2023 Community Health Needs Assessment

Washington Hospital Healthcare System

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1. EXECUTIVE SUMMARY

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The Patient Protection and Affordable Care Act (ACA) enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) every three years. The CHNA must be done by the last day of a hospital's taxable year, and hospitals must make the CHNA report widely available to the public. The CHNA must also gather input from experts in public health, local health departments, and the community. The community must include representatives of minority, low-income, medically underserved, and other vulnerable populations.

California Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Department of Health Care Access and Information (HCAI), formerly the Office of Statewide Health Planning and Development (OSHPD), that shall include, but not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals shall describe the process by which they involved community groups and local government officials in helping identify and prioritize the needs to be addressed. This community needs assessment shall be updated at least once every three years.[1] Per California Assembly Bill 1204, enacted in 2021, the community must include vulnerable populations, including the unhoused, people with disabilities, LGBTQ, medically underserved, low-income, of a minority population, or those with limited English proficiency.[2]

The 2023 CHNA is the fourth such assessment completed since the ACA was enacted. It builds upon the information and understanding that resulted from previous assessments. The latest CHNA process, completed in fiscal year 2023 and described in this report, was conducted by Washington Hospital Healthcare System ("Washington Hospital") in compliance with current legal requirements. This report was adopted by Washington Hospital's governing body, the Washington Township Health Care District Board of Directors, on May 10, 2023.

PROCESS AND METHODS

Washington Hospital began the current CHNA cycle in 2022. The hospital's goal was to gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the summer and fall of 2022 through key informant interviews with local health and community experts, focus groups with community leaders and representatives, and focus groups with community residents.

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[1] California Office of Statewide Health Planning and Development. (1998). Not-for-profit hospital community benefit legislation (Senate Bill 697), Report to the Legislature. Retrieved November 2019 from https://oshpd.ca.gov/wp-content/uploads/2018/07/SB-697-Report-to-the-Legislature-Community-Benefit.pdf

[2] California Legislative Information. (2021). AB-1204 Hospital equity reporting. Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1204

Secondary data were obtained from a variety of sources. Secondary data were available for Alameda County and for the three separate major cities in Washington Hospital's primary service area: Fremont, Newark, and Union City. The service area also includes unincorporated Sunol and a small part of southern Hayward, for which data were not available. Secondary data were gathered in fall and winter of 2022–2023.

In early 2023, community health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. The results of the prioritization appear below.

For the purposes of this assessment, Washington Hospital did not limit the definition of "community health" to traditional measures of health. Instead, the definition included indicators about the physical health of the area's residents, as well as the broader social and environmental determinants of health, such as access to healthcare, affordable housing, child care, education, and employment. This more inclusive definition reflects Washington Hospital's view that many factors affect community health, and it is essential to consider these factors to adequately understand and address community health needs.

PRIORITIZED HEALTH NEEDS

The previously described prioritization process produced a ranked list of the most pressing community health needs for the hospital's primary service area. Two needs, Diabetes & Obesity, and Heart/Stroke, tied for fourth place. All eight needs, listed in priority order (from highest to lowest), are:

- **Behavioral Health.** The community considered behavioral health a strong priority. The lack of access to behavioral health services and facilities was cited, pandemic isolation was a big concern, and parents expressed concern about alcohol and drug use. Statistics support CHNA participants' concerns: Depression-related feelings and alcohol/drug use are higher than the county among most Union City students as well as some Fremont and Newark students. Adult binge drinking and 7th grade binge drinking are both worse in Newark than the county overall.
- **Housing & Homelessness.** The cost of housing in the Bay Area is extremely expensive, and the community identified this as one of the most pressing health needs. Because housing is difficult to afford, community members described seeing more people struggling with other living expenses. The number of homeless people in Alameda County has increased in the last two years, a trend also seen in Fremont and Union City. In Fremont and Union City, the proportion of the population that is unsheltered is worse than in the county. We also know that some populations, especially Black residents, are overrepresented in the homeless population.
- **Economic Security.** Community input about economic security made up the highest proportion of discussion after healthcare access and delivery. The community described the high cost of living, and difficulty securing employment for individuals with health issues, disabilities, or those experiencing homelessness. The community described a sharp rise in food insecurity in summer 2022. While most data indicators, including multiple measures of poverty and income, were favorable for service area cities, data showed inequities by race. Overall, most BIPOC populations have lower incomes than their counterparts and higher proportions of their populations who are living in poverty.
- **Diabetes & Obesity.** The community expressed the need for access to healthy food and nutrition education. They also called out the need for recreation/fitness programs and more safe

spaces to recreate in their neighborhoods. This category met the threshold for a health need because of the statistical data; the proportions of children who are overweight are higher in Newark and Union City than in the county and state overall. Notably, the rates of adults with diabetes are worse in all three service area cities, and rates of diabetes ED visits and hospitalization are an issue in Fremont and Newark. Also, there are inequities by race for adult obesity and adults with diabetes.

- **Heart/Stroke.** Cerebrovascular issues such as stroke, heart disease, and heart attack are among the top causes of death in the county. The community did not discuss heart and stroke issues specifically, but did call out the need for recreation programs and nutritional education. Statistical data shows that service area cities fare worse than the county overall. In Union City, residents have worse rates than other service area cities and the county for emergency department visits (stroke, hypertension, and heart failure), hospitalizations (heart disease, hypertension), and mortality (acute myocardial infarction, heart disease, and ischemic heart diseases).
- **Healthcare Access & Delivery.** Access to healthcare and the experiences of receiving care were dominant in community input. Residents described difficulties affording health care, even for those who are insured, and a lack of adequate health care facilities in the service area. In terms of data, local statistics fare well compared to the county, including the proportion of insured residents, recent physical and dental visits, and access to internet at home. However, there are notable inequities: Pacific Islanders have lower rates of adult health insurance than their peers. Several populations have more difficulty obtaining care compared to all county residents: Native American, white, and multiracial.
- **Respiratory Health.** Statistical data for adult asthma and COPD both indicate that Union City does worse than the county overall in respiratory health. While COVID-19 is an undeniable respiratory health condition that has impacted service area cities, the community did not prioritize it over other needs.
- **Cancer.** Cancer qualifies as a health need because of racial and ethnic disparities. The overall cancer incidence rate in Assembly District 20 (AD20, an area analogous to Washington Hospital's service area) is worse than that of Alameda County overall. Overall cancer incidence is also higher for white, Black, and Latina/o residents of AD20 than residents of the county overall. Compared to the county, colorectal cancer incidence is worse for most AD20 residents except Asian/Pacific Islanders. Black residents of AD20 have a higher incidence of prostate cancer than county residents. Latina/o residents of AD20 have a higher incidence of pancreatic cancer than county residents. Finally, white residents of AD20 have higher incidence of female breast cancer, lung cancer, and melanoma than county residents.

For additional details, including statistical data and citations, see *Section 6: 2023 Prioritized Community Health Needs* and *Attachment 2: Secondary Data Tables*.

NEXT STEPS

After making this CHNA report publicly available by July 1, 2023, Washington Hospital will solicit feedback and comments about the report until two subsequent CHNA reports have been posted.[3] The hospital will also develop an implementation plan based on the CHNA results.

[3] https://www.whhs.com/about-us/community-connection/community-health-needs-assessment/

2. BACKGROUND

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT PURPOSE

The goals of the 2023 Community Health Needs Assessment (CHNA) are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, Washington Hospital Healthcare System ("Washington Hospital") will develop strategies to tackle critical health needs as well as improve the health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts.

The 2023 CHNA builds upon the findings of the 2020 CHNA (see below for evaluation of 2021–2023 implemented strategies) and previous assessments conducted by Washington Hospital. The 2023 report documents how the current CHNA was conducted and describes the related findings. As with prior CHNAs, this assessment also highlights the district's assets and resources (see *Section 7: Community Resources*).

Note that, for the purposes of this assessment, "community health" was not limited to traditional health measures. Washington Hospital considered indicators relating to the quality of life (e.g., access to healthcare, affordable housing, food security, education, and employment) and to the physical, environmental, and social factors that influence the health of the county's residents. This broader definition reflects the hospital's philosophy that many factors affect community health and that community health cannot be adequately understood without consideration of trends outside the realm of healthcare.

In addition to helping generate shared priorities around community health, Washington Hospital also used the 2023 CHNA to fulfill key state and federal mandates.

AFFORDABLE CARE ACT REQUIREMENTS

Enacted on March 23, 2010, the Affordable Care Act (ACA) provides guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a community health needs assessment every three years. The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. Final requirements were published in December 2014. The federal definition of community health needs comprises the social determinants of health and morbidity and mortality. This broad definition is indicative of a wider focus on both upstream and downstream factors that contribute to health. Such an expanded view presents opportunities for nonprofit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health, including social determinants.

Beyond providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, the ACA created more incentives for healthcare providers to focus on prevention of disease by including lower or no co-payments for

preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

SB 697 AND CALIFORNIA'S HISTORY OF ASSESSMENTS

California Senate Bill 697, enacted in 1994, requires private nonprofit hospitals to conduct a community needs assessment and to consult with the community on a plan to address their identified needs. An assessment must be conducted every three years. Hospitals are also required to submit an annual report to the California Department of Health Care Access and Information, HCAI (formerly the Office of Statewide Health Planning and Development, OSHPD) that describes the strategies that hospitals have engaged in to address the identified community needs. Per California Assembly Bill 1204, enacted in 2021, the community must include vulnerable populations, including people with disabilities, those with limited English proficiency, or those who are unhoused, LGBTQ, medically underserved, low-income, or of a minority population.[4]

The 2023 CHNA meets both state and federal requirements.

BRIEF SUMMARY OF THE PRIOR (2020) CHNA CONDUCTED

In 2018–2019, Washington Hospital collaborated with 14 local hospitals in Alameda and Contra Costa counties to assess community health needs. The 2020 CHNA report is posted on the Community Health Needs Assessment page of the hospital's website.[5]

The community health needs identified and prioritized through the 2020 CHNA process were:

- Behavioral Health
- Housing and Homelessness
- Healthy Eating/Active Living
- Healthcare Access and Delivery
- Social Determinants of Health
- Diabetes, Heart Disease, Hypertension, and Stroke
- Respiratory Health

EVALUATION FINDINGS FROM 2021–2023 IMPLEMENTED STRATEGIES

Washington Hospital addressed all of these critical community health needs in subsequent years through targeted programs and community partnerships. It also addressed cancer, which was not one of the identified needs from the 2020 CHNA but which is one of the top causes of death in Alameda County.[6] At the time this report was completed, Washington Hospital had impact results for fiscal years 2021 and 2022. Although not reflected herein, the hospital will continue to monitor and report the impact of strategies implemented in 2023.

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[4] California Legislative Information. (2021). AB-1204 Hospital equity reporting. Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1204

[5] https://www.whhs.com/about-us/community-connection/community-health-needs-assessment/

[6] California Department of Public Health. (2019). *Alameda County Health Status Profile.*

Behavioral Health

- The Washington Hospital Wellness Center hosted a monthly women's support group, Women Empowering Women. Three of these support group meetings focused on behavioral health topics, with an average of 14 participants at each meeting.
- Washington Township Medical Foundation provided onsite presentations at Ardenwood Elementary School for National Mental Health Awareness Month. Presentations were given to 10 classrooms of students in grades 1-6.
- Washington Hospital provided two in-person seminars on "Grief, Loss and Self Care" to local retirement communities. 40 adults attended.
- Washington Hospital's Maternal and Child Health Department hosted the BlueDot Walk to help raise awareness for Maternal Mental Health. 71 individuals participated.
- Washington Hospital hosted a virtual Health & Wellness Seminar on "Self-Care and Compassion". This presentation received 656 virtual views on Facebook and YouTube.
- Since 2021, Washington Hospital convenes a monthly "South County Partnership" meeting with representatives from healthcare organizations, city and county services, and non-profit organizations. These meetings focus on local mental health challenges and encourage collaboration between sectors to address community needs.
- Working in collaboration with Fremont Police Department and Fremont Human Services Department, Washington Hospital provides a social worker as part of a multidisciplinary team that brings comprehensive and compassionate care to community members with mental illness where they live. The Mobile Evaluation Team (MET) responds to calls for service in the field by offering case management services that connect clients with resources and educate them on programs and services.
- Washington Hospital collaborated with City of Fremont on Cities for Opportunity, a pilot project to identify frequent users of Emergency Department resources that could benefit from connection to county behavioral health services. Washington Hospital is currently exploring how to fully integrate this program after the end of the pilot period.
- Washington Township Medical Foundation expanded outpatient and inpatient behavioral health services. For outpatient care, staff expanded to two psychiatrists and one Licensed Marriage and Family Therapist. For inpatient care, one of our psychiatrists provided inpatient psychiatric consults for admitted patients and those with emergency needs.
- Washington Hospital is currently working with the Alameda County Behavioral Health Services Department to host space for a new behavioral health clinic. This clinic is set to open in late 2023/early 2024.

Housing and Homelessness

- Washington Hospital participates in the Tri-City Collaborative on Homelessness. The task force tracks community concerns, focuses efforts on the greater needs of the community, facilitates collaboration of homeless services and resources throughout the area. Meetings occur quarterly.
- Washington Hospital provides general grant funding to Abode Services, the largest homeless housing and service provider in the Bay Area. In addition, Washington Hospital has a staff representative on Abode Services Board of Directors.

Healthy Eating/Active Living

- Washington Hospital hosted two sports safety presentations for local youth athletic teams and coaches. 103 individuals attended.
- Washington Hospital hosted 19 free, virtual seminars focused on healthy eating and active living. These presentations included cooking and fitness demonstrations. More than 11,726 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital presented 7 on-site health seminars on Healthy Eating and Active Living to local senior living communities. Topics included fall prevention, joint replacement, and easy ways to stay active as you age. 178 adults attended these presentations.
- Washington Sports Medicine athletic trainers hosted first aid stations during 4 Special Olympics tournaments. The mission of Special Olympics is to provide athletic competition in a variety of Olympic-type sports for youth with intellectual disabilities. 986 student athletes attended these events.
- Washington Hospital's Sports Medicine program offered onsite sports physicals to 324 local student athletes.
- The Washington Hospital Wellness Center hosted a monthly women's support group, Women Empowering Women. Three of the support group meetings focused on healthy eating and active living topics, with an average of 18 participants at each meeting.
- The Washington Wellness Center promotes active living through exercise classes and services designed for people of all ages and fitness levels.

Healthcare Access and Delivery

- Washington Hospital provided 98,859 COVID-19 vaccinations for 44,329 unique individuals. Washington Hospital also provided 87,829 COVID-19 tests.
- Washington Hospital provided COVID-19 vaccinations and tests at a variety of community locations. Some of our community clinics included: Washington Hospital Healthcare System (ongoing), BACS, Masonic Homes of California, Little Apples Learning Center, City of Newark Library, City of Newark Tree Lighting Ceremony, Newark Unified School District (multiple facilities) and the Tesla manufacturing plant.
- Washington Hospital was selected by Alameda County as a trauma center and is progressing towards designation in 2027.
- Washington Hospital continued providing grants for mammograms to uninsured clients referred by community clinics such as Tiburcio Vasquez Health Center. These clients include women ages 40 to 70, or women ages 30 to 40 who are considered at high risk for breast cancer as defined by the Medicare program.
- Washington Hospital hosted three free, virtual seminars focused on healthcare access, including information on Medicare and Medi-Cal enrollment. 1,064 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital presented three on-site health seminars on Medicare enrollment to local senior living communities. 66 adults attended these presentations.
- Washington Hospital entered into a contract with Canopy Health to support the establishment of a lower cost and geographically customizable health plan option for employers and residents of the Bay Area.

- Washington Hospital entered into a three-year agreement with Alameda Alliance to broaden access to health care for MediCal members.
- Washington Hospital provides free Health Insurance Information Services (HIIS) to community members in the Tri-City Area. This service helps answer insurance questions about individual plans, group plans and government-sponsored programs such as Medicare, Medi-Cal and Covered California. It also specializes in understanding Advance Health Care Directives or Physicians Orders for Life Sustaining Treatments (POLSTs).
- Washington Hospital collaborates with ReCare and the City of Fremont to distribute free durable medical equipment to low-income community members.
- Washington Hospital operates a Lymphedema Garment program that offers free garments to low-income patients. 15 patients were served.

Social Determinants of Health

- Washington Hospital continued collaborating with a local drug rehabilitation center to provide tattoo removal. The program is designed to help young adults make positive changes in their lives by removing symbols of past negative behaviors and actions associated with gang and drug activities.
- Washington Hospital welcomed 12 students from Mission Valley Regional Occupational Program for a job shadowing program. The students were given the opportunity to spend eight hours in a specific operational area. Students were hosted for job shadowing in the Washington Special Care Nursery, 4W, 5W, 6W, the Sandy Amos Outpatient Infusion Center and the clinical laboratory.
- Washington Hospital hosted a Community Forum on Anti-Asian Hate. This event featured a panel of speakers as well as resource fair with community organizations sharing important information on maintaining safety and health in the Tri-City Area. 100 individuals attended.
- Washington Hospital hosted a tour for a Future Health Professionals clubs at a local high school in the Tri-City Area.
- Washington Hospital provides general grant funding to Avanzando, an organization dedicated to the advancement and empowerment of Latino youth and their families through education and leadership.
- Washington Hospital provides general grant funding to local educational foundations, including the New Haven Schools Foundation and The Fremont Education Foundation. They also provide two scholarships to high school graduates pursuing healthcare related careers.
- Washington Hospital created a Diversity, Equity and Inclusion taskforce to develop strategies that improve diversity and inclusion for staff and patients of the healthcare system.

Diabetes, Heart Disease, Hypertension, and Stroke

- Washington Hospital participated in 12 health fairs hosted by community organizations and local schools to provide health information, including free blood pressure checks and information about stroke prevention.
- Washington Hospital offers free monthly diabetes support group meetings and educational Diabetes Matters sessions to community members with diabetes.

- Washington Hospital hosted five free, virtual seminars focused on diabetes education. These presentations included information on managing diabetes during the pandemic and technology to monitor blood glucose levels. 1,909 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital hosted six free, virtual seminars focused on heart disease and hypertension. These presentations included information on heart attack symptoms and prevention. 2,378 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital presented one on-site health seminar on Carotid Artery Disease to a local senior living residence. 34 adults attended this presentation.
- Washington Hospital hosted two free, virtual seminars focused on risk factors, warning signs and prevention of stroke. 812 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital presented four on-site health seminars on Stroke Awareness to local senior living communities. 107 adults attended these presentations.
- Washington Hospital reviewed their stroke protocols to be in line with the updated Clinical Practice Guidelines. These protocols ensure and encourage the increased use of "RAPID" software for identifying strokes and expediting decision on appropriate therapies for stroke patients. To facilitate with rapid administration of IV thrombolytic Therapy to eligible patients, WHHS switched to Tenectaplase (TNKase) as recommended in the recent clinical practice guidelines. TNKase is an IV thrombolytic, which is administered over five seconds as an IV push, thus enabling our hospital to meet a shorter door to drug time.
- Washington Hospital progresses towards Joint Commission Thrombectomy Capable Stroke Center (TSC) certification. We are currently working to build required volumes to attain this certification by extending our neurosciences services to the central valley and northern California.
- Washington Hospital's Stroke Program received the American Heart Association/ American Stroke Association's Get With the Guidelines®-Stroke Gold Plus Quality Achievement Award. The award recognizes the hospital's commitment to ensuring that stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines based on the latest scientific evidence. Washington Hospital earned the award by meeting specific quality achievement measures for the diagnosis and treatment of stroke patients at a set level for a designated period. These measures include evaluation of the proper use of medications and other stroke treatments, with the goal of speeding recovery and reducing death and disability for stroke patients.
- Washington Hospital also received the associations' Target: Stroke Elite Plus award. To qualify for this recognition, hospitals must meet quality measures developed to reduce the time between the patient's arrival at the hospital and treatment with a clot-buster tissue plasminogen activator used to treat ischemic stroke.

Respiratory Health

- Washington Hospital hosts a monthly Better Breathing for Life support group for people with chronic lung conditions such as chronic asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis or other restricted lung disease. Currently there are 74 active members of the support group.

- Washington Hospital engaged in community education during the COVID-19 pandemic with educational articles in the Tri-City Voice on Post COVID Breathing Problems.
- Washington Hospital hosted 4 free, virtual seminars focused on respiratory health. These presentations included information about asthma and pulmonary rehab. 2,621 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital's pulmonary rehab team attended local health fairs to share information about lung health.
- Washington Hospital hosted 5 virtual seminars in response to COVID-19. 1,355 community members viewed these seminars on Facebook and YouTube.

Cancer

- Washington Hospital hosted four free, virtual seminars focused on prevention, screening, and early detection for various cancers (e.g., breast, lung, and skin). 2,815 community members viewed these seminars on Facebook and YouTube.
- Washington Hospital presented two on-site health seminars on breast cancer prevention and detection to local senior living communities. 51 adults attended these presentations.
- Washington Hospital hosted four special events to educate and honor cancer patients and survivors. 729 community members attended these special events.
- Washington Hospital acquired a new linear accelerator for Washington Hospital's Radiation Oncology Center. This treatment modality increases the hospital's ability to provide advanced radiation therapy to patients.
- Washington Hospital continued offering a lung cancer screening tool to patients to identify those who may be at high risk for developing lung cancer. A total of 115 new patients were identified as high risk and underwent low-dose computed tomography (LDCT).
- Washington Hospital was awarded a three-year accreditation from the Commission on Cancer. The Commission on Cancer is a program of the American College of Surgeons recognizing cancer care programs for their commitment to providing comprehensive, high-quality, and multidisciplinary patient-centered care.
- Washington Hospital was awarded a three-year accreditation from the American College of Surgeons National Accreditation Program for Breast Centers.
- Both accreditations were received without any deficiencies, demonstrating Washington Hospital's commitment to quality care based on national standards.
- Washington Hospital was also designated as a Breast Imaging Center of Excellence by the American College of Radiology (ACR).
- Washington Hospital hosted a skin cancer screening event at the Nakamura Clinic in Union City. A total of 22 people were screened. Of those, two were recommended for biopsy.
- In fall of 2022, Washington Hospital established a cancer survivorship program built on the coordination of services between care providers and specialists to provide an assessment of late psychosocial and physical effects of cancer. Through this program, a referral system with social work was established. The program also hosts a monthly general cancer survivor support group.
- The Washington Hospital Survivorship Committee meets quarterly. These meetings help coordinate efforts across oncology services and include representation from clinical staff, social work, nursing, community outreach, cancer registry program, physical therapy, lymphedema, and radiation oncology.

WRITTEN PUBLIC COMMENTS

Washington Hospital welcomes and encourages written public comments about its CHNA and implementation strategy reports. Feedback may be submitted through the Contact form on its website[7] or emailed directly to communityoutreach@whhs.com.

At the time this CHNA report was completed, Washington Hospital had not received any written comments about the (previous) 2020 CHNA report.[8] The hospital will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate staff members.

[7] https://www.whhs.com/contact-us/

[8] https://www.whhs.com/about-us/community-connection/community-health-needs-assessment/

3. ABOUT WASHINGTON HOSPITAL

Washington Hospital Healthcare System is a District hospital, opened in 1958. It is governed by an elected Board of Directors consisting of five members. Washington Hospital serves the residents of Fremont, Newark, Union City, and part of southern Hayward and unincorporated Sunol, and it encompasses approximately 124 square miles of Southern Alameda County. The District's population is approximately 350,145.[9]

MISSION STATEMENT

As the local Healthcare District, our mission is to meet the healthcare needs of the District residents through medical services, education, and research.

Within this scope, Washington Township Healthcare District is committed to assuming the leadership role in improving and maintaining the health status of its residents by:

- Identifying and assessing community healthcare needs.
- Developing mechanisms to respond to the identified need within the financial capabilities of the District.
- Committing to a culture of patient safety and accountability.
- Adopting identified best practices.
- Providing access to high quality, cost-effective health services through an integrated delivery system.
- Partnering with a diverse medical staff and other providers to meet the healthcare needs of district residents.
- Providing appropriate employee, professional, and community educational resources to enhance patient care and health promotion throughout the District.

VISION

To support the fulfillment of the mission, the District's strategic vision is to be the regional medical center of choice in Southern Alameda County offering quality services that span the full range of care within the available financial resources.

VALUES STATEMENT

- Our organizational values stem directly from the origins of the Hospital District in 1948. The District was formed to provide access to patient care services for the residents of the Township, at a time when people had to leave their community and travel significant distances to find hospital care. The District serves its community by providing high quality, affordable, and convenient care. We are committed not only in law, but in spirit to local accountability.
- Healthcare is an intensely personal service. Underlying all that we offer is the recognition that healthcare is not a commodity. Our essential purpose is to improve the human condition. Our reason for being begins and ends with our patients and our community, and we are committed to a "patient first" ethic. To our patients we owe comfort, compassion, and whenever possible, a

[9] Sum of the populations of the three major cities: Fremont, Newark, and Union City. Data from U.S. Census Bureau, 5-year Estimates, 2017-2021.

cure. Our efforts are focused not just on individuals and families, but also on the overall health of the community.

- It is our obligation to provide responsible stewardship of our resources, acting in all areas of our healthcare system with integrity, professionalism, and with respect for a patient's right to choice.
- To our fellow employees, volunteers, and members of our medical staff we owe a commitment to perform all of our responsibilities with loyalty, perseverance, self-discipline, and dependability. We achieve these goals through our organizational commitment to innovation, process improvements, and pursuit of excellence.

COMMUNITY BENEFIT PROGRAMS

Each year, Washington Hospital provides a host of innovative and impactful community benefit programs and services to underserved and underinsured residents. The hospital's community benefit programs and activities are designed to:

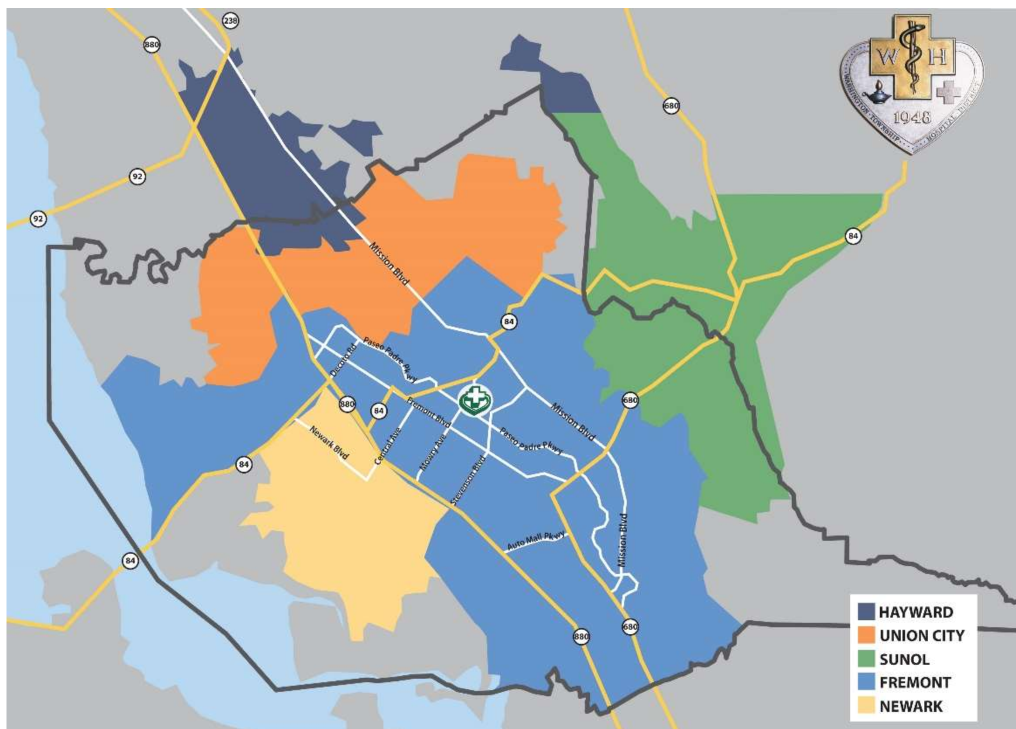
- Meet the specific healthcare needs of targeted populations;
- Expand availability of healthcare to those who need it most;
- Provide health information and education resources; and
- Teach participants about healthier lifestyles and the importance of staying healthy.

These programs are developed to meet the needs of the community.

COMMUNITY SERVED

The IRS 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 and does not

Figure 1. Map of Washington Township Healthcare District

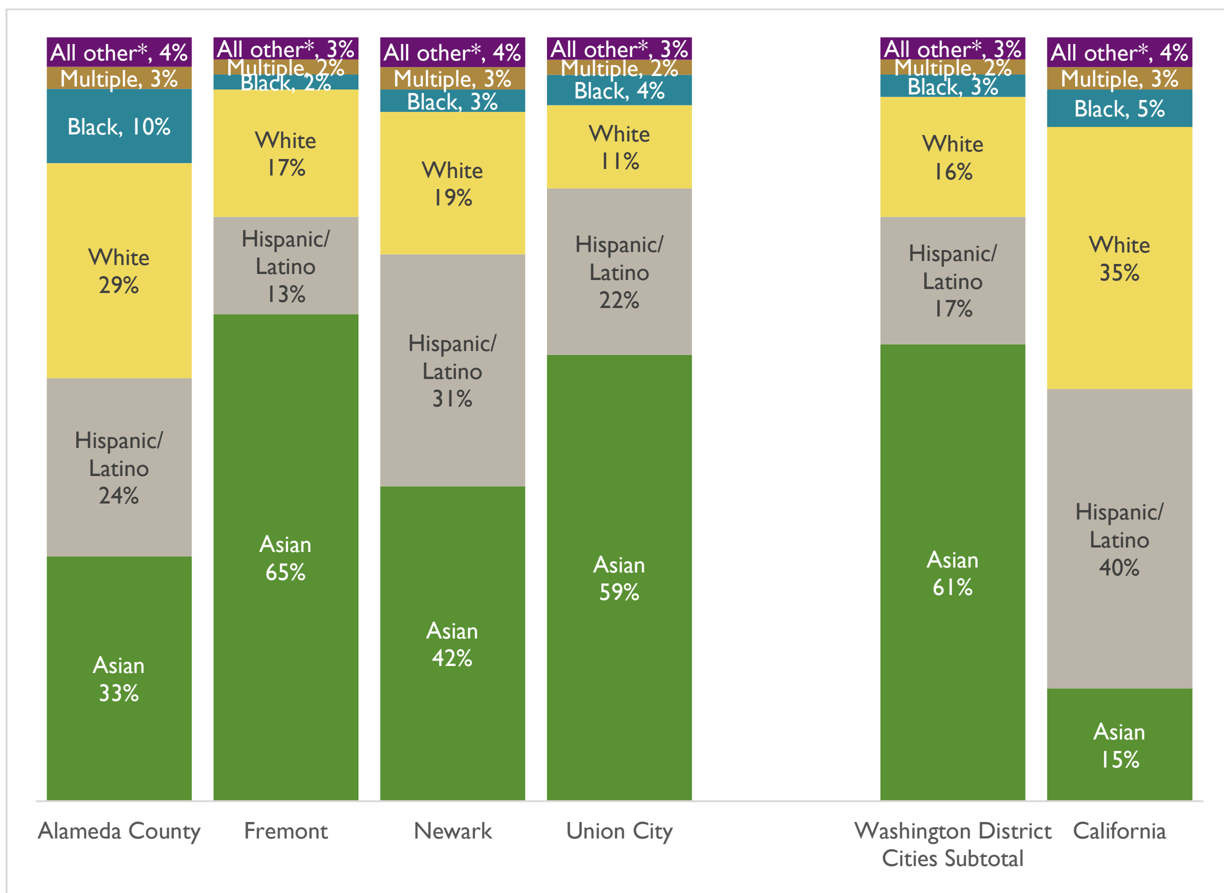


exclude low-income or underserved populations. Although Washington Hospital patients come from all around Alameda County, the majority reside in the southern part of Alameda County. Washington Hospital's primary service area comprises the cities of Fremont, Newark, Union City, and a portion of southern Hayward, as well as unincorporated Sunol (see map on previous page).

Demographics

In 2021, the estimated population of the major cities included in the primary service area was approximately 350,145.[10] Fremont is the largest city in the primary service area and the fourth-largest city in the San Francisco Bay Area. Washington Hospital's primary service area also includes portions of unincorporated Sunol and southern Hayward, for which population data are not available.

Figure 2. Race/Ethnicity Proportions, Major District Cities



Source: U.S. Census Bureau, Decennial Census, 2020. Notes: U.S. Census race/ethnicity estimates for 2017–2021 not available at time of report publication. Proportions are for race "alone" (single race) and non-Hispanic. * Purple segment is those of all other races combined (Pacific Islander/native Hawaiian, Native American, and "Other" race). Native American residents make up 0.2% of the city populations (not labeled in the chart). Those of "Other" race alone (not multi-racial) make up 1% or less of the cities' populations (not labeled in the chart). Pacific Islander/native Hawaiian make up 1% or less of the cities' populations (not labeled in the chart).

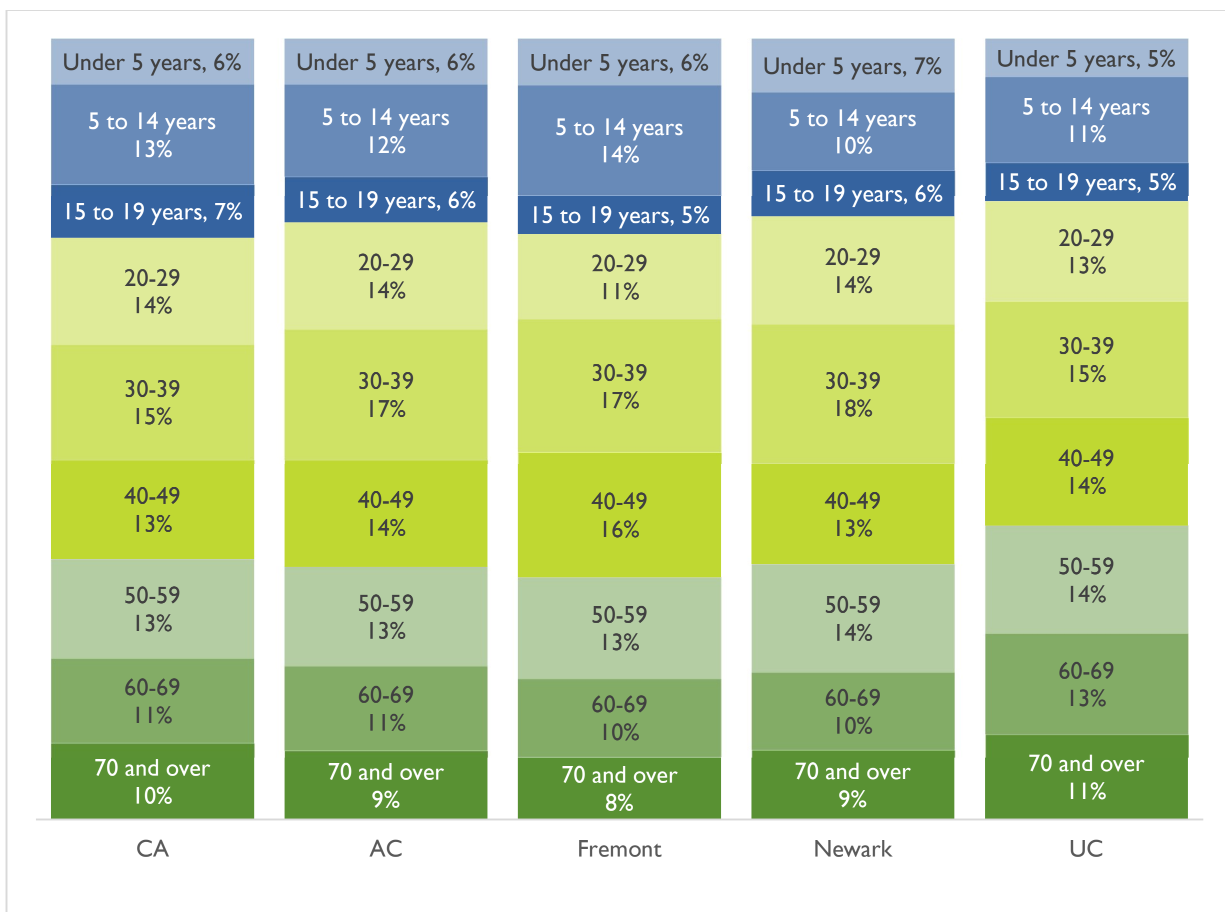
[10] U.S. Census Bureau, 5-year Estimates, 2017-2021.

The largest racial/ethnic group in Washington Hospital's primary service area cities is Asian, comprising at least one-third of the population in each city and two-thirds in Fremont. The service area cities have a larger proportion of Asian residents than the county and the state. Newark has a much higher proportion of Hispanic/Latino residents (30%) compared to the other two cities, the county, and the state.

The residents of Washington Hospital's primary service area speak a variety of languages. The most common languages include Spanish, Chinese (Cantonese and Mandarin), Hindi, and Tagalog. More than 15% of Fremont's population and more than 20% of Union City's population speak limited English.[11] Speaking limited English can be a barrier to an individual's economic security and access to healthcare.

Washington Hospital's primary service area cities' proportions of residents by age are displayed in the chart below. Union City's population skews a bit older than the other two cities.

Figure 3. Population by Age Range and City, Washington Hospital Primary Service Area



Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates 2017-2021. Notes: CA stands for California; AC stands for Alameda County; UC stands for Union City.

[11] Limited English is defined as those who are over five years of age and speak English less than "very well." U.S. Census Bureau. (2023). Data on Limited English is not available for Newark.

4. ASSESSMENT TEAM

HOSPITALS, OTHER PARTNER ORGANIZATIONS, AND CONSULTANTS

Washington Hospital's 2023 CHNA involved input from the following individuals:

- Angus Cochran, PhD, Chief, Community Support Services
- Kayla Gupta, MPH, Community Outreach Manager
- Alisa Curry, PT, DPT, Coordinator of Rehab Clinical Programs
- Donald Pipkin, MHA, Chief of Strategic Management
- Christine Nunez, MPH, Vice President of Ambulatory Care and Administrative Services
- Kimberly Hartz, Chief Executive Officer

Washington Hospital's conducted the CHNA with the support of consultants from Actionable Insights (AI), LLC, an independent local research firm. AI assisted with primary and secondary data collection and synthesis, as well as facilitation and documentation of key findings.

5. PROCESS AND METHODS

Washington Hospital Healthcare System directed the research firm Actionable Insights (AI) to collect data specific to the three cities in the hospital's primary service area. The CHNA data collection process took place over five months and culminated in a report written for Washington Hospital in the winter of 2022–2023. The phases of the process are depicted below (Figure 4).

Figure 4. CHNA Process

SECONDARY DATA COLLECTION

AI analyzed over 125 quantitative health indicators to assist Washington Hospital in understanding the health needs and in assessing its priorities in the community. AI collected data from existing sources using the Alameda County Public Health Department's data platform, https://www.healthyalamedacounty.org/, and other online data platforms, such as the Healthy Alameda County data platform and the U.S. Census Bureau. For the CNHA, each city's data were compared to regional benchmarks (Alameda County averages and rates) to help determine the severity of a health problem and to identify disparities. When trend data and/or data by ethnicity were available, they were reviewed to enhance understanding of the issue(s).

For details on specific sources and dates of the data referenced in this report, see *Attachment 2: Secondary Data Tables*.

INFORMATION GAPS AND LIMITATIONS

A lack of secondary data limited Washington Hospital in its ability to assess some health issues. Timely, reliable statistical information related to these topics was unavailable:

- Alzheimer's disease and dementia diagnoses
- Data for the part of southern Hayward in Washington Hospital's primary service area
- Data for unincorporated Sunol
- Diabetes among children
- Experiences of discrimination among vulnerable populations
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)
- Hepatitis C
- Oral/dental health
- Suicide among LGBTQI youth

COMMUNITY INPUT

AI conducted the primary research for this assessment. AI used three strategies for collecting community input: key informant interviews with health experts and community service experts, focus groups with professionals who represent and/or serve the community or residents, and focus groups with residents. Individuals representing vulnerable populations, including low-income, minority, LGBTQ, individuals with disabilities, limited English-proficient, and medically underserved, were included.[12]
AI, in collaboration with the hospital, generated primary research protocols based on facilitated discussion among the CHNA team's members about what they wanted to learn during the 2021–2023 CHNA. The study team sought to build upon prior CHNAs by focusing the primary research on topics and subpopulations that are less well understood by the statistical data. For example, the experiences of the population of disabled individuals in the hospital's primary service area are often obscured by statistics that represent the entire county's population. The 2023 study team specifically convened a focus group of professionals who serve disabled individuals and older adults to better understand this population through primary qualitative research.

Actionable Insights conducted the key informant interviews and focus groups for this assessment. AI recorded each interview and focus group as a standalone piece of data. Recordings were transcribed, and then AI used qualitative research software tools to analyze the transcripts for common themes. AI also tabulated how many times health needs were prioritized by each of the focus groups or described as a priority in a key informant interview. Washington Hospital used this tabulation to assess community health priorities.

Across the key informant interviews and focus groups, AI solicited input from 27 community leaders and representatives of various organizations and sectors.[13] These representatives either work in the health field or in community-based organizations focused on improving health and quality of life conditions by serving those from IRS- and California HCAI-identified vulnerable populations.

See *Attachment 1: Community Leaders, Representatives, and Members Consulted* for the names, titles, and expertise of these leaders and representatives, as well as the date and mode of consultation (focus group or key informant interview). See *Attachment 4: Qualitative Research Protocols* for details on the protocols and questions used.

Key Informant Interviews

In October 2022, Actionable Insights spoke with seven experts from Alameda County Public Health and various organizations in Southern Alameda County. Interviews were conducted virtually via Zoom for approximately one hour. Prior to each interview, participants were asked to complete a short online survey, in which they were asked to identify the health needs they felt were the most pressing among the people they serve. Interviewees could choose up to three needs from the list of needs presented to

[12] The IRS requires that community input include the low-income, minority, and medically underserved populations. California's HCAI requires that community input include the IRS-identified populations as well as vulnerable populations such as LGBTQ, unhoused individuals, individuals with disabilities, and individuals with limited English proficiency.

[13] Note that one of these individuals was both a key informant interviewee and a focus group attendee. This individual is counted only once in the total of 27, but is listed in both sections.

them, which had been identified in the hospital's service area in 2020, or could write in needs that were not on the 2020 list. Also in the survey, participants were advised of how their interview data would be used and were asked to consent to be recorded. Finally, participants were offered to be listed in the report and were asked to provide some optional basic demographic information.

Discussions centered around four questions for each health need prioritized by interviewees:

- How do you see the need playing out?
- Which populations are experiencing inequities with respect to this need?
- How have things changed in the last few years, related to this need?
- What is needed (including models/best practices) to better address this need?

AI sent a similar survey to focus group participants and asked focus groups the same questions during discussion. These questions were modified appropriately for each audience. Focus group discussions centered on the needs that had received the most votes from prospective participants in the online pre-survey.

See *Attachment 4: Qualitative Research Protocols* for complete protocols and questions, including pre-surveys. See *Attachment 1: Community Leaders, Representatives, and Members* Consulted for a list of key informants and focus group or interview details.

Focus Groups

AI conducted four focus groups in Southern Alameda County with a total of 21 professionals and 22 residents between September and November 2022. CHNA team members and/or nonprofit hosts recruited participants for the groups. To provide a voice to the community it serves, and in alignment with IRS regulations and California AB1204 (2021), the groups focused on vulnerable residents, including the unhoused, people with disabilities, LGBTQ, medically underserved, low-income, of a minority population, or those with limited English proficiency. Focus groups were asked the same questions as key informants, modified appropriately for each audience.

Table 1. List of Focus Groups Conducted for CHNA 2023

Topic or Population	Focus Group Host/Partner	Date	Number of Participants
Southern Alameda County	South County Partnership	9/20/2022	8
Disability community & older adults	Washington Hospital	10/7/2022	13
Spanish-speaking community members*	Newark Promotores Network	10/14/2022	15
English-speaking BIPOC community members*	Washington Hospital	11/8/2022	7

* Indicates resident/community member group.

CHNA Participant Demographics

A total of 49 people participated in focus groups or interviews for the CHNA. Thirty-nine participants (80%) provided demographic data.

The charts below show the age ranges of participants (N=39), as well as their race (N=38); note that individuals could choose more than one race. More than two in five (41%) participants were of Hispanic/Latino ethnicity (N=39). Most participants (90%) identified as female, with almost all of the rest identifying as male. On average, participants were aged 48 years.

Figure 5. Participant Age Groups

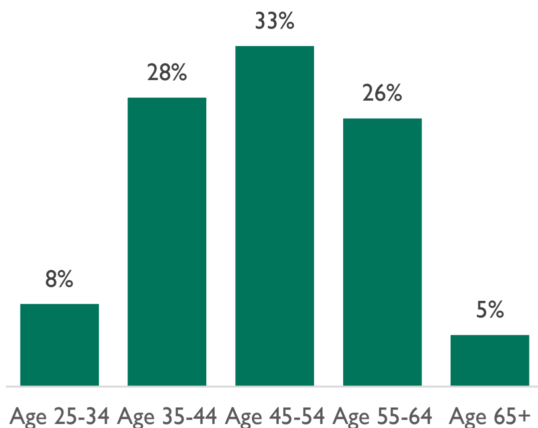
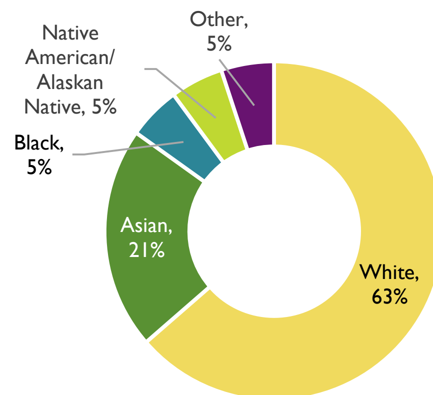


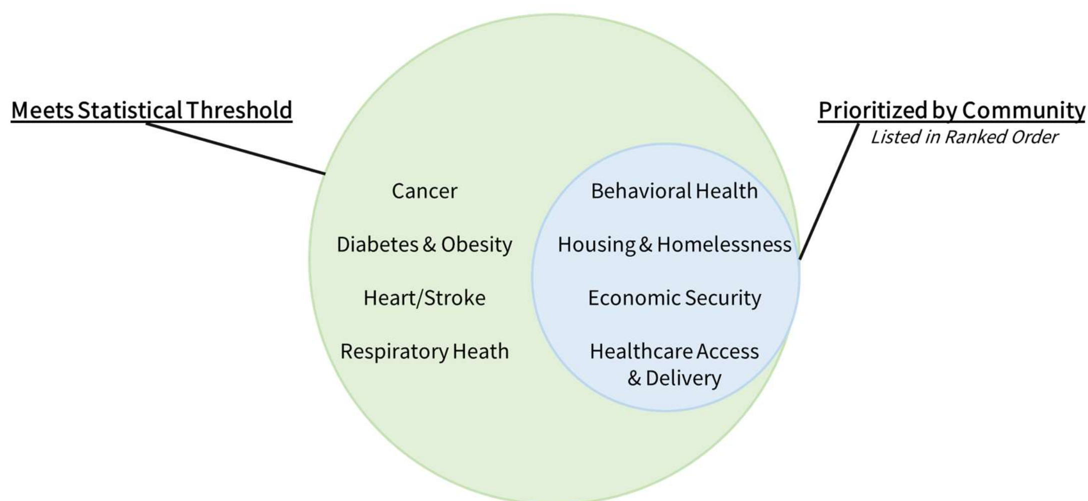
Figure 6. Participant Racial/Ethnic Groups



IDENTIFICATION OF COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as a community health need, an issue had to meet certain criteria, listed below Figure 7. See the *Definitions* box on the next page for additional terms and definitions.

Figure 7. Washington Hospital 2023 Health Needs Rubric



Health Needs Identification Criteria

1. Meets the definition of a health need (see the *Definitions* box, below).
2. At least two indicators for the health issue are available for the subcounty area.[14]
3. Meets the statistical data criteria:[14]
    a. Multiple indicators are worse than the county by 5% or more, or
    b. Multiple inequities by race/ethnicity are a concern.
4. Meets the community priority criterion: Prioritized (i.e., voted in as top three to discuss) by at least one-half of all community input cases (interviews or focus groups).

In 2023, this process led to the identification of eight community health needs that fit the criteria. That list of needs, in descending order of priority, appears below.

PRIORITIZATION OF HEALTH NEEDS

The IRS CHNA requirements state that hospital facilities must identify and prioritize the significant health needs of the community. As described previously, Actionable Insights solicited qualitative input from focus group and interview participants about which needs they thought were the highest priority (i.e., most pressing).

The hospital used this feedback to identify and rank the significant health needs as follows:

- Behavioral Health
- Housing & Homelessness
- Economic Security
- Diabetes & Obesity (tied)
- Heart/Stroke (tied)
- Healthcare Access & Delivery
- Respiratory Health
- Cancer

See *Section 6: 2023 Prioritized Community Health Needs* (pages 30-41) for a summarized description of each need. For further details, including statistical data, see *Attachment 2: Secondary Data Tables*.

DEFINITIONS

Health indicator: A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

Health need: A poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

Health Disparities and Inequities

Washington Hospital acknowledges the health impacts that come from racial/ethnic disparities. It is clear that inequitable health and economic outcomes can be attributed in part to structural and institutional

[14] For any Southern Alameda city (Fremont, Newark, and Union City) or Assembly District 20 (2019).

racism.[15] For example, BIPOC community members may cope with toxic stress due to their experiences of discrimination. The physical toll this can take on their bodies has no equivalent among white Americans. Additionally, inflammation from toxic stress contributes to greater comorbidities among the BIPOC population in the U.S. compared to whites.[16] BIPOC individuals are also more likely to work higher-risk and/or low-wage jobs, in part due to employment discrimination[17], and to live in crowded or substandard conditions and impoverished neighborhoods, in part due to historical red-lining policies and present-day housing discrimination.[18] All of these issues contribute to poorer health outcomes for BIPOC community members than white people for nearly all health conditions, including COVID-19 infection.

With regard to economic outcomes, people of color are more likely to have less formal schooling than whites, in part due to education discrimination[19] and in part because they are more likely to attend segregated, under-performing schools.[20] This, combined with possible employment discrimination, makes it more likely that they'll earn less, too.

COVID-19

In late 2019, a new coronavirus (SARS-CoV-2) appeared. It causes a respiratory illness that is now called COVID-19. The ensuing pandemic has been a health event of historic proportions. In absolute terms, the COVID-19 pandemic has surpassed the 1918 influenza (H1N1) pandemic, which killed 550,000 Americans (0.5% of the U.S. population at that time).[21]

The COVID-19 pandemic shows signs of continuing for the foreseeable future. In Alameda County, the numbers of COVID-19 cases and deaths peaked several times in 2020, 2021, and 2022. However, vaccinations—which began in early 2021—appear to be mitigating local hospitalizations and deaths.

See the next page for more information and statistics on COVID-19 infections, vaccinations, and deaths as of March 2023.

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[15] Garcia, M. A., Homan, P. A., García, C., & Brown, T. H. (2020). The color of COVID-19: structural racism and the pandemic's disproportionate impact on older racial and ethnic minorities. *The Journals of Gerontology: Series B*. Retrieved from https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1735&context=sociologyfacpub

[16] Adler, N. E., & Rehkopf, D. H. (2008). U.S. disparities in health: descriptions, causes and mechanisms. *Annual Review of Public Health*, 29:235–252.

[17] See meta-analysis: Neumark, D. (2018). Experimental research on labor market discrimination. *Journal of Economic Literature, 56*(3), 799-866. Retrieved from https://www.nber.org/system/files/working_papers/w22022/w22022.pdf

[18] Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA. Retrieved from https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf

[19] Adair, J. K. (2015). The impact of discrimination on the early schooling experiences of children from immigrant families. Washington, DC: Migration Policy Institute. Retrieved from https://www.migrationpolicy.org/research/impact-discrimination-early-schooling-experienceschildren-Immigrant-families

[20] Reardon, S.F., Weathers, E.S., Fahle, E.M., Jang, H., & Kalogrides, D. (2019). Is separate still unequal? New evidence on school segregation and racial academic achievement gaps. Retrieved from https://cepa.stanford.edu/content/separate-still-unequal-new-evidence-school-segregationand-Racial-academic-achievement-gaps

[21] Noymer, A., & Garenne, M. (2000). The 1918 influenza epidemic's effects on sex differentials in mortality in the United States. *Population and Development Review*, *26*(3), 565–581. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740912/. And Centers for Disease Control and Prevention. (2019).

These issues drove Washington Hospital to incorporate racial/ethnic disparities in the CHNA in the following ways, including as a key health need criterion:

- Compared data by race/ethnicity when available (see *Attachment 2: Secondary Data Tables*).
- Compared data by sub-county geographies when available (see *Attachment 2: Secondary Data Tables*).
- Asked every single key informant and focus group to identify local populations they felt were experiencing inequities related to each need that the informant or focus group prioritized (see *Attachment 4: Qualitative Research Protocols*).
- Among other criteria, identified an issue as a health need if multiple inequities by race/ethnicity were a concern (see *Identification of Community Health Needs* sub-section above).

COVID-19 *continued*

Because COVID-19 is a new virus, many health effects and healthcare needs are still emerging. This CHNA report summarizes what the participating hospitals know so far about the health condition and its social determinants. The hospital will continue to monitor and address health effects, trends, and healthcare needs of COVID-19 as it learns more about the disease, its progression, and its short- and long-term impacts.

Women in particular left the workforce in large numbers in 2020 and 2021, The pandemic has exacerbated existing inequities in the health and welfare of vulnerable populations in the U.S., when school closures created a need for child care, a responsibility much more likely to fall on their shoulders than men's. While Washington Hospital acknowledges the negative health effects of COVID-19 itself, this CHNA report focuses on identifying the broader health inequities and socioeconomic consequences of COVID-19 in its service area causing disproportionate illness and mortality for people in minority racial and ethnic groups (i.e., Black, Indigenous, and people of color: BIPOC), people with certain pre-existing health conditions, people living in crowded conditions, and people who are classified as "essential workers" (at higher risk of workplace exposure).[22] More than one in four people (28%) who were infected experience "long COVID," a set of lingering symptoms including "fatigue, body aches, shortness of breath, difficulty concentrating" that lasts a year or more.[23] And a small but not insignificant percentage (5%) of the U.S. adult population reports "struggling with activity limitations from long COVID."[23]

Perhaps the most far-reaching impacts of COVID-19 are socioeconomic. The government mandates shutting down or limiting activities in major industries (tourism, hospitality, brick-and-mortar retail and services, etc.) exacerbated the inequities experienced by many of the vulnerable populations identified above. Women, BIPOC, young people (ages 16–24), and those with low income (usually defined as less than 80% of the area median income) or without college degrees have also been impacted by job loss, housing insecurity, food insecurity, and other difficulties, all of which are likely to persist.

1918 Pandemic (H1N1 virus). Retrieved from https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

[22] Campbell, J. (2020). What are essential services and jobs during the coronavirus crisis? *Huffington Post*. Retrieved from: https://www.huffpost.com/entry/what-are-essential-services-jobs_l_5e74eaacc5b6f5b7c543370c

[23] Data: Burns, A. (2023). *Long COVID: What Do the Latest Data Show?* Kaiser Family Foundation. Retrieved from https://www.kff.org/policy-watch/long-covid-what-do-latest-data-show/

6. 2023 PRIORITIZED COMMUNITY HEALTH NEEDS

SUMMARIZED DESCRIPTIONS OF PRIORITIZED NEEDS

1 Behavioral Health

What Is the Issue?

Mental health—emotional and psychological well-being—is key to personal well-being, healthy relationships, and the ability to function in society.[24] According to the U.S. Substance Abuse and Mental Health Services Administration, 21% of the adult U.S. population was coping with a mental illness in 2020, and rates were highest among young adults (over 30% among people ages 18 to 25).[25] Mental and physical health are often closely related. For example, depression and anxiety can affect one's ability for self-care. Likewise, chronic diseases can lead to negative impacts on an individual's mental health.[26] Additionally, the use of substances such as alcohol, tobacco, and legal and illegal drugs can lead or contribute to many social, physical, mental, and public health problems, both for the individual using them and also their families and communities. Increasingly, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.[27]

Why Is It a Health Need?

The community considered behavioral health a strong priority, as evidenced by the fact that it was discussed at length in almost all key informant interviews and focus groups. The lack of access to behavioral health services and facilities was cited, including information about how to access existing resources. Not surprisingly, pandemic isolation was a big concern, especially for older adults, those with medical vulnerabilities, and LGBTQIA+ residents who may already have felt disconnected from their families at home and seek connection in community centers. Parents expressed concern about alcohol and drug use, which is supported by the data below. Students also report depression-related feelings at higher rates in some cities than in the county. Also, adult binge drinking and 7th grade binge drinking are both higher in Newark than in the county.

In terms of racial inequity, white, Black, and Hispanic/Latino students usually have highest rates of alcohol and drug use (see charts in *Figure 8*) but the only group that is worse than the county is in Newark Unified School District; 18% of Black youth use drugs and alcohol compared to 16% of Black youth in Alameda County overall. Also, multiracial adults and white adults have higher rates of likely serious psychological distress (24% and 13% respectively) than in the county overall (10%).

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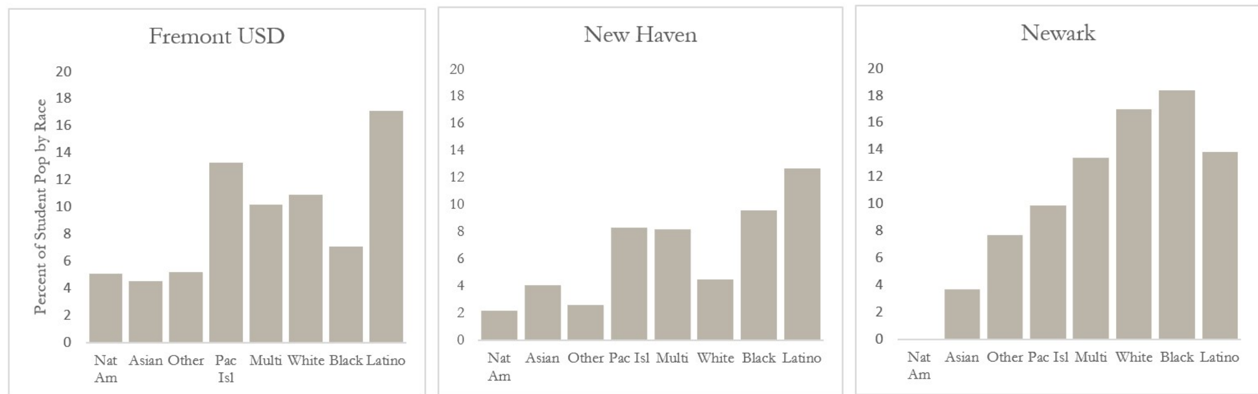
[24] Office of Disease Prevention and Health Promotion. (2018). *Mental Health and Mental Disorders*.

[25] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. U.S. Department of Health and Human Services, SAMHSA. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

[26] Lando, J., & Williams, S. (2006). A logic model for the integration of mental health into chronic disease prevention and health promotion. *Preventing Chronic Disease.* 2006 Apr. *3*(2): A61.

[27] Office of Disease Prevention and Health Promotion. (2018). *Substance Abuse.*

Figure 8. Student Alcohol and Drug Use by Race/Ethnicity for School Districts in Washington Hospital Service Area (Percentage)



Note: Nat Am=American Indian/Alaskan native; Pac Isl=Pacific Islander/native Hawaiian; Multi=Two or more races; Latino= Hispanic/Latina/o. Source: California Healthy Kids Survey. 2017-2019.

If I need mental healthcare, I can call and I'll get an appointment eight, 10 weeks out. [Somebody] who is on the street or in a harmful situation, they don't have eight to 10 weeks. Asking somebody to hold on that long to get care is like asking a fish to ride a bicycle, it's just not going to happen. So having access [for] somebody who is like, "In this moment, I would accept care right now." Cool. How do we connect? And I suspect it's a whole workforce issue, that there's just not enough people. Being able to move quickly to [provide] culturally responsive, appropriate care, it's just a giant gap. It's this giant, giant gap that we're facing.

– South County Partnership member

Table 2. Concerning Indicators for Behavioral Health

Indicator Name	Fremont	Newark	UC	AC
Alcohol: Binge Drinking, Adults (percent)	15.1	16.7	14.3	15.8
Alcohol/Drug Use in Past Month: 7th Grade (percent)	3.2	6.7	6.4	5.1
Alcohol/Drug Use in Past Month: 9th Grade (percent)	7.1	10.8	18.3	13.3
Alcohol/Drug Use in Past Month: NT (percent)	48.6	31.9	28.6	42.3
Alcohol: Binge Drinking: 7th Grade (percent)	0.2	0.8	0.1	0.2
Depression-Related Feelings: 7th Grade (percent)	22.1	28.6	34.7	25.6
Depression-Related Feelings: 9th Grade (percent)	27.6	34.5	41.5	29.9
Depression-Related Feelings: 11th Grade (percent)	36.9	**36.0**	41.4	35.2
Depression-Related Feelings: NT (percent)	42.9	32.4	47.1	37.4

Notes: Binge drinking is two or more occasions where five or more drinks of alcohol within a couple of hours were consumed. Brown shading indicates a statistic is worse than the county by 5% or more. UC stands for Union City; AC stands for Alameda County. NT stands for students in non-traditional schools. See *Attachment 2: Secondary Data Tables* for all sources.

❷ Housing & Homelessness

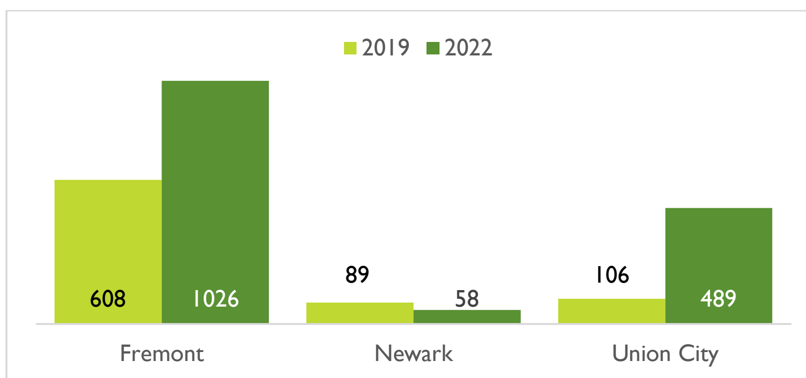
What Is the Issue?

The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.[28] Even when housed, if that housing is not affordable and exceeds 30 percent of a household's annual income, a family is often unable to afford other necessities, such as food, clothing, transportation, and medical care.[29] The U.S. Department of Health and Human Services also notes that "people with the lowest incomes may be forced to rent substandard housing that exposes them to health and safety risks."[30] Further, people who are experiencing homelessness have been shown to have more healthcare issues than people who aren't, to suffer from preventable illnesses at a greater rate, to require longer hospital stays, and face a greater risk of premature death.[31] Healthcare systems must monitor the local homeless population and identify the population's health needs. Additionally, remaining aware of housing conditions and affordability for all populations helps to inform a hospital's related efforts in the community.

Why Is It a Health Need?

The cost of housing in the Bay Area is extremely expensive, and the community identified this as one of the most pressing health needs. Because housing is difficult to afford, community members described seeing more people struggling with other living expenses. The number of homeless people in Alameda County has increased in the last two years (by 22%), a trend also seen in Fremont and Union City. In Fremont and Union City, the proportions of people who are unsheltered are worse than in the county.

Figure 9. Total Homeless Population by City and Year



Source: Applied Survey Research. Alameda County Point-in-Time Count. 2022.

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[28] Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis*. See also: The California Endowment. (2015). *Zip Code or Genetic Code: Which Is a Better Predictor of Health?*

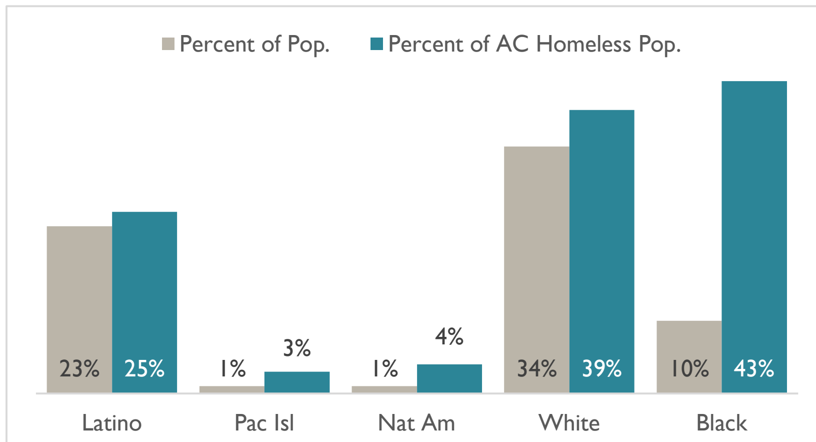
[29] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing*.

[30] U.S. Department of Health and Human Services. (Undated). Housing Instability. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030.

[31] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council.

Community members have taken note of the increase in people living in cars and encampments. In addition, emergency shelter space has been more limited because of COVID restrictions; this reduction in the number of beds impacts those who are escaping domestic abuse. We also know that some populations, especially Black residents, are overrepresented in the homeless population (i.e., the percent of homeless who are Black residents is much larger than the proportion of the overall population who are Black). (See *Figure 9*, previous page.)

Figure 10. Populations Overrepresented in the Alameda County Homeless Population



Source: Applied Survey Research. Alameda County Point-in-Time Count. 2022.

Table 3. Concerning Indicators for Housing & Homelessness

Indicator Name	Fremont	Newark	UC	AC
Total Homeless Count	1,026	58	489	9,747
Unsheltered homeless (percent of total count)	84	55	100	73
Chronically homeless (percent of total count)	27	48	--	28

Notes: HUD defines sheltered homeless persons as adults, children, and unaccompanied children who, on the night of the count, are living in shelters for the homeless. Brown shading indicates a statistic is worse than the county by 5% or more. UC stands for Union City; AC stands for Alameda County. See *Attachment 2: Secondary Data Tables* for all sources.

Our city just pushed out $15 million in rental assistance for folks, so right now we're still under an eviction moratorium for Alameda County... And so, I think when that moratorium is lifted, eventually we're going to see a lot of evictions and potentially more people ending up either having to leave the area or ending up in the homeless category.

– South County Partnership member

❸ Economic Security

What Is the Issue?

Social and economic environments are the greatest determinants of a population's health,[32] with a strong link between higher income and/or social status and better health. Childhood poverty has lasting effects: Even when economic and social environments later improve, childhood poverty still results in poorer long-term health outcomes.[33] Numerous studies have found that access to economic security programs (i.e., SNAP—formerly referred to as food stamps) and policies that positively influence economic conditions result in better long-term health and social outcomes.[34] Additionally, the National Poverty Center reports that increased education is associated with decreased rates of most acute and chronic diseases.[35] It is well established that educational attainment, employment rates, and household income are key indicators that show the economic vitality of an area and the buying power of individuals, including their ability to afford basic needs such as housing and healthcare.

Why Is It a Health Need?

Community input about economic security was dominant in every case; this input made up the highest proportion of the discussion after healthcare access and delivery. The community described the high cost of living, and difficulty securing employment for individuals with health issues, disabilities, or those experiencing homelessness. The community described a sharp rise in food insecurity in summer 2022. Overall, people were worried about an increase of residents losing their housing due to economic difficulties. In Newark and Union City per capita income is lower (6% and 13% respectively) than Alameda County. However, most data indicators, including measures of poverty, are favorable for Washington Hospital's service area cities. Data also show inequities by race (see table). Overall, most BIPOC populations have lower incomes than their counterparts and higher proportions of their populations who are living in poverty. Also, the proportions of youth not in school nor working are higher in Newark (1.7%) and Union City (1.8%) than in the county overall (0.7%).

Table 4. Concerning Indicators for Economic Security by Race/Ethnicity

Indicator Name	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC
Median Household Income	$83.0k	$82.7k	$130.2k	$97.5k	$56.7k	$120.5k	$99,712	$104.9k
Per Capita Income	$28.7k	$34.2k	$51.5k	$32.5k	$37.3k	$70.2k	$33,147	$49.9k
Children Living Below FPL	14.6%	15.3%	5.1%	13.5%	27.0%	5.0%	8.1%	10.2%

[32] County of Los Angeles Public Health. (2013). Social Determinants of Health: How Social and Economic Factors Affect Health.

[33] World Health Organization. (2018). *The Determinants of Health.*

[34] Center on Budget and Policy Priorities. (2018). Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits.

[35] Cutler, D.M., & Lleras-Muney, A. (2006). National Bureau of Economic Research. *Education and Health: Evaluating Theories and Evidence* (No. w12352).

Indicator Name	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC
Families Living Below FPL	9.0%	12.4%	4.7%	8.5%	13.5%	2.6%	6.4%	5.8%
Aged 65+ Living Below FPL	9.9%	22.4%	12.4%	10.6%	15.8%	6.3%	9.3%	9.8%

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. Latino stands for Hispanic/Latina/o. Nat Am stands for Native American/Alaskan native. Pac Isl stands for Pacific Islander/native Hawaiian. Multi stands for multiple races/ethnicities. AC stands for Alameda County. FPL stands for Federal Poverty Limit. See *Attachment 2: Secondary Data Tables* for all sources.

For Alameda County, there's an index for what it actually costs to live in our county. If you look at that and you look at the incomes of our population, about 20 percent of people are kind of hanging on by their toenails to stay housed, and that's not counting things like saving for a college education for your kid or taking a vacation. It's just the basics for a family to survive.

– South County Partnership member

❹ Diabetes & Obesity

What Is the Issue?

Nutrition and exercise are important aspects of a healthy lifestyle. The benefits of a healthy diet include preventing high cholesterol and high blood pressure, reducing the risks of developing diseases including cancer and diabetes, and helping to reduce the risks of obesity, osteoporosis, and dental cavities.[36] Getting regular exercise can reduce the risk of cardiovascular disease, type 2 diabetes, some cancers, and other physical issues,[37] while also strengthening bones and muscles, preventing falls for older adults, and increasing lifespan.[38] Despite the well-known benefits, most people do not follow recommended healthy food and exercise guidelines. Most significantly, a poor diet and lack of regular exercise can lead to adult and childhood obesity, a serious and costly health concern in the U.S. that often results in some of the leading causes of preventable death,[39] including type 2 diabetes.[40]

Why Is It a Health Need?

The community expressed the need for not only access to healthy food in grocery stores, but also to nutrition education in schools and communities. They also called out the need for recreation programs to prevent diabetes and more safe spaces to recreate/walk in their neighborhoods. This category met the threshold for a health need because of the statistical data; the proportions of children who are overweight are higher in Newark and Union City than in the county and state overall. Notably, the rates

[36] United States Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*

[37] The Mayo Clinic. (2016). Exercise: 7 Benefits of Regular Physical Activity.

[38] Harvard Health Publishing/Harvard Medical School. (2013). Balance Training Seems to Prevent Falls, Injuries in Seniors.

[39] Centers for Disease Control and Prevention. (2016). *Childhood Obesity Causes & Consequences*. See also: Centers for Disease Control and Prevention. (2018). *Adult Obesity Causes & Consequences*.

[40] Centers for Disease Control and Prevention (2018). *Diabetes Quick Facts.*

of adults with diabetes are worse in all three service area cities, and rates of diabetes ED visits and hospitalization are issues in Fremont and Newark. Also, there are inequities by race for adult obesity and diabetes. (See tables.)

Table 5. Concerning Indicators for Diabetes & Obesity

Indicator Name	Fremont	Newark	UC	AC
Adults with Diabetes (percent)	11.4	13.6	13.7	10.3
Diabetes ED Visits Rate	1396	2053.8	2280.7	1541
Diabetes Hospitalization Rate	1307.9	1592.1	1831.7	1512
Adults who are Obese (percent)	19.0	24.6	21.2	↑ 25.4
Children who are Overweight for Age (Ages 2-11) (percent)	13.3	15.0	15.2	↑ 14.3
Workers who Walk to Work (percent)	1.2	2.6	0.8	↑ 3.3

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. Where trends were available, color-coded arrows are used to show directionality (green marks positive trends, and red marks negative trends.) UC stands for Union City; AC stands for Alameda County. See *Attachment 2: Secondary Data Tables* for all sources.

Table 6. Concerning Indicators for Diabetes & Obesity by Race/Ethnicity

Indicator Name	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC
Adults with Diabetes	10.1%		11.5%		13.8%	9.6%	2.1%	10.3%
Adults who are Obese	29.2%		10.9%		43.8%	28.0%	38.5%	25.4%
Workers who Walk to Work	3.3%	6.8%	3.1%	3.6%	2.3%	3.8%	3.7%	3.3%

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. Latino stands for Hispanic/Latina/o. Nat Am stands for Native American/Alaskan native. Pac Isl stands for Pacific Islander/native Hawaiian. Multi stands for multiple races/ethnicities. AC stands for Alameda County. See *Attachment 2: Secondary Data Tables* for all sources.

I'm someone who has diabetes… It's very difficult to find affordable organic food, food classes, nutrition classes… That's something that's very important because there's a large percentage of us who are suffering from this illness.

– Southern Alameda County resident

4 Heart/Stroke

What Is the Issue?

Nationally, some 84 million people suffer from a form of cardiovascular disease.[41] Heart disease is the #1 killer of both men and women,[42] and stroke is the fifth leading cause of death and a significant cause of serious disability for adults.[43] Recent research has established that disparities exist between minority and non-minority cardiovascular health outcomes across the U.S.[44] Although some risk factors for heart disease and stroke are not controllable (age, race/ethnicity, gender), some risk factors can be controlled (high blood pressure, high cholesterol, obesity, excessive alcohol consumption, smoking, an unhealthy diet, lack of physical activity). Left untreated, these risk factors can lead to changes in the heart and blood vessels. Over time, those changes can lead to heart attacks, heart failure, strokes, and other forms of cardiovascular disease.[45] Addressing risk factors early in life can help in preventing chronic cardiovascular disease.[46, 47]

Why Is It a Health Need?

Cerebrovascular issues such as stroke, heart disease, and heart attack are among the top causes of death in the county. Statistical data shows that service area cities fare worse than the county overall. The community did not discuss heart and stroke issues specifically, but they did call out the need for recreation programs to prevent heart problems and for nutritional education for older adults. Heart and stroke issues are considered a health need because of the statistical data. Notably, in Union City, residents have worse rates than other service area cities and the county for emergency department visits (stroke, hypertension, and heart failure), hospitalizations (heart disease, hypertension), and mortality (acute myocardial infarction, heart disease, and ischemic heart diseases). Stroke mortality has been decreasing in Fremont and Newark but increasing in Union City, and it is higher there than the Healthy People 2030 benchmark. No data are available by race/ethnicity.

Table 7. Concerning Indicators for Heart/Stroke

Indicator Name	Fremont	Newark	UC	AC
Stroke ED Visits Rate	45.1	54.0	68.9	56.2
Hypertension ED Visits Rate	2311.1	2994.1	3517.9	2827.2
Heart Failure Emergency Dept Visit Rate	339.4	**423.5**	481.5	413.9

[41] Johns Hopkins Medicine. (2018). *Cardiovascular Disease Statistics.*

[42] Centers for Disease Control and Prevention. (2017). *Heart Disease Facts.*

[43] Centers for Disease Control and Prevention. (2018). *Stroke.*

[44] Graham, G. (2015). Disparities in cardiovascular disease risk in the United States. *Current Cardiology Reviews, 11*(3): 238-–245.

[45] American Heart Association. (2017). *What Is Cardiovascular Disease?*

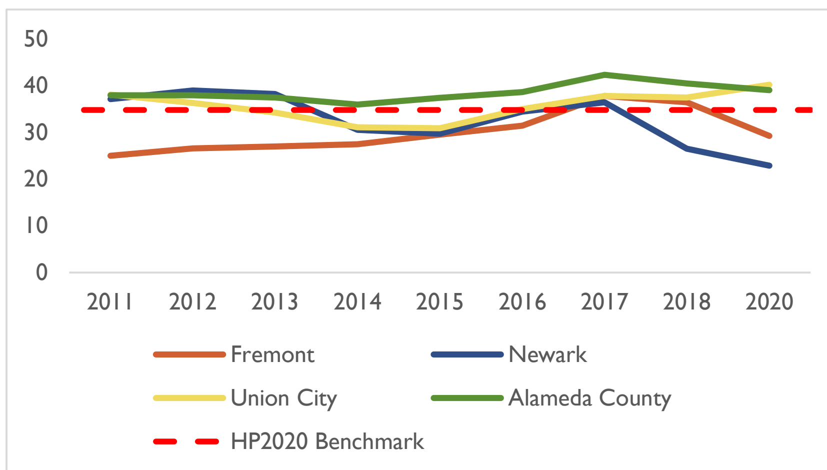
[46] The Mayo Clinic. (2016). Strategies to Prevent Heart Disease.

[47] Centers for Disease Control and Prevention. (2017). *Leading Causes of Death.*

Indicator Name	Fremont	Newark	UC	AC
Heart Disease Hospitalization Rate	464.6	534.4	622.2	565.7
Hypertension Hospitalizations Rate	1936.8	2264.3	2736.9	2520.5
Acute Myocardial Infarction Mortality Rate	14.3	14.7	27.8	19.9
Heart Disease Mortality Rate	86.9	90.9	120.1	109.0
Ischemic Heart Diseases Mortality Rate	49.9	48.7	75.6	56.0

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. Bold text indicates that an indicator is worse than the county but by less than 5%. UC stands for Union City; AC stands for Alameda County. ED stands for Emergency Department. See *Attachment 2: Secondary Data Tables* for all sources.

Figure 6: Stroke Mortality (Age-adjusted Rate per 100,000 pop.)



Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I60-I69.

6 Healthcare Access & Delivery

What Is the Issue?

Access to comprehensive healthcare is important to everyone's health and quality of life.[48] Components of access to care include insurance coverage and adequate numbers of primary and specialty care providers. Components of delivery of care include quality, transparency, timeliness, and cultural competence/cultural humility. Limited access to healthcare and compromised delivery can hinder people's ability to reach their full potential. As reflected in statistical and qualitative data, barriers to receiving quality care include high costs and a lack of availability, insurance coverage, and/or cultural competence on the part of providers. These barriers lead to unmet health needs, delays in receiving appropriate care, and an inability to attain preventive services.

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

Why Is It a Health Need?

Access to healthcare and the experiences of receiving care were dominant in the community input. Costs of insurance and healthcare services are still unaffordable, even for those who have insurance. Also, some community members who are employed but have trouble making ends meet find it difficult to qualify for Medi-Cal.

Residents perceive that there is a relative lack of facilities in southern Alameda County compared to other areas of the county. Monolingual Spanish-speaking residents described problems communicating with doctors and being unable to participate in some community health programs. Communication is also difficult for non-verbal residents, including those who are Deaf/Hard of Hearing. LGBTQ+ community members described recent improvements in health care delivery, and also stressed that more health professionals need to become culturally competent to serve this population. Cultural competency in healthcare is also important for those in the service area from non-Western cultures; for example, some families make health decisions together, but clinicians often do not include family members or communicate with them. Professionals who gave input described the ongoing difficulty in retaining healthcare staff due to cost of living and outmigration, creating a lack of capacity to serve residents, particularly in non-English languages.

In terms of statistics, local data fare well compared to the county, including the proportion of insured residents, those who had recent physical and dental visits, and access to internet at home. However, there are notable inequities. Pacific Islanders have lower rates of adult health insurance than their peers (66.7%). Several subpopulations have more difficulty obtaining care compared to the county population overall (13.1%): Native American (94%), white (17.1%), and multiracial (29.7%), as well as women overall (16% compared to 10% for men).

Table 8. Concerning Indicators for Healthcare Access & Delivery by Race/Ethnicity

Indicator Name	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC
Adults with Health Insurance (18-64)	90.3%		**93.4%**	66.7%	89.5%	96.3%	90.0%	93.2%
People Delayed or Had Difficulty Obtaining Care	6.9%	94.0%	11.1%		10.6%	17.1%	29.7%	13.1%

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. Latino stands for Hispanic/Latina/o. Nat Am stands for Native American/Alaskan native. Pac Isl stands for Pacific Islander/native Hawaiian. Multi stands for multiple races/ethnicities. AC stands for Alameda County. See *Attachment 2: Secondary Data Tables* for all sources.

Even though those people are – they have a degree, they have a full-time job, and they work in a high-tech company, but they still want a physician or provider that speaks their own language. I think that when they become sick, they really want people to speak their own language. They feel much more comfortable.

– BIPOC Southern Alameda County resident

❼ Respiratory Health (including COVID-19)

What Is the Issue?

Respiratory disorders affect the ability of the individual to breathe. Asthma, chronic obstructive pulmonary disorder (COPD), pneumonia, and lung cancer—each of which is chronic—are among the most common of respiratory disorders.[49] Asthma is an inflammation of the airways that causes them to swell and narrow, characterized by episodes of reversible breathing problems.[50] Symptoms range from mild to life-threatening. Asthma attacks can cause a range of issues from simple wheezing to extreme breathlessness.[51] According to the American Lung Association, "the most common risk factors for developing asthma [are] having a parent with asthma, having a severe respiratory infection as a child, having an allergic condition, or being exposed to certain chemical irritants or industrial dusts in the workplace."[52] In late 2019, a new coronavirus (SARS-CoV-2) appeared. It causes a respiratory illness that is now called COVID-19. The ensuing pandemic has been a health event of historic proportions. COVID-19 was one of the top three causes of death in the U.S. in 2021, while chronic lower respiratory disease was the sixth.[53]

Why Is It a Health Need?

Statistical data for Union City (below) qualified respiratory health as a need in the service area. Rates of visits to emergency departments for COPD and asthma hospitalizations among adults were both higher in Union City than in Alameda County. (Note that respiratory data by race are unavailable.)

While COVID-19 is an undeniable health condition that has impacted service area cities, the community did not prioritize it over other needs. Professionals did identify southern Hayward as a part of southern Alameda County that was hardest hit by COVID-19 infections. (See data about COVID-19 infections in the area in *Attachment 2: Secondary Data Tables*.)

Table 9. Concerning Indicators for Respiratory Health

Indicator Name	Fremont	Newark	UC	AC
Asthma Hospitalizations Rate (Adults 18+)	18.6	18.8	29.2	27.8
COPD Emergency Dept Visits Rate	355.3	**417.2**	437.1	413.5

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. UC stands for Union City; AC stands for Alameda County. COPD stands for Chronic Obstructive Pulmonary Disease. See *Attachment 2: Secondary Data Tables* for all sources.

[49] U.S. National Library of Medicine. (2018). *Lung Disease.*

[50] The Mayo Clinic. (2018). *Asthma Overview.*

[51] Centers for Disease Control and Prevention. (2018). *Asthma.*

[52] American Lung Association. (2018). *Asthma Risk Factors.*

[53] Centers for Disease Control and Prevention (CDC). (2021). *Leading Causes of Death.* CDC, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

8 Cancer

What Is the Issue?

Cancer is a generic term used to describe more than 100 conditions[54] in which abnormal cells divide uncontrollably, invading and killing healthy tissue. These abnormal cells can metastasize to other parts of the body via the blood and lymph systems. Cancer in all of its forms is the second leading cause of death in the U.S., following heart disease.[55] High-quality screening can serve to reduce cancer rates; however, complex factors contribute to disparities in cancer incidence and death rates among different ethnic, socioeconomic, and otherwise vulnerable groups. While personal, behavioral, and environmental factors are significant (e.g., smoking, exposure to known carcinogens), the key risk factors for cancer are social determinants of health, including lack of access to healthcare, low socioeconomic status, the natural and built environment where people live, and "institutional racism and the chronic stress it causes."[56]

Why Is It a Health Need?

Cancer qualifies as a health need because of the racial/ethnic disparities that are evident. Local cancer data are for Assembly District 20 (as defined in 2010 and displayed in Table 10 below), an analogous area to Washington Hospital's service area. The overall cancer incidence rate (418.6) in Assembly District 20 is worse than that of Alameda County overall (371.0). The table below displays the most common cancers and rates for racial/ethnic populations where the population fares worse than Alameda County overall, and overall cancer incidence, which is higher for white, Black, and Latina/o residents than for residents of the county overall.

Table 10. Concerning Indicators for Cancer, Assembly District 20 (2019)

Indicator Name	Latino	Asian/ Pac Isl	Black	White	AC
Incidence Rate: Breast (female)	119.9	105.8	106.0	156.0	121.6
Incidence Rate: Prostate (male)	90.4	61.9	134.9	90.2	86.9
Incidence Rate: Colorectal	36.6	26.5	47.7	34.3	32.3
Incidence Rate: Melanoma	7.1	--	--	39.1	18.9
Incidence Rate: Pancreatic	14.5	9.6	--	11.4	11.8
Incidence Rate: Lung	33.7	33.0	31.2	42.0	38.7
Incidence Rate: All Sites	440.5	320.5	454.5	559.3	380.1

Notes: Brown shading indicates a statistic is worse than the county by 5% or more. AC stands for Alameda County. See *Attachment 2: Secondary Data Tables* for all sources.

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[54] Centers for Disease Control and Prevention. (2018). *How to Prevent Cancer or Find It Early*.

[55] Centers for Disease Control and Prevention. (2021). *Leading Causes of Death*.

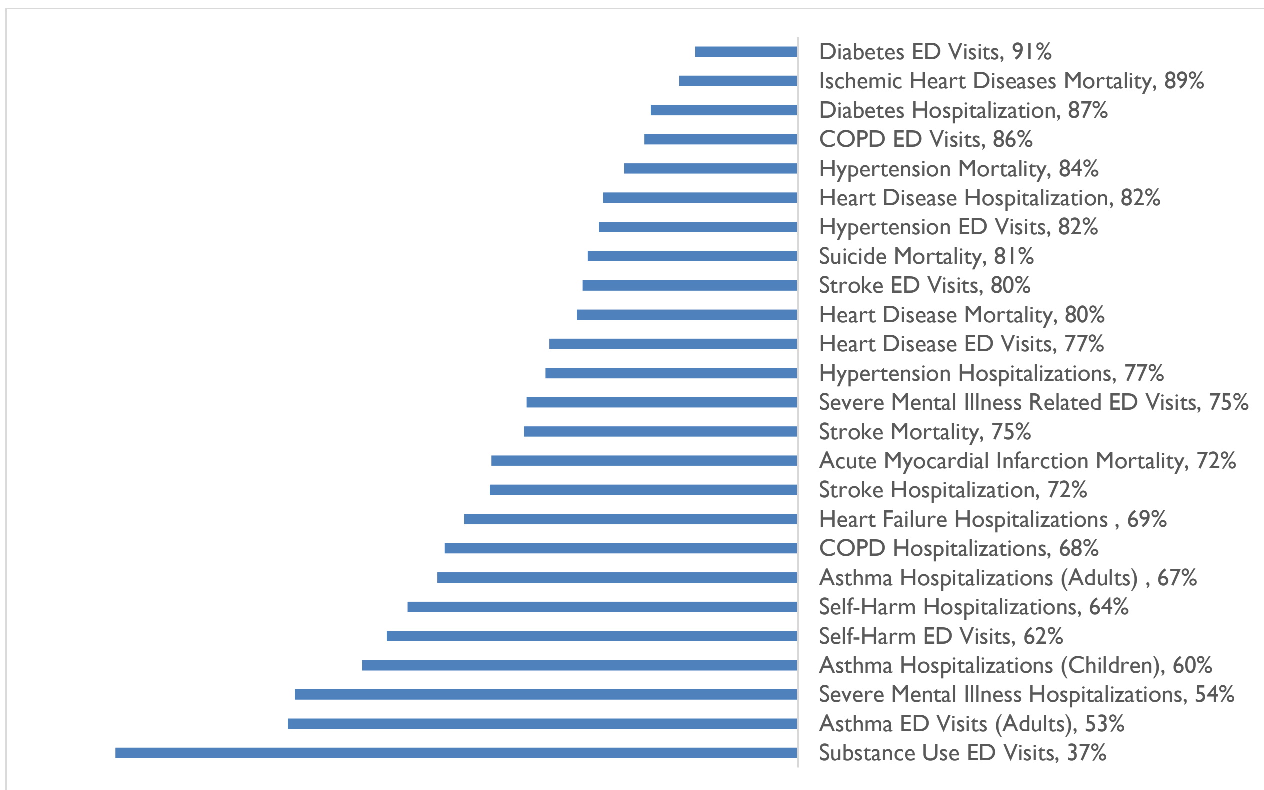
[56] National Cancer Institute. (2022). *Cancer Disparities*. Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

COMPARISON OF SERVICE AREA CITIES TO ALAMEDA COUNTY

In looking at key statistics, it is clear that certain cities in Washington Hospital's service area generally do better in comparison to Alameda County overall, while others do worse. The following charts compare each city's statistics to county statistics on 25 indicators related to four major health needs (Behavioral Health, Diabetes & Obesity, Heart/Stroke, and Respiratory Health).

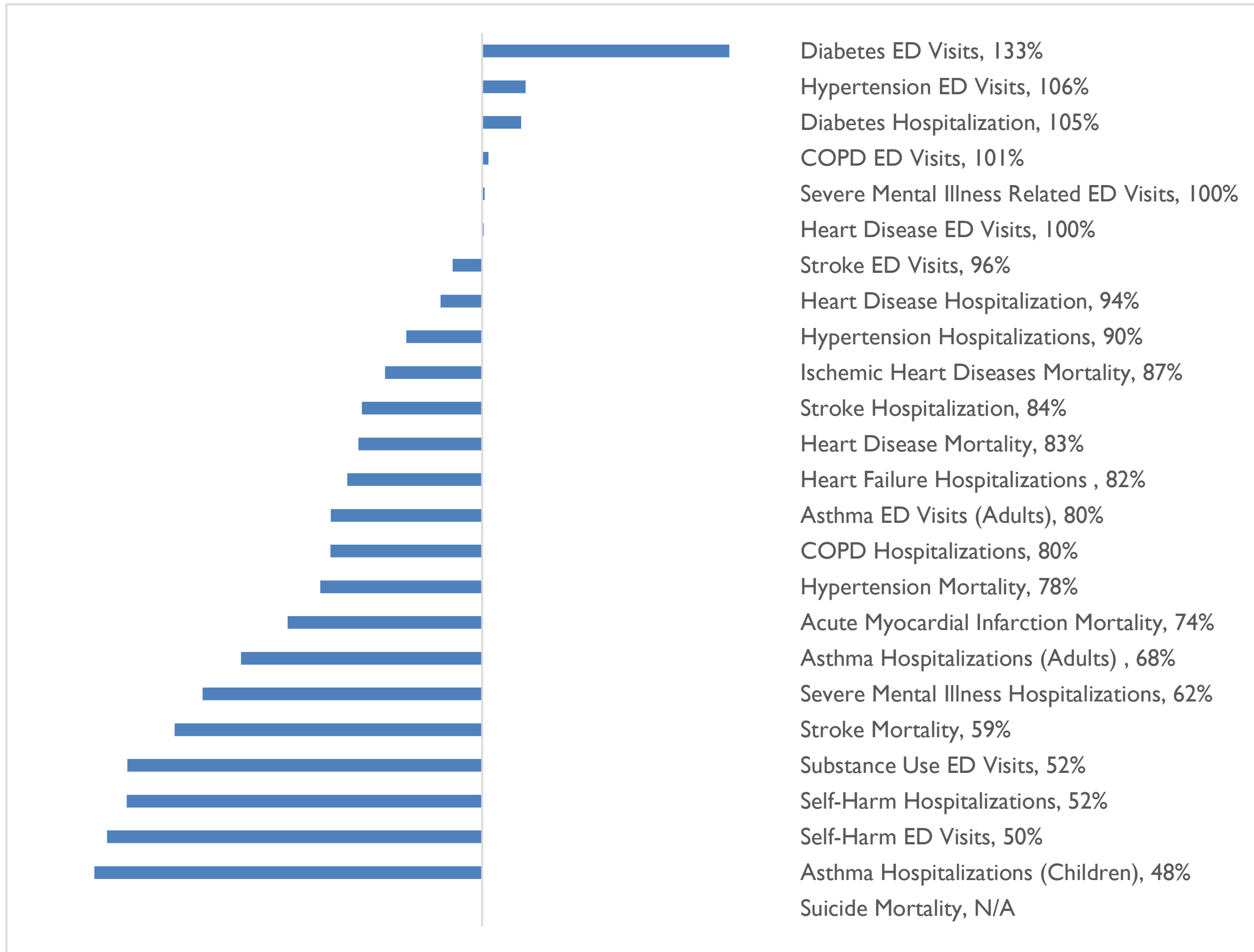
Fremont does better than the county on all 25 indicators. Two of the city's three worst indicators are related to Diabetes (ED visits and hospitalizations), and the third is ischemic heart disease mortality.

Figure 11. Fremont Comparison to Alameda County



Newark does better than the county on all but six of the 25 statistics. One of five Behavioral Health indicators (severe mental illness-related ED visits) is worse for Newark than the county.[57] Both Diabetes indicators (ED visits and hospitalizations) are worse. For Heart/Stroke, two of 12 indicators, hypertension and heart disease ED visits, are worse. Finally, one of five Respiratory Health indicators, COPD ED visits, is worse for Newark than the county.

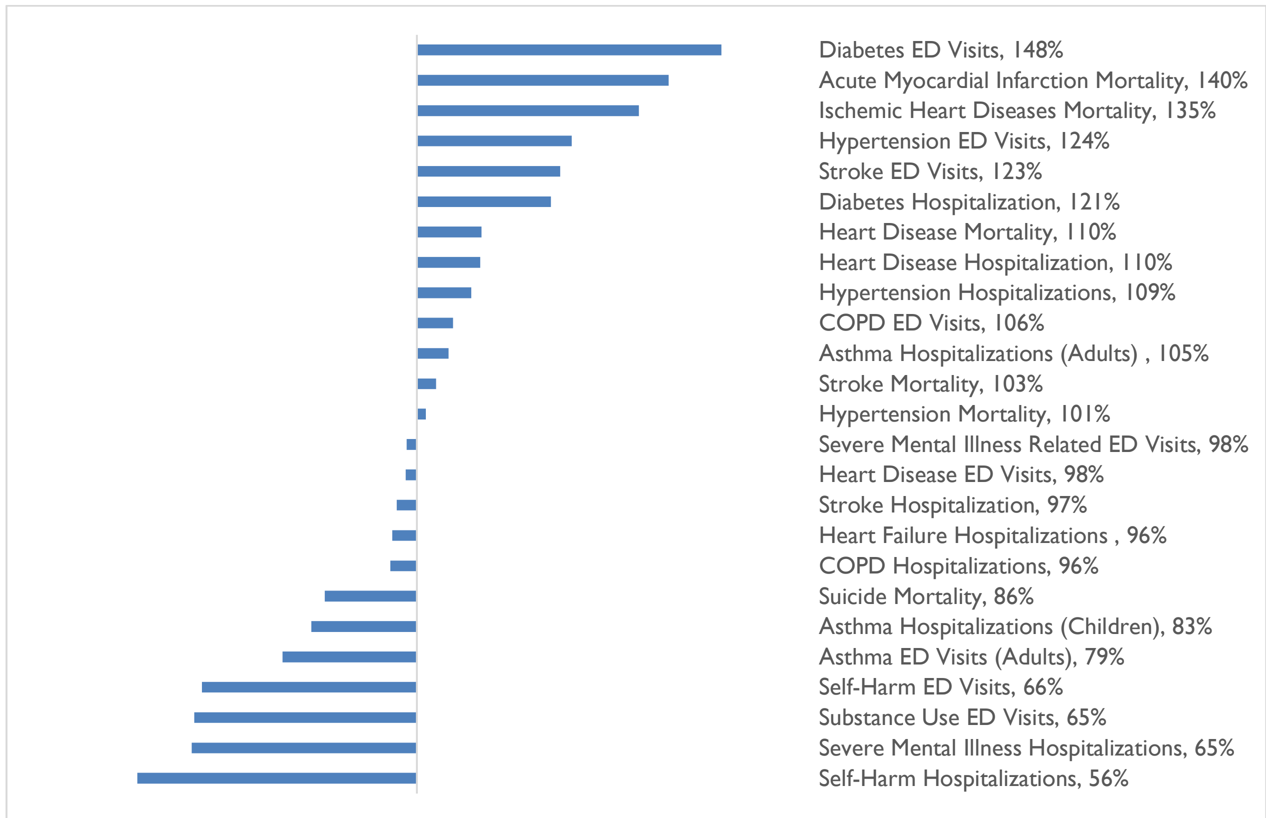
Figure 12. Newark Comparison to Alameda County



[57] For the sixth indicator, suicide mortality, there were too few suicides in Newark to generate a stable mortality rate that could be compared to the county.

Union City does better than the county on about half (12) of the 25 statistics, including all three Behavioral Health indicators. The city does worse on both Diabetes indicators (ED visits and hospitalizations). For Heart/Stroke, nine of the city's 12 indicators are worse; only stroke and heart failure hospitalizations and heart disease ED visits are better than the county's rates. Finally, two of five Respiratory Health indicators, COPD ED visits and adult asthma hospitalizations, are worse for Union City than the county.

Figure 13. Union City Comparison to Alameda County



7. COMMUNITY RESOURCES

Various hospitals and clinics, community-based organizations, government departments and agencies, and other resources in Southern Alameda County are engaged in addressing many of the community health needs identified by this assessment. Hospitals and clinics are listed below. For additional resources available to respond to the identified health needs of the local community, see *Attachment 3: Community Assets and Resources*.

HOSPITALS

- Alameda Health System, John George Psychiatric Hospital
- Fremont Hospital
- Kaiser Foundation Hospital-Fremont
- St. Rose Hospital
- Sutter Health Eden Medical Center
- Washington Hospital Healthcare System

FEDERALLY QUALIFIED HEALTH CENTERS

- Bay Area Community Health (multiple sites, incl. mobile clinics)
- Tiburcio Vasquez Health Center (multiple sites)

OTHER HEALTH CLINICS

- Alameda Health System (Hayward Wellness, Newark Wellness)
- Sutter Health Palo Alto Medical Foundation, Fremont Center
- Washington Township Medical Foundation (multiple sites)

8. CONCLUSION

Washington Hospital Healthcare System worked with its consultants, Actionable Insights, to complete the 2023 Community Health Needs Assessment. The 2023 CHNA meets federal and state requirements. By gathering secondary data and conducting new primary research, the hospital was able to understand the community's perception of health needs as well as prioritize health needs with consideration for how each compares against benchmarks.

The CHNA report was adopted by the Washington Township Health Care District Board of Directors on May 10, 2023.

Next steps for Washington Hospital Healthcare System:

- Make CHNA report publicly available on the Community Benefit page of the hospital's website by June 30, 2023.[58]
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs (independently and/or with local partners).
- Ensure strategies are adopted by the hospital.

[58] https://www.whhs.com/about-us/community-connection/community-health-needs-assessment/

9. LIST OF ATTACHMENTS

1. Community Leaders, Representatives, and Members Consulted
2. Secondary Data Tables
3. Community Assets and Resources
4. Qualitative Research Protocols
5. IRS Checklist

ATTACHMENT 1: COMMUNITY LEADERS, REPRESENTATIVES, AND MEMBERS CONSULTED

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities, and the medically underserved.

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Organizations							
1	Interview	James Wagner, Deputy Director of Clinical Operations, Alameda County Behavioral Health	Behavioral health	1	Low-income, medically underserved	Leader	10/11/2022
2	Interview	Alameda County Behavioral Health	Behavioral health	1	Low-income, medically underserved	Leader	10/11/2022
3	Interview	Yugi Albior, TransVision Supervisor, Bay Area Community Health (BACH)	LGBTQIA+ community	1	Medically underserved, minority groups	Leader, member	10/12/2022
4	Interview	Padmaja Magadala, HIV/TransVision Program Director, Bay Area Community Health (BACH)	LGBTQIA+ community	1	Medically underserved, minority groups	Leader	10/12/2022
5	Interview	Suzanne Shenfil, Director of Human Services, City of Fremont	Housing/ homelessness	1	Low-income, medically underserved	Leader	10/17/2022

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
6	Interview	Kimi Watkins-Tartt, Public Director, Alameda County Health Care Services Agency	Public health	1	Low-income, medically underserved, minority groups	Leader	10/24/2022
7	Interview	Evette Brandon, QIA Director, Alameda County Health Care Services Agency	Public health	1	Low-income, medically underserved, minority groups	Leader, member	10/24/2022
8	Focus Group	Host: South County Partnership	Southern Alameda County Health	8	Low-income, medically underserved, minority groups	(see below)	9/20/2022
		Attendees:					
		Annie Bailey, Administrator, City of Fremont, Human Services Department, Youth & Family Services Division				Leader	
		Angus Cochran, Chief, Community Support Services, Washington Hospital Healthcare System				Leader	
		Nick Cuevas, Recreation & Community Services Manager, City of Newark				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Jennifer Dow-Rowell, Executive Director, Safe Alternatives to Violent Environments (SAVE)				Leader	
		Lucy Hernandez, Director of Development, Community Relations, Bay Area Community Health (BACH)				Leader	
		Preet Kaur Sabharwal, Community Program Manager, The Hume Center				Leader	
		Director of Strategic Partnerships, Tiburcio Vasquez Health Center				Leader	
		Human Services Director, City of Fremont				Leader	
9	Focus Group	Host: Washington Hospital	Disability community & older adults	13	Medically underserved	(see below)	10/7/2022
		Attendees:					
		Marly Beck, Program Manager, Tri-City Volunteers Food Bank and Mobile Pantry				Leader	
		David Bible, Resident Experience Coordinator, Masonic Homes of California, Union City				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Shawn Fong, Ride-On Tri-City Program Manager, City of Fremont Human Services Department				Leader	
		Karen Grimsich, Administrator, City of Fremont				Leader	
		Patricia Osage, Executive Director, LIFE Eldercare				Leader	
		Lucy Rivello, Clinical Director, Regional Center of the East Bay (RCEB)				Leader	
		Anna Wang, Vice President of Local Programs and Community Relations, Friends of Children with Special Needs (FCSN)				Leader	
		Acacia Creek Retirement Community				Leader	
		Alameda County Behavioral Health Care Services				Leader	
		Deaf Counseling Advocacy & Referral Agency (DCARA)				Leader, member	
		Health and Wellness Coach, Union City Senior Commission				Leader	
		Recreation Supervisor, City of Newark				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Union City Family Center				Leader	
Community Members							
10	Focus Group	Host: Newark Promotores Network	Spanish-speaking community members	15	Minority groups, medically underserved	Members, representatives	10/14/2022
11	Focus Group	Host: Washington Hospital	English-speaking minority community members	7	Minority groups	Members	11/8/2022

ATTACHMENT 2: SECONDARY DATA TABLES

Data Table Notes

Data Tables are presented in health need prioritization order.

Emergency Department visits data and hospitalizations data: The International Classification of Diseases, Clinical Modification (ICD-CM) is a system used by healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded by hospitals in the United States. In California, these data are then submitted to California's Office of Statewide Health Planning and Development. Beginning October 1, 2015, medical coding changed from ICD-9-CM to ICD-10-CM. Due to the change, one cannot make comparisons or establish trends for hospitalization and emergency department visits between data before and after that point in time. For example, ICD-10-CM added 65,000 new codes that are now used to more precisely describe different illnesses and ailments. **Because those codes did not exist in ICD-9-CM, newly coded data cannot be compared with older data**.

Trends: Where trends were available, color-coded arrows are used to show directionality (green marks positive trends, and red marks negative trends.) Where the trend is unclear, or the rates were substantially similar in previous years, no arrow is used. Also, black arrows are used (without shading) for data that are neither positive nor negative (such as socio-demographic indicators).

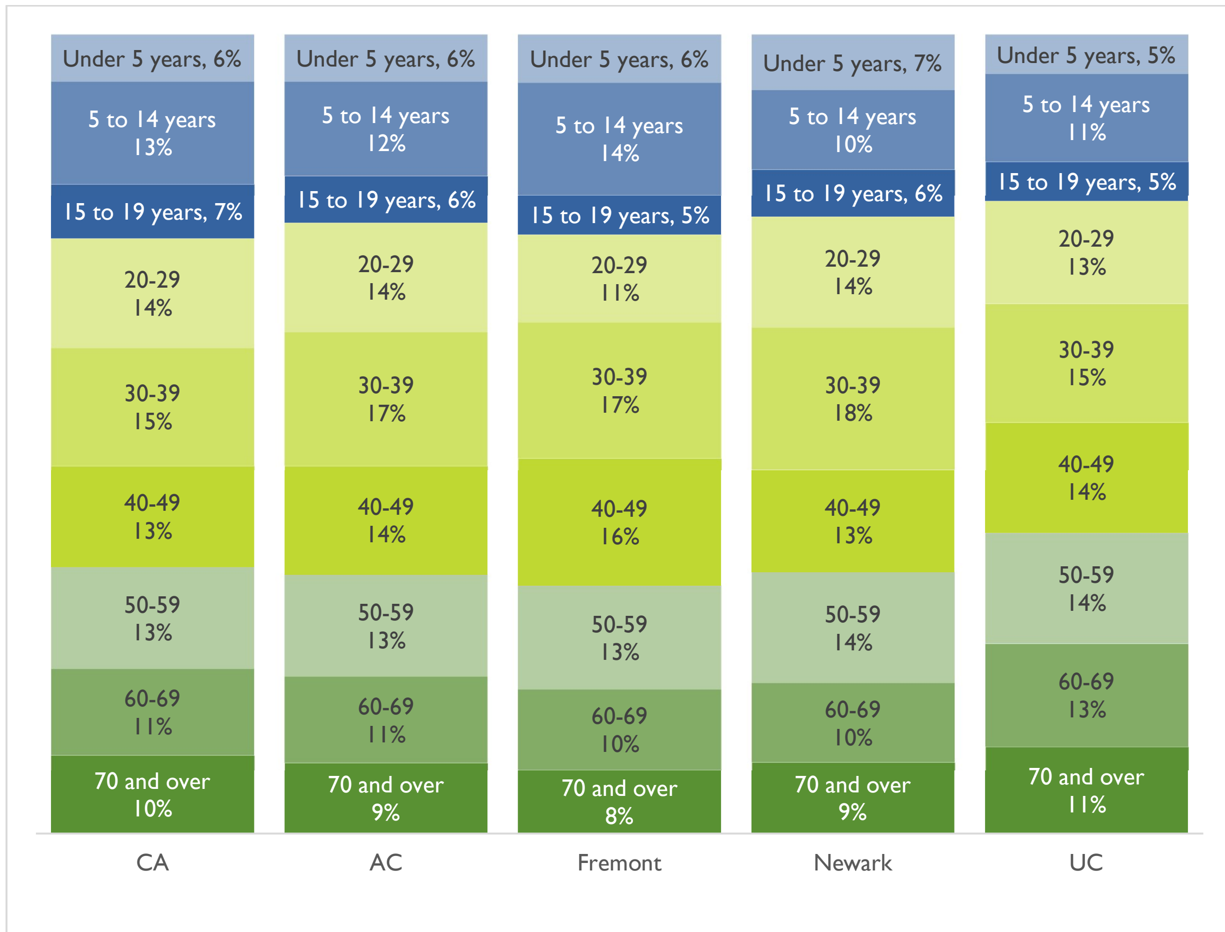
Demographics

Table 11. Total Population (Count and Percentage of County)

	Fremont	Newark	Union City	Alameda County
2007–2011	211,748 (14.2%)	42,322 (2.8%)	68,830 (4.6%)	1,494,876
2010–2014	221,654 (14.2%)	43,635 (2.8%)	71,675 (4.6%)	1,559,308
2013–2017	230,964 (14.2%)	45,554 (2.8%)	74,354 (4.6%)	1,629,615
2014–2018	233,083 (14.2%)	46,276 (2.8%)	74,601 (4.5%)	1,643,700
2017–2021[a]	↓ 231,502 (13.8%)	↑ 47,815 (2.9%)	↓ 70,828 (4.2%)	↑ 1,673,133

Source: U.S. Census Bureau, 5-Year Estimates. Table S0101. Note: [a] Estimates that contain the year 2020 are not comparable to other five-year estimates due to methodology differences that may exist between different data sources. See https://www.census.gov/programs-surveys/acs/guidance/comparing-acs-data/2021/5-year-comparison.html for more information.

Figure 14: Population by Age Range and City, 2017–2021



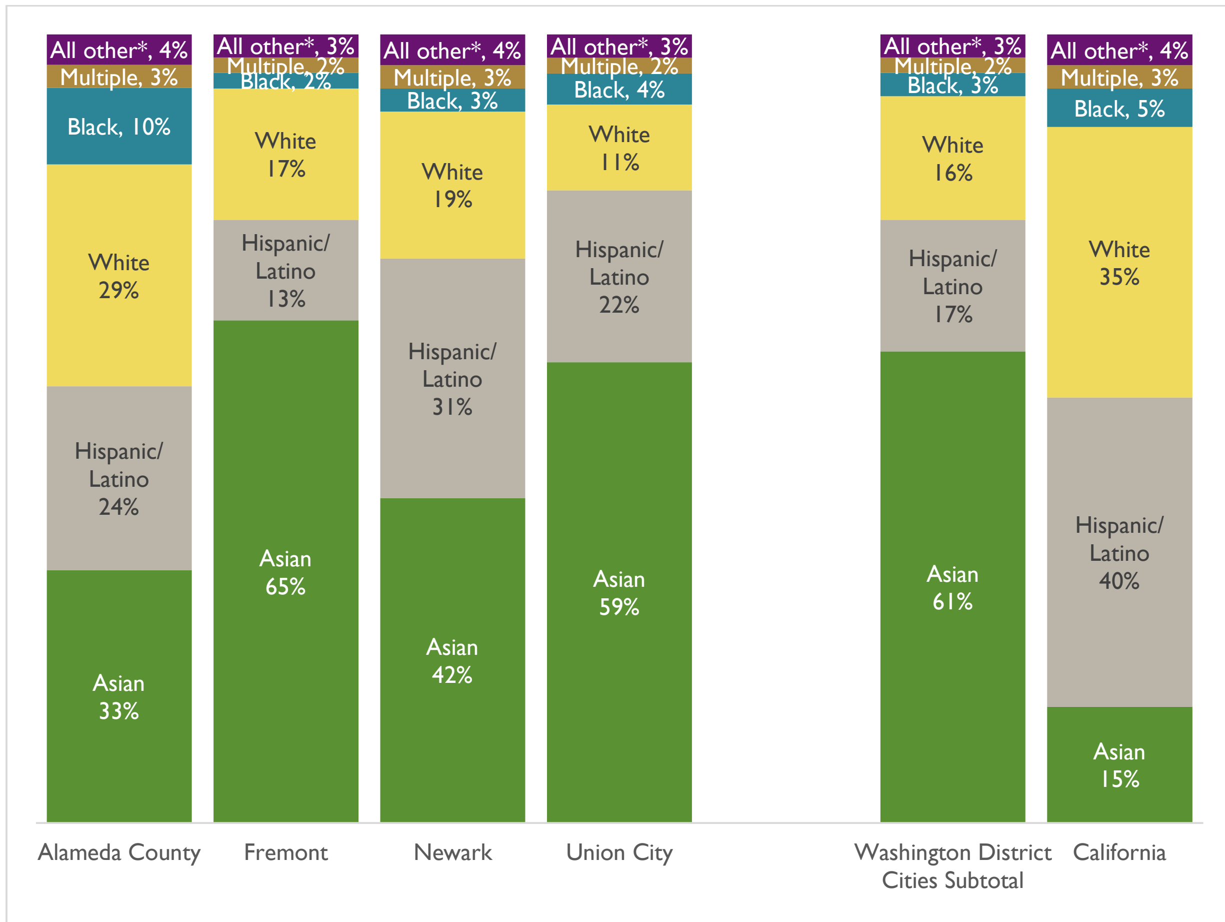
Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2017-2021. Notes: CA stands for California; AC stands for Alameda County; UC stands for Union City.

Table 12. Race/Ethnicity (Percentage), 2020

Race/Ethnicity	Fremont	Newark	Union City	Alameda County
Latino	13	31	22	24
White	17	19	11	29
Asian	65	42	59	33
Black	2	3	4	10
Two or More	2	3	2	3
Other	0.6	0.5	0.4	0.6
Pacific Islander	0.4	1.4	1.1	0.8

Source: U.S. Census Bureau Decennial Census, 2020. U.S. Census race/ethnicity estimates for 2017–2021 not available at time of report publication. Proportions

Figure 15: Population by Race/Ethnicity, 2020



Source: U.S. Census Bureau, Decennial Census, 2020. Notes: U.S. Census race/ethnicity estimates for 2017–2021 not available at time of report publication. Proportions are for race "alone" (single race) and non-Hispanic. * Purple segment is those of all other races combined (Pacific Islander/native Hawaiian, Native American, and "Other" race). Native American residents make up 0.2% of the city populations (not labeled in the chart). Those of "Other" race alone (not multi-racial) make up 1% or less of the cities' populations (not labeled in the chart). Pacific Islander/native Hawaiian make up 1% or less of the cities' populations (not labeled in the chart).

Behavioral Health

The last table in this section presents available data by race/ethnicity.

Table 13. Severe Mental Illness Related ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	1,840.1	2,436.4	**2,323.2**	2,265.5
2018–2020	↓ 1,716.4	↓ **2,294.4**	↑ 2,249.3	↑ 2,285.9

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 14. Severe Mental Illness Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	869.9	1,130.1	1,007.9	1,452.2
2018–2020	↓ 755.1	↓ 876.5	↓ 906.0	↓ 1403.4

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020.

Table 15. Self-inflicted Injury ED Visits (Age-Adjusted Rate per 100,000 Pop.)

		Fremont	Newark	Union City	Alameda County
2016–2017	Adult	53.9	69.0	40.5	93.6
	Child	179.6	137.2	140.6	197.0
	All ages	57.6	52.8	42.9	76.6
2022	All ages	↓ 32.0	↓ 25.5	↓ 34.0	↓ 51.4

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2022. For self-harm codes, see the CSTE definition at https://resources.cste.org/Injury-Surveillance-Methods-Toolkit/Home/GeneralInjuryIndicators. Note: Adults are 18 years old and older; children are under 18 years old.

Table 16. Self-Inflicted Injury Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	12.7	**17.7**	16.6	17.3
2018–2020	↑ 17.2	↓ 14.0	↓ 15.0	↑ 26.8

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. For self-harm codes, see the CSTE definition at https://resources.cste.org/Injury-Surveillance-Methods-Toolkit/Home/GeneralInjuryIndicators. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 17. Suicide Mortality (Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	7.5	7.1	8.9	9.0
2010–2012	7.3	6.6	7.3	8.6
2011–2013	6.3	5.0	4.2	8.6
2012–2014	6.5	7.2	4.0	9.1
2013–2015	6.0	5.8	7.3	9.4
2014–2016	5.9	8.6	**9.4**	9.3
2015–2017	6.7	5.3	8.3	8.7
2016–2018	7.3	6.9	6.5	8.7
2018–2020	↓ 6.7 (N=49)	-- (N<10)	↑ 7.1 (N=17)	↓ 8.3 (N=437)

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes U03, X60-X84, Y87.0. Note: N=Number (count).

Table 18. Depression-Related Feelings (Percentage)

		Fremont	Newark	Union City	Alameda County
2017–2019	7th Grade	22.1	28.6	34.7	25.6
	9th Grade	27.6	34.5	41.5	29.9
	11th Grade	**36.9**	**36.0**	41.4	35.2
	NT Schools	42.9	32.4	47.1	37.4

Source: California Healthy Kids Survey, 2017–2019. Notes: NT is "non-traditional." Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 19. Adults Ever Diagnosed with Depression (Percentage)

	Fremont	Newark	Union City	Alameda County
2019	13.1	**15.3**	12.8	14.8

Source: U.S. Centers for Disease Control and Prevention PLACES data. 2019. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 20. Adults with Likely Serious Psychological Distress (Percentage)

	Fremont	Newark	Union City	Alameda County
2019–2020	9.6	9.9	9.5	10.4

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019–2020.

Table 21. Severe Mental Illness Related ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2018–2020	1,048.9	1,336.5	1,485.3	1,703.1

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes F2[0-9]|F30[1-3,8-9]| F31[0-6]|F317[0-1,3,5,7]|F31[8-9]|F32[2-4]|F32[8-9]|F33[1-3]|F334[0-1]|F33[8-9]|F34|F39|F400|F4[1–2]|F431|F4[4-5]|F48[1–2]|F60|F50|F53|F91.

Table 22. Severe Mental Illness Related to Drugs and Alcohol ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2018–2020	6.0	9.1	8.4	19.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes F101[4-5]|F10180|F102[4-5]|F10280|F109[4-5]|F10980|F111[4-5]|F112[4-5]|F119[4-5]|F12150|F12180|F1225|F12280|F1295|F12980|F131[4-5]|F13180|F132[4-5]|F13280|F139[4-5]|F13980|F141[4-5]|F14180|F142[4-5]|F14280|F149[4-5]|F14980|F151[4-5]|F15180|F152[4-5]|F15280|F159[4-5]|F15980|F161[4-5]|F16180|F162[4-5]|F16280|F169[4-5]|F16980|F181[4-5]|F18180|F182[4-5]|F18280|F189[4-5]|F18980|F191[4-5]|F19180|F192[4-5]|F19280|F199[4-5]|F19980

Table 23. Severe Mental Illness Related to Drugs and Alcohol Hospitalizations (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2018–2020	9.3	11.0	11.0	36.4

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. See *Table 18* for ICD-10 codes.

Table 24. Substance Use ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	856.9	1,249.1	1,184.2	1,584.6
2018–2020	↓ 406.9	↓ 570.6	↓ 708.5	↓ 1,090.3

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes F1[0-6,8-9]|T40[0-9]..(A|$|\b).

Table 25. Substance Abuse, Dependence, and Overdose Related Hospitalizations (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2018–2020	273.5	339.7	378.9	825.7

Source: Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes F1[0-6,8-9]|T40[0-9]..(A|$|\b).

Table 26. Alcohol: Binge Drinking, Adults (Percentage)

	Fremont	Newark	Union City	Alameda County
2019	15.1	16.7	14.3	15.8

Source: U.S. Centers for Disease Control and Prevention PLACES data. 2019. Note: Binge drinking is consuming five or more drinks of alcohol within a couple of hours in the previous 30 days. Brown shading indicates that the data are worse than the county by 5% or more.

Table 27. Alcohol: Binge Drinking on Two Occasions in Past Month, Students (Percentage)

	Grade	Fremont Unified SD	Newark Unified SD	Union City New Haven USD	Alameda County
2017–2019	7th	0.2	0.8	0.1	0.2
	9th	0.4	0.0	0.6	0.7
	11th	0.8	2.0	1.5	2.0
	NT schools	4.3	2.6	0.0	4.5

Source: California Healthy Kids Survey. 2018–2019. Notes: Binge drinking is consuming five or more drinks of alcohol within a couple of hours. (For example, an estimated 0.2% of Fremont Unified 7th graders had binge drunk on 2 occasions (days) in the previous month). NT is "non-traditional." Brown shading indicates that the data are worse than the county by 5% or more.

Table 28. Alcohol/ Drug Use in the Past Month (Percentage)

	Grade	Fremont Unified SD	Newark Unified SD	Union City New Haven USD	Alameda County
2018–2020	7th	3.2	6.7	6.4	5.1
	9th	7.1	10.8	18.3	13.3
	11th	12.9	20.6	22.6	23.4
	NT schools	48.6	31.9	28.6	42.3

Source: California Healthy Kids Survey. 2018–2020. Notes: NT is "non-traditional." Brown shading indicates that the data are worse than the county by 5% or more.

Table 29. Population 65 and Over Living Alone

	Fremont	Newark	Union City	Alameda County
2016–2020	16.0	11.6	11.5	22.8

Source: U.S. Census Bureau Factfinder. American Community Survey 5-Year Estimates.

Table 30. Domestic Violence Calls

	Fremont	Newark	Union City	Alameda County
Calls (Count) (2020)	416	136	132	5,183
Crude Rate per 1,000 (2014–2016)	4.9	9.7	6.9	11.3

Sources: Calls: California Dept. of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance. July 2021.; California Dept. of Finance, Population Estimates and Projections. May 2021. Retrieved December 2022 from census.gov/programs-surveys/cbp.html; Rate: Alameda County Domestic Violence Review Team, Domestic Violence in Alameda County. June 2018.

Table 31. Behavioral Health Data by Race/Ethnicity

	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	Other
Adults Serious Psychological Distress	4.9		9.7		10.3	12.9	23.9	
Student AOD use, Alameda County	19.8	8.9	6.5	16.3	16.4	17.3	15.5	10.3
Student AOD use, Fremont Unified SD	17.1	5.1	4.5	13.3	7.1	10.9	10.2	5.2
Student AOD use, New Haven SD	12.7	2.2	4.1	8.3	9.6	4.5	8.2	2.6
Student AOD use, Newark Unified SD	13.8	0	3.7	9.9	18.4	17	13.4	7.7

Sources: Serious Psychological Distress: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019–2020; Student AOD use: California Healthy Kids Survey. 2018–2020. Note: AOD is "alcohol or drug." Brown shading indicates that the data are worse than the county by 5% or more. "Nat Am"= Native American/Alaskan native; "Pac Isl"=Pacific Islander/native Hawaiian; "Multi"=Two or more races.

Housing and Homelessness

Table 32. Owner-Occupied Housing Units (Percentage of All Units)

	Fremont	Newark	Union City	Alameda County
2007–2011	64.3	72.2	69.4	54.5
2010–2014	63.2	69.0	65.1	52.9
2013–2017	62.4	69.2	65.7	53.0
2016–2020	↓ 58.6	↓ 65.8	↓ 62.6	↓ 50.7

Source: U.S. Census Bureau Factfinder. American Community Survey 5-Year Estimates.

Table 33. Rent-Burdened Households (Percentage)

	Fremont	Newark	Union City	Alameda County
2007–2011	38.8	44.7	**51.0**	49.3
2010–2014	39.9	48.6	**50.4**	50.2
2013–2017	39.7	**49.9**	47.3	48.9
2016–2020	↓ 39.0	↓ 44.8	↓ 42.8	↓ 48.4

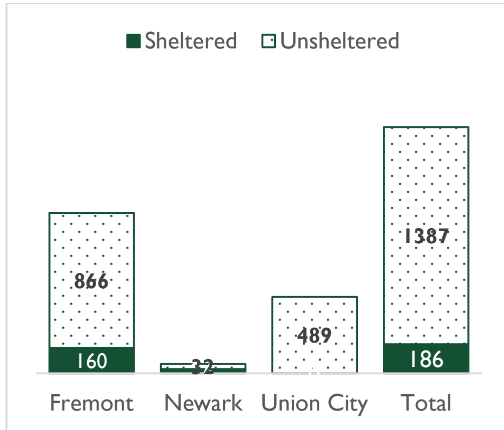
Source: U.S. Census Bureau Factfinder. Notes: A rent-burdened household is defined as a household in which the monthly rent is 30% or more of the household income. Bold indicates that the data are worse than the county, but by less than 5%.

Table 34. Individuals Experiencing Homelessness (Count)

<table>
<tr><th></th><th></th><th>Fremont</th><th>Newark</th><th>Union City</th><th>Alameda County</th></tr>
<tr><td rowspan="3">2017</td><td>Sheltered</td><td>197</td><td>42</td><td>0</td><td>1,766</td></tr>
<tr><td>Unsheltered</td><td>282</td><td>28</td><td>40</td><td>3,863</td></tr>
<tr><td>Total</td><td>479</td><td>70</td><td>40</td><td>5,629</td></tr>
<tr><td rowspan="3">2019</td><td>Sheltered</td><td>123</td><td>30</td><td>0</td><td>1,710</td></tr>
<tr><td>Unsheltered</td><td>485</td><td>59</td><td>106</td><td>6,312</td></tr>
<tr><td>Total</td><td>608</td><td>89</td><td>106</td><td>8,022</td></tr>
<tr><td rowspan="3">2022</td><td>Sheltered</td><td>↑ 160
(16% of all homeless)</td><td>↓ 26
(45% of all homeless)</td><td>0
(0% of all homeless)</td><td>↑ 2,612
(27% of all homeless)</td></tr>
<tr><td>Unsheltered</td><td>866
(84% of all homeless)</td><td>32
(55% of all homeless)</td><td>489
(100% of all homeless)</td><td>7,135
(73% of all homeless)</td></tr>
<tr><td>Total</td><td>↑ 1,026
Crude rate 451.0</td><td>↓ 58
Crude rate 122.3</td><td>↑ 489
Crude rate 712.0</td><td>↑ 9,747
Crude rate 591.2</td></tr>
</table>

Source: Applied Survey Research. Alameda County Homeless Count. 2017, 2019, and 2022. Additional calculations by Actionable Insights, LLC based on July 2022 population estimates. Notes: HUD defines sheltered homeless persons as adults, children, and unaccompanied children who, on the night of the count, are living in shelters for the homeless. Data not available by city prior to 2017. Brown shading indicates that the data are worse than the county by 5% or more.

Figure 16. Individuals Experiencing Homelessness, 2022 (Count)



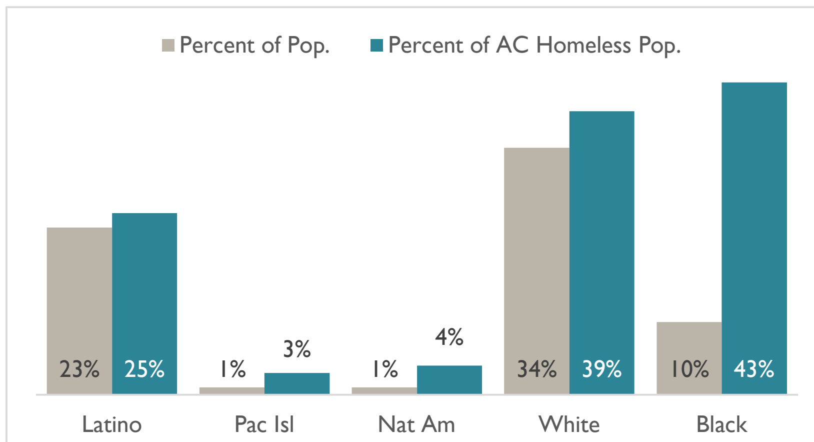
Source: Applied Survey Research. Alameda County Homeless Count. 2022.

Table 35. Alameda County Homeless Population by City (Percentage of County)

	Fremont	Newark	Union City	Alameda County
2022	5%	2%	2%	100%

Source: Applied Survey Research. Alameda County Homeless Count. 2022.

Figure 17. Proportion of Homeless Population by Race/Ethnicity



Source: Applied Survey Research. Alameda County Homeless Count. 2022.

Table 36. Homeless who are Chronically Homeless (Percentage)

	Fremont	Newark	Union City	Alameda County
2016–2020	27	48	--	28

Source: Applied Survey Research. Alameda County Homeless Count. 2022. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Economic Security

Please see the *Housing & Homelessness* section for data related to housing costs and numbers of persons experiencing homelessness. The last table in this section presents available data by race/ethnicity.

Table 37. Median Household Income (Dollars)

	Fremont	Newark	Union City	Alameda County
2007–2011	98,513	81,777	82,634	70,821
2010–2014	103,591	86,521	82,564	73,775
2013–2017	122,191	96,817	95,625	85,743
2016–2020	↑ 142,374	↑ 127,619	↑ 120,772	↑ 104,888

Source: U.S. Census Bureau; American Community Survey 5-Year Estimates, 2007–2020. Table B19013.

Table 38. Per-Capita Income (Dollars)

	Fremont	Newark	Union City	Alameda County
2016–2020	55,950	**47,136**	**43,336**	49,883

Source: U.S. Census Bureau; American Community Survey, 2016–2020 American Community Survey 5-Year Estimates. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 39. Poverty, Children Below 100% FPL (Percentage)

	Fremont	Newark	Union City	Alameda County
2010–2014	7.1	11.7	10.1	15.8
2011–2015	6.2	12.2	9.8	15.2
2012–2016	4.8	10.7	9.1	14.4
2013–2017	3.9	9.2	8.3	13.0
2016–2020	↓ 3.5	↓ 4.0	↓ 5.3	↓ 10.2

Source: U.S. Census Bureau; American Community Survey, American Community Survey 5-Year Estimates. 2010–2020. Note: FPL=Federal Poverty Limit.

Table 40. Poverty, Families Living Below 100% FPL (Percentage)

	Fremont	Newark	Union City	Alameda County
2016–2020	2.8	1.9	3.3	5.8

Source: U.S. Census Bureau; American Community Survey, 2016–2020 American Community Survey 5-Year Estimates. Note: FPL=Federal Poverty Limit.

Table 41. Poverty, People Aged 65 and Over Living Below 100% FPL (Percentage)

	Fremont	Newark	Union City	Alameda County
2010–2014	6.7	6.8	8.5	9.7
2011–2015	6.8	8.2	8.1	9.2
2012–2016	6.3	7.1	8.1	9.5
2014–2018	7.3	5.4	6.4	9.7
2016–2020	↓ 7.1	↓ 5.1	↑ 7.6	↑ 9.8

Source: U.S. Census Bureau; American Community Survey, American Community Survey 5-Year Estimates, 2010–2020. Table S1701. Note: FPL=Federal Poverty Limit.

Table 42. Youth Ages 16–19 Not in School nor Working (Percentage)

	Fremont	Newark	Union City	Alameda County
2016–2020	0.3	1.7	1.8	0.7

Source: U.S. Census Bureau; American Community Survey, 2016–2020 American Community Survey 5-Year Estimates. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 43. People 25 and Over with a Bachelor's Degree or Higher (Percentage)

	Fremont	Newark	Union City	Alameda County
2011–2014	51.7	28.9	35.0	42.1*
2012–2016	54.0	30.3	36.2	43.9
2016–2020	↑ 58.7	↑ 37.8	↑ 41.4	↑ 48.7

Source: U.S. Census Bureau, American Community Survey. *2011–2014 Alameda County rate is for 2010–2020. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 44. Economic Security Data by Race/Ethnicity

	Latino	Nat Am	Asian	Pac Isl/ Hawaiian	Black	White	Multi	AC Overall
Median Household Income	83.0k	82.7k	130.2k	97.5k	56.7k	120.5k	**99.7k**	104.9k
Per Capita Income	28.7k	34.2k	51.5k	32.5k	37.4k	70.2k	33.1k	49.9k
Children Living Below FPL	14.6	15.3	5.1	13.5	27.0	5.0	8.1	10.2
Families Living Below FPL	9.0	12.4	4.7	8.5	13.5	2.6	6.4	5.8
People 65+ Living Below FPL	**9.9**	22.4	12.4	10.6	15.8	6.3	9.3	9.8
High School Graduation Rate	79.3	80.9	95.4		79.8	91.8	89.7	86.9
People 25+ with a Bachelor's Degree or Higher	21.0	20.5	59.3	20.1	31.3	59.3	**46.7**	48.7

Source for High School Graduation Rate: California Department of Education. 2020–2021. Notes: For other year and source data, see corresponding tables above. Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%. "Nat Am"= Native American/Alaskan native; "Pac Isl"=Pacific Islander/native Hawaiian; "Multi"=Two or more races. AC stands for Alameda County. High School Graduation Rate data not available by city.

Table 45. Arrests (Rate per 1,000) by Age, Race/Ethnicity

	Latino	Nat Am	Asian	Pac Isl/ Hawaiian	Black	White	AC Overall
Juvenile Arrests	3.0				10.4	0.6	2.3
Adult Arrests	26.4				64.3	15.2	20.8

Source: California Department of Justice Criminal Justice Statistics Center. 2020. Notes: Brown shading indicates that the data are worse than the county by 5% or more. "Nat Am"= Native American/Alaskan native; "Pac Isl"=Pacific Islander/native Hawaiian; "Multi"=Two or more races. AC stands for Alameda County. These data were not available by city.

Diabetes & Obesity

The last table in this section presents available data by race/ethnicity.

Table 46. Adults with Diabetes (Percentage)

	Fremont	Newark	Union City	Alameda County
2019–2020	11.4	13.6	13.7	10.3

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019–2020. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 47. Diabetes ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	2,008.2	2,890.0	3,191.6	2,674.7
2018–2020	↓ 1,396	↓ 2,053.8	↓ 2,280.7	↓ 1,541.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017. ICD-10 codes E10, E11, E13. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 48. Diabetes Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	1,494.1	1,844.8	2,054.1	1,702.8
2018–2020	↓ 1,307.9	↓ 1,592.1	↓ 1,831.7	↓ 1,512.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 49. Adults who are Obese

	Fremont	Newark	Union City	Alameda County
2020	19.0	24.6	21.2	25.4

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2020.

Table 50. Children who are Overweight for Age (Ages 2–11) (Percentage)

	Fremont	Newark	Union City	Alameda County
2019–2020	13.3	15.0	15.2	14.3

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019–2020. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 51. Workers who Walk to Work

	Fremont	Newark	Union City	Alameda County
2016–2020	1.2	2.6	0.8	3.3

Source: U.S Census Bureau, 5-Year Estimates, American Community Survey. 2016–2020. Table DP02. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 52. Diabetes & Obesity Data by Race/Ethnicity

	Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC Overall
Adults with Diabetes	10.1		11.5		13.8	9.6	2.1	10.3
Adults who are Obese	29.2		10.9		43.8	28	38.5	25.4
Workers who Walk to Work	3.3	6.8	3.1	3.6	2.3	3.8	3.7	3.3

Notes: For year and source, see corresponding tables above. Brown shading indicates that the data are worse than the county by 5% or more. “Nat Am”= Native American/Alaskan native; “Pac Isl”=Pacific Islander/native Hawaiian; “Multi”=Two or more races. AC stands for Alameda County.

Heart Disease, Hypertension, and Stroke

Table 53. Adults with Heart Disease (Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2011–2012	5.7	5.8	**5.9**	5.8
2013–2014	5.4	5.2	5.5	5.5
2018–2019	↑ 5.8	↑ 5.5	↑ 5.8	↑ 5.9

Source: California Health Interview Survey (Neighborhood Edition). UCLA Center for Health Policy Research, Los Angeles, CA. 2019. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 54. Heart Disease ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	372.3	384.3	459.3	481.2
2018–2020	↓ 236.5	↓ **307.2**	↓ 301.1	↓ 306.4

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 55. Heart Disease Hospitalization (Age-Adjusted Rates per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	469.8	518.6	593.6	559.7
2018–2020	↓ 464.6	↑ 534.4	↑ 622.2	↑ 565.7

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020 (Codes I0[1,2,5-9], I11, I2[0-7], I3[0-5], I[4-5], I97[0,1], R001). Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 56. Heart Failure ED Visits and Hospitalizations (Age-Adjusted Rates per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
ED Visits 2018–2020	339.4	**423.5**	481.5	413.9
Hospitalizations 2018–2020	641.0	757.0	888.5	924.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 57. Heart Disease Mortality (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	126.1	126.6	124.7	133.8
2010–2012	121.7	120.7	125.0	130.4
2011–2013	118.8	111.4	135.6	128.1
2012–2014	107.9	106.1	**127.1**	123.1
2013–2015	102.7	101.3	109.7	121.0
2014–2016	97.2	105.2	**122.4**	119.5
2015–2017	100.8	**117.9**	133.4	116.5
2016–2018	95.6	**114.1**	140.5	111.6
2018–2020	↓ 86.9	↓ 90.9	↓ 120.1	↓ 109.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I00-I09, I11, I13, I20-I51. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 58. Ischemic Heart Disease Mortality (Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	80.8	83.8	92.4	84.1
2010–2012	76.6	71.9	91.2	80.6
2011–2013	76.8	65.2	88.9	77.6
2012–2014	69.4	63.1	77.0	72.3
2013–2015	65.0	60.9	65.7	69.8
2014–2016	58.6	63.0	76.3	67.0
2015–2017	58.3	77.7	82.3	63.4
2016–2018	53.0	73.4	83.9	57.6
2018–2020	↓ 49.9	↓ 48.7	↓ 75.6	↓ 56.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I20-I25. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 59. Acute Myocardial Infarction Mortality (Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	19.4	24.9	**25.9**	25.8
2010–2012	16.9	19.2	23.8	24.8
2011–2013	17.8	19.3	23.0	23.9
2012–2014	16.7	16.0	17.6	22.1
2013–2015	14.9	15.1	17.5	20.7
2014–2016	15.1	11.9	21.0	21.0
2015–2017	15.8	14.8	23.5	20.4
2016–2018	15.4	17.6	25.8	19.5
2018–2020	↓ 14.3	↓ 14.7	↑ 27.8	↑ 19.9

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I21-I22. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 60. Hypertension ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	4,092.7	**5,421.0**	5,874.8	5,405.0
2018–2020	↓ 2,311.1	↓ 2,994.1	↓ 3,517.9	↓ 2,827.2

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 code I10. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 61. Hypertension Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	2,430.9	3,007.0	**3,172.7**	3,058.0
2018–2020	1,936.8	2,264.3	2,736.9	2,520.2

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes I10-I13. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 62. Hypertension Mortality (Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	10.3	3.8	12.1	12.4
2010–2012	11.7	8.6	15.3	13.9
2011–2013	11.7	14.0	13.5	14.0
2012–2014	12.0	13.3	13.7	14.1
2013–2015	13.0	7.7	8.6	13.1
2014–2016	12.2	7.4	10.4	13.0
2015–2017	**14.1**	11.5	8.4	13.8
2016–2018	10.9	14.9	11.2	13.8
2018–2020	↑ 11.6	↓ 10.8	↑ **14.0**	13.8

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I10, I12, I15. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 63. Stroke ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	71.9	119.0	83.9	87.9
2018–2020	↓ 45.1	↓ 54.0	↓ 68.9	↓ 56.2

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes G45, G46, I6. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 64. Stroke Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	158.5	249.4	**223.8**	220.9
2018–2020	↓ 152.4	↓ 178.2	↓ 205.8	↓ 212.5

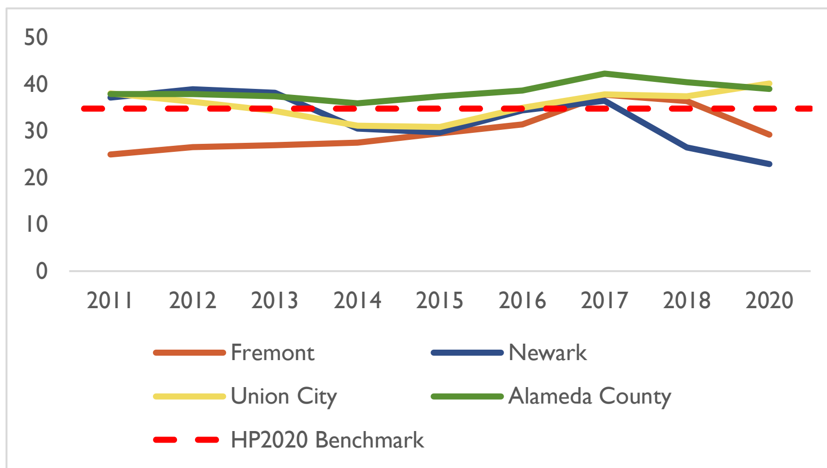
Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 codes G45, G46, I6. Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 65. Stroke Mortality (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	25.0	37.1	**38.0**	37.9
2010–2012	26.5	**38.9**	36.3	37.9
2011–2013	27.0	**38.2**	34.2	37.4
2012–2014	27.5	30.5	31.1	35.9
2013–2015	29.5	29.7	30.9	37.4
2014–2016	31.4	34.4	35.0	38.6
2015–2017	37.8	36.4	37.8	42.3
2016–2018	36.4	26.5	37.4	40.4
2018–2020	↓ 29.2	↓ 22.9	↑ **40.2**	↓ 39.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I60-I69. Notes: Bold indicates that the data are worse than the county, but by less than 5%. See chart below.

Figure 18. Stroke Mortality (Age-Adjusted Rate per 100,000 Pop.), by Year



Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. ICD-10 codes I60-I69.

Healthcare Access & Delivery

The last table in this section presents available data by race/ethnicity.

Table 66. Adults With Health Insurance Aged 18–64 (Percentage)

	Fremont	Newark	Union City	Alameda County
2010–2014	92.4	90.1	89.5	88.2
2011–2015	93.3	90.4	91.4	89.9
2012–2016	94.9	92.5	93.4	91.6
2013–2017	96.6	94.4	95.0	93.1
2018–2020	↓ **92.8**	↓ **91.9**	↓ 92.2	93.2

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 67. Adults Without Health Insurance Aged 18–64 (Percentage)

	Fremont	Newark	Union City	Alameda County
2019	9.2	**13.3**	11.9	12.8

Source: U.S. Centers for Disease Control and Prevention PLACES data. 2019. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 68. Adults Who Have Had a Recent Routine Checkup

	Fremont	Newark	Union City	Alameda County
2018–2020	69.7	**68.4**	69.8	69.4

Source: U.S. Centers for Disease Control and Prevention PLACES data. 2019. Note: A recent checkup is defined as taking place within the past year. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 69. Households with Internet Subscription (Percentage)

	Fremont	Newark	Union City	Alameda County
2016–2020	94.5	95.2	92.9	91.2

Source: U.S. Census Bureau; American Community Survey, 2016–2020 American Community Survey 5-Year Estimates, Table S2802.

Table 70. Recent Dentist Visit (Past Year) (Percentage)

	Fremont	Newark	Union City	Alameda County
Adults 2018	70.9	**65.9**	66.1	66.0
Children 2019–2020	**88.2**	**89.2**	**89.3**	89.7

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. Children: 2019–20. Adults: U.S. Centers for Disease Control and Prevention PLACES data. 2019. Note: Bold indicates that the data are worse than the county, but by less than 5%.

Table 71. Healthcare Access Data by Race/Ethnicity

	Latino	Nat Am	Asian	Pac Isl/ Hawaiian	Black	White	Multi	AC Overall
Adults with Health Insurance (18-64) (percent) (2018–2020)	90.3		93.4	66.7	**89.5**	96.3	**90.0**	93.2
People Delayed or Had Difficulty Obtaining Care (percent) (2019–2020)	6.9	94.0	11.1		10.6	17.1	29.7	13.1

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. Notes: No city-level data were available for People Delayed or Had Difficulty Obtaining Care. "Nat Am"= Native American/Alaskan native; "Pac Isl"=Pacific Islander/native Hawaiian; "Multi"=Two or more races. AC stands for Alameda County. Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

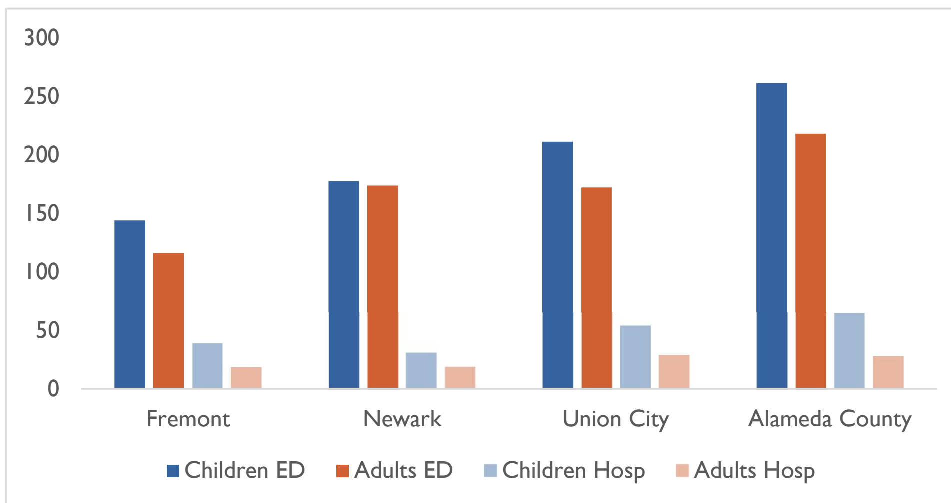
Respiratory Health

Table 72. Asthma ED Visits (Age-Adjusted Rate per 100,000 Pop.)

		Fremont	Newark	Union City	Alameda County
2016–2017	Adult	180.7	315.4	273.3	355.7
	Child	244.8	423.3	411.1	516.1
	All	263.2	440.4	400.9	512.4
2018–2020	Adult	115.9	173.7	171.9	218.0
	Child	143.7	177.6	211.1	261.2

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020 (Asthma codes: J45[2-9]). Note: Adults are 18 years and older; children are under 18 years old.

Figure 19. Asthma ED Visits by Age Group and City (Age-Adjusted per 100,000 Pop.)



Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2018–2020.

Table 73. Asthma Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

		Fremont	Newark	Union City	Alameda County
2016–2017	Adult	59.6	91.2	70.3	66.6
	Child	45.9	27.0	70.7	131.0
2018–2020	Adult	18.6	18.8	29.2	27.8
	Child	38.7	30.9	53.8	64.5

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 code J45. Note: Adults are 18 years and older; children are under 18 years old. Brown shading indicates that the data are worse than the county by 5% or more.

Table 74. COPD ED Visits (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	221.4	352.2	300.9	249.9
2018–2020	355.3	**417.2**	437.1	413.5

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020 (codes J44[0-4]). Notes: Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 75. COPD Hospitalization (Age-Adjusted Rate per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	490.9	646.8	624.8	674.3
2018–2020	363.5	428.6	515.7	538.0

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020. ICD-10 code J44.

Table 76. COVID-19 Data

	Washington Service Area	AC
Average daily COVID-19 hospital admissions (rate per 100,000 pop.)	3.6	27
Cases, Infections, and Tests		
Number of weekly cases	184	1,073
Cumulative total cases	23,033	405,321
Cumulative case rate (per 100,000 pop.)	6,578	24,127
Current rate of spread (R-eff)[59]	—	1.03*
14-day average test positivity rate	—	6.7%
Deaths		
Number of weekly deaths	0	2
Cumulative total deaths	315	2,205
Cumulative death rate (per 100,000 pop.)	90	131

[59] "The effective reproductive number (R-eff) is the average number of secondary infected persons resulting from an infected person. If R-eff > 1, the number of infected persons will increase. If R-eff < 1, the number of infected persons will decrease. At R-eff = 1, the number of infected persons remains constant." *California Communicable Diseases Assessment Tool.* Retrieved from https://calcat.covid19.ca.gov/cacovidmodels.

	Washington Service Area	AC
Vaccinations[60]		
Vaccinated, primary series (all ages)	—	86%
Vaccinated, primary series (age 65+)	—	95%
Vaccinated, bivalent booster	—	32%
Vaccinated, bivalent booster (age 65+)	—	61%

Sources: Alameda County: The New York Times. (2023). California Coronavirus Tracker. *The New York Times.* Data retrieved from https://www.nytimes.com/interactive/2023/us/california-covid-cases.html. Washington Service Area: Washington Hospital Healthcare System. (2023). Rates per 100,000 in Washington Service Area calculated by Actionable Insights. Notes: AC stands for Alameda County. — indicates data not available for Washington Hospital's primary service area. * Current rate of spread (R-eff) in California is 0.99. Current rate of spread is as of March 30, 2023. Average daily hospital admissions, 14-day test positivity rate, number of weekly cases, and number of weekly deaths are for the week of March 24-30, 2023. Vaccination percentages and all cumulative data represent the period from January 2020 to March 30, 2023.

[60] Vaccination data for Washington Hospital Healthcare System represent number of doses, not proportion of the population vaccinated. As of April 6, 2023, Washington Hospital had administered 103,695 doses of a COVID-19 vaccine, including 926 doses to children ages 6 months to four years and 3,873 doses to children ages 5–11 years. The hospital had also administered 27,655 COVID-19 boosters, include 160 to children ages 5–11 years.

Cancer

The last table in this section presents available data by race/ethnicity.

Table 77. Cancer Incidence (Age-Adjusted Rate per 100,000 Pop.), 2015–2019

Cancer Site	Assembly District 20 (2019)	Alameda County
All	418.6	371.0
Breast (Female)	122.3	121.6
Prostate (Male)	78.1	86.9
Colorectal	31.3	32.3
Melanoma	13.8	18.9
Pancreatic	10.8	11.8
Lung	36.4	38.7

Source: University of California, San Francisco. California Health Maps website. https://www.californiahealthmaps.org. Note: Brown shading indicates that the data are worse than the county by 5% or more.

Table 78. Cancer Screenings (Percentage)

	Year	Fremont	Newark	Union City	Alameda County
Cervical (Ages 21–65)	2018	81.6	82.0	**78.8**	81.6
Colon (Ages 50–75)	2018–2020	68.1	**66.2**	**65.3**	67.7
Mammogram in the Past 2 Years (Ages 50–74)	2018	77.2	75.8	76.6	75.0

Notes: Colon screening measures those who have had fecal occult blood test in the past year, a sigmoidoscopy in the past five years and a fecal occult blood test in the past three years or colonoscopy in the past year. Bold indicates that the data are worse than the county, but by less than 5%.

Table 79. Cancer Deaths: Greater Bay Area (Age-Adjusted Rate per 100,000 Pop.)

	Greater Bay Area	Alameda County
2019	115.5	157.1

Source: Greater Bay Area Cancer Registry.

Table 80. Adults who Smoke (Percentage)

	Fremont	Newark	Union City	Alameda County
2019	4.7	4.9	5.0	5.7
2020	2.3	2.4	2.3	2.5

Source: California Health Interview Survey. UCLA Center for Health Policy Research, Los Angeles, CA. 2019.

Table 81. Cancer Incidence Data by Race/Ethnicity

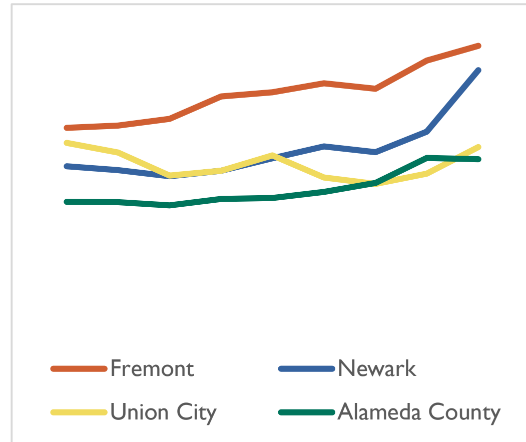
	Latino	Asian/ Pac Isl	Black	White	AC Overall
Incidence: breast (female) [a]	119.9	105.8	106.0	156.0	121.6
Incidence: prostate (male) [a]	**90.4**	61.9	134.9	90.2	86.9
Incidence: colorectal [a]	36.6	26.5	47.7	34.3	32.3
Incidence: melanoma [a]	7.1	--	--	39.1	18.9
Incidence: pancreatic [a]	14.5	9.6	--	11.4	11.8
Incidence: lung [a]	33.7	33.0	31.2	42.0	38.7
Incidence: all sites [a]	440.5	320.5	454.5	559.3	380.1

Source: University of California, San Francisco. California Health Maps website. 2015–2019. https://www.californiahealthmaps.org.
Notes: [a] Data is for Assembly District 20 (as of 2019). Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%. "Pac Isl"=Pacific Islander/native Hawaiian. AC stands for Alameda County.

General Health & Mortality

Table 82. Life Expectancy at Birth (Years)

	Fremont	Newark	Union City	Alameda County
2009–2011	83.7	82.7	83.3	81.8
2010–2012	83.7	82.6	83.1	81.8
2011–2013	83.9	82.5	82.5	81.8
2012–2014	84.4	82.6	82.6	81.9
2013–2015	84.6	82.9	83.0	81.9
2014–2016	84.8	83.2	82.4	82.1
2015–2017	84.6	83.1	82.3	82.3
2016–2018	85.3	83.6	**82.5**	82.9
2018–2020	↑ 85.7	↑ 85.1	↑ 83.2	82.9



Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2009–2020. Note: Life expectancy at birth is defined as the average number of years that a newborn can expect to live if he or she passes through life subject to the age-specific mortality rates of a given period. Bold indicates that the data are worse than the county, but by less than 5%.

Table 83. Life Expectancy at Birth (Years), by Race/Ethnicity

Latino	Nat Am	Asian	Pac Isl	Black	White	Multi	AC
83.7	**81.8**	88.6		74.6	**81.9**		82.8

Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2018–2020. Notes: Life expectancy at birth is defined as the average number of years that a newborn can expect to live if he or she passes through life subject to the age-specific mortality rates of a given period. “Nat Am”= Native American/Alaskan native; “Pac Isl”=Pacific Islander/native Hawaiian; “Multi”=Two or more races. Brown shading indicates that the data are worse than the county by 5% or more. Bold indicates that the data are worse than the county, but by less than 5%.

Table 84. Children with a Disability (Percentage)

	Fremont	Newark	Union City	Alameda County
2016–2020	1.6	2.0	1.6	2.8

Source: U.S Census Bureau, 5-Year Estimates, American Community Survey. 2016–2020.

Table 85. Poor Physical Health: 14+ Days in the Past Month (Percentage)

	Fremont	Newark	Union City	Alameda County
2019	8.1	10.0	9.1	10.1

Source: U.S. Centers for Disease Control and Prevention PLACES data. 2019.

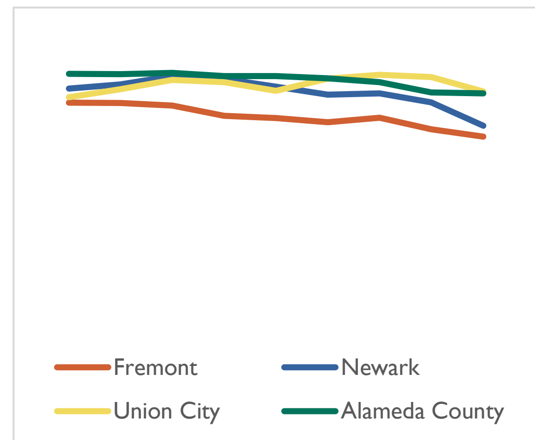
Table 86. Deaths: All Causes, 2018–2020

	Fremont	Newark	Union City	Alameda County
Count	3,207	734	1,332	30,311
Rate	449.6	476.9	562.6	558.7

Source: Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2020.

Table 87. Mortality Rate, All Causes (Age-Adjusted per 100,000 Pop.)

	Fremont	Newark	Union City	Alameda County
2009–2011	535.0	570.0	548.9	607.1
2010–2012	533.5	580.2	568.1	606.4
2011–2013	527.3	602.0	591.5	610.0
2012–2014	501.4	594.3	585.7	601.3
2013–2015	496.2	574.6	564.2	601.1
2014–2016	486.1	555.0	594.6	595.3
2015–2017	496.9	558.3	**605.2**	586.2
2016–2018	468.0	535.3	598.7	560.3
2018–2020	↓ 449.6	↓ 476.9	↓ **562.6**	↓ 558.7



Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Alameda County vital statistics files, 2009–2020. Note: Bold indicates that the data are worse than the county, but by less than 5%.

ATTACHMENT 3: COMMUNITY ASSETS AND RESOURCES

Behavioral Health

- 12-Step programs (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon/Alateen)
- Afghan Coalition
- Alameda County Tri-City Children and Youth Service
- Alameda Health System John George Psychiatric Hospital
- Bay Area Community Services (BACS)
- Boldly Me
- Building Futures
- Calico Center
- California Smoker's Helpline
- Cherry Hill Detox
- Citizens for Better Community
- Crisis Support Services of Alameda County 24-Hour Crisis Line
- CURA
- DeafPlus
- East Bay Agency for Children
- Family Education and Resource Center (FERC)
- Family Paths 24-Hour Parent Support Hotline
- Fremont Family Resource Center
- Friends of Children with Special Needs
- First 5 Alameda County
- HOPE Project Mobile Health Clinic
- Kaiser Behavioral Health classes (available to public)
- LIFE Eldercare Friendly Visitors
- Narika
- National Alliance on Mental Illness Alameda County South
- Rubicon Programs
- Ruby's Place (Casa de Ruby, Betty's Village)
- Safe Alternative to Violent Environments (SAVE)
- Second Chance, Inc.
- Seneca Center
- South Hayward Parish - Hayward Community Action Network
- Special Need Children Center
- Tobacco Control Coalition of Alameda County
- Union City Family Center
- Victory Outreach - Prison Counseling and Services; Residential Rehab Program, Hayward

Cancer

- American Cancer Society
- HERS Breast Cancer Foundation
- Tobacco Control Coalition of Alameda County

Diabetes & Obesity

- Alameda County Community Food Bank (multiple sites)
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Alameda County Public Health Department
- Alameda County Social Services Agency
- American Diabetes Association
- California State University, East Bay, Hayward Promise Neighborhood
- Centro de Servicios
- City of Fremont Parks & Recreation Division
- East Bay Regional Parks District
- Family Resource Center, Fremont
- Hayward Area Recreation & Park District
- LIFE Eldercare, Inc.
- Meals on Wheels of Alameda County
- Newark Recreation & Community Services Department
- Solid Rock Community Services, Newark
- Special Need Children Center
- Tri-City Volunteers Food Bank and Thrift Store
- Union City Community & Recreation Services Department
- Union City Family Center
- Viola Blythe Community Service Center of Newark
- Washington Hospital Healthcare System, Diabetes Education Center

Economic Security (includes food security, employment, education)

- Abode Services
- Alameda County Community Food Bank (searchable list)
- Alameda County Early Head Start and Head Start
- Alameda County Library
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Alameda County Social Services Agency
- Avanzado
- Bay Area Community Services (BACS)
- California State University, East Bay, Hayward Promise Neighborhood
- Centro de Servicios
- Citizens for Better Community
- Community Resources for Independent Living (CRIL)
- DeafPlus
- Eden I&R, Inc.

- First 5 Alameda County
- Fremont Education Foundation
- Fremont Family Resource Center
- Fremont Unified School District
- Friends of Children with Special Needs
- Give Teens 20/NavZ
- HOPE Project Mobile Health Clinic
- LIFE Eldercare Meals on Wheels
- Mission Valley ROP
- Narika, SEED Program
- New Haven Schools Foundation
- New Haven Unified School District
- Newark Education Foundation
- Newark Unified School District
- Ohlone Community College
- Rubicon Programs
- Solid Rock Community Services
- South Hayward Parish: Emergency Food Pantry
- Tri-City One-Stop Career Center (Employment Development Department)
- Tri-City Volunteers Food Bank & Thrift Store
- Union City Family Center

Healthcare Access & Delivery

HOSPITALS:

- Alameda Health System, John George Psychiatric Hospital
- Fremont Hospital
- Kaiser Foundation Hospital-Fremont
- St. Rose Hospital
- Sutter Health Eden Medical Center
- Washington Hospital Healthcare System

FEDERALLY QUALIFIED HEALTH CENTERS:

- Bay Area Community Health (multiple sites, incl. mobile clinics)
- Tiburcio Vasquez Health Center (multiple sites)

OTHER HEALTH CLINICS:

- Alameda Health System (Hayward Wellness, Newark Wellness)
- Sutter Health Palo Alto Medical Foundation, Fremont Center
- Washington Township Medical Foundation (multiple sites)

OTHER ORGANIZATIONS:

- Alameda-Contra Costa Transit District (AC Transit)
- Alameda County Health Care Services: HealthPAC
- Alameda County Social Services Agency
- Bay Area Rapid Transit (BART)

- East Bay Agency for Children
- Eden I & R, Inc.
- Family Resource Center, Fremont
- George Mark Children's House
- LIFE Eldercare Transportation Program
- Operation Access
- Paratransit
- Rubicon Programs Wellness Services
- Special Need Children Center
- Union City Family Center
- Union City Transit
- Washington Women's Center

Heart/Stroke

- American Heart Association
- Alameda County Community Food Bank (multiple sites)
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Alameda County Public Health Department
- Alameda County Social Services Agency
- California State University, East Bay, Hayward Promise Neighborhood
- Centro de Servicios
- City of Fremont Parks & Recreation Division
- East Bay Regional Parks District
- Family Resource Center, Fremont
- Hayward Area Recreation & Park District
- LIFE Eldercare, Inc.
- Meals on Wheels of Alameda County
- Newark Recreation & Community Services Department
- Solid Rock Community Services, Newark
- Tri-City Volunteers Food Bank and Thrift Store
- Union City Community & Recreation Services Department
- Union City Family Center
- Viola Blythe Community Service Center of Newark

Housing & Homelessness

- Abode Services
- Alameda County Homeless Project - Hayward (incl. Special Needs Housing)
- Alameda County Housing & Community Development
- Alameda County Social Services Agency
- Bay Area Community Services (BACS)
- Building Futures
- DeafPlus
- Everyone Home

- Fremont Family Resource Center
- HOPE Project Mobile Health Clinic
- Union City Family Center

Respiratory Health

- Alameda County Asthma Coalition
- Alameda County Public Health Department, Asthma Start Program
- Alameda County Healthy Homes Alliance
- American Lung Association
- Bay Area Healthy 880 Communities
- Breathe California
- Tobacco Control Coalition of Alameda County

ATTACHMENT 4: QUALITATIVE RESEARCH PROTOCOLS

WHHS CHNA Key Informant Interview (KII) Protocol (60 min.)

PREP

- Schedule, call, send survey and main questions [*minimum: 1 week ahead of time*]
- 48 hours before, prepare:
  - Review the individuals' backgrounds on LinkedIn and/or their organizations' websites; review their survey responses (health needs they identified).
  - Send reminder email; if any didn't respond to the survey (most pressing needs among those they serve), include the link and ask them to respond ASAP before the focus group.
  - Ensure you have slides of agenda/questions/identified needs ready.

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session. Remember, do not admit anyone who has not consented to recording.]

- Welcome and thanks.
- What the project is about:
  - Identifying health needs in our community here in the Washington service area, southern Alameda County, including social determinants of health (called the Community Health Needs Assessment or CHNA)
  - The report based on this assessment will be a snapshot in time, required of all non-profit hospitals in the U.S. every three years; this report will be published next year (in 2023) and consulted through 2026
  - Will inform investments that hospitals make to address community needs
- Our interview is scheduled for sixty minutes – does that still work for you?
- Today's questions:
  - Better understand the needs you identified as most pressing in southern Alameda County
  - Which populations are experiencing inequities related to the needs
  - How things may have changed recently (trends)
  - Any models or best practices you know of for addressing the needs
  - Areas of concern
  - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
  - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
  - Will record so that we can get the most accurate record possible.
  - Will not share the audio itself; transcript will go to hospital
  - We will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
  - Hospitals will make decisions about which needs they can best address
  - We can keep anything confidential, even the whole interview. Let me know at any time.

    - [*First half depends on their survey response:*] Plan to name *you/your organization* in the report where we list all the experts we consulted, but will not attach your name to any quotes we might use.
- Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email]
- [Make sure that recording is in progress.]

HEALTH NEEDS DISCUSSION (35 MIN.)

You identified [*read list*] as the most pressing needs for the people you serve. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. Please describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. *Probe:* Who is addressing the need?

[*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.

[*Prompts for populations if they are having trouble thinking of any*: income/education level, housing status, language, immigration status, age/generation, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lags what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: What resources would you like to see Washington offer? [*Prompts if needed:* Practices you have observed within your organization, in our county agencies, national practices you have heard about, or practices you have read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:
FURTHER DISCUSSION: THEIR EXPERTISE (5 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:
FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5 min.)

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospital?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this year, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)
Thank you for contributing your expertise and experience to the CHNA. You can look for Washington's CHNA report to be made publicly available on its website in the second half of 2023.
If anything occurs to you later that you would like to add to this discussion, please feel free to send me an email.

Washington Hospital CHNA FG Protocol - Professionals (60 min.)

PREP

- Schedule or work with host to schedule a group of 8-12 participants. If needed, create recruitment email/flier for hospital rep. Ahead of time, send participants:
  - Pre-focus group survey and main questions [*minimum: 1 week ahead of time*].
  - FG date, time, and Zoom login information
  - Advise that the session will be recorded
- 48 hours before, prepare:
  - Review the individuals' backgrounds on LinkedIn and/or their organizations' websites; review their survey responses (health needs they identified).
  - Send reminder email; if any didn't respond to the survey, include the link and ask them to respond ASAP before the focus group.
  - Ensure you have slides of agenda/questions/identified needs ready.

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in the Washington service area, southern Alameda County. This session will run until [*time*].
- My name is ____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call ask you to say your name before speaking.
- What the project is about:
  - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA)
  - The report based on this assessment will be a snapshot in time, required of all non-profit hospitals in the U.S. every three years; this report will be published next year (in 2023) and consulted through 2026
  - Will inform investments that hospitals make to address community needs
- Today's questions: *show slide/poster*
  - We'll go over them more in a minute.
    - Better understand the needs you identified as most pressing in southern Alameda County
    - Which populations are experiencing inequities related to the needs
    - Trends (How things may have changed recently)
    - Models or best practices you know of for addressing the needs
    - Areas of concern
    - [If not one of the needs identified:] Your expertise as it relates to the community's needs
    - [If not one of the needs identified:] Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
  - We are recording this group so that we can make sure to get your words right.
  - Will not share the audio itself; transcript or notes will go to hospital
  - When we are finished with all of the focus groups, we will summarize the things we learn.
  - We will also use some quotes in our reports, which we will keep anonymous.

- If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
  - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
  - For Zoom: We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
  - In-person: If you need to take an emergency call, please step outside so that we can continue the discussion here in the room.
  - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email.]

HEALTH NEEDS DISCUSSION (35 MIN.)

As a group, you identified [*read list*] as the most pressing needs for the people you serve -- these are the needs that were ranked the highest in the pre-survey. For each of these needs, I'll ask you four things [*read only* ***bold text*** *to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. You can choose to pass if you didn't rank the need highly or don't have anything to say about it."
   [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
   [*Prompts for populations if they are having trouble thinking of any*: income/education level, housing status, language, immigration status, age/generation, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lags what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this topic**, including **any models or best practices.** *Probe*: What resources would you like to see Washington offer? [*Prompts if needed:* Practices you have observed within your organization, in our county agencies, national practices you have heard about, or practices you have read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:
FURTHER DISCUSSION: THEIR EXPERTISE (5 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:
FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5 min.)

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (time permitting)
We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospital?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)
The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this year, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)
Thank you for contributing your expertise and experience to the CHNA. You can look for Washington's CHNA report to be made publicly available on its website in the second half of 2023.
If anything occurs to you later that you would like to add to this discussion, please feel free to send me an email.

WHHS CHNA FG Protocol - Community Members (60 min.)

PREP

- Work with host to schedule a group of 8-12 participants. If needed, create a recruitment email/flier for hospital rep. Ahead of time, have host send participants:
  - Pre-focus group health needs survey and main questions
  - FG date, time, and Zoom login information
  - Advise that the session will be recorded
- 48 hours before, prepare:
  - PDF of agenda/questions
  - Review pre-survey responses (if not everyone who's expected responses, let host know to send reminders)
  - Ensure you have slides of agenda/questions/identified needs ready.

INTRODUCTION (10 MIN.)
[Start recording from the beginning of the session. Remember, do not admit anyone who has not consented to recording.]

- Hello everyone. Today we are hosting a focus group about health here in Southern Alameda County. This session will run until [*time*].
- My name is _____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- Purpose:
  - You are here today to let nonprofit hospitals know what the biggest health needs are in our county.
  - This is called the Community Health Needs Assessment (CHNA), which is required every three years by the IRS, so it is an official, public report.
  - Hospitals will use this to plan how they will use their resources to improve health and wellness in our county.
- Today's questions: *show slide*
  - What are the needs?
    - Which groups of people are doing better or worse when it comes to the needs?
    - What can hospitals/health systems do to improve health in the community?
  - We will also talk about your pandemic experience and what you think the long-term effects will be (not just on health, but overall).
  - Lastly, we will get your perspective about equity and cultural competence when it comes to healthcare.
- Confidentiality:
  - We are recording this group so that we can make sure to get your words right.
  - We will only use first names here -- you will be anonymous. (If you want to use a fake name that's OK, too!)
  - Will not share the video itself; transcript will go to hospital.
  - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.

    - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
    - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
    - We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
    - You have a choice of a $40 gift card to Amazon or Target. Please chat your email address to my colleague [*name*] now, along with your choice. If you don't tell her which one you prefer, we'll send you an Amazon gift card.
    - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.

- Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email]
- Make sure that recording is in progress.

HEALTH NEEDS DISCUSSION (45 MIN.)

- To start off, we would like to know: **when you imagine a healthy community, what does it look like**? How does this compare/differ to any specific health concerns you have about your own community?

- As a group, you identified [*read list*] as the most pressing needs for the people you serve – these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it." [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
   [*Prompts for populations if they are having trouble thinking of any*: income/education level, housing status, language, immigration status, age/generation, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Finally, I'll ask you to describe, for that need, what you think the people in charge should do to support, enhance, facilitate, or fund to help communities become healthier. This may include resources you wish to see offered by the hospital, or services that you think are important to your health or improving everyone's well-being.

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-3 with second need, again with third need, then go on to the questions below.]

YOUR PANDEMIC EXPERIENCE (15 min.)

We all know that the coronavirus has been really disruptive to our normal lives since March of 2020. Specifically, we want to hear about your experience with getting health care since then.

- *[Facilitators call on participants one by one.]* Tell us about how the pandemic affected your ability to access healthcare.

  [Potential probes] Tell us more about your reasons for putting off a regular appointment or not seeing a provider for something that went wrong. Tell us your opinion of virtual appointments. How did you like them? What was good about them (maybe even better than an in-person appointment)? What about them could be improved?
- **Not only thinking about healthcare, but more generally:** What do you think the long-term impact of the pandemic will be on you, your family, and your friends and neighbors?

YOUR PERCEPTION OF EQUITY ISSUES (20 min.)

As you probably know, people have been talking about issues of equity much more than ever before. "Equity" means fairness and unbiased treatment. When it comes to health care, what's your perspective about equity and cultural competence? For example:

- What do you think are the barriers to everyone having the same access to healthcare?
- What do you think are the barriers to everyone getting the same quality of healthcare?
- We know how important it is that healthcare providers care for people in a respectful and culturally competent way. How can local providers do better in this area? Can you share any examples of something that's worked well in your experience?
- What can hospitals and health systems do to best address equity for you and the people in your community?

CLOSING (1 min.)
Thank you for contributing your ideas and experience to the CHNA.
You can contact us if you want any more information about the assessment. If anything occurs to you later that you would like to add, please feel free to send me an email.

ATTACHMENT 5: IRS CHECKLIST

Section §1.501(r)(3) of the Internal Revenue Service code describes the requirements of the CHNA.

Federal Requirements Checklist	Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)		
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(6)(F)	Section #2
B. Process & Methods		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section #4
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.	(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.		Section #3
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 1 & 2
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Section #5
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #5
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section #5 & Attachment 1

Federal Requirements Checklist	Regulation Section Number	Report Reference
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #5 & Attachment 1
I. Medically underserved populations	(b)(5)(i)(B)	Section #5 & Attachment 1
II. Low-income populations	(b)(5)(i)(B)	Section #5 & Attachment 1
III. Minority populations	(b)(5)(i)(B)	Section #5 & Attachment 1
c. Additional sources (optional) – (e.g., healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(ii)	Section #5 & Attachment 1
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #5 & Attachment 1
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #5 & Attachment 1
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Sections #5, #6, & Attachment 1
C. CHNA Needs Description & Prioritization		
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Section #6
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Section #6
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Section #5
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	Section #7 & Attachment 3
D. Finalizing the CHNA		
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Sections #1 & #5
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	Section #8
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	By 6/30/2023
a. May not be a copy marked "Draft".	(b)(7)(i)(A)	By 6/30/2023

Federal Requirements Checklist					Regulation Section Number	Report Reference
			b.	Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	By 6/30/2023
			c.	Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	By 6/30/2023
			d.	Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	By 6/30/2023
			e.	Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	By 6/30/2023
			f.	Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	By 6/30/2023

Further IRS requirements not applicable to this report:

- §1.501(r)-3(b)(iv) and (v): separate and joint CHNA reports
- §1.501(r)-3(d): requirements that apply to new hospital facilities, transferred or terminated hospital facilities, and newly acquired hospital facilities
- §1.501(r)-3(a)(2) and (c): implementation strategy requirements