2020 Community Health Needs Assessment

Washington Hospital Healthcare System

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- Melanie Espino, Co-Founder and Principal
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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 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 high-need populations.[1]

California Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development 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.[2]

As a district hospital, Washington Hospital Healthcare System is exempt from the legislative requirement prior to the Affordable Care Act. Nonetheless, for more than 20 years Washington Hospital has voluntarily conducted assessments to better understand the community's needs and to develop health improvement programs for district residents.

The 2020 CHNA is the third 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 2019 and described in this report, was conducted collaboratively by 14 local hospitals in Alameda and Contra Costa counties ("the Hospitals") 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 July 8, 2020.

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[1] U.S. Federal Register. (2014). Department of the Treasury, Internal Revenue Service, 26 CFR Parts 1, 53, and 602. Vol. 79, No. 250, December 31, 2014. Retrieved November 2019 from https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf

[2] 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

PROCESS AND METHODS

The Hospitals began the third CHNA cycle in 2018. The Hospitals' goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the summer and fall of 2018 through key informant interviews with local health experts, focus groups with community leaders and representatives, and focus groups with community residents.

Secondary data were obtained from a variety of sources. Secondary data were available for Alameda County and, in many cases, also for Washington Hospital's primary service area separately, which includes the cities of Fremont, Newark, and Union City, as well as unincorporated Sunol and a small part of South Hayward. Secondary data were gathered between spring and fall of 2019.

In October 2019, 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, the Hospitals did not limit the definition of "community health" to traditional measures of health. Instead, their definition included indicators about the physical health of the county'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. These seven needs, listed in priority order (from highest to lowest), are:

- **Behavioral Health.** In interviews and focus groups, the community ranked behavioral health (mental health and substance use) as its top priority. Depression and stress were the most common issues raised. Adverse childhood experiences were called out as drivers of behavioral health problems. Statistics support CHNA participants' concerns: The emergency department (ED) visit rates for severe mental illness in Newark and unincorporated Sunol are significantly higher than the Alameda County rate. In Union City, the rate of ED visits for self-injury exceeds the county rate. The suicide rates in Fremont and Newark are not higher than the county benchmark, but they are increasing.
- **Housing and Homelessness.** Maintaining safe and healthy housing also ranked high as a community priority. CHNA participants cited the high cost of housing as a driver of

stress and poor physical health. They were troubled by the rising number of individuals and families with unstable housing. Following a countywide trend, the number of people experiencing homelessness in Fremont, Newark, and Union City grew in 2019, including the number of unsheltered individuals. Poor housing quality is associated with asthma-related ED visits; adult asthma hospitalization rates are significantly higher in Newark and Union City than the county rate overall.

- **Healthy Eating/Active Living.** This health need, which comprises obesity, nutrition, diet, and fitness, also ranked as a high community priority. CHNA participants attributed sedentary lifestyles and poor nutrition to a lack of time, convenience, and money, among other factors. They worried most about the Latinx population. Statistics for aerobic capacity and body composition have been getting worse among youth in the hospital's primary service area. Youth in Union City fare significantly worse in meeting aerobic capacity standards than their peers in Alameda County overall. Based on measures of body composition, youth in Newark and Union City are more likely to be at health risk than their peers countywide.
- **Healthcare Access and Delivery.** CHNA participants expressed strong concerns about this need, which includes affordability of care and access to behavioral health services and specialists (including geriatric care), especially for Medi-Cal patients. Statistically, Union City residents may face greater language barriers to access than other county residents because a significantly larger than average proportion speak limited English. The mortality rate from all causes is significantly higher in Union City than the county rate.
- **Social Determinants of Health.** Economic insecurity, including food insecurity, ranked as a high priority of the community. CHNA participants emphasized that local jobs often do not pay workers enough to afford the high cost of living. Data show that significantly fewer adults in Newark and Union City have a bachelor's degree or higher. But even residents with college degrees may be vulnerable to poverty; higher education often does not prepare people for jobs that pay a proper living wage, according to the public health expert interviewed. Community members also discussed having difficulty accessing grocery stores that carry fresh food (because there are not any or many in close proximity). Statistics show that food access in Fremont, unincorporated Sunol, and Union City is significantly worse than the county average. Residents also complained about the lack of safe public spaces and community centers where they can exercise and participate in recreational activities.
- **Diabetes, Heart Disease, Hypertension, and Stroke.** Heart disease and stroke are leading causes of death nationwide, despite the fact that some risk factors — high blood pressure, high cholesterol, obesity, smoking, an unhealthy diet, sedentary lifestyle — can be controlled. The rates of diabetes hospitalizations in Newark and Union City surpass Alameda County's rates. Newark also has significantly higher rates of ED visits for diabetes and stroke. Hypertension is an issue in Union City (ED visits) and

unincorporated Sunol (hospitalizations). Union City and unincorporated Sunol residents are more commonly hospitalized for heart disease than their peers countywide.

- **Respiratory Health.** CHNA participants identified poor air quality as a driver of asthma. Data show that the rates of COPD-related ED visits and asthma hospitalizations in Newark and Union City are significantly worse than the Alameda County rate.

For additional details, including statistical data and citations, see Section 6: 2020 Prioritized Community Health Needs and Attachment 2: Secondary Data Tables.

NEXT STEPS

After making this CHNA report publicly available by September 1, 2020, 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/Community-Connection/Community-Health-Needs-Assessment.aspx

2. Background

CHNA REPORT PURPOSE

In 2018, 14 local hospitals in Alameda and Contra Costa counties ("the Hospitals") collaborated for the purpose of identifying critical health needs of the community. Washington Hospital worked with its partners to conduct an extensive community health needs assessment (CHNA). The 2020 CHNA builds upon earlier assessments conducted by the Hospitals.

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 the IRS's 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 morbidity, mortality, and social determinants of health. 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 lowering or eliminating 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 Office of Statewide Health Planning and Development that describes the strategies that hospitals have engaged in to address the identified community needs.

As a district hospital, Washington Hospital is exempt from the legislative requirement prior to the Affordable Care Act. Nonetheless, for more than 20 years Washington Hospital has voluntarily conducted assessments to better understand the community's needs and to develop health improvement programs for district residents.

BRIEF SUMMARY OF THE 2017 CHNA CONDUCTED

In 2016–2017, Washington Hospital participated in a similarly collaborative process to assess community health needs. The 2017 CHNA report is posted on the Community Health Needs Assessment page of the hospital's website.[4]

The community health needs identified and prioritized through the 2017 CHNA process were:

- Asthma
- Behavioral Health
- Cancer
- Cardiovascular Disease and Stroke
- Maternal and Child Health
- Obesity, Diabetes, and Healthy Eating/Active Living
- Violence and Injury Prevention

EVALUATION FINDINGS FROM 2018–2020 IMPLEMENTED STRATEGIES

Washington Hospital addressed all of these critical community health needs in subsequent years through targeted programs and community partnerships.

At the time this report was completed, Washington Hospital had impact results for fiscal years 2018 and 2019. Although not reflected herein, the hospital will continue to monitor and report the impact of strategies implemented in 2020.

Asthma

- In partnership with UCSF Health, Washington Hospital established a pediatric asthma protocol to provide a step-by-step guidance for evaluation and treatment of pediatric patients seen in the emergency department (ED) and other areas of the hospital for asthma, including education and discharge recommendations.
- Washington Hospital partnered with UCSF Health to participate in the Pathways to Improve Pediatric Asthma Care (PIPA) study. The study is to evaluate the effectiveness

[4] https://www.whhs.com/About/Community-Connection/Community-Health-Needs-Assessment.aspx

of clinical pathways for improving quality of care for children with asthma in a diverse national sample of ED and hospital settings.

- Washington Hospital hosted two free community seminars titled "Respiratory Health and Lung Cancer Prevention and Detection" and "Wildfire Smoke and Your Lungs: Do You Need to Worry?" More than 25 community members attended. The seminars were also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.[5]
- Washington Hospital featured "A Pathway to Better Pediatric Asthma Management" on Bay Area Healthier Together.[6] The programming covered understanding signs and symptoms of asthma and recognizing causes and triggers of asthma flare-ups.

Behavioral Health

- Washington Hospital provided a comprehensive health education series with expert speakers on various aspects of mental health. The aim of the series was to reduce the stigma around mental illness by highlighting the prevalence of mental health disorders and the importance of seeking help. Topics included: Understanding Mood Disorders; Understanding Anxiety Disorders; Understanding Psychotic Disorders; When Depression Occurs with Other Medical Conditions; Mental Wellness and Family Support: Caring for Those with Mental Health Disorders. More than 380 community members attended. The series was also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.
- As part of the Speaker's Bureau program, Washington Hospital provided four presentations on suicide prevention at local high schools and community events, including the Strategies for Wellness event hosted by Alameda County's Commission on the Status of Women. More than 450 community members attended.
- The Washington Hospital Wellness Center began a monthly women's support group, Women Empowering Women. The support group explored health topics regarding women's issues, including stress management, healthy relationships, complementary therapies for depression and anxieties, and overcoming body image and self-esteem issues. More than 15 women participated each month.
- Washington Hospital featured topics on mental health on Bay Area Healthier Together. The programming included "Separating Mental Illness Fact from Fiction" and "How to Support a Loved One with a Mental Health Disorder." There were more than 3,900 page views.

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[5] Washington Hospital's cable channel, InHealth, airs throughout Fremont, Newark, and Union City. The YouTube channel is https://www.youtube.com/user/WHHSInHealth

[6] Bay Area Healthier Together was a partnership between Washington Hospital Healthcare System and ABC7 San Francisco to provide the greater Bay Area with health-related information and education through on-air programming and online. https://www.youtube.com/user/WHHSInHealth

- 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 continued exploring collaboration with UCSF Health to develop an outpatient mental health clinic for adolescents.
- In partnership with Alameda County Supervisors Scott Haggerty and Richard Valle, Washington Hospital helped develop a two-day mental health summit. Programming on the first day supports mental health professionals; lectures on the second day focus on adolescent behavioral health with resources for families.

Cancer

- Washington Hospital established an affiliation with UCSF Health to develop the UCSF - Washington Cancer Center. The Center provides oncology patients with access to the latest cancer research, technology, and treatment through a highly coordinated network to better facilitate referrals and transfers to UCSF when needed.
- UCSF - Washington Cancer Center was approved by the Alliance for Clinical Trials in Oncology to develop a clinical research program.
- Washington Hospital designed and implemented an electronic ordering system for chemotherapy.
- Washington Hospital opened the Morris Hyman Critical Care Pavilion Inpatient Oncology Unit.
- Washington Hospital dedicated additional staffing resources to the oncology service line. Now an oncology pharmacist and an oncology social worker help patients understand treatment plans and provide information on the many complex issues raised by cancer, including medical and insurance coverage.
- Washington Hospital Food and Nutrition and Clinical Services co-designed nutrition fact sheets and guidelines specifically for cancer patients to maintain healthy body weight, increase strength, and decrease side effects during and after treatment.
- Washington Township Health Care District Board of Directors approved the acquisition of a new linear accelerator for Washington Hospital's Radiation Oncology Center. This treatment modality will increase the hospital's ability to provide advanced radiation therapy to patients.
- Washington Hospital purchased a digital tomosynthesis (3-D mammography) system. This tool improves the ability of mammography to detect early breast cancer and helps to reduce false positives.

- Washington Hospital hosted 22 free community seminars focused on prevention, screening, and early detection for various cancers (e.g., breast, cervical, ovarian, colorectal, lung, and skin). More than 1,550 community members attended.
- Washington Hospital was awarded a three-year accreditation from the Commission on Cancer for meeting the seven commendation-level standards. 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 two skin cancer screening events. A total of 30 people were screened. Of those, 17 were recommended for further evaluation, and three were recommended for biopsy.
- 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 106 new patients were identified as high risk and underwent low-dose computed tomography (LDCT) or noncontrast CT scans. Of those 106, three were diagnosed with cancer.
- Washington Hospital continued providing grants for mammograms to uninsured clients referred by community clinics such as Tri-City Health Center and 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. A total of 104 patients were referred and received free mammograms. Of the 104 mammograms, 18 resulted in abnormal findings and patients were referred to their primary healthcare provider for further testing and treatment.

Cardiovascular Disease and Stroke

- Washington Hospital hosted a health fair at the Washington Township Medical Foundation, Danielson Clinic in Newark. The free community event included glucose, cholesterol, blood pressure, and body mass index screenings and an opportunity to talk to experts on health insurance, diabetes, nutrition, heart disease, and stroke. More than 125 people attended the event, and 113 screenings were provided.
- As part of the Speaker's Bureau program, Washington Hospital provided community presentations on heart health and stroke prevention at local community organizations, including the Masonic Homes of California in Union City.
- Washington Hospital hosted 17 free community seminars focused on heart health and stroke prevention. More than 390 people attended. The seminars were also recorded and

aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.

- Washington Hospital hosted six free community seminars focused on women's heart health. More than 180 people attended. The seminars were also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.
- Washington Hospital hosted three free peripheral vascular disease screenings and three free abdominal aortic aneurysm screening events. A total of 623 community members were screened. Of those screened, 157 were found to have cardiovascular issues and were referred to their primary healthcare provider for further testing and treatment.
- Washington Hospital hosted three annual Stroke Awareness Day screening events. The free events screened community members for carotid artery blockage and atrial fibrillation. Attendees were also offered cholesterol, glucose, and blood pressure screenings. A total of 256 community members were screened. Of those screened, 99 were found to have cardiovascular issues and were referred for follow up with their primary healthcare provider for further testing and treatment.
- Washington Hospital Food and Nutrition and Clinical Services developed a bimonthly nutrition class for Mended Hearts. Mended Hearts is a support group hosted by Washington Hospital for those who have had heart surgery, heart attack, angioplasty, angina, or other cardiac conditions.
- In partnership with UCSF Health, Washington Hospital is developing a transcatheter aortic valve replacement (TAVR) program. TAVR is a minimally invasive procedure to replace a diseased or narrowed aortic heart valve.
- 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 the clot-buster tissue plasminogen activator, or tPA, the only drug approved by the U.S. Food and Drug Administration to treat ischemic stroke.
- Washington Hospital implemented RAPID Imaging technology to quickly analyze CT and MRI scans of patients having acute strokes to optimize patient selection for transfer

and thrombectomy. The software is fast and automated to reduce the "speed to decision" time—generally less than two minutes for actionable results.

- Washington Hospital adopted the new lifesaving acronym—B.E. F.A.S.T.—to remind community members of the common symptoms associated with a stroke. The revised F.A.S.T. (face, arms, speech, and time) acronym now includes B for balance and E for eye, meaning impaired vision.
- Washington Hospital dedicated online resources to increase community awareness of recognizing the signs of a stroke and the importance of calling 911 for immediate help. Emergency responders can quickly begin aid while transporting the patient to a hospital to optimize their chance for the best possible outcome. In 2018, 54 percent of ED stroke patients arrived by ambulance. In 2019, 64 percent of ED stroke patients arrived by ambulance.
- Washington Hospital featured topics on heart health and stroke on Bay Area Healthier Together. The programming included common risks for heart disease, an overview of aortic valve disease, improvements in stroke outcomes using advanced technology, stroke prevention, and signs of a stroke to watch for. There were more than 15,000 page views.

Maternal and Child Health

- In partnership with UCSF Health, Washington Hospital developed the Prenatal Diagnostic Center. The center provides comprehensive counseling, screening, and diagnostic testing for fetal disorders to help women and their partners make informed decisions. In addition, the Prenatal Diagnostic Center provides more advanced care for expectant mothers who have been diagnosed with a high-risk pregnancy. The center works with mothers from early pregnancy through delivery, managing their risks and developing labor/delivery plans.
- Washington Hospital was awarded a Baby-Friendly™ Hospital Initiative designation from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The designation recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.
- Washington Hospital featured topics on maternal and pediatric care on Bay Area Healthier Together. The programming included "Advanced Maternal-Fetal Care." There were more than 1,000 page views.

Obesity, Diabetes, and Healthy Eating/Active Living

- The Washington Hospital Outpatient Diabetes Center tailored its Diabetes Matters program to provide health information targeting specific populations. This customized approach added a focus on culturally sensitive and ethnically relevant nutrition recommendations for immigrant communities within the District. Food Across Cultures included Indian, Asian, Filipino, and Latino cuisines. The presentations explored modifying traditional recipes to make them healthier without losing their distinctive flavors. More than 55 people attended. The presentations were also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.
- The Washington Hospital Outpatient Diabetes Center led two annual Diabetes Alert Day screening events. The purpose of the event is to raise awareness of the seriousness of diabetes. Diabetes Education staff offered a one-minute, type 2 diabetes risk test, along with prevention education, in the lobbies of Washington Hospital and Washington West, as well as at Washington Township Medical Foundation locations in Union City and Newark. A total of 280 community members were screened.
- Washington Hospital participated in 19 health fairs hosted by community organizations, churches, and local schools to provide health information, including nutrition tips on the go and highlighted MyPlate, the current nutrition guide published by the USDA Center for Nutrition Policy and Promotion.
- Washington Sports Medicine hosted two health fairs at which athletic trainers offered sports physicals. The health fairs featured information highlighting the benefits of pre- and post-exercise nutrition. More than 225 student athletes attended.
- Washington Hospital hosted 31 free community seminars focused on diabetes and nutrition, including cooking demonstrations. More than 615 people attended. The seminars were also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.
- Washington Hospital hosted three Diabetes Awareness Health Fairs. The health fairs included free blood glucose, cholesterol, and blood pressure screenings, in addition to diabetic foot exams and speaker presentations. More than 367 people attended in total.
- The Washington Wellness Center promotes active living through an extensive variety of gentle therapy services in a safe and comfortable environment for both men and women. The center offers physical activities and services designed for people of all ages and all fitness levels.
- Washington Hospital featured topics on healthy lifestyles and diabetes on Bay Area Healthier Together. The programming included portion control to maintain a healthy weight, incorporating exercise into a daily routine, prevention of diabetes, and living with diabetes. There were more than 10,000 page views.

Violence and Injury Prevention

- Washington Hospital continued partnering 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. This free program requires participants to provide community service.
- Washington Hospital hosted four free community seminars focused on falls and injury prevention in addition to concussion care. More than 115 people attended. The seminars were also recorded and aired on Washington Hospital's cable channel, InHealth, and made available online on the InHealth YouTube Channel.
- Washington Sports Medicine athletic trainers hosted first aid stations during 10 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.
- Washington Sports Medicine acquired EYE-SYNC®, a cognitive assessment tool to test for concussions or other cognitive impairments. This cutting-edge eye tracking technology can diagnose concussions in less than 60 seconds, reducing long-term effects. Washington Sports Medicine physicians carry EYE-SYNC® with them when they are serving as athletic trainers at local high school football games.
- Steven Zonner, D.O., a member of the Washington Hospital Sports Medicine team, published a research study in the *Journal of the American Medical Association Ophthalmology* on the cumulative effect of subconcussive head impacts on high-school football players throughout the season.
- Washington Hospital's cable channel, InHealth, aired the following 67 public service announcements:

Autism Speaks (3)	Born Learning (3)	Breathe Easier (1)	Childhood Obesity Prevention (4)
Cyber Bullying (2)	Diabetes (3)	Heart Health Awareness (8)	High Blood Pressure (2)
Infection Prevention and Vaccinations (7)	Mental Health (2)	Nutrition (4)	Obesity Prevention (3)
Saved by the Scan: Low-Dose CT (3)	Stroke Awareness (4)	Texting and Driving (9)	Traffic Safety (9)

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 CHNA@whhs.com.

At the time this CHNA report was completed, Washington Hospital had not received any written comments about the (previous) 2017 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.aspx
[8] https://www.whhs.com/About/Community-Connection/Community-Health-Needs-Assessment.aspx

3. About Washington Hospital

Washington Hospital Healthcare System is a district hospital that opened in 1958. It is governed by an elected Board of Directors made up of five members. Washington Hospital serves the residents of Fremont, Newark, Union City, unincorporated Sunol, and a small portion of Hayward. This primary service area, also known as the Washington Township Health Care District, encompasses approximately 124 square miles of Southern Alameda County. The area's population is about 352,000, which represents nearly 22 percent of the whole county.[9]

MISSION STATEMENT

Our mission is to meet the healthcare needs of local residents through medical services, education, and research. Washington Township Health Care District is committed to assuming the leadership role in improving and maintaining the health status of the 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

[9] https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

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 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 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:

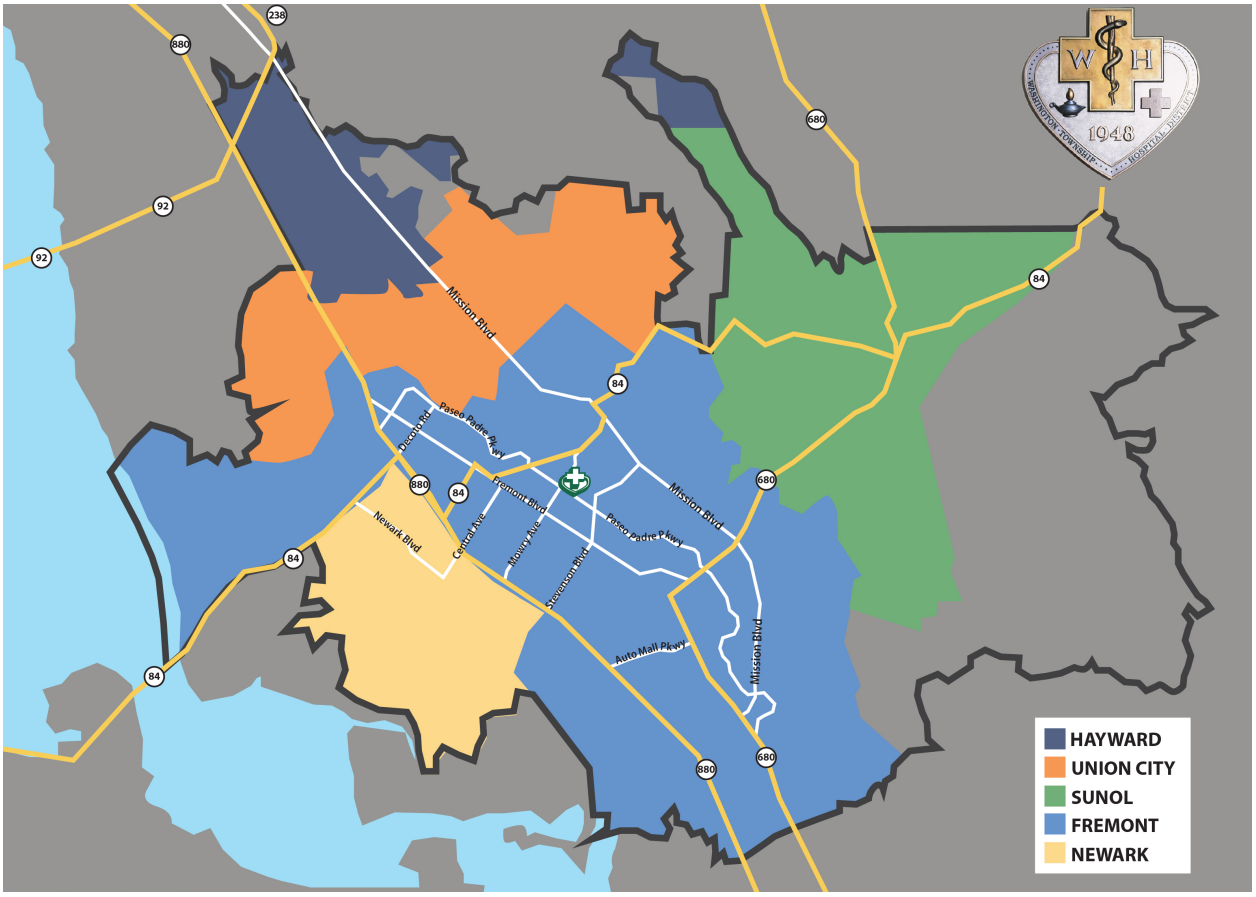
- Meet the specific healthcare needs of targeted populations
- Expand availability of healthcare to those who need it most
- Provide health information and education resources
- Teach participants about healthier lifestyles and the importance of staying healthy

These programs were 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 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 South Hayward, as well as unincorporated Sunol (Figure 1).

FIGURE 1. MAP, WASHINGTON TOWNSHIP HEALTH CARE DISTRICT



Source: Washington Hospital

Demographics

In 2017, the estimated population of the major cities that encompass the primary service area was approximately 352,000. Fremont is the largest city in the primary service area, and the fourth-largest city in the San Francisco Bay Area.[10] Unincorporated Sunol has a population of less than 1,000.[11] Washington Hospital's primary service area also includes a portion of South Hayward (Table 1).

[10] Fremont Community Profile. 2018. Retrieved from https://fremont.gov/DocumentCenter/View/6859/
[11] When a population is small, relatively minor differences in numbers (statistical data) may appear large.

TABLE 1. POPULATION BY CITY, WASHINGTON HOSPITAL PRIMARY SERVICE AREA

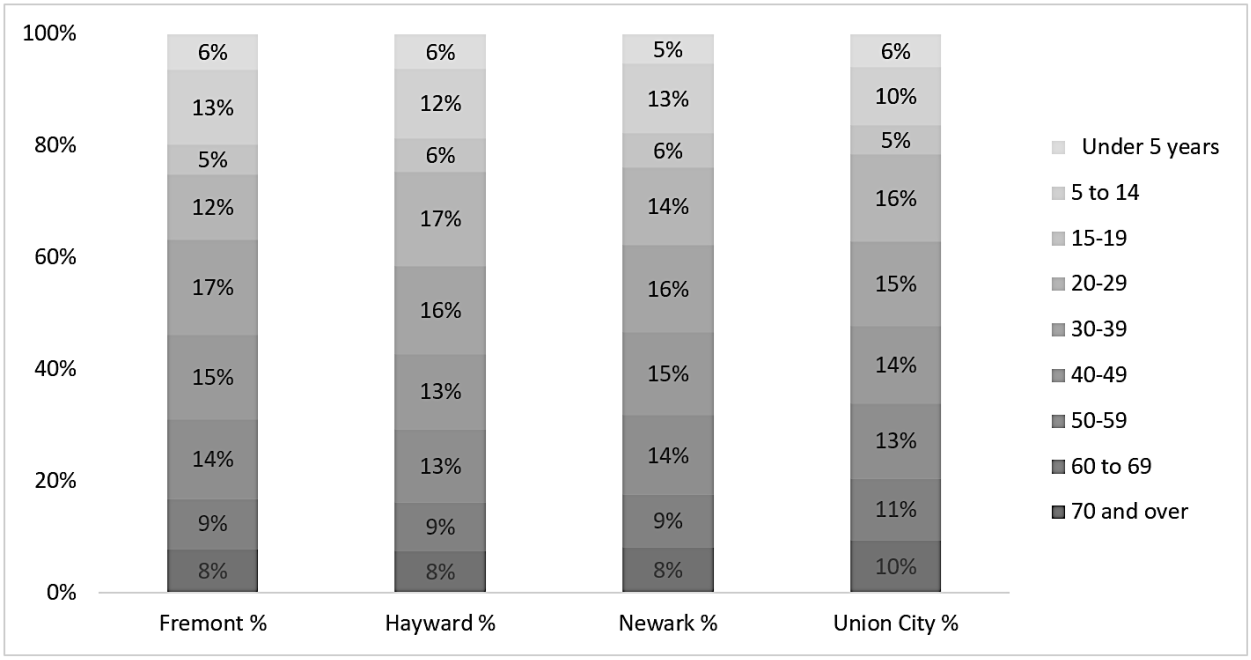
City	Population
Fremont	230,964
Union City	74,354
Newark	45,554
Unincorporated Sunol	967
Hayward (ZIP code 94544)	78,717*

** The hospital's primary service area includes only a small portion of 94544, but population counts are unavailable in increments smaller than individual ZIP codes. Source: U.S. Census Bureau, 5-Year Estimates, 2013–2017.*

TABLE 2. ZIP CODES, WASHINGTON HOSPITAL PRIMARY SERVICE AREA

ZIP	City/Place	Description
94536	Fremont	North central portion of Fremont, including Brookvale, Cabrillo, central-downtown Fremont, Centerville, and Glenmoor neighborhoods
94537	Fremont	ZIP code 94537 is a P.O. Box ZIP Code. There is no demographic data available for this type of ZIP Code.
94538	Fremont	Central south portion of Fremont, including Blacow, Grimmer, Irvington, Parkmont, and Sundale neighborhoods
94539	Fremont	Eastern portion of Fremont, including Canyon Heights, Mission Hills, Mission San Jose, Niles, and Vallejo Mills neighborhoods
94544	Hayward	A small portion of the southern part of this Hayward ZIP code bordering Union City
94555	Fremont	Northwest portion of Fremont, including Ardenwood, Cabrillo, Lakes and Birds, and Northgate neighborhoods
94560	Newark	Sole ZIP code for the City of Newark
94586	Sunol	Sole ZIP code for unincorporated Sunol
94587	Union City	Sole ZIP code for the City of Union City

FIGURE 2. POPULATION BY AGE RANGE AND CITY, WASHINGTON HOSPITAL PRIMARY SERVICE AREA



Source: U.S. Census Bureau, 5-Year Estimates, 2013–2017.

Fremont, Newark, and Union City have very similar characteristics based on age (Figure 2). For example, approximately 6 percent are children under 5 years old and approximately 58 percent are adults of working age between 20 and 59 years old. Union City has a larger proportion of seniors age 60 and older (21 percent) than Fremont and Newark (17 percent).

TABLE 3. RACE/ETHNICITY, ADULTS (PERCENTAGE)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
Hispanic or Latinx	13.5	33.8	20.9	7.9	22.5
White Non-Hispanic	24.9	33.4	21.0	88.6	42.6
Asian	57.4	30.6	53.2	6.7	28.9
Black	3.0	5.0	5.0	0.4	11.1
Two or More Races	5.5	7.6	6.2	0.4	6.4
Other	14.6	31.0	20.7	4.2	17.3

The data provided are for residents of one race, except for Two or More Races. Unincorporated Sunol's percentages by race have a high margin of error because the population is less than 1,000. Source: U.S. Census Bureau American Community Survey, 5-Year Estimates, 2013–2017.

As shown in Table 3, Fremont and Union City have larger Asian populations (57 percent and 53 percent, respectively) than White non-Hispanic populations (25 percent and 21 percent, respectively). Union City also has a sizable Hispanic/Latinx population (21 percent), as does Newark (34 percent). The ethnic makeup of unincorporated Sunol differs significantly, with a majority of White non-Hispanic residents (89 percent of the total population). The Black/African ancestry population (less than 1 percent to 5 percent) in each of these Southern Alameda County cities is significantly smaller than in Alameda County overall (11 percent) but similar to California overall (6 percent).[12] Alameda County's Black/African ancestry population is largely driven by the population of Oakland, the county seat, which has more than 101,000 residents, 24 percent of whom are Black/African ancestry.

AREA DEPRIVATION INDEX

For 20 years, the U.S. Health Resources and Services Administration has used the Area Deprivation Index (ADI) to measure the lack of basic necessities in communities. The ADI has been linked to health outcomes such as 30-day rehospitalization rates, cervical cancer incidence, cancer- and cardiovascular disease-related deaths, and mortality in general (from all causes). The current ADI combines 17 indicators of socioeconomic status (income, education, employment, housing conditions, etc.) from American Community Survey 5-year estimates, 2013–2017.

The ADI and percentile scores are calculated for Washington Hospital's primary service area[13] and for Alameda County using Census Block Group[14] level data (BroadStreet 2019). In general, the greater the percentile number, the worse the area is doing. Among the exceptions to that rule are median gross rent and median monthly home cost, where lower percentiles indicate higher rent and housing costs. Area percentiles and indicator values that are worse than Alameda County are indicated in **bold red** font (Table 4).

The median annual incomes in Fremont ($122,191), Newark ($96,817), and Union City ($95,625) are above the Alameda County benchmark ($85,743) and trending up. The median annual income in unincorporated Sunol is a steady $109,453.[15]

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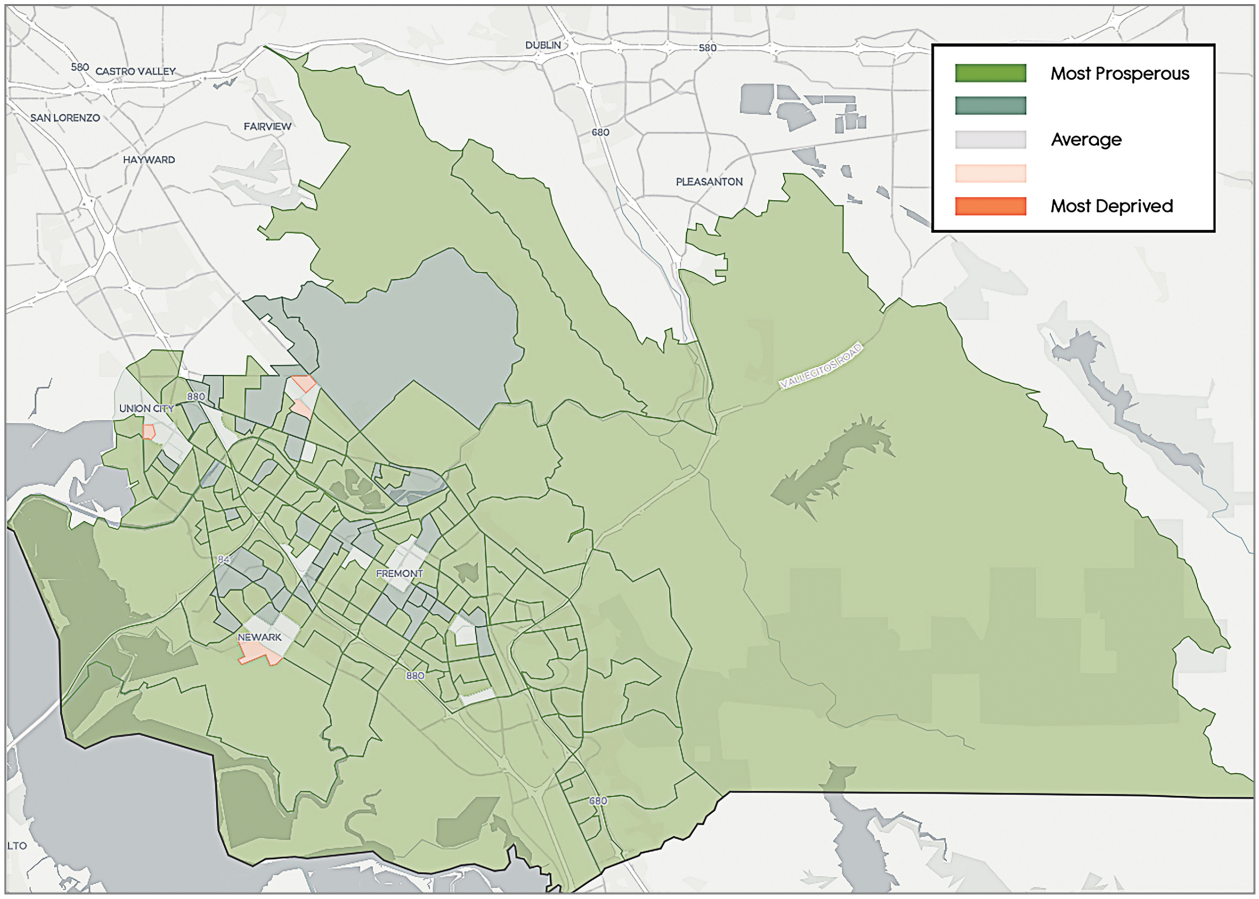
[12] U.S. Census Bureau American Community Survey, 5-Year Estimates, 2013–2017.
[13] For the ADI and percentile scores only, the Washington Hospital service area comprises the following cities: Fremont, Newark, unincorporated Sunol, and Union City.
[14] A Census Block Group is smaller than a Census Tract but larger than a Census Block. In urban areas, a Census Block is generally equivalent to a city block, but in suburban and rural areas may be defined by the Census in other ways. A Census Block Group encompasses multiple, usually contiguous, Census Blocks. (U.S. Census Bureau. [2018]. *Geography Program Glossary.*)
[15] Healthy Alameda County, 2013–2017.

TABLE 4. AREA DEPRIVATION INDEX, WASHINGTON HOSPITAL PRIMARY SERVICE AREA

Indicator Name	WHHS Percentile	WHHS Value	AC Percentile	AC Value
Area Deprivation Index	**12**	**78.3**	**29**	**88.6**
Families below poverty level	35	3.9%	54	8.1%
High school diploma/GED, adults ≥ age 25	43	91.6%	60	87.3%
Owner-occupied housing units	56	63.5%	68	52.6%
Households without a motor vehicle	49	4.7%	70	10.1%
Crowded households (>1 person per room)	**87**	**8.0%**	86	6.9%
Households without complete plumbing	39	0.2%	54	0.5%
Households without a telephone	51	1.7%	56	2.0%
Income disparity (log scale)	20	1.2	30	2.0
Median family income	12	$113,715	19	$97,145
Median gross rent	**6**	**$1,827**	12	$1,432
Median home value	5	$653,124	7	$593,500
Median monthly home cost	**8**	**$2,262**	13	$2,132
Population below 150% of poverty threshold	26	11.2%	46	19.2%
Single parent households with children < age 18	55	**20.9%**	55	19.5%
Less than high school education, adults ≥ age 25	59	4.1%	74	6.9%
Unemployment, ≥ age 16	46	5.7%	57	7.1%
Employed in white collar occupations, ≥ age 16	23	72.2%	31	68.6%

Sources: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017), and Census Block Group level data (BroadStreet 2019).

FIGURE 3. AREA DEPRIVATION INDEX MAP, WASHINGTON HOSPITAL PRIMARY SERVICE AREA



Source: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017), and Census Block Group level data (BroadStreet 2019).

4. Assessment Team

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

Community benefit managers from 14 local hospitals in Alameda and Contra Costa counties ("the Hospitals") contracted with Actionable Insights in 2018–2019 to conduct the Community Health Needs Assessment in 2019–2020.

The hospitals that partnered with Washington Hospital were:

- Kaiser Permanente–Greater Southern Alameda Area (Fremont and San Leandro Kaiser Foundation Hospitals)
- St. Rose Hospital
- Sutter Health Bay Area (Eden Medical Center)
- UCSF Benioff Children's Hospital Oakland

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights (AI), LLC, an independent, local research firm, completed the CHNA. For this assessment, AI assisted with CHNA planning in the following ways:

- conducted primary research of statistical data
- collected community input for secondary data
- synthesized primary and secondary data
- facilitated the process of identifying community health needs and assets
- assisted with determining the prioritization of community health needs
- documented the processes and findings into this report

Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for over 25 hospitals during the 2018–2020 CHNA cycle. More information about AI is available on the company's website.[16]

[16] http://www.actionablellc.com

5. Process and Methods

The Hospitals worked in collaboration on the primary and secondary data requirements of the CHNA. Washington Hospital Healthcare System directed the research firm Actionable Insights (AI) to collect additional data specific to the hospital's primary service area. The CHNA data collection process took place over 10 months and culminated in a report written for Washington Hospital in winter of 2019–2020. The phases of the process are depicted below (Figure 4).

FIGURE 4. CHNA PROCESS

SECONDARY DATA COLLECTION

AI analyzed nearly 300 quantitative health indicators to assist Washington Hospital in understanding the health needs and in assessing its priority in the community. AI collected data from existing sources using the CHNA.org[17] and other online data platforms, such as the California Department of Public Health and the U.S. Census Bureau. 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 that were identified as community needs. Timely, reliable statistical information related to these topics was unavailable:

- Adequacy of community infrastructure (sewerage, electrical grid, etc.)
- Adult use of illegal drugs and misuse/abuse of prescription medications (e.g., opioids)
- Alzheimer's disease and dementia diagnoses
- Diabetes among children
- Experiences of discrimination among vulnerable populations

[17] http://www.chna.org is a web-based resource funded by Kaiser Permanente as a way to support community health needs assessments and community collaboration. The platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in certain neighborhoods. The platform provides the capacity to view, map, and analyze these indicators as well as to understand ethnic disparities and compare local indicators with state and national benchmarks.

- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)
- Hepatitis C
- Mental health disorder prevalence
- Oral/dental health
- Suicide among LGBTQI youth
- Data for unincorporated Sunol
- Data for the part of South Hayward in Washington Hospital's primary service area

COMMUNITY INPUT

AI conducted the primary research for this assessment. AI used three strategies for collecting community input: key informant interviews with health experts, focus groups with professionals, and focus groups with residents.

Primary research protocols generated by AI with the Hospitals were based on facilitated discussion among the collaborative's members about what they wanted to learn during the 2019–2020 CHNA. The Hospitals sought to build upon prior CHNAs by focusing the primary research on the community's perception of mental health (identified as a major health need in the 2017 CHNA) and the experience with healthcare access and delivery (also identified as a major health need in 2016–2017). Relatively little recent quantitative data exist on these subjects.

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

Across the key informant interviews and focus groups, AI solicited input from 38 community leaders and representatives of various organizations and sectors. 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-identified high-need target populations.[18]

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.

[18] The IRS requires that community input include feedback from low-income, minority, and medically underserved populations.

KEY INFORMANT INTERVIEWS

Between June and August 2018, AI conducted primary research via key informant interviews with 14 local and/or regional experts from various organizations. These experts included individuals from the public health department, community clinic managers, and clinicians. Interviews were conducted in person or by telephone for approximately one hour. AI asked:

- What are the most important/pressing health needs in the local area?
- What drivers or barriers are impacting the top health needs?
- To what extent is healthcare access a need in the community?
- To what extent is mental health a need in the community?
- What policies or resources are needed to impact health needs?

FOCUS GROUPS

Input from Service Providers and Community Leaders

Four focus groups were conducted with a total of 24 service providers and community leaders in August and September 2018. The questions were the same as those used with key informants. AI modified the questions appropriately for each audience.

TABLE 5. DETAILS OF FOCUS GROUPS WITH PROFESSIONALS

Topic or Population	Focus Group Host/Partner	Date	Number of Participants
Social determinants of health	South County Partnership	8/2/2018	4
Adolescent health professionals and health promoters	Tri-City Health Center	8/24/2018	4
Safety net clinic leaders	Kaiser Foundation Hospital–San Leandro	9/4/2018	4
Mental health professionals	Kaiser Foundation Hospital–San Leandro	9/28/2018	12

Input from Residents

AI conducted three resident focus groups with a total of 34 residents in July and August 2018. The discussions centered on the same questions asked of key informants and other focus groups. AI modified the questions appropriately for each audience.

Nonprofit hosts recruited participants for the focus groups. To provide a voice to the community it serves, and in alignment with IRS regulations, the focus groups targeted residents who are medically underserved, low-income, or of a minority population.

TABLE 6. DETAILS OF FOCUS GROUPS WITH RESIDENTS

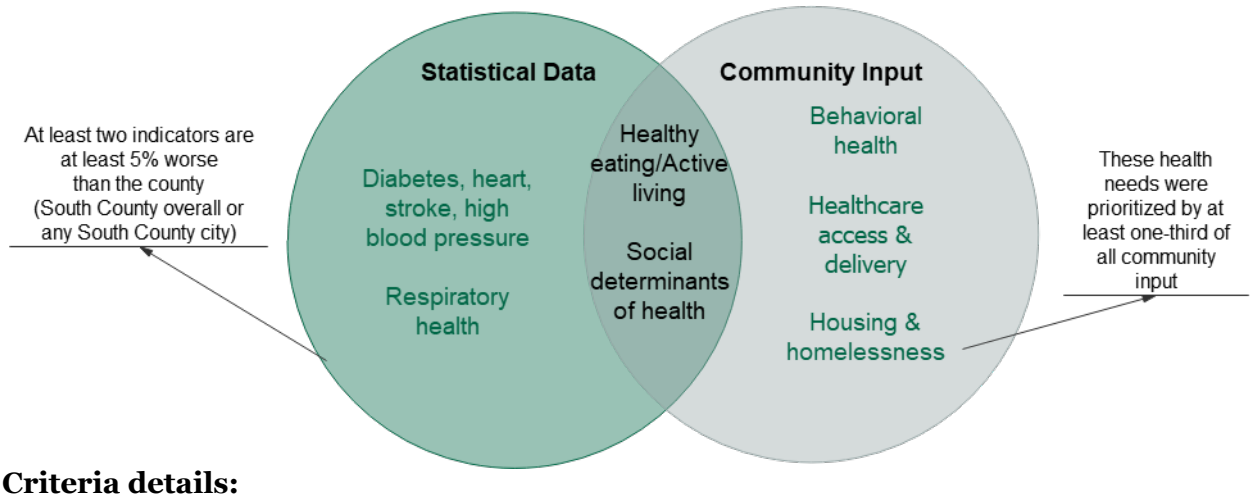
Population	Focus Group Host/Partner	Date	Number of Participants
Spanish-speaking parents of middle- and high school–age youth	La Familia Counseling	7/24/2018	12
At-risk youth	St. Rose Hospital	8/3/2018	7
Immigrants and refugees	Mujeres Unidas y Activas	8/28/2018	15

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, as depicted in the diagram below. *See the Definitions box on the next page for additional terms and definitions.*

FIGURE 5. WASHINGTON HOSPITAL 2020 HEALTH NEEDS RUBRIC

Actionable Insights (AI) analyzed secondary and qualitative data on a variety of issues. AI then synthesized the data for each issue and applied the criteria listed below to evaluate whether each issue qualified as a prioritized health need.



Criteria details:

1. Meets the definition of a "health need." (*See Definitions box on the next page.*)
2. a. Two or more direct indicators failed the county benchmark by ≥5 percent.
   b. If not (a), prioritized by at least one-third of key informants or focus groups.

In 2019, this process led to the identification of seven 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-order the significant health needs as follows:

- 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

DEFINITIONS

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

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

Health need: A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

Health outcome: A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality (death).

See Section 6: 2020 Prioritized Community Health Needs (pages 33–46) for a summarized description of each need. For further details, including statistical data, see Attachment 2: Secondary Data Tables.

6. 2020 Prioritized Community Health Needs

SUMMARIZED DESCRIPTIONS OF PRIORITIZED NEEDS

BEHAVIORAL HEALTH

Behavioral health, including mental health and substance use, is a high priority in the community: More than half of all focus groups and key informant interviews in the East Bay, including Washington Hospital's primary service area, prioritized behavioral health as a top health need. Focus group participants and key informants alike discussed the co-occurrence of mental health and substance use.

What Is the Issue?

Although there is no single definition, researchers agree that the minimum elements of well-being are having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing life satisfaction, fulfillment, and "positive function." Well-being looks beyond happiness to include one's ability to:[19]

- View the past, present, and future in a positive perspective
- Have positive relationships with parents, siblings, life partners, and peers who can provide support in difficult times
- Find and engage in activities that absorb the individual in the present moment
- Understand and feel the greater impact of personal actions and activities
- Have goals, ambitions, and achievements that provide a sense of satisfaction, pride, and fulfillment

Mental health—emotional and psychological well-being—is key to personal well-being, healthy relationships, and the ability to function in society.[20] Mental health and the maintenance of good physical health are closely related. 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.[21] The Mayo Clinic estimates that in 2015, roughly 20 percent of the adult U.S. population was coping with a mental illness.[22]

The use of substances such as alcohol, tobacco, and legal and illegal drugs affects not only the individuals using them, but also their families and communities. Smoking cigarettes, for instance, can harm nearly every organ in the body and cause a variety of diseases, including

[19] Centers for Disease Control and Prevention. (2016). *Health-Related Quality of Life: Well-Being Concepts*.
[20] Office of Disease Prevention and Health Promotion. (2018). *Mental Health and Mental Disorders*.
[21] 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.
[22] Centers for Disease Control and Prevention. (2018). *Learn About Mental Health*.

heart disease.[23] Exposure to secondhand smoke can create health problems for nonsmokers.[24] Substance use can lead or contribute to other costly social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, motor vehicle crashes, and HIV/AIDS.[25]

In recent years, advances in research have resulted in effective evidence-based strategies to treat various addictions. Brain-imaging technology and the development of targeted medications have helped to shift the perspective of the research community with respect to substance use. Increasingly, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.[26]

Why Is It a Health Need?

In interviews and focus groups, CHNA participants expressed strong concerns about behavioral health in the community. Depression and stress were the most common issues raised, and trauma and adverse childhood experiences (ACEs) were identified as drivers of behavioral health problems. Some participants discussed the impact of discrimination and institutionalized racism as generational traumas that contribute to inequitable health outcomes.

Local statistics support their concerns. Regarding substance use, emergency department (ED) visits among Southern Alameda County cities are highest in Newark (1,249.1 per 100,000), which is lower than the Alameda County benchmark. At the time of this report, city-level data on opioid deaths was not available, but Alameda County saw a 9 percent increase in opioid overdose deaths between 2016 and 2018 (crude rate of 3.4 per 100,000).[27]

Although the suicide rates in Southern Alameda, and in Alameda County as a whole, are lower than the Healthy People 2020 benchmark of 10 deaths per 100,000 people, the suicide rate in Fremont in 2017–2018 (7.3) was at its highest since 2011. The ED visit rate for severe mental illness (per 100,000) is significantly higher in Newark (2,436.4) and unincorporated Sunol (2,954.4), and slightly higher in Union City (2,323.2) than the Alameda County rate (2,265.5).[28] The self-inflicted injury hospitalization rate is also slightly higher in Newark (17.7) than the county rate overall (17.3).

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[23] Centers for Disease Control and Prevention. (2018). *Health Effects of Cigarette Smoking.*
[24] American Lung Association. (2017). *Health Effects of Secondhand Smoke.*
[25] World Health Organization. (2018). *Management of Substance Abuse.*
[26] Office of Disease Prevention and Health Promotion. (2018). *Substance Abuse.*
[27] California Department of Public Health California Opioid Overdose Surveillance Dashboard, skylab. https://skylab.cdph.ca.gov/ODdash
[28] All emergency room visits are age-adjusted per 100,000 people in the population.

HOUSING AND HOMELESSNESS

What Is the Issue?

The U.S. Department of Housing and Urban Development defines affordable housing as that which costs no more than 30 percent of a household's annual income. The expenditure of greater sums can result in the household being unable to afford other necessities, such as food, clothing, transportation, and medical care.[29] 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.[30] Further, a 2011 study by Children's Health Watch found that "children in families that have been behind on rent within the last year are more likely to be in poor health and have an increased risk of developmental delays than children whose families are stably housed."[31]

Homelessness correlates with poor health in that poor health can lead to homelessness and homelessness can lead to poor health.[32] 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.[33] A National Health Care for the Homeless study found that the average life expectancy for a person without permanent housing was at least 25 years less than that of the average U.S. citizen.[34] Thus, it is vital that healthcare systems monitor the local homeless population and identify the population's health needs.

Why Is It a Health Need?

In interviews and focus groups, maintaining safe and healthy housing—especially for renters and homeowners with low and/or fixed incomes—emerged as a top community priority. CHNA participants strongly linked housing with behavioral health, indicating that the stress of keeping a roof over their heads has a negative impact on families. Participants also recognized that housing costs influence residents' physical health: Some households spent less on food and medical care in recent years in order to pay for shelter, they said. The well-being of individuals experiencing homelessness concerned many community experts and residents, because homelessness puts people at greater risk of poor health outcomes.

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[29] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*
[30] 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?*
[31] Children's Health Watch. (2011). *Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent*.
[32] National Health Care for the Homeless Council. (2011). *Care for the Homeless: Comprehensive Services to Meet Complex Needs*.
[33] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council.
[34] National Coalition for the Homeless. (2009). *Health Care and Homelessness.*

The increasing number of unstably housed individuals and the displacement of families in the East Bay, including households with children, came up in many CHNA discussions. At the time of the interviews, experts cited a lack of strong rental control laws (and a lack of knowledge about the laws that do exist) in the community. Alameda County's public health expert expressed the need for more tenant protections to keep residents from being displaced. Focus group participants suggested that the imbalance of jobs and housing (i.e., many new jobs but few new housing units) was a major driver of the housing crisis.

In 2019, the numbers of individuals experiencing homelessness rose in Fremont (608), Newark (89), and Union City (106), following the county trend. The total number of people who were unsheltered in those three cities also increased (to 650).[35] Although ethnicity data is not available on the city level, the population experiencing homelessness countywide is disproportionately of African ancestry.[36]

Also, the proportion of residents living in overcrowded housing has increased since 2011, and is significantly higher in Fremont (9 percent), Newark (11 percent), and Union City (9 percent) than in Alameda County overall (7 percent). Rent-burdened households, or those which spend 30 percent or more of their income on rent, has remained high since 2011; in 2017, the proportion of residents living in rent-burdened households was lowest in unincorporated Sunol (37 percent) and highest in Newark (50 percent). The county overall was 49 percent.

Finally, poor housing quality (e.g., evidence of leaks, mold, and pests) is associated with asthma-related emergency department (ED) visits.[37] While the local rate of asthma ED visits is not worse than the county rate overall, adult asthma hospitalization is significantly higher in Newark (91.2 per 100,000) and Union City (70.3) than in the county overall (66.6). (S*ee the health need description for Respiratory Health.*)

[35] Overall, the number of individuals experiencing homelessness in Southern Alameda County (including the cities of Hayward, San Leandro, and San Lorenzo) rose in 2017 and again in 2019 (from 598 to 815, respectively).
[36] http://everyonehome.org/wp-content/uploads/2019/07/ExecutiveSummary_Alameda2019-1.pdf
[37] Urban Institute. (2017). *The Relationship Between Housing and Asthma Among School-Age Children.*

HEALTHY EATING/ACTIVE LIVING

Healthy Eating/Active Living was identified as a top health need by the East Bay community. This need covers concerns about obesity, nutrition, diet, and fitness.

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 risk of developing diseases including cancer and diabetes, and helping to reduce the risk of obesity, osteoporosis, and dental cavities.[38] For children and adolescents, a nutritious diet helps with growth and bone development, as well as improved cognitive function.[39] Likewise, as noted by the Centers for Disease Control and Prevention, "physical activity fosters normal growth and development, can reduce the risk of various chronic diseases, and can make people feel better, function better, and sleep better."[40] Getting regular exercise can help people of all ages combat obesity, reduce the risk of cardiovascular disease, type 2 diabetes, some cancers, and other physical issues.[41] Regular exercise can also help to strengthen bones and muscles, prevent falls for older adults, and increase an individual's chances of living longer.[42]

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.[43]

Taking in more calories than are burned through normal activity and exercise causes the excess calories to be stored as fat.[44] When one's weight is higher than the healthy standard for one's height, an individual is described as overweight or obese. Both conditions are measured by body mass index (BMI), a metric ratio of weight divided by the square of height.[45] Risk factors of obesity, in addition to unhealthy diet and inactivity, include genetic factors, underlying medical issues, family models, social and economic factors, and hormonal changes due to lack of sleep, pregnancy, or age. Smoking cessation and the side effects of certain medications can also

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[38] United States Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*
[39] World Health Organization. (2018). *Early Child Development–Nutrition and the Early Years.*
[40] Centers for Disease Control and Prevention. (2018). *Physical Activity Basics.*
[41] The Mayo Clinic. (2016). *Exercise: 7 Benefits of Regular Physical Activity.*
[42] Harvard Health Publishing/Harvard Medical School. (2013). *Balance Training Seems to Prevent Falls, Injuries in Seniors.*
[43] Centers for Disease Control and Prevention. (2016). *Childhood Obesity Causes & Consequences*. See also: Centers for Disease Control and Prevention. (2018). *Adult Obesity Causes & Consequences*.
[44] The Mayo Clinic. (2018). *Obesity*.
[45] Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.

contribute to obesity. Further, food insecurity and obesity often co-exist because "both are consequences of economic and social disadvantage."[46]

The Centers for Disease Control and Prevention estimates that nearly one in five children and nearly two in five adults in the U.S. are obese. Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.

Why Is It a Health Need?

Most feedback from focus group and interview participants related to the need for more community health education to improve healthy eating and active living (HEAL) habits, which could help prevent obesity and other chronic diseases. Culturally appropriate health education may be lacking, they said.

CHNA participants also connected healthy eating and active living to good mental health. However, they noted that the convenience and relatively low cost of fast food and unhealthy grocery items made buying and preparing nutritious meals less likely for busy families. The lack of motivation and time to exercise, the expense of gym memberships and sports or fitness programs, and the inconvenient scheduling of classes also contributed to sedentary lifestyles, they said.

Parents specifically discussed having difficulty encouraging their children to adopt healthy eating and active living habits in order to lose weight. The increased use of screens (including playing video games) was identified as a driver of sedentary lifestyles among youth. Experts noted that few adults walk or bike to work because they have long commutes. The Latinx population came up frequently as one of particular concern for HEAL-related conditions.

Youth are tested in fifth, seventh, and ninth grade for aerobic fitness (a walk test or one-mile run), and for body composition (proportion of body fat). They are categorized as "in the health fitness zone" (meeting standards), "needs improvement," or "at health risk." There are indications of concern in all four school districts in the Southern Alameda County: Fremont Unified School District, Newark Unified School District, New Haven Unified School District (Union City), and Sunol Glen Unified School District.

Regarding aerobic capacity, Union City fifth-, seventh-, and ninth-graders, as well as Newark fifth-graders, have significantly worse aerobic capacity compared to their peers countywide. For example:

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[46] Food Research and Action Center. (2015). *Food Insecurity and Obesity*.

- 44 percent of Union City fifth-graders failed to meet standards.[47]
- In all four school districts, the proportion of fifth-graders who failed standards increased 5.7 to 6.8 percentage points between 2016–2017 and 2017–2018.
- In all four school districts, the proportion of seventh-graders who need to improve their aerobic capacity rose between 2017 and 2018, following county trends.

Southern Alameda youth are significantly heavier (i.e., have higher levels of fat in their body composition) than their peers countywide. For example:

- In Fremont, over 27 percent of fifth- and seventh-graders fail standards for body composition.
- In Union City, 20 percent of fifth-graders, 21 percent of seventh-graders, and 16 percent of ninth-graders are at health risk for body composition.
- In Newark, over 46 percent of fifth-graders and 43 percent of seventh-graders fail standards for body composition. More than one in four fifth-graders and seventh-graders are already at health risk. Also, 18 percent of ninth-graders are health risk for body composition.
- In Union City, 42 percent of fifth-graders and 49 percent of seventh-graders fail standards for body composition.
- In Sunol, 19 percent of fifth-graders need improvement in body composition.

Mirroring county trends, the proportion of youth in Fremont, Newark, Union City, and Sunol who need to improve their body composition (i.e., reduce fat) has been increasing in all four school districts.

HEALTHCARE ACCESS AND 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.

[47] For standards, visit https://pftdata.org/files/hfz-standards.pdf
[48] Office of Disease Prevention and Health Promotion. (2015). http://www.healthypeople.gov

Why Is It a Health Need?

The community expressed strong concern about healthcare access and delivery. In focus groups and interviews, CHNA participants discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists (including geriatric care), especially for Medi-Cal patients. Behavioral health specialists were of particular concern: Participants said there are not enough service providers to meet local demand.

Many CHNA participants expressed alarm about the barriers to access faced by immigrants who are either ineligible for Medi-Cal due to their immigration status or eligible but fearful of being deported if they access services. With regard to healthcare delivery, the community identified needs for greater language support, culturally appropriate healthcare services, and whole-person care. Experts, also described the difficulty that LGBTQI community members, especially transgender patients, experience in finding medical professionals sensitive to their needs.

Statistics suggest that language may be a barrier to healthcare access in Southern Alameda County. A higher percentage of Union City residents (19 percent) speak limited English than the county average (18 percent). About 9 percent of Union City residents and 10 percent of Fremont residents live in linguistically isolated households, where no one age 14 or older speaks English very well; this is similar to the countywide percentage (10 percent).

Other statistics related to healthcare access and delivery (the rates for delay of care, health insurance, avoidable emergency department visits) in the hospital's primary service area are all better than the county's benchmarks. However, the mortality rate from all causes is significantly higher in Union City (598.7 per 100,000) than in Alameda County overall (560.3).

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are defined by the Centers for Disease Control and Prevention as the "conditions in the places where people live, learn, work, and play."[49] Such conditions include a wide variety of attributes, including access to quality education, access to economic and job opportunities, public safety, socioeconomic conditions, the natural environment, community design, etc.[50] For the purposes of this CHNA, we focus on socioeconomic conditions, including income and employment, and access to food and recreation. *See also the health need descriptions for Housing and Homelessness and Healthcare Access and Delivery.*

What Is the Issue?

The U.S. Surgeon General's "Vision for a Healthy and Fit Nation 2010" described how different elements of a community can support residents' healthy lifestyles. The various components of the physical environment, including sidewalks, bike paths, parks, and fitness facilities that are "available, accessible, attractive, and safe," all contribute to the extent and type of residents' physical activities.[51] Other community elements that support healthy lifestyles include local stores with fresh produce. Residents are more likely to experience food insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and there are limited transportation/transit options.[52]

The Centers for Disease Control and Prevention recommends policies and environments that support behaviors aimed at achieving and maintaining healthy weight in settings such as workplaces, educational institutions and communities.[53] For example, the availability of healthy and affordable food in retail and cafeteria-style settings allows individuals to make better food choices throughout the day. Otherwise, people may settle for caloric foods of low nutritional value.[54]

Our health-related behavior and physical environment are determinants of how long and how well we live. The greatest determinants of a population's health, however, are its social and economic environments.[55] Numerous studies have found that access to economic security programs (i.e., SNAP—formerly referred to as food stamps) results in better long-term health

[49] Centers for Disease Control and Prevention. (2018). *Social Determinants of Health: Know What Affects Health.*
[50] Healthy People 2020. (2019). *Social Determinants of Health.*
[51] Centers for Disease Control and Prevention. (2009). *Healthy Places*.
[52] Healthy People 2020. (2018). *Food Insecurity.*
[53] Healthy People 2020. (2015). *Nutrition and Weight Status*.
[54] Centers for Disease Control and Prevention. (2015). *Healthy Food Environments*.
[55] County of Los Angeles Public Health. (2013). *Social Determinants of Health: How Social and Economic Factors Affect Health.*

and social outcomes.[56] As the World Health Organization notes, "the context of people's lives determine[s] their health."

A link exists between higher income and/or social status and better health. On top of that, a secure social support system (families, friends, communities) plays a significant role in healthier populations. Childhood poverty has lasting effects: Even when economic and social environments later improve, childhood poverty still results in poorer long-term health outcomes.[57] The establishment of policies that positively influence economic and social conditions can improve health for a large number of people in a sustainable fashion over time.[58]

Educational attainment, along with 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. The relationship of educational attainment, employment, wages, and health have been well documented. Individuals with at least a high school diploma do better than those without a high school diploma on a number of measures, including income, health outcomes, life satisfaction, and self-esteem. For starters, the majority of jobs in the U.S. require more than a high school education.[59] Research has found that wealth among families in which the head of household has a high school diploma is 10 times higher than that of families in which the head of household dropped out of high school.[60] Additionally, the National Poverty Center reports that increased education is associated with decreased rates of most acute and chronic diseases.[61]

Why Is It a Health Need?

In interviews and focus groups, CHNA participants identified economic security as a top need in the community. They discussed food insecurity, the risk of homelessness, and employment. Residents emphasized that local jobs often do not pay enough given the high cost of living.

CHNA participants connected poverty with poor health outcomes and suggested that community members with lower incomes may have a harder time accessing care than others. Some participants observed that it's difficult for people to attend to their health when they cannot afford to miss work. They also cited the stressors of economic instability as a driver of

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[56] Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits*.
[57] World Health Organization. (2018). *The Determinants of Health.*
[58] Office of Disease Prevention and Health Promotion. (2018). *Social Determinants of Health.*
[59] Insight Center for Community Economic Development. (2014). https://www.insightcced.org
[60] Gouskova, E., & Stafford, F. (2005). Trends in Household Wealth Dynamics, 2001–2003. *Panel Study of Income Dynamics. Technical Paper Series, 05–03.*
[61] Cutler, D.M., & Lleras-Muney, A. (2006). National Bureau of Economic Research. *Education and Health: Evaluating Theories and Evidence* (No. w12352).

poor mental health. (*See also the health need descriptions for Behavioral Health and Healthcare Access and Delivery*.)

A wide variety of participants discussed concerns about education and academic achievement. Academic achievement came up most often as a driver of economic security (stable employment and sufficient wages). The public health expert emphasized that K–12 and higher education often do not prepare residents for jobs that provide a living wage.

A wide variety of experts and community members discussed concerns regarding education and academic achievement. Academic achievement came up most often as a driver of economic security related to stable employment and sufficient wages. The public health expert emphasized that both K–12 education and higher education often do not prepare residents for jobs that provide a living wage.

Focus group participants discussed security in terms of neighborhood safety as well, citing a lack of safe public spaces and community centers where residents can exercise or otherwise engage in recreational activities. Many neighborhood parks are not used because residents fear becoming victims of crime, participants said. Some parks also lack appropriate exercise equipment, and others offer no programs to encourage or teach residents to exercise, they said. In addition, language barriers may also keep some residents from accessing the recreational resources that are available. Parents called out the lack of free exercise and sports programs as a barrier to physical activity for children. Specifically, Hayward parents said the lack of access to a pool prevents youth from learning to swim and swimming for exercise.

With regard to food security, CHNA participants described difficulty accessing grocery stores that carry fresh food (because there are not any or many in close proximity), a preponderance of fast food restaurants, and dismay with the unhealthy food served at schools and provided by emergency food pantries. They said many people perceive that healthy ingredients are more expensive than packaged items and fast food. Public health experts in Alameda County identified the lack of access to recreation and to healthy food in certain areas ("food deserts") as drivers of poor community health. Statistics show that food access among Fremont, unincorporated Sunol, and Union City residents is significantly worse than the county average: 17 percent of Sunol residents, 13 percent of Fremont residents, and 9 percent of Union City residents have low access to a supermarket or large grocery store, compared with 8 percent of Alameda County residents overall.

The percentage of households in poverty has been decreasing across Washington Hospital's primary service area (ranging from 5 percent in Fremont to 9 percent in unincorporated

Sunol).[62] Similarly, the percentage of adults (ages 25 and older) in the service area who have a bachelor's degree or higher has been rising. However, significantly fewer adults have this level of education in Newark (30 percent) and Union City (36 percent) than the county average (44 percent).

DIABETES, HEART DISEASE, HYPERTENSION, AND STROKE

What Is the Issue?

Diabetes refers to chronic diseases that affect how the body uses glucose (blood sugar), its primary source of fuel. Type 2 diabetes accounts for roughly 90 percent of all diagnosed cases, with type 1 diabetes and gestational diabetes making up the rest (at about 5 percent each). The Centers for Disease Control and Prevention (CDC) estimate that 30 million people in the U.S. have diabetes and that an additional 84 million U.S. adults are pre-diabetic (have higher than normal blood glucose levels). Diabetes is the seventh-leading cause of death nationwide. Other serious health complications include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations.[63]

Type 1 diabetes is generally believed to be caused by a combination of genetic and environmental factors[64] and cannot be prevented, but type 2 diabetes and pre-diabetes are the result of the body losing its ability to generate sufficient insulin to maintain and regulate a healthy blood sugar level. Risk factors for type 2 diabetes include being physically inactive, overweight, and/or age 45 or older, as well as having pre-diabetes and/or a close family member with type 2 diabetes. Additionally, according to the CDC, certain ethnic groups (African ancestry, Latinx, Native American, Pacific Islanders, and some Asian groups) are at a higher risk of type 2 diabetes than others.

Nationally, some 84 million people suffer from a form of cardiovascular disease.[65] Heart disease is the #1 killer of both men and women,[66] and stroke is the fifth leading cause of death and a significant cause of serious disability for adults.[67] Recent research has established that disparities exist between minority and non-minority cardiovascular health outcomes across the United States.[68] Although some risk factors for heart disease and stroke are not controllable

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[62] Although unincorporated Sunol's poverty rate was somewhat stable at 9 percent between the periods of 2010–2014 and 2013–2017, the proportion of children in poverty was 32 percent, which is significantly higher than other Southern Alameda cities and the county. This may be due to the small population of unincorporated Sunol, which results in an unstable rate.
[63] Centers for Disease Control and Prevention (2018). *Diabetes Quick Facts.*
[64] The Mayo Clinic. (2018). *Diabetes Overview.*
[65] Johns Hopkins Medicine. (2018). *Cardiovascular Disease Statistics.*
[66] Centers for Disease Control and Prevention. (2017). *Heart Disease Facts.*
[67] Centers for Disease Control and Prevention. (2018). *Stroke.*
[68] Graham, G. (2015). Disparities in Cardiovascular Disease Risk in the United States. *Current Cardiology Reviews, 11*(3): 238–245.

(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.[69] Addressing risk factors early in life can help in preventing chronic cardiovascular disease.[70, 71]

Why Is It a Health Need?

In focus groups and interviews, CHNA participants mostly brought up issues related to the need for more community health education to boost healthy eating and active living, which could prevent obesity, diabetes, and other chronic diseases. Culturally appropriate health education may be lacking, participants said. (*See also the health need description for Healthy Eating/Active Living*.)

Statistically, heart disease hospitalizations are significantly higher in unincorporated Sunol (772.5 per 100,000) and Union City (593.6) than in the county as a whole (559.7). Hypertension is also an issue, as evidenced by the rate of related hospitalizations in unincorporated Sunol (4,337.3 per 100,000) and by the rate of related emergency department (ED) visits in Union City (5,874.8), both higher than the county rates (of 3,058.0 and 5,425.0, respectively). It's also worth noting that the hypertension mortality rate in Newark (14.9) is significantly higher than Fremont (10.9) and Union City (11.2) and the county (13.8). However, the heart disease mortality and ischemic heart disease mortality are worse in other cities. For example, here's how Union City compares to the county (in parentheses):

- Heart disease mortality rate: 140.5 (111.6), poorest since at least 2011
- Acute myocardial infarction mortality: 25.8 (19.5), poorest since 2011
- Ischemic heart disease mortality: 83.9 (57.6), poorest since 2013

The rates of diabetes hospitalizations are significantly higher in Newark and Union City (1,844.8 and 2,054.1, respectively) than the Alameda County rate (1,702.8). Newark also has significantly higher rates of (ED) visits for diabetes (2,890.0) and stroke (119.0 (ED) visits and 249.4 hospitalizations) compared to the county's rates (2,674.7, and 87.9 and 220.9, respectively). Newark also has the highest rate of hypertension deaths, which is at its highest (14.9 per 100,000) since at least 2011.

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[69] American Heart Association. (2017). *What Is Cardiovascular Disease?*
[70] The Mayo Clinic. (2016). *Strategies to Prevent Heart Disease.*
[71] Centers for Disease Control and Prevention. (2017). *Leading Causes of Death.*

RESPIRATORY HEALTH

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.[72] Asthma is an inflammation of the airways that causes them to swell and narrow, characterized by episodes of reversible breathing problems.[73] Symptoms range from mild to life-threatening. Asthma attacks can cause a range of issues from simple wheezing to extreme breathlessness.[74] 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."[75]

Why Is It a Health Need?

CHNA participants identified poor air quality as a driver of asthma. The asthma prevalence rates in Southern Alameda County are mostly better than the Alameda County rate overall and have been improving. However, Fremont's childhood asthma prevalence rate (19.4 per 100,000) is slightly worse than the county benchmark (18.9), and Union City's rate nearly as high (18.8). COPD department (ED) visits and asthma hospitalizations in Newark and Union City are significantly worse than the county's rates.

Certain other drivers of respiratory conditions, such as physical inactivity, are significantly higher among youth. (*See also the health need description for Healthy Eating/Active Living*.)

[72] U.S. National Library of Medicine. (2018). *Lung Disease.*
[73] The Mayo Clinic. (2018). *Asthma Overview.*
[74] Centers for Disease Control and Prevention. (2018). *Asthma.*
[75] American Lung Association. (2018). *Asthma Risk Factors.*

CANCER

Cancer is the second leading cause of death in the United States, after heart disease. High-quality screening can serve to reduce cancer rates; however, complex factors contribute to disparities in cancer incidence and death rates between different ethnic, socioeconomic, and disadvantage groups.

Statistically, Alameda County generally fares well with respect to cancer: Nearly all rates of incidence or death from various types of cancer meet or beat the state's benchmarks. For this reason, cancer was not identified as a health need in the 2020 Community Health Needs Assessment. However, it remains a community health concern.

Cancer Incidence Rates

The most current statistics for the Greater San Francisco Bay Area,[76] including Alameda County, show that over the past decade, annual incidence rates declined for various cancers:

- Bladder: males, –2.2 percent; females, –2.4 percent
- Colorectal: males, –3.4 percent; females, –3.9 percent
- Lung: males, –3.2 percent; females, –2.6 percent
- Prostate cancer: –7.6 percent
- Stomach cancers: males, –1.6 percent; females, –1.9 percent

During the same period, annual incident rates increased for three cancers:

- Malignant melanoma: males, +3.2 percent; females, +2.7 percent
- Thyroid cancer: males, +4.3 percent; females, +2.1 percent
- Uterine cancer: +1.6 percent

Cancer Mortality Rates

Regional statistics[77] also show that, over the past decade, annual incidence rates declined for various cancers, among them:

- Breast cancer: –2.5 percent
- Colorectal cancer: males, –3.6 percent; females, –3.3 percent
- Lung cancer: males, –4.0 percent; females, –3.4 percent
- Malignant melanoma: males, –3.2 percent; females, –6.8 percent

[76] University of California, San Francisco. (2019.) The Greater Bay Area Cancer Registry: Incidence and Mortality Annual Review, 1988–2016. Version 6/21/2019. See Attachment 2: Secondary Data Tables for additional details.
[77] IBID.

- Non-Hodgkin lymphoma: males, –3.8 percent; females, –3.7 percent
- Prostate cancer: –2.0 percent

The only mortality rate with an increase was uterine cancer (females, +3.3 percent).

Washington Hospital Cancer Care Program

Washington Hospital's Cancer Care Program offers a full array of treatments for patients who have received a cancer diagnosis. A team of physicians and staff are dedicated to delivering the best possible health outcomes to community members.

- UCSF - Washington Cancer Center oncology care providers offer access to treatment in a comforting, convenient environment.
- Washington Radiation Oncology Center provides high-quality, cost-effective radiation oncology services.
- Interventional Radiology (IR) physicians offer many options for the least invasive treatments available.
- Sandy Amos RN Infusion Center provides a comfortable, tranquil environment for patients who require frequent infusion therapy.
- Washington Cancer Genetics Program offers genetic counseling for individuals who are concerned about the risk of an inherited cancer predisposition.
- Washington Women's Center nurse navigators meet with patients to help guide them and their family members through the cancer treatment journey.

Washington Hospital has received the Commission on Cancer Outstanding Achievement Award for excellence in cancer care for three or more consecutive survey cycles. Each year since 2012, Washington Hospital has been designated as a Breast Imaging Center of Excellence by the American College of Radiology (ACR).

7. Community Resources

Various hospitals and clinics, community-based organizations, government departments and agencies, and other resources in Southern Alameda County has 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

- Tiburcio Vasquez Health Center (multiple sites)
- Tri-City Health Center (multiple sites, including mobile clinics)

OTHER HEALTH CLINICS

- RotaCare Clinic
- Sutter Health, Palo Alto Medical Foundation, Fremont Center
- Washington on Wheels Mobile Health Clinic
- Washington Township Medical Foundation (multiple sites)

8. Conclusion

Washington Hospital Healthcare System worked with 13 other hospitals, pooling expertise and resources, to complete the 2020 Community Health Needs Assessment. By gathering secondary data and conducting new primary research as a team, the Hospitals were 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 2020 CHNA meets federal and state requirements.

The CHNA report was adopted by the Washington Township Health Care District Board of Directors on July 8, 2020.

Next steps for Washington Hospital Healthcare System:

- Make CHNA report publicly available on the Community Benefit page of the hospital's website on September 1, 2020.[78]
- 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 or with partner hospitals).
- Ensure strategies are adopted by the hospital.

[78] https://www.whhs.com/About/Community-Connection/Community-Health-Needs-Assessment.aspx

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. The group included leaders from the county health systems, local government employees, clinicians, and nonprofit organizations.

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Organizations						
Interview	Dr. Kathleen Clanon, Medical Director, Alameda County Health Care Services	Whole person health	1	Medically underserved	Leader	6/29/2018
Interview	Dr. Erica Pan, Director, Division of Communicable Disease Control and Prevention, Alameda County Public Health Department	Infectious diseases	1	Health department representative	Leader	7/13/2018
Interview	Dr. Aaron Chapman, Medical Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018
Interview	James Wagner, Deputy Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Interview	Katherine Jones, Director, Adult & Older Adult System of Care, Behavioral Health Care Services of Alameda County	Behavioral health	1	Low-income, Medically underserved	Leader	8/13/2018
Interview	Colleen Chawla, Director, Alameda County Health Care Services	Healthcare access	1	Medically underserved	Leader	8/16/2018
Interview	Kristin Spanos, Chief Executive Officer, First 5 Alameda County	Needs of children ages 0–5	1	Low-income	Leader	8/20/2018
Interview	Kimi Watkins-Tartt, Deputy Director, Public Health, Alameda County Public Health Department	Public health	1	Health department representative	Leader	7/23/2018
Interview	Dr. Laura Miller, Chief Medical Officer, Community Health Center Network	Access to primary care among individuals of low socioeconomic status	1	Low-income, Medically underserved	Leader	7/20/2018
Interview	Katie Sandoval-Clark, Program Manager, Fresh Lifelines for Youth (FLY)	At-risk youth needs	1	Low-income, Minority	Leader	7/30/2018

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Interview	Yasmine Safinya-Davies, Psy.D., Executive Director, Safe Alternatives to Violent Environments (SAVE)	Community and family safety	1	Low-income, Minority	Leader	7/20/2018
Interview	Taylor Johnson, Executive Director, Tri-City Volunteers	Food insecurity	1	Low-income	Leader	8/17/2018
Interview	Denah Nunes, LCSW, Director of Health & Wellness Alameda County, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018
Interview	Louis Chicoine, Executive Director, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018
Focus Group	**Host:** South County Partnership	Social determinants of health	4	Low-income, Minority	(see below)	8/2/2018
	Attendees:					
	Bronwyn Hogan, Director, Community Rel, Abode	Social determinants of health			Leader	
	Suzanne Shenfil, Human Services Director, City of Fremont	Social determinants of health			Leader	

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
	Wil Lacro, VP of Business Development, Tiburcio Vasquez Health Center	Social determinants of health			Leader	
	Amy Hsieh, Development Manager, Tri-City Health Center	Social determinants of health			Leader	
Focus Group	**Host:** Tri-City Health Center	Needs of medically underserved individuals, especially adolescents	4*	Medically underserved	(see below)	8/24/2018
	Attendees:					
	Jorge Hernandez, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	
	Karrisa Havlicek, School Health Services Supervisor, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	

* One participant's name was withheld upon request.

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
	Lisa Martin, Clinic Manager, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	
Focus Group	**Host:** Kaiser Foundation Hospital-San Leandro	Needs of individuals using safety-net clinics	4	Low-income, Medically underserved	(see below)	9/4/2018
	Attendees:					
	Sarah Timmons, MPH, Health Education Supervisor, School-Based Health Center Department, La Clinica de La Raza	Needs of individuals using safety-net clinics			Leader	
	Atziri Rodriguez, Senior Program Manager, SBHC, Native American Health Center	Needs of individuals using safety-net clinics			Leader	
	David B. Vliet, Chief Executive Officer, Tiburcio Vasquez Health Center	Needs of individuals using safety-net clinics			Leader	
	Phyllis Pei, Director of Clinical Services, Tri-City Health Center	Needs of individuals using safety-net clinics			Leader	

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Focus Group	**Host:** Kaiser Foundation Hospital-San Leandro	Mental health	12	Medically underserved	(see below)	9/28/2018
	Attendees:					
	Chet Dayal, Bay Area South Asian Network of Therapists	Mental health			Leader	
	Shalini Dayal, Bay Area South Asian Network of Therapists	Mental health			Leader	
	Kathy Kimberlin, Executive Director, Boldly Me	Mental health			Leader	
	Annie Bailey, City of Fremont, Youth & Family Services	Mental health			Leader	
	Yolanda Chavez, City of Fremont, Youth & Family Services	Mental health			Leader	
	Claudia P. Del Rio, Director, La Familia Counseling	Mental health			Leader	
	Leticia Vargas de Gonzalez, MH Educator, La Familia Counseling	Mental health			Leader	

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
	Lisa Jackson, Program Coordinator, Career Pathways Intervention & Prevention, San Leandro Unified School District	Mental health			Leader	
	Monica Zuniga, Mental Health Specialist, Tiburcio Vasquez Health Center	Mental health			Leader	
	Elizabeth Martin, Tri-City Health Center	Mental health			Leader	
	Nikhat Nazneen, DGO, MBBS, Physician - Pediatrics, Tri-City Health Center	Mental health			Leader	
	Tam Nguyen, Tri-City Health Center	Mental health			Leader	

DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Residents (attendee names withheld)						
Focus Group	**Host:** La Familia Counseling	Parents of middle- and high school–age youth	12	Minority	Members	7/24/2018
Focus Group	**Host:** St. Rose Hospital	At-risk youth	7	Low-income, Minority	Members	8/3/2018
Focus Group	**Host:** Mujeres Unidas y Activas	Immigrants and refugees	15	Low-income, Minority	Members	8/28/2018

Attachment 2. Secondary Data Tables

CONTENTS

DATA TABLE NOTES

Sunol data: Small populations in communities such as unincorporated Sunol and random variation lead to rates that vary substantially from year to year.

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, this data is 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, an arrow is not used. Also, black arrows are used (without shading) for data which is neither positive nor negative (such as socio-demographic indicators).

BEHAVIORAL HEALTH

Table 1: Severe Mental Illness Related ED Visits Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Sunol	Alameda County
2016–2017	1,840.1	2,436.4	2,323.2	2954.4	2,265.5

Note: Yellow highlighting indicates that the data are worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 2: Severe Mental Illness Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	869.9	1,130.1	1,007.9	1,452.2

Note: Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 3: Self-inflicted Injury ED Visits Rate (Age-adjusted 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

Notes: Adults are 18 years old and older; children are under 18 years old. No data are worse than the county by 5% or more. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017. For self-harm codes, see the CSTE definition at https://resources.cste.org/Injury-Surveillance-Methods-Toolkit/Home/GeneralInjuryIndicators

Table 4: Self-Inflicted Injury Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	12.7	17.7	16.6	17.3

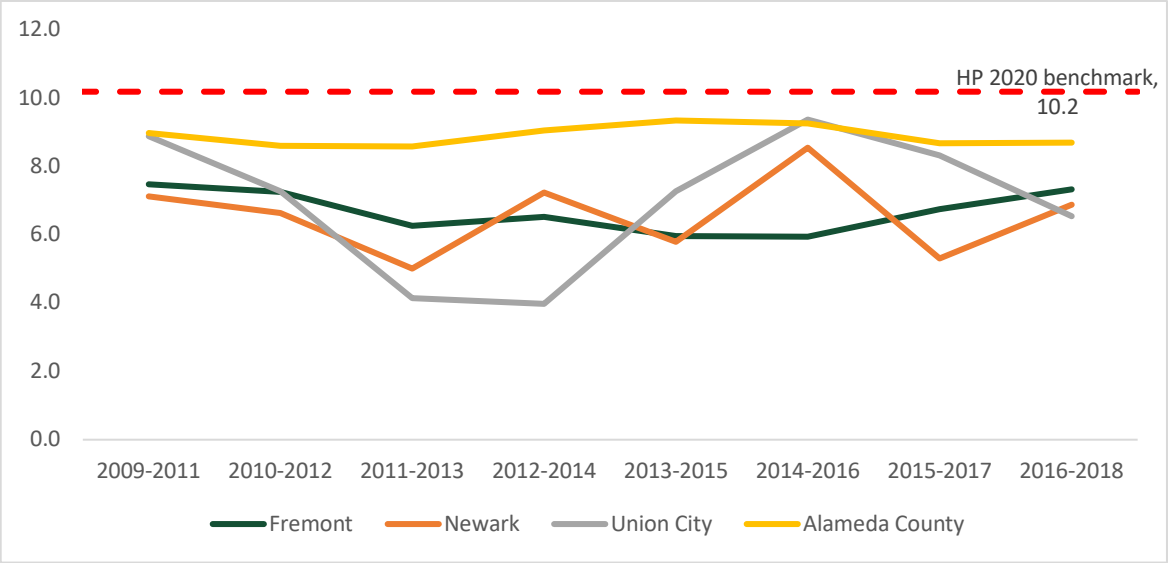
Note: No data are worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017. For self-harm codes, see the CSTE definition at https://resources.cste.org/Injury-Surveillance-Methods-Toolkit/Home/GeneralInjuryIndicators

Table 5: 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

Note: No data are worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes U03,X60-X84,Y87.0.

Figure 1: Suicide Mortality Rate (per 100,000 pop.)



Note: No data are worse than the county by 5% or more. 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 U03,X60-X84,Y87.0.

Table 6: Substance Use ED Visits Rate (age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	856.9	1,249.1	1,184.2	1,584.6

Note: Data were not available for Sunol; the numbers were too low for reporting purposes. 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 F10-F16, F18, F19.

HOUSING AND HOMELESSNESS

Table 7: Owner-Occupied Housing Units (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	64.3	72.2	69.4	76.4	54.5
2010–2014	63.2	69.0	65.1	77.0	52.9
2013–2017	62.4	69.2	65.7	71.3	53.0

Source: U.S. Census Bureau Factfinder.

Table 8: Overcrowded Housing Units (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	4.2	4.9	6.9	1.9	5.5
2010–2014	5.5	6.8	8.3	0.0	6.1
2013–2017	↑ 9.1	↑ 10.5	↑ 9.0	1.7	↑ 7.3

Note: Overcrowded housing is defined as more than one person per room. Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: U.S. Census Bureau Factfinder.

Table 9: Rent-Burdened Households (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	38.8	44.7	51.0	27.8	49.3
2010–2014	39.9	48.6	50.4	55.1	50.2
2013–2017	39.7	49.9	47.3	37.2	48.9

Notes: A rent-burdened household is defined as a household in which the monthly rent is 30% or more of the household income. No data are worse than the county by 5% or more. Source: U.S. Census Bureau Factfinder.

Table 10: Cost-Burdened Households (Percentage of Owner-Occupied)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	38.5	46.8	41.9	44.9	42.0
2010–2014	30.4	34.7	34.6	52.0	34.8
2013–2017	24.3	26.4	28.8	30.7	29.2

A cost-burdened household is defined as a household in which the monthly ownership cost is 30% or more of the household income. No data are worse than the county by 5% or more. Source: U.S. Census Bureau Factfinder.

Table 11: Individuals Experiencing Homelessness (Count)

	Fremont	Newark	Union City	Alameda County
2017	479	70	40	5,629
2019	↑ 608 (263.2 per 100,000)	↑ 89 (195.4 per 100,000)	↑ 106 (142.6 per 100,000)	↑ 8,022 (492.3 per 100,000)

Data not available by city prior to 2017. Red arrow indicates a worsening trend. Source: Applied Survey Research, 2017 and 2019, Alameda County Homeless Count. Additional calculations by Actionable Insights, LLC based on 2017 population estimates.

Table 12: Individuals Experiencing Homelessness (Sheltered, Count)

	Fremont	Newark	Union City	Alameda County
2017	197	42	0	1,766
2019	↓ 123 (53.3 per 100,000)	↓ 30 (65.9 per 100,000)	0 (0 per 100,000)	↓ 1,710 (104.9 per 100,000)

Counts were not available by city before 2017. Total for Alameda County: 2013: 1,927; 2015: 1,643.Source: Applied Survey Research, 2017 and 2019, Alameda County Homeless Count. Additional calculations by Actionable Insights, LLC based on 2017 population estimates.

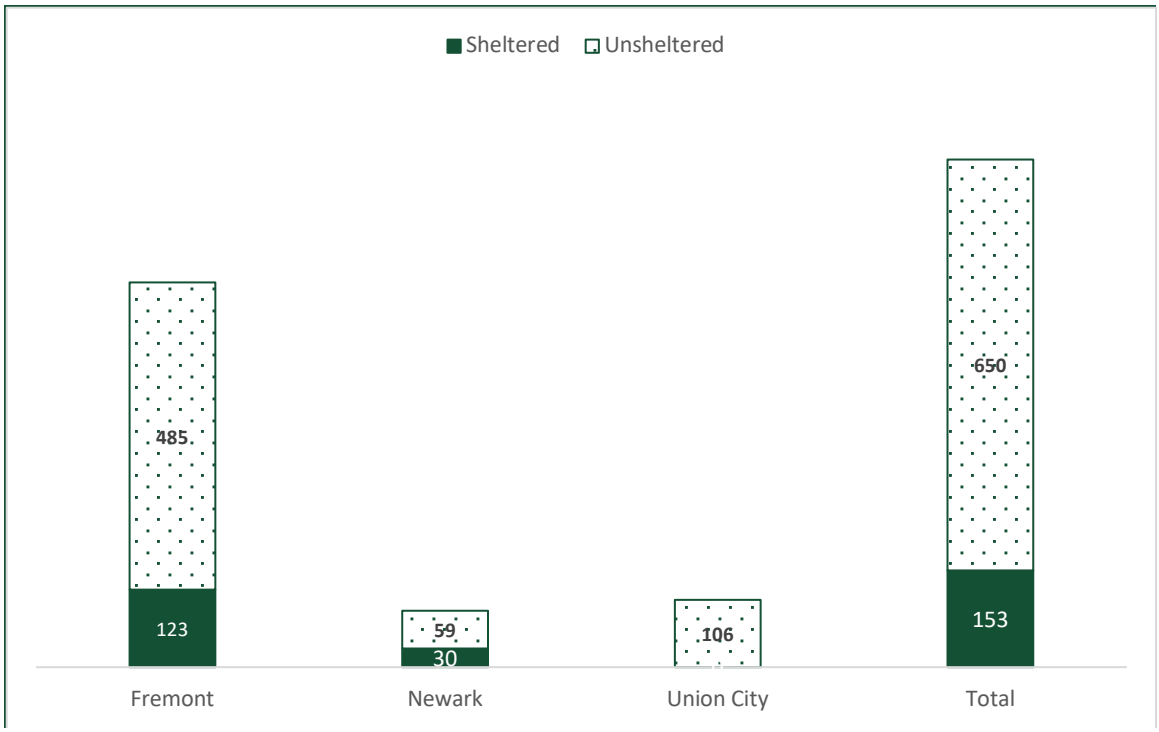
Table 13: Individuals Experiencing Homelessness (Unsheltered, Count)

	Fremont	Newark	Union City	Alameda County
2017	282	28	40	3,863
2019	↑ 485 (210.0 per 100,000)	↑ 59 (129.5 per 100,000)	↑ 106 (142.6 per 100,000)	↑ 6,312 (387.3 per 100,000)

Red arrow indicates a worsening trend. Source: Applied Survey Research, 2017 and 2019, Alameda County Homeless Count. Additional calculations by Actionable Insights, LLC, based on 2017 population estimates.

Figure 2: Homeless Count, 2019

The number of individuals experiencing homelessness in Southern Alameda County increased in 2017 and again in 2019 (from 598 to 803, respectively). Although ethnicity data are not available by city, the population experiencing homelessness countywide is disproportionately of African ancestry.



Source: Applied Survey Research, 2019, Alameda County Homeless Count.

HEALTHY EATING/ACTIVE LIVING

Table 14: Youth Fitness, Aerobic Capacity (Percentage)

Grade, Test	School Year	Fremont Unified School District	Newark Unified School District	New Haven Unified School District (Union City)	Sunol Glen Unified School District	Alameda County
5th Grade, Needs Improvement	2016–2017	17.2	33.3	38.4	15.2	26.5
	2017–2018	↑ 23.0	26.8	35.3	↑ 22.2	26.5
5th Grade, Health Risk	2016–2017	2.7	8.2	7.7	3.0	6.1
	2017–2018	2.6	8.1	↑ 8.2	2.8	↑ 6.5
7th Grade, Needs Improvement	2016–2017	16.5	9.8	19.8	5.0	22.3
	2017–2018	↑ 16.8	↑ 12.7	↑ 28.9	↑ 6.5	↑ 24.0
7th Grade, Health Risk	2016–2017	5.9	5.7	4.7	5.0	7.2
	2017–2018	5.6	4.1	4.3	0	↑ 8.6
9th Grade, Needs Improvement	2016–2017	15.4	19.9	14.6	0	26.3
	2017–2018	12.0	16.5	↑ 22.7	0	22.2
9th Grade, Health Risk	2016–2017	8.6	13.6	15.2	0	10.3
	2017–2018	8.2	8.1	↑ 15.3	0	↑ 11.5

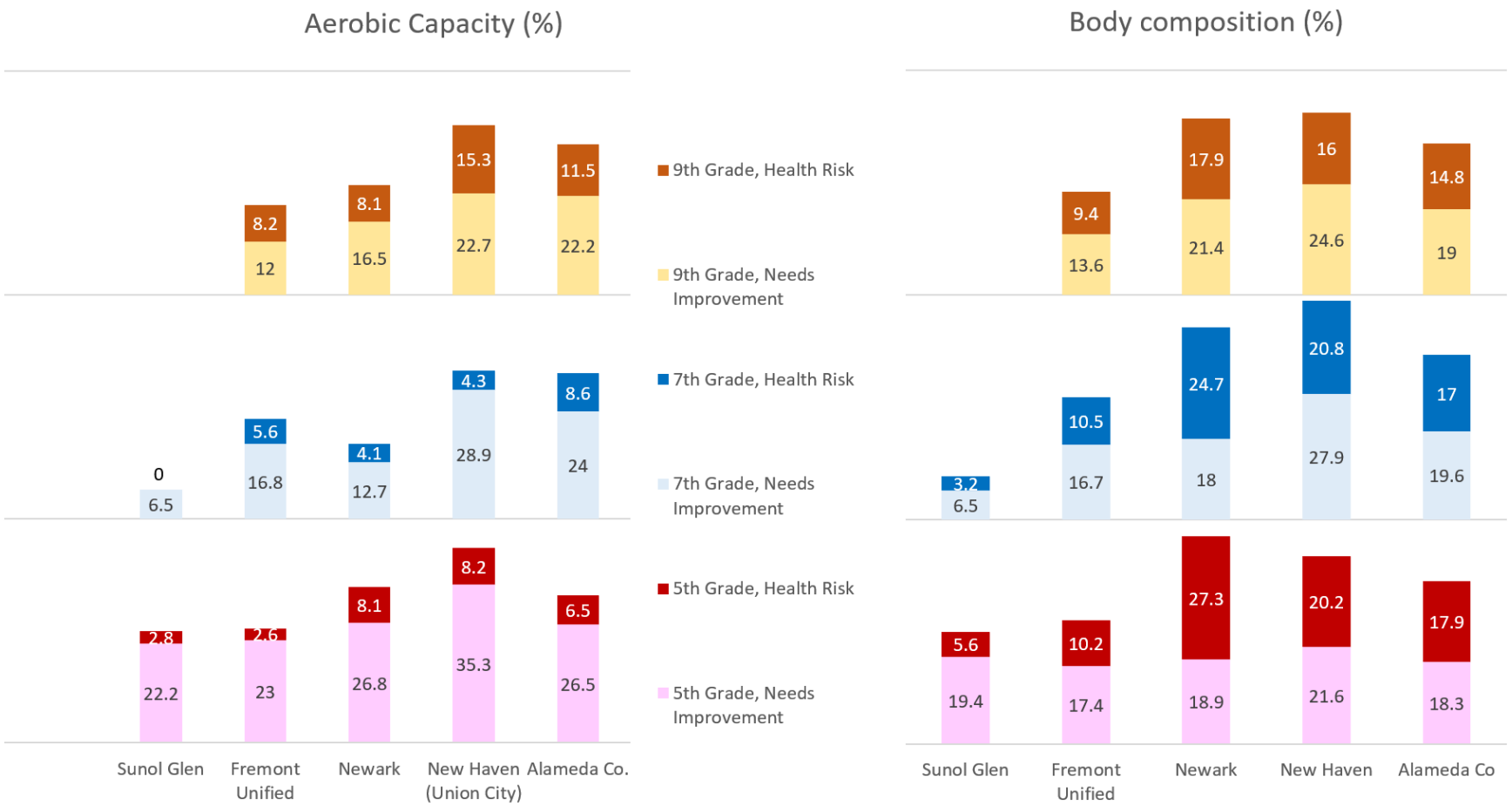
Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: California Department of Education Fitnessgram testing, 2016–2017 and 2017–2018. For standards, visit https://pftdata.org/files/hfz-standards.pdf. See Figure 3 for corresponding 2017–2018 chart.

Table 15: Youth Fitness, Body Composition (Percentage)

Grade, Test	School Year	Fremont Unified School District	Newark Unified School District	New Haven Unified School District (Union City)	Sunol Glen Unified School District	Alameda County
5th Grade, Needs Improvement	2016–2017	15.0	21.9	18.8	15.2	17.5
	2017–2018	↑ 17.4	18.9	↑ 21.6	↑ 19.4	↑ 18.3
5th Grade, Health Risk	2016–2017	9.4	25.0	23.6	9.0	17.3
	2017–2018	↑ 10.2	↑ 27.3	20.2	5.6	↑ 17.9
7th Grade, Needs Improvement	2016–2017	16.0	24.3	18.7	15.0	19.1
	2017–2018	↑ 16.7	18.0	↑ 27.9	6.5	↑ 19.6
7th Grade, Health Risk	2016–2017	10.6	18.9	22.7	5.0	15.3
	2017–2018	10.5	↑ 24.7	20.8	3.2	↑ 17.0
9th Grade, Needs Improvement	2016–2017	16.6	23.7	16.9	0	19.5
	2017–2018	13.6	21.4	↑ 24.6	0	19.0
9th Grade, Health Risk	2016–2017	9.4	20.3	17.8	0	15.0
	2017–2018	9.4	17.9	16.0	0	14.8

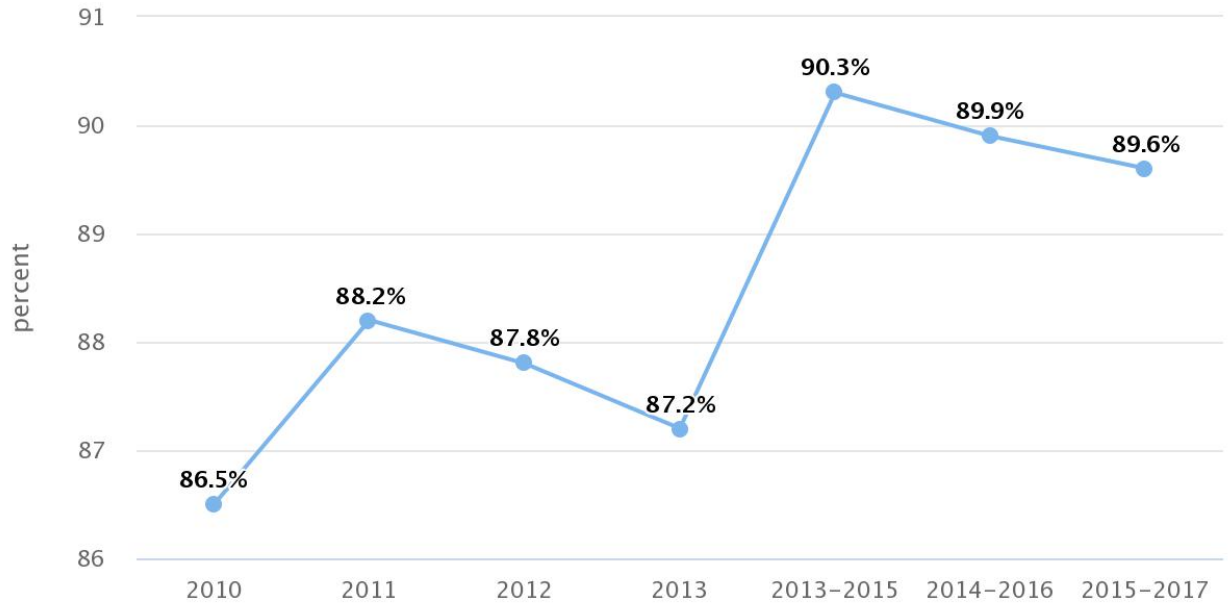
Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: California Department of Education Fitnessgram testing, 2016–2017 and 2017–2018. For standards, visit https://pftdata.org/files/hfz-standards.pdf. See Figure 3 for corresponding 2017–2018 chart.

Figure 3: Percent of Students Needing Improvement/At Risk Based on Fitness Tests, by Southern Alameda County School District (2017–2018)



Source: CDE FitnessGram, 2017–2018.

Figure 4: Mothers Who Received Early Prenatal Care, Alameda County (Percentage)



Source: California Department of Public Health. Retrieved from Healthy Alameda County.

Table 16: Population With Health Insurance (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

Data not available for unincorporated Sunol. Source: U.S. Census Bureau.

Table 17: Certified Farmers' Markets (Count)

	Fremont	Newark	Union City	Unincorporated Sunol
2012	2	1	2	0
2019	3	1	2	0

California certified farmers' markets are registered are registered under the provisions of California Food & Agricultural Code Section 47020 and operated in accordance with the associated chapter description and regulations.
Sources: California Farmers' Markets Association, 2019: California Department of Food & Agriculture, Certified Farmers' Markets by County as of October 1, 2019, https://www.cdfa.ca.gov/is/docs/CurrentMrktsCounty.pdf

SOCIAL DETERMINANTS OF HEALTH

See also the ADI map found in the Housing and Homelessness section of this report.

Table 18: Over Age 5, Limited English (Percentage of Population)

	Fremont	Union City	Alameda County
2011	21.0	26.2	19.6
2014	18.0	21.4	18.7
2017	↓ 17.5	↓ 19.1	↓ 18.0

Data not available for city of Newark or unincorporated Sunol. Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: U.S Census Bureau, 1-Year Estimates, American Community Survey (DP02). Limited English defined as those who speak English less than "very well."

Table 19: Linguistically Isolated Households (Percentage of Households)

	Fremont	Newark	Union City	Alameda County
2007–2011	11.5	10.5	12.3	10.3
2010–2014	10.1	7.5	12.7	10.1
2013–2017	↓ 9.6	↓ 7.0	↓ 9.0	↓ 9.6

Linguistically isolated households are those with no one with no one age 14 and over who speaks English "very well." Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. No data are worse than the county by 5% or more. Source: U.S. Census Bureau Factfinder.

Table 20: Median Household Income ($)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	98,513	81,777	82,634	72,656	70,821
2010–2014	103,591	86,521	82,564	82,750	73,775
2013–2017	↑ 122,191	↑ 96,817	↑ 95,625	↑ 109,453	↑ 85,743

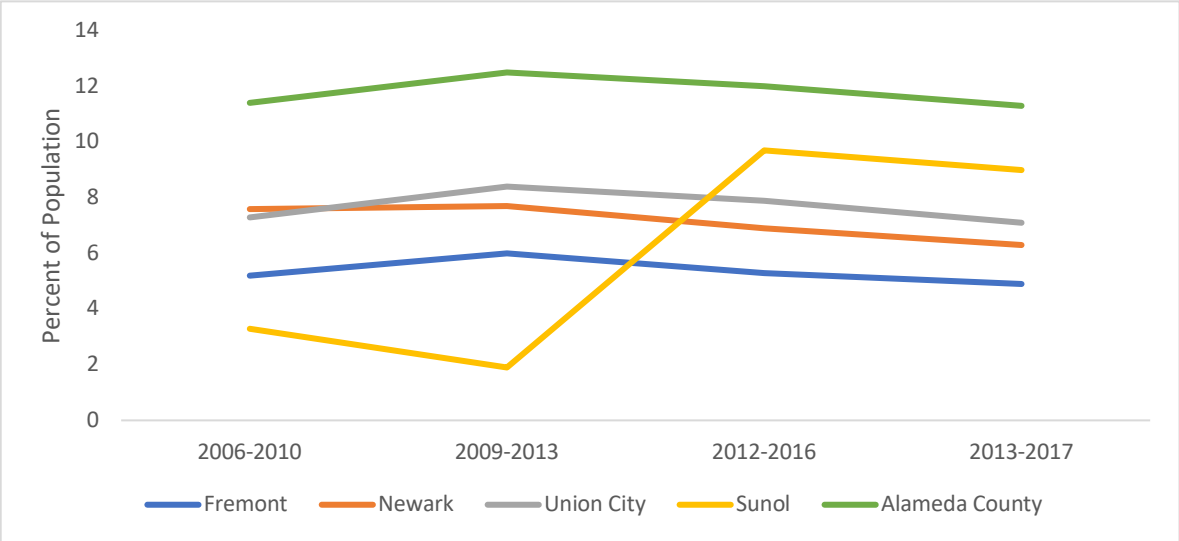
Source: U.S. Census Bureau Factfinder.

Table 21: Poverty - Population Below 100% FPL (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2006–2010	5.2	7.6	7.3	3.3	11.4
2009–2013	6.0	7.7	8.4	1.9	12.5
2012–2016	5.3	6.9	7.9	9.7	12.0
2013–2017	↓ 4.9	↓ 6.3	↓ 7.1	9.0	↓ 11.3

Poverty has been stable since 2006–2010, with Union City having the highest rate of poverty (7.1 in 2013–2017) compared to Newark and Fremont. Unincorporated Sunol's rates are unstable given the small population. Source: Healthy Alameda County.

Figure 5: Percent of Population Living Below 100% FPL by City and Time Period



Source: Healthy Alameda County.

Table 22: Poverty - Children Below 100% FPL (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2010–2014	7.1	11.7	10.1	13.1	15.8
2011–2015	6.2	12.2	9.8	10.8	15.2
2012–2016	4.8	10.7	9.1	29.9	14.4
2013–2017	↓ 3.9	↓ 9.2	↓ 8.3	↑ 32.2	↓ 13.0

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Healthy Alameda County.

Table 23: Households in Poverty Headed by Age 65+ (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2010–2014	6.7	6.8	8.5	10.1	9.7
2011–2015	56.8	8.2	8.1	10.0	9.2
2012–2016	6.3	7.1	8.1	7.2	9.5

Source: Healthy Alameda County.

Table 24: People 25+ With a Bachelor's Degree or Higher (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2011–2014	51.7	28.9	35.0	21.2	42.1*
2012–2016	↑ 54.0	↑ 30.3	↑ 36.2	↑ 45.8	↑ 43.9

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: U.S. Census Bureau Factfinder.
*Alameda County rate is for 2010–2014.

Table 25: Unemployed in the Civilian Labor Force, Population Over Age 16 (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	4.8	5.9	5.3	1.1	6.1
2010–2014	5.0	4.9	5.8	3.5	6.3
2013–2017	↓ 3.0	↓ 3.4	↓ 3.4	↓ 3.0	↓ 4.0

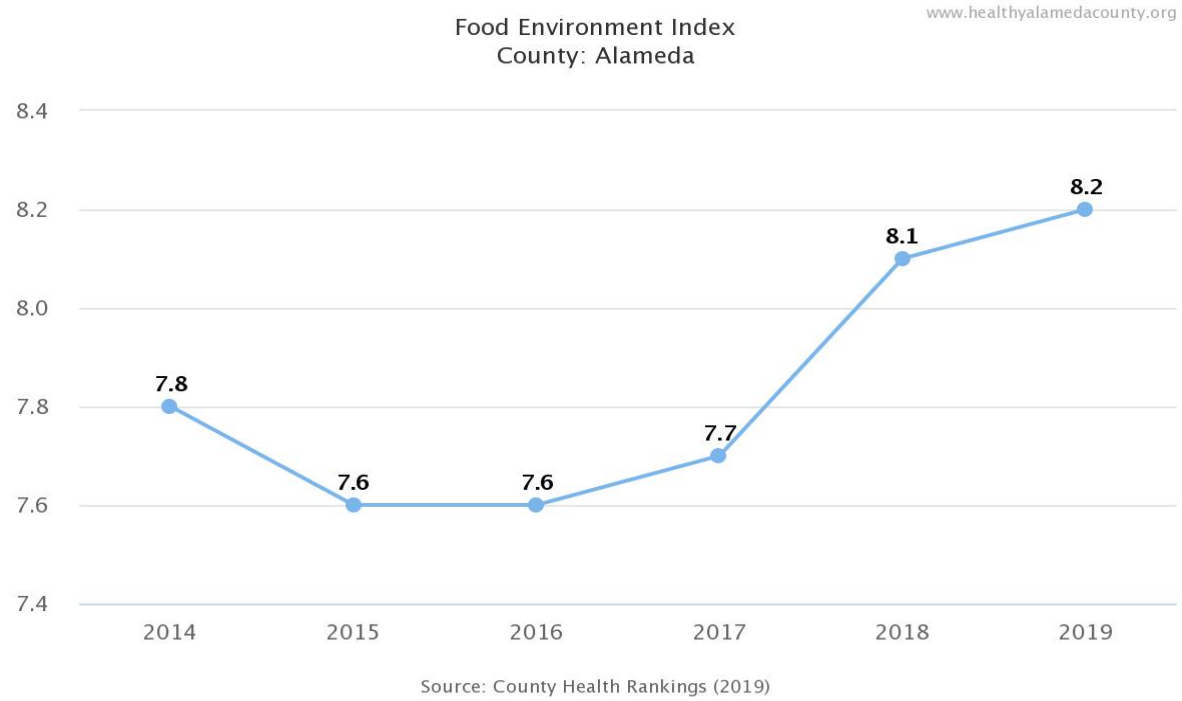
Unemployed labor force includes all civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last four weeks, and (3) were available to accept a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness. Source: U.S. Census Bureau Factfinder, 5-Year Estimates (Table DP03).

Table 26: Food Environment, Low Food Access (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2015	13.2	1.8	9.1	17.2	7.6

Yellow highlighting indicates that the data is worse than the county by 5% or more. The percentage of population without access to a supermarket or large grocery store. Source: Economic Research Service (ERS), U.S. Department of Agriculture (USDA). Food Access Research Atlas, Year 3 Report. www.ers.usda.gov/data-products/food-access-research-atlas/

Figure 6: Food Environment Index



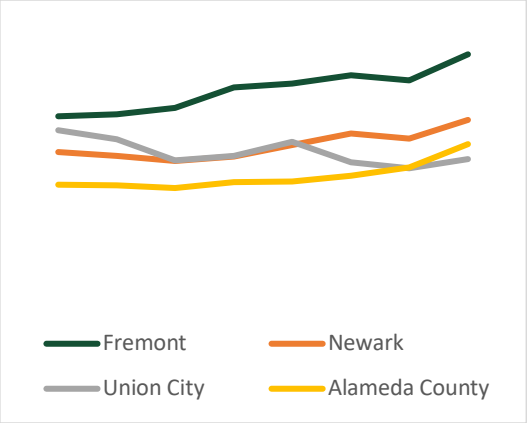
Data were not available by city. The food environment index ranges from 0 (worst) to 10 (best), It equally weights two measures of food access: the percentage of the population that is low-income and has low access to a grocery store, and the percentage of the population that did not have access to a reliable source of food during the past year (food insecurity). Source: County Health Rankings. Retrieved from Healthy Alameda County.

OTHER DEMOGRAPHIC INFORMATION

Table 27: 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

Figure 7: Life Expectancy at Birth (Years)

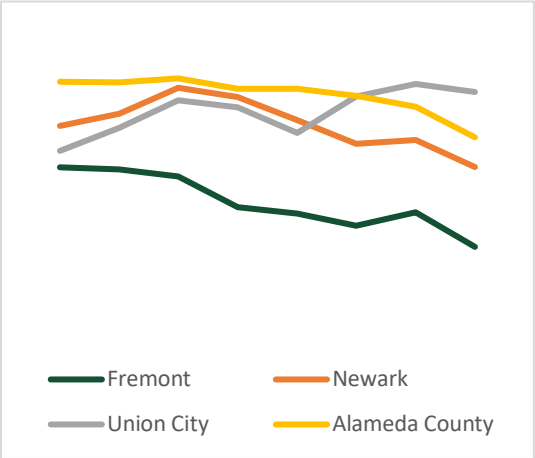


Note: Life expectancy at birth is defined as the average number of years that a newborn could expect to live if he or she were to pass through life subject to the age-specific mortality rates of a given period. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 28: 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

Figure 8: Mortality Rate - All Causes (Age-adjusted per 100,000 pop.)



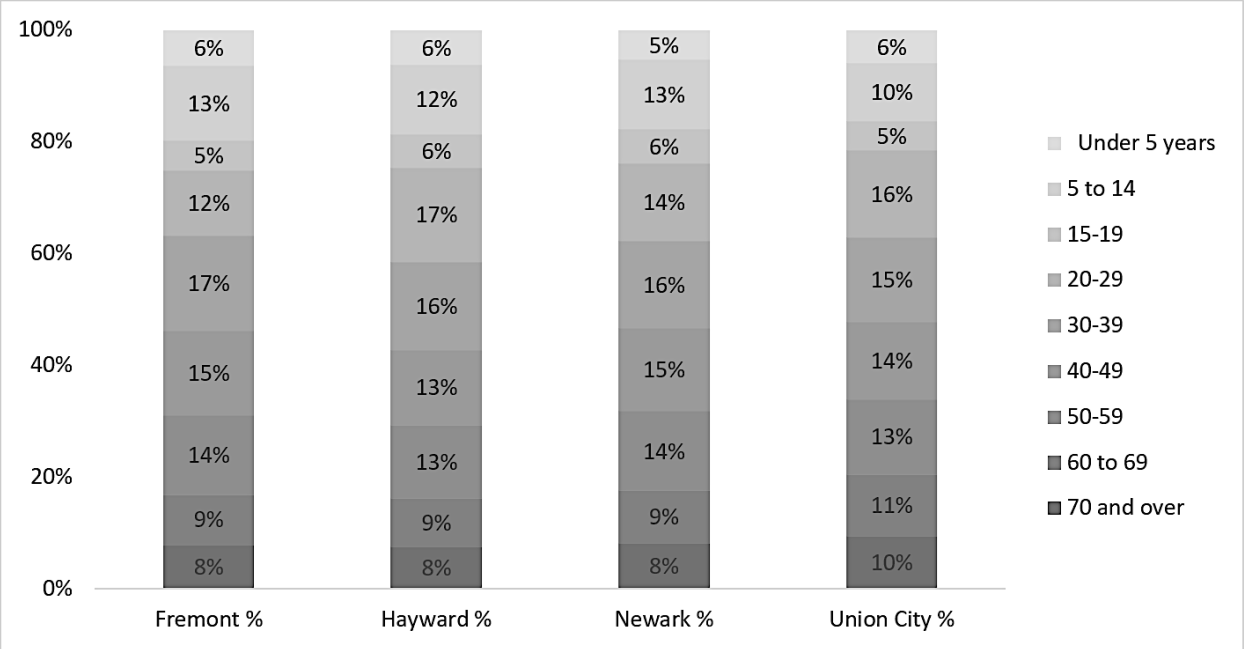
Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018.

Table 29: Table 29: Total Population (Count and Percent of County)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2007–2011	211,748 (14.2%)	42,322 (2.8%)	68,830 (4.6%)	760 (0.1%)	1,494,876
2010–2014	221,654 (14.2%)	43,635 (2.8%)	71,675 (4.6%)	956 (0.1%)	1,559,308
2013–2017	230,964 (14.2%)	45,554 (2.8%)	74,354 (4.6%)	967 (0.1%)	1,629,615

The hospital's primary service area also comprises a small portion of Hayward ZIP Code 94544. Data presented were not available on the sub-ZIP Code level. Source: U.S. Census Bureau, 5-Year Estimates, 2013–2017.

Figure 9: Population by Age Range and City, 2013–2017



Data not available for unincorporated Sunol. Source: U.S. Census Bureau, 5-Year Estimates, 2013–2017 (S0101).

Table 30: Race/Ethnicity 2017, Adults (Percentage)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
Hispanic or Latino	13.5	33.8	20.9	7.9	22.5
White Non-Hispanic	24.9	33.4	21.0	88.6	42.6
Asian	57.4	30.6	53.2	6.7	28.9
Black	3.0	5.0	5.0	0.4	11.1
Two or More Races	5.5	7.6	6.2	0.4	6.4
Other	14.6	31.0	20.7	4.2	17.3

Unincorporated Sunol's percent by race has a high margin of error because the population is less than 1,000 people.
Source: U.S. Census Bureau American Community Survey, 2013–2017 5-Year Estimates.

DIABETES, HEART DISEASE, HYPERTENSION, AND STROKE

Table 31: Diabetes ED Visits Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2016–2017	2,008.2	2,890.0	3,191.6	1,344.16	2,674.7

Yellow highlighting indicates that the data is worse than the county by 5% or more. 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.

Table 32: Diabetes Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2016–2017	1,494.1	1,844.8	2,054.1	1,664.3	1,702.8

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 33: Heart Disease Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2016–2017	469.8	518.6	593.6	772.5	559.7

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017 (Codes I0[1,2,5-9], I11, I2[0-7], I3[0-5], I[4-5], I97[0,1], R001).

Table 34: Heart Disease ED Visits Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Unincorporated Sunol	Alameda County
2016–2017	372.3	384.3	459.3	786.4	481.2

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 35: Congestive Heart Failure Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	80.6	75.8	83.9	90.0

No data are worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 36: Heart Disease Mortality 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

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes I00-I09, I11, I13, I20-I51.

Table 37: 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

Yellow highlighting indicates that the data is worse than the county by 5% or more. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes I20-I25.

Table 38: 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

Yellow highlighting indicates that the data is worse than the county by 5% or more. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes I21-I22.

Table 39: Hypertension ED Visits Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Sunol	Alameda County
2016–2017	4,092.7	5,421.0	5,874.8	4,316.3	5,405.0

Yellow highlighting indicates that the data is worse than the county by 5% or more. 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 code I10.

Table 40: Hypertension Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Sunol	Alameda County
2016–2017	2,430.9	3,007.0	3,172.7	4,337.3	3,058.0

Yellow highlighting indicates that the data is worse than the county by 5% or more. 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 I10-I13.

Table 41: 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

Yellow highlighting indicates that the data is worse than the county by 5% or more. Data were not available for Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes I10, I12, I15.

Table 42: Stroke ED Visits (Age-adjusted per 100,000 pop)

	Fremont	Newark	Union City	Alameda County
2016–2017	71.9	119.0	83.9	87.9

Yellow highlighting indicates that the data is worse than the county by 5% or more. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. 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 G45, G46, I6.

Table 43: Stroke Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	158.5	249.4	223.8	220.9

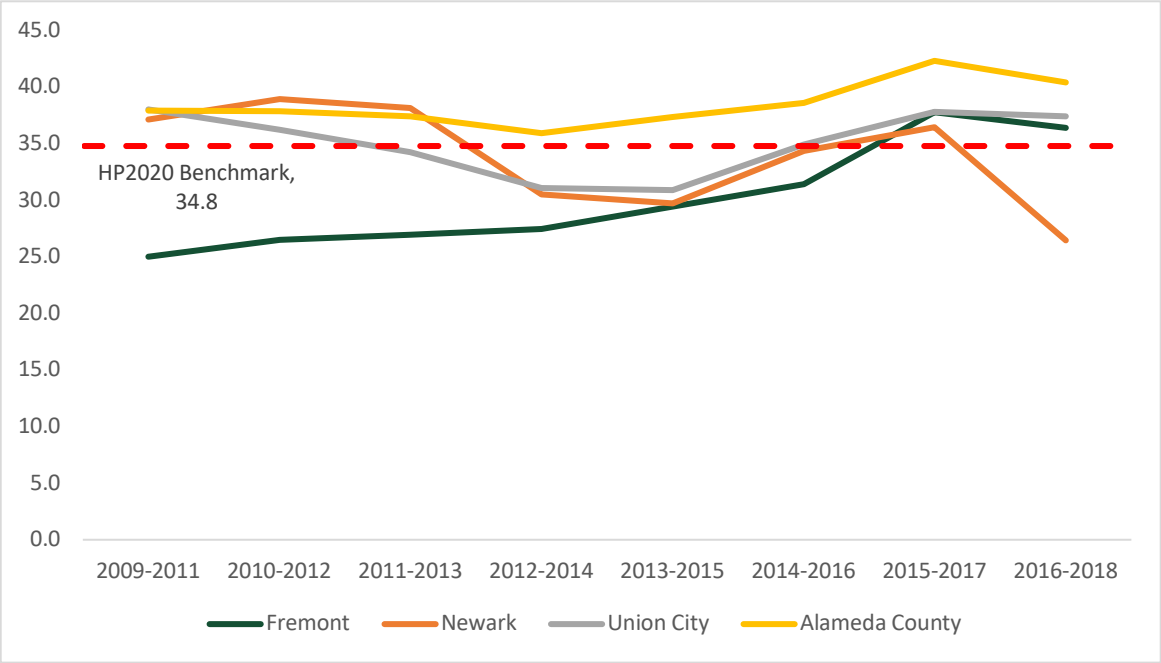
Yellow highlighting indicates that the data is worse than the county by 5% or more. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017. ICD-10 codes G45, G46, I6.

Table 44: Stroke Mortality 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

No data are worse than the county by 5% or more. Data were not available for Sunol as the numbers were too low for reporting purposes. See Figure 10 for corresponding chart. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from with data from Alameda County vital statistics files, 2009–2018. ICD-10 codes I60-I69.

Figure 10: Stroke Mortality 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, 2009–2018. ICD-10 codes I60-I69.

RESPIRATORY HEALTH

Table 45: Asthma ED Visits Rate (Age-adjusted 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

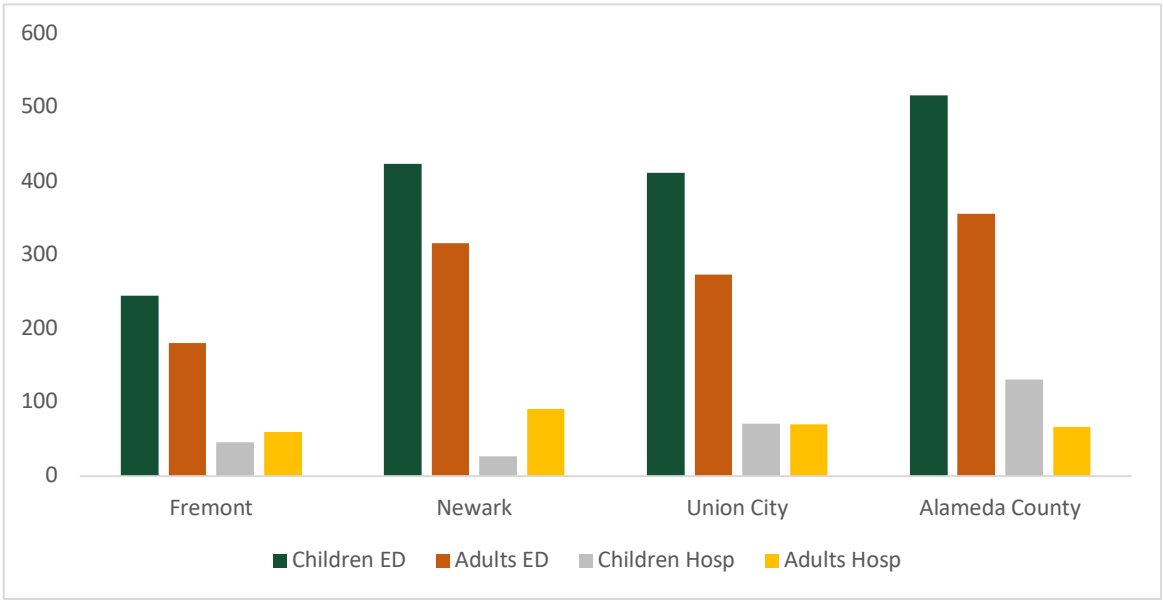
Adults are 18 years and older; children are under 18 years old. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. No data are worse than Alameda County by 5% or more. Sources: Current Search: Healthy Alameda/2016–2017 data: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017 (Asthma codes: J45[2-9]).

Table 46: Asthma Hospitalization Rate (Age-adjusted 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

Adults are 18 years and older; children are under 18 years old. Data were not available for unincorporated Sunol as the numbers were too low for reporting purposes. 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 code J45.

Figure 11: Asthma by Age Group and City, 2016–2017 (Age-adjusted per 100,000 pop.)



Age-adjusted rate per 100,000 population. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017.

Table 47: COPD ED Visits Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	221.4	352.2	300.9	249.9

Yellow highlighting indicates that the data is worse than the county by 5% or more. Data were not available for Sunol as the numbers were too low for reporting purposes. Source: Alameda County Public Health Community Assessment Planning & Evaluation (CAPE) Unit, with data from Office of Statewide Health Planning and Development, 2016–2017 (codes J44[0-4]).

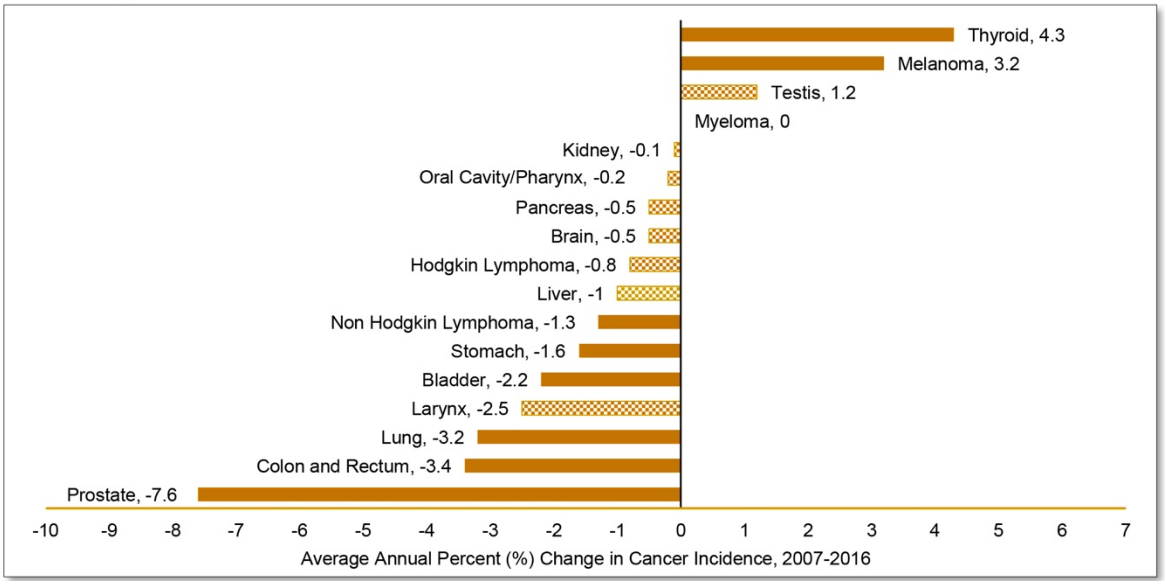
Table 48: COPD Hospitalization Rate (Age-adjusted per 100,000 pop.)

	Fremont	Newark	Union City	Alameda County
2016–2017	490.9	646.8	624.8	674.3

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 code J44.

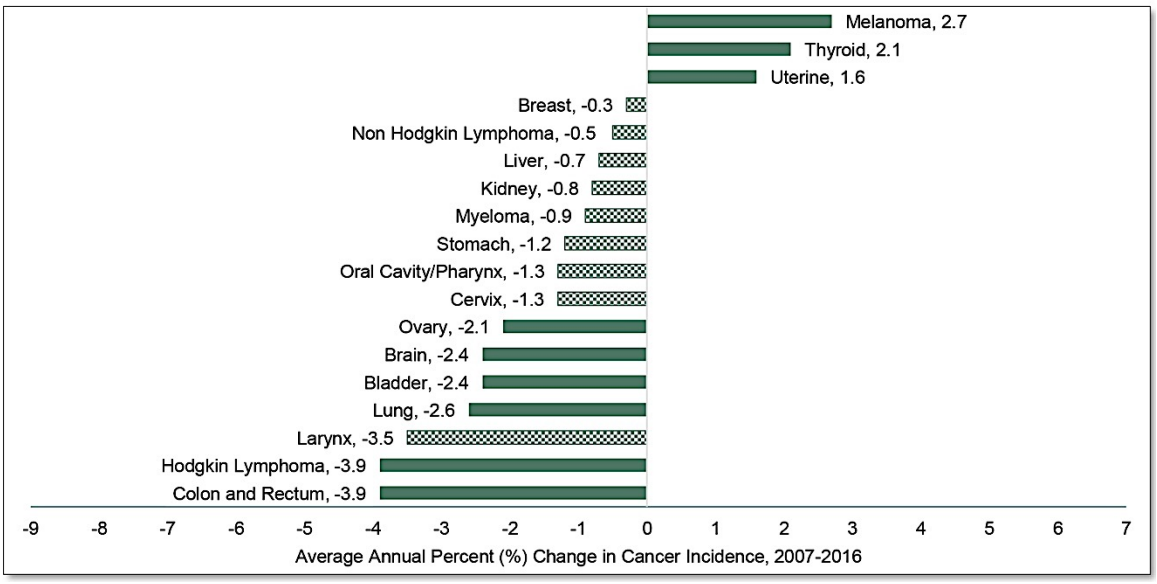
CANCER

Figure 12: Cancer Incidence, Greater Bay Area: Males (Average Annual Percent Change)



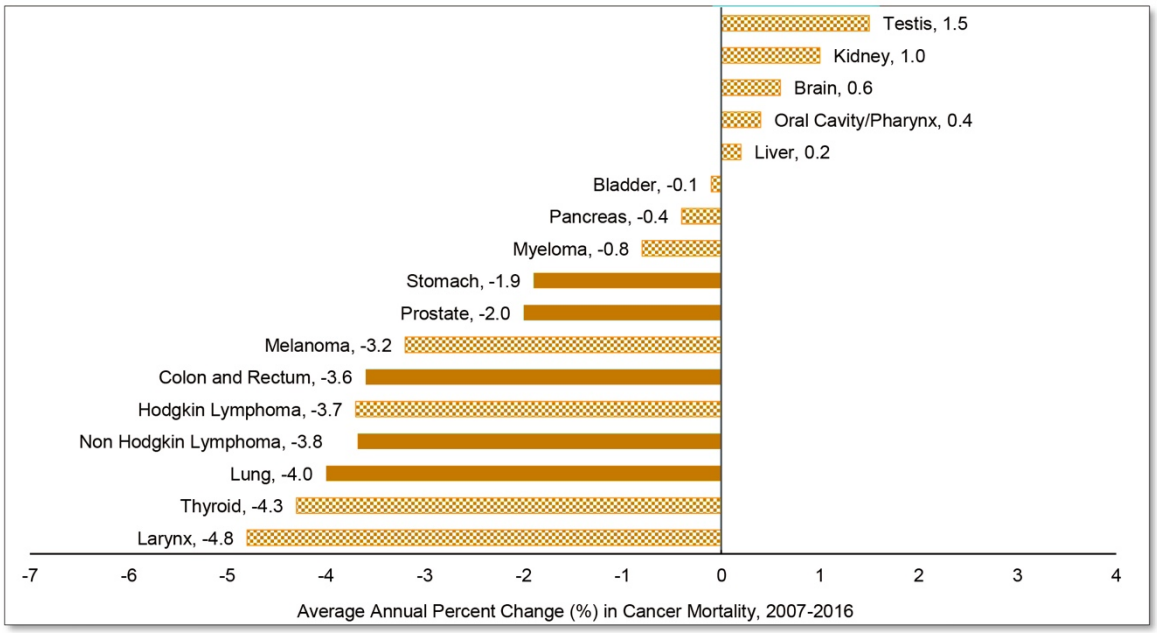
Solid bars indicate a statistically significant increase or decrease in average annual percent change from 2007 to 2016. Hatched bars indicate the change is not statistically significant. Source: University of California, San Francisco (2019), Greater Bay Area Cancer Registry.

Figure 13: Cancer Incidence, Greater Bay Area: Females (Average Annual Percent Change)



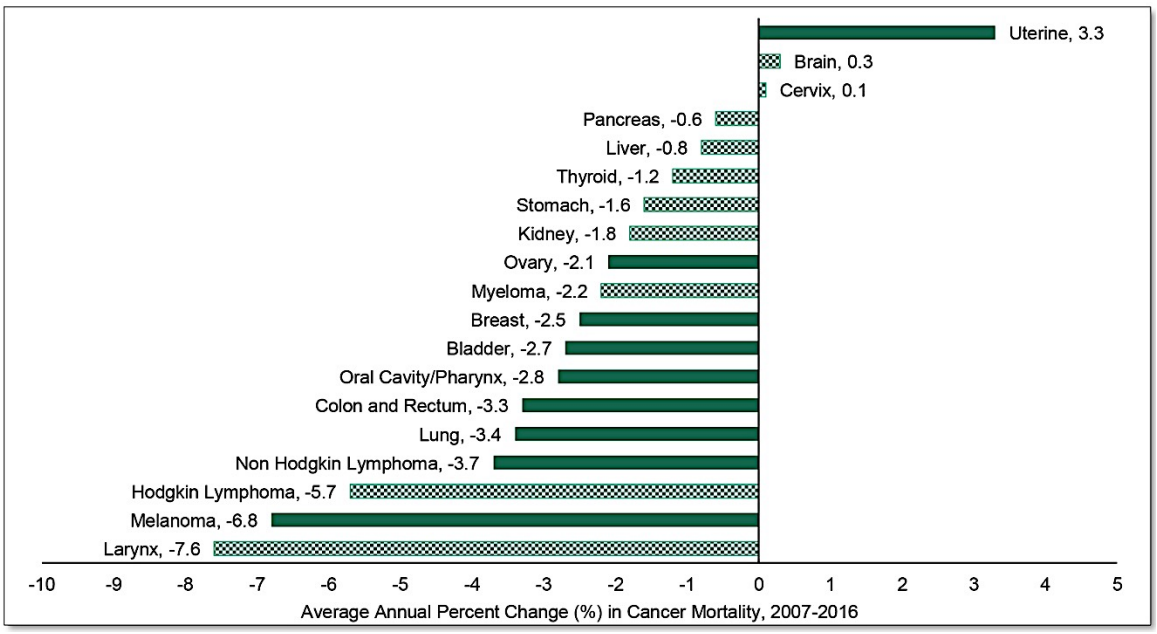
Solid bars indicate a statistically significant increase or decrease in average annual percent change from 2007 to 2016. Hatched bars indicate the change is not statistically significant. Source: University of California, San Francisco (2019), Greater Bay Area Cancer Registry.

Figure 14: Cancer Mortality, Greater Bay Area: Males (Average Annual Percent Change)



Solid bars indicate a statistically significant increase or decrease in average annual percent change from 2007 to 2016. Hatched bars indicate the change is not statistically significant. Source: University of California, San Francisco (2019), Greater Bay Area Cancer Registry.

Figure 15: Cancer Mortality, Greater Bay Area: Females (Average Annual Percent Change)



Solid bars indicate a statistically significant increase or decrease in average annual percent change from 2007 to 2016. Hatched bars indicate the change is not statistically significant. Source: University of California, San Francisco (2019), Greater Bay Area Cancer Registry.

Attachment 3. Community Assets and Resources

TABLE OF CONTENTS

Health Care Facilities and Agencies

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

HOSPITALS

- Alameda Health System John George Psychiatric, San Leandro
- Fremont Hospital
- Kaiser Foundation Hospital—Fremont
- St. Rose Hospital, Hayward
- Sutter Health Eden Medical Center, Castro Valley
- Washington Hospital Healthcare System, Fremont

FEDERALLY QUALIFIED HEALTH CENTERS

- Tiburcio Vasquez Health Centers (multiple sites)
- Tri-City Health Center (multiple sites, including mobile clinics)

OTHER HEALTH CLINICS

- RotaCare Clinic
- Sutter Health, Palo Alto Medical Foundation, Fremont Center
- Washington on Wheels Mobile Health Clinic
- Washington Township Medical Foundation (multiple sites)

Assets and Resources by Identified Health Need

HEALTH CARE ACCESS AND DELIVERY

- American Diabetes Association
- American Heart Association
- Drivers for Survivors
- East Bay Agency for Children
- Eden I & R, Inc.
- Family Resource Center, Fremont
- George Mark Children's Home
- HERS Breast Cancer Foundation
- HOPE Project Mobile Health Clinic
- LIFE Eldercare, Inc. - VIP Rides Program
- Operation Access
- Rubicon Programs
- Washington Women's Center

BEHAVIORAL HEALTH

- 12-Step programs (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon/Alateen)
- Abode Services
- Alameda County Health System
- Alameda County Social Services Agency
- Alameda County Tri-City Children and Youth Service
- Bay Area Community Services (BACS)
- Boldly Me
- Cherry Hill Detox, San Leandro
- 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
- HOPE Project Mobile Health Clinic
- Kaiser Behavioral Health classes (available to public)
- National Alliance on Mental Illness Alameda County South
- Rubicon Programs
- Safe Alternative to Violent Environments (SAVE)
- Second Chance, Inc.
- Seneca Center
- South Hayward Parish - Hayward Community Action Network

- St. Rose Hospital
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- Victory Outreach - Prison Counseling and Services; Residential Rehab Program, Hayward
- Washington Township Medical Foundation

CLIMATE AND NATURAL ENVIRONMENT

- Alameda County Citizens' Climate Lobby
- Children's Natural History Museum
- Don Edwards San Francisco Bay National Wildlife Refuge
- Earth Team
- East Bay Regional Park District
- Local Ecology and Agriculture Fremont (LEAF)
- The Watershed Project
- Tri-City Ecology Center

COMMUNITY AND FAMILY SAFETY

- A Safe Place
- Afghan Coalition
- Alameda County Family Justice Center
- Alameda Family Services
- Bay Area Community Services (BACS)
- Bay Area Women Against Rape (BAWAR)
- Building Blocks for Kids Collaborative
- Building Futures
- Calico Center
- Citizens for Better Community
- Community Violence Solutions
- DeafPlus
- First 5 Alameda County
- Fresh Lifelines for Youth
- Friends of Children with Special Needs
- Narika
- Ruby's Place
- Safe Alternatives to Violent Environments (SAVE)
- Special Needs Children Center
- Union City Family Center
- Youth Alive!

ECONOMIC SECURITY

- Abode Services
- Alameda County Community Food Bank (searchable list)
- Alameda County Early Head Start and Head Start
- Alameda County Homeless Project - Hayward (incl. Special Needs Housing)
- Alameda County Nutrition Services - Women, Infants, and Children (WIC)
- Bay Area Community Services (BACS)
- Building Blocks for Kids Collaborative
- Catholic Charities of the East Bay
- Centro de Servicios
- Community Resources for Independent Living (CRIL)
- DeafPlus
- East Bay Community Foundation
- Eden I&R, Inc.
- Fremont Resource Center
- HOPE Project Mobile Health Clinic
- OneChild
- Solid Rock Community Services, Newark
- 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

EDUCATION AND LITERACY

- Alameda County Library
- Avanzando Luna, Newark
- Children's Natural History Museum
- Fremont Education Foundation
- Fremont Unified School District
- Give Teens 20
- Mission Valley ROP
- New Haven Schools Foundation
- New Haven Unified School District
- Newark Education Foundation
- Newark Unified School District
- Ohlone Community College
- StarStruck Youth Theater
- Sunol Glen Unified School District

HEALTHY EATING/ACTIVE LIVING

See Economic Security for resources related to food insecurity.

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

HOUSING AND HOMELESSNESS

- Abode Services
- Alameda County Housing & Community Development
- Bay Area Community Services (BACS)
- DeafPlus
- East Bay Housing Organizations
- Everyone Home, San Leandro

TRANSPORTATION AND TRAFFIC

- Alameda-Contra Costa Transit District (AC Transit)
- Bay Area Rapid Transit (BART)
- Drivers for Survivors
- LIFE Eldercare, Inc.
- Mobility Matters (look up areas)
- Paratransit (all subregions)
- Union City Transit

Attachment 4. Qualitative Research Protocols

Prior to key informant interviews, professionals were provided with the 2016–2017 CHNA health needs list to consider.

Table 1. 2016–2017 HEALTH NEEDS LIST

Health Need	Examples
Asthma	
Cancer	
Heart Disease and Stroke	
Obesity, Diabetes, Fitness and Diet/Nutrition	Healthy eating, active living
Access to Food and Recreation	Safe food supply, access to fresh food, food security, places to recreate, exercise
Maternal and Infant Health	Premature births, infant mortality, prenatal care
Sexually-Transmitted Infections	Gonorrhea, chlamydia, HIV
Communicable Diseases	TB, flu, salmonella (separate from STIs)
Oral/Dental Health	
Unintended Injuries (accidents)	Car and pedestrian accidents, falls, drownings
Behavioral Health	Stress, depression, suicide, drug/alcohol/tobacco addiction
Community and Family Safety	Child/partner abuse, bullying, violent crime, human trafficking
Economic Security	Income, employment, education
Housing and Homelessness	Safe, clean and affordable housing
Climate and Natural Environment	Extreme weather, environmental contaminants
Transportation and Traffic	Safe, reliable, accessible
Healthcare Access and Delivery (both primary and specialty care)	Health insurance, costs of medicine, availability of providers, quality of care, getting appointments, patients being treated with respect

Key Informant Protocol – Professionals

Introduction – 5 min.

- Welcome and thanks
- What the project is about:
    Identifying health needs in our community (called the Community Health Needs Assessment or CHNA)
    - Required of all nonprofit hospitals in the U.S. every three years
    - The hospitals who serve Alameda and Contra Costa County residents are working together to meet this requirement. Those hospitals include John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care - ValleyCare, Sutter Health, UCSF Benioff Children's Hospital-Oakland, and Washington Hospital Healthcare System
    - Will inform investments that hospitals make to address community needs
- Scheduled for one hour - does that still work for you?
- Today's questions:
    - Most important health needs in [geographic sub-area]
    - Your perspective on [expertise area]
    - Which populations may have different or worse needs or experiences
    - Your suggestions for improvement
- What we'll do with the information you tell us today:
    - Notes will go to hospitals
    - Hospitals will make decisions about which needs they can best address, and how they may collaborate/complement each other's community work
    - Would like to record so that we can get the most accurate record possible
    - Will not share the audio itself
    - Can keep anything confidential, even whole interview. Let me know any time.
    - Permission to record?
- Any questions before I begin? *[If interviewer does not have the answer, commit to finding it and sending later via email.*

Health Needs Prioritization – 6-10 min.

Part of our task today is to find out which health needs you think are most important to the local population you serve. You may want to take a look at the list of health needs we sent you, many of which the community came up with when the hospitals did the Community Health Needs Assessment in this area in 2016. You can see that some of them are health conditions, and others reflect the social determinants of health (housing, education, cost of living, environment, etc.).

Thinking specifically about [geographic sub-area] …

1. **Are there any needs that should be added to the list?**

2. **Which three needs (2016 and others added) do you believe <u>the local people you serve</u> feel are the most ***<u>important</u>*** to address here in the next few years?** [See table above.]

Health Needs Discussion, Including Expertise Area – 20 min.

I am going to take you through a few questions about each of these needs.

3. **When you think about [health need 1]…**
    - What barriers exist to seeing better health in this area?

    Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime
    - What impact do these barriers have on people's health?
4. **Which groups, if any, are more affected by this health need than others?** Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.
5. **What trends, if any, have you seen in the last three years?**

    [Repeat 3-5 for each health need they prioritized.]
6. [Only if their expertise was not related to one or more of the needs chosen:] **You were invited to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

Only If Not Chosen as a Need: Access to Care – 5 min.

We know that access to care impacts all aspects of health. Access includes not only having insurance and being able to afford co-pays/premiums, but also having a primary care physician versus using urgent care or the ER, and being able to get timely appointments with various providers.

7. **Would you say that healthcare access [related to your specific expertise and/or population you serve] is sufficient or not? If not, what issues do you see?**
8. **What differences do you see, if any, among various groups in your work?** Prompts if needed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

Only If Not Chosen as a Need: Behavioral Health – 5 min.

In recent assessments, behavioral health arose as a top health need. By behavioral health, we mean everything ranging from sub-clinical issues like stress to severe mental illness, and including substance use/addiction.

9. **Do you agree? In your opinion, what are the specific behavioral health needs in our community?**
   Prompts if needed: Stress, depression, addiction; suicide; stigma; behavioral health care access

10. **In what ways might people who are struggling with behavioral health issues be doing worse than others when it comes to health?**
    Prompt if needed: Behavioral health issues driving other health needs?

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

11. **What are some existing assets, services, or strategies that are working well in the community to address these needs?**
    Prompts if needed: Particular community-based organizations, their programs/ services, hospitals and health care – specific offerings, specific social services

12. **What types of assets, services, or strategies does the community need more of to address these needs?**
    Prompts if needed*:* Preventive care? Deep-end services? Workforce changes? Are there any quick wins or low-hanging fruit?

13. **What new/revised policies or other public health approaches are needed, if any?**

[Time permitting] Additional comments

We thank you so much for answering our questions. In the few minutes we have left, is there anything else you would like us to add regarding community health needs?

Closing

OK, if anything occurs to you later that you would like to add to this interview, please just let us know. Thank you for contributing your expertise and experience to the CHNA. You can look for the hospital CHNAs to be made publicly available in 2019.

Focus Group Protocols

During focus groups, facilitators presented the 2016–2017 CHNA List (Table 1). At the recommendation of the Contra Costa County Public Health Officer, in focus groups with residents "behavioral health" was called "mental health." Questions found in these protocols refer to that list.

Focus Groups With Professional or Community Representatives

Introduction – 6 min.

- Welcome and thanks
- Introductions (everyone says their name, role, and organization, incl. facilitators)
- What the project is about:
    - Nonprofit hospitals' Community Health Needs Assessment required by IRS. Hospitals collaborating on East Bay CHNA work include: John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care - ValleyCare, Sutter Health, UCSF Benioff Children's Hospital-Oakland, and Washington Hospital Healthcare System
    - Identifying important health needs in our community
    - Ultimately, to plan on how to address health needs now and in future
- Today's questions (refer to agenda flipchart page)
- Introductions (facilitators, participants: names and organizations)
- Confidentiality:
    - When we are finished with all of the focus groups, we will look at all of the transcripts and summarize the things we learn.
    - Would like to record so that we can be sure to get your words right.
    - Now that we have introduced ourselves, we will only use first names here to preserve your anonymity. However, if you want to keep a comment anonymous, you may not want to name your organization.
    - We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
    - Transcripts will go to hospitals if that is OK with you.
    - Permission to record?
- What we'll do with the information you tell us today:
    - Hospitals will report the assessment to the IRS
    - Hospitals will use information for planning future investments
- Logistics
    - We will end at ____:____.
    - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
    - Cell phones: On vibrate; please take calls outside.
    - Bathroom location.

- Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone. Really want your opinions and perspectives, even – especially! – if they aren't the same as everyone else's.

Health Needs Prioritization – 10 min.

You are here to share your experience as a professional serving [e.g., seniors, persons experiencing homelessness, young adults, etc.].

Part of our task today is to find out which health needs you think are most important to the local population you serve. This poster has a list of the health needs, many of which the community came up with when the hospitals did the Community Health Needs Assessment in this area in 2016.

[Read all of the needs aloud from flipchart and define where needed (e.g., "Access and Delivery" means insurance, having a primary care physician, preventive care instead of ED, being treated with dignity and respect, wait times, etc.).]

1. **Are there any that you think should be added to the list?**
2. **Please think about the three from the list you believe the local people you serve feel are the most important to address here in the next 3 to 4 years.**

   What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important, to the local population you serve, to address in the next few years. We really want your perspective and opinion of the local population's feelings; it's totally OK if your opinion differs from others' in the room. Then we will discuss the results.

   [When participants have voted, start audio recorder.]

3. **Summarize voting results.** [Explain that we will spend the rest of our time reflecting on these three top priorities.]

Health Needs Discussion, Including Expertise Area – 20 min.

4. **When you think about [health need1]…**
   - What barriers exist to seeing better health in this area?

   Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime
   - What impact do these barriers have on people's health?
5. **Which groups, if any, are more affected by this health need than others?** Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

6. **What trends, if any, have you seen in the last three years?**

[Repeat questions 4-6 for each of the top health needs prioritized by the group.]

7. [Only if their expertise was not related to one or more of the needs chosen:] **You are here to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

Only If Not Voted a Top Need: Access to Care – 5 min.

We know that access to care impacts all aspects of health. Access includes not only having insurance and being able to afford co-pays/premiums, but also having a primary care physician versus using urgent care or the ER, and being able to get timely appointments with various providers.

8. **Would you say that healthcare access related to [the specific population you serve] is sufficient? Why or why not?**
9. **What differences do you see, if any, among various groups in your work?**
   Prompts: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

Only If Not Voted a Top Need: Behavioral Health – 5 min.

In recent assessments, behavioral health arose as a top health need. By behavioral health, we mean everything ranging from stress to severe mental illness, and including substance use/addiction.

10. **Do you agree? In your opinion, what are the specific behavioral health needs in our community?**
    Prompts if needed: Stress, depression, addiction; suicide; stigma; behavioral healthcare access
11. **In what ways might people who are struggling with behavioral health issues be doing worse than others when it comes to health?**
    Prompt if needed: Behavioral health issues driving other health needs?

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

12. **What are some existing assets, services, or strategies that are working well in the community to address these needs?**
    Prompts if needed: Particular community-based organizations, their programs/ services, hospitals and health care – specific offerings, specific social services
13. **What types of assets, services, or strategies does the community need more of to address these needs?**
    Prompts if needed: Preventive care? Deep-end services? Workforce changes? Are there any quick wins or low-hanging fruit?

14. **What new/revised policies or other public health approaches are needed, if any?**

Closing – 5 min.

- Thank you
- Repeat - What we will do with the information
- Look for CHNA reports to be publicly available in 2019

Focus Groups with Local Residents (90 min.)

Introduction – 6 min.

- Welcome and thanks
- Introductions (all say name and, if comfortable, where they work, incl facilitators)
- What the project is about:
    - Nonprofit hospitals' Community Health Needs Assessment (CHNA) required by IRS. Hospitals collaborating on East Bay CHNA work include: John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care - ValleyCare, Sutter Health, UCSF Benioff Children's Hospital-Oakland, and Washington Hospital Healthcare System
    - Identifying important health needs in our community
    - Hospitals will plan how to address health needs now and in future
- Today's questions (refer to agenda flipchart page)
- Confidentiality:
    - Would like to record so that we can be sure to get your words right.
    - We will only use first names here – you will be anonymous.
    - Transcripts will go to hospitals if that is OK with you.
    - 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 hospitals can read your own words. We will not use your name when we give them those quotes.
    - Is anyone not OK with recording? [remember to start audio recorder!]
- What we'll do with the information you tell us today:
    - Hospitals will report the assessment to the IRS
    - Hospitals will use information for planning future investments
- Logistics
    - We will end at ____:____.
    - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
    - Cell phones: On vibrate; please take calls outside.
    - Bathroom location
    - Incentives – please sign the sheet

- Guidelines: It's OK to disagree, but 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.

Imagining a Healthy Community – 5 min.

Take a moment to picture, in your mind, a healthy community. [Pause].

1. **When you imagine a healthy community, what does it look like?**

   Prompt if needed: What makes a community healthy?

Health Needs Prioritization – 10 min.

Part of our task today is to find out which health needs you think are most important. This poster has a list of the health needs, many of which the community came up with when the hospitals did the Community Health Needs Assessment in this area in 2016.

[Read all of the needs aloud from flipchart and define where needed (e.g. "Access and Delivery" means insurance, having a primary care physician, preventive care instead of ED, being treated with dignity and respect, wait times, etc.).]

2. **Are there any that should be added to the list?**
3. **Please think about the three from the list you <u>personally</u> believe are the most <u>*important*</u> to address here in the next few years.**

   What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important to address in the next 3-4 years. We really want your personal perspective and opinion; it's totally OK if it's different from others' here in the room. Then we will discuss the results of your votes.

4. **Summarize voting results.** [Explain that we will spend the rest of our time reflecting on these three top priorities.]

Understanding the Needs – 15 min.

5. **When you think about [health need1]…**
   - What barriers exist to people getting healthy or staying healthy?

   Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime
   - What impact do these barriers have on people's health?
   - When you think about this need, are any groups of people worse off than others? If so, which groups?

Prompts for groups if they are having trouble thinking of anything: Children, youth, adults, seniors; specific ethnicities [e.g., Latino, Southeast Asian, Pacific Islanders]; low-income; mono-lingual non-English speakers; LGBTQ

6. **Do you think that things have been getting better, stayed the same, or gotten worse, in the last three years or so? [If things have changed: How?]**

[Repeat questions 5-6 for each of the top health needs prioritized by the group.]

Only If Not Voted a Top Need: Access to Care – 5-10 min.

7. **What about healthcare access?**
   - Is everyone able to get health insurance for their needs?
   - Is everyone able to afford to pay for health services and medication?
   - Is everyone able to get to the doctors they need when they need to?
   - Do people mostly have a primary care doctor, or do they mostly use urgent care or the ER instead? [*If the latter:* Why?]
   - What about specialists? Are people able to see one when they need it?

Only If Not Voted a Top Need: Mental Health – 5-10 min.

8. **What about mental health?** Mental health was one of the top health needs last time. By mental health, we mean everything ranging from stress, substance use, and depression, to serious mental illness.

   a. **In your opinion, what are the specific mental health needs in our community?**
      Prompt if needed: Conditions like stress, depression, addiction; outcomes like suicide; concerns about stigma; access to mental health care

   b. **Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how?** [Elicit drivers.]

Equity and Cultural Humility – 15 min.

9. **Do you think that everyone in our community is getting the same health care, and has the same access to care? If not, what are the barriers for them?**
   Prompt: Think about all of the people in our community… children, youth, adults, seniors… some have different ethnicities, languages, sexual orientations, and religions. They may be disabled or be low-income or be experiencing homelessness. It could also be people from different geographic parts of the community have different experiences.

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

10. **What are some resources, services, or strategies that are working well in the community to address these needs?**

Prompts if needed: Certain community-based organizations or their programs/ services, specific hospitals and/or health care programs/services, specific social services

11. **What types of resources, services, or strategies, if any, does the community need more of to address these needs?**
    Prompt if needed: Preventive care? Deep-end services? Workforce changes?
12. **What kinds of changes could those in charge here in the community make to help all of us stay healthy?**

Closing – 5 min.

- Thank you
- Repeat - What we will do with the information
- Incentives – **after you turn in the demographic survey**

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 and 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

Federal Requirements Checklist	Regulation Section Number	Report Reference
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
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., health care consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, health care 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)	Section 5
C. CHNA Needs Description and 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 5 + 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	Section 2
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 website" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	**Date(s) on which a-f below were done:**
a. May not be a copy marked "Draft."	(b)(7)(ii)	September 1, 2020

		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 website established by another entity).	(b)(7)(i)(A)	September 1, 2020
		c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	September 1, 2020
		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)	September 1, 2020
		e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	September 1, 2020
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	September 1, 2020

Further IRS requirements available:

- §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