CHNA

2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Washington Hospital Healthcare System

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ASR

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1. EXECUTIVE SUMMARY

Community Health Needs Assessment (CHNA) Background

The Affordable Care Act (ACA), enacted by Congress on March 23, 2010, stipulates that nonprofit hospital organizations complete a community health needs assessment (CHNA) every three years and make it widely available to the public. This assessment includes feedback from the community and experts in public health, clinical care, and others. This CHNA serves as the basis for implementation strategies that are filed with the Internal Revenue Service (IRS).

The IRS requires that the hospital conduct a CHNA and adopt an implementation strategy for each of its facilities by the last day of its taxable year, which for Washington Hospital Healthcare System (Washington Hospital) is September 30, 2017. The CHNA itself was conducted in 2015, meeting the requirement that the assessment be conducted in the same tax year it is due, or in the two years immediately preceding that year.

This 2016 assessment is the second such assessment conducted since the ACA was enacted and builds upon the information and understanding that resulted from the 2013 CHNA. This 2016 CHNA report documents how the CHNA was conducted and describes the related findings. The Washington Township Health Care District Board of Directors adopted the 2013 CHNA on June 11, 2014.

Process & Methods

Twelve local hospitals in Alameda and Contra Costa Counties ("the Hospitals") began the second CHNA cycle in 2015. 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 2015 via 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 – see Appendix D for a complete list.

In November 2015, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then further prioritized and the results of the prioritization are included on the next page.

Prioritized Needs

Based on community input and secondary data, Washington Hospital generated a list of 11 health needs and prioritized a total of seven. These needs are listed below in alphabetical order.

Health Needs Identified by CHNA Process, in Alphabetical Order

1. **Asthma –** Asthma prevalence is higher in the Washington Hospital service area than in the state overall. Washington Hospital service area cities (including the 94544 zip code) have higher proportions of adults, teens, and children diagnosed with asthma than the county and the state. All of the cities in the Washington Hospital service area have higher asthma Emergency Department (ED) visit rates than the state with the exception of Fremont. In Alameda County, the hospitalization rates for asthma in younger adults (18-39 years old) and for Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults (40 and over) are higher than the state rates.
2. **Behavioral Health –** The Washington Hospital service area parallels the state on a number of mental health and substance use indicators; however, there is high usage of the hospital EDs in parts of the service area for mental illness related issues. In addition, Alameda County has higher ED visit rates than the state for substance abuse visits and non-fatal visits among youth (13-20 years old) for intentional injury.
3. **Cancer –** In Alameda County, cancer rates are close to state and national benchmarks overall, but incidence and mortality rates show ethnic disparities. Black women in Alameda County has significantly higher breast cancer mortality rates than any other ethnic group in the county. In addition, Blacks in Alameda County have high lung and prostate cancer incidence and mortality rates. Data from 2013 on cancer case counts for specific cities in the Washington Hospital service area show that Fremont has the highest number of each type of cancer (breast, cervical, colorectal, lung, and prostate). In addition, when looking at the different cancer case counts, breast cancer has the highest counts in each city compared to all other types of cancers.
4. **Cardiovascular Disease and Stroke –** The prevalence and death rate for all types of heart disease in the Washington Hospital service area is below the state average. However, coronary heart disease, congestive heart failure, and stroke are high in the service area, especially in Union City and the 94544 zip code in Hayward. The coronary heart disease death rate is lower in the Washington Hospital service area cities (including the 94544 zip code) than the state rate, but higher than the Healthy People 2020 (HP2020) objective.
5. **Maternal and Child Health –** In Alameda County, there are ethnic disparities in maternal and child health. Infant mortality and low birthweight are more severe for Alameda County's Black population than for other ethnicities. In addition, in Alameda County, food security is of concern.
6. **Obesity, Diabetes, and Healthy Eating/Active Living –** In Alameda County, the percentage of overweight youth is higher than in the state overall. Youth obesity is higher in parts of the Washington Hospital service area than the county and the state. Diabetes hospitalization rates are lower in the Washington Hospital service area cities, with the exception of Union City and the 94544 zip code of Hayward. A lower percentage of Washington Hospital service area residents commute to work by walking or riding a bike compared to the county or the state.
7. **Violence and Injury Prevention –** In Alameda County, the death rate due to assault and the death rate of pedestrians killed by motor vehicles are higher than the HP2020 objectives. The ED visit rates in Alameda County for assault non-fatal, youth intentional injuries, and domestic violence non-fatal are higher than the rates for the state.

Details of each health need are described in-depth in Section 8, "Community Health Needs."

Next Steps

After making this CHNA report publicly available in 2017, Washington Hospital will develop individual implementation plans based on this shared data.

2. INTRODUCTION/BACKGROUND

Purpose of CHNA Report & ACA Requirements

Enacted on March 23, 2010, the ACA provides guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations 501(r), one of which is conducting a CHNA 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 2016 CHNA meets both state (SB697) and federal (ACA) requirements.

The federal definition of community health needs includes the social determinants of health in addition to morbidity and mortality. This broad definition of health needs is indicative of the 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 the social determinants of health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, the ACA created more incentives for healthcare providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

Impact of the ACA on CHNA

The last CHNA report conducted was in 2013, before the full implementation of the ACA. Healthcare access was a top concern for the community and nonprofit hospitals and remains so in 2016.

The intent of the ACA is to increase the number of insured individuals and make insurance affordable through Medi-Cal expansion and healthcare exchanges implemented by participating states. While the ACA has expanded coverage of care for many people and families, there still exists a large population of people who remain uninsured as well as those who experience barriers to healthcare, including costs of healthcare premiums and services and getting access to timely, coordinated, culturally appropriate services.

State and County Impacts

Following the institution of the ACA in January 2014, Medi-Cal expanded in California to low-income adults who were not previously eligible for coverage. Specifically, adults earning less than 138% of the Federal Poverty Level (FPL, approximately $15,856 annually for an individual) are now eligible for Medi-Cal. In 2014, "Covered California," a State Health Benefit Exchange, was created to provide a marketplace for healthcare coverage for any

Californian. In addition, Americans and legal residents with incomes between 139% and 400% of the FPL can benefit from subsidized premiums.[1]

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,[2] according to data cited by the California Health Care Foundation. According to the California Health Interview Survey, in 2013 19% of the population aged 18-64 in Alameda County was not insured (191,000 people).[3] Previous years (2011 and 2012) had seen the uninsured rate at 14%, demonstrating an unexpected increase between 2011 and 2013 in Alameda County.[4] Also according to the California Health Interview Survey, in 2014 18% of the population aged 18-64 in Contra Costa County was not insured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013, when 16% of that population was uninsured.[5]

Although some Alameda County residents may have obtained health insurance for the first time, health insurance costs, the cost of care, and access to timely appointments remain a concern. As discussed later in this report, residents (including those whose insurance plans did not change since ACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. Indeed, professionals who participated in this assessment also expressed concern about the lack of a sufficient number of doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance. This is supported by evidence that there has been an increase in the percentage of people who said they had forgone care because they could not get an appointment (from 5% in 2013 to 8% in 2014).[6]

While 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports. While healthcare access is important in achieving health, a broader view takes into consideration the influence of other factors including income, education, and where a person lives. These factors are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. These underlying social and economic factors cluster and accumulate over one's life and influence health inequities across different populations and places.[7] According to the Robert Wood Johnson Foundation's approach of what creates good health, health outcomes are largely shaped by social and economic factors (40%), followed by health behaviors (30%), clinical care (20%), and the physical environment (10%).[8] To address the bigger picture of what creates good health, healthcare systems are increasingly extending beyond the walls of medical offices to the places where people live, learn, work, and play.

[1] http://www.healthforcalifornia.com/covered-california.
[2] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411/.
[3] Insured/uninsured figures for Alameda County for 2014 are not considered statistically stable.
[4] California Health Interview Survey (CHIS), 2011-2014. Retrieved Dec. 11, 2015 from http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography.
[5] California Health Interview Survey (CHIS), 2011-2014. Retrieved Dec. 11, 2015 from http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography.
[6] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411/.
[7] Santa Clara County Public Health Department, 2014 *Santa Clara County Community Health Assessment*.
[8] http://www.countyhealthrankings.org/our-approach.

3. About Our Hospital

Washington Hospital is a District hospital which 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, and part of south Hayward and unincorporated Sunol, and it encompasses approximately 124 square miles of Southern Alameda County. The District's population is approximately 429,500.

The 2013 CHNA was coordinated in conjunction with the Hospital Council of Northern California. The report included input from the Alameda County Public Health Department and the City of Berkeley Public Health Department. The 2013 CHNA was adopted on June 11, 2014, by the Washington Township Health Care District Board of Directors.

In accordance with proposed IRS regulations pursuant to the Patient Protection and Affordable Care Act of 2010, for the purposes of Washington Hospital Healthcare System's CHNA, the service area of focus includes the Washington Township Health Care District boundaries of Fremont, Newark, Union City, Sunol, and a portion of the Hayward ZIP codes 94544 and 94545. The District area in 94545 consists of a golf course and there are no residential homes on the land; therefore, for the purposes of this report, when referring to Hayward, this will include the area of 94544 solely.

Mission

As the local Health Care District, our mission is to meet the healthcare needs of District residents through medical services, education, and research. Within this scope, 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.
- Providing appropriate employee, professional, and community educational resources to enhance patient care and health promotion throughout the District.

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

Values Statement

- Our organizational values stem directly from the origins of the Hospital District in 1948. The District was formed to provide access to patient care services for the residents of the Township, at a time when people had to leave their community and travel

significant distances to find hospital care. The District serves its community by providing high-quality, affordable, and convenient care. We are committed not only in law but in spirit to local accountability.

- Healthcare is an intensely personal service. Underlying all that we offer is the recognition that healthcare is not a commodity. Our essential purpose is to improve the human condition. Our reason for being begins and ends with our patients and our community. To our patients we owe comfort, compassion, and whenever possible, a cure. Our efforts are focused not just on the individual, but also on the overall health of the community.
- It is our obligation to provide responsible stewardship of our resources, acting in all areas of our healthcare system with integrity, professionalism, and with respect for a patient's right to choice.
- To our fellow employees, volunteers, and members of our medical staff we owe a commitment to perform all of our responsibilities with loyalty, perseverance, self-discipline, and dependability. We achieve these goals through our organizational commitment to process improvements and pursuit of excellence.

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.

Washington Hospital collaborated on the 2016 CHNA with other hospitals (Kaiser Permanente and St. Rose Hospital) in the Greater Southern Alameda County area.

Geographic Description of the Community Served (Towns, Counties, and/or ZIP codes)

Although Washington Hospital patients come from all around Alameda County, the majority reside in the southern part of Alameda County. The Washington Hospital service area mainly covers the cities of Hayward, Union City, Newark, Sunol, and Fremont. The ZIP codes are 94536, 94538, 94539, 94544, 94555, 94560, 94586, and 94587. The city of Sunol has a population of less than 1,000. Readers should be aware that when the population is small, relatively minor differences in numbers can appear large.

Demographic Profile of Community Served

Population

The U.S. Census estimates a population of 429,503 in the Washington Hospital service area (U.S. Census Bureau, American Community Survey, 2009-2013). More than half of the total population in the Washington Hospital service area (54%) is in Fremont while 18% is in Hayward. Nearly one quarter (24%) of the population in the Washington Hospital service area is under the age of 18, while 11% is 65 years or older, leaving approximately two-thirds who are adults under the age of 65.

City	County	Population
Fremont	Alameda	232,206
Newark	Alameda	45,336
Union City	Alameda	74,494
Sunol	Alameda	959
Hayward (94544 specifically)	Alameda	76,508
Total population		*429,503*

Data sources: U.S. Census Bureau, American Community Survey, 2014. July 2015 estimate from the 2010 Census. U.S. Census Bureau.

Racial/Ethnic Population

The Washington Hospital service area covers eight ZIP codes with a diverse racial/ethnic population. As displayed in the table below, the largest racial group in the Washington Hospital service area is Asian, followed by White. Together these two races make up three quarters of the population. Nearly a quarter of the population is of Latino ethnicity (of any race).

Race Alone/Ethnicity	Washington Hospital Service Area	94536	94538	94539	94544	94555	94560	94586	94587
White	30.8%	38.1%	31.8%	19.6%	39.0%	20.9%	37.9%	65.1%	21.6%
Asian	44.0%	39.7%	43.5%	72.1%	21.9%	63.9%	29.5%	25.9%	51.6%
Black	5.3%	4.4%	4.6%	1.3%	10.4%	4.0%	4.6%	3.0%	5.7%
Pacific Islander/ Native Hawaiian	1.3%	0.5%	0.6%	0.4%	2.9%	1.1%	1.3%	0.1%	1.5%
American Indian/Alaskan Native	0.6%	0.6%	0.6%	0.3%	0.6%	0.8%	0.5%	0.0%	0.6%
Some other race	11.4%	8.9%	12.5%	1.6%	18.8%	3.6%	18.5%	2.4%	11.8%
Multiple races	6.6%	7.8%	6.3%	4.6%	6.4%	5.7%	7.8%	3.5%	7.3%
Latino (of any race)	23.3%	18.6%	20.7%	3.6%	46.0%	8.2%	33.1%	5.2%	22.0%

Note: Percentages do not add to 100% because they overlap.
Data source: U.S. Census Bureau, American Community Survey, 2009-2013.

Economic Characteristics of the Washington Hospital Service Area by City

Economic characteristics vary by city in the Washington Hospital service area. Between 4.0% and 3.5% are unemployed (data is not available for Sunol or 94544 zip code in Hayward), and there is a wide range in the median per capita income from $22, 943 in the 94544 zip code in Hayward to $51,704 in Sunol. Lower percentages of households in

Fremont, Newark, Union City, and Sunol had Food Stamp/SNAP benefits in the past month compared to the 94544 zip code in Hayward (less than 6% compared to 13%). Less than 15% of residents in each of the Washington Hospital service area cities live below the FPL, with less than 10% in Newark, Fremont, and Sunol.

City	Unemployment Rate	Median per Capita Income	Percentage of Households with Cash Public Assistance Income	Percentage of Households with Food Stamps/SNAP Benefits in the Past 12 Months	Percentage of People Living Below the FPL
Fremont	3.5%	$40,815	3.5%	3.7%	6.3%
Newark	3.8%	$31,825	5.1%	5.9%	7.8%
Union City	4.0%	$29,899	3.5%	3.9%	10.6%
Sunol	No data	$51,704	1.1%	0.5%	3.6%
94544 (part of Hayward)	No data	$22,943	4.8%	13.1%	14.8%

Data source: American Community Survey, 5-year estimates for 2014. U.S. Bureau of Labor Statistics. Figure for October and November 2015.

Socio-demographic Indicators

The 94544 zip code in Hayward has the highest percentage of female-headed households (17% versus 6%-13%) and percentage of adults 25 and older with less than a 9th grade education (15% versus 4%-8%) compared to the other cities in the Washington Hospital service area. Between 4% and 6% of residents in the Washington Hospital service area cities are veterans. There is also a wide range in the percentage of foreign-born residents (16%-46%) and the percentage of non-U.S. citizens (25%-57%), with Union City having the highest percentage of foreign-born residents and the 94544 zip code in Hayward having the highest percentage of non-U.S. citizens.

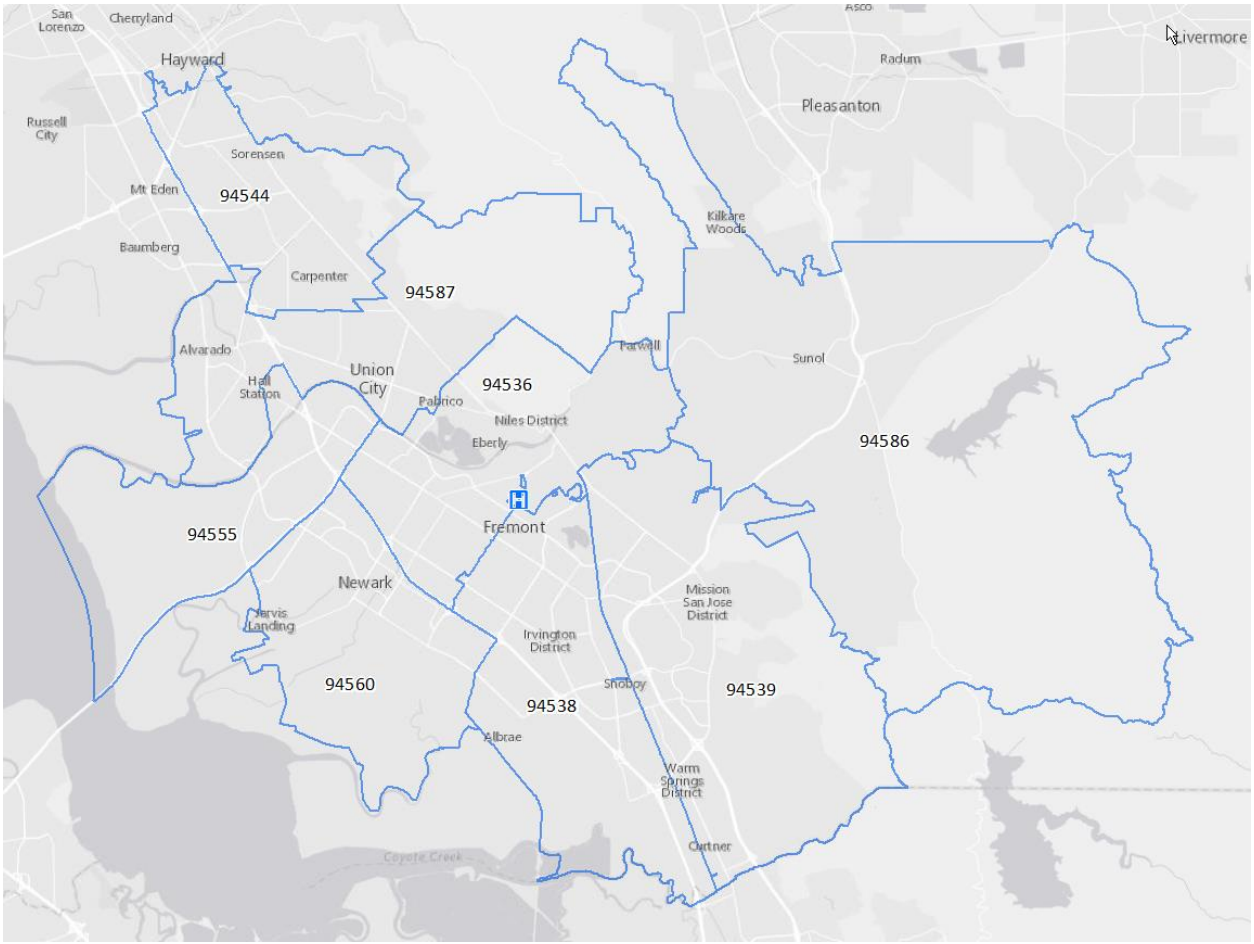
Between 18% and 32% of residents in the Washington Hospital service area cities have limited English proficiency (with the exception of Sunol with 7%); that is, they "speak a language other than English at home and speak English less than 'very well.'" According to the Community Commons data platform, this indicator is relevant because "an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education."

City	Percentage of Households that are Female-Headed	Percent of Adults 25 and Older with Less than 9th Grade Education	Percentage of Veterans	Percentage Foreign-Born	Percentage not a U.S. Citizen	Percentage who Speak English Less than "Very Well"
Fremont	9.4%	4.0%	4.2%	44.0%	44.2%	19.5%
Newark	12.9%	6.3%	4.9%	34.6%	33.1%	18.1%
Union City	12.6%	7.3%	4.2%	46.0%	38.4%	24.6%
Sunol	6.3%	7.6%	5.9%	15.7%	24.7%	7.3%
94544 (a part of Hayward)	16.8%	14.5%	5.2%	40.9%	57.0%	32.1%

Data source: American Community Survey, 5-year estimates for 2014.

Map of Community Served

Washington Hospital Healthcare System Service Area Map



4. Assessment Team

Hospitals & Other Partner Organizations

Community benefit managers from twelve local hospitals in Alameda and Contra Costa Counties ("the Hospitals") contracted with Applied Survey Research in 2015 to conduct the CHNA in 2016. The Hospitals comprised:

- John Muir Health
- Kaiser Permanente Diablo (Antioch and Walnut Creek hospitals)
- Kaiser Permanente East Bay (Oakland and Richmond hospitals)
- Kaiser Permanente Greater Southern Alameda (Fremont and San Leandro hospitals)
- St. Rose Hospital
- San Ramon Regional Hospital
- Stanford Health Care – ValleyCare
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

Identity & Qualifications of Consultants

The CHNA was completed by ASR, a nonprofit social research firm. For this assessment ASR conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the process of identification of community health needs and assets and of prioritization of community health needs, and documented the process and findings into a report.

ASR was uniquely suited to provide the Hospitals with consulting services relevant to conducting the CHNA. The team that participated in the work, including Dr. Jennifer van Stelle, Abigail Stevens, Angie Aguirre, Samantha Green, Martine Watkins, Chandrika Rao, Melanie Espino, Kristin Ko, James Connery, Christina Connery, Emmeline Taylor, Paige Combs, and sub-contractors Dr. Julie Absey, Robin Dean, Lynn Baskett, and Nancy Ducos, brought together diverse, complementary skill sets and various schools of thought (public health, anthropology, sociology, social ethics, psychology, education, public affairs, healthcare administration, and public policy).

In addition to their research and academic credentials, the ASR team has a 35-year history of working with vulnerable and underserved populations including young children, teen mothers, seniors, low-income families, immigrant families, families who have experienced domestic violence and child maltreatment, the homeless, and children and families with disabilities.

Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Alameda, Contra Costa, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties, Marin County, Nevada County, Pajaro Valley, and Solano and Napa Counties.

5. 2013 CHNA SUMMARY & RESULTS

A CHNA for Washington Hospital was completed in September 2013 to satisfy the IRS requirement, and it was adopted by Washington Township Health Care District Board of Directors in June 2014, according to guidelines proposed in the ACA. As of the time of this CHNA report, our hospital had not received written comments about the 2013 CHNA report.

The 2013 CHNA identified health needs that formed the foundation for Washington Hospital's implementation strategies for fiscal years 2015 and 2016 (July 1, 2014 – June 30, 2016). These health needs included heart health, diabetes, stroke prevention, cancer prevention, weight management, public safety, mental health, and other areas. The following is a summary of what has been accomplished during this time period to address the identified needs.

2013 Washington Hospital CHNA Health Needs List

- Heart Health
- Diabetes
- Stroke Prevention
- Cancer Prevention
- Weight Management
- Public Safety
- Mental Health
- Other

Heart Health	• Washington Hospital established a Clinical Operations Reducing Readmissions Committee. One of the initiatives is to follow up with congestive heart failure (CHF) patients by phone to ensure they have obtained medications and attend follow-up appointments. • The Washington on Wheels Mobile Health Clinic received several grants to fund operational expenses. This allowed staff to continue to provide services to uninsured patients; services include wellness visits, medical physicals, prescription drug follow-up visits, and blood pressure, glucose, and cholesterol screenings, all of which directly affect heart health. • Washington Hospital conducted two free peripheral vascular disease screenings and three free abdominal aortic aneurysm screening events. • A total of 576 community members were screened. Of those screened, 104 were found to have cardiovascular issues and were referred for follow up with their primary healthcare provider for further testing and treatment.

Diabetes	• Washington Hospital hosted three Diabetes Awareness Health Fairs; over 325 community members attended. • Washington Hospital continued providing Diabetes Matters, a free monthly diabetes education class with expert speakers to help all community members increase their knowledge about diabetes followed by a group discussion. From July 1, 2014, through June 30, 2016, over 190 community members attended. Washington Hospital's television station, InHealth, also recorded and aired the programming. • From July 1, 2014 – June 30, 2016, Washington on Wheels Mobile Health Clinic continued to provide free blood sugar screenings during the summer months; 1,121 community members were screened. Of those screened, 107 people were found to have elevated blood glucose and were referred to follow-up with their primary healthcare provider for further testing and treatment. • Washington Outpatient Diabetes Center continued offering the BASICS Program. The BASICS Program is a comprehensive approach to successfully manage diabetes. More than 90% of participants who have completed the BASICS Program have reduced their A1C blood test values (the gold standard 3-month glucose level) to less than 7%. o As of July 2015, Washington Hospital expanded the program to the Washington Township Medical Foundation Newark Clinic site. This provided greater access to the residents of Newark where hospitalization and emergency room visits rates were high due to diabetes.
Stroke Prevention	• Washington Hospital continued providing a four-part Stroke Education Series to the community. o The series includes: ▪ Part 1: Introduction - Stroke and Risk Factors for Stroke ▪ Part 2: Acute Management of Stroke and Chronic Care and Stroke Rehabilitation ▪ Part 3: Stroke Prevention and Other Disease Processes and Healthy Lifestyle - Be Smart and Avoid Stroke ▪ Part 4: Living with Stroke and Future in Diagnosis and Management o From July 1, 2014, through June 30, 2016, over 150 community members attended. • Washington Hospital adopted the Act FAST campaign. Act FAST is an easy way to remember and identify the most common symptoms of a stroke. The Hospital also distributed Act FAST refrigerator magnets at large community events in addition to stroke awareness programs and seminars. • On the first Tuesday of each May, members of the Washington Hospital stroke team partner with EMS responders to pass out cards

	identifying the signs and symptoms of a stroke to commuters at the Fremont BART station. • Washington Hospital hosted three annual Stroke Awareness Day screening events. The free screening consists of a Doppler study of the neck, an EKG, and blood pressure, cholesterol, and glucose screenings. o A total of 304 community members were screened. Of those screened, 72 were found to be at high risk for stroke based on other risk factors and were referred to follow up with their primary healthcare provider for further testing and treatment.

Cancer Prevention	• 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 ages 30 to 40 who are asymptomatic and considered at high risk for breast cancer as defined by the Medicare program.
	  o From July 1, 2014 – June 30, 2016, 135 patients were referred and received free mammograms. Of the 135 mammograms performed, 33 cases resulted in abnormal findings and were referred for follow up with their primary healthcare provider for further testing and treatment.
	• Washington Hospital continued using the Gail Model to identify women who may be at high risk for developing breast cancer.
	  o From July 1, 2014 – June 30, 2016, 82 patients were identified as high risk for developing breast cancer. High risk patients are encouraged to obtain an annual MRI and consult with medical oncologists for consideration of chemoprevention.
	  o Of the 82 patients, 34 underwent recommended MRI breast exams, one breast cancer incidence was identified, and one patient with atypical ductal hyperplasia was identified.
	• Washington Hospital hosted three Annual Think Pink! Breast Health Awareness events. Think Pink offers women the latest information on breast care and other tips for leading a healthier life. During the event, Washington Hospital medical staff and clinicians presented lectures on nutritious foods for breast health, survivorship, and how to prevent breast cancer, including an overview of the Gail Model.
	• Washington Hospital implemented a lung cancer screening tool to identify those who may be at high risk for developing lung cancer.
	  o From July 1, 2014 – June 30, 2016, 33 patients were identified as high risk and underwent low-dose computed tomography (LDCT) or non-contrast CT scans. No cancers were identified; however, patients will undergo annual LDCT scans.
	• Through an affiliation with the University of California San Francisco Medical Center (UCSF), Washington Hospital continued to offer a cancer genetics program, which provided private consultations for genetic counseling and risk assessment for cancer.

	○ From July 1, 2014 – June 30, 2016, 98 patients were referred to Washington Hospital for genetic counseling and risk assessment for cancer. Of the 98 patients, 54 were screened, 11 had positive mutations, and 10 results are pending. • Washington Hospital hosted 11 free community seminars focused on prevention, screening, and early detection for various cancers, e.g., breast, colorectal, lung, prostate, and skin, as part of the Health and Wellness Series. Over 1,040 community members attended.
Weight Management	• Washington Hospital hosted 14 free community seminars focused on nutrition education. From July 1, 2014, through June 30, 2016, over 400 community members attended. • Washington Hospital participated in 11 local school health fairs; over 2,375 students, parents, and teachers received information on healthy eating, eating on the go, and tips to fuel a young athlete. • Washington Hospital continued to coordinate with the Alameda County Food Bank and CalFresh programs to ensure that families with lower incomes have access to healthy, fresh foods. The Food and Nutrition/Clinical Services Department staff volunteered at the Alameda County Food Bank; staff helped prepare food bags for pick-up. • Washington Hospital Foundation and the Washington Hospital Employees' Association donated funds to TCV Food Bank and Thrift Store (Tri-City Volunteers) towards the purchase of a mobile food pantry, increasing access to healthy food to underserved communities.
Public Safety	• The Washington Hospital Maternal Child Health Department provided child passenger safety information to families being discharged from the hospital with new babies and car seat inspections for families with small children. • Washington Hospital's television station, InHealth, aired the following public service announcements: ○ Acetaminophen Overuse Danger ○ Arthritis ○ Autism ○ Bike Safety ○ Car Seat Safety ○ Childhood Obesity ○ Cyber Bullying ○ Diabetes ○ Enterovirus D68 ○ Flu Prevention ○ Food Safety ○ General Vaccination ○ Genetic Counseling ○ Heart Disease ○ Nutrition ○ Obesity Prevention ○ Shingles ○ Texting and Driving

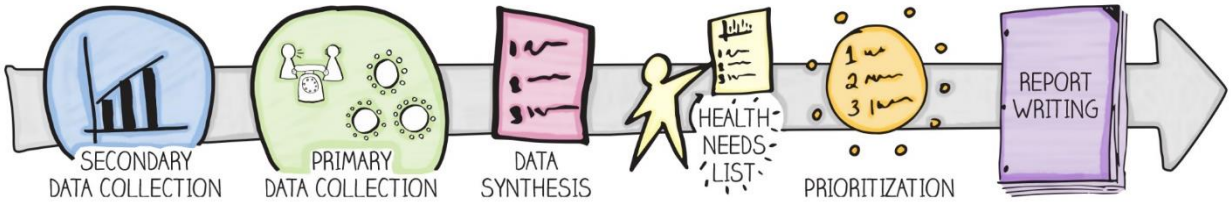
	○ Toddler Seat ○ Sports-Related Concussions ○ Stroke Awareness ○ Whooping Cough ○ Zika Virus • Washington Hospital worked with the City of Fremont to implement improvements to enhance pedestrian safety at the Civic Center Drive crosswalk adjacent to the Hospital. Some of the many improvements included installation of rectangular rapid flashing beacons (RRFBs), travel lanes on Civic Center Drive were reduced to 9 feet wide, and buffered lanes were added between the bicycle lane and the travel lane. Washington Hospital is currently evaluating implementing a stop light for additional safety measures. • Washington Sports Medicine and Washington Outpatient Rehabilitation Center established a bimonthly sports medicine education series for coaches, athletes, parents, and athletic trainers; topics include prevention and treatment of injuries. • Washington Sports Medicine continued providing education to high school athletic departments on concussion safety. Sports Medicine also recently implemented EYE-SYNC®, a cognitive assessment tool to test for concussion and/or other cognitive impairments immediately after an on-field collision. This virtual reality tool drastically reduces the time it takes to diagnose a concussion.
Mental Health	• Washington Hospital began preliminary discussions with Alameda Health System to explore a possible collaboration to increase access to mental health resources within the District. • Washington Hospital developed a matrix outlining local mental health resources for increased access to services. The matrix includes a list of comprehensive healthcare services such as drug rehabilitation centers for teens, psychiatric hospitals, and centers for outpatient and inpatient services. However, a majority of the services are located in Northern Alameda County.
Other	• Washington Hospital continued providing grants for emergency room care, laboratory, and medical imaging services to uninsured clients referred to Washington Hospital by community clinics and organizations such as Tri-City Health Center, Tiburcio Vasquez Health Center, and CURA (drug rehabilitation center). Washington Hospital plans to continue providing these services to ensure care for chronic and acute illness for some of the most vulnerable community members. • Washington Hospital provided a hand hygiene program educating 1st through 3rd graders within the District on how to properly wash hands and why it is so important. • From July 1, 2014 – June 30, 2016, Washington Hospital provided 145 classroom presentations, reaching 3,707 students.

- Washington Hospital also distributed small bottles of hand sanitizer at various health fairs in addition to large public functions such as the Fremont Free Summer Concerts in Central Park.
- Washington Hospital successfully executed improvements to reduce C. difficile rates.
    - Some of the improvements included:
        - Education for departments: Environmental Services, Medical Imaging, transport & lift team, Nuclear Medicine & EKG/ECHO staff.
        - Improved cleaning and disinfection procedure, e.g., cleaning "high-touch" surface areas with bleach wipes.
        - Rounding on the floors by observing compliance for isolation precautions, allowing for one-to-one staff education, and increased accountability of Environmental Services staff.
- Washington Hospital provided free access to health education to assist community members in making informed decisions about their health and healthcare. Sources of education included Washington Hospital's Community Health Resource Library; the Hospital's website; a weekly health column in the Tri-City Voice newspaper promoting health and safety education, as well as personal wellness tips; and Washington Hospital's television station, InHealth, which airs throughout Fremont, Newark, and Union City, as well as being available online.

6. Process & Methods

The Hospitals worked in collaboration on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over five months and culminated in a report written for the Hospitals in the spring of 2016.

Alameda and Contra Costa Counties – Hospitals' CHNA Process



Primary Qualitative Data (Community Input)

The Hospitals contracted with ASR to conduct the primary research. They used three strategies for collecting community input: key informant interviews with health experts, focus groups with professionals, and focus groups with residents.

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulated all health needs that were mentioned, along with health drivers discussed. ASR then tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in key informant interviews. This tabulation was used in part to assess community health priorities.

Community Leader Input

In all, ASR consulted with 44 community representatives of various organizations and sectors. These representatives either work in the health field or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- County Public Health (5)
- Other health centers or systems (11)
- Mental/behavioral health or violence prevention providers (12)
- School system representatives (2)
- City or county government representatives (3)
- Nonprofit agencies providing basic needs (11)

See Appendix F for the titles and expertise of key stakeholders along with the dates and modes of consultation (focus group or key informant interviews).

See Appendix G for key informant interview and focus group protocols.

Key Informant Interviews

ASR conducted primary research via key informant interviews with 18 Alameda County experts from various organizations. Between June and October 2015, experts including the public health officers, community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

ASR interviewed experts in person or by telephone for approximately one hour. Informants were asked to identify the top needs of their constituencies, including specific groups or areas with greater or special needs, how access to healthcare has changed in the post-ACA environment, drivers of the health needs they identified and barriers to health, and suggested solutions for the health needs they identified, including existing or needed resources.

Stakeholder Focus Groups

ASR conduced three focus groups with stakeholders in August and September 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, healthcare access and barriers, and assets and resources that exist or are needed to address the community's top health needs, including policies, programs, etc.

Details of Focus Groups with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Mental health	National Alliance on Mental Illness	08/20/15	8
Minority (Asian)	Community Ambassador Program for Seniors (CAPS) Afghan Coalition	09/02/15	8
Veterans	U.S. Department of Veterans Affairs, Oakland Vet Center	09/23/15	10

Please see Appendix F for a full list of community leaders/stakeholders consulted and their credentials.

Resident Input

ASR conducted resident focus groups between August and October 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, the community's experience of healthcare access and barriers, and assets and resources that exist or are needed to address the community's top health needs.

To provide a voice to the community it serves in Alameda County, the study team targeted participants who are medically underserved, in poverty, and/or socially or linguistically isolated. One focus group was held with community members. This resident group was held in Union City, a relatively central location in Southern Alameda County. The nonprofit host, Centro De Servicios, serves uninsured residents and recruited the residents to participate.

Details of Focus Groups with Residents

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Immigrant population	Centro De Servicios	09/18/15	10

2016 Resident Participant Demographics

Ten community members participated in the focus group discussions in Alameda County. ASR asked all participants to complete an anonymous demographic survey, the results of which are reflected below.

- 100% of participants (10) completed a survey.
- 100% (10) of participants were Latino.
- 100% (10) were between the ages of 18 and 64 years old. 50% were younger than 40, and 50% were 40 or older.
- 10% (1) were uninsured, while 40% had benefits through Medi-Cal or Medicare. The rest had private insurance.
- Residents lived in various areas of southern Alameda County: Hayward (7), Union City (2), and Cherryland (1).
- 80% (8) reported having an annual household income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Alameda County for two adults with no children ($38,817). This demonstrates a fair level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

Secondary Quantitative Data Collection

ASR analyzed over 150 health indicators to assist the Hospitals with understanding the health needs in Alameda County and prioritizing them. Data from existing sources were collected using the Community Commons data platform customized for Kaiser Permanente, the UCLA data platform for the California Health Interview Survey (AskCHIS), Office of Statewide Health Planning and Development (OSHPD), and other online sources. In addition, ASR collected data from the Alameda County Public Health Department.

As a further framework for the assessment, the Hospitals requested that ASR address the following questions in its analysis:

- How do these indicators perform against accepted benchmarks (HP 2020; statewide and national averages)?

- Are there disparate outcomes and conditions for people in the community?

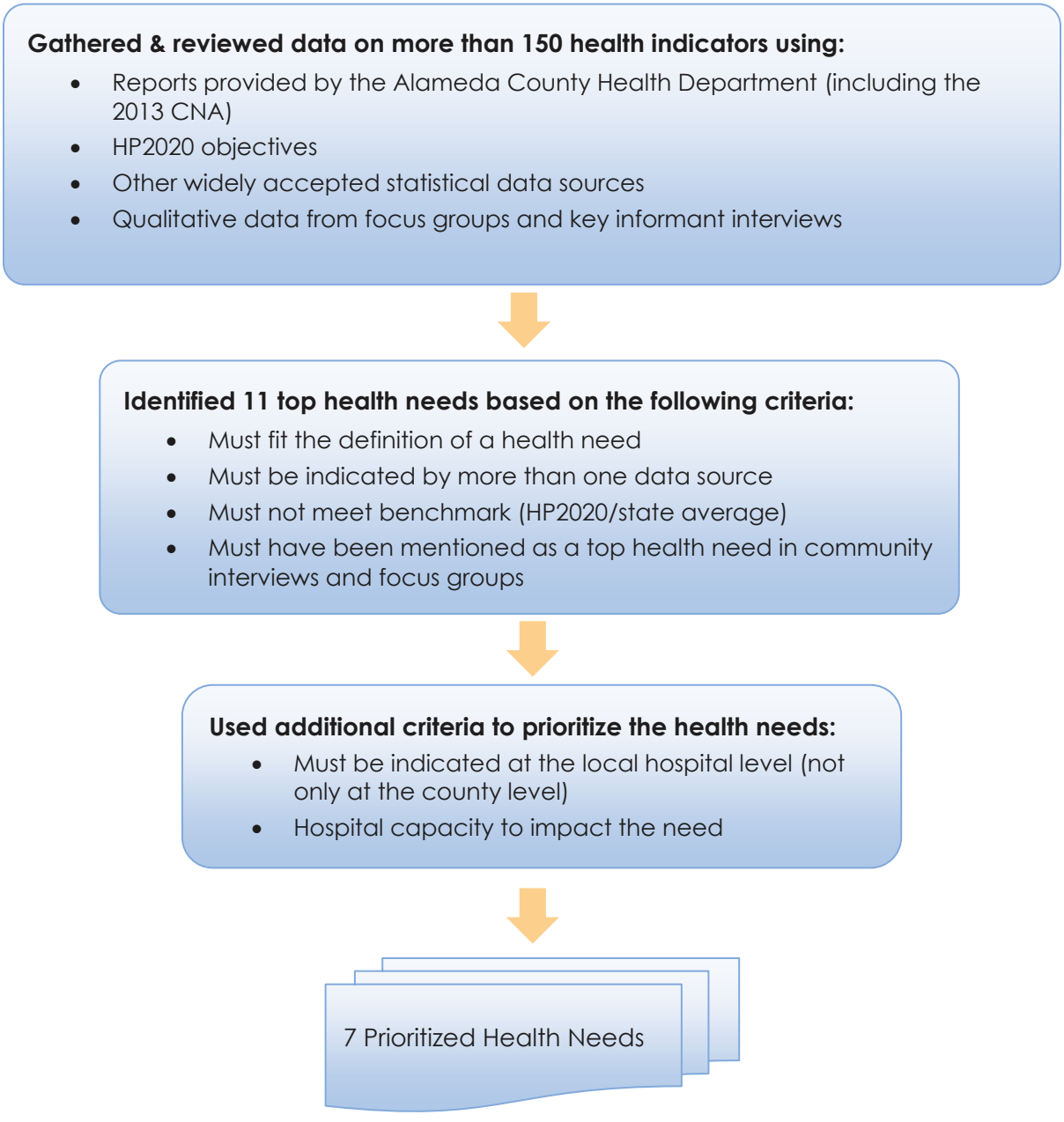
Information Gaps & Limitations

ASR and the Hospitals were limited in their ability to assess some of the identified community health needs due to a lack of secondary data. Such limitations included data on sub-populations, such as foreign-born, the LGBTQ population, and incarcerated individuals. Health topics in which data are limited include: bullying, substance abuse (particularly, use of illegal drugs and misuse of prescription medication), use of e-cigarettes and related behaviors such as vaping, dental health (particularly dental caries), consumption of sugar-sweetened beverages (SSBs), elder health, disabilities, flu vaccines, quality of life and stressors, police-associated violence, human trafficking, discrimination and perceptions related to race, sexual behaviors, and extended data on breastfeeding.

7. Identification & Prioritization of Community Health Needs

Overview of the Prioritization Process

To identify Washington Hospital's health needs, the 2016 CHNA followed a series of steps shown in the graphic below.



Identification of Community Health Needs

As described in Section 6, a wide variety of experts and community members were consulted about the health of the community. Community members were frank and forthcoming about their personal experiences with health challenges and their perceptions about the needs of their families and community.

Collectively, they identified a diverse set of health conditions and demonstrated a clear understanding of the health behaviors and other drivers (environmental and clinical) that affect the health outcomes. They spoke about prevention, access to care, clinical practices that work and don't work, and their overall perceptions of the community's health.

In order to generate a list of health needs, ASR used a spreadsheet (known as the "data culling tool") to list indicator data and evaluate whether they were "health needs." The indicator data collected included Community Commons web platform data, secondary data from county public health department reports, and qualitative data from focus groups and key informant interviews.

In order to be categorized as a prioritized community health need, all four of the following criteria needed to be met:

1. The issue must fit the definition of a "health need."
2. The issue is suggested or confirmed by more than one source of secondary and/or primary data.
3. At least one related indicator performs poorly against the Healthy People 2020 ("HP2020") benchmark or, if no HP2020 benchmark exists, against the state average.
4. The need must meet a minimum threshold of being prioritized by the community (e.g. was prioritized by at least five of fourteen key informant interviews or one of four focus groups).

Any health needs that did not reach the primary data threshold in criterion #4 above needed to meet the following criteria to qualify as a priority health need:

(a) Three or more indicators must miss a state or national benchmark by 5% or more from target
(b) At least one indicator must show an ethnic disparity.

Terminology

Health **condition:** A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

Health **driver:** A behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health.

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.

Health **indicator:** A characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly).

A total of 11 health conditions or drivers fit all four criteria or conditional criteria and were considered as top community health needs.

Prioritization of Health Needs

Washington Hospital further prioritized the list of health needs based on the following criteria:

1) **Local level:** The health needs had to be evident at the local hospital level. Needs for which there were only county level data were not prioritized.

2) **Hospital expertise:** Washington Hospital has the capacity and expertise to impact the need.

A total of 7 health needs were retained and are described in Section 8 below.

8. COMMUNITY HEALTH NEEDS

Asthma

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. Asthma is considered a significant public health burden and its prevalence has been rising since 1980. In the Washington Hospital service area, the percentage of adults with asthma is higher in Newark (16%) and Fremont (16%) than Union City (15%) and the 94544 zip code in Hayward (15%). All cities in the Washington Hospital service area have higher percentages of adults (18 and older) who were told they have asthma, compared to the county (14%) and the state (14%). More children and teens in Union City (24%), Fremont (24%), and the 94544 zip code in Hayward (22%) have asthma than in the county (20%) and the state (15%). The community felt they are more aware of and concerned about childhood asthma than adult asthma.

The 94544 zip code in Hayward has the highest asthma ED visit rate (846.4 per 100,000) and Fremont has the lowest visit rate (393.2) of Washington Hospital service area cities compared to the state and county averages (498.7 and 649.0, respectively). The rate of COPD or asthma hospitalizations for older adults in Alameda County (297.0) is close to the rate for the state (296.0). However, hospitalizations for younger adults in Alameda County (31.0) is higher than the rest of the state (25.0).

Behavioral Health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Substance abuse is related to mental health because many cope with mental health issues by using drugs or abusing alcohol.

The rate of ED visits for mental illness problems is much higher in Newark (391.5 per 100,000), Union City (397.8), Sunol (341.6), the 94544 zip code of Hayward (782.6), and Alameda County (489.3) than in the state overall (320.0). The ED visit rate for substance use is also higher in the 94544 zip code of Hayward (2488.9 per 100,000) and the city of Sunol (1416.3), as well as Alameda County overall (1642.7) than in the state (1275.4). Additionally, ED visits for intentional injury by youth are higher in Alameda County (954.1 per 100,000) than in the state (738.7).

Compared to the state (9.8 per 100,000), the death rate due to suicide is lower in Alameda County (8.2) and in all the cities in the Washington Hospital service area with the exception of Sunol, which is much higher than the state (40.1).

Cancer

Cancer is the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening. In Alameda County, the breast cancer incidence rate is 127.9 per 100,000, higher than the 121.5 rate for the state overall. The prostate cancer incidence rate in Alameda County is 103.1, higher than the 98.0 rate for the state overall.

Ethnic disparities can also be seen in incidence and mortality rates. White women in Alameda County have higher incidence rates for breast cancer (155.4) than all women in Alameda County (127.9) and White women in California overall (138.3). Black women in Alameda County have significantly higher breast cancer mortality rates (27.6) than any other ethnic group in the county. The colorectal cancer incidence rate in Alameda County for Blacks (37.3) is higher than the county (34.2) and state (35.3) averages for everyone. Blacks in Alameda County also have very high lung cancer incidence (57.4) and mortality rates (52.2). In addition, the prostate cancer incidence (192.8) and mortality (49.7) rates for Blacks in Alameda County are higher than the county (incidence 103.1, mortality 20.4) and state (incidence 98.0, mortality 19.5) averages and compared to Blacks overall in California (incidence 158.4, mortality 43.0)

Data from 2013 on cancer case counts for specific cities in the Washington Hospital service area show that Fremont has the highest number of each type of cancer (breast, cervical, colorectal, lung, and prostate). In addition, when looking at the different cancer case counts, breast cancer has the highest counts in each city compared to all the other types of cancers.

Cardiovascular Disease and Stroke

Nationally, more than one in three adults (81.1 million) live with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death respectively, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease.

Black residents of Alameda County are much more likely than other groups to die from any kind of heart disease (374.4 per 100,000 versus 245.2 for Alameda County, overall). The coronary heart disease hospitalization rates for the 94544 zip code of Hayward (402.9 per 100,000), Newark (290.7), Union City (300.0), and Sunol (315.6) are higher than the county (232.8) and state (247.8) averages. Deaths due to coronary heart disease are much higher in the Washington Hospital service area cities of Fremont (125.3), Newark (125.8), Union City (128), Sunol (130.5), and the 94544 zip code of Hayward (154.9) than the HP2020 objective (103.4).

Congestive heart failure hospitalizations are high in Alameda County (195.9 per 100,000) and in certain parts of the Washington Hospital service area. Union City has a very high rate (225.4), but not as high as the 94544 zip code in Hayward (265.5).

Only in Union City (281.0 per 100,000) is the stroke hospitalization rate higher than the state average (215.5).

Maternal and Child Health

The topic area of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birthweight, infant mortality, and access to prenatal care. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.

In 2013, the infant mortality rate for Black children (10.4 per 1,000) was much higher than the Alameda County average (4.2) and the rate for Asian (3.0), White (3.1), and Latino (4.1) children. Infants in Alameda County born to Black mothers were also more likely to suffer low birthweight (10%) than those born to mothers of other ethnicities in the county (Asian 9%, multiracial 7%, Latino 6%, White 6%, Pacific Islander 5%). Black expectant mothers (90%) were more likely to receive prenatal care in their first trimester than American Indian/Alaska Native (83%) and Latina (88%) women but not as likely as Asian/Pacific Islander (92%), White (92%), and multiracial women (92%).

Obesity, Diabetes, and Healthy Eating/Active Living

Healthy diets and achievement and maintenance of a healthy body weight reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives.

Alameda County has a higher percentage of overweight youth (23%) than the state overall (19%), while youth obesity in Alameda County (16%) is lower than for the state (19%). In the 94544 zip code of Hayward (39%), Newark (35%), and Union City (31%), youth obesity is alarmingly high. The proportion of youth who are overweight in those areas (94544: 15%, Union City: 13%, Newark: 14%), however, is lower than in the county (23%) and the state (19%). Additionally, in Alameda County there are ethnic disparities in youth obesity and the percentage of overweight youth. Latino (27%) and Black (24%) youth are more likely to be overweight than their peers of other races or ethnicities. Of the youth in Alameda County who are obese, 53% are Latino, 18% are Black, 15% are White, 11% are Asian, and 3% are multiple races.

In the 94544 zip code of Hayward and Union City, there are very high diabetes hospitalization rates (1,492.0 per 100,000 and 1,098.8) compared to the state (1,017.7).

The percentage of people who are physically active in terms of commuting to work by walking or riding a bike is notably lower in all of the Washington Hospital service area cities (including the 94544 zip code of Hayward) than the county and state averages. The percentage of children in the 94544 zip code of Hayward (48%) who are physically inactive

is higher than in the county (36%) and state (36%). In Alameda County, Latino (51%) and Black (45%) children have much higher levels of inactivity than the county and state overall and higher than other Latino (42%) and Black (43%) children in California.

Alameda County has a higher density of fast food restaurants (79.7 establishments per 100,000 population) than the state average of 74.9.

Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. In 2014, 15% of the population in Alameda County reported experiencing food insecurity at some point during the year, higher than the state average of 14%. The percentage of families living below the FPL in the Washington Hospital service area and in the county overall is lower than the state average.

Violence and Injury Prevention

Violence and intentional injury contribute to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse disorders, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long-term behavioral and emotional problems in youth.

The death rate due to homicide is higher in the 94544 zip code of Hayward (11.4 per 100,000), Newark (7.9), and Alameda County (8.5) than in the state (5.2) and the HP2020 objective (5.5). The death rate for pedestrians killed by motor vehicles is much higher in Union City (4.0 per 100,000) than in the state (2.0) and slightly higher in Alameda County (1.5) than the HP2020 objective (1.4).

Alameda County has a lower assault (injury) rate (394.3 ED visits per 100,000) than the HP2020 objective (461.2), but assault injuries are more common in Alameda County than in the state overall (290.3). The youth intentional injury rate is quite a bit higher in Alameda County (954.1 ED visits per 100,000) than in the state (738.7). The occurrence of domestic violence is more frequent in Alameda County (12.1 ED visits per 100,000) than in the state (9.5). The unintentional injury ED visit rates in the Washington Hospital service areas cities are all below the HP2020 objective (8,310.1) with the exception of the 94544 zip code in Hayward (8,544.9).

9. CONCLUSION

The Hospitals worked in collaboration to meet the requirements of the federally required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and doing new primary research as a team, the Hospitals were able to collectively understand the community's perception of health needs and prioritize health needs with an understanding of how each compares against benchmarks.

After making this CHNA report publicly available in 2017, each hospital will develop individual implementation plans based on this shared data.

10. LIST OF APPENDICES

Appendix A: Health Needs Profiles

Appendix B: IRS Checklist

Appendix C: Glossary

Appendix D: Secondary Data Sources

Appendix E: Indicator List

Appendix F: List of Community Leaders and Their Credentials

Appendix G: Focus Group and Key Informant Interview Protocols

Appendix H: Community Assets and Resources

APPENDIX A: HEALTH NEEDS PROFILES

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

Profile of Washington Hospital Healthcare System Health Needs

ASTHMA

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath.[i] Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and being overweight.

ASTHMA PREVALENCE IS HIGH

Asthma prevalence is higher in the service area than in the state overall. The community is more aware of and concerned about childhood asthma than adult asthma.

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. The populations with higher rates of asthma include Blacks, people living below the Federal Poverty Level, children, and people with certain exposures in the workplace.[i]

Asthma is considered a significant public health burden and its prevalence has been rising since 1980.[i] Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Why Is It a Community Health Need?

While Alameda County's air quality was better than the state's as a whole, three of the cities in the Washington Hospital Healthcare System (Washington Hospital) service area had higher asthma Emergency Department (ED) visit rates than the state. Washington Hospital cities also had higher proportions of adults, teens, and children diagnosed with asthma than the county and the state.

	Washington Hospital Healthcare System Service Area					
	Fremont	Newark	Union City	Sunol	Alameda County	CA State
Air Quality: % of days exceeding fine particulate matter (PM2.5) standards. Population adjusted average [ii]	Countywide measures only				0.0% [iii]	0.46%
Hospitalization Rate for Chronic Obstructive Pulmonary Disease (COPD) (chronic bronchitis or emphysema) or Asthma in Older Adults (Ages 40 and over). Rate is risk adjusted and per 100,000 [iv]	Countywide measures only				**297.0**	296.0
Hospitalization Rate for Asthma in Younger Adults (Ages 18-39). Rate is risk adjusted and per 100,000 [v]	Countywide measures only				**31.0**	25.0
Asthma Emergency Department Visits Rate. Rate is age adjusted and per 100,000	393.2[vi]	**617.4**[vi]	**619.6**[vi]	**768.9** [vii]	**649.0** [vi]	498.7 [viii]
Asthma Prevalence (Adult): % Adults 18 and older ever told they have asthma	**15.6%** [ix]	**16.1%** [ix]	**15.2%** [ix]	n/a	13.7% [x]	13.8% [x]
Asthma Prevalence (Children and Teens): % Children and Teens ages 1-17 ever diagnosed with asthma	**24.0%** [ix]	n/a	**24.1%** [ix]	n/a	**20.1%** [xi]	15.2% [xi]

- Fremont had a notably low asthma ED visit rate (393.2 per 100,000) compared to the other cities in the Washington Hospital service area.

- The proportion of adults with asthma was higher in Newark (16.1%) than in Fremont (15.6%) and Union City (15.2%). Data are not available for Sunol. All cities had higher adult asthma than the county (13.7%) and the state (13.8%)
- More children and teens in Fremont (24.0%) and Union City (24.1%) had asthma than in the county (20.1%) and the state (15.2%). Data are not available for Newark and Sunol
- The rate of asthma hospitalizations for older adults in Alameda County (297.0) was close to the rate for the state (296.0). However, hospitalizations for younger adults in Alameda County (31.0) was higher than the rest of the state (25.0)

What Does the Community Say?

- Residents said asthma is a "bigger deal" in elementary school
- The community had concerns about how asthma will be managed without a hospital nearby
- The community expressed concern about childhood asthma
- Depending on the time of the year, according to residents, there can be high number of pediatric respiratory problems

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified asthma as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publically on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

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[i] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015
[ii] US Environmental Protection Agency: 2012
[iii] 0% denotes all days were within NAQSS Standards
[iv] Office of Statewide Health Planning and Development: 2014
[v] Office of Statewide Health Planning and Development: 2014
[vi] Office of Statewide Health Planning and Development: 2014
[vii] Office of Statewide Health Planning and Development: 2011-13
[viii] Office of Statewide Health Planning and Development: 2013
[ix] California Health Interview Survey: 2011-12
[x] California Health Interview Survey: 2014
[xi] California Health Interview Survey: 2013-14

Profile of Washington Hospital Healthcare System Health Needs

BEHAVIORAL HEALTH

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. It plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. [i]

HIGH EMERGENCY DEPARTMENT USE

Three of the cities in the WHHS service area have had higher than average rates of emergency department visits for mental illness

Why Is It a Community Health Need?

The Washington Hospital Healthcare System (Washington Hospital) service area paralleled the state on a number of mental health and substance use indicators, however there appears to have been high usage of the hospital emergency department in parts of the Washington Hospital service area for mental illness related issues.

MENTAL HEALTH & SUBSTANCE USE DATA BY CITY

	Washington Hospital Healthcare System Service Area					
Indicators (Rate per 100,000)	Fremont	Newark	Union City	Sunol	Alameda County	CA State
Severe Mental Illness Related Emergency Department Visit Rate. Rate is per 100,000 [ii]	288.6	391.5	397.8	341.6	489.3	320.0 [iii]
Self-inflicted Injury Emergency Department Visit Rate. Rate is per 100,000 [iv]	77.8	94.7	84.3	40.5	103.1	115.5
Substance Use Emergency Department Visit Rate. Rate is age-adjusted and per 100,000 [v]	809.8	1148.6	1119.6	1416.3	1642.7	1275.4
Percentage of Household Expenditures Spent on Alcoholic Beverages [vi]	13.7%	12.7%	12.2%	[vii]	suppressed	12.9%
Intentional Self-Harm (suicide) Death Rate. Rate is age-adjusted and per 100,000 [viii]	6.7	5.9	7.3	40.1	8.2	9.8
Non-fatal Emergency Department Visit Rate Among Youth 13-20 for Intentional Injury (assault and self-harm). Rate is per 100,000 [ix]	Countywide measures only				954.1	738.7
Need of Mental Health Care. Percentage of adults, age 18+, needing mental health care in the past 12 months [x]	Countywide measures only				13.6%	15.9%
Lack of Social and Emotional Support. Percentage of adults, age 18+, receiving inadequate social/emotional support [xi]	Countywide measures only				25.5%	24.6%

- The rate of emergency department (ED) visits for mental illness problems was much higher in Alameda County (489.3 per 100,000) than in the state overall (320.0). It was also high in the cities of Newark (391.5), Union City (397.8), and Sunol (341.6)
- Emergency department visits for self-inflicted injuries were lower throughout the WHHS service area than in the state overall

- However, the ED visit rate for substance use was higher in both Alameda County overall (1642.7 per 100,000) and in the city of Sunol (1416.3) than in the state (1275.4). Fremont (809.8), Newark (1148.6), and Union City (1119.6) were all below the state average
- In Fremont, the percentage of household expenditures spent on alcohol (13.7%) was slightly higher than the state average (12.9%)
- Compared to the state (9.8 per 100,000), the death rate due to suicide is lower in Alameda County (8.2) and in the cities of Fremont (6.7), Newark (5.9), and Union City (7.3), but much higher in Sunol (40.1)
- ED visits for intentional injury by youth was higher in Alameda County (954.1) than in the state (738.7)
- The percentage of adults receiving inadequate social/emotional support in Alameda County (25.5%) was only slightly higher than in the state overall (24.6%)
- While risk factors such as binge drinking (Alameda County: 11.7%, state: 15%) and poor mental health (Alameda County: 8.2%, state: 11.1%) were better in Alameda County than in the state, there was a slightly higher percentage of heavy drinkers in Alameda County (6.5%) than in the state (5.8%) [xix]

What Does the Community Say?

- Participants did not consider mental health an illness
- The community members felt there is a lack of mental health providers
- Residents reported a lack of information as to where and who to speak with to obtain services
- The community members had experienced poor discharge procedures and lack of follow-up after mental health emergencies
- Participants said there was a lack of "placement care" and behavioral health services for adolescents
- Residents reported that a lot of mental health providers do not accept insurance

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified mental health as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publicly on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

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[i] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[ii] Office of Statewide Health Planning and Development: 2012-2014
[iii] Office of Statewide Health Planning and Development: 2013
[iv] Office of Statewide Health Planning and Development: 2012-2014
[v] Office of Statewide Health Planning and Development: 2012-2014
[vi] Nielsen, Nielsen SiteReports: 2014
[vii] Recent data are not available
[viii] California Department of Public Health, Death Public Use Data: 2010-12
[ix] California Department of Public Health, California EpiCenter: 2011-2013
[x] University of California Center for Health Policy Research, California Health Interview Survey: 2013-2014
[xi] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-2012

Profile of Washington Hospital Healthcare System Health Needs

CANCER

Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues. Cancer cells can spread to other parts of the body through the blood and lymph systems. There are more than 100 kinds of cancer.[i] Cancer is the second most common cause of death in the United States.[ii] Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening and vaccination services.

ETHNIC DISPARITIES IN CANCER RATES

Alameda County incidence and mortality rates for various cancers are higher for certain ethnicities.

Nationally, Black men are more likely to get and die from cancer, followed by White, Latino, American Indian/Alaskan Native, and Asian/Pacific Islander men.[iii] Among women, White women are more likely to get cancer, but Black women are more likely to die from cancer.[3] Complex and interrelated factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most salient factors are associated with a lack of health care coverage and low socioeconomic status (SES).[iv]

Why Is It a Community Health Need?

Recent data on cancer case counts for specific cities in the Washington Hospital Healthcare System (Washington Hospital) service area are as follows:

CANCER IN WASHINGTON HOSPITAL SERVICE AREA IN 2013[v]

Cancer Site	Washington Hospital Healthcare System Service Area				
	Fremont	Newark	Union City	Sunol	Alameda County
	Incidence Counts	Incidence Counts	Incidence Counts	Incidence Counts	Mortality Counts
All Cancers	717	201	247	7	2,239
Breast	131	33	36	<5	191
Cervical	8	<5	<5	<5	16
Colorectal	58	24	31	<5	189
Lung	75	19	24	<5	497
Prostate	90	24	33	<5	127

In Alameda County, cancer rates are close to state and national benchmarks overall, but incidence and mortality rates show ethnic disparities; the most sizable disparities are highlighted in the bullets below.

CANCER INCIDENCE & MORTALITY RATES FOR THE COUNTY AND STATE, 2013[vi]

Cancer Site	Alameda County		CA State		HP 2020 Objectives	
	Incidence Rate	Mortality Rate	Incidence Rate	Mortality Rate	Incidence Rate[vii]	Mortality Rate
	(Incidence and mortality rates are age-adjusted and per 100,000)					
All Cancers	394.1	139.8	398	146.5	n/a	161.4
Breast	**127.9**	**20.7**	121.5	20.0	n/a	20.7
Cervical	5.9	1.7	7.1	2.4	7.2	2.2
Colorectal	34.2	11.4	35.3	13.1	39.9	14.5
Lung	42.6	31.5	42.8	32.0	n/a	45.5
Prostate	**103.1**	**20.4**	98.0	19.5	n/a	21.8

- The breast cancer incidence rate in Alameda County was 127.9 per 100,000, higher than the 121.5 for the state overall viii
- The prostate cancer incidence rate in Alameda County was 103.1, higher than the 98.0 for the state overall [ix]
- White women in Alameda county had much higher incidence rates for breast cancer (155.4) than White women in California (138.3) and all women in Alameda County (127.9) overall [x]
- Black women in Alameda County had significantly higher breast cancer mortality rates (27.6) than any other ethnic group in the county and higher than the county average (20.7) and the state average (20.0) for all women [xi]
- The colorectal cancer incidence rate in Alameda County for Blacks (37.3) was higher than the county (34.2) and state (35.3) averages for everyone [xii]
- While California has one of the lowest smoking rates in the country, compared to the rest of the state (incidence 42.8, mortality 32.0) and to the county (incidence 42.6, mortality 31.5), Blacks in Alameda had very high lung cancer incidence (57.4) and mortality rates (52.2).[xiii] In 2013-2014, 19.1% of Blacks reported being current smokers, compared to 14.1% of Whites, 10.8% of Latinos, 9.5% of Asian/Pacific Islanders, and 26.5% of American Indian/Alaskan Natives [xiv]
- The prostate cancer incidence (192.8) and mortality (49.7) rates for Blacks in Alameda County were astronomical compared to the county (incidence 103.1, mortality 20.4) and state (incidence 98.0, mortality 19.5) averages and compared to Blacks overall in California (incidence 158.4, mortality 43.0) [xv]

What Does the Community Say?

Community comments mainly focused on transportation issues (difficulty in getting to and from treatment).

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified cancer as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publically on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

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[i] *How to Prevent Cancer or Find It Early*. Cancer Prevention and Control, Centers for Disease Control and Prevention. Web. Dec. 2015.
[ii] *Fast Stats, Leading Causes of Death*. Centers for Disease Control and Prevention. Web. Dec. 2015.
[iii] *Cancer Rates by Race and Ethnicity.* Cancer Prevention and Control, Centers for Disease Control and Prevention. Web. Dec. 2015.
[iv] *Cancer Health Disparities*. National Cancer Institute. Web. Dec. 2015.
[v] California Cancer Registry, 2013
[vi] California Cancer Registry, 2013
[vii] n/a=HP2020 uses different indicators or does not set objectives for this indicator
[viii] California Cancer Registry, 2013
[ix] California Cancer Registry, 2013
[x] California Cancer Registry, 2013
[xi] California Cancer Registry, 2013
[xii] California Cancer Registry, 2013
[xiii] California Cancer Registry, 2013
[xiv] Behavioral Risk Factor Surveillance System, 2013-2014.
[xv] California Cancer Registry, 2013

Profile of Washington Service Area Health Needs

CARDIOVASCULAR DISEASE/STROKE

Nationally, more than one in three adults (81.1 million) live with one or more types of cardiovascular disease (CVD).[i] In addition to being the first and third leading causes of death, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.[1] There are significant disparities based on gender, age, race/ethnicity, geographic area, and socioeconomic status in the prevalence of risk factors, access to timely treatment, treatment outcomes, and mortality of heart disease and stroke.

CONSISTENTLY WORRYING TRENDS IN UNION CITY

Union City is high for coronary heart disease, congestive heart failure, and stroke

The primary risk factors[1] for heart disease and stroke, such as high blood pressure and cholesterol, cause changes in the heart and blood vessels that over time can lead to heart attacks, heart failure, and strokes. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease.

Why Is It a Community Health Need?

The prevalence and death rate for all types of heart disease in the Washington Hospital Healthcare System (Washington Hospital) service area was below the state average. However, coronary heart disease and congestive heart failure were high in the Washington Hospital service area.

CARDIOVASCULAR DISEASE & STROKE INDICATORS

	Washington Hospital Healthcare System Service Area						
Indicators	Fremont	Newark	Union City	Sunol	Alameda County	CA State	HP 2020
Heart Disease Prevalence: percentage adults ever diagnosed with any type of heart disease [ii]	5.4%	5.2%	5.5%	No data	5.5%	5.9%	n/a
All Types of Heart Disease Death Rate, for 35+. Rate is age-adjusted and per 100,000 [iii]	Countywide measures only				245.2	300.4	n/a
Coronary Heart Disease Hospitalization Rate. Rate is age-adjusted and per 100,000	229.4 [iv]	290.7 [v]	300.0 [vi]	315.6 [vii]	232.8 [viii]	247.8 [ix]	n/a
Coronary Heart Disease Death Rate. Rate is age-adjusted and per 100,000 [x]	125.3	125.8	128.0	130.5	133.6	163.2	103.4
Congestive Heart Failure Hospitalization Rate. Rate is age-adjusted and per 100,000 [xi]	151.7	179.8	225.4	89.3	195.9	174.1 [xii]	n/a
Stroke Hospitalization Rate. Rate is age-adjusted and per 100,000 [xiii]	161.5	196.3	281.0	No data	191.3	215.5 [xiv]	n/a
Stroke (cerebrovascular disease) Death Rate. Rate is age-adjusted and per 100,000 [xv]	Countywide measures only				34.4	34.4	34.8
Percentage of adults who have been told they have high blood pressure (Hypertension) [xvi]	Countywide measures only				23.7%	28.5%	26.9%

- Black residents of Alameda County were much more likely than other groups to die from any kind of heart disease (374.4 per 100,000 versus 245.2 for Alameda County, overall)
- Newark, Union City, and Sunol had coronary heart disease hospitalization rates (290.7 per 100,000, 300.0, and 315.6, respectively) that were higher than the county (232.8) and state (247.8) averages
- Deaths due to coronary heart disease were much higher in California (163.2 per 100,000) than the HP2020 objective (103.4). In Alameda County (133.6) and the Washington Hospital service area cities of Fremont (125.3), Newark (125.8), Union City (128), and Sunol (130.5), they were not as high as the rest of the state, but still higher than the HP2020 objective
- Congestive heart failure hospitalizations were also high in Alameda County (195.9 per 100,000) and parts of the Washington Hospital service area. Union City had a very high rate (225.4). Newark (179.8) was about the same as the state average (174.1), while Fremont (151.5) and Sunol (89.3) were well below it
- Only in Union City (281.0 per 100,000) is the stroke hospitalization rate higher than the state average (215.5)
- The stroke death rate in Alameda County (34.4 per 100,000) is the same as the state average
- The percentage of adults in Alameda County who have high blood pressure (23.7%) is slightly lower than the state average (28.5%) and the HP2020 objective (26.9%)

What Does the Community Say?

- Residents said that, in specific geographic areas, there are few/no supermarkets or farmers' markets offering healthy food, and there is a lack of access to open spaces for exercise
- Key informants noted that they are seeing an increase in the number of Afghani and Indian residents with cardiac problems; that there are lots of multiple diagnoses (e.g., obesity, hypertension, asthma all co-occurring); and that Latinos & Blacks tend to have higher levels of hypertension and other risk factors

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified cardiovascular disease and stroke as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publicly on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

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[i] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[ii] California Health Interview Survey: 2014
[iii] Centers for Disease Control, National Center for Health Statistics, Deaths National Vital Statistics System: 2011-2013
[iv] Office of Statewide Health Planning and Development: 2012-2014
[v] Office of Statewide Health Planning and Development: 2012-2014
[vi] Office of Statewide Health Planning and Development: 2012-2014
[vii] Office of Statewide Health Planning and Development: 2010-2012
[viii] Office of Statewide Health Planning and Development: 2012-2014
[ix] Office of Statewide Health Planning and Development: 2013
[x] California Department of Public Health, CDPH – Death Public Use Data: 2010-2012
[xi] Office of Statewide Health Planning and Development: 2012-2014
[xii] Office of Statewide Health Planning and Development: 2013
[xiii] Office of Statewide Health Planning and Development: 2012-2014
[xiv] Office of Statewide Health Planning and Development: 2013
[xv] Office of Statewide Health Planning and Development: 2012-2014
[xvi] California Health Interview Survey: 2014

Profile of Washington Service Area Health Needs

MATERNAL AND CHILD HEALTH

Improving the well-being of mothers, infants, and children is an important public health goal. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system.[i] The topic of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.[1]

ETHNIC DISPARITIES IN MATERNAL AND CHILD HEALTH

Infant mortality and low birthweight are more severe for Alameda County's Black population than for other ethnicities

Why Is It a Community Health Need?

While indicators of extreme poverty and maternal and child health are encouraging, overall in Alameda County, food security is of concern. There are also ethnic disparities in maternal and child health in Alameda County.

POVERTY

Indicators	Washington Hospital Healthcare System Service Area					CA State	HP 2020
	Fremont	Newark	Union City	Sunol	Alameda County		
Percentage of Families Living Below the Federal Poverty Level [ii]	4.1%	5.6%	6.0%	6.8%	8.8%	12.3%	n/a
Percentage of the Population that Experienced Food Insecurity at Some Point During the Year [iii]	Countywide measures only				14.9 %	13.9%	n/a

- The percentage of families living below the Federal Poverty Level in the Washington Hospital service area and in the county overall was lower than the state average
- Food insecurity is associated with chronic diseases such as hypertension, diabetes, and obesity. It is also a sign of other community vulnerabilities such as poverty, lack of access to social services, and insufficient food systems. In 2014, 14.9% of the population in Alameda County reported experiencing food insecurity at some point during the year, higher than the state average of 13.9%
- Infant mortality, low birthweight, and prenatal care in Alameda County (4.6 per 1000, 6.9%, and 90.6%, respectively) were better than or similar to state averages (4.7, 6.7%, and 83.6%) and the HP2020 objectives (6.0 for infant mortality and 7.8% for low birth weight)
- However, there were ethnic disparities in Alameda County. Asian/Pacific Islander (91.9%) and White (92.3%) expectant mothers were much more likely to receive prenatal care in their first trimester than American Indian/Alaska Native (82.9%) and Latina (88.2%) women; and somewhat more likely to receive care than Black (90.3%) and multiracial women (91.5%) [iv]

- Furthermore, in 2013, the infant mortality rate for Black children (10.4 per 1000) was much higher than the Alameda County average (4.2) and the rate for Asian (3.0), White (3.1), and Latino (4.1) children [v]
- Infants in Alameda County born to Black mothers were also more likely to suffer low birthweight (9.8%) than those born to mothers of other ethnicities in the county (Asian 8.9%, multiracial 7.1%, Latino 6.1%, White 5.7%, Pacific Islander 5.1%) [vi]

INFANT MORTALITY, LOW BIRTHWEIGHT & PRENATAL CARE

	Washington Hospital Healthcare System Service Area						
Indicators	Fremont	Newark	Union City	Sunol	Alameda County	CA State	HP 2020
Infant Mortality Rate. Rate is per 1,000 births [vii]	Countywide measures only				4.6	4.7	6.0
Percentage of Births of Low Birthweight [viii]	Countywide measures only				6.9%	6.7%	7.8%
Percentage of Infants whose Mothers Received Prenatal Care in the First Trimester [ix]	Countywide measures only				90.6%	83.6%	n/a

What Did the Community Say?

- The community felt sexual health education & general healthy decision-making for teens was lacking

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified maternal and child health as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publicly on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

[i] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[ii] American Community Survey: 2010-2014
[iii] Feeding America: 2014
[iv] California Department of Public Health: 2013
[v] Alameda County Public Health Department: 2011-2013
[vi] Alameda County Public Health Department: 2013
[vii] California Department of Public Health: 2013
[viii] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Natality public-use data: 2014
[ix] California Department of Public Health, Center for Health Statistics: 2013

Profile of Washington Hospital Healthcare System Health Needs

OBESITY/DIABETES/HEAL (HEALTHY EATING ACTIVE LIVING)

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Without a properly functioning insulin system, blood glucose levels become elevated and other metabolic abnormalities occur, potentially leading to serious outcomes such as reduced life expectancy, increased risk of heart disease, kidney failure, amputations, and blindness.[i] Physical inactivity and obesity are strongly associated with the development of type 2 diabetes, the most common form. People who are genetically susceptible to type 2 diabetes are more vulnerable when these risk factors are present.[ii] Obesity is also a risk factor for cardiovascular disease and health problems that can include heart attack, heart failure, stroke, cancer, arthritis, and others.[iii] The risk of diabetes and other diseases can be lowered by losing weight and making lifestyle changes. Efforts to change diet and activity level address individual behaviors, as well as the policies and environments that support these behaviors.[iv]

HIGH RISK FOR SERIOUS OUTCOMES

Some areas in the WHHS Service Area have high diabetes hospitalization rates and high youth obesity.

Type 2 diabetes disproportionately affects Blacks, American Indians, Asian Americans, Latinos, and Pacific Islanders. These groups also make up a disproportionate share of the poor and uninsured. [v] Low income and food-insecure populations are especially vulnerable to obesity because they have less access to nutritious foods and to quality health care. They also may undergo cycles of abundance and deprivation, have less opportunity to exercise, and experience more stress.[vi]

Why Is It a Community Health Need?

Diabetes is the seventh leading cause of death in the United States and over a quarter of the people who have diabetes are undiagnosed.[vii] A smaller proportion of people in Alameda County (6.8%) were diagnosed with diabetes as compared to the state (8.9%), and adult obesity was quite a bit lower in Alameda County (19.8%) than in the state overall (27%). However:

DIABETES-RELATED INDICATORS IN THE WASHINGTON HOSPITAL SERVICE ARE

Indicators	Fremont	Newark	Union City	Sunol	Alameda County	CA State
Overweight (Youth): Percentage of children in grades 5,7, and 9 within the overweight body composition category [viii]	14.7%	13.8%	13.2%	8.9%	**22.8%**	19.3%
Obesity (Adults): Percentage of adults 18 and older who have a Body Mass Index (BMI) of 30 or over [ix]	Countywide measures only				19.8%	27.0%
Obesity (Youth): Percentage of children in grades 5,7, and 9 within the obese body composition category [x]	**19.2%**	**35.0%**	**30.7%**	8.9%	15.5%	19.0%
Diabetes Prevalence: Percentage of adults 18 and older who have ever been diagnosed with diabetes [xi]	Countywide measures only				6.8%	8.9%
Diabetes Hospitalization Rate (Rate is per 100,000 and age adjusted) [xii]	771.6	999.6	**1098.8**	303.7	879.6	1017.7 [xiii]

Indicators	Fremont	Newark	Union City	Sunol	Alameda County	CA State
Physical Inactivity (Youth): Percentage of children in grades 5,7, and 9 within the "high risk" or "needs improvement" categories for aerobic capacity [xiv]	25.5%	33.8%	32.9%	23.2%	**36.1%**	35.9%
Walking/Biking to Work: Percentage of the population that commutes to work by walking or riding a bike [xv]	**2.0%**	**1.7%**	**1.5%**	**2.4%**	5.7%	3.8%

- In Union City, there were very high diabetes hospitalization rates (1098.8 per 100,000) compared to the state (1017.7 per 100,000). Hospitalizations due to diabetes complications are potentially preventable with good care, management, and patient education
- In Alameda County the percentage of people who are physically active in terms of commuting to work by walking or riding a bike (5.7%) was higher than for the state overall (3.8%). However, in the areas of Fremont (2.9%), Union City (1.5%), Newark (1.7%), and Sunol (2.4%) that percentage was notably lower than the state average
- Alameda County had a higher percentage of overweight youth (22.8%) than the state overall (19.3%). In both Alameda County and the state, Latino (Alameda county: 27.3%, state: 21.6%) and Black (Alameda county: 24.1%, state: 20.3%) youth were more likely to be overweight than their peers of other races or ethnicities
- While youth obesity in Alameda County (15.5%) was lower than for the state (19.0%), in the specific areas of Union City (30.7%) and Newark (35.0%), youth obesity was alarmingly high. The proportion of youth who are overweight in those areas (Union City: 13.2%, Newark: 13.8%), however, was lower than in the county (22.8%) and the state (19.3%)
- Of the youth in Alameda County who are obese, 53.0% were Latino, 17.9% were Black, 14.7% were White, 11.3% were Asian, and 3.0% were multiple race
- The percentage of children in Alameda County who are physically inactive (36.1%) was slightly higher than in the state (35.9%). In Fremont (25.5%), Union City (32.9%), and Newark (33.8%) that percentage fell below the state and county averages. In Alameda County, Latino (50.8%) and Black (45.2%) children had much higher levels of inactivity than the county and state overall and higher than other Latino (42.2%) and Black (43.2%) children in California
- In 2014, 14.9% of the population in Alameda County reported experiencing food insecurity at some point during the year, higher than the state average of 13.9% [xvi]
- Availability of food in Alameda county overall was better than for the state. In Alameda County there were 24.7 grocery stores per 100,000 population, while in California it was 21.7 [xvii]
- However, Alameda County had a higher density of fast food restaurants (79.7 establishments per 100,000 population) than the state average of 74.9 [xviii]
- While risk factors such as binge drinking (Alameda County: 11.7%, State: 15%) and hypertension (Alameda County: 22.5%, State: 27.2%) were better in Alameda County than in the state, there was a slightly higher percentage of heavy drinkers in Alameda County (6.5%) than in the State (5.8%) [xix]

What Does the Community Say?

- Community members complained of a lack of access to healthy foods (i.e., fresh produce)
- The community felt it was expensive to eat healthy
- Residents were experiencing food insecurity: Families are stretching one weeks' worth of food to three weeks
- Community members said there was a lack of affordable sports and recreational activities for youth and adults (e.g., fitness classes, open spaces for exercise)
- The community believed that culturally familiar food is unhealthy: "Eating healthy isn't always a top priority for new immigrants; eating food that is familiar to them provides comfort."
- Residents said health providers do not give culturally-specific nutrition recommendations
- A key informant noted there are lots of multiple diagnoses (e.g., obesity, hypertension, asthma all co-occurring)

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified obesity, diabetes, and healthy eating/active living as some of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publically on its website. Each hospital's Implementation Strategy report describes in detail the investments made in the community, including programming and partnerships.

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[i] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. July 2016.
[ii] National Institute of Diabetes and Digestive and Kidney Diseases. Web. July 2016
[iii] National Heart Lung and Blood Institute. Web. July 2016
[iv] *Healthy People 2020*. Office of Disease Prevention and Health Promotion. Web. December 2015.
[v] Alliance to Reduce Disparities in Diabetes. Web. July 2016
[vi] Food Research and Action Center. Web. July 2016
[vii] American Diabetes Association. Web. July 2016
[viii] California Department of Education, FITNESSGRAM® Physical Fitness Testing: 2013-2014
[ix] California Health Interview Survey: 2014
[x] California Department of Education, FITNESSGRAM® Physical Fitness Testing: 2013-2014
[xi] California Health Interview Survey: 2014
[xii] Office of Statewide Health Planning and Development: 2012-2014
[xiii] Office of Statewide Health Planning and Development: 2013
[xiv] California Department of Education, FITNESSGRAM® Physical Fitness Testing: 2013-2014
[xv] US Census Bureau. American Community Survey: 2010-2014
[xvi] Feeding America: 2014
[xvii] US Census Bureau, County Business Patterns. Additional analysis by CARES: 2013
[xviii] US Census Bureau, County Business Patterns. Additional analysis by CARES: 2013
[xix] California Behavioral Risk Factor Surveillance System: 2014

Profile of Washington Hospital Healthcare System Health Needs

VIOLENCE/INJURY PREVENTION

Violence and intentional injury contribute to poor health outcomes for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk for depression, substance abuse, anxiety, reproductive health problems, and suicidal behavior.[i] Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. In one study, individuals who reported feeling unsafe when going out during the day were 64% more likely to be in the lowest quartile of mental health.[ii] Witnessing and experiencing violence can cause long term behavioral and emotional problems in youth. For example, a study in the San Francisco Bay area showed that youth who were exposed to violence showed higher rates of self-reported PTSD, depressive symptoms, and perpetration of violence.[iii]

VIOLENCE RATES WORSE THAN STATE

Violent injuries and deaths are higher than state averages in some parts of the service area

Why Is It a Community Health Need?

While unintentional injuries in the Washington Hospital Healthcare System (Washington Hospital) service area are not higher than state averages or Healthy People 2020 (HP2020) objectives, violence is more likely to occur in Alameda County and some of the cities in the Washington Hospital service area.

INJURY DATA BY SERVICE AREA

	Washington Hospital Healthcare System Service Area						
Indicators (Rate per 100,000)	**Fremont**	**Newark**	**Union City**	**Sunol**	**Alameda County**	**CA State**	**HP 2020** [iv]
Death Rate due to Unintentional Injury. Rate is age-adjusted and per 100,000 [v]	Countywide measures only				23.9	28.2	36.4
Unintentional Injury Emergency Department Visit Rate. Rate is per 100,000 [vi]	5037.5	6274.8	6195.2	7352.5	6749.6	No data	8310.1
Death Rate due to Assault (homicide). Rate is age-adjusted and per 100,000 [vii]	2.7	**7.9**	4.5	0.0	**8.5**	5.2	5.5
Death Rate of Pedestrians Killed by Motor Vehicles. Rate is age-adjusted and per 100,000 [viii]	1.3	0.0	**4.0**	0.0	**1.5**	2.0	1.4
Assault (injury) Non-fatal Emergency Department Visit Rate. Rate is per 100,000 [ix]	Countywide measures only				**394.3**	290.3	461.2
Youth Intentional Injury Emergency Department Visit Rate (ages 13-20). Rate is per 100,000 [x]	Countywide measures only				**954.1**	738.7	n/a
Domestic Violence Non-fatal Emergency Department Visit Rate (females 10 years and older). Rate is per 100,000 [xi]	Countywide measures only				**12.1**	9.5	n/a

- The unintentional injury emergency department visit rates in Fremont (5037.5 ED visits per 100,000), Newark (6274.8), Union City (6195.2), Sunol (7352.5), and Alameda County (6749.6) overall were all below the HP2020 objective (8310.1) for this indicator
- The death rate due to homicide was higher in Newark (7.9 per 100,000) and Alameda County (8.5) than in the state (5.2) and higher than the HP2020 objective (5.5)
- The death rate for pedestrians killed by motor vehicles was much higher in Union City (4.0 per 100,000) than in the state (2.0) and slightly higher in Alameda County (1.5) than the HP2020 objective (1.4)
- Alameda County had a lower Assault (injury) rate (394.3 emergency department (ED) visits per 100,000) than the HP2020 objective (461.2), but assault injuries were more common in Alameda county than in the state overall (290.3)
- The youth intentional injury rate was quite a bit higher in Alameda County (954.1 ED visits per 100,000) than in the state (738.7)
- The occurrence of domestic violence was more frequent in Alameda County (12.1 ED visits per 100,000) than in the state (9.5)

What Does the Community Say?

- Residents worried about being attacked when they walk along the streets
- Community members felt there is a lack of empathy from healthcare and law enforcement towards victims
- Regarding domestic violence (DV), community members reported:
  - a lack of effective screening for DV victims. Often DV victims are prevented by abuser from having a primary care provider
  - poor communication/lack of connection between clinics and DV organizations for referrals
  - not enough providers and facilities for DV victims; existing facilities have wait lists

Commitment to Improving Community Health

In 2016, in collaboration with 11 other hospitals throughout Alameda and Contra Costa Counties, the CHNA process identified violence/injury prevention as one of the top health needs in the community based on statistical data and community input. Each hospital posts its final 2016 Community Health Needs Assessment (CHNA) publicly on its website. Each hospital's Implementation Strategy Report describes in detail the investments made in the community, including programming and partnerships.

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[i] Krug, E.G., Dalhberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (Eds.). (2002). World report on violence and health. World Health Organization, Geneva, Switzerland. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

[ii] Guite, H.F., Clark, C., & Ackrill, G. (2006). The impact of the physical and urban environment on mental well-being. *Public Health 120:*1117-1126 as cited in Human Impact Partners. Retrieved from http://www.humanimpact.org/evidencebase/category/violent_crime_in_a_community_impacts_physical_and_mental_health

[iii] Perez-Smith, A.M., Albus, K.E., & Weist, M.D. (2001). Exposure to violence and neighborhood affiliation among inner-city youth. *Journal of Clinical Child Psychology, 30*(4):464-472; Ozer, E.J. & McDonald, K.L. (2006). Exposure to violence and mental health among Chinese American urban adolescents. *Journal of Adolescent Health, 39*(1):73-79, as cited in Human Impact Partners retrieved from http://www.humanimpact.org/evidencebase/category/violent_crime_in_a_community_impacts_physical_and_mental_health

[iv] n/a=HP2020 uses different indicators or does not set objectives for this indicator

[v] California Department of Public Health: 2012-2014

[vi] Office of Statewide Health Planning and Development: 2012-2014

[vii] California Department of Public Health, Death Public Use Data: 2010-2012

[viii] California Department of Public Health, Death Public Use Data: 2010-2012

[ix] California Department of Public Health, California EpiCenter: 2011-2013

[x] California Department of Public Health, California EpiCenter: 2011-2013

[xi] California Department of Public Health, California EpiCenter: 2011-2013

Appendix B: IRS Checklist

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

Federal Requirements Checklist	Regulation Section Number	Report Section / Appendix
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)	Sec. 5
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)	Sec. 5
B. PROCESS & METHODS		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Sec. 6
Identifies any third parties contracted to assist in conducting the CHNA.	(b)(6)(F)(ii)	Sec. 6
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)	Sec. 3
Describes how the community was determined.	(b)(6)(i)(A)	Sec. 3
Describes demographics and other descriptors of the hospital service area.	(b)(3)	Sec. 3
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	Sec. 7
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Sec. 7 App. D

Federal Requirements Checklist	Regulation Section Number	Report Section / Appendix
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Sec. 7 App. G
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)	Sec. 7 App. F
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Sec. 7 App. F
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)	Sec. 7 App. F
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)	Sec. 7 App. F
I. Medically underserved populations		
II. Low-income populations		
III. Minority populations	(b)(5)(i)(B)	
c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers, and community health centers).	(b)(5)(ii)	Sec. 7
Describes how such input was provided (e.g., through focus groups, interviews, or surveys).	(b)(6)(F)(iii)	Sec. 6 Sec. 7
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Sec. 6
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Sec. 7
C. CHNA NEEDS DESCRIPTION & PRIORITIZATION		
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Sec. 7 App. A
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Sec. 7

Federal Requirements Checklist	Regulation Section Number	Report Section / Appendix
		App. A
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Sec. 7
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)	App. H
D. FINALIZING THE CHNA		
The CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Exec Sum
The 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)	By Sept 2017
The final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	By Sept 2017
a. May not be a copy marked "Draft".	(b)(7)(ii)	
b. Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
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)	
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

Appendix C: Glossary

Abbreviation	Term	Description/Notes
AC	Alameda County	
BRFSS	Behavioral Risk Factor Surveillance System	Survey implemented by CDC
CA	California	
CCC	Contra Costa County	
CDC	Centers for Disease Control and Prevention	
CDE	California Department of Education	
CDHS	California Department of Health Services	
CDPH	California Department of Public Health	
CHNA	Community Health Needs Assessment	
DHHS	United States Department of Health and Human Services	
DV	Domestic violence	
FPL	Federal poverty level	An annual metric of income levels determined by DHHS.
HIV	Human immunodeficiency virus	Sexually transmitted virus that can lead to AIDS.
HP2020	Healthy People 2020	National, 10-year aspirational benchmarks set by federal agencies & finalized by a federal interagency workgroup under the auspices of the U.S. Office of Disease Prevention and Health Promotion, managed by DHHS.
HUD	United States Department of Housing and Urban Development	
LGBTQI	Lesbian/ Gay/ Bisexual/ Transgender/ Questioning/ Intersex	
PHD	Public health department	

Appendix D: Secondary Data Sources

1. Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
2. Alameda County Public Health Department. http://www.healthyalamedacounty.org/. Various.
3. California Department of Education. 2012-2013.
4. California Department of Education. 2013.
5. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
6. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
7. California Department of Public Health, CDPH – Breastfeeding Statistics. 2012.
8. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
9. California Department of Public Health, CDPH – Tracking. 2005-2012.
10. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
11. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
12. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
13. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
15. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
16. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
17. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
18. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
19. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
20. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
21. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
22. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
23. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
24. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
25. Centers for Medicare and Medicaid Services. 2012.

26. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
27. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
28. Environmental Protection Agency, EPA Smart Location Database. 2011.
29. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
30. Feeding America. 2012.
31. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
32. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
33. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
34. New America Foundation, Federal Education Budget Project. 2011.
35. Nielsen, Nielsen Site Reports. 2014.
36. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
37. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
38. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
39. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS Neighborhood Edition. 2015.
40. University of California Los Angeles (UCLA) Center for Health Policy Research. AskCHIS. 2015.
41. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
42. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
43. US Census Bureau, American Community Survey. 2009-2013.
44. US Census Bureau, American Housing Survey. 2011, 2013.
45. US Census Bureau, County Business Patterns. 2011.
46. US Census Bureau, County Business Patterns. 2012.
47. US Census Bureau, County Business Patterns. 2013.
48. US Census Bureau, Decennial Census. 2000-2010.
49. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
50. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
51. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
52. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
53. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
54. US Department of Education, EDFacts. 2011-2012.
55. US Department of Health & Human Services, Administration for Children and Families. 2014.
56. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
57. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
58. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
59. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.

60. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Healthy People 2020. http://www.healthypeople.gov/. 2015.
61. US Department of Housing and Urban Development. 2013.
62. US Department of Labor, Bureau of Labor Statistics. June 2015.
63. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
64. US Drought Monitor. 2012-2014

Appendix E: Indicator List

Indicator Variable	Data Source
Age 0-4 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 18-24 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 25-34 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 35-44 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 45-54 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 5-17 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 55-64 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 65+ (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Assault Injuries Rate (per 100,000 Pop.)	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Assault Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Asthma Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data, additional data analysis by CARES, 2011, **and** Alameda County Public Health Department. Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Asthma Prevalence (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Average Daily School Breakfast Program Participation Rate	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program. 2013.

Indicator Variable	Data Source
Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
BMI > 30.0 Prevalence (Obese) (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
Breast Cancer Deaths (Rate per 100,000 Pop. (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Cancer, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Childhood (0-14) Asthma Hospitalization Rate (per 100,000 Pop. (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Children and Teens with Asthma (1-17) (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Children Who Visited Dentist Within Past 12 Months (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Chlamydia Infection Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2012.
Cigarette Expenditures, Percentage of Total Household Expenditures	Nielsen, Nielsen Site Reports. 2014.
Colorectal Cancer Deaths Rate (per 100,000 Pop. (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Coronary Heart Disease Hospitalization Rate (per 100,000 Pop. (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Dentists, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
Depression (Percentage, Medicare Beneficiaries)	Centers for Medicare, and, Medicaid, Services. 2012.
Diabetes Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diagnosed Diabetes Prevalence (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012, and Alameda County Public Health Department, Alameda County Health Data Profile, 2014, **and** Contra Costa Health Services and Hospital Council of

Indicator Variable	Data Source
	Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Disability (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Domestic Violence Injuries Rate (per 100,000 Pop. (Females Age 10+))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Drought Weeks (Any) (Percentage)	US, Drought, Monitor. 2012-14.
Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Fast Food Restaurants, Rate (Per 100,000 Pop.)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Federally Qualified Health Centers, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
Female Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Food Insecurity (Percentage, Population)	Feeding, America. 2012.
Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Full Immunization at 24 Months (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Gini Index Value (Income Inequality)	US Census Bureau, American Community Survey. 2009-13.
Grade 4 ELA Test Score Not Proficient (Percentage)	California, Department of Education., 2012-13.
Grocery Stores, Rate (Per 100,000 Pop.)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Head Start Programs Rate (Per 10,000 Children Under Age 5)	US Department of Health & Human Services, Administration for Children and Families. 2014.
Heart Disease Prevalence (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Heat-related Emergency Department Visits, Rate (per 100,000 Pop.)	California Department of Public Health, CDPH - Tracking. 2005-12.
Hemoglobin A1c Test, Annual (Percentage, Medicare Enrollees with Diabetes)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
High Blood Pressure and Not Taking Medication (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Indicator Variable	Data Source
High Blood Pressure Prevalence (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
High School Cohort Graduation Rate	California, Department of Education. 2013.
Hispanic or Latino (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HIV Hospitalizations Age-Adjusted Discharge Rate (per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Homicide, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Households where Housing Costs Exceed 30% of Income (Percentage)	US Census Bureau, American Community Survey. 2009-13.
HUD-Assisted Units, Rate (per 10,000 Housing Units)	US Department of Housing and Urban Development. 2013.
Inadequate Fruit / Vegetable Consumption (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09.
Inadequate Fruit/Vegetable Consumption (percentage, Population Age 2-13)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Income at or Below 200% FPL (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Infant Mortality Rate (Per 1, 000 Births)	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10.
Insured Population Receiving Medicaid (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Intentional Injuries, Rate (per 100,000 Pop.(Youth Age 13 - 20))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Limited English Proficiency (Percentage, Population Age 5+)	US Census Bureau, American Community Survey. 2009-13.
Linguistically Isolated Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Liquor Stores, Rate (Per 100,000 Pop.)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Live Within 1/2 Mile of a Park (Percentage, Population)	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.
Live within Half Mile of Public Transit (Percentage, Population)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Living in a HPSA-Dental (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.
Living in a HPSA-Primary Care (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.

Indicator Variable	Data Source
Living in Car Dependent (Almost Exclusively) Cities (Percentage)	Walk Score®. 2012.
Low Birth Weight Births (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Low Food Access (Percentage, Population)	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.
Male Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Mammogram in Past 2 Year (Percentage, Female Medicare Enrollees)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
Median Age	US Census Bureau, American Community Survey. 2009-13.
Mental Health Care Provider Rate (Per 100,000 Pop.)	University of Wisconsin Population Health Institute, County Health Rankings. 2014.
Missed School Days Due to Dental Problem (At Least One Day) (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Mothers Breastfeeding (Any) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers Breastfeeding (Exclusively) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers with Late or No Prenatal Care (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Never Screened for HIV / AIDS (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
No Air Conditioning (Percentage, Housing Units)	US Census Bureau, American Housing Survey. 2011, 2013.
No High School Diploma (Percentage, Population Age 25+)	US Census Bureau, American Community Survey. 2009-13.
No Leisure Time Physical Activity (Percentage, Population)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
No Motor Vehicle (Percentage, Households)	US Census Bureau, American Community Survey. 2009-13.
Obese Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Obesity (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012, and UCLA Center for Health Policy Research, AskCHIS, 2015.
Occupied Housing Units with One or More Substandard Conditions (Percentage)	US Census Bureau, American Community Survey. 2009-13.

Indicator Variable	Data Source
Overweight (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Ozone (03) - Days Exceeding Standards, Pop. Adjusted Average (Percentage)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Particulate Matter 2.5 - Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
People Delayed or had Difficulty Obtaining Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
People with a Usual Source of Health Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Physically Inactive Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccination (Age-Adjusted) (Percentage, Population Age 65+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Poor Dental Health (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Poor Mental Health (Percentage, Adults 18+)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Poor or Fair Health (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Population Change, 2000-2010 (Percentage)	US Census Bureau, Decennial Census. 2000 - 2010.
Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2009-13.
Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Population with HIV / AIDS, Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2010.
Potentially Exposed to Unsafe Drinking Water (Percentage, Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Poverty (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.

Indicator Variable	Data Source
Poverty, Children (Percentage, Population Under Age 18)	US Census Bureau, American Community Survey. 2009-13.
Pre-School Enrollment (Percentage, Population Age 3-4)	US Census Bureau, American Community Survey. 2009-13.
Preventable Hospital Events Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Primary Care Physicians, Rate (per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
Rape Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Rate of Reported AIDS Cases (per 100,000 Pop.)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Receiving SNAP Benefits (Percentage, Population)	US Census Bureau, Small Area Income & Poverty Estimates. 2011.
Recreation and Fitness Facilities, Rate (Per 100,000 Pop.)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2012.
Regular Pap Test (Age-Adjusted) (Percentage, Adults Females Age 18+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Robbery Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
School Expulsion Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
School Suspension Rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). 2013-14.
Screened for Colon Cancer (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Severe Mental Illness Related Emergency Department Visits (Rate per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Smoking Cigarettes (Age-Adjusted) (Percentage, Population)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.

Indicator Variable	Data Source
Stroke, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Students Eligible for Free or Reduced Price Lunch (Percentage)	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.
Substance Use Emergency Department Visit Rate (Rate per 100,000 (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Suicide, Age-Adjusted Mortality Rate (per 100,000 Pop.)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Teen Birth Rate (Per 1, 000 Female Pop. Under Age 20)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Teens Who Engage in Regular Physical Activity (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Tuberculosis Incidence Rate (per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Unable to Afford Dental Care, Youth (Percentage, Population Age 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2015 - June.
Uninsured Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Vacant Housing Units (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Walking or Biking to Work (Percentage, Aged 16+)	US Census Bureau, American Community Survey. 2009-13.
Walking/Skating/Biking to School (Percentage, Aged 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Weather Observations with High Heat Index Values (Percentage)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
WIC-Authorized Food Stores, Rate (Per 100,000 Pop.)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Without Adequate Social / Emotional Support (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Without Dental Insurance (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.

Indicator Variable	Data Source
Without Recent Dental Exam (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Without Regular Doctor (Percentage, Total Population)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Workers Commuting by Car, Alone (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Workers Commuting More than 60 Minutes (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Years of Potential Life Lost, Rate (per 100,000 Pop.)	University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2008-10.
Youth Without Recent Dental Exam (Percentage)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.

Appendix F: List of Community Leaders and Their Credentials

The following leaders were consulted for their expertise in the community. They were identified based on their professional expertise and knowledge of target groups*, including children, youth, older adults, low-income populations, minorities, and the medically underserved. The coalition included leaders from health systems including the Alameda and Contra Costa Counties' Public Health Departments, local hospital and health care agency leaders and representatives, local government employees, appointed county government leaders, school districts, and nonprofit organizations. *For a description of members of the community who participated in focus groups, please see Section 6 "Resident Input."*

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
County Health/Public Health	Alameda County Public Health	Epidemiologist	Public health	Leader	1, 2, 3	Interview	06/24/15
County Health/Public Health	Alameda County Public Health	Deputy Director	Public health	Leader	1, 2, 3	Interview	08/27/15
County Health/Public Health	Alameda County Public Health Department,	Nutritionist	Healthy eating/ active living	Representative	1, 3	Interview	09/08/15

* Target group represented:
1: Public health knowledge/expertise
2: Federal, tribal, regional, state, or local health departments/agencies
3: Represent target populations: a) medically underserved, b) low-income, c) minority

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
	Healthy Living for Life						
County Health/Public Health	Alameda County Public Health/Health Care Services	Medical Director	Public health	Leader	1, 2, 3	Interview	08/10/15
County Health/Public Health	Alameda County Public Health/Health Care Services	Director, Public Health Officer	Public health	Leader	1, 2, 3	Interview	08/10/15
Education	Health Pathways, Oakland Unified School District	Director	Education, child health	Leader	1, 3	Interview	09/03/15
Education	Health Pathways, Oakland Unified School District	Coordinator, Health Access/School-Based Health Centers	Education, child health	Leader	1, 3	Interview	09/03/15
Local Health	Citizens for Better Community	Dentist, Health Committee Chair	Minority	Leader, Member	1, 3	Focus group	09/02/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Local Health	Kaiser Permanente	Associate Physician	Minority	Leader, Member	1, 3	Focus group	09/02/15
Local Health	Kaiser Permanente	Psychiatrist	Minority	Leader, Member	1, 3	Focus group	09/02/15
Local Health	Tiburcio Vasquez Health Center	Chief Executive Officer	Low-income, underserved	Leader	1, 3	Interview	08/31/15
Local Health	Tri-City Health Center	Development Officer	Low-income, underserved	Leader	1, 3	Interview	10/19/15
Local Health	Tri-City Health Center	Chief Executive Officer	Low-income, underserved	Leader	1, 3	Interview	10/19/15
Local Health	U.S. Department of Veterans Affairs, Martinez Outpatient Clinic	Caregiver Support Coordinator	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Local Health	Washington Hospital Healthcare System	Emergency Services Administrator	Public health, low-income, underserved	Representative	1, 3	Interview	09/18/15
Local Health	Washington Hospital	Continuing Care Coordinator	Mental health	Representative	1, 3	Interview	10/14/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
	Healthcare System						
Local Health	Washington's Womens' Center	Clinic Coordinator	Low-income, underserved, women	Leader	1, 3	Interview	10/01/15
Local Health	Washington's Womens' Health Specialists	Obstetrician-Gynecologist	Low-income, underserved, women	Leader	1, 3	Interview	10/01/15
Non-Profit	Abode Services	Executive Director	Access to care, low-income, homelessness	Leader	3	Interview	09/23/15
Non-Profit	American Lung Association	Regional Advocacy Director	Tobacco policy, minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	American Red Cross Northern California Coastal Region	Director, International Services and Service to the Armed Forces	Veterans	Leader	3	Focus group	9/23/15
Non-Profit	Armed Forces Services Corporation	Financial Coach	Veterans	Leader	3	Focus group	9/23/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Non-Profit	Canine Guardians Assistance Dogs	Trainer	Veterans, disabilities	Leader	1, 3	Focus group	9/23/15
Non-Profit	Canine Guardians Assistance Dogs	Executive Director	Veterans, disabilities	Leader	1, 3	Focus group	9/23/15
Non-Profit	Citizens for Better Community	Treasurer	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	Davis Street Family Resource Center	Executive Director	Low-income, underserved	Leader	3	Interview	08/24/15
Non-Profit	East Bay Community Recovery Project	Case Manager/ Housing Specialist	Veterans, housing	Leader	1, 3	Focus group	9/23/15
Non-Profit	Employment Development Department, Eden Area Multiservice Center	Veteran Representative	Veterans, employment	Leader	3	Focus group	9/23/15
Non-Profit	Filipinos 4 Justice	Youth Services Director	Minority	Leader, Member	3	Focus group	09/02/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Rep-resentative/ Member	Target Group Repre-sented*	Consul-tation Method	Date Consul-ted (2015)
Non-Profit	Filipinos 4 Justice	Youth Counselor	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15
Non-Profit	National Alliance on Mental Illness	Mentor	Mental health	Representative	3	Focus group	08/20/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
Non-Profit	Rotary Club Fremont	Past President, International Services Committee Chair	Minority	Leader, Member	3	Focus group	09/02/15
Non-Profit	SAVE (Safe Alternatives to Violent Environments)	Director of Programs	Safety/violence	Leader	3	Interview	10/08/15
Non-Profit	The Coming Home Project	Clinical Coordinator	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Non-Profit	Tri-City Elder Coalition	Karen Grimsich, Administrator, Aging & Family Services	Older adults	Leader	3	Interview	08/04/15
Non-Profit	U.S. Department of Veterans Affairs, Oakland Vet Center	Counselor	Veterans, mental health	Leader	1, 3	Focus group	9/23/15
Non-Profit	Veterans Yoga Project	Founder & Executive Director	Veterans, mental health	Leader	1, 3	Focus group	9/23/15

Sector	Organization	Title	Focus Population/ Topic/ Expertise	Target Group Role (Leader/ Representative/ Member	Target Group Represented*	Consultation Method	Date Consulted (2015)
N/A	Centro De Servicios	N/A	Immigrant population	Members (10)	3	Focus group	09/18/15

Appendix G: CHNA Focus Group and Key Informant Interview Protocols

Professionals (Providers) Focus Group Protocol

Introductory remarks

- Welcome and thanks
- What the project is about:
    - We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
    - Identifying unmet health needs in your community, extending beyond patients.
    - Ultimately, to invest in community health strategies that will lead to better health outcomes.
- Why we're here *(put on flipchart page)*:
    - Learn about health needs in your community.
    - Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment.
    - Talk about impact of various other things that influence health.
    - Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed.

What we'll do with the information you tell us today

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all focus group discussions will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Focus Group Questions

1. Community Health Needs & Prioritization

When your local hospitals did their Community Health Needs Assessments in 2013, these are the health needs that came up. (Using a list based on all of the needs identified by any hospital. List is at end of protocol.) *(Show list on flipchart page.)*

a. We'd like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on this list that should be added. *(Write them on the list.)*
   i. Overall?
   ii. Specific needs for groups by gender, age, ethnicity, geography, etc.?

Define unmet health needs: Needs that are not being addressed very well. For example, maybe we don't know how to prevent these problems, or we don't have enough medicines or treatments, or maybe there aren't enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

b. Please think about the top three from the list (including the added needs, if any) you believe are the most important to address in your community – the needs that still need attention.

   You'll find some sticky colored dots on the table; once you've decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

   We will discuss your ideas on how these might be able to be addressed later in our conversation.

c. Any particular subpopulations that are disproportionately affected? *(Prompt for ethnic minorities, LGBTQ, low-income population, urban vs. rural/geographically isolated, etc.)* Any other trends you are seeing in the past 5 years or so? How are the needs changing? We will discuss your ideas on how these might be able to be addressed later in our conversation.

2. Access to Care

We would like to get your perspective on how access has changed in the post- Affordable Care Act environment.

a) Based on your observations and interactions with the clients you serve, to what extent are your clients aware of how to obtain health care? *(Explain if needed: Where to find a clinic, how to make an appointment, etc.)*

b) To what extent are your clients aware of how to obtain health insurance?

c) What barriers to access still exist? *(Focus on comparison pre- and post-ACA)*
   i. Is the same proportion still medically uninsured/under-insured; or is it a smaller proportion, or a larger proportion than before ACA?
   ii. Do more people, the same, or fewer people have a primary care physician than before ACA?
   iii. Are people using the ER as primary care to the same degree, less, or more than before ACA?
   iv. Is the same proportion of the community facing difficulties affording health care, or is it a smaller proportion, or a greater proportion than before ACA?

d) Now thinking about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

3. Drivers/Barriers

What other drivers or barriers are contributing to the health needs that you prioritized? We will talk about solutions in just a minute.
Prompts if they are having trouble thinking of anything:

- Transportation
- Housing
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

4. Suggestions/Improvements/Solutions

Now that we have discussed the most challenging health needs and issues related to access to care, we are going to ask you about some possible solutions. **For the needs you prioritized earlier…**

a) Are there any policy changes you would recommend that could address these issues?
b) Are there existing assets or resources available to address these needs that people are not using? Why?
c) What other assets or resources are needed?

Resource question prompts, if they are having trouble thinking of anything:

▪ Specific new/expanded programs or services? ▪ Increase knowledge/understanding? ▪ Address underlying drivers like poverty, crime, education? ▪ Facilities (incl. hospitals/clinics)	▪ Infrastructure (transportation, technology, equipment) ▪ Staffing (incl. medical professionals) ▪ Information/educational materials ▪ Funding ▪ Collaborations and partnerships ▪ Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- The final Community Health Needs Assessment Report will be published in approximately March 2016 on all of the hospitals' websites

Residents (Non-Professionals) Focus Group Protocol

Introductory remarks

- Welcome and thanks
- What the project is about:
    - We are helping the non-profit hospitals in your area conduct a Community Health Needs Assessment, required by the IRS and the State of California.
    - Identifying unmet health needs in your community, extending beyond patients.
    - Ultimately, to invest in community health strategies that will lead to better health outcomes.
- Why we're here *(put on flipchart page)*:
    - Learn about health needs in your community.
    - Understand your perspective on healthcare access in the post-Affordable Care Act/Obamacare environment.
    - Talk about impact of various other things that influence health.
    - Hear from you what community assets that you are already aware of can help with health needs, and what community assets might still be needed.

What we'll do with the information you tell us today

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all focus group discussions will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Focus Group Questions

1. Community Health Needs & Prioritization

When your local hospitals did their Community Health Needs Assessments in 2013, these are the health needs that came up. (Using a list based on all of the needs identified by any hospital. List is at end of protocol.) *(Show list on flipchart page.)*

a. We'd like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on this list that should be added. *(Write them on the list.)*
   i. Overall?
   ii. Specific needs for groups by gender, age, ethnicity, geography, etc.?

Define unmet health needs: Needs that are not being addressed very well. For example, maybe we don't know how to prevent these problems, or we don't have enough medicines or treatments, or maybe there aren't enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

b. Please think about the top three from the list (including the added needs, if any) you believe are the most important to address in your community – the needs that still need attention.

   You'll find some sticky colored dots on the table; once you've decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

   We will discuss your ideas on how these might be able to be addressed later in our conversation.

2. Access to Care

We are interested in hearing from you about your experiences accessing health services in your community.

a) First, a little about health insurance:
   i. Have any of you enrolled in health insurance in the last two years…
      - For the first time?
      - After a lapse in insurance?
   ii. What has kept you from enrolling, or from getting better coverage?

b) Now, some questions about the "coverage" (benefits) that you do have:
   i. Do you have more or better insurance "coverage" than you had two years ago, or is it the same, or worse?
   ii. Are you more likely now, than you were two years ago, to visit a primary care doctor instead of ER or urgent care; or are you just as likely as before; or less likely?

c) What prevents you from getting the health care you need?

d) Now thinking about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

3. Drivers/Barriers

What else is influencing the health needs that you prioritized? We will talk about solutions in just a minute.

Prompts if they seem to be having trouble coming up with anything:
- Transportation
- Housing or the built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms

- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

4. Suggestions/Improvements/Solutions

Now that we have identified the most challenging health needs impacting your community, as well as your experiences in accessing health services, we would like to ask you about some possible solutions. **For the needs you prioritized earlier…**

a) Are there existing assets or resources available to address these needs that people are not using? Why?
b) What other assets or resources are needed?

Resource question prompts if they are having trouble coming up with anything:

▪ Specific new/expanded programs or services? ▪ Increase knowledge/understanding? ▪ Address underlying drivers like poverty, crime, education? ▪ Facilities (incl. hospitals/clinics)	▪ Infrastructure (transportation, technology, equipment) ▪ Staffing (incl. medical professionals) ▪ Information/educational materials ▪ Funding ▪ Collaborations and partnerships ▪ Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- The final Community Health Needs Assessment Report will be published in approximately March 2016 on all of the hospitals' websites
- *Collect surveys*
- *Pass out incentives and get signed receipts*

Key Informant Interview Protocol

Introduction

What the project is about:

- We are helping the non-profit hospitals in Alameda and Contra Costa Counties conduct a Community Health Needs Assessment, required by the IRS and the State of California.
- Identifying unmet health needs in our community, extending beyond patients.
- Ultimately, to invest in community health strategies that will lead to better health outcomes.

You were chosen to be interviewed for your particular perspective on health in your community ("regarding [topic]" – *if chosen for special topic and not overall perspective on health, identify here*).

What we'll do with the information you tell us today:

- Your responses will be summarized and your name will not be used to identify your comments.
- Notes and summary of all interviews will go to the hospitals.
- The hospitals will make decisions about which needs their individual hospitals can best address, and how the hospitals may collaborate or complement each other's community outreach work.

Preamble

Our questions mainly relate to:

1. Health needs
2. Healthcare access in the post-Affordable Care Act environment
3. Other challenges contributing to health needs
4. Suggestions/solutions (both in terms of policies and in terms of local resources)

Interview questions

1. Background

First, please tell me a little about your current role and the organization you work for.

2. Health needs

Next, we would like to get your opinion on the top health needs among those you serve.

a) In your opinion, which health needs do you believe are the most important to address among those you serve/your constituency?

b) In your opinion, what are the health needs that are not being met very well right now among those you serve/your constituency?

c) Are there any specific groups that have greater health needs, or special health needs?
   i. Differences by gender
   ii. Within specific ethnic groups
   iii. Among different age groups like seniors or children
   iv. Within different parts of the county
   v. Any other specific groups

If they identified more than three health needs, ask question d; if not, go on to section 3.

d) Which would you say are the most urgent or pressing of all the health needs that you've named?

3. Challenges: Access to healthcare – post-ACA

We would like to get your perspective on how access has changed in the post- Affordable Care Act environment.

a) Based on your observations and interactions with the clients you serve, to what extent are clients aware of how to obtain health care? *(Explain if needed: Where to find a clinic, how to make an appointment, etc.)*
b) To what extent are clients aware of how to obtain health insurance?
c) What barriers to access still exist? *(Focus on comparison pre- and post-ACA)*
   i. Is the same proportion still medically uninsured/under-insured?
   ii. Do more people or fewer people have a primary care physician?
   iii. Are people using the ER as primary care to the same degree?
   iv. Is the same proportion of the community facing difficulties affording health care?
d) Now thinking specifically about the mental health needs in your community, what keeps people from getting the prevention and/or early intervention mental health/counseling services they need?

4. Other Challenges

Are there any other drivers or barriers that are contributing to health needs? We will talk about solutions in just a minute.

Prompts if they are having trouble thinking of anything:

- Transportation
- Housing
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- SES (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

5. Suggestions/Improvements/Solutions

Now that we have discussed health needs and issues related to access to care, we are going to ask you about some possible solutions. **In order to maintain or improve the health of your community…**

a) Are there any policy changes you would recommend that could address these issues? Consider those that are readily achievable and politically feasible.
b) Are there existing resources available to address these needs? If so, why aren't people using them?
c) What other resources are needed?
d) Of the resources/solutions to improve health, which do you feel is the most significant improvement needed, second, and third?

Resource question prompts if they are having trouble thinking of anything:

▪ Specific new/expanded programs or services? ▪ Increase knowledge/understanding? ▪ Address underlying drivers like poverty, crime, education? ▪ Facilities (incl. hospitals/clinics)	▪ Infrastructure (transportation, technology, equipment) ▪ Staffing (incl. medical professionals) ▪ Information/educational materials ▪ Funding ▪ Collaborations and partnerships ▪ Expertise

Concluding Remarks

- Thanks for your time and sharing your perspective
- Confidential notes and summary of discussions to client
- Reminder about what will be done with the information
- Final CHNA report will be published in Spring 2016 on all of the hospitals' websites

Alameda/Contra Costa Counties Health Needs 2013

Access to preventative, primary, and specialty care (e.g., geography, language, cost, insurance eligibility)
Active living (increased exercise & activity)
Asthma (prevention/management)
Delivery of preventative, primary, and specialty care (e.g., quality of services, coordination of care)
Dental care (access to services)
Economic security (poverty)
Education/vocational training programs
Health literacy/health education (incl. adequate Spanish/other lang. capacity, health resources) and appropriate referral
Healthy eating (affordable healthy food, abundance of fast food, food insecurity, nutrition)
Mental health (services affordable, local)
Parenting skills & support
Peri-natal care (Black populations)
Pollution/clean environment (air, waste, etc.)
Substance abuse (treatment services affordable, local)
Transportation (safe, reliable, accessible)
Violence (safe environment, violence prevention, outdoor safety, safe places to be active)

Appendix H: Community Assets & Resources

The following resources are available to respond to the identified health needs of the community.

Overall:

Existing Healthcare Facilities

- John Muir Health
- Kaiser Permanente – Diablo (Antioch and Walnut Creek)
- Kaiser Permanente – East Bay (Oakland and Richmond)
- Kaiser Permanente – Greater Southern Alameda (Fremont and San Leandro)
- Saint Rose Hospital
- San Ramon Regional Hospital
- Stanford Health Care – ValleyCare
- UCSF Benioff Children's Hospital – Oakland
- Washington Hospital

Existing Clinics

- Abode Services: HOPE Project Mobile Health Clinic
- Highland Hospital and Clinics
- India Community Center
- Newark Wellness Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- Washington on Wheels Mobile Health Clinic
- Washington Township Medical Foundation
- Winton Wellness Clinic

Other Existing Community Resources and Programs

The following community resources and programs are listed by health need.

Asthma
▪ Tri-City Medical Services ▪ Washington Hospital and Healthcare Services

Behavioral Health
▪ Abode Services: Greater HOPE (Homeless Outreach and People Empowerment) ▪ Abode Services: HOPE Project Mobile Health Clinic ▪ Abode Services: STAY (Supportive Housing for Transitional Aged Youth) ▪ ACBHCS - Crisis Response Program ▪ ACBHCS - Geriatric Assessment & Response Team ▪ ACBHCS - Tri-City Children's Outpatient Services ▪ ACBHCS - Tri-City Community Support Center ▪ Alameda County Housing and Community Development Shelter + Care ▪ BACS - Adult Day Care Services ▪ Building Opportunities for Self-Sufficiency (BOSS) - Behavioral Healthcare Transitional Housing ▪ BOSS - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward ▪ Cal-SAFE - Tri-City Cal-SAFE Program ▪ Centro de Servicios ▪ Child, Family and Community Services (CFCS) - Burke Cal-SAFE Program ▪ CFCS - Southern Alameda County Early Head Start and Head Start ▪ Christian Counseling Centers, Inc. Fremont Christian Counseling Center ▪ EYFC - New Start Tattoo Removal ▪ Family Paths – 24-hour Parent Support Hotline ▪ Family Paths – Counseling Services ▪ FCHSD – Fremont Senior Center ▪ FCHSD – Youth and Family Services ▪ Filipino Advocates for Justice - Youth Development ▪ Fremont Hospital ▪ Fremont Hospital – 23-Hour Behavioral Crisis Assessment ▪ Fremont Hospital – Acute Inpatient Care Program ▪ Fremont Hospital – Chemical Dependency Intensive Outpatient Program ▪ HARPD – Matt Jimenez Community Center ▪ Kidango, Inc. – Early Head Start/Head Start Programs

Behavioral Health
▪ Kidango, Inc. – Mental Health ▪ Kidango, Inc. – Special Needs/Early Intervention Services ▪ La Familia - Outpatient Counseling Program ▪ Multi Lingual Counseling Center, Inc. ▪ Pregnancy Choices Clinic ▪ Safe Alternative to Violent Environments (SAVE) - 24-Hour Crisis Line ▪ SAVE - Emergency Shelter ▪ SAVE - Individual Counseling and Support Group ▪ Schuman-Lilies Clinic Fremont ▪ Second Chance – Anger Management ▪ Second Chance – Hayward Center ▪ Second Chance – Newark Center ▪ Seneca Center for Children and Families - Public School-Based Outpatient Counseling for HUSD ▪ South Hayward Parish – Hayward Community Action Network ▪ Terra Firma Diversion/Educational Services – Court Ordered Adult Diversion Programs ▪ Terra Firma Diversion/Educational Services - Domestic Violence and Anger Management Classes ▪ Tiburcio Vasquez Health center - School based health services – Logan Health Center ▪ Tiburcio Vasquez Health Center - School based health services – Tennyson Health Center ▪ Tiburcio Vasquez Health Center: Behavioral Health Center ▪ Tri-City HIV/AIDS Care and Treatment Program ▪ Tri-City Women's Services ▪ USG – Department of Veterans Affairs (VA) - Fremont Outpatient Clinic ▪ Victory Outreach - Prison Counseling and Services; Residential Rehab Program - Hayward ▪ Washington Hospital Healthcare System - Health Connection

Cancer
▪ Cancer Prevention Institute Of California CPIC - Cancer Detection Program: Every Woman Counts Call Center

Cardiovascular Disease and Stroke
▪ ACMC: Winton Wellness Center ▪ Eden Youth and Family Center - Hayward Day Labor Center ▪ Tri-City Medical Services ▪ Washington Hospital and Healthcare Services ▪ Washington on Wheels Mobile Health Clinic

Maternal and Infant Health
▪ St. Rose Hospital – Silva Pediatric Medical Clinic

Obesity, Diabetes, and Healthy Eating/Active Living
▪ ACPHD - WIC ▪ BACS - Adult Day Care Services ▪ BOSS - Short-term Special Needs Housing: South County Homeless Project (Mental Health) – Hayward ▪ Centro de Servicios ▪ CFCS - Southern Alameda County Early Head Start and Head Start ▪ City of Newark - Senior Center for Adults ages 55+ ▪ Eden Youth and Family Center - Hayward Day Labor Center ▪ FCHSD - Fremont Senior Center ▪ Kidango, Inc. - Early Head Start/Head Start Programs ▪ LIFE Eldercare, Inc. - Meals on Wheels ▪ Salvation Army - Tri-Cities Corps Community Center - USDA Commodity and Food Programs ▪ Second Chance - Emergency Shelter ▪ South Hayward Parish - Emergency Food Pantry ▪ South Hayward Parish - Hayward Community Action Network ▪ South Hayward Parish - Senior Meal Site ▪ Tri-City Free Breakfast Program ▪ Tri-City Medical Services ▪ TVHC - WIC ▪ Viola Blythe Community Service Center of Newark ▪ Washington Hospital and Healthcare Services ▪ Washington Hospital Healthcare System - Diabetes Program ▪ Washington on Wheels Mobile Health Clinic

Violence and Injury Prevention
▪ Safe Alternatives to Violent Environments (SAVE) ▪ Washington Hospital Tattoo Removal Program