondary data and input from those who represent the broad interests of the community. Wherever possible, we have applied a racial equity analysis to data collection and analysis.

For the 2022 CHNA, Kaiser Permanente Walnut Creek Medical Center has identified the following significant health needs, in priority order:

1. Access to care
2. Mental & behavioral health
3. Housing
4. Transportation
5. Income & employment

To address those needs, Kaiser Permanente Walnut Creek Medical Center has developed an implementation strategy (IS) for the priority needs it will address, considering both Kaiser Permanente's and the community's assets and resources. The CHNA report and three-year IS are publicly available at https://www.kp.org/chna.

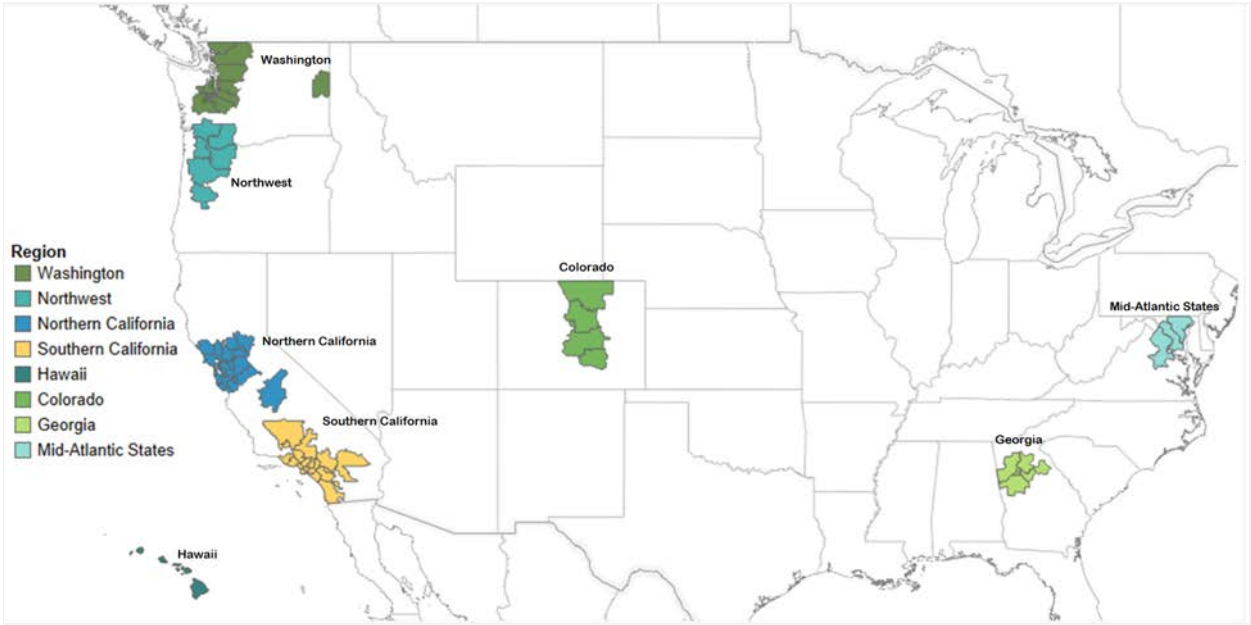
Introduction/background

About Kaiser Permanente

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. For 75 years, Kaiser Permanente has been committed to shaping the future of health and health care — and helping our members, patients, and communities experience more healthy years. We are recognized as one of America's leading health care providers and nonprofit health plans.

Kaiser Permanente is committed to helping shape the future of health care. Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. We currently serve 12.5 million members in 8 states and the District of Columbia. Care for members and patients is focused on their total health and guided by their personal Permanente Medical Group 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.

Kaiser Permanente regions and CHNA service areas



About Kaiser Permanente Community Health

At Kaiser Permanente, we recognize that where we live and how we live has a big impact on our health and well-being. Our work is driven by our mission: to provide high-quality, affordable health care services and to improve the health of our members and our communities. It's also driven by our heritage of prevention and health promotion, and by our conviction that good health is a fundamental right.

As the nation's largest nonprofit, integrated health system, Kaiser Permanente is uniquely positioned to improve the health and wellbeing of the communities we serve. We believe that being healthy isn't just a result of high-quality medical care. Through our resources, reach, and partnerships, we are addressing unmet social needs and community factors that impact health. Kaiser Permanente is accelerating efforts to broaden the scope of our care and services to address all factors that affect people's health. Having a safe place to live, enough money in the bank, access to healthy meals and meaningful social connections is essential to total health. Now is a time when our commitment to health and values compel us to do all we can to create more healthy years for everyone. We also share our financial resources, research, nurses and physicians, and our clinical practices and knowledge through a variety of grantmaking and investment efforts.

As we reflect on how 2020 changed the world, we must recognize that communities everywhere are coping with unprecedented challenges magnified by the COVID-19 pandemic and a renewed struggle for racial equity and social justice.

Through our continued focus on expanding our community health approach we laid the foundation for an acceleration of work to meet the challenges posed by the public health crises we now face. We dedicated ourselves to improving the social health of our 12.5 million members and the millions of people who live in the communities we serve.

Learn more about Kaiser Permanente Community Health at https://about.kaiserpermanente.org/community-health.

Kaiser Permanente's approach to community health needs assessment

The Affordable Care Act (ACA) was enacted in March 2010 to make health insurance available to more people, expand the Medicaid program, and support innovative medical care delivery to lower health care costs. The ACA also requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years and develop an implementation strategy (IS) in response to prioritized needs.

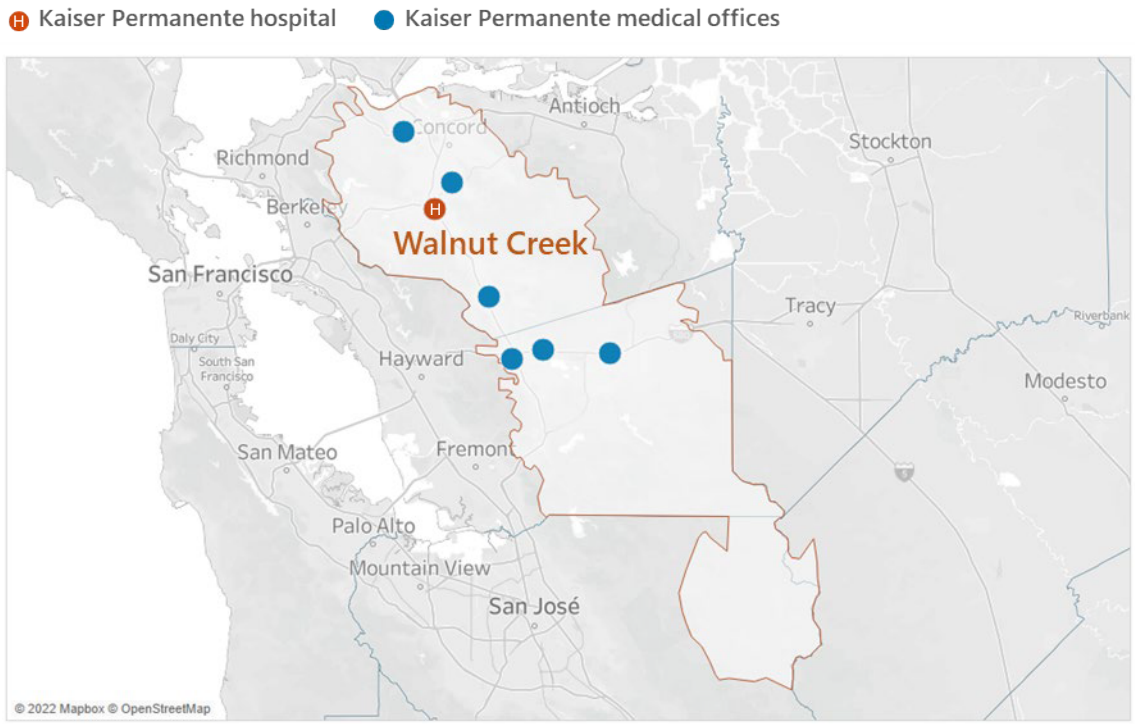
Kaiser Permanente's CHNA process is driven by a commitment to improve health equity. Our assessments place a heavy emphasis on how the social determinants of health — including structural racism, poverty, and lack of access to health-related resources such as affordable housing, healthy food, and transportation — are affecting the health of communities. By analyzing community-level data and consulting individuals with deep and broad knowledge of health disparities, the Community Health team in each Kaiser Permanente service area has identified and prioritized needs unique to the community served. Each service area has developed an IS for the priority needs it will address, considering both Kaiser Permanente's and the community's assets and resources.

The Kaiser Permanente Walnut Creek Medical Center 2022 CHNA report and three-year IS are available publicly at https://www.kp.org/chna. In addition, the IS will be filed with the Internal Revenue Service using Form 990, Schedule H.

Community served

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

Walnut Creek service area



Walnut Creek service area demographic profile

Total population:	777,404
American Indian/Alaska Native	0.2%
Asian	21.0%
Black	2.5%
Hispanic	15.7%
Multiracial	4.4%
Native Hawaiian/other Pacific Islander	0.3%
Other race/ethnicity	0.2%
White	55.5%
Under age 18	22.9%
Age 65 and over	16.2%

Impact of structural racism in our communities

Hundreds of public health departments and other government agencies across the U.S. have declared racism a public health crisis. By structuring opportunity and assigning value based on how a person looks, racism operates at all levels of society and denies many individuals and communities the opportunity to attain their highest level of health. Racism is a driving force in social determinants of health like housing, education, and employment, and is a barrier to achieving health equity.

The inequality and disparities that have existed for people of historically underrepresented groups, such as communities of color, women, and low-income communities, have been made more visible by the COVID-19 pandemic. Data show that Hispanic, Black, and Indigenous populations are disproportionately affected by the disease and its economic impacts. In addition to the health crisis and amplification of existing health disparities, COVID-19 has also brought troubling reports of bias and discrimination against Asian Americans and others.

Since summer 2020, we've witnessed a raising of the consciousness of Americans and the world to a reality that we can no longer ignore: the treatment of Black Americans in our country is unacceptable. This is a moment in time when we must stand together against the racism and social injustice that remain endemic in our society and create long-term trauma that damages individuals' and communities' physical, mental, and social health. By pairing an acknowledgment of history with community-level data, we can work together to address the impacts of racism and discrimination.

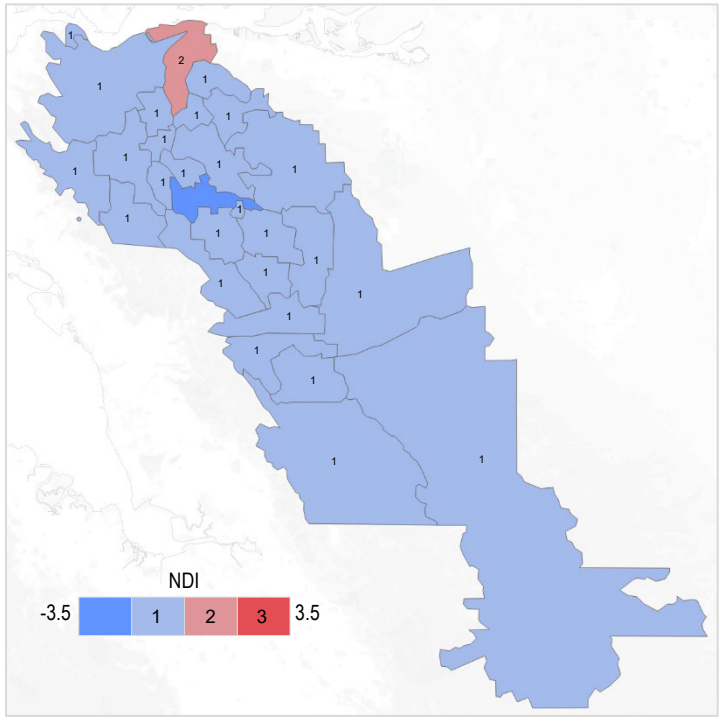
Neighborhood disparities in the Walnut Creek service area

The Neighborhood Deprivation Index (NDI) is a validated scale comprised of several of the social factors associated with lack of opportunity to be as healthy as possible. These measures are proxies for underlying determinants that disproportionately affect communities of color, including lack of employment opportunities, racist policies and practices, and unequal treatment by educational and criminal justice systems.

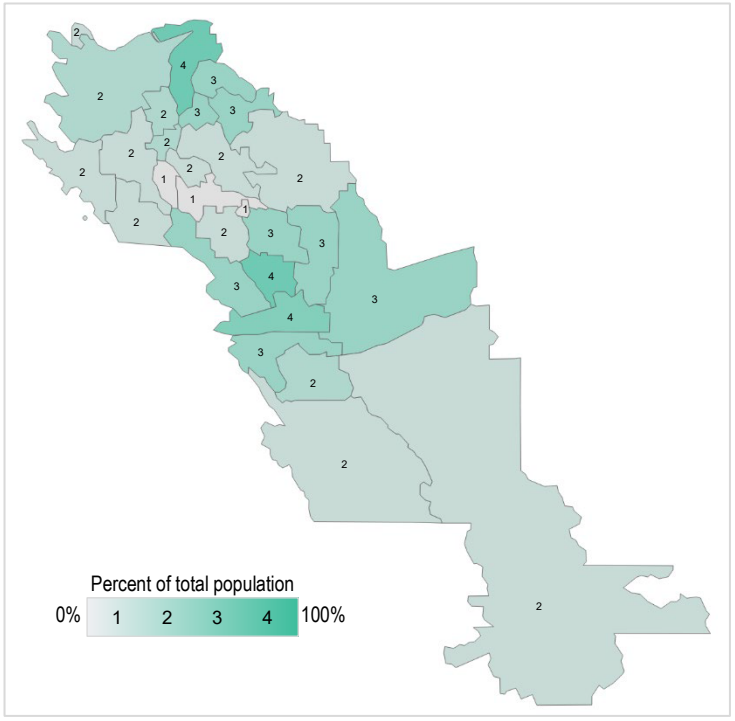
The map on the left shows the NDI for ZIP codes in the Walnut Creek service area. Areas with the highest NDI often are those with the highest proportion of people of color, shown in the smaller map on the right.

WALNUT CREEK SERVICE AREA

Neighborhood Deprivation Index



People of color



Kaiser Permanente's CHNA process

The CHNA process allows Kaiser Permanente to better understand the unique needs, stories, and opportunities to advance health and health equity in each of our communities. We are committed to gathering community perspectives on the disproportionate impacts of the COVID-19 pandemic as well as the impact of structural racism. Wherever possible, we have applied a racial equity analysis to data collection and analysis.

Identifying the highest priority needs for CHNA with an equity lens informs our community investments and helps us develop strategies aimed at making long-term, sustainable change, allowing us to deepen the strong relationships we have with other organizations that are working to improve community health. 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.

Hospitals and other partners that collaborated on the CHNA

Hospitals

John Muir Health, Stanford Health Care – ValleyCare, UCSF Benioff Children's Hospital Oakland

Other organizations

Alameda County Public Health Department, Contra Costa Health Services

Consultants who were involved in completing the CHNA

Applied Survey Research (ASR) is a nonprofit social research firm dedicated to helping people build better communities by collecting meaningful data, facilitating information-based planning, and developing custom strategies. The firm was founded on the principle that community improvement, initiative sustainability, and program success are closely tied to assessment needs, evaluation of community goals, and development of appropriate responses.

Methods used to identify and prioritize needs

Secondary data

Kaiser Permanente's innovative approach to CHNA includes the development of a free, web-based data platform. The data platform provides access to a core set of approximately 100 publicly available indicators to understand health using the County Health Rankings population health framework, which emphasizes social and environmental determinants of health. The data platform is available to the public at kp.org/chnadata. Specific sources and dates of secondary data are listed in Appendix A.

Community input

In addition to reviewing the secondary data available through the Community Health Data Platform and other local sources, each Kaiser Permanente service area collected primary data through key informant interviews with individuals and groups of individuals. To identify issues that most impact the health of the community, Kaiser Permanente Fresno Medical Center Community Health reached out to local public health experts, community leaders with expertise on local health needs, and individuals with knowledge and/or lived experience of racial health disparities. If

available, insights from community partners' data collection were also considered in the assessment of needs. For a complete profile of community input, see Appendix B.

Written comments

Kaiser Permanente provides the public an opportunity to submit written comments on the service area's previous CHNA reports through CHNA-communications@kp.org. This email will continue to allow for written community input on the service areas' most recently conducted CHNA report.

As of the time of this CHNA report development Kaiser Permanente Walnut Creek Medical Center had not received written comments about the previous CHNA report. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Kaiser Permanente Walnut Creek Medical Center staff.

Identifying priority health needs

Each Kaiser Permanente service area analyzed and interpreted the primary and secondary data and used a set of criteria to determine what constitutes a health need in the community, including severity and magnitude of the need and evidence of clear disparities or inequities. Once all the community health needs were identified, they were prioritized, based on the criteria, resulting in a list of significant community health needs.

In conjunction with this report, Kaiser Permanente Walnut Creek Medical Center has developed an implementation strategy (IS) for the priority health needs it will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The IS will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the IS will be posted publicly on our website, https://www.kp.org/chna.

Identification and prioritization of the community's health needs

Process for identifying community needs in the Walnut Creek service area

Before beginning the prioritization process, Kaiser Permanente Walnut Creek Medical Center Community Health chose a set of criteria to use in prioritizing the list of health needs:

- **Severity and magnitude of need:** Includes how measures compare to national or state benchmarks, relative number of people affected, impact of the pandemic on the need.
- **Community priority:** The community prioritizes the issue over other issues
- **Clear disparities or inequities:** Differences in health factors or outcomes by geography, race/ethnicity, economic status, age, gender, or other factors

Measures in the Community Health Data Platform were clustered into 16 potential health needs, which formed the backbone of a prioritization tool to identify significant health needs in each service area. The prioritization tool aligned data collection methods with the set of criteria and could be customized to reflect important considerations in each community.

For secondary data, a score was assigned to each need (4: very high, 3: high, 2: medium, 1: lower) based on how many measures were more than 20 percent worse than national and/or state benchmarks. Themes from key informant interviews and other data sources were identified, clustered, and assigned scores on the same scale. Both the data platform and primary data informed scores for geographic, racial/ethnic, and other disparities.

In conversations with Kaiser Permanente Walnut Creek Medical Center Community Health stakeholders, each data collection method was assigned a weight, based on rigor of the data collection method, relative importance in ranking of needs (such as clearly identified racial disparities), and other considerations. Weighted values for each potential need were summed, converted to a percentile score for easy comparison, and then ranked highest to lowest to determine the five significant health needs.

Description of prioritized significant health needs in the Walnut Creek service area

1. Access to care: Access to comprehensive, quality health care services — including having insurance, local care options, and a usual source of care — is important for ensuring quality of life for everyone. The Walnut Creek service area outperforms California and Contra Costa County across many measures of access to care, such as the percent of insured adults and children. However, some indicators of inadequate care such as rates of preterm birth and the likelihood of death from COVID-19 are higher for Black residents. As of October 2021, Black residents of the Walnut Creek service area had disproportionately higher rates of COVID-19 cases and deaths compared with the Walnut Creek service area overall. Key informants noted the challenges of accessing medical services when transportation is needed, the costs of medical insurance, and disproportionate access to services for people of color.

2. Mental & behavioral health: Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities. Mental and behavioral health outcomes tend to look better overall in the Walnut Creek service area compared to the rest of Contra Costa County, though not for all racial and ethnic groups. White residents of the Walnut Creek service area have the highest rates of deaths of despair, suicide death, and opioid overdose death compared with the rates for other racial and ethnic groups in the Walnut Creek service area. Key informants expressed a lot of concern for mental and behavioral health among youth in the Walnut Creek service area, noting an uptick in youth suicidal ideation and attempts. Informants reported long wait times to get an appointment with a mental health provider and the delays are even longer if someone is seeking a Spanish-speaking therapist.

3. Housing: Having a safe place to call home is essential for the health of individuals and families. The median rental cost is higher across the Walnut Creek service area when compared with the state of California, as is the median income of the region. High measures of housing burden, such as overcrowded housing, tend to concentrate in the center of the service area, including some neighborhoods with higher Hispanic populations. The ZIP code with the highest proportion of Hispanic residents has the highest rate of overcrowded housing, where a home has more people than rooms. Key informants noted specific populations most affected by homelessness in the Walnut Creek service area as those over 60-years-old, foster youth, and the LGBTQ population.

4. Transportation: People are healthier in communities that are walkable, bikeable, and transit-oriented. Transportation presents a major barrier, especially for those in the workforce attempting to commute to work. Long commutes—greater than 60 minutes alone, each way —impact residents of all racial and ethnic groups. The Walnut Creek service area had higher rates of residents with long commutes than the state or the nation. Key informants reported challenges with accessing public transportation, such as the time it takes to get to places. During the COVID-19 pandemic, public transportation was scaled back, making it even harder for residents to commute to their jobs or get to medical appointments.

5. Income & employment: Economic opportunity provides individuals with jobs, income, a sense of purpose, and opportunities to improve their economic circumstances over time. Residents in the Walnut Creek service area have higher than average income earnings, lower rates of poverty, and lower unemployment rates compared to the rest of California. Still, a breakdown of measures such as median income by racial and ethnic group points to the presence of disparity. Some ZIP codes with relatively higher proportions of Hispanic residents have drastically lower median incomes. The unemployment rate also tends to be higher in Hispanic neighborhoods. Key informants shared that wages do not match the high cost of living in the area.

Health need profiles

Detailed descriptions of the significant health needs in the Walnut Creek service area follow.

Health need profile: Access to care

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Access to comprehensive, quality health care services — including having insurance, local care options, and a usual source of care — is important for ensuring quality of life for everyone.

The Affordable Care Act (ACA) helped extend insurance coverage to many previously uninsured individuals and families, especially in Medicaid expansion states. Still, families with low income and people of color are more likely to be uninsured, and even with the ACA, many find insurance to be unaffordable.

Health insurance coverage increases use of preventive services and helps ensure people do not delay seeking medical treatment. Having an adequate number of primary care resources in a community also is important, including federally qualified health centers (FQHCs), which serve patients regardless of ability to pay.

Insurance by itself does not guarantee access to appropriate care, and many community members experience barriers related to language, transportation options, and differential treatment based on race, as well as access to fewer health care resources.

Furthermore, the COVID-19 pandemic has disrupted health care for millions of Americans as health care resources were diverted from primary and preventive care, with telehealth becoming an increasingly important source of care. Existing racial and health inequities have been brought to light by the pandemic, with people of color accounting for disproportionate shares of COVID-19 cases, hospitalizations, and deaths.

The Walnut Creek service area outperforms California and Contra Costa County across many measures of access to care, such as the percent of insured adults and children.[1] However, some indicators of inadequate care such as rates of preterm birth[2] and the likelihood of death from COVID-19[3] are higher for Black residents.

- Of all live births in the Walnut Creek service area 2016-2020, 4.7 percent were born with low birth weight. This rate is nearly double (9 percent of all live births) for Black infants in the Walnut Creek service area (see table below).[2]
- As of October 2021, Black residents of the Walnut Creek service area had disproportionately higher rates of COVID-19 cases (8,133 per 100,000 people) and deaths (219 per 100,000 people) compared with the Walnut Creek service area overall, with 5,584 cases per 100,000 people and 77 deaths per 100,000 people.[3]

Access to health care in the Walnut Creek service area is a “super need” according to key informants. When accessing medical services that require transportation, those who use public transportation describe long, inconvenient travel times and needing to take significant time off work to get to an appointment. Additional barriers mentioned by the informants were the costs of medical insurance and care for those without medical insurance. Those with Medi-Cal report long wait times for specialty care, waiting as long as six months as recounted by one informant.

Specific populations, noted by the informants, that disproportionally experience issues when accessing health care included:

- people of color who live in pockets of poverty where access to services is an issue,
- those that are monolingual non-English speaking who do not have access to forms and translators in their language,
- people who are LGBTQ that are being mistreated and misgendered,
- people with undocumented status, afraid they will be deported if they go to the doctor, and
- residents of the Tri-Valley in need of dental care, especially children, needing general anesthesia who must travel outside the area for such services.

> [LGBTQ] end up hurting themselves for not being heard (e.g., putting off appointments that shouldn’t be because their identities aren’t being affirmed or they’re treated differently for their identity).
>
> – Nonprofit organization leader

To address barriers to accessing services, the informants suggested health care providers partner with trusted leaders (e.g., faith-based) to build trust. Additionally, they recommended health care organizations hire providers that mirror the population as well as increase provider cultural humility.

Since physical access was an issue, the informants suggested bringing satellite sites or mobile health vans into communities that do not have clinics nearby.

While some residents appreciated the switch to virtual visits and found them to be more convenient, the informants noted that not everyone has access to a computer with internet for appointments or virtual visits. They shared that others, especially some older adults, do not feel comfortable using a computer and thus other in-person options need to be available.

> Livermore has more of the low-income, monolingual Spanish-speaking, and farm worker communities. They totally lack health equity across the board. There is no health system out there that supports them and who they are. [Hospitals] would have to do a lot of outreach and engagement to get the trust of these [low-income, monolingual Spanish-speaking] communities.
>
> – Nonprofit organization leader

> Language serves as a barrier for some (e.g., having access to forms written in their preferred language or having translators). I continue to see that burden of young people serving as translators. And sometimes due to citizenship status, opting out not to get health care.
>
> – Nonprofit organization leader

PRETERM BIRTH AND LOW BIRTH WEIGHT RATE, WALNUT CREEK SERVICE AREA, 2016-2020

Values in red (*) are more than 20% higher than the Walnut Creek service area rate; values in blue (†) are more than 20% lower.

	Preterm birth	Low birth weight
Contra Costa County	7.4%	5.5%
Walnut Creek service area	6.5%	4.7%
Black	**9.1%***	**8.8%***
Asian	**7.8%***	**7.1%***
Hispanic	6.6%	4.7%
White	5.5%	**3.4%†**

Age-adjusted rates per 100,000 population; data not available for all population groups
Source: Contra Costa Health Services, California Comprehensive Birth & Death Files

[1] American Community Survey, 2015-2019
[2] Contra Costa Health Services, California Comprehensive Birth & Death Files, 2016-2020
[3] Contra Costa Health Services, CalREDIE and CAIR2, October 2021

Health need profile: Mental & behavioral health

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Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities.

Anxiety, depression, and suicide ideation are on the rise due to the COVID-19 pandemic, particularly among Black and Hispanic Americans.

Those facing challenges related to lower economic opportunity often experience high levels of stress in their daily lives, coupled with fewer resources for coping. Children and youth experiencing stress have an increased likelihood of poorer mental and physical health.

Deaths of despair — those due to suicide, drug overdose, and alcoholism — are on the rise, and males, American Indian/Alaska Native people, and those who are unemployed are at greater risk.

Communities across the country are experiencing a critical lack of capacity to meet the increased demand for mental health services. At the same time, rapid adoption of digital platforms for behavioral health services has helped reduce barriers to in-person mental health care.

Contra Costa County, which contains part of the Walnut Creek service area, has more mental health providers (423 per 100,000 people) than other regions of the state of California (352 per 100,000 people) and the nation (247 per 100,000 people).[1] Mental and behavioral health outcomes tend to look better overall in the Walnut Creek service area compared to the rest of Contra Costa County, though not for all racial and ethnic groups.[2]

White residents of the Walnut Creek service area have the highest rates of deaths of despair (31 per 100,000 people), suicide death (11 per 100,000 people), and opioid overdose death (8.9 per 100,000 people) compared with the rates for other racial and ethnic groups in the Walnut Creek service area. These rates for white residents are also higher than Contra Costa County overall (see table below).[2]

Key informants expressed a lot of concern for mental and behavioral health among youth in the Walnut Creek service area. Numerous informants mentioned an uptick in youth suicidal ideation and attempts. Other populations the informants highlighted as having increased and unmet mental and behavioral health needs were older adults, unhoused, undocumented, and LGBTQ communities.

The informants described many barriers to accessing mental and behavioral health services. They highlighted the stigma associated with seeing a therapist. In addition, there are long wait times to get an appointment with a mental health provider and delays are even longer if someone is seeking a Spanish-speaking therapist. Also, the informants noted that there are very few therapists in the Tri-Valley area.

The COVID-19 pandemic and shelter-in-place orders increased residents' need for mental and behavioral health care. The informants described the stress and anxiety people felt due to fears of getting sick, losing their job, and/or being isolated.

> This [mental health] is a huge issue from the young ones, middle schoolers, high schoolers, and beyond. We see parents that are really traumatized for their kids. They are seeing their kids being very depressed, reclusive, afraid to go out, suicidal.
>
> – Nonprofit organization leader

The informants stated the importance of bringing mental health services into the communities, via mobile mental health units or school wellness centers. Those familiar with the local education system said there was a need for more counselors at schools. Others noted the need for long-term residential mental health facilities.

> It is very frustrating for children, adults, people of all ages who are always on waiting lists because there are not enough Spanish-speaking therapists.
>
> – Hispanic focus group participant

DEATHS OF DESPAIR, SUICIDE, AND OPIOID OVERDOSE DEATHS WALNUT CREEK SERVICE AREA, 2016-2020

Values in red (*) are more than 20% higher than the Walnut Creek service area rate; values in blue (†) are more than 20% lower.

	Deaths of despair	Suicide	Opioid overdose
Contra Costa County	30.2	9.5	7.1
Walnut Creek service area	25.4	9.2	6.2
White	**31.0***	**11.0***	**8.9***
Hispanic	23.1	**5.2†**	5.4
Asian	**9.0†**	**5.4†**	*NA*

Age-adjusted rates per 100,000 population; data not available for all population groups
Source: Contra Costa Health Services, California Comprehensive Birth & Death Files

[1] CMS National Provider, 2019
[2] Contra Costa Health Services, California Comprehensive Birth & Death Files, 2016-2020

Health need profile: Housing

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Having a safe place to call home is essential for the health of individuals and families.

American families' greatest single expenditure is housing, and for most homeowners, their most significant source of wealth. Because of historic discriminatory lending policies and some current lending practices, people of color — especially Black community members — have been denied the opportunity to purchase a home, leading to enduring inequities.

Housing costs have soared in recent years, with many families experiencing difficulty paying for housing. Black and Hispanic renters in particular are more likely to live in cost-burdened households and face housing instability. Job loss associated with the COVID-19 pandemic, coupled with expiration of the federal eviction moratorium, has made many renters' situation even more precarious.

Homelessness across the U.S. was on the rise before the pandemic, including for families with children. In 2020, the number of single adults living outdoors exceeded the number living in shelters for the first time. Even more moved outside because of the pandemic, leading to a crisis in street homelessness in many American cities.

The median rental cost is higher across the Walnut Creek service area when compared with the state of California, as is the median income of the region. High measures of housing burden, such as overcrowded housing, tend to concentrate in the center of the Walnut Creek service area, including some neighborhoods with higher Hispanic populations.[1]

- Between 2015 and 2019, the median rental cost for the Walnut Creek service area was $2,237, 32 percent higher than the California state rate of $1,689.[1]
- ZIP code 94520 has the highest rate of overcrowded housing, where a home has more people than rooms. It also has the highest rate of Hispanic residents (55 percent) relative to other ZIP codes in the Walnut Creek service area (see figure below).[1]

Key informants agreed that affordable housing is a critical and unmet need. They noted the high cost of living in the Walnut Creek service area. They also spoke about how there is limited affordable housing and new affordable housing is expensive to build.

The informants commented on the link between housing and other needs such as income and employment, mental and behavioral health, and substance abuse. They spoke about the hierarchy of needs and when people are worried about paying for housing, their health care "goes to the bottom of the list".

Housing and homelessness is also connected to other factors such as COVID-19 and fire season. The informants mentioned that multiple families may live in one home, and with the COVID-19 shelter-in-place orders, it increased the spread of COVID-19 amongst family members. Likewise, if people need to evacuate due to local fires, more residents may be displaced and at increased risk of COVID-19 if they go into a shelter with others. One informant noted, "Without shelter, populations that are already vulnerable are more vulnerable."

Specific populations the informants noted as being most affected by homelessness in the Walnut Creek service area are those over 60-years-old, foster youth, and LGBTQ population.

> It's so overwhelming for people and the team here [Central Contra Costa County]. It's homelessness, violence, poor nutrition. It's all these things. Wraparound services are so needed, and people don't have the wherewithal to go to multiple places to get things done.
>
> – Nonprofit organization leader

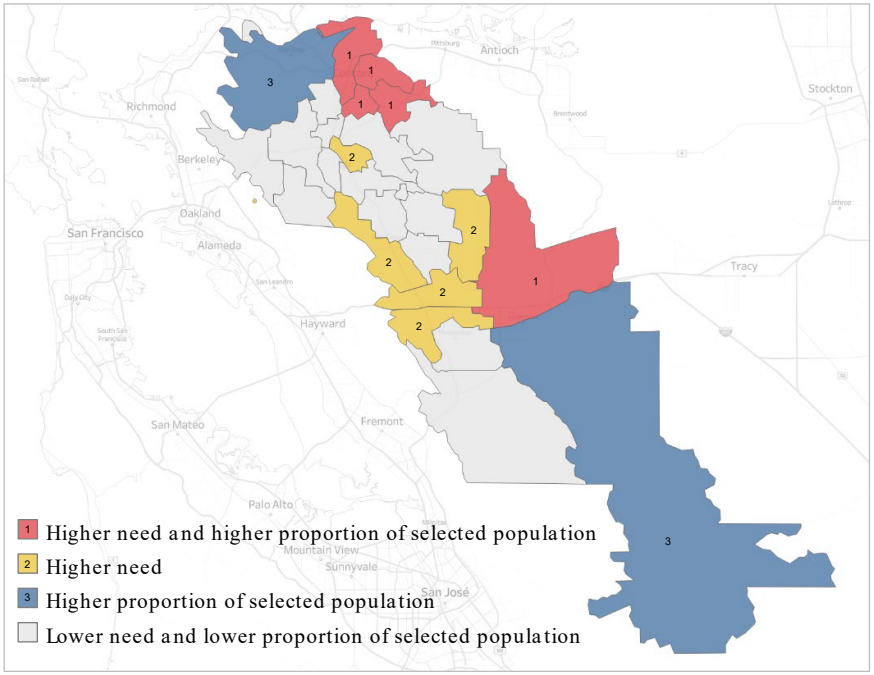
To address housing and homelessness in the Walnut Creek service area, the informants said the issue needs to be viewed holistically. Temporary shelters and permanent housing need to be created that include wrap-around services such as mental health, employment, and substance abuse services.

The informants spoke about how the temporary eviction moratorium has been a huge help for many people and they are concerned about it ending. They suggested that lobbying is needed to change policies, such as getting rental assistance checks to keep people housed and extending the eviction moratorium.

> I can't stress enough how we need to create sustainable housing. People in the suburbs and east (i.e., Livermore) are house poor, in fragile health and isolated. People [who] can't pay taxes on their home are behind on paying their mortgage and when they lose assets, they lose everything. The magnitude of the crisis is huge.
>
> – Nonprofit organization leader

OVERCROWDED HOUSING, WALNUT CREEK SERVICE AREA, 2015-2019

Areas shaded red (1) are ZIP codes with a higher **Hispanic** population and a higher overcrowded housing rate relative to other ZIP codes in the Walnut Creek service area. Additional areas of high overcrowded housing rates are shaded yellow.



Source and Notes: *Kaiser Permanente Community Health Data Platform*

[1] American Community Survey, 2015-2019

Health need profile: Transportation

People are healthier in communities that are walkable, bikeable, and transit-oriented. Yet many urban and suburban neighborhoods lack sidewalks, safe crossings, and consistent access to affordable public transit, and people with lower incomes are more likely to be transit-insecure.

Those who rely on public transit to access health care services often face long travel distances and wait times for connections, leading to missed appointments.

The U.S. transportation system relies largely on motorized transportation, with numerous implications for health. Nearly three-quarters of workers living in Kaiser Permanente communities drive alone to work.

The health impacts of heavy dependence on automobiles include air pollution, traffic crashes, and physical inactivity. In cities such as Portland, Oregon, Black residents experience higher rates of traffic-related fatalities, including those caused by motorists failing to yield to Black pedestrians in a crosswalk.

Having a lower income and lacking reliable transportation are both associated with prescription medication nonadherence. When limited access to public transit is combined with lack of safety promoting infrastructure, such as protected bike lanes and streets free of potholes, people without their own cars can feel trapped by an inability to get around.

Transportation presents a major barrier, especially for those in the workforce attempting to commute to work. Long commutes—greater than 60 minutes alone, each way —impact residents of all racial and ethnic groups (see figure below). Out of all residents 16 or older in the Walnut Creek service area, 17 percent drive to work alone with a commute of longer than 60 minutes, one way. This rate is higher than the rate of long commutes for California (11 percent) and the nation (8 percent).[1]

Key informants reported that public transportation in the Walnut Creek service area is also a barrier, as bus stops and BART stations are not easily accessible, and it takes a long time for riders to get to the places they want to go. According to the informants, there is a perception that public transportation is not clean or safe. They shared that transportation is more of a barrier for people with lower incomes, people with disabilities, older adults, people in the Tri-Valley, and people of color.

During the COVID-19 pandemic this was all made worse as public transportation was scaled back. The informants explained the communities that struggled with transportation before the pandemic, and relied on it the most, were the most impacted by the reduction in public transportation. In addition, residents were afraid of catching COVID-19 on public transportation. These factors made it difficult for residents to commute to their jobs or get to medical appointments.

> People in East County [Tri-Valley] usually have to travel, and some people do not have access to transportation in order to access health care. For low-income communities and communities of color, transportation and travelling to a site is a barrier. Older adults are also struggling with transportation.
>
> – Nonprofit organization leader

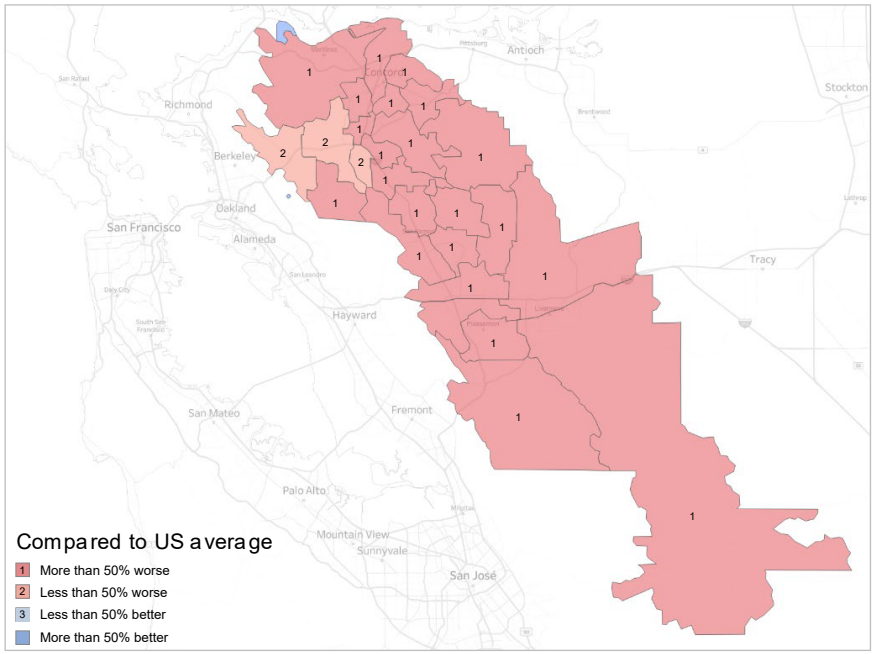
The informants suggested investing in creative transportation alternatives, such as granting taxi vouchers to nonprofit organizations, thus helping clients get to their organization or other needed services. They also recommended more collaboration between medical offices and transportation to increase coordination and make the systems more efficient.

People were a lot more afraid to take public transportation because of the exposure. Even when they wanted to, I've had friends who've cancelled their appointments because they did not want to risk being out in the public.

– Older adult focus group participant, Central Contra Costa County

COMMUTE ALONE >60 MIN, WALNUT CREEK SERVICE AREA, 2015-2019

Areas shaded red (1) are ZIP codes with a higher solo, long commute rate relative to other ZIP codes in the Walnut Creek service area.



Source and Notes: Kaiser Permanente Community Health Data Platform

Health need profile: Income & employment

KAISER PERMANENTE®

Economic opportunity provides individuals with jobs, income, a sense of purpose, and opportunities to improve their economic circumstances over time.

People with steady employment are less likely to have an income below poverty level and more likely to be healthy.

Currently around 11 percent of people living in Kaiser Permanente communities — and 14 percent of children — live in poverty. Those not having enough resources to meet daily needs such as safe housing and enough food to eat are more likely to experience health-harming stress and die at a younger age.

Americans with lower incomes are more likely to live in neighborhoods lacking access to healthy food and safe physical activity and have higher exposure to environmental pollutants. Compared to white Americans, those who identify as Black, Hispanic, or American Indian are more likely to have lower incomes, fewer educational opportunities, and shorter life expectancies.

Income inequality has been increasing over recent decades. During the first year of the COVID-19 pandemic, higher levels of economic inequality were associated with higher levels of COVID incidence and deaths.

Residents in the Walnut Creek service area have higher than average income earnings,[1] lower rates of poverty,[1] and lower unemployment rates[2] compared to the rest of California. Still, a breakdown of measures such as median income by racial and ethnic group points to the presence of disparity.[1]

- While median income for the Walnut Creek service area was $142,000, some ZIP codes with a relatively high rate of Hispanic residents have drastically lower median incomes, such as ZIP code 94520 which has a median income of $61,000, less than half the Walnut Creek service area rate.[1]
- The unemployment rate for the Walnut Creek service area, as of 2020, was 13 percent. It tends to be higher in Hispanic neighborhoods and geographically around the city of Concord. ZIP codes 94520 and 94519 both reported the unemployment rate of 17 percent (see figure below).[2]

There was consensus among key informants that income and employment in the Walnut Creek service area is getting worse. The informants spoke about wages that do not match the high cost of living in the area. They shared that families are weighing the costs of working and paying child care against collecting unemployment benefits, and are opting more for unemployment. In addition, residents, especially those in the Tri-Valley area, must commute long distances (sometimes hours long) to get to a job. COVID-19 has made the situation worse with more job loss, and increased homelessness, domestic violence, and mental health needs.

The informants reported that there are income and employment inequities for certain communities. For example, they described the Monument Corridor area of Concord as having more people with lower income and a primarily Hispanic neighborhood. According to the informants, the LGBTQ communities, especially transgender youth, face discrimination when applying for jobs. In addition, informants noted that entry-level jobs for young people don't usually come with health benefits, forcing them to pay out of pocket for health insurance or to opt out of seeking medical care entirely. They described how COVID-19 disproportionately impacted the health and income of these already vulnerable communities.

> COVID pandemic laid bare and amplified and worsened the pre-existing reality that Black/Brown and lesbian/gay, elders, the people suffering before pandemic, just got crushed by the pandemic.
>
> – Nonprofit organization leader

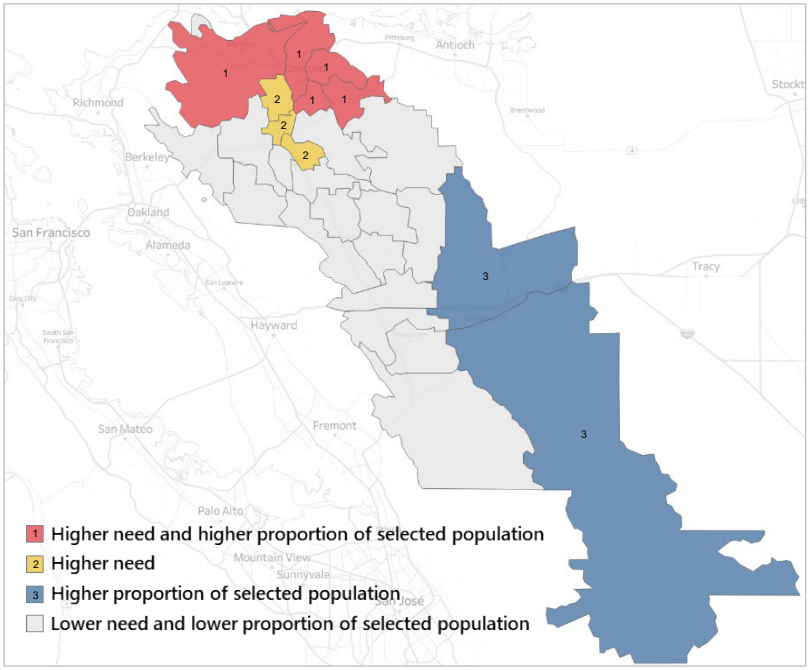
The informants expressed concern about people not being connected with job training. They wanted more job training opportunities, especially for people of color. They advocated for additional programs with case management to refer people to job training as well as housing, food, and other needs and services. Many informants felt that universal basic income was a solution to address economic disparities.

I'd be working 12 hours a day, 13, 14 hours a day and then commuting three hours each way, so that's like a 20-hour day. I did that for six years and it almost killed me.

– Formerly unhoused focus group participant

UNEMPLOYMENT RATE, WALNUT CREEK SERVICE AREA, 2020

Areas shaded red (1) are ZIP codes with a higher **Hispanic** population and a higher unemployment rate relative to other ZIP codes in the Walnut Creek service area. Additional areas of high unemployment rates are shaded yellow.



Source and Notes: *Kaiser Permanente Community Health Data Platform*

[1] American Community Survey, 2015-2019

[2] Esri Demographics, 2020

Community resources potentially available to respond to health needs

The CHNA process included an identification of existing community assets and resources to address health needs. The Walnut Creek service area includes community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations that address many community health needs.

Key resources available to respond to the identified health needs of the community are listed in Appendix C.

Kaiser Permanente Walnut Creek Medical Center 2019 Implementation Strategy evaluation of impact

In the 2019 IS process, all Kaiser Permanente service areas planned for and drew on a broad array of resources and strategies to improve the health of our communities, such as grantmaking, in-kind resources, and partnerships, as well as several internal Kaiser Permanente programs including Medicaid, the Children's Health Insurance Program (CHIP) and other government-sponsored programs, charitable health coverage, medical financial assistance, health professional training, and research. In addition to our direct spend, we also leveraged assets from across Kaiser Permanente to help us achieve our mission to improve the health of communities. This comprehensive approach includes activities around supplier diversity, socially responsible investing, and environmental stewardship.

Kaiser Permanente Walnut Creek Medical Center's 2019 Implementation Strategy (IS) report identified activities to address significant health needs prioritized in the 2019 CHNA report. The impact of those activities is described in this section; the complete 2019 IS report is available at https://www.kp.org/chna.

Kaiser Permanente Walnut Creek Medical Center 2019 Implementation Strategy priority health needs

1. Health care access and delivery
2. Behavioral health
3. Economic security

2019 Implementation Strategy evaluation of impact by health need

Grants to community-based organizations are a key part of the contributions Kaiser Permanente makes each year to address identified health needs, and we prioritize work intended to reduce health disparities and improve health equity. Kaiser Permanente also serves the community through programs to improve access to care, including Medicaid, charitable health coverage, and medical financial assistance. At the time this CHNA report was completed, Kaiser Permanente Walnut Creek Medical Center Community Health had information on the impact of these activities from 2020 and 2021 and will continue to monitor strategies implemented in 2022.

Kaiser Permanente Walnut Creek Medical Center addresses community health needs in multiple ways, including grantmaking, access to care programs, and socially responsible investing. Several of those activities during 2020-2021 are highlighted in the table below.

Additionally, the Kaiser Permanente Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives. During 2020-2021 a portion of money managed by this foundation was used to award 11 grants totaling $851,330 in service of 2019 IS health needs in the Walnut Creek service area.

One example of a key accomplishment in response to our 2019 IS includes support for food distribution programs that provide nutritious foods to low-income families and individuals and outreach and enrollment campaigns to increase CalFresh enrollment for eligible community members to

address food insecurity. Food insecurity has been a rising concern throughout COVID-19. The Food Bank of Contra Costa and Solano (FBCCS) was able to pivot services during the pandemic to ensure that food distribution continued to reach individuals and families in need. FBCCS will ensure that all students receiving CalFresh or free and reduced-price meals are also receiving Pandemic EBT (Electronic Benefits Transfer) supplemental benefits, host CalFresh trainings for community partner organizations, including schools, and distribute 910,900 pounds of produce and shelf-stable foods to 8,200 students at Central and East Contra Costa partner schools.

As the health and economic toll of COVID-19 continued to mount, Kaiser Permanente accelerated efforts to broaden the scope of our care and services to address all factors that affect people's health. For example, in 2020 Kaiser Permanente provided grants totaling $6.3 million to strengthen COVID-19 prevention and response for people experiencing homelessness across our regions and service areas. In 2021, Kaiser Permanente continued to play a critical leadership role in responding to the evolving needs of our members and community during the pandemic. For example, Kaiser Permanente allocated $225,000 in the Walnut Creek Medical Center Area to deploy grassroots strategies to increase uptake in COVID-19 vaccines among communities disproportionately impacted by the pandemic, remove barriers to access, and address misinformation about vaccine safety and efficacy. With its $95,000 grant, Contra Costa Health Services trained and deployed COVID-19 Adult Ambassadors to act as trusted messengers within the Black and Hispanic communities in East and Central Contra Costa, with a goal of reaching 10,000 individuals.

Kaiser Permanente Walnut Creek Medical Center 2019 IS priority health needs and strategies

Health care access and delivery

Care and coverage: Kaiser Permanente Walnut Creek Medical Center ensures health access by serving those most in need of health care through Medicaid, the Children's Health Insurance Program (CHIP) and other government-sponsored programs, charitable health coverage, and medical financial assistance.

	Individuals served		Amount	
	2020	2021	2020	2021
Medicaid, CHIP and other government-sponsored programs	11,659	13,558	$11,814,159	$3,434,399
Charitable Health Coverage	101	87	N/A	$383
Medical Financial Assistance	6,296	5,077	$5,610,162	$5,004,484
Total care & coverage	18,056	18,722	$17,424,321	$8,439,266

Other health care access and delivery strategies: During 2020-2021, 26 grants were awarded to community organizations, for a total investment of $542,746 to address health care access and delivery in the Walnut Creek service area.

Examples and outcomes of most impactful other strategies

Connecting Families to Health Care

La Clinica de La Raza, Inc. was awarded $25,000 to increase outreach and enrollment in East and Central Contra Costa County. The program is expected to serve about 1,260 individuals through presentations, tabling, one on-one health care navigation support in utilizing health care services, as well as connect participants to social services as needed during this public health crisis.

COVID-19 Adult Ambassadors

Contra Costa County was awarded $95,000 to increase vaccination rates among the communities hardest hit by the pandemic. The program is expected to serve about 10,000 individuals by addressing inequitable access barriers that prevent timely vaccination.

Core Support for Safety Net Health Services

Axis Community Health was awarded $25,000 to ensure the ongoing delivery of essential care to low-income and uninsured patients who reside in the Tri-Valley area of Eastern Alameda County. The program is expected to serve about 75 individuals by ensuring access to care for patients, particularly during this pandemic time when there is pent-up need for health services.

Behavioral health

During 2020-2021, 15 grants were awarded to community organizations, for a total investment of $261,442 to address behavioral health in the Walnut Creek service area.

Examples and outcomes of most impactful strategies

Mentes Positivas En Accion

Monument Impact was awarded $25,000 to teach skills and practices to reduce and manage stress and anxiety, positively impacting entire families while breaking down the stigma associated with mental health. The program is expected to serve about 30 individuals by delivering five - 8 week sessions of Mentes Positivas en Accion to Latinx community members in Central and East Contra Costa County who are experiencing anxiety, stress and/or depression.

Parent Outreach Coordinator

Livermore Valley Joint Unified School District (LVJUSD) was awarded $25,000 to support the ongoing Coordination of Services Team (COST) and family engagement around mental health and access to care, including COVID-19. The program is expected to serve about 2,500 individuals by working with LVJUSD staff and outside partners to support the mental health and well-being, removing barriers to service, increasing physical activity, COVID-19 support, and staff well-being at the two schools.

Economic security

During 2020-2021, 34 grants were awarded to community organizations, for a total investment of $818,733 to address economic security in the Walnut Creek service area.

Examples and outcomes of most impactful strategies

2021-22 Food Bank Food for Life and Thriving Schools Partnership Program

Food Bank of Contra Costa and Solano was awarded $50,000 over 2 years to help ensure food-insecure individuals have access to the healthy food their bodies need, regardless of their ability to pay. The program is expected to serve about 22,330 individuals by providing healthy food to students through school-based programs to target short-term food insecurity, while connecting eligible individuals with government assistance programs such as CalFresh, WIC, and Pandemic EBT in order to help reduce food insecurity in the long-term.

Quality Jobs & Careers in Contra Costa
Rubicon Program**s** was awarded $100,000 over 2 years to help individuals with barriers to employment in East and West Contra Costa County prepare for employment, apply for jobs, secure employment, and thrive at work. The program is expected to serve about 550 individuals by helping them prepare for employment, apply for jobs, secure employment, and thrive at work.
Built for Zero Accelerator Project
Contra Costa Health Services was awarded $95,000 to bring on a temporary consultant (Improvement Advisor) to support implementing improvement processes, creating measurable goals, and tools over a 6-12 month period. The role will serve about 1,570 individuals experiencing unsheltered homelessness and help ensure that the system is set up to best serve and measure outcomes of that population over time.

Appendix

A. Secondary data sources

B. Community input

C. Community resources

Appendix A: Secondary data sources

Kaiser Permanente Community Health Data Platform

	Source	Dates
1.	American Community Survey	2015 - 2019
2.	Behavioral Risk Factor Surveillance System	2020
3.	CDC, Interactive Atlas of Heart Disease and Stroke	2016 - 2018
4.	Center for Medicare & Medicaid Services	2018
5.	CMS National Provider Identification	2019
6.	Dept of Education ED Facts & state data sources	Varies
7.	EPA National Air Toxics Assessment	2014
8.	EPA Smart Location Mapping	2013
9.	Esri Business Analyst	2020
10.	Esri Demographics	2020
11.	FBI Uniform Crime Reports	2014 - 2018
12.	Feeding America	2018
13.	FEMA National Risk Index	2020
14.	Harvard University Project (UCDA)	2018
15.	HRSA Area Resource File	2019
16.	HUD Policy Development and Research	2020
17.	National Center for Chronic Disease Prevention and Health Promotion	2018
18.	National Center for Education Statistics	2017 - 2018
19.	National Center for Health Statistics	2018
20.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
21.	NCHS National Vital Statistics System	2015 - 2019
22.	NCHS US Small-area Life Expectancy Estimates Project	2010 - 2015
23.	NCI State Cancer Profiles	2013 - 2017
24.	NCI United States Cancer Statistics	2013 - 2017
25.	NHTSA Fatality Analysis Reporting System	2014 - 2018
26.	US Geological Survey; National Land Cover Database	2016
27.	USDA Food Environment Atlas	2016

Additional secondary data sources

	Source	Dates
1.	Contra Costa Health Services	2016-2021
2.	California Health Interview Survey (CHIS)	2020
3.	California Healthy Kids Survey (CHKS)	2017-2019
4.	Bay Area Equity Atlas	2019

Appendix B. Community input

	Data collection method	Affiliation	Number	Perspectives represented	Role	Date
1	Key Informant Interview	Association of Bay Area Governments (ABAG)	1	Older adults and transit-riding adults	Leader	8/4/2021
2	Key Informant Interview	Abode Services	1	People experiencing homelessness in the Bay Area	Leader	8/20/2021
3	Key Informant Interview	Alameda County Transportation Commission	1	Transit-reliant and transit-riding populations in Alameda County	Leader	7/14/2021
4	Key Informant Interview	Greenlining	1	Communities of color	Leader	8/12/2021
5	Key Informant Interview	Asian Health Services	1	Asian, Pacific Islander residents and families	Leader	8/20/2021
6	Key Informant Interview	Contra Costa County Employment and Human Services	1	Older adults and persons with disabilities	Leader	8/17/2021
7	Key Informant Interview	Contra Costa Health Services - Health Care for the Homeless	1	Individuals and families experiencing homelessness	Representative	8/6/2021
8	Key Informant Interview	CoCoKids	1	Youth from lower income families, especially from Hispanic and Black neighborhoods, monolingual Spanish-speakers	Leader	8/4/2021
9	Key Informant Interview	Community Clinic Consortium/Alameda Health Consortium/La Clinica de la Raza	2	Medi-Cal recipients, individuals and families with lower income, Hispanic populations	Leaders, Representative	8/18/2021
10	Key Informant Interview	Contra Costa County Transportation Commission	2	Public transit riders	Leader, Representative	8/17/2021
11	Key Informant Interview	Contra Costa Family Justice Center	1	Survivors of domestic violence	Leader	8/9/2021
12	Key Informant Interview	Day Break Adult Day Center & Alameda County Age-friendly Coalition	2	Older adults	Leaders	8/3/2021
13	Key Informant Interview	Department of Conservation and Development	1	Older adults, people with disabilities, and public transit riding adults	Leader	8/5/2021
14	Key Informant Interview	East Bay Asian Local Development Corporation (EBALDC)/Berkeley Food and Housing Project/Bay Area Community Services (BACS)	3	Residents experiencing or at the risk of homelessness	Leaders	8/24/2021

	Data collection method	Affiliation	Number	Perspectives represented	Role	Date
15	Key Informant Interview	Eden Housing Resident Services, Inc.	1	Older adults with lower incomes, families, and persons with disabilities	Representative	8/17/2021
16	Key Informant Interview	Ensuring Opportunity	1	Residents with lower income	Representative	8/19/2021
17	Key Informant Interview	Food Bank of Contra Costa & Solano	1	Food insecure adults and families	Leader	7/16/2021
18	Key Informant Interview	Fred Finch Youth Center & Lincoln	5	Youth, especially Hispanic and Black youth	Leader, Representatives	7/29/2021
19	Key Informant Interview	Health Care Services Agency (HCSA) Homeless and Coordination & Everyone Home	2	Residents experiencing homelessness	Leader, Representative	8/19/2021
20	Key Informant Interview	Healthy Richmond	1	Communities of color, immigrant communities, and individuals and families with lower incomes	Representative	8/3/2021
21	Key Informant Interview	Horizon Services, Project Eden	1	Youth with substance use disorders	Representative	8/13/2021
22	Key Informant Interview	Latina Center	1	Hispanic parents, children, survivors of domestic violence, older adults	Leader	8/16/2021
23	Key Informant Interview	Livermore VJUSD	2	School-aged youth (K-12)	Leader, Representative	8/27/2021
24	Key Informant Interview	Loaves & Fishes of Contra Costa	1	Food insecure residents	Leader	8/11/2021
25	Key Informant Interview	Monument Crisis Center	1	Food insecure, especially families and older adults	Leader	8/25/2021
26	Key Informant Interview	NAMI	2	Families and residents impacted by mental illness	Leaders	7/30/2021
27	Key Informant Interview	Ombudsman/Empowered Aging	1	Older adults in residential care and skilled nursing facilities	Leader	8/23/2021
28	Key Informant Interview	Open Heart Kitchen	1	Food insecure adults, older adults, and children	Leader	7/22/2021
29	Key Informant Interview	Partnership for Trauma Recovery	1	Refugees and asylum seekers	Leader	8/18/2021
30	Key Informant Interview	Rainbow Community Center	1	LGBTQI+ youth, adults, and older adults	Leader	8/20/2021

	Data collection method	Affiliation	Number	Perspectives represented	Role	Date
31	Key Informant Interview	Rubicon	1	Adults and parents with children experiencing unemployment and underemployment	Leader	7/26/2021
32	Key Informant Interview	Shelter Inc	2	Unhoused individuals and families or those at-risk of becoming homeless, including veterans and domestic violence survivors	Representatives	8/5/2021
33	Key Informant Interview	Side by Side (TAY)	1	Transitional Age Youth	Representative	8/31/2021
34	Key Informant Interview	SparkPoint	3	Residents with lower income, especially people of color, including Asian, South Asian, Indian, Hispanic, and women of color	Representatives	8/6/2021
35	Key Informant Interview	Contra Costa County Behavioral Health	6	Residents with disabilities and older adults	Leader, Representatives	8/19/2021
36	Key Informant Interview	STAND!	1	Survivors of domestic violence, youth	Leader	8/18/2021
37	Key Informant Interview	Tri-Valley Haven	2	Survivors of domestic violence	Leaders	8/4/2021
38	Key Informant Interview	Unity Council	1	Food insecure or unemployed adults, children, and older adult populations	Leader	9/1/2021
39	Focus Group	Central Contra Costa County residents, conducted by Contra Costa County Health Services	2	Black community	Members	9/29/2021
40	Focus Group	Central Contra Costa County residents, conducted by Contra Costa County Health Services	10	Hispanic community	Members	9/23/2021
41	Focus Group	Central Contra Costa County residents, conducted by Contra Costa County Health Services	9	Older adults (65 and over)	Members	9/28/2021
42	Focus Group	Tri-Valley community residents, conducted by Alameda County Public Health Department	9	Older adults (65 and over)	Members	9/24/2021
43	Focus Group	Tri-Valley community residents, conducted by Alameda County Public Health Department	9	Formerly unhoused	Members	10/6/2021

Appendix C. Community resources

Identified need	Resource provider name	Summary description
Multiple needs	Contra Costa Health Services	Our mission at CCHS is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems. https://cchealth.org/
Access to care	La Clínica de la Raza	The mission of La Clínica de La Raza is to improve the quality of life of the diverse communities we serve by providing culturally appropriate, high-quality, and accessible health care for all. https://laclinica.org/
	Axis Community Health	The mission of Axis Community Health is to provide quality, affordable, accessible and compassionate health care services that promote the well-being of all members of the community. www.axishealth.org
Housing	Shelter, Inc.	The mission of SHELTER, Inc. is to prevent and end homelessness for low-income, homeless, and disadvantaged families and individuals by providing housing, services, support, and resources that lead to self-sufficiency. www.shelterinc.org
Income & employment	Alameda County Community Food Bank	Alameda County Community Food Bank passionately pursues a hunger-free community. Alameda County Community Food Bank — Feeding America's 2016-2017 Food Bank of the Year — has been at the forefront of hunger relief efforts in the Bay Area since 1985. http://www.accfb.org
	Food Bank of Contra Costa and Solano	Food Bank of Contra Costa and Solano leads the fight to end hunger, in partnership with our community and in service of our neighbors in need. http://www.foodbankccs.org
Mental & behavioral health	Contra Costa Crisis Center	The mission of Contra Costa Crisis Center is to keep people alive and safe, help them through crisis, and provide or connect them with culturally relevant resources in the community. To this end, we operate Contra Costa County's 24-hour crisis, suicide, grief, homeless, child abuse, and elder abuse hotlines; we answer all local calls to the National Suicide Prevention Line. http://www.crisis-center.org
Transportation	Mobility Matters	Mobility Matters provides mobility management services in Contra Costa County facilitation collaboration and coordination between public and private transportation providers creating a network of integrated options that primarily address the mobility needs of seniors, individuals with disabilities, and low-income individuals. www.mobilitymatterscc.com