Sutter Health

SUTTER DELTA MEDICAL CENTER

2019 Community Health Needs Assessment

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Actionable Insights, LLC

- Melanie Espino, Co-Founder and Principal
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1. Executive Summary

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The Patient Protection and Affordable Care Act (ACA), which was enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) every three years. The CHNA must be done by the last day of a hospital's taxable year, and hospitals must make the CHNA report widely available to the public. The CHNA must also include input from experts in public health, local health departments, and the community. The community must include representatives of minority, low-income, medically underserved, and other high-need populations.[1]

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development that shall include, but not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals shall describe the process by which they involved community groups and local government officials in helping identify and prioritize the needs to be addressed. This community needs assessment shall be updated at least once every three years.[2]

The 2019 CHNA is the third such assessment completed since the ACA was enacted. It builds upon the information and understanding that resulted from previous assessments. The latest CHNA process, completed in fiscal year 2019 and described in this report, was conducted collaboratively by 14 local hospitals in Alameda and Contra Costa counties ("the Hospitals") in compliance with current legal requirements.

The 2019 CHNA will serve as the basis for implementation strategies that are required to be filed with the IRS as part of the hospital organization's 2019 Form 990, Schedule H, four and a half months into the next taxable year.[2]

PROCESS AND METHODS

The Hospitals began work on the 2019 CHNA in the spring of 2018. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs.

Community input was obtained during the summer and fall of 2018 through key informant interviews with local health experts and focus groups with community leaders, representatives, and residents. Secondary data were obtained from a variety of sources. (*See Attachment 4: Secondary Data Sources for a complete list*.) Secondary data were collected for Contra Costa County as a whole and, in many

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

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

cases, also for the county's eastern subregion—Sutter Delta Medical Center's primary service area—separately. (*See map on page 12.*)

In November 2018, the Hospitals identified health needs by synthesizing primary qualitative research (community input) and secondary quantitative data (statistics), and then filtering those needs against a set of criteria. Needs were then prioritized by using a second set of criteria. (*See Section 6: Identification and Prioritization of Community Health Needs for details.*) In January 2019, Sutter Health, John Muir Health, and Kaiser Permanente convened a meeting with key leaders in Contra Costa County, including representatives from the Bay Area Regional Health Inequities Initiative, Community Clinic Consortium, Contra Costa County Office of Education, Contra Costa Health Services (the public health department), and East Bay Community Foundation. Meeting participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs. The results of the prioritization appear below.

For the purposes of this assessment, the Hospitals did not limit the definition of "community health" to traditional measures. Historically, health assessments have focused on statistics related to specific ailments or medical conditions such as asthma, cancer, diabetes, heart disease, and stroke. Although these data are significant, they do not take into account factors that influence health. For this CHNA, the Hospitals also considered various social and environmental determinants of health, including access to healthcare, affordable housing, child care, education, and employment. This broader approach reflects Sutter Delta Medical Center's view that many factors influence people's health, and it is essential to consider these factors to adequately understand and address the community's health needs.

2019 PRIORITIZED HEALTH NEEDS

Based on the previously described prioritization process, a ranked list of the most pressing community health needs for Sutter Delta Medical Center's service area emerged. These nine health needs, listed in priority order (from highest to lowest),[3] are:

- **Behavioral Health.** The community prioritized behavioral health, which refers to both mental health and substance use, as its top health need. Depression and stress were the most common issues raised in interviews and focus groups with local residents, health experts, and service providers. Mental health statistics underscore the community's concerns: A significantly higher percentage of adults in Contra Costa County, compared to the state, have recently taken regular prescription medication for an emotional or mental health issue. Among seventh graders, school bullying is significantly worse in Contra Costa County than the state average, and ethnic disparities exist across multiple mental health indicators for youth. The co-occurrence of mental health and substance use came up in many community discussions. Opioid prescription drug claims are higher in Eastern Contra Costa County than the benchmark. In addition, marijuana, alcohol, and other drug use is highest among Latinx youth.[4]
- **Economic Security.** This health need consists of employment issues and homelessness risk. In focus groups, residents emphasized that local jobs often do not pay enough to afford the high cost of living and that people earning low wages are among those who can least afford to miss work to see a doctor. Statistics show that many residents struggle financially. In Eastern Contra

[3] Behavioral Health and Economic Security tied for first place. They're at the top of the list in alphabetical order.

[4] The term "Latinx" is employed as a gender-neutral way to refer to Latin American and Hispanic individuals of any race.

Costa County, the percentage of the population enrolled in government assistance programs is substantially higher than the state average, and the percentage of adults with at least some post-secondary education is significantly lower. Additionally, disparities exist among ethnic groups in educational attainment, the rate of uninsured individuals, and people living in poverty.

- **Housing and Homelessness.** The community ranked safe and healthy housing as a high priority. Contra Costa County data reveal various issues: The median rent is significantly higher than the state average—and has been increasing. Possibly due to high cost of rent, the proportion of children living in crowded housing has been increasing as well. Poor housing quality is associated with childhood asthma prevalence and asthma-related emergency room visits; child and youth asthma diagnoses and hospitalizations are significantly higher in Contra Costa County than the state benchmark. With regard to homelessness, the 2017 Point-in-Time count recorded 137 people experiencing homelessness in Antioch, second only to Concord (188 people) among cities in Contra Costa County. Overall, the county's population experiencing homelessness is disproportionately White.
- **Healthcare Access and Delivery.** The community expressed strong concerns about this health need, including the affordability of care and the lack of access to specialty care, especially for Medi-Cal patients. Statistics show that a larger proportion of Contra Costa County residents have delayed or have had difficulty obtaining care than the state average. The ratio of Federally Qualified Health Centers to residents is significantly worse locally than the California benchmark. A significantly larger percentage of Contra Costa County adults had a recent ER visit compared to the state average. Poor access to healthcare is associated with higher rates of many health conditions—including asthma, cancer, and heart disease/stroke—because it precludes preventive screenings and early treatment. Asthma hospitalizations overall, and for children separately, are significantly worse in Contra Costa County than the average state rates. Further, the percentage of residents in the local area who smoke tobacco, which can aggravate asthma, is higher than the state average. Asthma can also be exacerbated by pollution; the local area has a significantly higher density of roads than the state average. And, although air quality measures are better than the state, asthma prevalence among adults in the local area is significantly worse than benchmarks. Cancer incidence rates (breast, colorectal, lung, and prostate) are worse in Eastern Contra Costa County than the state benchmarks. Locally, cancer mortality is much higher among African American residents**,** and somewhat higher among White residents, than the state benchmark. Local African American residents are less likely to have been screened for breast cancer (i.e., have had a mammogram) than the White residents. Stroke hospitalizations and deaths in Eastern Contra Costa County exceed the benchmarks; local African American residents disproportionately die from stroke compared to residents of other ethnicities.
- **Education and Literacy.** Limited literacy is correlated with low educational attainment, which is in turn associated with poor health outcomes. The proportion of local fourth graders who read at or above proficiency is significantly lower than the state average. Additionally, student truancy is higher in Contra Costa County than the state average. Ethnic disparities are evident: African American and Latina girls have significantly higher rates of teen pregnancy than girls of other ethnicities, which can interrupt or end their educational trajectory. African American youth are also overrepresented among high school dropouts compared to students of other ethnicities.

- **Healthy Eating/Active Living.** This health need combines access to food and recreation, food insecurity, diabetes, obesity, and nutrition, diet, fitness. The community expressed concerns that culturally appropriate health education may be lacking in Contra Costa County. Statistically, there are fewer grocery stores and produce vendors per capita in the Eastern Contra Costa County than the state benchmark. The percentage of the local population receiving SNAP benefits is substantially higher than the state average. A greater proportion of local youth are physically inactive than the state average, and youth obesity is significantly higher in the local area as well. In addition, the countywide rate of diabetes hospitalization among children and youth exceeds the state average.
- **Community and Family Safety.** Community and family safety ranked as one of the top health needs in Contra Costa County. With regard to intentional injury, focus group and interview participants most frequently talked about domestic violence, violent crime, and unsafe neighborhoods. Participants worried most about children and youth, especially when it came to being bullied (online and in-person), becoming victims of violence, and acting out trauma. Some participants also indicated that human trafficking is a growing problem in Antioch. With regard to accidents, the county's rates of children and youth being hospitalized for both poisoning and traumatic injury (intentional and unintentional) significantly exceed state benchmarks. The rate of fatalities from firearms (intentional or unintentional) also surpasses the state average.
- **Transportation and Traffic.** Many CHNA participants discussed transportation as a barrier to seeing the doctor and getting to work. They expressed frustration with the costs and limitations (such as the lack of frequency or service) of public transportation, particularly BART, which is not widely accessible in Eastern Contra Costa County despite the extension of the Pittsburg line. A significantly smaller proportion of local residents live within half a mile of a public transit stop, compared to other state residents. Commutes by car can also wear on residents; a significantly greater proportion of local area commuters drive alone to work more than 60 minutes in each direction.
- **Climate/Natural Environment.** Feedback from the community about the environment primarily concerned poor air quality, which was attributed to pollution and identified as a driver of asthma. Residents indicated that local refineries were a cause of air pollution (e.g., refinery fires). Road network density contributes to greater traffic, which can increase air pollution; Eastern Contra Costa County has a significantly higher density of roads than the state average. Trees can mitigate the effects of air pollution and heat; however, tree canopy coverage is lower in the local area than the state average.

For additional details, including statistical data and sources, see Section 7: Summarized Descriptions of 2019 Prioritized Health Needs and the data tables found in Attachment 5: Secondary Data Tables.

NEXT STEPS

After making this CHNA report publicly available by December 31, 2019, Sutter Delta Medical Center will solicit feedback and comments about the report until two subsequent CHNA reports have been posted.[5] The hospital will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by May 15, 2020.

[5] https://www.sutterhealth.org/for-patients/community-health-needs-assessment

2. Background

In 2018, 14 local hospitals in Alameda and Contra Costa counties ("the Hospitals") collaborated for the purpose of identifying critical health needs of the community. Sutter Delta Medical Center worked with its partners to conduct an extensive community health needs assessment (CHNA). The 2019 CHNA builds upon earlier assessments conducted by the Hospitals.

PURPOSE OF CHNA REPORT AND AFFORDABLE CARE ACT REQUIREMENTS

The Affordable Care Act (ACA) provided guidance at a national level for CHNAs for the first time when enacted on March 23, 2010. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a community health needs assessment every three years. The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. Final requirements were published in December 2014.

Traditionally, health needs assessments have studied data on mortality, morbidity, and health risks related to specific diseases or conditions, such as asthma, cancer, diabetes, heart disease, and stroke. The ACA expanded the scope of "community health needs assessment" to include social determinants of health, such as access to healthcare, affordable housing, child care, education, and employment. This broader approach reflects Sutter Delta Medical Center's view that many factors influence people's health, and it is essential to consider them all in order to adequately understand and address the community's health needs.

Beyond providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream health influences. For example, the ACA created more incentives for healthcare providers to focus on disease prevention by lowering or eliminating co-payments for preventative screenings. Through the ACA, funding has also been established to support community-based prevention (efforts to stop people from having an illness or health condition) and early intervention (detecting and mitigating conditions in their earliest stages).

SB 697 AND CALIFORNIA'S HISTORY WITH PAST ASSESSMENTS

California Senate Bill 697, enacted in 1994, requires private nonprofit hospitals to conduct a community needs assessment and to consult with the community on a plan to address their identified health needs. An assessment must be conducted every three years. Hospitals are also required to submit an annual report to the California Office of Statewide Health Planning and Development that describes the strategies that hospitals engaged in to address the identified community needs.

The 2019 CHNA meets both state and federal requirements.

BRIEF SUMMARY OF THE 2016 CHNA CONDUCTED

Sutter Delta Medical Center's 2016 CHNA report is posted on the Community Benefit page of the Sutter Health's website.[6]

The community health needs identified and prioritized through the 2016 CHNA process were:

1. Access to Quality Primary Care Health Services
2. Access to Affordable, Healthy Food
3. Access to Basic Needs, such as Housing and Employment
4. Access to Mental, Behavioral, and Substance Abuse Services
5. Safe and Violence-Free Environment
6. Health Education and Health Literacy
7. Access to Transportation and Mobility
8. Access to Specialty Care

WRITTEN PUBLIC COMMENTS ON THE 2016 CHNA

Community feedback on Sutter Delta Medical Center's 2016 CHNA report was solicited on Sutter Health's website. At the time the 2019 CHNA report was completed, Sutter Delta Medical Center had not received any written comments about the 2016 CHNA report. The hospital will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate staff.

Sutter Delta Medical Center welcomes comments from the public on the 2019 Community Health Needs Assessment. Written comments on any CHNA report may be submitted by:

- Emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org
- Sending a letter via U.S. mail to the hospital's address: 3012 Summit Street, 3rd Floor, Oakland, CA 94609, ATTN: Community Benefit.
- Leaving a note in-person at the hospital's Information Desk.

[6] https://www.sutterhealth.org/pdf/for-patients/chna/sdmc-2016-chna.pdf

3. About Sutter Delta Medical Center

Sutter Delta Medical Center, part of the Sutter Health network, is a nationally ranked acute care facility located in Antioch. Sutter Delta's roots in Eastern Contra Costa County date back 40 years.

Sutter Delta implements the most advanced technologies and recruits top-notch physicians, so it can offer an array of outstanding inpatient and outpatient services. That means patients and their loved ones don't have to leave the community to receive high-quality care.

COMMUNITY BENEFIT

Community benefit programs and activities provide treatment and/or promote health and healing as a response to community needs; they are not provided for marketing purposes.

Community benefit:

- Generates a low or negative financial return
- Responds to needs of special populations, such as people living in poverty and other disenfranchised individuals
- Supplies services or programs that would likely be discontinued—or would need to be provided by another not-for-profit or government provider—if the decision was made on a purely financial basis
- Responds to public health needs
- Involves education or research that improves overall community health

COMMUNITY SERVED

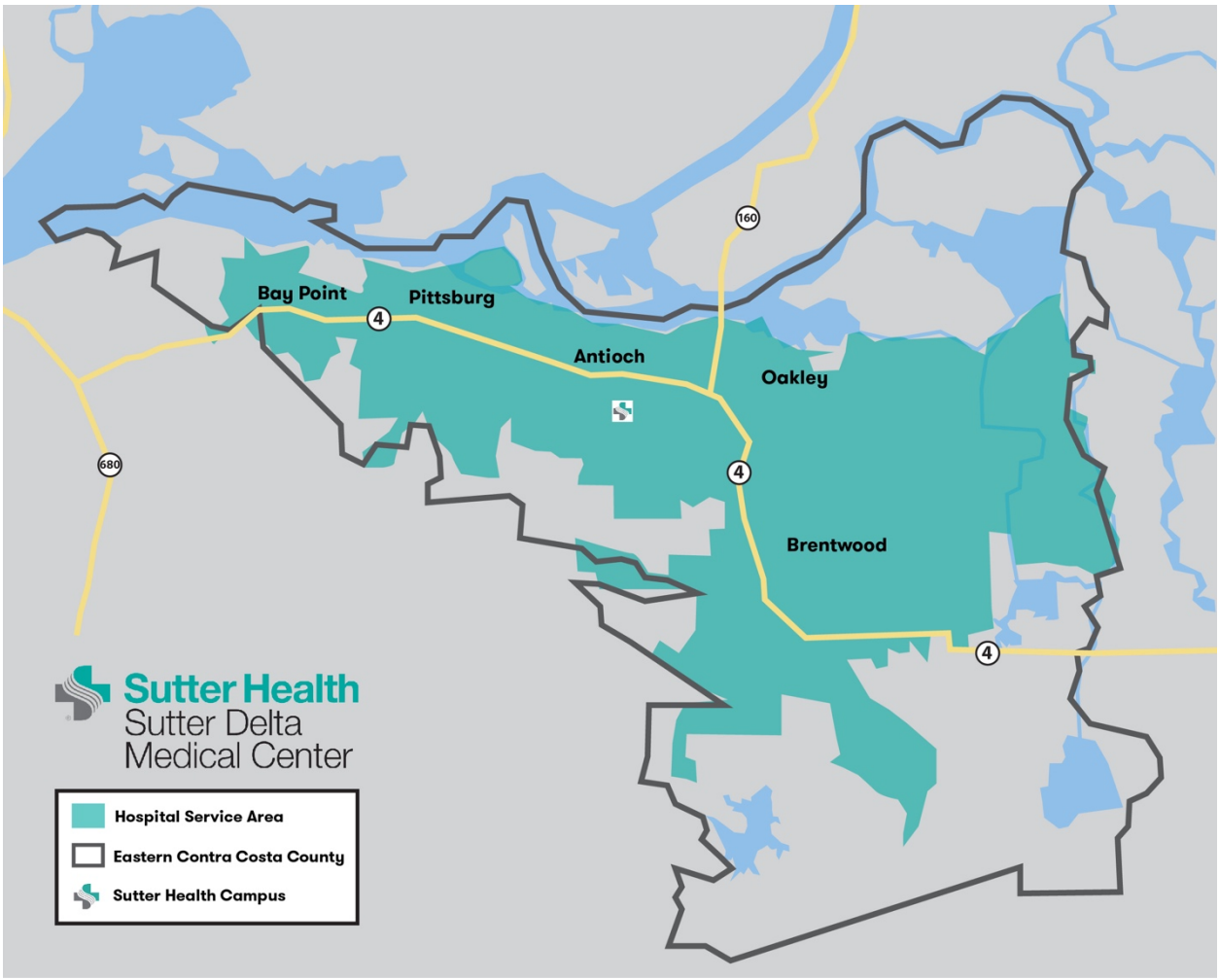
The Internal Revenue Service defines the community served as individuals who live within the hospital's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

Sutter Delta Medical Center is located in the city of Antioch in Eastern Contra Costa County. Sutter Delta Medical Center's hospital service area includes six ZIP codes surrounding the hospital and its neighboring communities.[7] As previously noted, the medical center collaborated on the 2019 CHNA with other healthcare facilities serving the Eastern Contra Costa County region. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, which include the cities of Antioch, Bay Point, Brentwood, Byron, Discovery Bay, Knightsen, Oakley, and Pittsburg.

The map (Figure 1) on the next page shows the alignment of the Eastern Contra Costa County region with Sutter Delta Medical Center's service area.

[7] Sutter Delta Medical Center's service area covers ZIP codes 94509, 94513, 94531, 94548, 94561, and 94565.

FIGURE 1. SUTTER DELTA MEDICAL CENTER SERVICE AREA MAP, EASTERN CONTRA COSTA COUNTY



DEMOGRAPHICS

The U.S. Census estimates a population of 318,900 in the Eastern Contra Costa County (E-CCC) area. The two largest ethnic subpopulations are White and Latinx in both the E-CCC area (36 percent and 35 percent, respectively) and Contra Costa County as a whole (46 percent and 25 percent, respectively). The E-CCC area is highly diverse (Table 1): About 36 percent of the population is White, about 35 percent of residents are Latinx, and about 13 percent are African American. Residents of multiple races account for 5 percent of area residents. Nearly one in four Contra Costa County residents is foreign-born.[8]

[8] U.S. Census Bureau. (2017). American Community Survey, 5-Year Estimates, 2013–2017.

TABLE 1. DEMOGRAPHICS, EASTERN CONTRA COSTA COUNTY

Ethnicity		Socioeconomic Data	
Total Population	318,900	Living in poverty (<100% federal poverty level)	12.7%
White	35.9%	Children in poverty	18.0%
Latinx[9]	34.6%	Unemployment	3.1%
African American	13.1%	Uninsured population	9.6%
Asian	10.2%	Adults with no high school diploma	15.0%
Pacific Islander/Native Hawaiian	0.7%		
Native American/Alaska Native	0.4%		
Some other race	0.2%		
Multiple races	5.0%		

Percentages do not add to 100% because they overlap. Source: U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

Income has a significant impact on health outcomes. The median household income in Contra Costa County is about $83,000, higher than California (about $66,000) and neighboring Alameda County (about $80,000).[10] As shown in the chart (Figure 2) on the next page, 34 percent of the Contra Costa County population lives in households with incomes of $100,000 or more, 28 percent in households with incomes between $50,000 and $100,000, and 38 percent below $50,000. By comparison, the 2018 Self-Sufficiency Standard for a two-adult family with two children in Contra Costa County was about $102,900.[11]

Despite the fact that one third of households in the county earn more than $100,000 per year (Table 1), nearly 13 percent of E-CCC residents live below 100 percent of the federal poverty level.[12] In addition, 18 percent of the children in E-CCC are below the federal poverty level. Approximately 10 percent of people in E-CCC are uninsured.

Housing costs are high: The 2018 median home price is about $624,000, and the median rent is $2,749 per month in Contra Costa County.[13]

[9] The term "Latinx" is employed as a gender-neutral way to refer to Latin American and Hispanic individuals of any race.

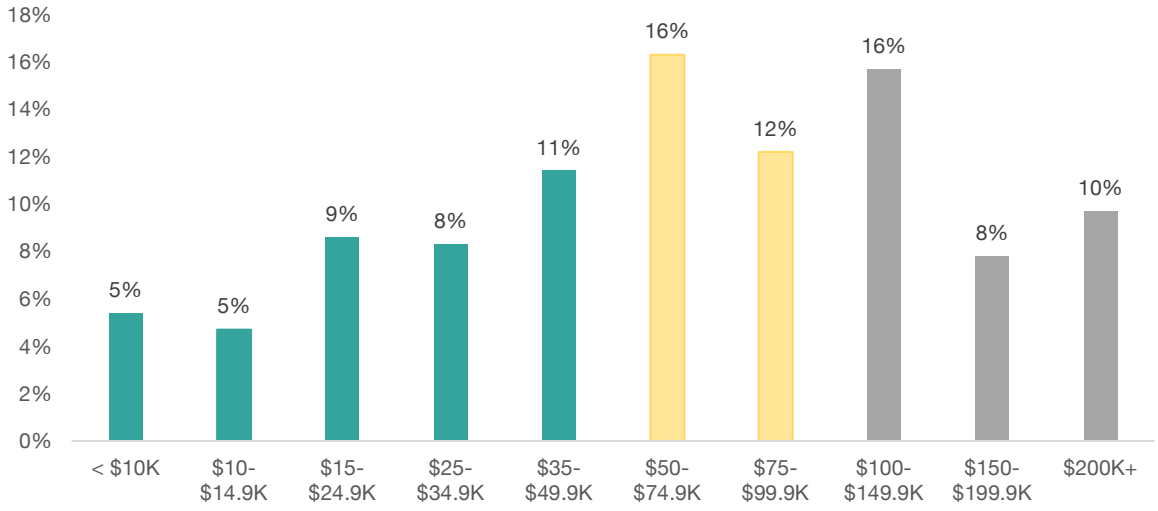
[10] U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012-2016.

[11] The Insight Center for Community Economic Development. (2018). *Self-Sufficiency Standard Tool.* Retrieved December 2018 from https://insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california/

[12] U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

[13] Zillow, data through November 30, 2018: https://www.zillow.com

FIGURE 2. HOUSEHOLDS BY INCOME RANGE, CONTRA COSTA COUNTY



Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2013–2017. Table S1901.

AREA DEPRIVATION INDEX

For 20 years, the U.S. Health Resources and Services Administration has used the Area Deprivation Index (ADI) to gauge the lack of basic necessities in communities. The ADI measures social vulnerability by combining 17 indicators of socioeconomic status, including income, employment, education, and housing conditions. The ADI has been linked to health outcomes such as 30-day hospital readmission rates, cardiovascular disease death, cervical cancer incidence, cancer deaths, and all-cause mortality.

The ADI is a standardized score, with 100 being the mean. Most—more than 99 percent—of U.S. communities score between 40 and 160. The ADI score of 43 for the Eastern Contra Costa County area[14] was calculated using Census Block Group level data (Table 2).[15] The most deprived census tracts are shown in **dark orange** in the map (Figure 3) on page 16. Based on the ADI score, the area was determined to be in the 49th percentile. (Percentiles range from 0 to 100, with an ADI percentile of 50 indicating the national midpoint.) In general, the higher the percentile, the greater the deprivation. The exceptions are home value, monthly home costs, and gross rent, where a lower percentile indicates higher costs.

The 17 indicators that make up the index, along with the value for Eastern Contra Costa County and for California as a whole, appear on the next page (Table 2). For most indicators, a lower score and percentile is desired. Area percentiles and indicator values that are worse than those of California are noted in **bold red**.

[14] For the ADI and percentile scores only, the Eastern Contra Costa County area comprises the cities/towns of Antioch, Bay Point, Brentwood, Byron, Discovery Bay, Knightsen, Oakley, Pittsburg, and includes the following ZIP codes: 94509, 94513, 94514, 94531, 94561, and 94565.

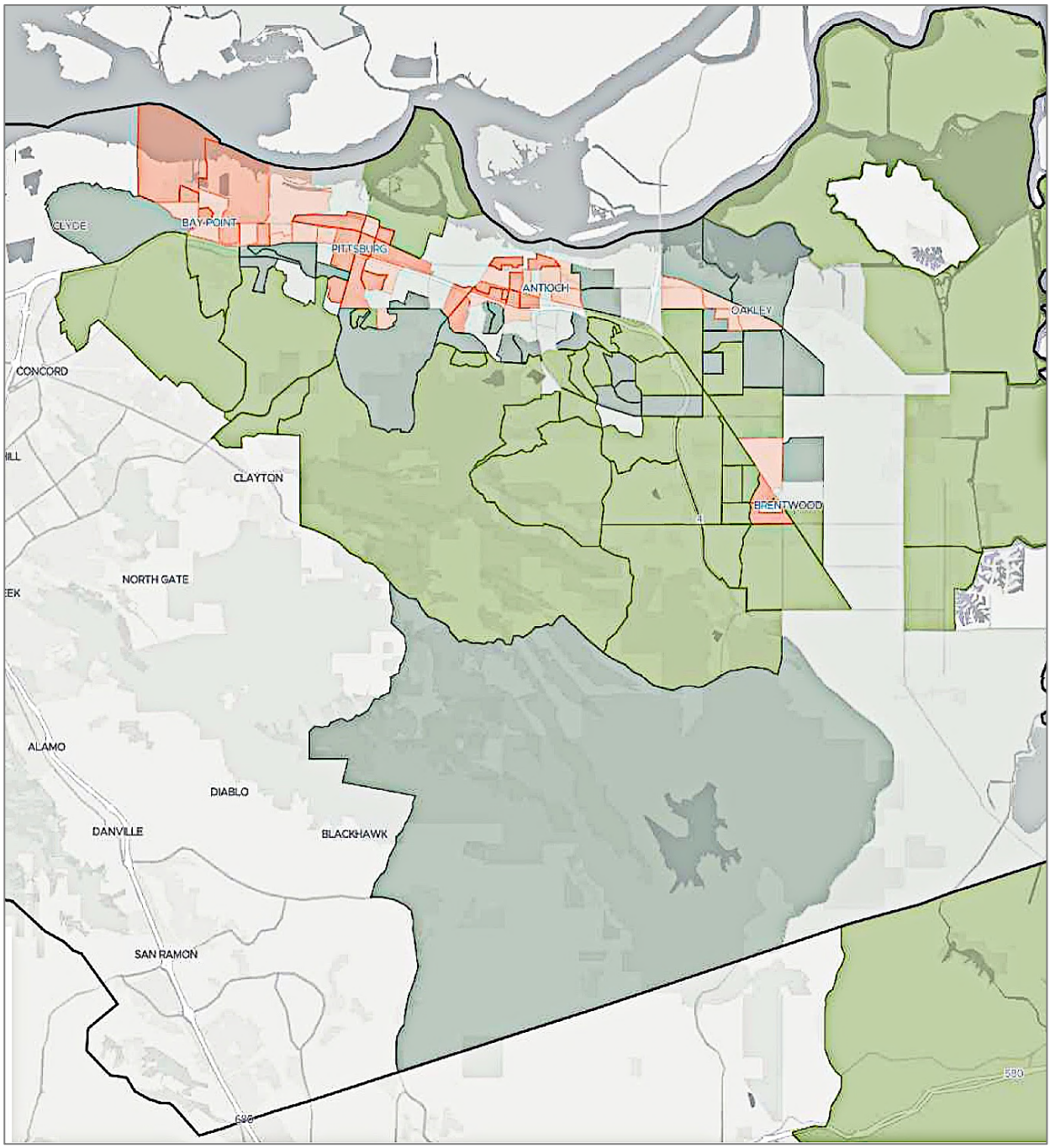
[15] A Census Block Group is smaller than a Census Tract, but larger than a Census Block. In urban areas, a Census Block is generally equivalent to a city block, but in suburban and rural areas may be defined by the Census in other ways. A Census Block Group encompasses multiple, usually contiguous, Census Blocks. (U.S. Census Bureau. 2018. Geography Program Glossary.)

Table 2. Area Deprivation Index, Eastern Contra Costa County

Indicator	E-CCC Percentile	E-CCC Value	CA Percentile	CA Value
Area Deprivation Index	**43**	**95.1**	**49**	**98.1**
Families below poverty level	59	10.3%	64	11.9%
Owner-occupied housing units	58	63.3%	68	54.1%
Households without a motor vehicle	53	5.4%	62	7.5%
Crowded households (>1 person per room)	83	6.1%	89	8.3%
Households without complete plumbing	30	0.3%	52	0.4%
Households without a telephone	53	1.8%	59	2.2%
Income disparity (log scale)	31	1.9	36	2.2
Median family income	29	$79,856	32	$74,913
Median gross rent	**9**	**$1,579**	17	$1,313
Median home value	22	$315,018	11	$441,468
Median monthly home cost	17	$1,758	20	$1,768
Population below 150% of poverty threshold	49	21.1%	59	25.9%
Single parent households with children < age 18	**81**	**34.5%**	67	23.8%
High school diploma/GED, adults ≥ age 25	68	84.3%	74	81.9%
Less than high school education, adults ≥ age 25	78	8.2%	84	10.0%
Unemployment ≥ age 16	**72**	**9.8%**	68	8.9%
Employed in white collar occupations, ≥ age 16	**57**	**55.3%**	47	60.5%

Source: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017) and Census Block Group level data (BroadStreet 2018).

Figure 3. Area Deprivation Index Map, Eastern Contra Costa County



Source: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017), and Census Block Group level data (BroadStreet 2018).

4. Assessment Team

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

Community benefit managers from Sutter Delta Medical Center and two other local hospitals in Eastern Contra Costa County ("the E-CCC Hospitals") contracted with Actionable Insights in 2018 to conduct the Community Health Needs Assessment in 2019.

The hospitals that partnered with Sutter Delta Medical Center in Eastern Contra Costa County were:

- John Muir Health
- Kaiser Foundation Hospital–Antioch

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights (AI), LLC, an independent local research firm, completed the CHNA. For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the process of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for over 25 hospitals during the 2018–2019 CHNA cycle. More information about AI is available on its website.[16]

[16] http://actionablellc.com/

5. Process and Methods

The Eastern Contra Costa County ("the E-CCC Hospitals") worked in collaboration on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over seven months and culminated in separate reports written for each of the E-CCC Hospitals in the spring of 2019. The phases of the process are depicted below.

SECONDARY DATA COLLECTION

AI analyzed over 180 quantitative health indicators to assist the E-CCC Hospitals in understanding the health needs and assessing their priority in the community. AI collected data from existing sources using the Community Commons[17] data platform and other online sources such as the California Department of Public Health and the U.S. Census Bureau. The decision to include these additional data was made, and these data were collected, by the E-CCC Hospitals. The E-CCC Hospitals, as a group, determined that these additional data would bring greater depth to the CHNA in their community. When trend data and/or data by ethnicity were available, they were reviewed to enhance understanding of the issue(s).

As a further framework for the assessment, the E-CCC Hospitals—in collaboration with other healthcare facilities in Alameda and Contra Costa counties ("the Hospitals")—requested that AI address the following questions in its analysis:

- How do these indicators perform against accepted benchmarks (Healthy People 2020 objectives and statewide averages)?
- Are there disparate outcomes and conditions for people in the community?

Healthy People, an endeavor of the U.S. Department of Health and Human Services, provides 10-year national objectives for improving the health of Americans. Based on scientific data spanning 30 years, these national objectives serve as targets for improvement. The most recent set of objectives is for the year 2020 (HP2020). Year 2030 objectives are currently under development.[18]

For details on specific sources and dates of the data used, see Attachment 4: Secondary Data Sources, and Attachment 6: Secondary Data Indicators Index.

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

[18] U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov

INFORMATION GAPS AND LIMITATIONS

A lack of secondary data limited AI and the E-CCC Hospitals in their ability to fully assess some of the identified community health needs. Information gaps and limitations included:

- Adult use of illegal drugs and misuse/abuse of prescription medications (opioids, etc.)
- Alzheimer's disease and dementia diagnoses
- Breastfeeding practices at home
- Community infrastructure (sewerage, electrical grid, etc.) adequacy
- Data broken out by Asian subgroups
- Diabetes among children
- Experiences of discrimination among vulnerable populations
- Health of undocumented immigrants
- Hepatitis C
- Mental health disorders
- Oral/dental health
- Suicide among LGBTQ youth

COMMUNITY INPUT

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

Primary research protocols generated by AI in collaboration with the Hospitals in Alameda and Contra Costa counties were based on facilitated discussion among the hospitals' representatives about what they wished to learn during the 2019 CHNA. The Hospitals sought to build upon prior CHNAs by focusing the primary research on the community's perception of mental health (identified as a major health need in the 2016 CHNA) and their experience with healthcare access and delivery (also identified as a major health need in 2016). Relatively little timely quantitative data exist on these subjects.

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

Through the key informant interviews and focus groups, AI solicited input from 37 residents and 43 community leaders and representatives. The leaders and representatives worked either in the health field or in community-based organizations focused on improving health and quality of life conditions by serving those from IRS-identified high-need populations.[19] Contra Costa Health Services (the public health department) facilitated the focus groups and provided input into the protocols.

See Attachment 2: Community Leaders, Representatives, and Members Consulted for their names, titles, and expertise of along with the date and mode of consultation (focus group or key informant interview). See Attachment 1: Qualitative Research Protocols for protocols and questions.

[19] The IRS requires that community input include the low-income, minority, and medically underserved populations.

KEY INFORMANT INTERVIEWS

Between June and August 2018, AI conducted primary research via key informant interviews with 16 local and/or regional experts from various organizations. These experts included individuals from the public health department, community clinic managers, and clinicians. Interviews were conducted in person or by telephone for approximately one hour. AI asked:

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

FOCUS GROUPS

Input From Professionals and Community Leaders

Three focus groups were conducted with a total of 27 professionals and community leaders in August and September 2018. The questions were the same as those used with key informant interviewees.

TABLE 3. DETAILS OF FOCUS GROUPS WITH PROFESSIONALS

Topic or Population	Focus Group Host/Partner	Date	Number of Participants
Professionals who serve individuals living in poverty	Multifaith Action Coalition	8/14/2018	7
Central and Eastern Contra Costa County community-based organizations	Kaiser Foundation Hospital–Walnut Creek	8/27/2018	13
Eastern Contra Costa County community-based organizations	Kaiser Foundation Hospital–Antioch	9/17/2018	7

Input From Residents

Four resident focus groups were conducted with a total of 37 residents in August and September 2018 (Table 4). The discussions centered around the same five questions asked of the key informant interviewees, which AI modified appropriately for each audience. Nonprofit hosts such as Loaves & Fishes recruited participants for the groups. To provide a voice to the community, and in alignment with IRS regulations, the focus groups targeted residents who are medically underserved, low-income, or of a minority population.

Table 4. Details of Focus Groups With Residents

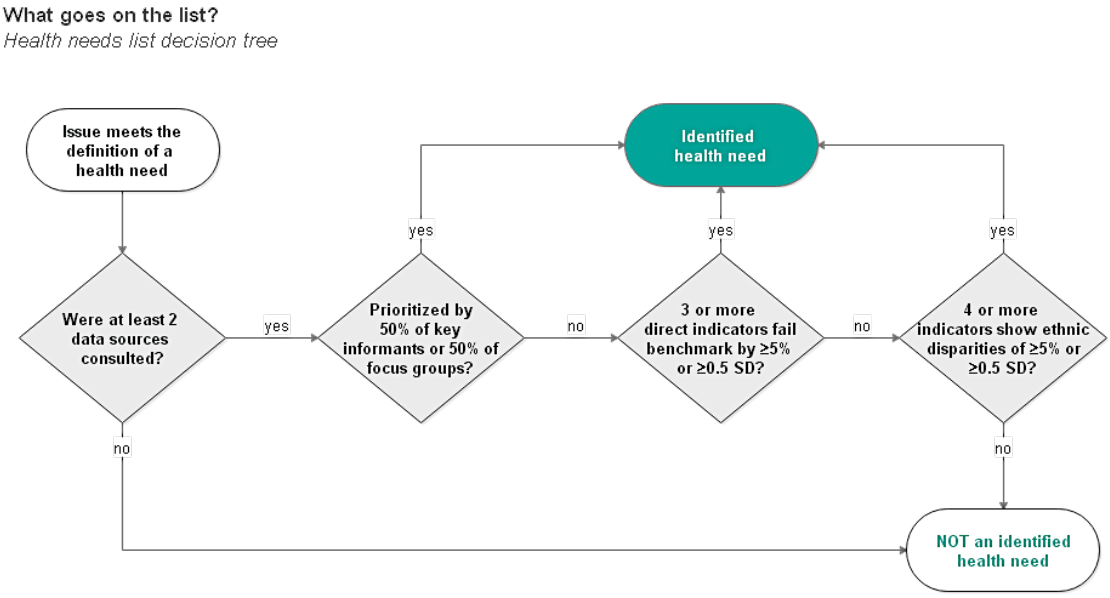
Population	Focus Group Host/Partner	Date	Number of Participants
Individuals experiencing homelessness or housing instability	Loaves & Fishes	8/6/2018	9
Individuals of minority, low-income, and/or re-entry status	Rubicon Programs – Antioch	8/29/2018	5
Young adults, ages 18–25	Los Medanos College	8/30/2018	14
Older adults	Stoneman Village	9/17/2018	9

6. Identification and Prioritization of Community Health Needs

PROCESS OF IDENTIFYING COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced. In order to be identified as one of the community's prioritized health needs, an issue had to meet certain criteria, as depicted in Figure 4. (*For terms and definitions, see the Legend below the diagram and the Definitions box on the next page.*)

FIGURE 4. COMMUNITY HEALTH NEEDS IDENTIFICATION CRITERIA



LEGEND

- A **benchmark** is either the California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.
- A **data source** is either a statistical data set, such as those found throughout the California Cancer Registry, or a qualitative data set, such as the material resulting from the interviews and focus groups that were conducted for the Hospitals.
- A **direct indicator** is a statistic that explicitly measures a health need. For example, the lung cancer incidence rate is a direct indicator of the cancer health need, while the percentage of the population that currently smokes cigarettes is not a direct indicator of the cancer health need.

CRITERIA

1. Meets the definition of a "health need." (*See Definitions box at right.*)
2. At least two data sources were consulted.
3. a. Prioritized by at least half of key informant interviewees or focus groups.
   b. If not (a), three or more direct indicators fail the benchmark by ≥5% or show a ≥0.5 standard deviation.
   c. If not (b), four or more indicators must show ethnic disparities of ≥5% or a ≥ 0.5 standard deviation.

Actionable Insights (AI) analyzed information (including qualitative data from focus groups and key informant interviews) on a variety of issues, then synthesized that information and applied the criteria described above to evaluate whether each issue qualified as a prioritized community health need.

In 2019, this process led to the identification of nine health needs that fit all three criteria. The list of needs, in priority order, appears on the next page.

For more information about each health need, including statistical data and sources, see Attachment 5: Secondary Data Tables.

DEFINITIONS

Health condition: A disease, impairment, or other state of physical or mental 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. May be a social determinant of health.

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

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

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

PROCESS OF PRIORITIZING COMMUNITY HEALTH NEEDS

The IRS Community Health Needs Assessment (CHNA) requirements state that hospital facilities must identify and prioritize significant health needs of the community. As described in Section 5: Process and Methods, qualitative input was solicited from focus group and interview participants about which needs they thought were the highest priority (most pressing). The E-CCC Hospitals used this input to identify the significant health needs listed in this report. Therefore, the health needs list itself reflects the health priorities of the community.

In January 2019, John Muir Health, Kaiser Permanente, and Sutter Health collaboratively convened a meeting with key leaders in Contra Costa County, including representatives from Bay Area Regional Health Inequities Initiative, Community Clinic Consortium, Contra Costa County Office of Education, Contra Costa Health Services, and East Bay Community Foundation. At the meeting with these representatives, Actionable Insights presented the results of the 2019 CHNA to the attendees and facilitated the prioritization of the health needs by the participants.

Participants considered a set of criteria in prioritizing the list of health needs. The criteria chosen by the E-CCC Hospitals before beginning the prioritization process were:

- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Community priority:** This refers to the extent to which the community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. This criterion was ranked by Actionable Insights based on the frequency with which the community expressed concern about each health outcome.
- **Magnitude/scale of the need:** This refers to the number of people affected by the health need.
- **Multiplier effect:** This refers to the idea that a successful solution to the health need has the potential to solve multiple problems.
- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against relevant benchmarks.

Participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs.

The 2019 health needs for Sutter Delta Medical Center, listed in priority order (from highest to lowest),[20] are:

1. **Behavioral Health**
2. **Economic Security**
3. **Housing and Homelessness**
4. **Healthcare Access and Delivery**
5. **Education and Literacy**
6. **Healthy Eating/Active Living**
7. **Community and Family Safety**
8. **Transportation and Traffic**
9. **Climate/Natural Environment**

Summary descriptions of each appear in Section 7: Summarized Descriptions of 2019 Prioritized Health Needs, which starts on the next page.

[20] Behavioral Health and Economic Security tied for first place. They're at the top of the list in alphabetical order.

7. Summarized Descriptions of 2019 Prioritized Health Needs

BEHAVIORAL HEALTH

Behavioral health, which includes mental health and substance use, is one of the strongest priorities of the community. The community prioritized behavioral health as a top health need for the East Bay in over half of all focus groups and key informant interviews.

Mental Health

What Is the Issue?

While there is no single definition, researchers agree that the minimum elements of well-being include: having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing life satisfaction, fulfillment, and "positive function." Well-being looks beyond happiness to include one's ability to:[21]

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

Mental health—emotional and psychological well-being, along with the ability to cope with normal, daily life—is key to personal well-being, healthy relationships, and the ability to function in society.[22] Mental health and the maintenance of good physical health are closely related. Common mental health disorders such as depression and anxiety can affect one's ability for self-care. Likewise, chronic diseases can lead to negative impacts on an individual's mental health.[23] Mental health issues affect a large number of Americans. The Mayo Clinic estimates that roughly 20 percent of the adult U.S. population in 2015 was coping with a mental illness.[24]

Why Is It a Health Need?

Behavioral health is one of the needs about which the community expressed the strongest concerns. Depression and stress were the most common issues raised. Focus group participants and key informant interviewees in Contra Costa County discussed the co-occurrence of mental health and substance use conditions. The community identified trauma and adverse childhood experiences (ACEs) as drivers of behavioral health problems. A number of participants described the impact of

[21] Centers for Disease Control and Prevention. (2016). *Health-Related Quality of Life: Well-Being Concepts*.

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

[23] Lando, J., & Williams, S. (2006). A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion. *Preventing Chronic Disease.* 2006 Apr; *3*(2): A61.

[24] Centers for Disease Control and Prevention. (2018). *Learn About Mental Health*.

discrimination and institutionalized racism as generational trauma, which has contributed to inequitable health outcomes.

Mental health statistics for adults are of concern; selected mental health statistics are shown in Table 5. A significantly larger proportion of adults in the Contra Costa County, compared to the state, need help for mental health issues. Also, a significantly higher percentage of adults in the county, compared to the state, have recently taken regular prescription medication for an emotional or mental health issue. Additionally, social isolation may be a driver for poor mental health; the number of social associations (i.e., social clubs, business and professional associations) per capita in the local area is worse than the benchmark.

Mental health statistics for children and youth suggest a need for an increased focus on addressing the issue. Among seventh graders, school bullying is significantly worse in Contra Costa County than the state average. Children in foster care experience poor mental health at a much higher rate than the general population.[25] In the county, the rate of children in foster care and median time in foster care are both increasing. Moreover, median months in foster care for children is higher in the county than the state median figure.

TABLE 5. SELECTED MENTAL HEALTH STATISTICS

Indicator	Indicator Type	Value	State Avg.
Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)	percent	**18.9**	16.4
Bullied at School, 7th Graders (CCC) (CHKS)	percent	**42.3**	39.4
Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (CCC) (AskCHIS)	percent	**16.0**	11.1
Social Associations (per 10,000) (E-CCC) (CHNA.org)	rate	**3.9**	6.5
Time in Foster Care (Median Months) (CCC) (Kidsdata.org)	number	**17.5**	15.6

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Ethnic disparities exist across multiple mental health indicators for youth (Table 6), including cyberbullying (Pacific Islander youth fare the worst), depression-related feelings (the highest proportion of youth experiencing such feelings are Latinx and Pacific Islander), school connectedness (African American youth feel the least connected), and suicidal ideation (Native American youth fare the worst). Among adults, the rate of suicide in the local area is higher than the benchmark for Whites only. Levels of school connectedness, when low, have been shown to be associated with depression and suicidal ideation.[26]

[25] National Conference of State Legislatures. (2016). *Mental Health and Foster Care.*

[26] See, for example, Joyce, H. D., & Early, T. J. (2014). The Impact of School Connectedness and Teacher Support on Depressive Symptoms in Adolescents: A Multilevel Analysis. *Children and Youth Services Review*, 39, 101–107. See also: Marraccini, M. E., &

Table 6. Selected Mental Health Race/Ethnicity Statistics

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Cyber-Bullied More Than Once (CCC) (CHKS)	percent	#	8.5%	7.7%	6.8%	**10.8%**	8.1%	**9.6%**	**10.2%**	**9.9%**
Depression-Related Feelings (CCC) (CHKS)	percent	#	23.4%	**31.6%**	**24.8%**	**31.2%**	19.2%	20.2%	**28.5%**	**31.4%**
School Connected-ness: Low (CCC) (CHKS)	percent	#	6.5%	**20.5%**	6.4%	**10.4%**	**8.0%**	**11.3%**	**12.0%**	**12.0%**
Seriously Considered Suicide (CCC) (CHKS)	percent	#	15.0%	**29.6%**	**15.8%**	**18.6%**	**16.0%**	**11.7%**	**20.2%**	**16.0%**
Suicide Deaths (E-CCC) (CHNA.org)	rate	10.2 (HP)	**13.1**	6.9	5.6					5.8

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable.
 # Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.
"HP" denotes the Healthy People 2020 aspirational goal.
See Attachment 5 for full descriptions and sources of all indicators.

Brier, Z. (2017). School Connectedness and Suicidal Thoughts and Behaviors: A Systematic Meta-analysis. *School Psychology Quarterly*, *32*(1), 5–21.

Substance Use

What Is the Issue?

The use of substances such as alcohol, tobacco, and other drugs (both legal and illegal) affects not only the individuals using them, but also their families and communities. Smoking cigarettes, for instance, can harm nearly every organ in the body and cause a variety of diseases, including heart disease.[27] Exposure to secondhand smoke can create health problems for nonsmokers.[28] Opioid medications, which are highly addictive pain relievers, have been widely misused and in 2017 were declared the subject of a public health emergency.[29]

Substance use can lead or contribute to other costly social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, auto accidents, and HIV/AIDS.[30] In recent years, advances in research have resulted in effective evidence-based strategies to treat various addictions. Brain imaging technology and the development of targeted medications have helped to shift the perspective of the research community with respect to substance use. Increasingly, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.[31]

Why Is It a Health Need?

Substance use falls within the category of behavioral health. Focus group participants and key informant interviewees across the county discussed the co-occurrence of mental health and substance use conditions. Smoking and lung cancer incidence rates are both significantly higher than benchmarks in Eastern Contra Costa County (Table 7). Additionally, opioid prescription drug claims are higher than the benchmark in the local area. Countywide, the use of marijuana, alcohol, and other drug is highest among Latinx youth (Table 8).

TABLE 7. SELECTED SUBSTANCE USE STATISTICS

Indicator	Indicator Type	Value	State Avg.
Current/Former Smokers, Adults (E-CCC) (CHNA.org)	percent	**15.9**	13.7
Lung Cancer Incidence (E-CCC) (CHNA.org)	rate	**47.4**	44.6
Opioid Prescription Drug Claims (E-CCC) (CHNA.org)	percent	**7.7**	7.0

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

[27] Centers for Disease Control and Prevention, (2018). *Health Effects of Cigarette Smoking.*
[28] American Lung Association. (2017). *Health Effects of Secondhand Smoke.*
[29] U.S. Department of Health and Human Services. (2019). *What Is the U.S. Opioid Epidemic?*
[30] World Health Organization. (2018). *Management of Substance Abuse.*
[31] Office of Disease Prevention and Health Promotion. (2018). *Substance Abuse.*

TABLE 8. SELECTED SUBSTANCE USE RACE/ETHNICITY STATISTICS

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Recent Alcohol/Drug Use – Youth (CCC) (CHKS)	percent	#	23.1%	17.5%	8.0%	18.1%	12.1%	12.8%	20.9%	**24.2%**
Recent Marijuana Use – Youth (CCC) (CHKS)	percent	#	11.6%	**12.3%**	3.6%	10.0%	5.3%	5.9%	**12.4%**	**13.1%**

Values in bold are the least favorable.
 # Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.
See Attachment 5 for full descriptions and sources of all indicators.

ECONOMIC SECURITY

What Is the Issue?

Our health-related behaviors, physical environment, and access to quality healthcare are all determinants of how long and how well we live. The most important determinants of population health, however, are our economic and social environments.[32] Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs.[33] A link exists between higher income and/or social status and better health. Numerous research studies have found that access to government assistance programs such as SNAP (formerly referred to as food stamps) results in better long-term health and social outcomes.[34] As the World Health Organization notes, "the context of people's lives determine[s] their health."

Beneficial social environments are shaped by existence of accessible community resources and safe and socially connected (close-knit) neighborhoods. A secure social support system (families, friends, communities) plays a significant role in healthier populations.[33, 35]

Childhood poverty has long-term effects. Even when economic and social environments later improve, childhood poverty still results in poorer long-term health outcomes.[36] The establishment of policies that positively influence economic and social conditions can improve health for a large number of people in a sustainable fashion over time.[37]

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

[33] Prevention Institute. (2015). *Making the Case with THRIVE: Background Research on Community Determinants of Health.*

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

[35] National Research Council & Institute of Medicine. (2013). Physical and Social Environmental Factors. *U.S. Health in International Perspective: Shorter Lives, Poorer Health.* Woolf, S.H., & Aron, L., editors. Washington, D.C.: National Academies Press.

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

[37] Office of Disease Prevention and Health Promotion. (2018). *Social Determinants of Health.*

Why Is It a Health Need?

In addition to housing, overall economic security was one of the top priorities of the community. With regard to this need, key informant interviewees and focus group participants discussed food insecurity, risk of homelessness, and employment. Residents emphasized that although plenty of jobs may exist in the local area, these jobs do not pay enough considering the high cost of living.

The community made the connection between poverty and poor health outcomes. Focus group participants suggested that people with lower incomes may have a harder time accessing care (*see the Healthcare Access and Delivery description*). A number of participants observed that people working low-wage jobs are among those who can least afford to miss work in order to attend to their health. These participants also cited the stressors of economic instability as one of the most pressing drivers of poor mental health (*see the Behavioral Health description*).

Individuals receiving government assistance must meet low-income thresholds. The percentages of the local-area population enrolled government assistance programs such as SNAP benefits and Medicaid or other public insurance are substantially higher than the state average. Also, the cost of child care for infants and preschoolers is significantly higher in the county than the state average (Table 9).

Presence of sufficient financial institutions in the community is a measure of financial inclusion; these institutions support resident access to the tools and services needed to realize economic stability.[38] There are far fewer banking institutions per capita in Eastern Contra Costa County than in the state overall (Table 9). As noted above, educational attainment is correlated with income. The proportion of adults with at least some post-secondary education, and those with an Associate's Degree or higher are both significantly lower in the local area than the benchmark.

TABLE 9. SELECTED ECONOMIC SECURITY STATISTICS

Indicator	Indicator Type	Value	State Avg.
Adults With an Associate's Degree or Higher, Ages 25+ (E-CCC) (CHNA.org)	percent	**31.0**	39.8
Adults With Some Post-secondary Education, Ages 25–44 (E-CCC) (CHNA.org)	percent	**60.1**	63.6
Banking Institutions (per 10,000) (E-CCC) (CHNA.org)	rate	**1.9**	2.7
Cost of Infant Childcare, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	**14,979**	13,327
Cost of Preschool Childcare, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	**10,895**	9,106
Medicaid/Public Insurance Enrollment (E-CCC) (CHNA.org)	percent	**23.6**	21.8
SNAP Benefits (E-CCC) (CHNA.org)	percent	**10.7**	9.4

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

[38] Community Commons. https://www.communitycommons.org/chna/

There are significant ethnic disparities in economic security among area residents (Table 10). For example, the highest proportion of adults in Eastern Contra Costa County without a high school diploma exist among the Latinx population and people of "Other" ethnicities.[39] The highest proportion of local residents in poverty are African American individuals. More residents of "Other" ethnicities than any other group in the local area are uninsured.

TABLE 10. SELECTED ECONOMIC SECURITY RACE/ETHNICITY STATISTICS

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Adults with No High School Diploma (E-CCC) (CHNA.org)	percent	17.9%	6.3%	6.4%	11.5%	13.7%	**19.8%**	**35.4%**	9.3%	**33.1%**
Children Below 100% FPL (E-CCC) (CHNA.org)	percent	21.9%	8.2%	**27.4%**	12.4%	20.5%	14.1%	**25.0%**	16.0%	21.6%
Population Below 100% FPL (E-CCC) (CHNA.org)	percent	15.8%	7.3%	**20.2%**	9.8%	10.3%	13.3%	**17.3%**	14.9%	**15.8%**
Uninsured Population (E-CCC) (CHNA.org)	percent	12.6%	6.2%	6.3%	7.3%	**14.8%**	**13.9%**	**17.0%**	7.6%	**15.1%**

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

[39] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

HOUSING AND HOMELESSNESS

What Is the Issue?

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care.[40] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.[41] Further, a 2011 study by Children's Health Watch found that "[c]hildren in families that have been behind on rent within the last year are more likely to be in poor health and have an increased risk of developmental delays than children whose families are stably housed."[42]

Homelessness is correlated with poor health in that either poor health can lead to homelessness or homelessness can lead to poor health.[43] People experiencing homelessness have been shown to have more healthcare issues than people who aren't, suffer from preventable illnesses at a greater rate, experience longer hospital stays, and have a greater risk of premature death.[44] A National Health Care for the Homeless study found that the average life expectancy for a person without permanent housing was at least 25 years less than that of the average U.S. citizen.[45]

Why Is It a Health Need?

Maintaining safe and healthy housing was identified as a top community priority. Recent increases in housing costs especially affect renters and those with low and/or fixed incomes. Key informant interviewees and focus group participants strongly linked housing and mental health, indicating that the stress of maintaining housing is negatively impacting families, including children. The community also recognized the connection between housing and physical health, stating that households have spent less on food and medical care due to the increased cost of housing in recent years. The health of those experiencing homelessness was of concern to a wide variety of experts and resident groups as homeless individuals are at greater risk of poor health outcomes.

Professionals and residents described concerns about the increasing number of unstably housed individuals and the displacement of families in the East Bay. Experts cited a lack of strong tenant protections (such as the right to legal counsel)—and a lack of knowledge about protections that may exist—in the community. Focus group participants suggested that the imbalance of jobs and housing (many new jobs, mostly in the knowledge economy, but few new housing units, especially affordable ones) was a major driver of the housing crisis.

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

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

[42] Children's Health Watch. (2011). Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent.

[43] National Health Care for the Homeless Council. (2011). Care for the Homeless: Comprehensive Services to Meet Complex Needs.

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

[45] National Coalition for the Homeless. (2009). *Health Care and Homelessness.*

The median rent in the county is significantly higher than the state average and has been increasing (Table 11). Possibly due to high cost of rent, the proportion of children living in crowded housing has been rising in the county.

Table 11. Selected Housing and Homelessness Statistics

Indicator	Indicator Type	Value	State Avg.
Asthma Diagnoses, Children Ages 1–17 (CCC) (Kidsdata.org)	percent	**16.9**	15.2
Asthma Hospitalizations, Children Ages 0–4 (per 10,000) (CCC) (Kidsdata.org)	rate	**22.7**	19.6
Median Rent, 2 Bedrooms (CCC) (Zilpy)	dollars	**2,390**	2,150

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Poor housing quality (e.g., evidence of leaks, mold, and pests) is associated with childhood asthma prevalence and asthma-related emergency room visits.[46] Child and youth asthma diagnoses, and hospitalizations for asthma among young children (ages 0–4), are significantly higher in Contra Costa County compared to the state (Table 11).

The city of Antioch had 137 individuals experiencing homelessness during the 2017 Point-in-Time count, second only to Concord (188) among cities in Contra Costa County.[47] The population experiencing homelessness in the county is disproportionately White (Table 12).

Table 12. Selected Housing and Homelessness Race/Ethnicity Statistics

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Homeless Population (CCC) (PIT)	percent	#	48%	33%	4%*					22%

Values in bold are the least favorable. Blank cells indicate data were unavailable.
 # Benchmarks not available; comparison category is White.
** Statistic is for Asian/Pacific Islander combined.*
See Attachment 5 for full descriptions and sources of all indicators.

[46] Urban Institute. (2017). The Relationship Between Housing and Asthma Among School-Age Children.
[47] Contra Costa Council on Homelessness. (July 2017). *2017 Point in Time Count: A Snapshot of Contra Costa County*.

HEALTHCARE ACCESS AND DELIVERY

Healthcare access and delivery was a high priority of the community. This need is associated with many different health conditions, including asthma, cancer, and heart disease/stroke.

What Is the Issue?

Access to comprehensive, quality healthcare is important for health and for increasing the quality of life for everyone.[48] Components of access to care include insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include quality, transparency, and cultural competence/cultural humility. Limited access to healthcare and compromised healthcare delivery negatively impact a person's quality of life. As reflected in statistical and qualitative data gathered for the community health needs assessment, barriers to receiving quality care include high cost, lack of appointment availability, lack of insurance coverage, and lack of cultural competence on the part of providers. These barriers lead to unmet health needs, delays in receiving appropriate care, and an inability to attain preventive services.

Why Is It a Health Need?

The community expressed strong concern about healthcare access and delivery. Focus group participants and key informant interviewees discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists (including geriatric care), especially for Medi-Cal patients. Access to behavioral health services was of particular concern; the community indicated that the behavioral health workforce was of insufficient size to adequately address the demand. Lack of access to oral health services was also identified in the local area. The healthcare workforce overall was a topic frequently addressed by professionals, who cited low reimbursement rates for clinicians as a barrier to offering services to Medi-Cal patients.

Many focus group participants and key informant interviewees expressed alarm about healthcare access barriers faced by immigrants who are either ineligible for Medi-Cal due to their immigration status, or fearful of being deported if they should access services for which they are eligible. With regard to healthcare delivery for these populations, the community often identified the need for greater language support, culturally appropriate healthcare services, and whole-person care (i.e., integration of physical and behavioral health care with services that address the social determinants of health). Additionally, experts described the difficulty experienced by LGBTQ residents, especially transgender individuals, in finding medical professionals sensitive to their needs.

A larger proportion of the county's residents delayed or didn't obtain care when compared to the state average (Table 13). Good access to primary care can forestall the need for avoidable emergency room (ER) visits and hospitalizations.[49] The percentage of recent ER visits in Contra Costa County is significantly higher than the state, both overall and specifically for older adults.

The ratio of Federally Qualified Health Centers (FQHCs) to residents is significantly worse in the local area than the state, which can make it tougher for Medicare beneficiaries to access specialty care such

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

[49] Pourat, N., Davis, A. C., Chen, X., Vrungos, S., & Kominski, G. F. (2015). In California, Primary Care Continuity Was Associated with Reduced Emergency Department Use and Fewer Hospitalizations. *Health Affairs*. *34*(7), 1113-1120.

as dental care (Table 13). In addition, the ratio of students to school nurses and to school-based speech, language, and hearing specialists are both much higher (worse) in the county than the state overall.

Table 13. Selected Healthcare Access and Delivery Statistics

Indicator	Indicator Type	Value	State Avg.
Adults Delayed/Didn't Get "Other Medical" Care (CCC) (AskCHIS)	percent	**11.0**	9.8
Federally Qualified Health Centers (E-CCC) (CHNA.org)	rate	**1.0**	2.5
Medicaid/Public Insurance Enrollment (E-CCC) (CHNA.org)	percent	**23.6**	21.8
Premature Death, Racial/Ethnic Disparity Index (E-CCC) (CHNA.org)	number	**46.6**	36.8
Recent ER Visit, Adults (CCC) (AskCHIS)	percent	**24.2**	21.4
Recent ER Visit, Adults 65+ (CCC) (AskCHIS)	percent	**30.4**	22.0
Students per School Nurse (CCC) (Kidsdata.org)	number	**5,393**	2,784
Students per School Speech/Language/Hearing Specialist (CCC) (Kidsdata.org)	number	**1,359**	1,263

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

The percentage of the population in Eastern Contra Costa County enrolled in Medicaid or other public insurance is substantially higher than the state average. More residents of "Other" ethnicities are uninsured than any other group in the local area.

In regard to inequitable health outcomes, the index of premature death based on ethnicity (i.e., premature death for non-Whites versus Whites) is significantly worse in the local community compared to the state (Table 13). Ethnic disparities can also be seen in specific health indicators (Table 14). For example, the rate of diabetes management in the county was lowest, and preventable hospital events were highest, among African American patients.

Table 14. Selected Healthcare Access and Delivery Race/Ethnicity Statistics

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (E-CCC) (CHNA.org)	percent	81.8%	**82.2%**	77.2%						
Preventable Hospital Events (E-CCC) (CHNA.org)	rate	35.9	32.5	**48.5**						
Uninsured Population (E-CCC) (CHNA.org)	percent	12.6%	6.2%	6.3%	7.3%	**14.8%**	**13.9%**	**17.0%**	7.6%	**15.1%**

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable. See Attachment 5 for full descriptions and sources of all indicators.

Asthma and Respiratory Conditions

What Is the Issue?

Respiratory disorders affect a person's ability to breathe. Asthma, chronic obstructive pulmonary disorder (COPD), pneumonia, and lung cancer are among the most common respiratory disorders.[50] Asthma is an inflammation of the airways that causes them to swell and narrow, characterized by episodes of reversible breathing problems.[51] Symptoms range from mild to life-threatening. Asthma attacks can cause a range of issues from simple wheezing to extreme breathlessness.[52] According to the American Lung Association, "the most common risk factors for developing asthma [are] having a parent with asthma, having a severe respiratory infection as a child, having an allergic condition, or being exposed to certain chemical irritants or industrial dusts in the workplace."[53]

[50] U.S. National Library of Medicine. (2018) *Lung Disease.*
[51] The Mayo Clinic. (2018). *Asthma Overview.*
[52] Centers for Disease Control and Prevention. (2018).
[53] American Lung Association. (2018). *Asthma Risk Factors.* 2018.

Why Is It a Health Need?

Asthma ED visits and hospitalizations overall, and asthma hospitalizations for children and youth separately, are worse in the county compared to the state (Table 15). In the county, asthma diagnoses for children/youth are significantly worse than the benchmark and are increasing. Finally, the average cost of asthma hospitalization is significantly higher in the county than the state (Table 15).

TABLE 15. SELECTED ASTHMA STATISTICS

Indicator	Indicator Type	Value	State Avg.
Asthma Diagnoses, Children Ages 1–17 (CCC) (Kidsdata.org)	percent	**16.9**	15.2
Asthma ED Visits, All Ages (per 10,000) (CCC) (CDPH)	rate	**64.6**	49.5
Asthma Hospitalizations, All Ages (per 10,000) (CCC) (Kidsdata.org)	rate	**8.5**	7.6
Asthma Hospitalizations, Children Ages 0–4 (per 10,000) (CCC) (Kidsdata.org)	rate	**22.7**	19.6
Asthma Hospitalizations, Children/Youth Ages 5–17 (per 10,000) (CCC) (Kidsdata.org)	rate	**7.9**	7.7
Asthma Prevalence, Adults (E-CCC) (CHNA.org)	percent	**16.5**	14.8
Average Charge per Asthma Hospitalization (CCC) (CDPH)	dollars	**45,784**	39,860
Road Network Density (road miles per square mile of land) (E-CCC) (CHNA.org)	rate	**4.6**	2.0
Tree Canopy Cover (E-CCC) (CHNA.org)	percent	**7.2**	8.3

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators

Asthma can be exacerbated by pollution. The community identified poor air quality as a driver of asthma. Road network density contributes to greater traffic, which can increase air pollution.[54] The local area has a significantly higher density of roads compared to the state average (Table 15); particulates from traffic can contribute to asthma**.** Although Eastern Contra Costa County's air quality measures are better than the state's, adult asthma prevalence in the local area is significantly worse than the benchmark. Asthma can also be exacerbated by heat. Trees can mitigate heat island effects (e.g., from roads or parking lots); however, tree canopy coverage in the local area is significantly lower than the state average (Table 15). Among various ethnic groups in the county, asthma hospitalizations are highest for African American residents (Table 16).

[54] Community Commons. https://www.communitycommons.org/chna/

TABLE 16. SELECTED ASTHMA RACE/ETHNICITY STATISTICS

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Asthma Hospitalizations, All Ages (per 10,000) (CCC) (CDPH)	rate	7.6	6.3	**26.0**	4.8*					**8.1**

Values in bold are the least favorable. Blank cells indicate that data were unavailable.
** Statistic is for Asian/Pacific Islander combined.*
See Attachment 5 for full descriptions and sources of all indicators.

Cancer

What Is the Issue?

Cancer is a generic term used to describe a condition in which abnormal cells divide uncontrollably, invading and killing healthy tissue. These abnormal cells can metastasize to other parts of the body via the blood and lymph systems. With more than 100 kinds of cancer,[55] it is the second leading cause of death in the U.S., following heart disease.[56] High-quality screening can serve to reduce cancer rates; however, a variety of complex factors contribute to disparities in cancer incidence and death rates among different ethnic, socioeconomic, and otherwise vulnerable groups. While personal, behavioral, and environmental factors are significant (e.g., smoking, exposure to known carcinogens), the most important risk factors for cancer are lack of health insurance and low socioeconomic status.[57]

Why Is It a Health Need?

Incidence rates for some types of cancer (breast, colorectal, lung, and prostate) are worse in the local area than the state (Table 17). Cancer mortality is much higher than the benchmark among the local area's African American population, and somewhat higher among the local White population (Table 18). Locally, the African American population is less likely to have been screened for breast cancer (i.e., have had a mammogram) than the White population.

[55] Centers for Disease Control and Prevention. (2018). *How to Prevent Cancer or Find It Early*.
[56] Centers for Disease Control and Prevention. (2017). *Leading Causes of Death*.
[57] National Cancer Institute. (2018). *Cancer Disparities*.

Table 17. Selected Cancer Statistics

Indicator	Indicator Type	Value	State Avg.
Breast Cancer Incidence, Females (E-CCC) (CHNA.org)	rate	**130.6**	120.7
Colon and Rectum Cancer Incidence (E-CCC) (CHNA.org)	rate	**40.0**	37.2
Lung Cancer Incidence (E-CCC) (CHNA.org)	rate	**47.4**	44.6
Prostate Cancer Incidence (E-CCC) (CHNA.org)	rate	**126.5**	109.2

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

Table 18. Selected Cancer Race/Ethnicity Statistics

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries (E-CCC) (CHNA.org)	percent	59.7%	**64.2%**	56.3%						
Cancer Deaths (E-CCC) (CHNA.org)	rate	147.3	**156.0**	**199.5**	94.6		83.6			117.2

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable.
** Statistic is for Asian/Pacific Islander combined.*
See Attachment 5 for full descriptions and sources of all indicators.

Heart Disease and Stroke

What Is the Issue?

Nationally, some 84 million people suffer from a form of cardiovascular disease.[58] According to the Centers for Disease Control and Prevention, heart disease is the number one killer for both men and women, while stroke is the fifth leading cause of death and a significant cause of serious disability for adults. It is estimated that the current annual direct and indirect costs of cardiovascular disease and stroke are approximately $315 billion and increasing annually.[59, 60] Recent research has established that disparities exist between minority and non-minority cardiovascular health outcomes across the U.S.[61]

Although some risk factors for heart disease and stroke (age, race/ethnicity, gender) are not controllable, others (high blood pressure, high cholesterol, obesity, excessive alcohol consumption, smoking, an unhealthy diet, lack of physical activity) can be controlled. Left untreated, these risk factors can lead to changes in the heart and blood vessels. Over time, those changes can lead to heart attacks, heart failure, strokes, and other forms of cardiovascular disease.[62] Addressing risk factors early in life can help in preventing chronic cardiovascular disease.[63]

Why Is It a Health Need?

Stroke hospitalizations and deaths in the local area exceed the benchmarks (Table 19). Smoking can negatively affect cardiovascular and cerebrovascular health. The percentage of residents in the local area who smoke tobacco is higher than the state average. (*See also the Healthy Eating/Active Living description.*) Locally, African American residents disproportionately die from stroke compared to residents of other ethnicities (Table 20).

TABLE 19. SELECTED HEART DISEASE AND STROKE STATISTICS

Indicator	Indicator Type	Value	State Avg.
Current/Former Smokers, Adults (E-CCC) (CHNA.org)	percent	**15.9**	13.7
Stroke Deaths (E-CCC) (CHNA.org)	rate	**40.1**	35.4
Stroke Hospitalizations, Medicare Beneficiaries (per 1,000) (E-CCC) (CHNA.org)	rate	**7.9**	7.4

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

[58] Johns Hopkins Medicine. (2018). *Cardiovascular Disease Statistics.*
[59] Centers for Disease Control and Prevention. (2017). *Heart Disease Facts.*
[60] Centers for Disease Control and Prevention. (2018). *Stroke.*
[61] Graham, G. (2015). Disparities in Cardiovascular Disease Risk in the United States. *Current Cardiology Reviews, 11*(3): 238–245.
[62] American Heart Association. (2017). *What Is Cardiovascular Disease?*
[63] The Mayo Clinic. (2016). Strategies to Prevent Heart Disease.

TABLE 20. SELECTED HEART DISEASE AND STROKE RACE/ETHNICITY STATISTICS

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Stroke Deaths (E-CCC) (CHNA.org)	rate	35.4	**40.1**	**53.6**	33.1					34.8

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable. See Attachment 5 for full descriptions and sources of all indicators.

EDUCATION AND LITERACY

What Is the Issue?

Literacy is generally understood to mean the ability to read and write, although the term also includes skills related to listening, speaking, and using numbers (numeracy). Limited literacy is correlated with low educational attainment, which is associated with poor health outcomes. Individuals at risk for low English literacy include immigrants, those living in households where English is not spoken, and individuals with minimal education.[64]

Pre-school education is positively associated with readiness for and success in school, as well as long-term economic benefits for individuals and society, including greater educational attainment, higher income, and lower engagement in delinquency and crime.[65] Educational attainment, along with employment rates and household income, are key indicators that show the economic vitality of an area and the buying power of individuals, including their ability to afford basic needs such as housing and healthcare.

The relationships between educational attainment and employment, wages, and health have been well documented. Individuals with at least a high school diploma do better on a number of measures than high school dropouts, including income, health outcomes, life satisfaction, and self-esteem.[66] The National Poverty Center reports that increased education is associated with decreased rates of most acute and chronic diseases.[67] Additionally, research has found that wealth among families in which the head of household has a high school diploma is 10 times higher than that of families in which the head of household dropped out of high school.[68] Moreover, the majority of jobs in the U.S. require more than a high school education.[66]

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[64] Office of Disease Prevention and Health Promotion. (2018). *Language and Literacy.* https://www.healthypeople.gov

[65] Barnett, W.S., & Hustedt, J.T. (2003). Preschool: The Most Important Grade. *Educational Leadership*, *60*(7):54-57.

[66] Insight Center for Community Economic Development. (2014). www.insightcced.org

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

[68] Gouskova, E. & Stafford, F. (2005). Trends in Household Wealth Dynamics, 2001–2003. *Panel Study of Income Dynamics. Technical Paper Series, 05–03.*

Why Is It a Health Need?

A wide variety of key informant interviewees and focus group participants discussed concerns regarding education and academic achievement. Academic achievement came up most often as a driver of economic security related to stable employment and sufficient wages, two components of economic security. The public health expert interviewed described educational attainment as a gateway to self-sufficiency and a major contributing factor to homeownership.

Preschool enrollment is significantly lower in Eastern Contra Costa County compared to the state average (Table 21). The proportion of local fourth graders who are reading at or above proficiency is also significantly lower than the state. Student suspensions exceed the state average. In addition, student truancy is higher in Contra Costa County than the state average.

TABLE 21. SELECTED EDUCATION AND LITERACY STATISTICS

Indicator	Indicator Type	Value	State Avg.
Preschool Enrollment (E-CCC) (CHNA.org)	percent	**44.0**	48.6
Reading At or Above Proficiency (E-CCC) (CHNA.org)	percent	**40.0**	43.9
Students per Academic Counselor (CCC) (Kidsdata.org)	number	**1,014**	792
Suspensions (per 100 enrolled students) (E-CCC) (CHNA.org)	rate	**12.0**	5.9
Teen Births (per 1,000 females ages 15–19) (E-CCC) (CHNA.org)	rate	17.9	29.3
Truancy (per 100 students) (CCC) (Kidsdata.org)	rate	**37.8**	31.4

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Ethnic disparities are evident in education and literacy-related indicators (Table 22). African American and Latina girls have significantly higher rates of teen pregnancy, which can interrupt or end their educational trajectory, than girls of other ethnicities. African American youth are also over-represented among high school drop-outs compared to youth of other ethnicities.

TABLE 22. SELECTED EDUCATION AND LITERACY RACE/ETHNICITY STATISTICS

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
High School Dropout (Adjusted) (CCC) (Kidsdata.org)	percent	10.7%	3.7%	**11.3%**	1.7%				5.7%	8.5%
Teen Births (per 1,000 females ages 15–19) (CCC) (Kidsdata.org)	rate	23.2	4.6	21.9					10.1	**24.3**

Values in bold are the least favorable. Blank cells indicate that data were unavailable.
See Attachment 5 for full descriptions and sources of all indicators.

HEALTHY EATING/ACTIVE LIVING

Healthy eating/active living was identified as a top health need by the community. This need comprises access to food and recreation, food insecurity, diabetes and obesity, and nutrition, diet, and fitness.

Access to Food and Recreation

What Is the Issue?

The U.S. Surgeon General's Vision for a Healthy and Fit Nation 2010 report described how different elements of a community can support residents' healthy lifestyles. The various components of the physical environment, including sidewalks, bike paths, parks, and fitness facilities that are "available, accessible, attractive and safe," all contribute to the extent and type of residents' physical activities.[69] Presence of local stores with fresh produce support healthy eating. Residents are more likely to experience food insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and there are limited transportation/transit options.[70]

The CDC recommends policies and environments that support behaviors aimed at achieving and maintaining healthy weight in settings such as workplaces, educational institutions, healthcare facilities, and communities.[71] For example, the availability of healthy and affordable food in retail and cafeteria-style settings allows individuals to make better food choices throughout the day. Otherwise, people may settle for caloric foods of low nutritional value.[72]

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[69] Centers for Disease Control and Prevention. (2009). *Healthy Places*.
[70] Healthy People 2020. (2018). *Food Insecurity.*
[71] Healthy People 2020. (2015). *Nutrition and Weight Status*
[72] Centers for Disease Control and Prevention. (2015). *Healthy Food Environments*.

Why Is It a Health Need?

Focus group participants cited a lack of safe public spaces and community centers where residents can engage in recreational activities and exercise. Although some neighborhoods have parks, many of them are not used because residents fear becoming victims of crime. Some parks lacked appropriate exercise equipment, while others offered no programs to encourage or teach residents to exercise.

Parents specifically mentioned the lack of free exercise and sports programs as a barrier to physical activity for children. One interviewee connected the long commutes to work experienced by many residents of Eastern Contra Costa County with the lack of time to exercise; together, these factors were described as possibly contributing to the low local demand for exercise programs.

With regard to food access, residents described difficulty accessing grocery stores that carry fresh food, the preponderance of fast food restaurants, and their dismay with the unhealthy food served at schools and provided by food banks. Access to healthy food stores is significantly lower in the local area compared to the state average (Table 23). Further, there are fewer grocery stores and produce vendors per capita in the local area compared to the state (Table 23).

TABLE 23. SELECTED ACCESS TO FOOD AND RECREATION STATISTICS

Indicator	Indicator Type	Value	State Avg.
Grocery Stores and Produce Vendors (E-CCC) (CHNA.org)	rate	**1.5**	2.4
Low Access to Healthy Food Stores (E-CCC) (CHNA.org)	percent	**19.8**	13.4

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

Food Insecurity

What Is the Issue?

Food insecurity is defined as the "lack of consistent access to enough food for an active, healthy life."[73] Hunger and food insecurity are related but distinct concepts; hunger is the physical discomfort related to "prolonged, involuntary lack of food," while food insecurity refers to a "lack of available financial resources for food at the household level."[74, 75] Measurements of various levels of food insecurity, from marginal to low or very low, include anxiety about food insufficiency, household food shortages, reduced "quality, variety, or desirability" of food, diminished nutritive intake, and "disrupted eating patterns."[75]

In 2017, approximately one in eight Americans experienced food insecurity, of which more than one third were children.[74] Individuals who are food-insecure may be more likely to experience various poor health outcomes/health disparities, including obesity. Children who experience food insecurity are also at

[73] U.S. Department of Agriculture, Economic Research Service. (2018). *Food Security in the U.S.*
[74] Feeding America. (2018). *What Is Food Insecurity?*
[75] U.S. Department of Agriculture, Economic Research Service. (2018). *Definitions of Food Security.*

greater risk for developmental complications and/or delays compared to children who are food-secure. In addition, food insecurity may have a detrimental impact on children's mental health.[76]

Why Is It a Health Need?

Community participants specifically mentioned food insecurity, and often expressed the perception that healthy food is more expensive than fast food and packaged foods.

The percentage of the Eastern Contra Costa County residents receiving SNAP benefits is substantially higher than the state average (Table 24). Among them, the groups most likely to receive SNAP benefits are African Americans and Pacific Islanders (Table 25). Among all students, African American students are least likely to have eaten breakfast.

Table 24. Selected Food Insecurity Statistics

Indicator	Indicator Type	Value	State Avg.
SNAP Benefits (E-CCC) (CHNA.org)	percent	**10.7**	9.4

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Table 25. Selected Food Insecurity Race/Ethnicity Statistics

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Did Not Eat Breakfast (CCC) (CHKS)	percent	#	25.7%	**43.1%**	23.1%	**34.2%**	**35.3%**	**40.1%**	**34.0%**	**38.7%**
SNAP Benefits (E-CCC) (CHNA.org)	percent	9.4%	6.4%	**23.4%**	7.5%	**21.4%**	**14.2%**	**11.6%**	**15.2%**	**11.6%**

Values in bold are the least favorable.
 # Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.
See Attachment 5 for full descriptions and sources of all indicators.

[76] Healthy People 2020. (2018). *Food Insecurity.*

Diabetes

What Is the Issue?

Diabetes refers to a category of diseases that affects how the body uses glucose (blood sugar), the body's primary source of fuel. Type 1 diabetes and type 2 diabetes are chronic,[77] with type 2 diabetes accounting for roughly 90 percent of all diagnosed cases and type 1 diabetes accounting for approximately 5 percent. Gestational diabetes accounts for the rest. The Centers for Disease Control and Prevention (CDC) estimates that 30 million people in the U.S. have diabetes, and that an additional 84 million U.S. adults are pre-diabetic. The more serious health complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations.[78]

While type 1 diabetes is generally believed to be caused by a combination of genetic and environmental factors and cannot be prevented, type 2 diabetes and pre-diabetes (higher-than-normal blood glucose levels) are the result of the body losing its ability to generate sufficient insulin to maintain and regulate a healthy blood sugar level, the CDC notes. Risk factors for type 2 diabetes include being physically inactive, being overweight, being age 45 or older, having a close family member with type 2 diabetes, and having pre-diabetes. Additionally, certain ethnic groups (African American, Latinx, Native American, Pacific Islanders, and some Asian groups) are at a higher risk of type 2 diabetes.[78]

As the seventh leading cause of death in the U.S., diabetes is costly. The CDC estimates the annual medical costs and lost work/wages attributable to diabetes is in excess of $300 billion annually, and overall medical costs for those diagnosed with diabetes are twice as high as for those who do not have diabetes.[78]

Why Is It a Health Need?

Most focus group and key informant interviewee feedback related the need for more community health education in order to increase the knowledge and practice of healthy eating and active living, which would prevent obesity, diabetes, high blood pressure, and other chronic diseases. Health education can support the behavioral and lifestyle changes that are needed to manage chronic conditions. Culturally appropriate health education may be lacking, according to participants.

The rate of diabetes hospitalization among children and youth is higher for the county than the state (Table 26). The rate of diabetes management in Eastern Contra Costa County is lowest among African American patients (Table 27).

TABLE 26. SELECTED DIABETES STATISTICS

Indicator	Indicator Type	Value	State Avg.
Diabetes Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)	percent	1.5	1.4

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

[77] The Mayo Clinic. (2018). *Diabetes Overview*.

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

TABLE 27. SELECTED DIABETES RACE/ETHNICITY STATISTICS

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (E-CCC) (CHNA.org)	percent	81.8%	**82.2%**	77.2%						

Values in bold are the least favorable. Blank cells indicate that data were unavailable.
See Attachment 5 for full descriptions and sources of all indicators.

Obesity

What Is the Issue?

Taking in more calories than are burned through normal activity and exercise causes the excess calories to be stored as fat.[79] When one's weight is higher than the healthy standard for one's height, an individual is described as overweight or obese. Both conditions are measured by body mass index (BMI), a metric ratio of weight divided by the square of height.[80] Risk factors of obesity, in addition to unhealthy diet and inactivity, include genetic factors, underlying medical issues, family behavior, social and economic factors, and hormonal changes due to lack of sleep, pregnancy, or age. The side effects of certain medications can also contribute to obesity.[79] Further, food insecurity and obesity often co-exist because "both are consequences of economic and social disadvantage." That is, low-income populations often face a lack of access to affordable, healthy food and instead have access to cheaper food that generally has higher calories but is nutritionally poor. Additionally, stress, disordered eating, lower access to recreation, and greater exposure to advertising for unhealthy products (e.g., fast food, soda) increase the likelihood of obesity among food-insecure individuals.[81]

Nearly one in five children and nearly two in five adults in the U.S. are obese.[80] Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (e.g., anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.[79, 80]

Why Is It a Health Need?

The community prioritized conditions related to diet and physical activity. Most focus group and key informant interviewee feedback related to the need for more community health education in order to increase healthy eating and active living, which would help prevent obesity, diabetes, high blood pressure, and other chronic diseases. Culturally appropriate health education may be lacking, according

[79] The Mayo Clinic. (2018). *Obesity*.
[80] Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.
[81] Food Research & Action Center. (2015). *Food Insecurity and Obesity*.

to participants. Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living to lose weight.

Youth obesity is significantly higher in Eastern Contra Costa County compared to the state average (Table 28). Locally, obesity is highest among Pacific Islander youth and among African American adults (Table 29).

Table 28. Selected Obesity Statistics

Indicator	Indicator Type	Value	State Avg.
Obesity (Youth) (E-CCC) (CHNA.org)	percent	**22.3**	20.1

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Table 29. Selected Obesity Race/Ethnicity Statistics

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Obesity (Adult) (E-CCC) (CHNA.org)	percent	26.5%	21.6%	**35.6%**	10.7%					**29.7%**
Obesity (Youth) (E-CCC) (CHNA.org)	percent	20.1%	15.8%	**22.6%**	10.9%	**42.4%**	0.0%	18.1%†	17.0%	**27.5%**

Values in bold are the least favorable. Blank cells indicate that data were unavailable.
† Statistic is for Filipino population.
See Attachment 5 for full descriptions and sources of all indicators.

Nutrition, Diet, and Fitness

What Is the Issue?

The benefits of fitness and a healthy, nutritious diet are commonly known and well-documented. As noted by the Centers for Disease Control and Prevention, "physical activity fosters normal growth and development, can reduce the risk of various chronic diseases, and can make people feel better, function better, and sleep better."[82] Getting regular exercise can help people of all ages combat obesity, reduce the risk of cardiovascular disease, type 2 diabetes, some types of cancer, and a host of other physical issues.[83] Regular exercise can also help to strengthen bones and muscles, prevent falls for older adults, and increase an individual's chances of living longer.[83, 84]

[82] Centers for Disease Control and Prevention. (2018). *Physical Activity Basics.*
[83] The Mayo Clinic. (2016). Exercise: 7 Benefits of Regular Physical Activity.
[84] Harvard Health Publishing/Harvard Medical School. (2013). Balance Training Seems to Prevent Falls, Injuries in Seniors.

Likewise, the benefits of a healthy diet include preventing high cholesterol and high blood pressure, reducing the risks of developing diseases including cancer and diabetes, and helping to reduce the risks of obesity, osteoporosis, and dental cavities.[85] For children and adolescents, a nutritious diet helps with growth and bone development, as well as improved cognitive function.[86]

Despite these well-known benefits most people, young and old alike, do not meet the recommended healthy food and exercise guidelines. Most significantly, a poor diet and lack of regular exercise can lead to childhood and adult obesity, a serious and costly health concern in the U.S. that often results in some of the leading causes of preventable death.[87] The early prevention of obesity is vital because the likelihood of obese children becoming obese adults is believed to increase from about 20 percent at 4 years old to 80 percent by adolescence.[88]

Why Is It a Health Need?

The community connected healthy eating and active living to good mental health. Residents, however, noted that the relatively lower cost and convenience of unhealthy grocery items and fast food, makes buying and preparing fresh food less likely for busy families. Additionally, experts discussed the fact that few people walk or bike to work because they have long commutes.

Residents talked about the lack of motivation and lack of time to exercise (busyness), the high cost of gym memberships and sports or exercise programs, and the inconvenient times of exercise classes. Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living to lose weight. Regarding physical activity, the community identified the increased use of screens (including video games) among youth as a driver of sedentary lifestyles. The Latinx population was mentioned frequently as a population of particular concern for conditions related to diet and physical activity. Further, workers from Eastern Contra Costa County have significantly longer commutes than the state average, driving more than 60 minutes each direction (Table 30); CHNA participants said this can affect the time individuals have available for engaging in physical activity and healthy cooking or eating.

A greater proportion of Eastern Contra Costa County youth are physically inactive compared to the state average (Table 30). More specifically, a significantly smaller proportion of local children and youth walk or bike to school, compared to the state average. Youth populations with the highest levels of physical inactivity in the local region are Pacific Islanders (Table 31). Also, the percentage of ninth graders in Contra Costa County who meet fitness standards has been declining. Among Contra Costa County's fifth, seventh, and ninth graders, Latinx students are least likely to meet fitness standards.

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[85] U.S. Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*

[86] World Health Organization. (2018). Early Child Development: Nutrition and the Early Years.

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

[88] Stanford Health Care, https://stanfordhealthcare.org/medical-conditions/healthy-living/obesity/prevention.html

Table 30. Selected Nutrition, Diet, and Fitness Statistics

Indicator	Indicator Type	Value	State Avg.
Children Walking or Biking to School (E-CCC) (CHNA.org)	percent	**18.7**	39.3
Current/Former Smokers, Adults (E-CCC) (CHNA.org)	percent	**15.9**	13.7
Driving Alone to Work, Long Distances (E-CCC) (CHNA.org)	percent	**58.1**	39.3
Physical Inactivity (Youth) (E-CCC) (CHNA.org)	percent	**40.9**	37.8

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Table 31. Selected Nutrition, Diet, and Fitness Race/Ethnicity Statistics

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Physical Inactivity (Youth) (E-CCC) (CHNA.org)	percent	37.8%	32.6%	**46.0%**	30.6%	**57.3%**	0.0%	36.4%†	**38.1%**	**45.0%**
Students Meeting Fitness Standards, 5th Graders (CCC) (Kidsdata.org)	percent	26.4%	**39.8%**	19.7%	**41.0%**	**26.4%**		**26.6%†**	**29.5%**	15.5%
Students Meeting Fitness Standards, 7th Graders (CCC) (Kidsdata.org)	percent	32.5%	**40.9%**	23.2%	**35.1%**	21.6%		31.3%†	30.8%	21.2%
Students Meeting Fitness Standards, 9th Graders (CCC) (Kidsdata.org)	percent	37.6%	**42.3%**	26.8%	**43.0%**		32.4%	**42.1%†**	30.9%	23.6%

Values in bold are the least favorable. Blank cells indicate that data were unavailable.
† Statistic is for Filipino population.
See Attachment 5 for full descriptions and sources of all indicators.

One key informant interviewee expressed concern that mobile home parks are using wells to provide drinking water to park residents that may be contaminated. Lack of access to clean drinking water affects physical health in a variety of ways, including the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay. [89, 90]

COMMUNITY AND FAMILY SAFETY

Crime and Intentional Injury

What Is the Issue?

Crime, violence, and intentional injury are related to poorer physical and mental health for the victims, the perpetrators, and the community at large.[91] Crime in a neighborhood causes fear, stress, feelings of being unsafe, and poor mental health. In one study, individuals who reported feeling unsafe to go out during the day were much more likely to experience poor mental health.[92] As reported by the World Health Organization, even apart from any direct physical injury, victims of violence have been shown to suffer from a higher risk of depression, substance use, anxiety, reproductive health problems, and suicidal behavior.[93] Additionally, exposure to violence has been linked to negative effects on people's mental health, including post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior themselves.[94]

Why Is It a Health Need?

With regard to sources of intentional injury, key informant interviewees and focus group participants most frequently talked about domestic violence. Qualitative research participants also discussed violent crime in general. Residents reported they have seen an increase in violence. Human trafficking was mentioned as a community concern as well. Some participants indicated that human trafficking is a growing problem in Antioch.

Mental health, including trauma, was often mentioned in relation to crime and intentional injury. A number of participants described the impact of discrimination and racially motivated violence on mental health.

Children and youth were the populations about which participants expressed the most concern. Issues identified for these populations included online and in-person bullying, being victims of violence, and

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[89] French, C., Kaiser, L., Gomez-Camacho, R., Lamp, C., & de la Torre, A. (2014). Improving Water Quality in Rural Immigrant Communities. *Policy Brief*, (3)3. Center for Poverty Research, University of California, Davis.

[90] American Dental Association. (2019). MouthHealthy: 4 Reasons Water Is the Best Beverage for Your Teeth.

[91] Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (2002). The World Report on Violence and Health. *The Lancet*, *360*(9339), 1083–1088.

[92] Guite, H.F., Clark, C., & Ackrill, G. (2006). The Impact of the Physical and Urban Environment on Mental Well-Being. *Public Health*, *120*(12), 1117-1126.

[93] World Health Organization. (2017). *10 Facts About Violence Prevention*.

[94] 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.

acting out trauma. Finally, the community recognized the connection between unsafe neighborhoods and the lack of outdoor play or other physical activities.

Statistically, a significantly greater proportion of ninth and 11th graders in Contra Costa County, compared to the state, perceive their schools as unsafe (Table 32). Among seventh graders, school bullying is significantly worse in Contra Costa County than the state average. Additionally, gang membership among ninth and 11th graders in the county significantly exceeds the state average.

TABLE 32. SELECTED CRIME AND INTENTIONAL INJURY STATISTICS

Indicator	Indicator Type	Value	State Avg.
Bullied at School, 7th Graders (CCC) (CHKS)	percent	**42.3**	39.4
Gang Membership, 9th Graders (CCC) (CHKS)	percent	**8.7**	7.5
Gang Membership, 11th Graders (CCC) (CHKS)	percent	**8.0**	7.5
School Perceived as Unsafe/Very Unsafe, 9th Graders (CCC) (CHKS)	percent	**8.7**	7.7
School Perceived as Unsafe/Very Unsafe, 11th Graders (CCC) (CHKS)	percent	**8.4**	6.5

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

Ethnic disparities exist across multiple crime and intentional injury indicators for children and youth (Table 33). These include: cyberbullying (Pacific Islander youth fare the worst), in-person bullying at school (African American youth fare the worst), fear of being beaten up at school (the highest proportion who experience this fear are Native American and African American youth), gang membership (the highest proportion of gang members are among multiethnic and Pacific Islander youth), school climate (Latinx and African American youth are most likely to attend schools they perceive as unsafe), juvenile felony arrests (African American youth are arrested in much higher proportion than others), and substantiated child abuse and neglect (African American children and youth fare the worst). Among adults in Contra Costa County, jail incarceration rates are highest among African Americans (Table 33).

Table 33. Selected Crime and Intentional Injury Race/Ethnicity Statistics

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Bullied at School (CCC) (CHKS)	percent	#	32.8%	**43.2%**	**36.7%**	**38.4%**	23.4%	31.8%	**36.8%**	31.8%
Fear of Being Beaten Up at School (CCC) (CHKS)	percent	#	11.3%	**14.5%**	**11.6%**	**16.0%**	**36.7%**	11.2%	**12.7%**	**14.5%**
Gang Membership (CCC) (CHKS)	percent	#	5.9%	**7.9%**	4.1%	**9.1%**	2.9%	**6.3%**	**9.4%**	**7.2%**
Jail Incarceration (CCC) (Vera)	rate	278.9	98.1	**616.0**	9.8*					250.5
Juvenile Felony Arrest Rate (per 1,000) (CCC) (Kidsdata.org)	rate	5.3	2.1	**22.0**				1.3		3.6
School Perceived as Unsafe/Very Unsafe (CCC) (CHKS)	percent	#	4.2%	**10.0%**	**5.3%**	**6.3%**	3.5%	**8.4%**	**8.6%**	**9.6%**
Substantiated Child Abuse and Neglect (per 1,000) (CCC) (Kidsdata.org)	rate	8.2	3.6	**13.4**	1.8*					4.2

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable.
 # Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.
** Statistic is for Asian/Pacific Islander combined*
See Attachment 5 for full descriptions and sources of all indicators.

Unintended Injuries/Accidents

What Is the Issue?

The most common unintended injuries or accidents worldwide are motor vehicle crashes, drowning, falls, fires and burns, and poisonings.[95] In 2016, unintentional injury was the third leading cause of death overall in the United States.[96] The most common unintended injuries causing death in the U.S. are falls, traffic accidents, and poisonings (including overdose of prescription medications).[97, 98] Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.[99]

Common among older adults, falls are a growing concern, because the percentage of the U.S. population 65 years old and older is projected to double—from 46 million to 98 million people—between now and 2060, which means nearly one in every four Americans will be a senior citizen.[100] Unintentional injuries are also the leading cause of death and hospitalization in California for children 16 years old and younger.[101]

Why Is It a Health Need?

Key informant interviewees and focus group participants expressed the most concern about unintentional injuries occurring among children and youth. Most community input about this health need came from experts, who cited unintentional injuries as a leading cause of death for both children and older adults. Experts emphasized the need for prevention of falls among seniors (often occurring in the home) and children (specifically, from open windows). Motor vehicle crashes were also noted, with related mention of the use of car seats to prevent injuries to young children if collisions should occur.

The rate of traumatic injury hospitalizations (whether intentional or unintentional) among children and youth in the county is significantly higher than the benchmark (Table 34). Similarly, the rate of children and youth being hospitalized for poisoning in Contra Costa County is significantly higher than the state average. The rate of fatalities from firearms in the county (whether intentional or unintentional) also significantly exceeds the state's rate. Pedestrian accident deaths in Eastern Contra Costa County are significantly higher than the state average. Finally, motor vehicle crash deaths in Eastern Contra Costa County are disproportionately experienced by African American residents (Table 35).

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[95] Norton, R., Hyder, A.A., Bishai, D., Peden, M., et al. (2007). Unintentional Injuries. *Disease Control Priorities in Developing Countries.*

[96] Centers for Disease Control and Prevention. (2017). *Mortality in the United States, 2016.*

[97] Centers for Disease Control and Prevention. (2017). *Accidents or Unintentional Injuries.*

[98] National Safety Council. (2018). Unintentional Injuries Are the #1 Cause of Death From Infancy to Middle Age.

[99] Office of Disease Prevention and Health Promotion. (2018). *Injury and Violence Prevention.*

[100] Population Reference Bureau. (2016). *Aging in the United States.*

[101] California Department of Public Health, (2018). *Child Passenger Safety (CPS) in California.*

TABLE 34. SELECTED UNINTENTIONAL INJURY STATISTICS

Indicator	Indicator Type	Value	State Avg.
Firearm Fatalities (CCC) (CHR)	rate	**9.0**	8.0
Pedestrian Accident Deaths (E-CCC) (CHNA.org)	rate	**2.6**	2.3
Poisoning Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)	percent	**1.3**	0.9
Traumatic Injury Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)	percent	**1.5**	1.1

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

TABLE 35. SELECTED UNINTENTIONAL INJURY RACE/ETHNICITY STATISTICS

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths (E-CCC) (CHNA.org)	rate	8.6	7.2	**10.2**	2.7					5.2

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable.
See Attachment 5 for full descriptions and sources of all indicators.

TRANSPORTATION AND TRAFFIC

What Is the Issue?

In the U.S. in 2010, 13.6 million motor vehicle crashes killed nearly 33,000 people and injured 3.9 million more, at an estimated cost to the U.S. economy of $242 billion. The major contributors to motor vehicle crashes include drunk driving, distracted driving, speeding, and not using seat belts.[102] Increased road use is correlated with increased motor vehicle accidents,[103] while more traffic (road congestion) causes travel delays, greater fuel consumption, and higher greenhouse gas emissions via vehicle exhaust.[102] Vehicle exhaust is a known risk factor for heart disease, stroke, asthma, and cancer. Thus, it is important to monitor the miles traveled by vehicles over time to better understand the various potentially adverse health consequences.[104] The benefits of active transportation such as walking or riding a bicycle include improving health, saving money by not having to purchase a car or gasoline, and reducing impact on the

[102] U.S. Department of Transportation, National Highway and Traffic Safety Administration. (2015). *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised)*, DOT HS 812 013. 2015 (revised). See also: Centers for Disease Control and Prevention. (2017). *Motor Vehicle Safety: Cost Data and Prevention Policies*, which suggests that the figures have not changed significantly since 2010.

[103] Cohen, P. (2014, October 8). Miles Driven and Fatality Rate: U.S. States, 2012. Sociological Images [web log].

[104] Health Matters in San Francisco. (2008). *Heavy Traffic Can Be Heartbreaking.*

environment. Combining alternative transport with traffic countermeasures can both improve health and reduce traffic-related injuries in communities.

Why Is It a Health Need?

Many key informant interviewees and focus group participants discussed transportation as a barrier to seeing the doctor and getting to work. The community talked about the difficulty of using public transportation to get to East Bay locations because of poor reliability, limited bus and BART lines, long public transit travel times, and expensive fares (especially for BART). Some participants described the fear of becoming a victim of a crime at BART stations, while others stated that access for the disabled (i.e., working elevators) is unreliable at BART stations. The community said that Eastern Contra Costa County is not widely accessible via BART, despite the extension of the Pittsburg line.

The Eastern Contra Costa County region has a significantly higher density of roads than the state average (Table 36). Compared to the state average, a significantly greater proportion of local residents drive to work alone more than 60 minutes in each direction, contributing to the traffic load on the roads. Additionally, a significantly smaller proportion of local residents live within half a mile of a public transit stop compared to other state residents. Pedestrian accident deaths in Eastern Contra Costa County are significantly higher than the state average. Finally, motor vehicle crash deaths in Eastern Contra Costa County are disproportionately experienced by African American residents (Table 37).

Table 36. Selected Transportation and Traffic Statistics

Indicator	Indicator Type	Value	State Avg.
Driving Alone to Work, Long Distances (E-CCC) (CHNA.org)	percent	**58.1**	39.3
Pedestrian Accident Deaths (E-CCC) (CHNA.org)	rate	**2.6**	2.3
Public Transit Stops Within 0.5 Miles (E-CCC) (CHNA.org)	percent	**12.8**	16.8
Road Network Density (road miles per square mile of land) (E-CCC) (CHNA.org)	rate	**4.6**	2.0

Values in bold are the least favorable. Rates are per 100,000 except where noted.
See Attachment 5 for full descriptions and sources of all indicators.

Table 37. Selected Transportation and Traffic Race/Ethnicity Statistics

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths (E-CCC) (CHNA.org)	rate	8.6	7.2	**10.2**	2.7					5.2

Values in bold are the least favorable. Rates are per 100,000 except where noted. Blank cells indicate that data were unavailable.
See Attachment 5 for full descriptions and sources of all indicators.

CLIMATE/NATURAL ENVIRONMENT

What Is the Issue?

Living in a healthy environment is critical to an individual's quality of life and physical health. The Office of Disease Prevention and Health Promotion reports that globally nearly 25 percent of all deaths and diseases can be attributed to environmental issues. Those environmental issues include air, water, food, and soil contamination, as well as natural and technological disasters.[105] For those whose health is already compromised, exposure to negative environmental issues can compound their problems.[106] Therefore, it follows that any effort to improve overall health must include consideration of those societal and environmental factors that increase the likelihood of exposure and disease. Recent reports on climate change highlight the importance of considering environmental health in the context of climate health, which is projected to have an increasing impact on sea levels, air quality, patterns of infectious diseases, and the severity of natural disasters, such as fires, floods, and droughts.[107]

Why Is It a Health Need?

Feedback from the community about the environment was primarily related to poor air quality, which was attributed to pollution. Key informant interviewees and focus group participants identified poor air quality as a driver of asthma. They also pointed to climate change as the cause of severe weather events and wildfires in Eastern Contra Costa County. In addition, residents indicated that local refineries were a cause of air pollution (e.g., refinery fires), and implicated recent wildfires as well.

Road network density contributes to greater traffic, which can increase air pollution.[108] Eastern Contra Costa County has a significantly higher density of roads compared to the state average (Table 38). Particulates from traffic can contribute to asthma. Although air quality measures are better than the state benchmarks, adult asthma prevalence in the local region is significantly worse. Countywide, asthma hospitalizations among children are significantly worse than the state benchmark. Asthma can be exacerbated by heat and pollution. The tree canopy is a protective factor against pollution and "heat island effects." However, tree canopy coverage in Eastern Contra Costa County is significantly lower than the state average (Table 38).

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[105] Office of Disease Prevention and Health Promotion. (2018). *Environmental Health*.

[106] Morris, G., & Saunders, P. (2017). The Environment in Health and Well-Being. *Oxford Research Encyclopedias.*

[107] U.S. Global Change Research Program. (2018). *Fourth National Climate Assessment.*

[108] Community Commons. https://www.communitycommons.org/chna/

TABLE 38. SELECTED ENVIRONMENT STATISTICS

Indicator	Indicator Type	Value	State Avg.
Asthma Hospitalizations, Children Ages 0–4 (per 10,000) (CCC) (Kidsdata.org)	rate	**22.7**	19.6
Asthma Prevalence, Adults (E-CCC) (CHNA.org)	percent	**16.5**	14.8
Road Network Density (road miles per square mile of land) (E-CCC) (CHNA.org)	rate	**4.6**	2.0
Tree Canopy Cover (E-CCC) (CHNA.org)	percent	**7.2**	8.3

Values in bold are the least favorable. See Attachment 5 for full descriptions and sources of all indicators.

For additional details, including statistical data and sources, see the data tables found in Attachment 5: Secondary Data Tables.

8. Community Resources

The following healthcare facilities serve Eastern Contra Costa County. *For additional providers, see Attachment 3: Community Assets and Resources.*

HOSPITALS

- John Muir Behavioral Health Center, Concord
- John Muir Health, Concord and Walnut Creek
- Kaiser Permanente, Antioch
- Sutter Delta Medical Center, Antioch

FEDERALLY QUALIFIED HEALTH CENTERS

- Brighter Beginnings
- La Clínica (Monument, Oakley, and Pittsburg Medical)

OTHER HEALTH CLINICS

- Antioch Health Center
- Bay Point Family Health Center
- Brentwood Health Center
- Pittsburg Health Center
- RotaCare Pittsburg Free Medical Clinic

9. Evaluation Findings: 2017–2019 Implemented Strategies

The final regulations issued by the Department of Treasury on December 29, 2014, regarding nonprofit hospitals conducting CHNAs require that each hospital's CHNA report include: "… 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) (p. 78969)."[109]

Prior to this report, Sutter Delta Medical Center conducted its most recent CHNA in 2016.

The 2016 CHNA identified eight community health needs. Working within its mission and capabilities, Sutter Delta Medical Center selected the following needs to address in its community benefit implementation strategy:

1. Access to Primary Healthcare Services
2. Access to Basic Needs, such as Housing and Employment
3. Access to Mental, Behavioral and Substance Abuse Services
4. Health Education and Health Literacy
5. Access to Transportation and Mobility

See Attachment 7 for a detailed evaluation of the impact of actions taken by Sutter Delta Medical Center to address the health needs identified in the 2016 CHNA.

[109] U.S. Department of the Treasury, Internal Revenue Service. (December 31, 2014). *Federal Register*, Vol. 79, No. 250.

10. Conclusion

Sutter Delta Medical Center collaborated with partners in Eastern Contra Costa County ("the E-CCC Hospitals") to meet the requirements of the federally mandated CHNA by pooling expertise, guidance, and resources for a shared 2019 assessment. By gathering secondary data and conducting new primary research with other healthcare facilities, the E-CCC Hospitals were able to collectively understand the community's perception of health needs and prioritize health needs with an understanding of how the data for each compare to state and other benchmarks.

Next Steps for Sutter Delta Medical Center:

- Ensure the 2019 CHNA is adopted by the hospital board and made publicly available on the Community Benefit page of Sutter Health's website by December 31, 2019.[110]
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs (independently or with partner hospitals).
- Ensure strategies are adopted by the hospital board and filed with the IRS by May 15, 2020.

[110] https://www.sutterhealth.org/community-benefit

11. List of Attachments

1. Qualitative Research Protocols
2. Community Leaders, Representatives, and Members Consulted
3. Community Assets and Resources
4. Secondary Data Sources
5. Secondary Data Tables
6. Secondary Data Indicators Index
7. Evaluation Findings: Impact of 2017–2018 Implemented Strategies
8. IRS Checklist

Attachment 1. Qualitative Research Protocols

Key Informant Protocols: Professionals

Prior to key informant interviews, professionals were provided the 2016 CHNA health needs list (Table 39) to consider.

TABLE 39. 2016 HEALTH NEEDS LIST

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

Introduction – 5 min.

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

Health Needs Prioritization – 6–10 min.

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

Thinking specifically about [geographic sub-area] …

1. **Are there any needs that should be added to the list?**
2. **Which three needs (2016 and others added) do you believe the local people you serve feel are the most important to address here in the next few years? [See table above.]**

Health Needs Discussion, Including Expertise Area – 20 min.

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

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

Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime

- What impact do these barriers have on people's health?

4. **Which groups, if any, are more affected by this health need than others?**
   Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.
5. **What trends, if any, have you seen in the last three years? [Repeat 3-5 for each health need they prioritized.]**
6. **[Only if their expertise was not related to one or more of the needs chosen by interviewee:] You were invited to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

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

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

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

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

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

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

Suggestions/Improvements/Solutions – 5–10 min.

In addition to what we have already talked about…

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

Prompts if needed*:* Preventive care? Deep-end services? Workforce changes? Are there any quick wins or low-hanging fruit?

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

[Time permitting] Additional comments

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

Closing

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

Focus Group Protocols

During focus groups, facilitators presented the 2016 CHNA List. (*See Table 39 on the first page of this attachment; at the recommendation of the Contra Costa County public health officer, in focus groups with residents, "Behavioral Health" was called "Mental Health."*) Questions found in these protocols refer to that list.

FOCUS GROUPS WITH PROFESSIONALS OR COMMUNITY REPRESENTATIVES

Introduction – 6 min.

- Welcome and thanks
- Introductions (everyone says their name, role, and organization, incl. facilitators)
- What the project is about:
    - Nonprofit hospitals' Community Health Needs Assessment required by IRS. Hospitals collaborating on East Bay CHNA work include: John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care - ValleyCare, Sutter Health, UCSF Benioff Children's Hospital-Oakland, and Washington Hospital Healthcare System
    - Identifying important health needs in our community
    - Ultimately, to plan on how to address health needs now and in future
- Today's questions (refer to agenda flipchart page)
- Introductions (facilitators, participants: names and organizations)
- Confidentiality:
    - When we are finished with all of the focus groups, we will look at all of the transcripts and summarize the things we learn.
    - Would like to record so that we can be sure to get your words right.
    - Now that we have introduced ourselves, we will only use first names here to preserve your anonymity. However, if you want to keep a comment anonymous, you may not want to name your organization.
- We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
- Transcripts will go to hospitals if that is OK with you.
- Permission to record?

- What we'll do with the information you tell us today:
    - Hospitals will report the assessment to the IRS
    - Hospitals will use information for planning future investments
    - Logistics
    - We will end at ___:___.
    - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
    - Cell phones: On vibrate; please take calls outside.
    - Bathroom location.
    - Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone. Really want your opinions and perspectives, even – especially! – if they aren't the same as everyone else's.

Health Needs Prioritization – 10 min.

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

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

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

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

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

    [When participants have voted, start audio recorder.]

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

Health Needs Discussion, Including Expertise Area – 20 min.

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

    Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime

- What impact do these barriers have on people's health?

5. **Which groups, if any, are more affected by this health need than others?**
   Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.
6. **What trends, if any, have you seen in the last three years? [Repeat questions 4-6 for each of the top health needs prioritized by the group.]**
7. **[Only if their expertise was not related to one or more of the needs chosen:] You are here to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

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

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

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

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

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

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

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

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

Closing – 5 min.

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

FOCUS GROUPS WITH LOCAL RESIDENTS

Introduction – 6 min.

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

Imagining a Healthy Community – 5 min.

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

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

    Prompt if needed: What makes a community healthy?

Health Needs Prioritization – 10 min.

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

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

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

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

Understanding the Needs – 15 min.

5. **When you think about [health need1]…**
   - What barriers exist to people getting healthy or staying healthy?
     Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime
   - What impact do these barriers have on people's health?
   - When you think about this need, are any groups of people worse off than others? If so, which groups?

   Prompts for groups if they are having trouble thinking of anything: Children, youth, adults, seniors; specific ethnicities [e.g., Latino, Southeast Asian, Pacific Islanders]; low-income; mono-lingual non-English speakers; LGBTQ
6. **Do you think that things have been getting better, stayed the same, or gotten worse, in the last three years or so? [If things have changed: How?]**

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

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

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

- What about specialists? Are people able to see one when they need it?

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

8. **What about mental health? Mental health was one of the top health needs last time. By mental health, we mean everything ranging from stress, substance use, and depression, to serious mental illness.**
9. **In your opinion, what are the specific mental health needs in our community?**
   Prompt if needed: Conditions like stress, depression, addiction; outcomes like suicide; concerns about stigma; access to mental healthcare
10. **Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how? [Elicit drivers.]**

Equity and Cultural Humility – 15 min.

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

Suggestions/Improvements/Solutions – 5–10 min.

In addition to what we have already talked about…

12. **What are some resources, services, or strategies that are working well in the community to address these needs?**
    Prompts if needed: Certain community-based organizations or their programs/ services, specific hospitals and/or healthcare programs/services, specific social services
13. **What types of resources, services, or strategies, if any, does the community need more of to address these needs?**
    Prompt if needed: Preventive care? Deep-end services? Workforce changes?
14. **What kinds of changes could those in charge here in the community make to help all of us stay healthy?**

Closing – 5 min.

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

Attachment 2. Community Leaders, Representatives, and Members Consulted

Actionable Insights (AI) conducted the primary qualitative research for Sutter Delta Medical Center's 2019 Community Health Needs Assessment. The research firm used three strategies for collecting community input: key informant interviews with health experts, focus groups with professionals, and focus groups with residents. Contra Costa Health Services (the public health department) facilitated the focus groups.

The community leaders, representatives, and members consulted by AI and Contra Costa Health Services were chosen for their expertise and/or for belonging to an IRS high-need population (low-income, minority, medically underserved, etc.). Research participants included residents as well as representatives of county health systems, local government, nonprofit organizations, and healthcare facilities. Overall, input was solicited from 37 residents and 43 community leaders and representatives in Eastern Contra Costa County. Their names, target groups represented, and other details appear in Tables 40–44.

TABLE 40. COMMUNITY LEADERS: KEY INFORMANT INTERVIEWEES

Name, Title, Agency	Topic or Population	Target group(s) represented	Date input gathered
Diane Burgis, Supervisor, Contra Costa County, District III	Needs of Eastern Contra Costa County population	Low-income, Minority	6/27/2018
Ken Carlson, Board Chair, John Muir Community Health Fund	Community health	Medically underserved	7/31/2018
Ana Castro, Coordinator, Educational Services, Antioch Unified School District	K–12 student health and education	Low-income, Minority	7/25/2018
Kristin Connelly, President & Chief Executive Officer, East Bay Leadership Council	Economic security	Low-income	8/21/2018
Pam Di Franco, RN, MSN, PHN, Clinic Nurse Manager, Society of St. Vincent de Paul of Contra Costa County	Economic security	Low-income, Medically underserved	8/16/2018
Barbara Hunt, Development Director, St. Vincent de Paul of Contra Costa County	Economic security	Low-income, Medically underserved	8/16/2018
Rhonda James, Chief Executive Officer, STAND! for Families Free of Violence	Community & family safety	Low-income, Minority	8/17/2018
Devorah Levine, Assistant Director, Contra Costa County Employment & Human Services	Medically underserved	Low-income, Medically underserved	8/2/2018

Name, Title, Agency	Topic or Population	Target group(s) represented	Date input gathered
Lavonna Martin, Director, Health, Housing, and Homeless Services, Contra Costa County Health Services	Needs of individuals experiencing homelessness	Low-income	7/13/2018
Kevin McAllister, Executive Director, Rainbow Community Center	LGBTQ population needs	Medically underserved, Minority	8/1/2018
Dan Peddycord, Director of Public Health, Contra Costa County Health Services	Public health	Health department representative	7/23/2018
Kirsten Rigsby, Executive Director, Village Community Resource Center	Latino population needs	Minority	8/14/2018
Hector J. Rojas, AICP, Senior Planner, City of Pittsburg	Community development	Low-income	8/17/2018
Bob Sanchez, Director of Student Services, Antioch Unified School District	K–12 student health and education	Low-income, Minority	7/25/2018
Allison Staulcup Becwar, Chief Program Officer, Lincoln	Mental health needs	Medically underserved	8/17/2018
Dr. Matthew P. White, Acting Director of Behavioral Health, Medical Director, Contra Costa County Health Services	Behavioral health	Medically underserved	7/31/2018

TABLE 41. COMMUNITY LEADERS: NEEDS OF INDIVIDUALS LIVING IN POVERTY FOCUS GROUP PARTICIPANTS

Date Held	**8/14/2018**
Host	**Multifaith Action Coalition**
Target Group(s) Represented	**Low-income**
Number of Participants	**7**
Participant Name, Title, Agency	Pamela Abbey, Retired United Methodist Clergy David Bressler, Co-Chair, Health Task Force, Multi-Faith ACTION Coalition Doug Leich, Chair, Racial Justice Working Group, Multi-Faith ACTION Coalition Rev. Will McGarvey, Executive Director, Interfaith Council of CCC, and Co-Convener, Multi-Faith Action Coalition Pat Reyes, Co-Chair, Health Task Force, Multi-Faith ACTION Coalition Melody Howe Weintraub, Chair, Advocacy Task Force, Multi-Faith ACTION Coalition April Wise, Co-Chair, Health Care Task Force, Multi-Faith ACTION Coalition

Table 42. Community Leaders: Needs of Central and Eastern Contra Costa County Population Focus Group Participants

Date Held	**8/27/2018**
Host	**Kaiser Foundation Hospital–Walnut Creek**
Target Group(s) Represented	**Low-income**
Number of Participants	**13**
Participant Name, Title, Agency	Dena Betti, Executive Director, #hersmile Nonprofit Carole Dorham-Kelly, Chief Program Officer, Rubicon Programs Andrea Fati, Program Director, Shelter, Inc. Helene Glaser, RN, MSN, Nurse, RotaCare Pittsburg Free Medical Clinic at St. Vincent de Paul Ray (Heracio) Harts, Executive Director, Healthy Hearts Institute John Jimno, Principal, Park Middle School, Antioch Unified School District Denise Milosevich, MPH, Manager, Nutrition & Physical Activity, Contra Costa Health Services, Public Health Department Jessica Rojas, Program Director, School Board Services of Contra Costa, Lincoln Caitlin Sly, Program Director, Food Bank of Contra Costa and Solano Catherine Stafford, Child Health & Nutrition Manager, CocoKids Dave Thompson, Program Director, Monument Impact Ali Uscilka, Program Director, Healthy & Active Before 5 Amy Weiss, Director, Refugee & Immigrant Services, Jewish Family & Community Services/EB

Table 43. Community Leaders: Needs of Eastern Contra Costa County Population Focus Group Participants

Date Held	**9/17/2018**
Host	**Kaiser Foundation Hospital–Antioch**
Target Group(s) Represented	**Low-income**
Number of Participants	**7**
Participant Name, Title, Agency	Wendy Escamilla, Clinic Administrator, Brighter Beginnings Darren Gapultos, Community School Coordinator, Pittsburg Unified School District Susun Kim, Executive Director, Family Justice Center Alejandra Plascencia, Community Liaison – East and Central County, First 5 Contra Costa Mayra Preciado, School Counselor, Antioch Unified School District Robert Prinz, Education Director, Bike East Bay Brianna Robinson, Director of Programs, Opportunity Junction

Table 44. Community Residents: Focus Group Participants

Host	Population	Total Participants*	Target Group(s) Represented	Date Held
Loaves & Fishes	Individuals experiencing homelessness or housing instability	9	Low-income, Medically underserved	8/6/2018
Rubicon Programs-Antioch	Individuals of minority, low-income, and/or re-entry status	5	Low-income, Medically underserved, Minority	8/29/2018
Los Medanos College	Young adults, ages 18–25	14	Low-income	8/30/2018
Stoneman Village	Older adults	9	Low-income	9/17/2018

* Community residents participated on the condition of anonymity.

Attachment 3. Community Assets and Resources

TABLE OF CONTENTS

Please note this list of Community Assets and Resources is not exhaustive. Additional organizations working to promote health and well-being of the community in response to identified health needs may not be reflected here.

Health Care Facilities and Agencies

The following healthcare facilities are available in Contra Costa County. Many hospitals provide charity care and cover Medi-Cal shortfalls.

HOSPITALS

- John Muir Health, Concord and Walnut Creek
- John Muir Behavioral Health Center, Concord
- Kaiser Permanente, Antioch
- Sutter Delta Medical Center, Antioch

FEDERALLY QUALIFIED HEALTH CENTERS

- Brighter Beginnings
- La Clínica (Monument, Oakley, and Pittsburg Medical)

OTHER HEALTH CLINICS

- Antioch Health Center
- Bay Point Family Health Center
- Brentwood Health Center
- Pittsburg Health Center
- RotaCare Pittsburg Free Medical Clinic

Assets and Resources by Identified Health Need

The following tables provide the names, summary descriptions, and websites for various healthcare assets and resources available in Eastern Contra Costa County to address identified health needs.

BEHAVIORAL HEALTH

Resource Name	Summary Description	Website
#hersmile Nonprofit	Funds programs that empower and inspire people to thrive despite adversity, with the goal of promoting healing and resiliency during tragedies and difficult times	https://hersmile.org/
Center for Human Development	Facilitates the growth and strengthening of communities by providing services for at-risk youth, individuals, and families	http://chd-prevention.org/
Child Abuse Prevention Council of Contra Costa County	Runs programs to prevent child abuse by strengthening families and building healthy communities in Contra Costa County	https://www.capc-coco.org/
Contra Costa Crisis Center	Provides support, counseling, and hope to people in emotional or psychological distress	https://www.crisis-center.org/
Contra County Health Services	Cares for and improves the health of all people in Contra Costa County, giving special attention to those who are most vulnerable	https://cchealth.org/
Jewish Family & Community Services East Bay	Promotes the well-being of individuals and families of all ages, races, and religions with essential mental health and social services at every stage of life	https://jfcs-eastbay.org/
Lincoln	Provides children with support and services, from an early age through high-school graduation	http://lincolnfamilies.org/
NAMI (National Alliance Mental Illness)	Builds better lives for the millions of Americans affected by mental illness as the nation's largest grassroots mental health organization	https://www.nami.org/
Putnam Clubhouse	Helps adults in Contra Costa County coping with mental illness regain their lives	https://www.putnamclubhouse.org/
Ujima: East	Supports families recovering from alcoholism, drug addiction, and behavioral health problems	http://www.ujimafamily.org/programs/ujima-east-outpatient-treatment-program/

CLIMATE AND NATURAL ENVIRONMENT

Resource Name	Summary Description	Website
Agricultural Natural Resources Trust	Conserves working family ranches and farms, landscapes, open spaces, natural habitats, and the communities they support	https://www.ag-trust.org/
Contra Costa County Climate Leaders (4CL)	Works with the county and its 19 cities to inform, support, and encourage the measurement and reduction of greenhouse gas emissions	http://www.cccclimateleaders.org/
Contra Costa County Citizens' Climate Lobby	Focuses on educating and mobilizing support for effective and fair carbon pricing	https://citizensclimatelobby.org/chapters/CA_Contra_Costa/
Contra Costa Watershed Forum	Identifies common principles among parties involved in creek and watershed issues and promotes actions that transform these principles into multi-objective enhancements of creeks and watersheds throughout the county	http://cocowaterweb.org/
Earth Team	Empowers youth to become lifelong environmental stewards; students learn about sustainability, environmental restoration, climate change, waste reduction, and watersheds	http://www.earthteam.net/
EcoVillage Farm Learning Center	Strives to create a healthy, sustainable environment and socially/economically just society for present and future generations	http://ecovillagefarm.org/
Generation Green	Educates and inspires Contra Costa County residents and stakeholders to reduce their impact on the Earth, to reuse materials, to respect the planet, and to implement sustainable actions to reduce their carbon footprint	http://www.generationgreen.com/
Sustainable Contra Costa	Citizens, educators, innovators, and organizations design and build pathways to ecologically sustainable, economically vibrant, and socially just communities for all	http://sustainablecoco.org/
The Watershed Project	Inspires Bay Area communities to understand, appreciate, and restore their local watersheds	http://thewatershedproject.org/

COMMUNITY AND FAMILY SAFETY

Resource Name	Summary Description	Website
Center for Human Development	Facilitates the growth and strengthening of communities by providing services for at-risk youth, individuals, and families	http://chd-prevention.org/
Child Passenger Safety Program	Supports the standardization and quality-control course with content and instructors to ensure that information and materials being taught and disseminated are up-to-date, accurate, and consistent	https://www.in.gov/cji/2388.htm
Community Violence Solutions	Works to end sexual assault and family violence by providing services to survivors of sexual assault or abuse and their families	https://cvsolutions.org/
Contra Costa Family Justice Center	Brings together the community to support the healing of family violence survivors as well as to integrate capable partners with a comprehensive service approach to renew individuals and the community from a trauma of family violence	http://www.cocofamilyjustice.org/
First 5 Contra Costa County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities, and improve the lives of children ages 0–5 and their families	http://www.first5coco.org/
One Day at a Time	Provides youth with a supportive network of peers, opportunities for academic and personal growth, and exposure to positive transformative experiences	https://www.odatec.org/
STAND! for Families Free of Domestic Violence	Strives to break the cycle of violence in families impacted by domestic violence and child abuse by providing services around therapy, crisis lines, and educational opportunities	http://www.standffov.org/
Youth Intervention Network	Trains community volunteers to work with youth in crisis and their families in a wraparound model	https://npcresearch.com/project/youth-intervention-network/

ECONOMIC SECURITY

Resource Name	Summary Description	Website
Catholic Charities of the East Bay	Offers services to aid youth, children, and families facing difficulties with immigration, eviction, literacy, or surviving traumatic violence	https://www.cceb.org/
Contra Costa County Employment & Human Services	Partners with the community to deliver quality services to ensure access to resources that support, protect, and empower individuals and families to achieve self-sufficiency	https://ehsd.org/
Food Bank of Contra Costa and Solano	Leads the fight to end hunger, in partnership with the community and in the service of neighbors in need	https://www.foodbankccs.org/
Opportunity Junction	Strives to help program participants achieve self-sustaining employment in the long-term	https://www.opportunityjunction.org/
Rubicon Programs	Equips East Bay residents with resources to break the cycle of poverty	http://rubiconprograms.org/
SparkPoint Bay Point, United Way Bay Area	Brings together individuals, nonprofits, businesses, and government entities to fight for a strong, vibrant, and healthy community; also enables neighbors to invest in one another to fight for health, education, and financial stability	https://uwba.org/sparkpoint/

EDUCATION AND LITERACY

Resource Name	Summary Description	Website
CocoKids	Champions and advances quality child care and early education	https://www.cocokids.org/
Contra Costa County Office of Education	Provides direct services to some of the county's most vulnerable students, including young people who are incarcerated, homeless, or in foster care, and students who have severe physical or emotional challenges	https://www.cccoe.k12.ca.us/
Contra Costa Early Head Start and Head Start	Offers services to children ages 0–5 years under the Head Start and Early Head Start and state preschool programs, which also include a Home Base Option. Direct comprehensive services include: disabilities, health services, mental health, nutrition, parent involvement, and school readiness	https://ehsd.org/headstart/childcare-preschool/head-start-early-head-start-and-state-preschool/
First 5 Contra Costa	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities, and improve the lives of children ages 0–5 and their families	http://www.first5coco.org/

SCHOOL DISTRICTS IN EASTERN CONTRA COUNTY

School District	Location	Website
Antioch Unified	Antioch	https://www.antiochschools.net/
Brentwood Union	Brentwood	https://www.brentwood.k12.ca.us/
Byron Union	Byron	https://www.byronunionschooldistrict.us/
Knightsen Elementary	Knightsen	https://kes-kesd-ca.schoolloop.com/
Liberty Union High	Brentwood	https://ca01001129.schoolwires.net/
Oakley Union Elementary	Oakley	https://www.ouesd.k12.ca.us/
Pittsburg Unified	Pittsburg	https://www.pittsburg.k12.ca.us/

HEALTHCARE ACCESS AND DELIVERY

Resource Name	Summary Description	Website
American Cancer Society	Aims to freeing the world from cancer by funding and conducting research, sharing expert information, supporting patients, and spreading the word about prevention	https://www.cancer.org/
American Diabetes Association	Educates people about ways to live healthier lives and support friends and loved ones living with diabetes	http://www.diabetes.org/in-my-community/local-offices/san-francisco-california/
American Heart Association	Strives to prevent and cure heart disease	https://www.heart.org/en/affiliates/california/greater-bay-area
American Lung Association	Works to save lives by improving lung health and preventing lung disease, through advocacy, education, and research	https://www.lung.org/
Brighter Beginnings	Supports healthy births and successful development of children by partnering with parents and helping to build strong communities	http://www.brighter-beginnings.org/
CancerCare	Provides free, professional support services and information to help people manage the emotional, practical, and financial challenges of cancer	https://www.cancercare.org/
Community Oral Health Program	Collaborates with schools and community partners to increase access to oral health services by linking children, youth, and families to no- or low-cost dental resources	https://cchealth.org/dental/
Contra Costa Dental Clinics	Provides dental services in Contra Costa County	https://cchealth.org/dental/dental-ccc.php
Contra Costa Dental Society	Serves members/the public and promotes oral health through communication, education, leadership, and service	https://www.ccdds.org/
Contra Costa Health Services	Cares for and improves the health of everyone in Contra Costa County with special attention to those who are most vulnerable to health problems	https://cchealth.org/
Contra Costa School–Based Health Services	Offers school-based health services to children and students up to 19–20 years of age through mobile health clinic vans and satellite health centers throughout Contra Costa County	https://cchealth.org/school-based-clinic/

Resource Name	Summary Description	Website
Every Woman Counts	Provides free breast and cervical cancer screening and diagnostic services, public and provider education, early detection, case management and integrated preventive services to underserved populations	https://www.dhcs.ca.gov/services/Cancer/ewc/Pages/default.aspx
HIV/AIDS Consortium	Advocates and supports people affected by HIV/AIDS, plans prevention and care services, develops recommendations, and advises governments and community leaders	https://cchealth.org/hiv/consortium/
The Leukemia & Lymphoma Society	Strives to find a cure for leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families	https://www.lls.org/
Planned Parenthood of Northern California	Delivers comprehensive sexual and reproductive health services	https://www.plannedparenthood.org/planned-parenthood-northern-california
Regional Asthma Management Program	Aims to reduce the burden of asthma with a focus on health equity	http://www.rampasthma.org/
Ronald McDonald Care Mobile Dental Clinic	Provides pediatric health services for underserved populations through health education and treatment and referral services	https://www.rmhc.org/ronald-mcdonald-care-mobile
STI testing clinics directory	Maintains an extensive list of public and private STD testing locations and in-home STD testing options	https://www.saferstdtesting.com
Women's Cancer Resource Center	Helps women with cancer improve their quality of life through education, practical assistance, and support services	https://www.wcrc.org/

HEALTHY EATING/ACTIVE LIVING

See also Economic Security for resources related to food insecurity.

Resource Name	Summary Description	Website
Ambrose Recreation and Park District	Provides park facilities, programs, and activities for all ages in order to serve the diverse recreational needs of individuals and families and to enrich the quality of life for all residents	https://www.ambroserec.org/
Bike East Bay	Promotes healthy, sustainable communities by making bicycling safe, fun and accessible	https://bikeeastbay.org/
City of Antioch Recreation Department	Unifies and strengthens the community by creating quality experiences that inspire lifelong learning	https://www.antiochca.gov/recreation/
CocoKids	Champions and advances quality child care and early education	https://www.cocokids.org/
Contra Costa Boys & Girls Club	Runs an after-school youth development and extended learning program	https://bgccontracosta.org/
Contra Costa Health Services	Contra County Health Services is committed to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems	https://cchealth.org/
East Bay Regional Park District	Manages multiple parks in the East Bay that offer outdoor activities	https://www.ebparks.org/
East County Midnight Basketball	Offers youth in Antioch, Oakley, and Brentwood a positive place where they get help to develop the teamwork, education, and vocational skills necessary to be successful	https://www.facebook.com/pages/East-Cnty-Midnight-Basketball-Lgue/910602302343651
18 Reasons	Empowers community members with the confidence to buy, cook, and eat good food every day	https://18reasons.org/
First 5 Contra Costa	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities, and improve the lives of children ages 0–5 and their families	http://www.first5coco.org/
Food Bank of Contra Costa and Solano	Fights to end hunger, in partnership with the community and in the service of local individuals in need	https://www.foodbankccs.org/
Fresh Approach	Improves healthy food access in the community via farmers markets, community gardens, and cooking and nutrition classes	https://www.freshapproach.org/

Resource Name	Summary Description	Website
Healthy and Active Before 5	Prevents obesity in kids ages 0–5 by building partnerships and environments for healthy eating and active play	https://cchealth.org/obesity/before-five.php
Healthy Hearts Institute	Empowers individual and community transformation through health and wellness	https://www.healthyhearts.co/
Loaves and Fishes of Contra Costa	Provides community-based food programs and partner services that focus on basic needs	https://www.loavesfishescc.org/
Meals on Wheels Diablo Region	Delivers nutritious meals to, and performs wellness checks on, frail and/or homebound seniors	https://www.mowdiabloregion.org/
Rollingwood-Wilart Park Recreation and Park District	Provides recreation and park services	https://contracostasda.specialdistrict.org/recreation-park
Village Community Resource Center	Focuses on improving neighborhood conditions through prevention-based programs in the following three areas: education, health services, and social services	http://www.vcrcbrentwoodca.org/
White Pony Express	Helps eliminate hunger and poverty by delivering “the abundance all around us” to people in need	https://www.whiteponyexpress.org/
Women, Infants & Children (WIC) nutrition program locations, Brentwood and Pittsburg	Helps pregnant women, new mothers, and young children eat well and learn about nutrition and stay healthy. Provides services to pregnant and postpartum women, as well as children under 5 years old	https://cchealth.org/wic/index.php

HOUSING AND HOMELESSNESS

Resource Name	Summary Description	Website
Contra Costa Health Services – Health, Housing and Homelessness	Provides much-needed services and support to homeless individuals and families countywide	https://cchealth.org/h3/
Contra Costa Interfaith Housing	Addresses the effects of poverty and homelessness by providing permanent housing solutions and vital support services to highly vulnerable families and individuals	https://ccinterfaithhousing.org
Love-A-Child Missions Homeless Recovery Shelter	Provides women and children with services they need to ease and end their crisis of homelessness and substance abuse	https://loveachildmissions.org
Satellite Affordable Housing Associates (SAHA)	Offers quality affordable homes and services that empower people and strengthen neighborhoods	https://www.sahahomes.org/apply
SHELTER, Inc.	Aims to prevent and end homelessness for low-income and disadvantaged families and individuals by providing housing, resources, services, support that lead to self-sufficiency	https://shelterinc.org/about/

TRANSPORTATION AND TRAFFIC

Resource Name	Summary Description	Website
Alameda-Contra Costa Transit District (AC Transit)	Provides regional bus service	http://www.actransit.org/
Bay Area Rapid Transit (BART)	Provides elevated and subway rail travel across Bay Area counties	https://www.bart.gov/
Bay Wheels	Offers an affordable, accessible mode of transportation via a bicycle-sharing service (operated by Lyft), with discounted memberships for low-income individuals	https://www.lyft.com/bikes/bay-wheels
Bike East Bay	Promotes a healthy, sustainable community by making cycling safe, fun and accessible	https://bikeeastbay.org/
Mobility Matters	Facilitates collaboration and coordination among public and private transportation providers, creating a network of integrated options that primarily address the mobility needs of seniors, individuals with disabilities, and low-income individuals	https://www.mobilitymatterscc.com/
Paratransit	Runs a public-transit service for people who are unable to use regular buses or trains because of a disability or disabling health condition	https://www.eastbayparatransit.org/
Tri Delta Transit	Operates 15 local bus routes Monday-Friday, five local bus routes on weekends and holidays, door-to-door bus service for senior citizens and people with disabilities, and shuttle services for community events	http://trideltatransit.com/

Attachment 4. Secondary Data Sources

The following sources (Table 45) were consulted to compile the data tables that underlie the 2019 Community Health Needs Assessment.

TABLE 45. SECONDARY DATA SOURCES

Source	Year(s)
American Housing Survey	2011–2013
Annie E. Casey Foundation, KIDS COUNT Data Center (Jul. 2016)	2015
Applied Survey Research. (2017). Alameda County Homeless Census and Survey. Watsonville, CA	2017
Area Health Resource File	2006–2010, 2012–2014, 2015, 2015, 2016
Bureau of Labor Statistics	2016, 2018
California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau	2016
California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015)	2014
California Department of Education	2014–2015, 2014–2017, 2015–2016, 2016–2017, 2018
California Department of Education, California Healthy Kids Survey (WestEd)	2011–2013, 2013–2015
California Department of Public Health	2014–2016, 2015, 2017
California Department of Public Health, Birth Profiles by ZIP code	2011
California Department of Public Health, Breastfeeding Statistics	2012
California Department of Public Health, Death Public Use Data	2010–2012
California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section	2010–2012, 2013–2015
California Department of Public Health, STD Control Branch	2014–2016, 2017
California Department of Public Health, STD Control Branch, Data Request, September 2017. Gonorrhea data.	2014–2016
California Department of Public Health, Tuberculosis Control Branch, Data request, September 2017	2014–2016, 2016
California Department of Public Health: 2011–2016 Death Records	2011–2016
California Department of Education, California Basic Educational Data System (CBEDS) (Jun. 2016)	2015
California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS) (May 2016)	2015
California Department of Education, Coordinated School Health and Safety Office custom tabulation and California Basic Educational Data System (May 2017)	2016
California Department of Education, DataQuest (Jun. 2016)	2015
California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015

Source	Year(s)
California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009	2016
California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990–1999, 2000–2010, 2010–2060 (Oct. 2016)	2016
California Department of Justice, Arrest Data	2015
California Department of Justice, Criminal Justice Statistics Center, Domestic Violence–Related Calls for Assistance Database (1998–2003) and Online Query System (Aug. 2015)	2014
California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files	2013
California Department of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017)	2013
California Department of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb. 2016)	2016
California Department of Public Health, Sexually Transmitted Diseases Data	2015
California EpiCenter	2013–2014
California Office of Statewide Health Planning and Development (OSHPD); special tabulation 2016	2009–2011, 2011, 2012–2014, 2013–2015, 2014, 2015, 2016
California State Highway Patrol	2015
Centers for Disease Control and Prevention, CDC WONDER mortality data	2010–2016, 2012–2016, 2013–2016, 2014–2016
Centers for Disease Control and Prevention, Natality data on CDC WONDER	2013
Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS)	2005–2009, 2006–2010, 2006–2012, 2011–2012, 2014, 2015, 2016
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2013, 2015
Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data and Statistics	2015
Centers for Medicare and Medicaid Services	2015, 2014, 2013, 2012, 2011, 2010
Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health, Advancing data-in-action partnerships for children and children with special health care needs in California counties and cities using synthetic estimation from the 2011–12 National Survey of Children's Health and 2008–2012 American Community Survey (Nov. 2016)	2011–2012
Child Care Regional Market Rate Survey, 2014	2014
Climate Impact Lab	2016
Consolidated Planning/CHAS Data	2011–2015
Contra Costa Council on Homelessness. (2017). 2017 Point in Time Count: A Snapshot of Contra Costa County	2017
County Business Patterns	2016, 2015, 2014, 2013, 2012
County Health Rankings	2010, 2012–2014, 2014, 2015, 2016, 2017
Dartmouth Atlas of Health Care	2015, 2014, 2013, 2012, 2011, 2010

Source	Year(s)
Decennial Census	2010
Environmental Protection Agency National Air Toxics Assessment	2011
Environmental Protection Agency, EPA Smart Location Database	2011, 2013
Fatality Analysis Reporting System	2011–2015
FCC Fixed Broadband Deployment Data	2016
Federal Bureau of Investigation, FBI Uniform Crime Reports	2012–2014
Feeding America	2014, 2016
Fitnessgram Physical Fitness Testing	2016–2017
Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America)	2014
Health Resources and Services Administration	2016
Insight Center for Community Economic Development	2014
Institute for Health Metrics and Evaluation	2014
Interactive Atlas of Heart Disease and Stroke	2012–2014
Mapping Medicare Disparities Tool	2015
Martin et al. (2015), Births: Final Data for 2013	2013
National Cancer Institute	2011–2015
National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program, Research data, 1973–2013 (Nov. 2015)	2009–2013
National Center for Chronic Disease Prevention and Health Promotion	2013, 2015
National Center for Education Statistics – Common Core of Data	2015–2016
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013–2014, 2015, 2016
National Environmental Public Health Tracking Network	2014, 2013, 2012, 2011, 2010, 2009, 2008
National Flood Hazard Layer	2011
National Land Cover Database 2011	2011
National Survey of Children's Health	2016
National Vital Statistics Reports, *64*(1) (Mar. 2015)	2015
National Vital Statistics System	2004–2010, 2008–2014, 2011–2015
Nielsen Demographic Data (PopFacts)	2014
Nielsen SiteReports	2014
North America Land Data Assimilation System (NLDAS)	2013, 2012, 2011, 2010, 2009, 2008, 2007, 2006
Opportunity Nation	2017
Population Reference Bureau, analysis of data from the National Survey of Children's Health and the American Community Survey (Mar. 2018)	2016
Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Nov. 2015, Dec. 2017)	2014, 2016
Population Reference Bureau, Population Estimates 2010–2016 (Aug. 2017)	2016
Provider of Services File	2018
Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008, 2009, 2011, and 2013. Public Health Institute, Survey Research Group	2008, 2009, 2011, and 2013

Source	Year(s)
Safe Drinking Water Information System	2015
State Cancer Profiles	2010–2014, 2011–2015
U.S. Cancer Statistics Working Group, United States cancer statistics: 1999–2013 incidence and mortality web-based report (Apr. 2016)	2009–2013
U.S. Census Bureau, American Community Survey	2012–2016, 2016
U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES.	2016
U.S. Census Bureau, Small Area Income and Poverty Estimates	2015
U.S. Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas	2014, 2015
U.S. Department of Education, EDFacts (Accessed via DATA.GOV)	2014–2015, 2015–2016
U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S. 2014 and 2017 (Mar. 2018)	2017
U.S. Drought Monitor	2012–2014
UCLA Center for Health Policy Research, California Health Interview Survey	2009, 2011–2012, 2013–2014, 2014, 2014–2015, 2015, 2015–2016, 2016
University of Missouri, Center for Applied Research and Environmental Systems	2012–2015
University of Wisconsin Population Health Institute, County Health Rankings	2018
Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates (Accessed 17 August 2018)	2013, 2015
Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016)	2013
Zilpy.com, Rental Market Trends (Oct. 2018)	2018

Attachment 4. Secondary Data Tables, Eastern Contra Costa County

TABLE OF CONTENTS

INTRODUCTION

Health needs data found in the following tables were collected from these sources:

- California Department of Public Health (CDPH) county health status profiles, accessed via https://www.cdph.ca.gov/Programs/CHSI/Pages/Individual-County-Data-Sheets.aspx, pulled on July 24, 2018
- California Health Interview Survey (CHIS), accessed via http://ask.chis.ucla.edu/, pulled on August 5, 2018
- California Healthy Kids Survey (CHKS), accessed via http://chks.wested.org/query-chks/, pulled on August 5, 2018
- The new CHNA data platform, replacing Community Commons (CHNA.org), accessed via http://chna.org/kp, pulled on May 17, 20181
- County Health Rankings (CHR), accessed via http://www.countyhealthrankings.org/app/california/2018/rankings/contra-costa/county/factors/overall/snapshot, pulled on July 30, 2018
- KidsData.org, a program of the Lucile Packard Foundation for Children's Health, accessed via https://www.kidsdata.org, pulled on August 5, 2018
- Vera Institute of Justice Incarceration Trends, accessed via http://trends.vera.org/rates/contra-costa-county-ca?incarcerationData=all, pulled on July 31, 2018
- Zilpy, accessed via http://www.zilpy.com/, pulled on November 12, 2018

Statistical data tables compare local data to California state benchmarks or national goals, whichever is more stringent. The absolute percentage difference was calculated by subtracting the local value from the benchmark (or national goal), then divided by the latter, and taking the absolute value of the result. For example, if the local value of an indicator is 10.0, and the state value is 8.3, the absolute percentage difference is (10.0-8.3)/8.3 = 20.5%. If the directionality of the indicator suggests that a lower value is better, this indicator would be flagged as missing the benchmark by 20.5%.

The source (data platform) of every indicator is noted in parentheses after the indicator name (see

Attachment 4. CHNA.org indicators are for the Eastern Contra Costa County area only. Other indicators are county-wide, as shown by the parenthetical "(CCC)." When the CDC's Healthy People 2020

"Other Health," which is last.

[1] Data updated September 4, 2018.

EXAMPLE:

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Asthma ED Visits, All Ages (per 10,000) (CCC) (CDPH)	**rate**	**64.6**	**49.5**	N/A	**30.5%**
Asthma Prevalence, Adults (CHNA.org)	**percent**	**16.5**	**14.8**	**-0.5**	**11.5%**
Asthma Hospitalizations, Children/Youth Ages 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	**7.9**	7.7	N/A	2.6%
Climate-Related Mortality Impacts (CHNA.org)	percent	0.4	8.4	1.0	95.2%
Driving Alone to Work, Long Distances (CHNA.org)	**percent**	**58.1**	**39.3**	**-2.4**	**47.8%**
Ozone Levels (CHNA.org)	percent	37.6	42.0	0.7	10.5%
Physical Inactivity (Adult) (CHNA.org)	percent	**17.8**	17.3	-0.2	2.9%
Road Network Density (road miles per square mile of land) (CHNA.org)	**rate**	**4.6**	**2.0**	**-1.8**	**130.0%**
Suicide Deaths (CHNA.org)	rate	9.7	10.2 (HP)	0.2	4.9%
Tree Canopy Cover (CHNA.org)	**percent**	**7.2**	**8.3**	-0.2	**13.3%**
Uninsured Children (CHNA.org)	percent	4.2	10.4	3.0	59.6%

Geographic area indicators that are at least two standard deviations (SD) or at least 5% worse than the benchmark have an asterisk, appear in **bold type**, and are highlighted in dark orange (e.g., "Driving Alone to Work, Long Distances" above). Those that are at least one SD worse have an asterisk, appear in **bold type**, and are highlighted in light orange (e.g., "Road Network Density" above). Those that are at least a half SD worse have an asterisk, appear in **bold type**, and are highlighted in yellow (e.g., "Asthma Prevalence, Adults" above). Indicators that are worse than their benchmark, but by less than a half SD, have their actual statistic (value) in **bold type**, rather than the entire indicator row, and are highlighted in gray (e.g., "Physical Inactivity (Adult)" above). When SDs are not available, the indicators that are worse than their benchmark by less than 5% only have their statistic in **bold type** (e.g., "Asthma Hospitalizations, Children/Youth Ages 5–17" above).

Indicators that are within one SD better of the benchmark are merely highlighted in gray (e.g., "Ozone Levels" above). Those at least one SD better than the benchmark are highlighted in light blue (e.g., "Climate-Related Mortality Impacts" above), and those at least two SDs better are highlighted in dark blue (e.g., "Uninsured Children" above). All indicators are rounded to the nearest tenth decimal point except when their values are less than one; then they are rounded to the nearest hundredth.

For the Race and Ethnicity tables, in which comparisons are made by race/ethnicity to the benchmark, statistics that are in **bold type** and highlighted in dark orange are at least 5% worse than the benchmark.

A trend is a pattern observed over time. When trend data were available, they are described below the data tables. A "mixed" trend means that the trend pattern is not clear.

BEHAVIORAL HEALTH

Mental Health

TABLE 46. STATISTICAL DATA FOR BEHAVIORAL HEALTH

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)**	**percent**	**18.9**	**16.4**	N/A	**15.2%**
***Adults Seeing Healthcare Provider for Behavioral Health Services (CCC) (AskCHIS)**	**percent**	**16.5**	**13.4**	N/A	**23.1%**
Adults with Any Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	58.4	61.0	N/A	4.3%
Adults with Four or More Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	15.2	15.9	N/A	4.4%
***Bullied at School, 7th Graders (CCC) (CHKS)**	**percent**	**42.3**	**39.4**	N/A	**7.4%**
Bullied at School, 9th Graders (CCC) (CHKS)	percent	**35.0**	34.4	N/A	1.7%
Bullied at School, 11th Graders (CCC) (CHKS)	percent	**28.8**	27.6	N/A	4.3%
Children in Foster Care (CCC) (Kidsdata.org)	rate	3.7	5.8	N/A	36.2%
Children Needing and Receiving Behavioral Health Care Services (CCC) (Kidsdata.org)	percent	62.5	62.7	N/A	0.3%
Children with Two or More Adverse Experiences (Parent Reported) (CCC) (Kidsdata.org)	percent	14.7	16.4	N/A	10.4%
Cyberbullied More Than Once, 7th Graders (CCC) (CHKS)	percent	**9.8**	9.4	N/A	4.3%
Cyberbullied More Than Once, 9th Graders (CCC) (CHKS)	percent	**12.5**	12.4	N/A	0.8%
Cyberbullied More Than Once, 11th Graders (CCC) (CHKS)	percent	**12.6**	12.4	N/A	1.6%
Deaths by Suicide, Drug or Alcohol Poisoning (CHNA.org)	rate	29.5	34.2	0.5	13.7%
Depression Among Medicare Beneficiaries (CHNA.org)	percent	14.1	14.3	0.1	1.4%
Depression-Related Feelings, 7th Graders (CCC) (CHKS)	percent	21.9	25.4	N/A	13.8%
Depression-Related Feelings, 9th Graders (CCC) (CHKS)	percent	28.0	31.5	N/A	11.1%
Depression-Related Feelings, 11th Graders (CCC) (CHKS)	percent	31.8	33.4	N/A	4.8%
Domestic Violence Calls for Assistance (CCC) (KidsData.org)	rate	4.6	6.0	N/A	23.3%
Domestic Violence Hospitalizations (CHNA.org)	**rate**	**6.3**	**4.9**	-0.4	**28.6%**
Frequent Mental Distress (CCC) (CHR)	percent	10.0	10.6	N/A	5.7%
***Homicide (CCC) (CHR)**	**rate**	**6.0**	**5.0**	N/A	**20.0%**
Insufficient Social and Emotional Support (CHNA.org)	percent	20.9	24.7	1.1	15.4%
Meaningful Participation in School: Low, 7th Graders (CCC) (CHKS)	percent	27.6	31.3	N/A	11.8%
Meaningful Participation in School: Low, 9th Graders (CCC) (CHKS)	percent	34.9	37.9	N/A	7.9%
Meaningful Participation in School: Low, 11th	percent	35.0	36.9	N/A	5.1%

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Graders (CCC) (CHKS)					
Mental Health Hospitalization, Children Ages 5–14 (CCC) (Kidsdata.org)	rate	2.2	2.5	N/A	12.0%
Mental Health Hospitalization, Youth Ages 15–19 (CCC) (Kidsdata.org)	rate	8.7	9.8	N/A	11.2%
Mental Health Providers (CHNA.org)	rate	301.1	288.7	0.1	4.3%
Poor Mental Health Days (CHNA.org)	number	3.5	3.7	0.5	5.4%
Recent Informal Community Engagement (Met with Others) (Adult) (CCC) (AskCHIS)	percent	**15.9**	16.5	N/A	3.6%
***Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (CCC) (AskCHIS)**	**percent**	**16.0**	**11.1**	N/A	**44.1%**
School Connectedness: Low, 7th Graders (CCC) (CHKS)	percent	9.0	10.2	N/A	11.8%
School Connectedness: Low, 9th Graders (CCC) (CHKS)	percent	11.0	11.5	N/A	4.3%
School Connectedness: Low, 11th Graders (CCC) (CHKS)	percent	**12.8**	12.5	N/A	2.4%
Seriously Considered Suicide, 9th Graders (CCC) (CHKS)	percent	16.7	19.0	N/A	12.1%
Seriously Considered Suicide, 11th Graders (CCC) (CHKS)	percent	**18.3**	18.1	N/A	1.1%
Seriously Considered Suicide, Adults (CHNA.org)	percent	7.0	10.0	1.1	30.0%
***Social Associations (per 10,000) (CHNA.org)**	**rate**	**3.9**	**6.5**	**-1.9**	**40.0%**
Students per School Psychologist (CCC) (Kidsdata.org)	number	959	1,265	N/A	24.2%
Suicide Deaths (CHNA.org)	rate	9.7	10.2 (HP)	0.2	4.9%
***Time in Foster Care (Median Months) (CCC) (Kidsdata.org)**	**number**	**17.5**	**15.6**	N/A	**12.2%**
Young People Not in School and Not Working (CHNA.org)	percent	6.7	7.7	0.4	13.0%

Trends

Trend data are available on certain indicators.

- Adults Needing Help for Behavioral Health Issue: Trend is mixed.
- Children in Foster Care: Downward trend since 2000, slight upward trend since 2010.
- Children without Secure Parental Employment: Generally trending down since 2009.
- Mental Health Hospitalizations, Children Ages 5–14: Long-term trend mixed, trending down since 2011.
- Mental Health Hospitalizations, Youth Ages 15–19: Long-term trend mixed, trending slightly up since 2014.
- Mental Diseases and Disorders Hospitalizations, Children/Youth Ages 0–17: Trend is mixed.
- Time in Foster Care, Median Months: Mixed trend, slightly upward since 2009.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 47. STATISTICAL DATA FOR BEHAVIORAL HEALTH BY ETHNICITY

Indicator	Ind. Type	Bench mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi Race	Hisp / Lat (Any Race)
Caring Adults at School: Low (CCC) (CHKS)	percent	#	10.3%	**18.9%**	**10.5%**	**10.8%**	**28.0%**	**12.6%**	**12.9%**	**16.9%**
Cyberbullied More Than Once (CCC) (CHKS)	percent	#	8.5%	7.7%	6.8%	**10.8%**	8.1%	**9.6%**	**10.2%**	**9.9%**
Depression-Related Feelings (CCC) (CHKS)	percent	#	23.4%	**31.6%**	**24.8%**	**31.2%**	19.2%	20.2%	**28.5%**	**31.4%**
Meaningful Participation at School: Low (CCC) (CHKS)	percent	#	27.3%	**28.5%**	25.9%	**29.5%**	**55.1%**	**40.7%**	**32.6%**	**40.4%**
School Connectednes: Low (CCC) (CHKS)	percent	#	6.5%	**20.5%**	6.4%	**10.4%**	**8.0%**	**11.3%**	**12.0%**	**12.0%**
Seriously Considered Suicide (CCC) (CHKS)	percent	#	15.0%	**29.6%**	**15.8%**	**18.6%**	**16.0%**	11.7%	**20.2%**	**16.0%**
Suicide Deaths (CHNA.org)	rate	10.2 (HP)	**13.1**	6.9	5.6					5.8

Blank cells indicate data were unavailable.
Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.

Substance Use/Tobacco

TABLE 48. STATISTICAL DATA FOR SUBSTANCE USE/TOBACCO

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)**	**percent**	**18.9**	**16.4**	N/A	**15.2%**
***Adults Seeing Healthcare Provider for Behavioral Health Services (CCC) (AskCHIS)**	**percent**	**16.5**	**13.4**	N/A	**23.1%**
Beer, Wine, and Liquor Stores (per 10,000) (CHNA.org)	rate	0.54	1.06	1.6	49.1%
Chronic Liver Disease/Cirrhosis Deaths (CCC) (CDPH)	rate	8.6	12.2	N/A	29.5%
***Current/Former Smokers, Adults (CHNA.org)**	**percent**	**15.9**	**13.7**	**-0.6**	**16.1%**
Deaths by Suicide, Drug or Alcohol Poisoning (CHNA.org)	rate	29.5	34.2	0.5	13.7%
Excessive Drinking (CHNA.org)	percent	31.7	33.4	0.5	5.1%
Heart Disease Deaths (CHNA.org)	rate	69.2	99.5	1.5	30.5%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000) (CHNA.org)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries (CHNA.org)	percent	5.4	7.0	1.0	22.9%
Impaired Driving Deaths (CHNA.org)	percent	28.1	29.0	0.2	3.1%
Low Birth Weight (CHNA.org)	percent	6.7	6.8	0.1	1.5%
***Lung Cancer Incidence (CHNA.org)**	**rate**	**47.4**	**44.6**	**-0.5**	**6.3%**
***Opioid Prescription Drug Claims (CHNA.org)**	**percent**	**7.7**	**7.0**	-0.4	**10.0%**
Poor Mental Health Days (CHNA.org)	number	3.5	3.7	0.5	5.4%
Recent Alcohol/Drug Use, 7th Graders (CCC) (CHKS)	percent	7.8	10.4	N/A	25.0%
Recent Alcohol/Drug Use, 9th Graders (CCC) (CHKS)	percent	20.7	23.2	N/A	10.8%
Recent Alcohol/Drug Use, 11th Graders (CCC) (CHKS)	percent	31.7	33.4	N/A	5.1%
Recent Marijuana Use, 7th Graders (CCC) (CHKS)	percent	2.7	4.2	N/A	35.7%
Recent Marijuana Use, 9th Graders (CCC) (CHKS)	percent	11.0	12.3	N/A	10.6%
Recent Marijuana Use, 11th Graders (CCC) (CHKS)	percent	18.6	18.0	N/A	3.3%
Very Low Birth Weight (CCC) (Kidsdata.org)	percent	1.1	1.2	N/A	8.3%

Trends

Trend data are available on certain indicators.

- Very Low Birth Weight: Trend is relatively flat since 1995.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 49. STATISTICAL DATA FOR SUBSTANCE USE/TOBACCO BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Heart Disease Deaths (CHNA.org)	rate	99.5	71.3	**106.7**	46.9					53.4
Recent Alcohol/Drug Use – Youth (CCC) (CHKS)	percent	#	23.1%	17.5%	8.0%	18.1%	12.1%	12.8%	20.9%	**24.2%**
Recent Marijuana Use – Youth (CCC) (CHKS)	percent	#	11.6%	**12.3%**	3.6%	10.0%	5.3%	5.9%	**12.4%**	**13.1%**

Blank cells indicate data were unavailable.
Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.

CLIMATE/NATURAL ENVIRONMENT

TABLE 50. STATISTICAL DATA FOR CLIMATE/NATURAL ENVIRONMENT

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Active Asthma Prevalence, All Ages (CCC) (CDPH)**	**percent**	**10.6**	**8.3**	N/A	**27.7%**
***Asthma Hospitalizations, All Ages (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**8.5**	**7.6**	N/A	**11.8%**
***Asthma Hospitalizations, Children Ages 0-4 (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**22.7**	**19.6**	N/A	**15.8%**
Asthma Hospitalizations, Children/Youth Ages 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	**7.9**	7.7	N/A	2.6%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000) (CHNA.org)	rate	2.0	2.4	0.7	16.7%
***Asthma Prevalence, Adults (CHNA.org)**	**percent**	**16.5**	**14.8**	**-0.5**	**11.5%**
Climate-Related Mortality Impacts (CHNA.org)	percent	0.4	8.4	1.0	95.2%
Drinking Water Violations (CHNA.org)	number	0	0.8	2.0	100.0%
Driving Alone to Work (CHNA.org)	percent	71.0	73.5	0.3	3.4%
***Driving Alone to Work, Long Distances (CHNA.org)**	**percent**	**58.1**	**39.3**	**-2.4**	**47.8%**
Drought Severity (CHNA.org)	percent	90.4	92.8	0.4	2.6%
Flood Vulnerability (CHNA.org)	percent	3.7	3.7	0.0	0.0%
Heat Index (CHNA.org)	percent	0	2.7	0.6	100.0%
Ozone Levels (CHNA.org)	percent	37.6	42.0	0.7	10.5%
Particulate Matter 2.5 Levels (CHNA.org)	percent	9.3	10.7	0.7	13.1%
***Public Transit Stops Within 0.5 Miles (CHNA.org)**	**percent**	**12.8**	**16.8**	**-0.5**	**23.8%**
Respiratory Hazard Index (CHNA.org)	number	1.8	2.2	0.5	18.2%
***Road Network Density (road miles per square mile of land) (CHNA.org)**	**rate**	**4.6**	**2.0**	**-1.8**	**130.0%**
***Tree Canopy Cover (CHNA.org)**	**percent**	**7.2**	**8.3**	-0.2	**13.3%**

Trends

No trend data are available.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 51. STATISTICAL DATA FOR CLIMATE/NATURAL ENVIRONMENT BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Asthma Hospitalizations, All Ages (per 10,000) (CCC) (CDPH)	rate	7.6	6.3	**26.0**	4.8*					**8.1**

Blank cells indicate data were unavailable.
* Statistic is for Asian/Pacific Islander combined.

COMMUNITY AND FAMILY SAFETY

Crime/Intentional Injury

TABLE 52. STATISTICAL DATA FOR CRIME/INTENTIONAL INJURY

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Beer, Wine, and Liquor Stores (per 10,000) (CHNA.org)	rate	0.54	1.06	1.6	49.1%
***Bullied at School, 7th Graders (CCC) (CHKS)**	**percent**	**42.3**	**39.4**	N/A	**7.4%**
Bullied at School, 9th Graders (CCC) (CHKS)	percent	**35.0**	34.4	N/A	1.7%
Bullied at School, 11th Graders (CCC) (CHKS)	percent	**28.8**	27.6	N/A	4.3%
Cyberbullied More Than Once, 7th Graders (CCC) (CHKS)	percent	**9.8**	9.4	N/A	4.3%
Cyberbullied More Than Once, 9th Graders (CCC) (CHKS)	percent	**12.5**	12.4	N/A	0.8%
Cyberbullied More Than Once, 11th Graders (CCC) (CHKS)	percent	**12.6**	12.4	N/A	1.6%
Domestic Violence Calls for Assistance (CCC) (KidsData.org)	rate	4.6	6.0	N/A	23.3%
Domestic Violence Hospitalizations (CHNA.org)	**rate**	**6.3**	**4.9**	-0.4	**28.6%**
Fear Being Beaten Up at School, 7th Graders (CCC) (CHKS)	percent	23.3	24.7	N/A	5.7%
Fear Being Beaten Up at School, 9th Graders (CCC) (CHKS)	percent	16.9	17.9	N/A	5.6%
Fear Being Beaten Up at School, 11th Graders (CCC) (CHKS)	percent	10.9	11.9	N/A	8.4%
***Firearm Fatalities (CCC) (CHR)**	**rate**	**9.0**	**8.0**	N/A	**12.5%**
Gang Membership, 7th Graders (CCC) (CHKS)	percent	7.0	8.1	N/A	13.6%
***Gang Membership, 9th Graders (CCC) (CHKS)**	**percent**	**8.7**	**7.5**	N/A	**16.0%**
***Gang Membership, 11th Graders (CCC) (CHKS)**	**percent**	**8.0**	**7.5**	N/A	**6.7%**
***Homicide (CCC) (CHR)**	**rate**	**6.0**	**5.0**	N/A	**20.0%**
Injury Deaths (CHNA.org)	rate	44.3	46.6	0.2	4.9%
Jail Admissions, Ages 15-64 (CCC) (Vera)	rate	3,534.8	3,805.9	N/A	7.1%
Jail Incarceration, Ages 15-64 (CCC) (Vera)	rate	161.0	278.9	N/A	42.3%
Juvenile Felony Arrests, Ages 10-17 (per 1,000) (CCC) (Kidsdata.org)	rate	4.3	5.3	N/A	18.9%
School Perceived as Unsafe/Very Unsafe, 7th Graders (CCC) (CHKS)	percent	9.1	9.3	N/A	2.2%
***School Perceived as Unsafe/Very Unsafe, 9th Graders (CCC) (CHKS)**	**percent**	**8.7**	**7.7**	N/A	**13.0%**
***School Perceived as Unsafe/Very Unsafe, 11th Graders (CCC) (CHKS)**	**percent**	**8.4**	**6.5**	N/A	**29.2%**
Substantiated Child Abuse and Neglect (per 1,000 under age 18) (CCC) (KidsData.org)	rate	4.3	8.2	N/A	47.6%
***Traumatic Injury Hospitalizations, Children Ages 0-17 (CCC) (Kidsdata.org)**	**percent**	**1.5**	**1.1**	N/A	**36.4%**
Violent Crimes (CHNA.org)	rate	366.0	402.7	0.3	9.1%

Data Without Benchmarks

Certain indicators have no state or national comparison.

- The prison incarceration rate was 241.3 per 100,000 residents ages 15–64 in Contra Costa County in 2013 (Vera).

Trends

Trend data are available on certain indicators.

- Domestic Violence Calls for Assistance: Downward trend since 1998.
- Jail Incarceration: Generally trending down since 2003.
- Juvenile Felony Arrest Rate: Trending down since 2007.
- Substantiated Child Abuse and Neglect: Generally trending down since 2001.
- Traumatic Injury Hospitalizations, Children Ages 0-17: Trend is mixed.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 53. STATISTICAL DATA FOR CRIME/INTENTIONAL INJURY BY ETHNICITY

Indicator	Ind. Type	Bench mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi Race	Hisp / Lat (Any Race)
Bullied at School (CCC) (CHKS)	percent	#	32.8%	**43.2%**	**36.7%**	**38.4%**	23.4%	31.8%	**36.8%**	31.8%
Fear Being Beaten Up at School (CCC) (CHKS)	percent	#	11.3%	**14.5%**	**11.6%**	**16.0%**	**36.7%**	11.2%	**12.7%**	**14.5%**
Gang Membership (CCC) (CHKS)	percent	#	5.9%	**7.9%**	4.1%	**9.1%**	2.9%	**6.3%**	**9.4%**	**7.2%**
Jail Incarceration (CCC) (Vera)	rate	278.9	98.1	**616.0**	9.8*					250.5
Juvenile Felony Arrest Rate (per 1,000) (CCC) (Kidsdata.org)	rate	5.3	2.1	**22.0**				1.3		3.6
School Perceived as Unsafe/Very Unsafe (CCC) (CHKS)	percent	#	4.2%	**10.0%**	**5.3%**	**6.3%**	3.5%	**8.4%**	**8.6%**	**9.6%**
Substantiated Child Abuse and Neglect (per 1,000) (CCC) (Kidsdata.org)	rate	8.2	3.6	**13.4**	1.8*					4.2

Blank cells indicate that data were unavailable.
Benchmarks available only by grade. Ethnicity data available only in the aggregate. Comparison category is White.
* Statistic is for Asian/Pacific Islander combined.

Unintended Injury/Accidents

Table 54. Statistical Data for Unintended Injury/Accidents

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Beer, Wine, and Liquor Stores (per 10,000) (CHNA.org)	rate	0.54	1.06	1.6	49.1%
Elevated Blood Lead Levels in Children Ages 0–5 (CCC) (Kidsdata.org)	percent	0.1	0.2	N/A	50.0%
Elevated Blood Lead Levels in Children/Youth Ages 6–20 (CCC) (Kidsdata.org)	percent	0.2	0.3	N/A	33.3%
***Firearm Fatalities (CCC) (CHR)**	**rate**	**9.0**	**8.0**	N/A	**12.5%**
Impaired Driving Deaths (CHNA.org)	percent	28.1	29.0	0.2	3.1%
Injury Deaths (CHNA.org)	rate	44.3	46.6	0.2	4.9%
Motor Vehicle Crash Deaths (CHNA.org)	rate	6.4	8.6	0.7	25.6%
***Pedestrian Accident Deaths (CHNA.org)**	**rate**	**2.6**	**2.3**	**-0.5**	**13.0%**
***Poisoning Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)**	**percent**	**1.3**	**0.9**	N/A	**44.4%**
***Traumatic Injury Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)**	**percent**	**1.5**	**1.1**	N/A	**36.4%**
Unintentional Injury Deaths (CCC) (CDPH)	rate	26.1	30.3	N/A	13.9%

Trends

Trend data are available on certain indicators.

- Elevated Blood Lead Levels in Children Ages 0–5: Relatively unchanged since 2007.
- Elevated Blood Lead Levels in Children/Youth Ages 6–20: Relatively unchanged at since 2009.
- Poisoning Hospitalizations, Children Ages 0–17: Trend is mixed.
- Traumatic Injury Hospitalizations, Children Ages 0–17: Trend is mixed.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

Table 55. Statistical Data for Unintended Injury/Accidents by Ethnicity

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths (CHNA.org)	rate	8.6	7.2	**10.2**	2.7					5.2

Blank cells indicate that data were unavailable.

ECONOMIC SECURITY

TABLE 56. STATISTICAL DATA FOR ECONOMIC SECURITY

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Adults with an Associate's Degree or Higher, Age 25+ (CHNA.org)**	**percent**	**31.0**	**39.8**	**-0.9**	**22.1%**
Adults with No High School Diploma, Age 25+ (CHNA.org)	percent	15.0	17.9	0.5	16.2%
***Adults with Some Post-secondary Education, Ages 25-44 (CHNA.org)**	**percent**	**60.1**	**63.6**	-0.4	**5.5%**
***Banking Institutions (per 10,000) (CHNA.org)**	**rate**	**1.9**	**2.7**	**-1.1**	**29.6%**
Child Care Availability (Licensed) (CCC) (Kidsdata.org)	percent	30	25	N/A	20.0%
Children Below 100% FPL (CHNA.org)	percent	18.0	21.9	0.6	17.8%
Children in Single-parent Households (CHNA.org)	percent	**33.3**	31.8	-0.3	4.7%
Children without Secure Parental Employment (CCC) (Kidsdata.org)	percent	27.2	32.8	N/A	17.1%
Cost Burdened Households (CHNA.org)	percent	**43.1**	42.8	-0.1	0.7%
***Cost of Infant Child Care, Annually, Child Care Center (CCC) (Kidsdata.org)**	**dollars**	**14,979**	**13,327**	**N/A**	**12.4%**
***Cost of Preschool Child Care, Annually, Child Care Center (CCC) (Kidsdata.org)**	**dollars**	**10,895**	**9,106**	**N/A**	**19.6%**
Free and Reduced Price Lunch (CHNA.org)	percent	54.4	58.9	0.4	7.6%
High Speed Internet (CHNA.org)	percent	98.2	95.4	0.3	2.9%
Income Inequality - 80/20 Ratio (CHNA.org)	number	3.6	5.1	2.8	29.4%
Median Household Income (CHNA.org)	number	82,881	65,812	1.2	25.9%
***Medicaid/Public Insurance Enrollment (CHNA.org)**	**percent**	**23.6**	**21.8**	-0.3	**8.3%**
Opportunity Index (CHNA.org)	number	60.0	51.9	1.0	15.6%
Population Below 100% FPL (CHNA.org)	percent	12.7	15.8	0.7	19.6%
***SNAP Benefits (CHNA.org)**	**percent**	**10.7**	**9.4**	-0.3	**13.8%**
Unemployment (CHNA.org)	percent	3.1	4.0	0.5	22.5%
Uninsured Children (CHNA.org)	percent	4.2	10.4	3.0	59.6%
Uninsured Population (CHNA.org)	percent	9.6	12.6	1.0	23.8%
Young People Not in School and Not Working (CHNA.org)	percent	6.7	7.7	0.4	13.0%

Trends

Trend data are available on certain indicators.

- Child Care Availability (Licensed): Relatively unchanged since 2000.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 57. STATISTICAL DATA FOR ECONOMIC SECURITY BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Adults with No High School Diploma (CHNA.org)	percent	17.9%	6.3%	6.4%	11.5%	13.7%	**19.8%**	**35.4%**	9.3%	**33.1%**
Children Below 100% FPL (CHNA.org)	percent	21.9%	8.2%	**27.4%**	12.4%	20.5%	14.1%	**25.0%**	16.0%	21.6%
Median Household Income (CHNA.org)	dollars	65,812	96,220	**52,917**	102,276		**58,507**	**57,053**	72,339	**61,038**
Population Below 100% FPL (CHNA.org)	percent	15.8%	7.3%	**20.2%**	9.8%	10.3%	13.3%	**17.3%**	14.9%	15.8%
SNAP Benefits (CHNA.org)	percent	9.4%	6.4%	**23.4%**	7.5%	**21.4%**	**14.2%**	**11.6%**	**15.2%**	**11.6%**
Uninsured Children (CHNA.org)	percent	10.4%	2.6%	2.6%	4.1%	7.5%	10.2%	6.8%	3.6%	5.6%
Uninsured Population (CHNA.org)	percent	12.6%	6.2%	6.3%	7.3%	**14.8%**	**13.9%**	**17.0%**	7.6%	**15.1%**

EDUCATION AND LITERACY

TABLE 58. STATISTICAL DATA FOR EDUCATION AND LITERACY

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Adults with an Associate's Degree or Higher, Age 25+ (CHNA.org)**	**percent**	**31.0**	**39.8**	**-0.9**	**22.1%**
Adults with No High School Diploma, Age 25+ (CHNA.org)	percent	15.0	17.9	0.5	16.2%
***Adults with Some Post-secondary Education, Ages 25-44 (CHNA.org)**	**percent**	**60.1**	**63.6**	-0.4	**5.5%**
Children in Linguistically Isolated Households (CCC) (Kidsdata.org)	percent	8.0	10.5	N/A	23.8%
Cost of Preschool Child Care, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	**10,895**	9,106	N/A	19.6%
Expulsions (per 100 enrolled students) (CHNA.org)	rate	0.05	0.08	0.5	37.5%
High School Dropout (Adjusted)[2] (CCC) (Kidsdata.org)	percent	5.8	10.7	N/A	45.8%
High School Graduates Completing College Prep Courses (CCC) (Kidsdata.org)	percent	48.9	43.4	N/A	12.7%
High Speed Internet (CHNA.org)	percent	98.2	95.4	0.3	2.9%
Juvenile Felony Arrests, Ages 10-17 (per 1,000) (CCC) (Kidsdata.org)	rate	4.3	5.3	N/A	18.9%
On-Time High School Graduation (CHNA.org)	percent	85.6	82.9	0.5	3.3%
***Preschool Enrollment (CHNA.org)**	**percent**	**44.0**	**48.6**	**-0.5**	**9.5%**
***Reading At or Above Proficiency (CHNA.org)**	**percent**	**40.0**	**43.9**	**-0.5**	**8.9%**
***Students per Academic Counselor (CCC) (Kidsdata.org)**	**number**	**1,014**	**792**	N/A	**28.0%**
***Suspensions (per 100 enrolled students) (CHNA.org)**	**rate**	**12.0**	**5.9**	**-2.2**	**103.4%**
Teen Births (per 1,000 females ages 15–19) (CHNA.org)	rate	17.9	29.3	1.2	38.9%
***Truancy (per 100 students) (CCC) (Kidsdata.org)**	**rate**	**37.8**	**31.4**	N/A	**20.4%**

Trends

Trend data are available on certain indicators.

- Children in Linguistically Isolated Households: Mixed.
- High School Dropout (Adjusted): Downward trend since 2010.
- High School Graduates Completing College Prep Courses: Trending up since 2008.
- Students Per Academic Counselor: Trending down (i.e., improving) since 2013.
- Teen Births: Generally trending down since 1996.
- Truancy: Trend is mixed.

[2] From KidsData.org: "The adjusted cohort dropout rate measures the percentage of students who exit grades 9-12 Without a high school diploma, GED, or special education certificate of completion and do not remain enrolled after the end of the fourth year."

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 59. STATISTICAL DATA FOR EDUCATION AND LITERACY BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
High School Dropout (Adjusted) (CCC) (Kidsdata.org)	percent	10.7%	3.7%	**11.3%**	1.7%				5.7%	8.5%
High School Graduates Completing College Prep Courses (CCC) (Kidsdata.org)	percent	43.4%	57.6%	**26.1%**	71.8%	**26.7%**		57.6%†	51.8%	**34.9%**
Teen Births (per 1,000 females ages 15–19) (CCC) (Kidsdata.org)	rate	23.2	4.6	21.9					10.1	**24.3**

Blank cells indicate that data were unavailable.
† Statistic is for Filipino.

HEALTHCARE ACCESS AND DELIVERY

Access and delivery affect many different health conditions, including asthma, cancer, heart disease/stroke, oral health, and communicable diseases such as sexually-transmitted infections (STIs).

Access to and Delivery of Healthcare

TABLE 60. STATISTICAL DATA FOR ACCESS TO AND DELIVERY OF HEALTHCARE

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
30-Day Readmissions (CHNA.org)	percent	13.6	14.4	0.8	5.6%
***Adults Delayed/Didn't Get "Other Medical" Care (CCC) (AskCHIS)**	**percent**	**11.0**	**9.8**	N/A	**12.2%**
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000) (CHNA.org)	rate	2.0	2.4	0.7	16.7%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries (CHNA.org)	percent	63.6	59.7	0.8	6.5%
Dentists (CHNA.org)	rate	82.4	80.3	0.1	2.6%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	**81.6**	81.8	-0.1	0.2%
***Federally Qualified Health Centers (CHNA.org)**	**rate**	**1.0**	**2.5**	**-0.8**	**60.0%**
Lack of Dental Insurance Coverage (CHNA.org)	percent	32.3	38.5	0.9	16.1%
***Medicaid/Public Insurance Enrollment (CHNA.org)**	**percent**	**23.6**	**21.8**	-0.3	**8.3%**
Mental Health Providers (CHNA.org)	rate	301.1	288.7	0.1	4.3%
Poor or Fair Health, Adults (CHNA.org)	percent	12.1	17.2	1.4	29.7%
Poor Physical Health Days, Adults (CHNA.org)	number	3.3	3.7	0.9	10.8%
***Premature Death, Racial/Ethnic Disparity Index (CHNA.org)**	**number**	**46.6**	**36.8**	**-1.2**	**26.6%**
Preventable Hospital Events (CHNA.org)	rate	33.8	35.9	0.3	5.8%
Primary Care Physicians (CHNA.org)	rate	98.3	78.1	0.9	25.9%
Recent Dental Exam (Youth) (CHNA.org)	percent	**86.6**	86.7	0.0	0.1%
Recent Dental Visit (Adults) (CCC) (AskCHIS)	percent	74.2	70.3	N/A	5.5%
***Recent ER Visit, Adults (CCC) (AskCHIS)**	**percent**	**24.2**	**21.4**	N/A	**13.1%**
***Recent ER Visit, Adults 65+ (CCC) (AskCHIS)**	**percent**	**30.4**	**22.0**	N/A	**38.2%**
Recent Primary Care Visit (CHNA.org)	percent	73.2	72.4	0.2	1.1%
***Students per School Nurse (CCC) (Kidsdata.org)**	**number**	**5,393**	**2,784**	N/A	**93.7%**
Students per School Psychologist (CCC) (Kidsdata.org)	number	959	1,265	N/A	24.2%
***Students per School Speech/Language/Hearing Specialist (CCC) (Kidsdata.org)**	**number**	**1,359**	**1,263**	N/A	**7.6%**
Uninsured Children (CHNA.org)	percent	4.2	10.4	3.0	59.6%
Uninsured Population (CHNA.org)	percent	9.6	12.6	1.0	23.8%

Trends

Trend data are available on certain indicators.

- Students per School Nurse: Generally trending down (i.e., improving) since 2011.
- Students per School Psychologist: Trending down (i.e., improving) since 2012.
- Students per School Speech/Language/Hearing Specialist: Trending down (i.e., improving) since 2012.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 61. STATISTICAL DATA FOR ACCESS TO AND DELIVERY OF HEALTHCARE BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries (CHNA.org)	percent	59.7%	64.2%	**56.3%**						
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	81.8%	82.2%	**77.2%**						
Preventable Hospital Events (CHNA.org)	rate	35.9	32.5	**48.5**						
Uninsured Children (CHNA.org)	percent	10.4%	2.6%	2.6%	4.1%	7.5%	10.2%	6.8%	3.6%	5.6%
Uninsured Population (CHNA.org)	percent	12.6%	6.2%	6.3%	7.3%	**14.8%**	**13.9%**	**17.0%**	7.6%	**15.1%**

Blank cells indicate data were unavailable.

Asthma and Respiratory Conditions

TABLE 62. STATISTICAL DATA FOR ASTHMA AND RESPIRATORY CONDITIONS

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Active Asthma Prevalence, All Ages (CCC) (CDPH)**	**percent**	**10.6**	**8.3**	N/A	**27.7%**
***Asthma Diagnoses, Children Ages 1–17 (CCC) (Kidsdata.org)**	**percent**	**16.9**	**15.2**	N/A	**11.2%**
***Asthma ED Visits, All Ages (per 10,000) (CCC) (CDPH)**	**rate**	**64.6**	**49.5**	N/A	**30.5%**
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000) (CHNA.org)	rate	2.0	2.4	0.7	16.7%
***Asthma Hospitalizations, All Ages (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**8.5**	**7.6**	N/A	**11.8%**
***Asthma Hospitalizations, Children Ages 0-4 (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**22.7**	**19.6**	N/A	**15.8%**
Asthma Hospitalizations, Children/Youth Ages 5–17 (per 10,000) (CCC) (Kidsdata.org)	rate	**7.9**	7.7	N/A	2.6%
***Asthma Prevalence, Adults (CHNA.org)**	**percent**	**16.5**	**14.8**	**-0.5**	**11.5%**
***Average Charge per Asthma Hospitalization (CCC) (CDPH)**	**dollars**	**45,784**	**39,860**	N/A	**14.9%**
Ozone Levels (CHNA.org)	percent	37.6	42.0	0.7	10.5%
Particulate Matter 2.5 Levels (CHNA.org)	percent	9.3	10.7	0.7	13.1%
Respiratory Hazard Index (CHNA.org)	number	1.8	2.2	0.5	18.2%

Trends

Trend data are available on certain indicators.

- Asthma Diagnoses, Children Ages 1–17: Long-term trend mixed; trending down since 2009.
- Asthma Hospitalizations, Children Ages 0-–4: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Ages 0–17: Long-term trend mixed, trending up since 2012.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 63. STATISTICAL DATA FOR ASTHMA AND RESPIRATORY CONDITIONS BY ETHNICITY

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Asthma ED Visits, All Ages (per 10,000) (CCC) (CDPH)	rate	49.5	38.6	**233.0**	25.3*					**65.1**
Asthma Hospitalizations, All Ages (per 10,000) (CCC) (CDPH)	rate	7.6	6.3	**26.0**	4.8*					**8.1**

Blank cells indicate data were unavailable. * Statistic is for Asian/Pacific Islander combined.

Cancer

Table 64. Statistical Data for Cancer

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Breast Cancer Deaths, Females (CCC) (CDPH)	rate	19.0	19.1	N/A	0.5%
***Breast Cancer Incidence, Females (CHNA.org)**	**rate**	**130.6**	**120.7**	**-1.1**	**8.2%**
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries (CHNA.org)	percent	63.6	59.7	0.8	6.5%
Cancer Deaths (CHNA.org)	rate	146.7	147.3	0.1	0.4%
Childhood Cancer Diagnoses Ages 0–19 (CCC) (Kidsdata.org)	rate	15.7	17.4	N/A	9.8%
***Colon and Rectum Cancer Incidence (CHNA.org)**	**rate**	**40.0**	**37.2**	**-1.2**	**7.5%**
Colorectal Cancer Deaths (CCC) (CDPH)	rate	**12.9**	12.8	N/A	0.8%
***Current/Former Smokers, Adults (CHNA.org)**	**percent**	**15.9**	**13.7**	**-0.6**	**16.1%**
Lung Cancer Deaths (CCC) (CDPH)	rate	**29.2**	28.9	N/A	1.0%
***Lung Cancer Incidence (CHNA.org)**	**rate**	**47.4**	**44.6**	**-0.5**	**6.3%**
Prostate Cancer Deaths (CCC) (CDPH)	rate	**20.1**	19.6	N/A	2.6%
***Prostate Cancer Incidence (CHNA.org)**	**rate**	**126.5**	**109.2**	**-2.2**	**15.8%**

Trends

Trend data are available on certain indicators.

- Childhood Cancer Diagnoses: Mixed in earlier years, relatively flat since 2006.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

Table 65. Statistical Data for Cancer by Ethnicity

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries (CHNA.org)	percent	59.7%	64.2%	**56.3%**						
Cancer Deaths (CHNA.org)	rate	147.3	**156**	**199.5**	94.6		83.6			117.2
Childhood Cancer Diagnoses, Ages 0–19 (CCC) (Kidsdata.org)	rate	17.4	16.4		10.4*					16.9

Blank cells indicate data were unavailable.
* Statistic is for Asian/Pacific Islander combined.

Communicable Diseases (Not STIs)

Table 66. Statistical Data for Communicable Diseases

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Adults 18+ with Influenza Vaccination (CCC) (AskCHIS)ǂ	percent	55.9	43.4	N/A	28.8%
Influenza and Pneumonia Deaths (CCC) (CDPH)	rate	10.0	14.3	N/A	30.1%
Influenza Vaccination, All Ages (CCC) (AskCHIS)	percent	55.5	44.8	N/A	23.9%
Kindergarteners with Required Immunizations (CCC) (Kidsdata.org)	percent	95.1	92.8	N/A	2.5%
***Tuberculosis Incidence (CCC) (CDPH)**	**rate**	**4.0**	**1.0 (HP)**	N/A	**300% (HP)**

ǂ AskCHIS data on influenza vaccination for children ages 0–17 and older adults (65+) not provided because the data are statistically unstable.

Trends

Trend data are available on certain indicators.

- Kindergarteners with Required Immunizations: Relatively unchanged since 2002.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

Table 67. Statistical Data for Communicable Diseases by Ethnicity

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Adults 18+ with Influenza Vaccination (CCC) (AskCHIS)	percent	43.4%	53.7%							56.9%

Blank cells indicate that data were unavailable.

Heart Disease/Stroke

TABLE 68. STATISTICAL DATA FOR HEART DISEASE/STROKE

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Current/Former Smokers, Adults (CHNA.org)**	**percent**	**15.9**	**13.7**	**-0.6**	**16.1%**
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	**81.6**	81.8	-0.1	0.2%
Exercise Opportunities (CHNA.org)	percent	95.9	93.6	0.3	2.5%
Heart Disease Deaths (CHNA.org)	rate	69.2	99.5	1.5	30.5%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000) (CHNA.org)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries (CHNA.org)	percent	5.4	7.0	1.0	22.9%
Obesity (Adult) (CHNA.org)	percent	24.9	26.5	0.2	6.0%
***Obesity (Youth) (CHNA.org)**	**percent**	**22.3**	**20.1**	**-0.6**	**10.9%**
Physical Inactivity (Adult) (CHNA.org)	percent	**17.8**	17.3	-0.2	2.9%
***Physical Inactivity (Youth) (CHNA.org)**	**percent**	**40.9**	**37.8**	**-0.5**	**8.2%**
***Stroke Deaths (CHNA.org)**	**rate**	**40.1**	**35.4**	**-1.0**	**13.3%**
***Stroke Hospitalizations, Medicare Beneficiaries (per 1,000) (CHNA.org)**	**rate**	**7.9**	**7.4**	**-0.6**	**6.8%**
Stroke Prevalence, Medicare Beneficiaries (CHNA.org)	percent	**3.8**	3.7	-0.3	2.7%
Walkable Destinations (CHNA.org)	percent	39.3	29.0	0.6	35.5%

Trends

No trend data are available.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 69. STATISTICAL DATA FOR HEART DISEASE/STROKE BY ETHNICITY

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	81.8%	82.2%	**77.2%**						
Heart Disease Deaths (CHNA.org)	rate	99.5	71.3	**106.7**	46.9					53.4
Obesity (Adult) (CHNA.org)	percent	26.5%	21.6%	**35.6%**	10.7%					**29.7%**
Obesity (Youth) (CHNA.org)	percent	20.1%	15.8%	**22.6%**	10.9%	**42.4%**	0.0%	18.1% †	17.0%	**27.5%**
Physical Inactivity (Youth) (CHNA.org)	percent	37.8%	32.6%	**46.0%**	30.6%	**57.3%**	0.0%	36.4% †	**38.1%**	**45.0%**
Stroke Deaths (CHNA.org)	rate	35.4	**40.1**	**53.6**	33.1					34.8

Blank cells indicate data were unavailable.
† Indicates statistic is for Filipino.

Maternal/Infant Health

Table 70. Statistical Data for Maternal/Infant Health

Indicator	Indicator Type	Value	State Avg	SDs	% Different
***Asthma Hospitalizations, Children Ages 0–4 (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**22.7**	**19.6**	N/A	**15.8%**
Breastfeeding (CCC) (CDPH)	percent	96.7	93.8	N/A	3.1%
Child Mortality (CCC) (CHR)	rate	30	40	N/A	25.0%
Children Below 100% FPL (CHNA.org)	percent	18.0	21.9	0.6	17.8%
Early Prenatal Care (CCC) (CDPH)	percent	86.9	83.3	N/A	4.3%
Elevated Blood Lead Levels in Children Ages 0–5 (CCC) (Kidsdata.org)	percent	0.1	0.2	N/A	50.0%
Infant Deaths (CHNA.org)	rate	4.2	5.0	1.0	16.0%
Life Expectancy at Birth (CHNA.org)	number	81.4	80.8	0.4	0.7%
Low Birth Weight (CHNA.org)	percent	6.7	6.8	0.1	1.5%
***Preschool Enrollment (CHNA.org)**	**percent**	**44.0**	**48.6**	**-0.5**	**9.5%**
Pre-Term Births (CHNA.org)	percent	8.9	9.0	0.1	1.1%
Teen Births (per 1,000 females ages 15–19) (CHNA.org)	rate	17.9	29.3	1.2	38.9%
Very Low Birth Weight (CCC) (Kidsdata.org)	percent	1.1	1.2	N/A	8.3%

Trends

Trend data are available on certain indicators.

- Asthma Hospitalizations, Children Ages 0–4: Generally trending downward since 2005.
- Teen Births: Generally trending down since 1996.
- Very Low Birth Weight: Trend is relatively flat since 1995.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

Table 71. Statistical Data for Maternal/Infant Health by Ethnicity

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Child Mortality (CCC) (CHR)	rate	40	20	**70**						30
Children Below 100% FPL (CHNA.org)	percent	21.9%	8.2%	**27.4%**	12.4%	20.5%	14.1%	**25.0%**	16.0%	21.6%
Teen Births (per 1,000 females ages 15–19) (CCC) (Kidsdata.org)	rate	23.2	4.6	21.9					10.1	**24.3**

Blank cells indicate data were unavailable.

Oral Health

TABLE 72. STATISTICAL DATA FOR ORAL HEALTH

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Current/Former Smokers, Adults (CHNA.org)**	**percent**	**15.9**	**13.7**	**-0.6**	**16.1%**
Condition of Teeth (Adults): Less Than Good (CCC) (AskCHIS)	percent	24.0	29.3	N/A	18.1%
Dentists (CHNA.org)	rate	82.4	80.3	0.1	2.6%
Health Professional Shortage Area – Dental (CHNA.org)	percent	0	13.2	0.5	100.0%
Lack of Dental Insurance Coverage (CHNA.org)	percent	32.3	38.5	0.9	16.1%
Recent Dental Exam (Youth) (CHNA.org)	percent	**86.6**	86.7	0.0	0.1%
Recent Dental Visit (Adults) (CCC) (AskCHIS)	percent	74.2	70.3	N/A	5.5%
Soft Drink Consumption (CHNA.org)	percent	**18.3**	18.1	0.0	1.1%

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

Sexually Transmitted Infections

TABLE 73. STATISTICAL DATA FOR SEXUALLY TRANSMITTED INFECTIONS

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Chlamydia Incidence (CHNA.org)	rate	388.4	459.9	0.6	15.5%
Chlamydia Incidence Among Youth Ages 10–19 (CCC) (Kidsdata.org)	rate	702.7	709.2	N/A	0.9%
***Gonorrhea Incidence, Females (CCC) (CDPH)**	**rate**	**246.0**	**218.0**	N/A	**12.8%**
Gonorrhea Incidence, Males (CCC) (CDPH)	rate	295.6	372.6	N/A	20.7%
Gonorrhea Incidence Among Youth Ages 10–19 (CCC) (Kidsdata.org)	rate	**123.5**	121.2	N/A	1.9%
HIV/AIDS Deaths (CHNA.org)	rate	77.7	323.9	3.0	76.0%
HIV/AIDS Incidence (CCC) (CDPH)	rate	247.2	391.7	N/A	36.9%
HIV/AIDS Prevalence (CHNA.org)	rate	217.8	374.6	0.5	41.9%
Syphilis Incidence (Male) (CCC) (CDPH)‡	rate	13.4	22.5	N/A	40.4%

‡ Female syphilis incidence rate not provided because it is statistically unstable.

Trends

Trend data are available on certain indicators.

- Chlamydia Incidence Among Youth Ages 10–19: Slight upward trend since 2012.
- Gonorrhea Incidence Among Youth Ages 10–19: Long-term trend mixed; flat since 2012.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 74. STATISTICAL DATA FOR SEXUALLY TRANSMITTED INFECTIONS BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Chlamydia Incidence Among Youth Ages 10–19 (CCC) (Kidsdata.org)	rate	709.2	495.5	3,028.0	143.2*					531.1
Gonorrhea Incidence Among Youth Ages 10–19 (CCC) (Kidsdata.org)	rate	121.2	53.4	712.1	13.4*					84.0

Blank cells indicate data were unavailable.
* Statistic is for Asian/Pacific Islander combined.

HEALTHY EATING/ACTIVE LIVING

TABLE 75. STATISTICAL DATA FOR HEALTHY EATING/ACTIVE LIVING

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Adequate Fruit and Vegetable Consumption, Children Ages 2–11 (CCC) (Kidsdata.org)‡	percent	36.0	32.0	N/A	12.5%
***Children Walking or Biking to School (CHNA.org)**	**percent**	**18.7**	**39.3**	**-2.2**	**52.4%**
***Current/Former Smokers, Adults (CHNA.org)**	**percent**	**15.9**	**13.7**	**-0.6**	**16.1%**
Diabetes Deaths (CCC) (CDPH)	rate	17.6	20.7	N/A	15.0%
***Diabetes Hospitalizations, Children Ages 0–17 (CCC) (Kidsdata.org)**	**percent**	**1.5**	**1.4**	N/A	**7.1%**
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	**81.6**	81.8	-0.1	0.2%
Diabetes Prevalence (CHNA.org)	percent	8.3	8.4	0.0	1.2%
Did Not Eat Breakfast, 7th Graders (CCC) (CHKS)	percent	29.2	34.0	N/A	14.1%
Did Not Eat Breakfast, 9th Graders (CCC) (CHKS)	percent	32.5	38.3	N/A	15.1%
Did Not Eat Breakfast, 11th Graders (CCC) (CHKS)	percent	35.1	39.4	N/A	10.9%
Driving Alone to Work (CHNA.org)	percent	71.0	73.5	0.3	3.4%
***Driving Alone to Work, Long Distances (CHNA.org)**	**percent**	**58.1**	**39.3**	**-2.4**	**47.8%**
Exercise Opportunities (CHNA.org)	percent	95.9	93.6	0.3	2.5%
Food Environment Index (CHNA.org)	number	8.1	7.8	0.5	3.3%
Food Insecurity (CHNA.org)	percent	12.5	13.4	0.5	6.7%
Free and Reduced Price Lunch (CHNA.org)	percent	54.4	58.9	0.4	7.6%
***Grocery Stores and Produce Vendors (CHNA.org)**	**rate**	**1.5**	**2.4**	**-1.4**	**37.5%**
***Low Access to Healthy Food Stores (CHNA.org)**	**percent**	**19.8**	**13.4**	**-0.9**	**47.8%**
Heart Disease Deaths (CHNA.org)	rate	69.2	99.5	1.5	30.5%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000) (CHNA.org)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries (CHNA.org)	percent	5.4	7.0	1.0	22.9%
Obesity (Adult) (CHNA.org)	percent	24.9	26.5	0.2	6.0%
***Obesity (Youth) (CHNA.org)**	**percent**	**22.3**	**20.1**	**-0.6**	**10.9%**
Physical Inactivity (Adult) (CHNA.org)	percent	**17.8**	17.3	-0.2	2.9%
***Physical Inactivity (Youth) (CHNA.org)**	**percent**	**40.9**	**37.8**	**-0.5**	**8.2%**
***Public Transit Stops Within 0.5 Miles (CHNA.org)**	**percent**	**12.8**	**16.8**	**-0.5**	**23.8%**
***SNAP Benefits (CHNA.org)**	**percent**	**10.7**	**9.4**	-0.3	**13.8%**
Soft Drink Consumption (CHNA.org)	percent	**18.3**	18.1	0.0	1.1%
***Stroke Deaths (CHNA.org)**	**rate**	**40.1**	**35.4**	**-1.0**	**13.3%**
***Stroke Hospitalizations, Medicare Beneficiaries (per 1,000) (CHNA.org)**	**rate**	**7.9**	**7.4**	**-0.6**	**6.8%**
Stroke Prevalence, Medicare Beneficiaries (CHNA.org)	percent	**3.8**	3.7	-0.3	2.7%
Students Meeting Fitness Standards, 5th Graders (CCC) (Kidsdata.org)	percent	30.6	26.4	N/A	15.9%
Students Meeting Fitness Standards, 7th Graders (CCC) (Kidsdata.org)	percent	34.2	32.5	N/A	5.2%
Students Meeting Fitness Standards, 9th Graders (CCC) (Kidsdata.org)	percent	38.9	37.6	N/A	3.5%
Walkable Destinations (CHNA.org)	percent	39.3	29.0	0.6	35.5%

‡ Kidsdata.org data on children ages 12–17 adequate fruit and vegetable consumption in Contra Costa County suppressed due to small numbers.

Trends

Trend data are available on certain indicators.

- Diabetes Hospitalizations, Children Ages 0–17: Trend is mixed.
- Students Meeting Fitness Standards, 5th Graders: Trend is mixed.
- Students Meeting Fitness Standards, 7th Graders: Trend is mixed.
- Students Meeting Fitness Standards, 9th Graders: Trending down since 2014.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 76. STATISTICAL DATA FOR HEALTHY EATING/ACTIVE LIVING BY ETHNICITY

Indicator	Ind. Type	Bench mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries (CHNA.org)	percent	81.8%	82.2%	**77.2%**						
Did Not Eat Breakfast (CCC) (CHKS)	percent	#	25.7%	**43.1%**	23.1%	**34.2%**	**35.3%**	**40.1%**	**34.0%**	**38.7%**
Heart Disease Deaths (CHNA.org)	rate	99.5	71.3	**106.7**	46.9					53.4
Obesity (Adult) (CHNA.org)	percent	26.5%	21.6%	**35.6%**	10.7%					**29.7%**
Obesity (Youth) (CHNA.org)	percent	20.1%	15.8%	**22.6%**	10.9%	**42.4%**	0.0%	18.1%†	17.0%	**27.5%**
Physical Inactivity (Youth) (CHNA.org)	percent	37.8%	32.6%	**46.0%**	30.6%	**57.3%**	0.0%	36.4%†	**38.1%**	**45.0%**
SNAP Benefits (CHNA.org)	percent	9.4%	6.4%	**23.4%**	7.5%	**21.4%**	**14.2%**	**11.6%**	**15.2%**	**11.6%**
Stroke Deaths (CHNA.org)	rate	35.4	**40.1**	**53.6**	33.1					34.8
Students Meeting Fitness Standards, 5th Graders (CCC) (Kidsdata.org)	percent	26.4%	39.8%	**19.7%**	41.0%	26.4%		26.6%†	29.5%	**15.5%**
Students Meeting Fitness Standards, 7th Graders (CCC) (Kidsdata.org)	percent	32.5%	40.9%	**23.2%**	35.1%	**21.6%**		31.3%†	**30.8%**	**21.2%**
Students Meeting Fitness Standards, 9th Graders (CCC) (Kidsdata.org)	percent	37.6%	42.3%	**26.8%**	43.0%		**32.4%**	42.1%†	**30.9%**	**23.6%**

Blank cells indicate data were unavailable.
Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.
† Indicates statistic is for Filipino.

HOUSING AND HOMELESSNESS

TABLE 77. STATISTICAL DATA FOR HOUSING AND HOMELESSNESS

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Asthma Diagnoses, Children Ages 1–17 (CCC) (Kidsdata.org)**	**percent**	**16.9**	**15.2**	N/A	**11.2%**
***Asthma Hospitalizations, Children Ages 0–4 (per 10,000) (CCC) (Kidsdata.org)**	**rate**	**22.7**	**19.6**	N/A	**15.8%**
Asthma Hospitalizations, Children/Youth Ages 5–17 (per 10,000) (CCC) (Kidsdata.org)	rate	**7.9**	7.7	N/A	2.6%
***Banking Institutions (per 10,000) (CHNA.org)**	**rate**	**1.9**	**2.7**	**-1.1**	**29.6%**
Beer, Wine, and Liquor Stores (per 10,000) (CHNA.org)	rate	0.54	1.06	1.6	49.1%
Children Living in Crowded Households (CCC) (Kidsdata.org)	percent	16.7	28.2	N/A	40.8%
Cost Burdened Households (CHNA.org)	percent	**43.1**	42.8	-0.1	0.7%
Home Ownership (CCC) (AskCHIS)	percent	62.3	55.2	N/A	12.9%
Homeless Children Ages 0-17 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	0	88.0	N/A	100%
Homeless Individuals Who Are Unsheltered (CCC) (PIT; HUD)	percent	57	78.0	N/A	26.9%
Homeless Public School Students (CCC) (Kidsdata.org)	percent	1.5	4.4	N/A	65.9%
Homeless Young Adults Ages 18–24 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	50.8	81.8	N/A	37.9%
Housing Problems (CHNA.org)	percent	44.8	45.6	0.2	1.8%
***Median Rent, 2 Bedrooms (CCC) (Zilpy)**	**dollars**	**2,390**	**2,150**	N/A	**11.2%**
Segregation Index (CHNA.org)	number	0.32	0.43	1.1	25.6%
Severe Housing Problems (CHNA.org)	percent	24.4	27.3	0.7	10.6%

Data Without Benchmarks

Certain indicators have no state or national comparison.

- Homeless Point-in-Time (PIT): A total of 1,607 individuals experienced homelessness in Contra Costa County in the 2017 point-in-time count.

Trends

Trend data are available on certain indicators.

- Children Living in Crowded Households: Generally trending up since 2007.
- Homeless Children Ages 0–17 Who Are Unsheltered: Zero since 2015.
- Homeless Population, Contra Costa County: Decreasing since 2015.
- Homeless Young Adults Ages 18–24 Who Are Unsheltered: Trending down since 2015.
- Median Rent, Two Bedrooms: Increasing over past year.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 78. STATISTICAL DATA FOR HOUSING AND HOMELESSNESS BY ETHNICITY

Indicator	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Homeless Population (CCC) (PIT)	percent	#	48%	33%	4%*					22%

Blank cells indicate data were unavailable.
Benchmarks not available; comparison category is White.
* Statistic is for Asian/Pacific Islander combined.

TRANSPORTATION AND TRAFFIC

TABLE 79. STATISTICAL DATA FOR TRANSPORTATION AND TRAFFIC

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
Beer, Wine, and Liquor Stores (per 10,000) (CHNA.org)	rate	0.54	1.06	1.6	49.1%
Driving Alone to Work (CHNA.org)	percent	71.0	73.5	0.3	3.4%
***Driving Alone to Work, Long Distances (CHNA.org)**	**percent**	**58.1**	**39.3**	**-2.4**	**47.8%**
Impaired Driving Deaths (CHNA.org)	percent	28.1	29.0	0.2	3.1%
Motor Vehicle Crash Deaths (CHNA.org)	rate	6.4	8.6	0.7	25.6%
***Pedestrian Accident Deaths (CHNA.org)**	**rate**	**2.6**	**2.3**	**-0.5**	**13.0%**
***Public Transit Stops Within 0.5 Miles (CHNA.org)**	**percent**	**12.8**	**16.8**	**-0.5**	**23.8%**
***Road Network Density (road miles per square mile of land) (CHNA.org)**	**rate**	**4.6**	**2.0**	**-1.8**	**130.0%**
Walkable Destinations (CHNA.org)	percent	39.3	29.0	0.6	35.5%

Trends

No trend data are available.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 80. STATISTICAL DATA FOR TRANSPORTATION AND TRAFFIC BY ETHNICITY

Indicators	Indicator Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths (CHNA.org)	rate	8.6	7.2	**10.2**	2.7					5.2

Blank cells indicate that data were unavailable.

OVERALL HEALTH

TABLE 81. STATISTICAL DATA FOR OVERALL HEALTH

Indicator	Indicator Type	Value	State Avg.	SDs	% Different
***Alzheimer's Disease Deaths (CCC) (CDPH)**	**rate**	**37.2**	**34.2**	N/A	**8.8%**
Frequent Physical Distress (CCC) (CHR)	percent	9.0	10.9	N/A	17.4%
Life Expectancy at Birth (CHNA.org)	number	81.4	80.8	0.4	0.7%
Poor or Fair Health, Adults (CHNA.org)	percent	12.1	17.2	1.4	29.7%
Poor Physical Health Days, Adults (CHNA.org)	number	3.3	3.7	0.9	10.8%
Population Below 100% FPL(CHNA.org)	percent	12.7	15.8	0.7	19.6%
***Population with Any Disability (CHNA.org)**	**percent**	**12.4**	**10.6**	**-1.0**	**17.0%**
Premature Death (CHNA.org)	rate	4,712	5,251	0.5	10.3%
***Students per Social Worker (CCC) (Kidsdata.org)**	**number**	**34,960**	**12,870**	N/A	**171.6%**

Trends

Trend data are available on certain indicators.

- Students per Social Worker: Generally trending down (i.e., improving) since 2011.

Race and Ethnicity

Some indicators are available by ethnicity, which may show disparities in certain populations.

TABLE 82. STATISTICAL DATA FOR OVERALL HEALTH BY ETHNICITY

Indicator	Ind. Type	Bench-mark	White	Afr Am	Asian	Pac Isl	Nat Am	Other	Multi-Race	Hisp / Lat (Any Race)
Population with Any Disability (CHNA.org)	percent	10.6%	**14.1%**	**16.3%**	9.3%	9.7%	**19.6%**	9.3%	**11.9%**	9.8%

Attachment 6. Secondary Data Indicators Index

The health needs indicators found in this index were collected from these sources:

- 2017 Point in Time (PIT) Count: A Snapshot of Homelessness in Contra Costa County, accessed via https://cchealth.org/h3/coc/pdf/PIT-report-2017.pdf, pulled on July 31, 2018
- California Department of Public Health (CDPH) county health status profiles, accessed via https://www.cdph.ca.gov/Programs/CHSI/Pages/Individual-County-Data-Sheets.aspx, pulled on July 24, 2018
- California Health Interview Survey (CHIS), accessed via http://ask.chis.ucla.edu/, pulled on August 5, 2018
- California Healthy Kids Survey (CHKS), accessed via http://chks.wested.org/query-chks/, pulled on August 5, 2018
- The new CHNA data platform, replacing Community Commons (CHNA.org), accessed via http://chna.org/kp, pulled on May 17, 2018[1]
- County Health Rankings (CHR), accessed via http://www.countyhealthrankings.org/app/california/2018/rankings/contra-costa/county/factors/overall/snapshot, pulled on July 30, 2018
- KidsData.org, a program of the Lucile Packard Foundation for Children's Health, accessed via https://www.kidsdata.org, pulled on August 5, 2018
- U.S. Department of Housing and Urban Development (HUD) 2017 Annual Homeless Assessment Report to Congress, accessed via https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf, pulled on July 31, 2018
- Vera Institute of Justice Incarceration Trends (Vera), accessed via http://trends.vera.org/rates/contra-costa-county-ca?incarcerationData=all, pulled on July 31, 2018
- Zilpy, accessed via http://www.zilpy.com/, pulled on November 12, 2018

Indicator	Health Needs	Description	Source	Year(s)
30-Day Readmissions (CHNA.org)	Healthcare Access and Delivery	This indicator reports the percentage of Medicare fee-for-service beneficiaries readmitted to a hospital within 30 days of an initial hospitalization discharge. This indicator is relevant as a measure of quality of care.	Dartmouth Atlas of Health Care	2014, 2013, 2012, 2011, 2010

[1] Data updated September 4, 2018.

Indicator	Health Needs	Description	Source	Year(s)
Active Asthma Prevalence (CHNA.org)	Healthcare Access and Delivery: Asthma	Percentage of county residents reporting they currently have asthma	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from UCLA Center for Health Policy Research, California Health Interview Survey	2014
Adequate Fruit and Vegetable Consumption, Children Ages 2–11 (Kidsdata.org)	Obesity/HEAL/Diabetes	Estimated percentage of children ages 2–11 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily, by age group (e.g., in 2013–2014, an estimated 22.4% of California youth ages 2–11 ate at least five servings of fruits/vegetables daily)	UCLA Center for Health Policy Research, California Health Interview Survey	2013–2014
Adults 18+ With Influenza Vaccination (AskCHIS)	Healthcare Access and Delivery: Communicable Diseases (Not STIs)	Percentage of adults 18+ reporting they have had the flu vaccine in the past 12 months	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Adults Needing Help for Behavioral Health Issue (AskCHIS)	Behavioral Health: Mental Health	Percentage of adults needing help for emotional/mental health problems or use of alcohol/drugs	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)	Behavioral Health: Mental Health	This indicator reports the percentage of adults who self-report that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs.	California Health Interview Survey	2016
Adults With an Associate's Degree or Higher (CHNA.org)	Economic Security	This indicator reports the percentage of the population ages 25 years and older with an Associate's degree or higher. This indicator is relevant because educational attainment is an important determinant of health, influencing health knowledge and behaviors, employment and income, and social standing and social networks.	U.S. Census Bureau, American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Adults With Any Adverse Childhood Experiences (Kidsdata.org)	Behavioral Health: Mental Health	Estimated percentage of adults 18 and older exposed to adverse childhood experiences before age 18, by household type	Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008, 2009, 2011, and 2013. Public Health Institute, Survey Research Group	2008, 2009, 2011, 2013
Adults With Four or More Adverse Childhood Experiences (Kidsdata.org)	Behavioral Health: Mental Health	Estimated percentage of adults 18 and older exposed to four or more adverse childhood experiences before age 18, by household type	Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008, 2009, 2011, and 2013. Public Health Institute, Survey Research Group	2008, 2009, 2011, 2013
Adults With No High School Diploma (CHNA.org)	Economic Security	This indicator reports the percentage of the population 25 years and older without at least a high school diploma or equivalent. This indicator is relevant as a measure of educational attainment, an important determinant of health and opportunity across a lifespan.	U.S. Census Bureau, American Community Survey	2012–2016
Adults With Some Post-secondary Education (CHNA.org)	Economic Security	This indicator reports the percentage of adults ages 25–44 years with at least some post-secondary education. This indicator is relevant because educational attainment is an important determinant of health, influencing health knowledge and behaviors, employment and income, and social standing and social networks.	U.S. Census Bureau, American Community Survey	2012–2016
Alzheimer's Disease Deaths (CDPH)	Other Health	Age-adjusted rate of death due to Alzheimer's per 100,000 population per year	California Department of Public Health: 2011–2016 Death Records	2011–2016
Asthma Deaths (CHNA.org)	Healthcare Access and Delivery: Asthma	Age-adjusted rate of asthma mortality per 1,000,000 population	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from California Death Statistical Master Files	2008–2010
Asthma Diagnoses, Children Ages 1–17 (Kidsdata.org)	Healthcare Access and Delivery: Asthma	Percentage of children ages 1–17 whose parents report that their child has ever been diagnosed with asthma	UCLA Center for Health Policy Research, California Health Interview Survey	2015

Indicator	Health Needs	Description	Source	Year(s)
Asthma ED Visits, All Ages (CDPH)	Healthcare Access and Delivery: Asthma	Age-adjusted rate of asthma emergency department visits per 10,000 residents, by age and overall	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from California Office of Statewide Health Planning and Development (OSHPD)	2014
Asthma Hospitalizations (CHNA.org)	Healthcare Access and Delivery: Asthma; Climate/Natural Environment; Healthcare Access and Delivery	This indicator reports the patient discharge rate among Medicare-fee-for-service per 10,000 population for asthma and related complications. This indicator is relevant because it is a measure of the burden of asthma, a significant cause of morbidity among children and adults in the U.S. that is often exacerbated by poor air quality and other environmental conditions.	Mapping Medicare Disparities Tool	2015
Asthma Hospitalizations, Children Ages 0–4 (Kidsdata.org)	Healthcare Access and Delivery: Asthma	Number of asthma hospitalizations per 10,000 population, by age group	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau	2016
Asthma Hospitalizations, Children/Youth Ages 5–17 (Kidsdata.org)	Healthcare Access and Delivery: Asthma	Number of asthma hospitalizations per 10,000 population, by age group	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau	2016

Indicator	Health Needs	Description	Source	Year(s)
Asthma Prevalence (CHNA.org)	Healthcare Access and Delivery: Asthma; Climate/Natural Environment	This indicator reports the percentage of the population 18 years and older with asthma. This indicator is relevant because it is a measure of the burden of asthma, a significant cause of morbidity in the U.S. that is often exacerbated by poor air quality and other environmental conditions.	UCLA Center for Health Policy Research, California Health Interview Survey	2014
Average Charge per Asthma Hospitalizations (CDPH)	Healthcare Access and Delivery: Asthma	Average charge for hospitalization for asthma. Charges for asthma hospitalizations are the only type of data available to assess the costs of asthma in California counties. However, there are many other costs associated with asthma, including other types of health care utilization, medications, and indirect costs due to factors such as school and work missed.	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD)	2014
Banking Institutions (CHNA.org)	Economic Security	This indicator reports the number of banking institutions (commercial banks, savings institutions and credit unions) per 10,000 population. This indicator is relevant because an adequate supply of financial institutions enables financial inclusion, empowering people with tools and services to realize financial health and wellbeing.	U.S. Census Bureau, County Business Patterns	2015, 2014, 2013, 2012
Beer, Wine, and Liquor Stores (CHNA.org)	Community and Family Safety: Crime/Intentional Injury; Community and Family Safety: Unintentional Injuries/Accidents; Economic Security; Behavioral Health: Substance Use/Tobacco	This indicator reports the number of beer, wine, and liquor stores per 10,000 population. This indicator is relevant because it measures alcohol outlet density which helps characterize policy and environmental factors that affect excessive alcohol use, a leading cause of preventable death in the U.S.	U.S. Census Bureau, County Business Patterns	2015, 2012, 2014, 2013

Indicator	Health Needs	Description	Source	Year(s)
Breast Cancer Incidence (CHNA.org)	Healthcare Access and Delivery: Cancers	This indicator reports the age-adjusted incidence rate of breast cancer among females per 100,000 population per year. This indicator is relevant because it is a measure of the burden of breast cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat breast cancer which is among the most common cancers affecting women.	State Cancer Profiles	2010–2014
Breast Cancer Screening (Mammogram) (CHNA.org)	Healthcare Access and Delivery: Cancers; Healthcare Access and Delivery	This indicator reports the percentage of female Medicare enrollees, ages 67 and older, who have received one or more mammograms in the past two years. This indicator is relevant because breast cancer screening enables early detection and treatment; low levels of screening may suggest a lack of access to preventive care, lack of health knowledge, insufficient provider outreach, and existence of other barriers to utilization of services.	Dartmouth Atlas of Health Care	2014
Bullied at School, 7th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 7th grade, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Bullied at School, 9th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 9th grade, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Bullied at School, 11th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 11th grade, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Cancer Deaths (CHNA.org)	Healthcare Access and Delivery: Cancers	This indicator reports the age-adjusted rate of death due to malignant neoplasm (cancer) per 100,000 population per year. This indicator is relevant as a measure of the burden of cancer, a leading cause of death in the U.S.	National Vital Statistics System	2011–2015
Child Mortality (CHR)	Healthcare Access and Delivery: Maternal/Infant Health	Number of deaths among children under age 18 per 100,000	CDC WONDER mortality data	2013–2016
Childhood Cancer Diagnoses (Kidsdata.org)	Healthcare Access and Delivery: Cancers	Number of new cancer diagnoses per 100,000 children/youth ages 0–19 over a five-year period, by race/ethnicity and age group	National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program, Research data, 1973–2013 (Nov. 2015)	2009–2013
Children Below 100% FPL (CHNA.org)	Economic Security; Other Health	This indicator reports the percentage of children ages 0–17 years that live in households with incomes below 100% of the Federal Poverty Level (FPL). This indicator is relevant as a measure for the concentration of poverty, and because it highlights a group requiring special consideration, targeted services and outreach by providers.	U.S. Census Bureau, American Community Survey	2012–2016
Children in Foster Care (Kidsdata.org)	Behavioral Health: Mental Health	Number of children and youth under age 21 in foster care per 1,000 on July 1 of each year	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016); Annie E. Casey Foundation, KIDS COUNT Data Center (Jul. 2016)	2015
Children in Linguistically Isolated Households (Kidsdata.org)	Economic Security	Estimated percentage of children ages 0–17 living in households in which (1) no person age 14 or older speaks English only, and (2) no person age 14 or older, who speaks a language other than English, speaks English very well	Population Reference Bureau, analysis of data from the U.S. Census Bureau, American Community Survey microdata files (Dec. 2017)	2016

Indicator	Health Needs	Description	Source	Year(s)
Children in Single-Parent Households (CHNA.org)	Economic Security	This indicator reports the percentage of children that live in households with only one parent present. This indicator is relevant because children from single-parent households are at increased risk for presenting emotional and behavioral problems, developing depression, using tobacco, alcohol and other substances, and for all-cause morbidity and mortality.	U.S. Census Bureau, American Community Survey	2012–2016
Children Living in Crowded Households (Kidsdata.org)	Economic Security	Estimated percentage of children under age 18 living in households with more than one person per room of the house. “Rooms” include living rooms, dining rooms, kitchens, bedrooms, finished recreation rooms, enclosed porches, and lodger’s rooms.	Population Reference Bureau, analysis of data from the U.S. Census Bureau, American Community Survey microdata files (Nov. 2015)	2014
Children Needing and Receiving Behavioral Health Care Services (Kidsdata.org)	Behavioral Health: Mental Health	Percentage of children ages 2–17 who need mental health treatment or counseling and who have received mental health services in the past 12 months	Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health, Advancing data-in-action partnerships for children and children with special health care needs in California counties and cities using synthetic estimation from the 2011/12 National Survey of Children’s Health and 2008–2012 U.S. Census Bureau, American Community Survey (Nov. 2016)	2011–2012
Children Walking or Biking to School (CHNA.org)	Obesity/HEAL/Diabetes	This indicator reports the percentage of children walk, bike, or skate to school at least occasionally, according to their parent/guardian. This indicator is relevant as a measure of quality of the physical/built environment and active transportation systems, and because active commuting to school promotes regular physical activity, which can help improve fitness, build strong bones and muscles, control weight, reduce depression and anxiety, and reduce risk for chronic disease.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016

Indicator	Health Needs	Description	Source	Year(s)
Children With Two or More Adverse Experiences (Parent Reported) (Kidsdata.org)	Behavioral Health: Mental Health	Estimated percentage of children ages 0–17 who have experienced two or more adverse experiences	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the U.S. Census Bureau, American Community Survey (Mar. 2018)	2016
Children Without Secure Parental Employment (Kidsdata.org)	Economic Security	Estimated percentage of children under age 18 living in families where no resident parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey	Population Reference Bureau, analysis of data from the U.S. Census Bureau, American Community Survey microdata files (Nov. 2015)	2014
Chlamydia Incidence (CHNA.org)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator reports incidence rate of chlamydia cases per 100,000 population per year. This indicator is relevant because it is a measure of the burden of chlamydia, a common sexually transmitted infection for which effective interventions for prevention and treatment exist.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2016
Chlamydia Incidence Among Youth Ages 10–19 (Kidsdata.org)	Healthcare Access and Delivery: Sexually Transmitted Infections	Number of chlamydia infections per 100,000 youth ages 10–19	California Department of Public Health, Sexually Transmitted Diseases Data; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2010, 2010–2060; Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data and Statistics; U.S. Census Bureau, Population Estimates Program, Estimates of the Resident Population by Sex and Age for the United States, 2000–2010, 2010–2015 (Sept. 2016)	2015
Chronic Liver Disease/ Cirrhosis Deaths (CDPH)	Behavioral Health: Substance Use/Tobacco	Chronic liver disease and cirrhosis age-adjusted death rate per 100,000 population	California Department of Public Health: 2011–2016 Death Records	2011–2016

Indicator	Health Needs	Description	Source	Year(s)
Climate-Related Mortality Impacts (CHNA.org)	Climate/Natural Environment	This indicator reports the median estimated economic impacts from changes in all-cause mortality rates, across all age groups, as a percentage of county gross domestic product (GDP). This indicator is relevant because climate-change is a significant threat to public health for which interventions may exist to prevent or mitigate climate-related health impacts.	Climate Impact Lab	2016
Colon and Rectum Cancer Incidence (CHNA.org)	Healthcare Access and Delivery: Cancers	This indicator reports the age-adjusted incidence rate of colon and rectum cancer cases per 100,000 population per year. This indicator is relevant because it is a measure of the burden of colon and rectum cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat colorectal cancers.	State Cancer Profiles	2010–2014
Condition of Teeth (Adults): Less Than Good (AskCHIS)	Healthcare Access and Delivery: Oral Health	Percentage of adults with fair or poor teeth condition	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Cost-Burdened Households (CHNA.org)	Economic Security	This indicator reports the percentage of households for which housing costs exceed 30% of total household income. This indicator is relevant because it offers a measure of housing affordability; affordable housing helps ensure individuals can financially meet basic needs for health care, child care, food, transportation, and other costs.	U.S. Census Bureau, American Community Survey	2012–2016
Cost of Infant Child Care, Annually, Child Care Center (Kidsdata.org)	Economic Security	Average annual cost of licensed child care, by facility type and age group of children	California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015); cost data are from the Child Care Regional Market Rate Survey, 2014	2014

Indicator	Health Needs	Description	Source	Year(s)
Cost of Preschool Child Care, Annually, Child Care Center (Kidsdata.org)	Economic Security	Average annual cost of licensed child care, by facility type and age group of children	California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015); cost data are from the Child Care Regional Market Rate Survey, 2014	2014
Current Smokers (CHNA.org)	Healthcare Access and Delivery: Cancers; Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes; Healthcare Access and Delivery: Oral Health; Behavioral Health: Substance Use/Tobacco	This indicator reports the percentage of adults 18 years and older that self-report smoking cigarettes some days, most days or every day, or that self-report having smoked at least 100 cigarettes in their lifetime. This indicator is relevant because current behaviors are determinants of future health; the leading cause of preventable death in the U.S., tobacco use can cause long-term health impacts, including cardiovascular diseases, respiratory diseases, and cancers.	UCLA Center for Health Policy Research, California Health Interview Survey	2014
Cyberbullied More Than Once, 7th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 7th grade, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Cyberbullied More Than Once, 9th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 9th grade, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Cyberbullied More Than Once, 11th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	Percentage of public school students in 11th grade, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Deaths by Suicide, Drug, or Alcohol Poisoning (CHNA.org)	Behavioral Health: Mental Health; Behavioral Health: Substance Use/Tobacco	This indicator reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses per 100,000 population. This indicator is relevant because high rates of death of despair may signal broader issues in the community related to mental health, and substance use.	National Vital Statistics System	2011–2015
Delayed/Didn't Get Care (AskCHIS)	Healthcare Access and Delivery	Percentage of adults reporting they had delayed or did not get medical care	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Lack Dental Insurance Coverage (CHNA.org)	Healthcare Access and Delivery: Oral Health	This indicator reports the percentage of adults ages 18 and older who self-report that they do not have dental insurance (at the time of the interview). This indicator is relevant because having insurance enables access to dental care, a prerequisite for good oral health and overall health.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016
Dentists (CHNA.org)	Healthcare Access and Delivery; Healthcare Access and Delivery: Oral Health	This indicator reports the number of licensed dentists (including DDSs and DMDs) per 100,000 population. This indicator is relevant because an inadequate supply of dentists may limit access to dental care, a prerequisite for good oral health and overall health.	U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File	2015
Depression Among Medicare Beneficiaries (CHNA.org)	Behavioral Health: Mental Health	This indicator reports the percentage of the Medicare fee-for-service population with depression. This indicator is relevant as a measure of the burden of depression, a leading cause of disability in the U.S.; depression both influences and is influenced by physical health, affecting individuals' participation in health-promoting behaviors and presenting with multiple chronic comorbidities.	Centers for Medicare and Medicaid Services	2015

Indicator	Health Needs	Description	Source	Year(s)
Depression-Related Feelings, 7th Graders (CHKS)	Behavioral Health: Mental Health	Estimated percentage of public school students in 7th grade, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Depression-Related Feelings, 9th Graders (CHKS)	Behavioral Health: Mental Health	Estimated percentage of public school students in 9th grade, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Depression-Related Feelings, 11th Graders (CHKS)	Behavioral Health: Mental Health	Estimated percentage of public school students in 11th grade, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017).	2013–2015
Diabetes Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Obesity/HEAL/Diabetes	Number hospital discharges among children ages 0–17 for diabetes, as a percentage of all child discharges, excluding newborns	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015
Diabetes Management (Hemoglobin A1c Test) (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Healthcare Access and Delivery; Obesity/HEAL/Diabetes	This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test of blood sugar levels administered by a health care professional in the past year. This indicator is relevant because blood sugar monitoring enables disease management and treatment of diabetes complications; low levels of testing may suggest a lack of access to preventive care, lack of health knowledge, insufficient provider outreach, and existence of other barriers to utilization of services.	Dartmouth Atlas of Health Care	2015

Indicator	Health Needs	Description	Source	Year(s)
Diabetes Prevalence (CHNA.org)	Obesity/HEAL/Diabetes	This indicator reports the percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes.	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2013
Did Not Eat Breakfast, 7th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in 7th grade, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Did Not Eat Breakfast, 9th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in 9th grade, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Did Not Eat Breakfast, 11th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in 11th grade, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Domestic Violence Calls for Assistance (KidsData.org)	Community and Family Safety: Crime/Intentional Injury	Number of domestic violence calls for assistance per 1,000 adults ages 18–69	California Department of Justice, Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance Database (1998–2003) and Online Query System (Aug. 2015)	2014
Domestic Violence Hospitalizations (CHNA.org)	Community and Family Safety: Crime/Intentional Injury	This indicator reports the rate of non-fatal emergency department visits for domestic violence incidents among females ages 10 years and older per 100,000 population. This indicator is relevant as a proxy measure of intimate partner and domestic violence, and may signal broader issues in the community, such as economic insecurity and substance misuse.	EPICENTER California EpiCenter	2013–2014
Drinking Water Violations (CHNA.org)	Climate/Natural Environment	This indicator reports the presence or absence of health-based violations in community water systems over a specified time frame. This indicator is relevant as a measure of drinking water safety, a prerequisite for good health.	Safe Drinking Water Information System	2015

Indicator	Health Needs	Description	Source	Year(s)
Driving Alone to Work (CHNA.org)	Climate/Natural Environment; Obesity/HEAL/Diabetes	This indicator reports the percentage of the civilian non-institutionalized population 16 years and older that commute alone to work by motor vehicle. This indicator is relevant as a measure of quality of the physical/built environment, and public transportation and active transportation systems.	U.S. Census Bureau, American Community Survey	2012–2016
Driving Alone to Work, Long Distances (CHNA.org)	Climate/Natural Environment; Obesity/HEAL/Diabetes	This indicator reports the percentage of the civilian non-institutionalized population with long commutes to work, over 60 minutes each direction. This indicator is relevant as a measure of quality of the physical/built environment, regional employment trends, and public transportation and active transportation systems.	U.S. Census Bureau, American Community Survey	2012–2016
Drought Severity (CHNA.org)	Climate/Natural Environment	This indicator reports the population-weighted percentage of weeks in drought from January 1, 2012–December 31, 2014. This indicator is relevant because it highlights communities vulnerable to the effects of drought, and associated health impacts.	U.S. Drought Monitor	2012–2014
Elevated Blood Lead Levels in Children Ages 0–5 (Kidsdata.org)	Community and Family Safety: Unintentional Injuries/Accidents;	Percentage of children/youth ages 0–5 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group	California Department of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017)	2013
Elevated Blood Lead Levels in Children/Youth Ages 6–20 (Kidsdata.org)	Community and Family Safety: Unintentional Injuries/Accidents;	Percentage of children/youth ages 6–20 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group	California Department of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017)	2013

Indicator	Health Needs	Description	Source	Year(s)
Excessive Drinking (CHNA.org)	Healthcare Access and Delivery: Cancers; Community and Family Safety: Crime/Intentional Injury; Healthcare Access and Delivery: Heart Disease/Stroke; Behavioral Health: Substance Use/Tobacco	This indicator reports the percentage of adults 18 years and older that self-report heavy alcohol consumption. This indicator is relevant as a proxy measure of alcohol use; a leading cause of preventable death in the U.S., excessive alcohol use can cause short- and long-term health impacts, including injuries, violence, risky sexual behavior, pregnancy complications and fetal alcohol spectrum disorders, certain cancers, heart and liver disease, and mental health, substance dependency and social problems.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016
Exercise Opportunities (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of the population that live in close proximity to a park or recreational facility. This indicator is relevant because good access to parks and recreational facilities promotes physical activity and is associated long-term physical and mental health benefits.	County Health Rankings	2010; 2014
Expulsions (CHNA.org)	Community and Family Safety: Crime/Intentional Injury; Economic Security	This indicator reports the rate of expulsions per 100 enrolled students. This indicator is relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcome, including experiences of stress and trauma.	California Department of Education	2016–2017
Fear of Being Beaten Up at School, 7th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 7th grade, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Fear of Being Beaten Up at School, 9th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 9th grade, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Fear of Being Beaten Up at School, 11th Graders) (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 11th grade, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Federally Qualified Health Centers (CHNA.org)	Healthcare Access and Delivery	This indicator reports the rate of Federally Qualified Health Centers (FQHCs) per 100,000 total population within the service area. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations, and receive federal funding to promote access to ambulatory care in medically underserved areas.	Provider of Services File	2016
Female Received Birth Control Information From Doctor (AskCHIS)	Healthcare Access and Delivery: Maternal/Infant Health	Percentage of females who received birth control information from her doctor	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Firearm Fatalities (CHR)	Community and Family Safety: Crime/Intentional Injury; Community and Family Safety: Unintentional Injuries/Accidents	Number of deaths due to firearms per 100,000 population	CDC WONDER mortality data	2012–2016
Flood Vulnerability (CHNA.org)	Climate/Natural Environment	This indicator reports the estimated percentage of housing units within the special flood hazard area (SFHA) per county. This indicator is relevant because it highlights communities vulnerable to flooding and associated health impacts.	National Flood Hazard Layer	2011

Indicator	Health Needs	Description	Source	Year(s)
Food Environment Index (CHNA.org)	Obesity/HEAL/Diabetes	This indicator reports the food environment index score, a measure of affordable, close, and nutritious food retailers in a community, for which scores range between 0 (poorest food environment) and 10 (optimum food environment). This indicator is relevant because it highlights communities with lower access to healthy foods; good access to healthy food retailers promotes healthier eating behaviors and associated health benefits, including lower risk for obesity and related chronic diseases.	Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America)	2014
Food Insecurity (CHNA.org)	Economic Security; Healthcare Access and Delivery: Maternal/Infant Health; Obesity/HEAL/ Diabetes	This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the report year.	Feeding America	2014
Free and Reduced Price Lunch (CHNA.org)	Economic Security; Obesity/HEAL/Diabetes	This indicator reports the percentage of public school students eligible for free or reduced price lunches. This indicator is relevant because it provides a proxy measure for the concentration of low-income students within a school.	CCD NCES – Common Core of Data	2015–2016
Gang Membership, 7th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 7th grade, and nontraditional students, reporting whether they currently consider themselves a member of a gang	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Gang Membership, 9th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 9th grade, and nontraditional students, reporting whether they currently consider themselves a member of a gang	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Gang Membership, 11th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 11th grade, and nontraditional students, reporting whether they currently consider themselves a member of a gang	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Gonorrhea Incidence Among Youth Ages 10–19 (Kidsdata.org)	Healthcare Access and Delivery: Sexually Transmitted Infections	Number of gonorrhea infections per 100,000 youth ages 10–19	California Department of Public Health, Sexually Transmitted Diseases Data; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2010, 2010–2060; Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data and Statistics; U.S. Census Bureau, Population Estimates Program, Estimates of the Resident Population by Sex and Age for the United States, 2000–2010, 2010–2015 (Sept. 2016)	2015
Gonorrhea Incidence, Females (CCC) (CDPH)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator shows the gonorrhea incidence rate in female cases (ages 15–44) per 100,000 population.	California Department of Public Health, STD Control Branch, Data Request, September 2017. Gonorrhea data	2014–2016
Gonorrhea Incidence, Males (CCC) (CDPH)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator shows the gonorrhea incidence rate in male cases (ages 15–44) per 100,000 population.	California Department of Public Health, STD Control Branch, Data Request, September 2017. Gonorrhea data	2014–2016
Grocery Stores and Produce Vendors (CHNA.org)	Obesity/HEAL/Diabetes	This indicator reports the number of grocery stores per 10,000 population. This indicator is relevant because it measures density of healthy food outlets which helps characterize policy and environmental factors that affect eating behaviors; healthy eating habits support overall health, and lower risk for obesity and related chronic diseases.	U.S. Census Bureau, County Business Patterns	2015, 2014, 2013, 2012
Health Professional Shortage Area – Dental (CHNA.org)	Healthcare Access and Delivery: Oral Health	This indicator reports the percentage of the population that lives in a designated Health Professional Shortage Area, defined as having a shortage of dental health professionals. This indicator is relevant because an inadequate supply of dental health professionals may limit access to dental care, a prerequisite for good oral health and overall health.	Health Resources and Services Administration	2016

Indicator	Health Needs	Description	Source	Year(s)
Healthy Food Stores (Low Access) (CHNA.org)	Economic Security; Obesity/HEAL/Diabetes	This indicator reports the percentage of the population that do not live in close proximity to a large grocery store or supermarket. This indicator is relevant because it highlights communities with lower access to healthy foods; good access to healthy food retailers promotes heathier eating behaviors and associated health benefits, including lower risk for obesity and related chronic diseases.	USDA – Food Access Research Atlas	2014
Heart Disease Deaths (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes; Behavioral Health: Substance Use/Tobacco	This indicator reports the age-adjusted rate of death due to coronary heart disease per 100,000 population. This indicator is relevant because it is a measure of the burden of heart disease, the leading cause of death in the U.S.	National Vital Statistics System	2011–2015
Heart Disease Hospitalizations (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes; Behavioral Health: Substance Use/Tobacco	This indicator reports the hospitalization rate for coronary heart disease among Medicare beneficiaries 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population. This indicator is relevant because it is a measure of the burden of heart disease, the leading cause of death in the U.S.	Interactive Atlas of Heart Disease and Stroke	2012–2014
Heart Disease Prevalence (Medicare Population) (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes; Behavioral Health: Substance Use/Tobacco	This indicator reports the percentage of the Medicare-fee-for-service population that self-report having been diagnosed with heart disease by a doctor.	Centers for Medicare and Medicaid Services	2015

Indicator	Health Needs	Description	Source	Year(s)
Heat Index (CHNA.org)	Climate/Natural Environment	This indicator reports the percentage of days per year with recorded heat index values (a measure of temperature and humidity) of over 100 degrees Fahrenheit. This indicator is relevant because it is a measure of exposure to extreme heat events which can trigger heat stress conditions and respiratory symptoms, increase death rates, and increase the risk of foodborne illness.	North America Land Data Assimilation System (NLDAS)	2013, 2012, 2011, 2010, 2009, 2008, 2007, 2006
High School Dropout (Adjusted) (Kidsdata.org)	Economic Security	Percentage of public high school students who do not complete high school, based on the four-year adjusted cohort dropout rate	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS) (May 2016)	2015
High School Graduates Completing College Prep Courses (Kidsdata.org)	Economic Security	Percentage of public school 12th grade graduates completing courses required for University of California (UC) and/or California State University (CSU) entrance, with a grade of "C" or better (e.g., in 2015, 43.4% of 12th grade graduates in California completed courses required for UC and/or CSU entrance)	California Department of Education, California Basic Educational Data System (CBEDS) (Jun. 2016)	2015
High-Speed Internet (CHNA.org)	Economic Security	This indicator reports the percentage of population with access to high-speed internet. This indicator is relevant because internet access opens up opportunities for employment and education.	FCC Fixed Broadband Deployment Data	2016
HIV/AIDS Deaths (CHNA.org)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator reports the rate of death due to HIV and AIDS per 100,000 population. This indicator is relevant because it is a measure of the burden of HIV/AIDS, and may suggest the existence of barriers to accessing care.	National Vital Statistics System	2008–2014
HIV/AIDS Incidence (CCC) (CDPH)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator shows the HIV incidence rate in individuals ages 13 and older per 100,000 population.	California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section reporting periods are: Current Period 2013–2015, Previous Period 2010–2012	2013–2015

Indicator	Health Needs	Description	Source	Year(s)
HIV/AIDS Prevalence (CHNA.org)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator reports prevalence of HIV infection per 100,000 population. This indicator is relevant because it is a measure of the burden of HIV/AIDS, a life-threatening chronic disease for which effective interventions for treatment and prevention exist.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013
Home Ownership (AskCHIS)	Economic Security	Percentage of adults who own their home	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Homeless Children Ages 0–17 Who Are Unsheltered (Kidsdata.org)	Economic Security	Number of unaccompanied children found to be homeless during the national point-in-time (PIT) count of homeless individuals, by age group and shelter status (e.g., 1,451 California children ages 0–17 were found to be homeless and unsheltered during the 2017 PIT count)	U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S. 2014 and 2017 (Mar. 2018)	2017
Homeless Individuals Who Are Unsheltered (PIT; HUD)	Economic Security	The percentage of homeless individuals living in encampments, cars, parks, or abandoned buildings	2017 Point in Time Count: A Snapshot of Contra Costa County; U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S.	2017
Homeless Public School Students (Kidsdata.org)	Economic Security	Percentage of public school students recorded as being homeless at any point during a school year (e.g., 4.4% of California students were recorded as being homeless at some point during the 2016 school year)	California Department of Education, Coordinated School Health and Safety Office custom tabulation and California Basic Educational Data System (May 2017)	2016
Homeless Young Adults Ages 18–24 Who Are Unsheltered (Kidsdata.org)	Economic Security	Number of unaccompanied young adults found to be homeless during the national point-in-time (PIT) count of homeless individuals, by age group and shelter status (e.g., 1,451 California children ages 0–17 were found to be homeless and unsheltered during the 2017 PIT count)	U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S. 2014 and 2017 (Mar. 2018)	2017
Homicide (CHR)	Community and Family Safety: Crime/Intentional Injury	Number of deaths due to homicide per 100,000 population	CDC WONDER mortality data	2010–2016

Indicator	Health Needs	Description	Source	Year(s)
Housing Problems (CHNA.org)	Economic Security	This indicator reports the percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Housing unit is severely overcrowded (>1 person per room); or Household is severely cost burdened (all housing costs represent over >30% of monthly income). This indicator is relevant because it highlights communities wherein housing or quality of life is considered substandard.	U.S. Census Bureau, American Community Survey	2012–2016
Impaired Driving Deaths (CHNA.org)	Community and Family Safety: Unintentional Injuries/Accidents; Behavioral Health: Substance Use/Tobacco	This indicator reports the percentage of motor vehicle crash deaths in which alcohol played a role. This indicator is relevant because alcohol is a leading cause of preventable death in the U.S., and impaired driving is the leading cause of alcohol-related deaths.	Fatality Analysis Reporting System	2011–2015
Income Inequality – 80/20 Ratio (CHNA.org)	Economic Security	This indicator reports the ratio of household income at the 80th percentile to household income at the 20th percentile. This indicator is relevant because it highlights communities with greater disparities between low- and high-income households; income inequality is a strong predictor of health status, health disparities, and social and environmental vulnerabilities.	U.S. Census Bureau, American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Individuals Experiencing Homelessness (PIT)	Economic Security	The number of homeless individuals counted during the county's Point-in-Time Count (PIT). The PIT includes only people who fit the HUD definition of homelessness: (1) an individual or family living in a supervised publicly or privately operated shelter, designated to provide temporary living arrangement (including congregate shelters, transitional housing, and hotels/motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals), or (2) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground.	Contra Costa Council on Homelessness. (2017). 2017 Point-in-Time Count: A Snapshot of Contra Costa County	2017
Infant Deaths (CHNA.org)	Healthcare Access and Delivery: Maternal/Infant Health	This indicator reports the rate of death among infants less than 1 year old per 1,000 births. This indicator is relevant because infant mortality is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File	2006–2010
Influenza Vaccination (all ages) (AskCHIS)	Healthcare Access and Delivery: Communicable Diseases (Not STIs)	Percentage of the population who had a flu vaccine in the last 12 months	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Injury Deaths (CHNA.org)	Community and Family Safety: Crime/Intentional Injury; Community and Family Safety: Unintentional Injuries/Accidents	This indicator reports the number of deaths from intentional and unintentional injuries per 100,000 population. This indicator is relevant because death from injury is a leading cause of death in the U.S., and the leading cause of death among those ages 1–44; high injury mortality may signal broader issues in the community.	National Vital Statistics System	2011–2015

Indicator	Health Needs	Description	Source	Year(s)
Insufficient Social and Emotional Support (CHNA.org)	Behavioral Health: Mental Health	This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health and Human Services, Health Indicators Warehouse	2006–2012
Jail Admissions (Vera)	Community and Family Safety: Crime/Intentional Injury	Rate of annual jail admissions per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates (Accessed 17 August 2018)	2015
Jail Incarceration (Vera)	Community and Family Safety: Crime/Intentional Injury	Rate of jail incarceration per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates (Accessed 17 August 2018)	2015
Juvenile Felony Arrests (Kidsdata.org)	Community and Family Safety: Crime/Intentional Injury; Economic Security	Number of juvenile felony arrests per 1,000 youth ages 10–17	California Department of Justice, Arrest Data; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990–1999, 2000–2010, 2010–2060 (Oct. 2016)	2015
Kindergarteners With Required Immunizations (Kidsdata.org)	Healthcare Access and Delivery: Communicable Diseases (Not STIs)	Percentage of children in kindergarten with all required immunizations	California Department of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb. 2016)	2016
Life Expectancy at Birth (CHNA.org)	Healthcare Access and Delivery: Maternal/Infant Health; Other Health	This indicator reports the average life expectancy at birth in years. This indicator is relevant as a measure of overall mortality across a population.	IHME_LE Institute for Health Metrics and Evaluation	2014
Low Birth Weight (CHNA.org)	Healthcare Access and Delivery: Maternal/Infant Health; Behavioral Health: Substance Use/Tobacco	This indicator reports the percentage of total births that are low birthweight (under 2500 grams). This indicator is relevant because low birthweight is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	National Vital Statistics System	2008–2014
Lung Cancer Incidence (CHNA.org)	Healthcare Access and Delivery: Cancers; Behavioral Health: Substance Use/Tobacco	This indicator reports the age-adjusted incidence rate of lung cancer per 100,000 population. This indicator measures the burden of lung cancer, which may be useful for targeting interventions to prevent, screen for, and treat lung cancer, which is the leading cause of cancer deaths.	State Cancer Profiles	2010–2014

Indicator	Health Needs	Description	Source	Year(s)
Meaningful Participation at School: Low, 7th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 7th grade, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Meaningful Participation at School: Low, 9th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 9th grade, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Meaningful Participation at School: Low, 11th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 11th grade, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Median Income (CHNA.org)	Economic Security	This indicator reports median inflation-adjusted household income. Median Household Income is the income where half of households in a county earn more and half of households earn less.	U.S. Census Bureau, American Community Survey	2012–2016
Median Rent (Zilpy)	Housing and Homelessness	This indicator reports median rent for a two-bedroom unit in October 2018.	Zilpy.com	2018
Medicaid/Public Insurance Enrollment (CHNA.org)	Economic Security; Healthcare Access and Delivery	This indicator reports the percentage of the population that is enrolled in Medicaid or another public health insurance program. This indicator is relevant because Medicaid provides insurance coverage for groups with special health needs, including low-income children, adults and people with disabilities; when combined with poverty data, this indicator may help identify gaps in coverage and barriers access.	U.S. Census Bureau, American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Mental Health Hospitalization, Children Ages 5–14 (Kidsdata.org)	Behavioral Health: Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5–14, by age group	California Office of Statewide Health Planning and Development special tabulation; California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009; Population Reference Bureau, Population Estimates 2010–2016 (Aug. 2017)	2016
Mental Health Hospitalization, Youth Ages 15–19 (Kidsdata.org)	Behavioral Health: Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth ages 15–19, by age group	California Office of Statewide Health Planning and Development special tabulation; California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009; Population Reference Bureau, Population Estimates 2010–2016 (Aug. 2017)	2016
Mental Health Providers (CHNA.org)	Healthcare Access and Delivery	This indicator reports the number of mental health care providers (including psychiatrists, psychologists, clinical social workers, and counsellors) per 100,000 population. This indicator is relevant because an inadequate supply of providers may limit access to mental health care.	U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File	2016
Motor Vehicle Crash Deaths (CHNA.org)	Community and Family Safety: Unintentional Injuries/Accidents;	This indicator reports the age-adjusted rate of death due to motor vehicle crashes per 100,000 population. This indicator is relevant because motor vehicle crashes are a leading cause of death in the U.S., and the leading cause of death among teens, despite being preventable.	National Vital Statistics System	2011–2015
Obesity (Adult) (CHNA.org)	Healthcare Access and Delivery: Asthma; Healthcare Access and Delivery: Cancers; Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of adults 18 years and older that self-report having a Body Mass Index (BMI) greater than 30.0 (the threshold for obesity).	UCLA Center for Health Policy Research, California Health Interview Survey	2014

Indicator	Health Needs	Description	Source	Year(s)
Obesity (Youth) (CHNA.org)	Healthcare Access and Delivery: Asthma; Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in 5th, 7th, and 9th grades ranking within the "High Risk" category for body composition on the Fitnessgram physical fitness test. This indicator is relevant because it is a proxy measure of the burden of obesity among children; childhood obesity is linked with short- and long-term implications for health, including social and mental health impacts, diabetes, and heart disease.	Fitnessgram Physical Fitness Testing	2016–2017
On-Time High School Graduation (CHNA.org)	Economic Security	This indicator reports the on-time high school graduation rate per cohort. This indicator is relevant as a measure of educational attainment, an important determinant of health and opportunity across the lifespan.	California Department of Education	2014–2015
Opioid Prescription Drug Claims (CHNA.org)	Behavioral Health: Substance Use/Tobacco	This indicator reports the number of Medicare Part D prescription claims for opiates as a percentage of total Medicare Part D prescription drug claims. This indicator is relevant as a proxy measure of opiate prescription drug use.	Centers for Medicare and Medicaid Services	2015
Opportunity Index (CHNA.org)	Economic Security	This indicator reports the opportunity index score, a measure of community well-being, for which scores range between 0 (indicating no opportunity) and 100 (indicating maximum opportunity). This indicator is relevant as a measure of economic, education, health and community factors that affect opportunity and well-being.	Opportunity Nation	2017

Indicator	Health Needs	Description	Source	Year(s)
Ozone Levels (CHNA.org)	Healthcare Access and Delivery: Asthma; Climate/Natural Environment	This indicator reports the percentage of days per year with Ozone (O_3) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb). This indicator is relevant because it is a measure of exposure to O_3 which can cause and exacerbate respiratory health issues, including onset of respiratory symptoms, decreased lung function, and aggravated asthma and lung diseases.	National Environmental Public Health Tracking Network	2014, 2013, 2012, 2011, 2010, 2009, 2008
Particulate Matter 2.5 Levels (CHNA.org)	Healthcare Access and Delivery: Asthma; Healthcare Access and Delivery: Cancers; Climate/Natural Environment	This indicator reports the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient Air Quality Standard of 35 micrograms per cubic meter. This indicator is relevant because it is a measure of exposure to PM2.5 which is linked with respiratory and cardiovascular health issues, including onset of respiratory symptoms, decreased lung function, and aggravated asthma, and heart and lung diseases.	National Environmental Public Health Tracking Network	2014, 2013, 2012, 2011, 2010, 2009, 2008
Pedestrian Accident Deaths (CHNA.org)	Community and Family Safety: Unintentional Injuries/Accidents;	This indicator reports the rate of death due to pedestrian accident per 100,000 population. This indicator is relevant because high pedestrian mortality may signal issues within communities affecting the safety of streets and pedestrian infrastructure.	Fatality Analysis Reporting System	2011–2015
Physical Inactivity (Adult) (CHNA.org)	Healthcare Access and Delivery: Cancers; Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of adults 20 years and older that self-report not participating in physical activities or exercise. This indicator is relevant because current behaviors are determinants of future health; physical inactivity increases risk for many adverse health conditions, including heart disease, diabetes, and certain cancers, and shortens life expectancy.	National Center for Chronic Disease Prevention and Health Promotion	2013

Indicator	Health Needs	Description	Source	Year(s)
Physical Inactivity (Youth) (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in 5th, 7th, and 9th grades ranking within the "High Risk" or "Needs Improvement" zones for aerobic capacity on the Fitnessgram physical fitness test. This indicator is relevant as a proxy measure of physical activity levels among children; regular physical activity in children can help improve fitness, build strong bones and muscles, control weight, reduce depression and anxiety, and reduce risk for chronic diseases.	Fitnessgram Physical Fitness Testing	2016–2017
Poisoning Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Community and Family Safety: Unintentional Injuries/Accidents;	Number hospital discharges among children ages 0–17 for the poisoning diagnoses as a percentage of all child discharges, excluding newborns	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015
Poor Mental Health Days (CHNA.org)	Behavioral Health: Mental Health; Behavioral Health: Substance Use/Tobacco; Other Health	This indicator reports the age-adjusted average number of self-reported mentally unhealthy days per month among adults. This indicator is relevant because it provides a measure of mental health status and quality of life.	Behavioral Risk Factor Surveillance System	2015
Poor or Fair Health (CHNA.org)	Healthcare Access and Delivery; Other Health	This indicator reports the percentage of adults that self-report having poor or fair health. This indicator is relevant because it is a measure of general poor health status and quality of life.	Behavioral Risk Factor Surveillance System	2015
Poor Physical Health Days (CHNA.org)	Healthcare Access and Delivery; Other Health	This indicator reports the age-adjusted, average number of self-reported physically unhealthy days per month among adults. The indicator is relevant because it provides a measure of general physical health status and quality of life.	Behavioral Risk Factor Surveillance System	2015

Indicator	Health Needs	Description	Source	Year(s)
Population Below 100% FPL (CHNA.org)	Economic Security; Other Health	This indicator reports the percentage of the population living in households with incomes below the Federal Poverty Level (FPL). This indicator is relevant as a measure for the concentration of poverty, and because it highlights a group requiring special consideration, targeted services and outreach by providers.	U.S. Census Bureau, American Community Survey	2012–2016
Population in Limited English Households (CHNA.org)	Economic Security	This indicator reports the percentage of the population 5 and older living in Limited English speaking households. A "Limited English speaking household" is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English "very well."	U.S. Census Bureau, American Community Survey	2012–2016
Population That Is Linguistically Isolated (CHNA.org)	Economic Security	This indicator reports the percentage of the population 5 years and older that is considered linguistically isolated who (1) speak a language other than English at home, and (2) speak English less than "very well." This indicator is relevant because it highlights communities requiring special consideration, targeted services and outreach by providers.	U.S. Census Bureau, American Community Survey	2012–2016
Population With Any Disability (CHNA.org)	Other Health	This indicator reports the percentage of the total non-institutionalized civilian population with a disability. This indicator is relevant as a measure of the burden due to disability, and because disabled individuals comprise a population with certain needs for targeted services and outreach by providers.	U.S. Census Bureau, American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Pre-Term Births (CHNA.org)	Healthcare Access and Delivery: Maternal/Infant Health	This indicator reports the percentage of total births that are pre-term (occurring before 37 weeks of pregnancy). This indicator is relevant because preterm birth is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File	2012–2014
Premature Death (CHNA.org)	Other Health	This indicator reports the rate of death among people younger than 75 years old per 100,000 population. This indicator is relevant as a measure of the extent of premature mortality.	County Health Rankings	2012–2014
Premature Death, Racial/Ethnic Disparity Index (CHNA.org)	Other Health	This indicator reports a summary measure of disparity (Index of Disparity) in premature death on the basis of race and ethnicity. This indicator is relevant as a measure of the extent to which premature mortality varies between racial and ethnic background groups.	National Vital Statistics System	2004–2010
Preschool Enrollment (CHNA.org)	Economic Security; Healthcare Access and Delivery: Maternal/Infant Health	This indicator reports the percentage of the population aged 3 to 4 years that is enrolled in preschool. This indicator is relevant because early childhood education improves cognitive and social development of children, is a protective factor against disease and disability in adulthood, and may minimize gaps in school readiness between lesser and more economically advantaged children.	U.S. Census Bureau, American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Preventable Hospital Events (CHNA.org)	Healthcare Access and Delivery; Other Health	This indicator reports the patient discharge rate for conditions that are ambulatory care sensitive (e.g., pneumonia, dehydration, asthma, diabetes) per 1,000 population. This indicator is relevant as a measure of preventable hospital events, and demonstrates a possible return on investment' from interventions that reduce admissions, such as those that improve access to primary care resources.	Dartmouth Atlas of Health Care	2014
Primary Care Physicians (CHNA.org)	Healthcare Access and Delivery	This indicator reports the number of primary care physicians (including MDs and DOs practicing general family medicine and general practice, and MDs practicing general internal medicine and general pediatrics) per 100,000 population. This indicator is relevant because an inadequate supply of primary care physicians may limit access to preventive health care services.	U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File	2014
Prison Incarceration (Vera)	Community and Family Safety: Crime/Intentional Injury	Rate of individuals in state prison from county per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates (Accessed 17 August 2018)	2013
Prostate Cancer Incidence (CHNA.org)	Healthcare Access and Delivery: Cancers	This indicator reports the age-adjusted incidence rate of prostate cancer among males per 100,000 population per year. This indicator is relevant because it is a measure of the burden of prostate cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat prostate cancer which is among the most common cancers affecting men.	State Cancer Profiles	2010–2014

Indicator	Health Needs	Description	Source	Year(s)
Public Transit Stops (CHNA.org)	Climate/Natural Environment; Obesity/HEAL/Diabetes	This indicator measures the percentage of the population living within 0.5 miles of a transit stop. This indicator is relevant because it is a measure of access to public transportation. Data are available only for population living within cities that report transit data using General Transit Feed Specification (GTFS) standards.	Environmental Protection Agency, EPA Smart Location Database	2013
Reading At or Above Proficiency (CHNA.org)	Economic Security	This indicator reports the percentage of children in grade 4 whose reading skills tested at or above the "proficient" level for the English Language Arts portion of the state-specific standardized test.	US Department of Education, EDFacts (Accessed via DATA.GOV)	2015–2016
Recent Alcohol/Drug Use, 7th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 7th grade, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Alcohol/Drug Use, 9th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 9th grade, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Alcohol/Drug Use, 11th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 11th grade, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Dental Exam (Youth) (CHNA.org)	Healthcare Access and Delivery; Healthcare Access and Delivery: Oral Health	This indicator reports the percentage of children aged 2 to 11 years with teeth that have visited a dentist in the past year. This indicator is relevant because it measures preventive dental care services utilization which contributes to good oral and overall health.	UCLA Center for Health Policy Research, California Health Interview Survey	2014

Indicator	Health Needs	Description	Source	Year(s)
Recent Dental Visit (Adults) (AskCHIS)	Healthcare Access and Delivery; Healthcare Access and Delivery: Oral Health	Percentage of adults who had a dental visit up to one year ago	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Recent ER Visit (AskCHIS)	Healthcare Access and Delivery	Percentage of adults who had visited an emergency room in the past 12 months	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Recent ER Visit, Adults 65+ (AskCHIS)	Healthcare Access and Delivery	Percentage of adults 65 and older who had visited an emergency room in the past 12 months	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Recent Formal Community Engagement (Volunteer Work) (Adult) (AskCHIS)	Behavioral Health: Mental Health	Percentage of adults who engaged in formal volunteer work for community problems within the past year	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Recent Informal Community Engagement (Met With Others) (Adult) (AskCHIS)	Behavioral Health: Mental Health	Percentage of adults who met informally with others about community problems within the past year	UCLA Center for Health Policy Research, California Health Interview Survey	2016
Recent Marijuana Use, 7th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 7th grade, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Marijuana Use, 9th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 9th grade, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Marijuana Use, 11th Graders (CHKS)	Behavioral Health: Substance Use/Tobacco	Estimated percentage of public school students in 11th grade, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Primary Care Visit (CHNA.org)	Healthcare Access and Delivery	This indicator reports the percentage of adults 18 years and older that visited a primary care clinician at least once within the past year.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016
Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (AskCHIS)	Behavioral Health: Mental Health	Percentage of adults who have taken prescription medicine for an emotional/mental health issue for at least two weeks within the past year	UCLA Center for Health Policy Research, California Health Interview Survey	2016

Indicator	Health Needs	Description	Source	Year(s)
Respiratory Hazard Index (CHNA.org)	Healthcare Access and Delivery: Asthma; Climate/Natural Environment	This indicator reports the respiratory hazard index, for which scores greater than 1.0 mean respiratory pollutants are likely to increase risk of non-cancer adverse health effects over a lifetime. This indicator is relevant because it is a measure of exposure to respiratory hazards and risk for associated health impacts.	EPA National Air Toxics Assessment	2011
Road Network Density (CHNA.org)	Climate/Natural Environment	This indicator reports road network density, or road miles per square mile. This indicator is relevant as a measure of connectivity, but also traffic density, vehicle emissions and air quality.	EPA Smart Location Database	2011
School Connectedness: Low, 7th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 7th grade, and nontraditional students by level of connectedness to school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
School Connectedness: Low, 9th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 9th grade, and nontraditional students by level of connectedness to school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Connectedness: Low, 11th Graders (CHKS)	Behavioral Health: Mental Health	Percentage of public school students in 11th grade, and nontraditional students by level of connectedness to school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Perceived as Unsafe/Very Unsafe, 7th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 7th grade, and nontraditional students reporting the level of safety they feel at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Perceived as Unsafe/Very Unsafe, 9th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 9th grade, and nontraditional students reporting the level of safety they feel at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Perceived as Unsafe/Very Unsafe, 11th Graders (CHKS)	Community and Family Safety: Crime/Intentional Injury	Percentage of public school students in 11th grade, and nontraditional students reporting the level of safety they feel at school	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Segregation Index (CHNA.org)	Economic Security	This indicator reports the segregation index score, a measure of the spatial distribution or evenness of population demographic groups, for which index values range between 0.0 (indicating even distribution) and 1.0 (indicating maximum segregation). This indicator is relevant as a measure of residential segregation with implications affecting spatial and socioeconomic mobility.	U.S. Census Bureau, Decennial Census	2010
Seriously Considered Suicide, 9th Graders (CHKS)	Behavioral Health: Mental Health	Estimated percentage of public school students in 9th grade, and nontraditional programs who seriously considered attempting suicide in the previous year, by grade level	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Seriously Considered Suicide, 11th Graders (CHKS)	Behavioral Health: Mental Health	Estimated percentage of public school students in 11th grade, and nontraditional programs who seriously considered attempting suicide in the previous year, by grade level	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Seriously Considered Suicide (CHNA.org)	Behavioral Health: Mental Health	This indicator reports the percentage of adults 18 years and older that self-report having seriously thought about committing suicide. This indicator is relevant because suicide is a leading cause of preventable death among young people in the U.S.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016
Severe Housing Problems (CHNA.org)	Economic Security	This indicator reports the percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Housing unit is severely overcrowded (> 2 persons per room); or Household is severely cost burdened (all housing costs represent >50% of monthly income). This indicator is relevant because it highlights communities wherein housing or quality of life is considered substandard.	U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy (CHAS) data	2011–2015

Indicator	Health Needs	Description	Source	Year(s)
SNAP Benefits (CHNA.org)	Economic Security	This indicator reports the estimated percentage of households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant as a proxy measure for community food security, poverty and socioeconomic status; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.	U.S. Census Bureau, American Community Survey	2012–2016
Social Associations (CHNA.org)	Behavioral Health: Mental Health	This indicator reports the number of social associations (e.g., civic organizations, recreational clubs and facilities, political organizations, labor organizations, business associations, professional organizations) per 10,000 population. This indicator is relevant as a measure of community vitality.	U.S. Census Bureau, County Business Patterns	2015, 2014, 2013, 2012
Soft Drink Consumption (CHNA.org)	Obesity/HEAL/Diabetes; Healthcare Access and Delivery: Oral Health	This indicator reports the percentage of adults that self-report drinking a soda or sugar sweetened beverage at least once daily. This indicator is relevant as a measure of soft drink consumption; drinking soft drinks increases risk for diabetes, heart disease, and other chronic diseases.	UCLA Center for Health Policy Research, California Health Interview Survey	2014
Stroke Deaths (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the age-adjusted rate of death due to cerebrovascular disease (stroke) per 100,000 population. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	National Vital Statistics System	2011–2015

Indicator	Health Needs	Description	Source	Year(s)
Stroke Hospitalizations (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the hospitalization rate for Ischemic stroke among Medicare beneficiaries 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	Interactive Atlas of Heart Disease and Stroke	2012–2014
Stroke Prevalence (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of the Medicare fee-for-service population diagnosed with stroke. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	Centers for Medicare and Medicaid Services	2015, 2014, 2013, 2012, 2011, 2010
Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in 5th grade meeting 6 of 6 fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015
Students Meeting Fitness Standards, 7th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in 7th grade meeting 6 of 6 fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015
Students Meeting Fitness Standards, 9th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in 9th grade meeting 6 of 6 fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015
Students per Academic Counselor (Kidsdata.org)	Economic Security	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Academic Counselor. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per School Nurse (Kidsdata.org)	Healthcare Access and Delivery	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by School Nurse. Smaller numbers indicate that students have greater access to support service personnel	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016).	2015

Indicator	Health Needs	Description	Source	Year(s)
Students per School Psychologist (Kidsdata.org)	Healthcare Access and Delivery; Behavioral Health: Mental Health	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by School Psychologist. Smaller numbers indicate that students have greater access to support service personnel	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per School Speech/Language/Hearing Specialist (Kidsdata.org)	Healthcare Access and Delivery	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Speech/Language/Hearing Specialist. Smaller numbers indicate that students have greater access to support service personnel	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per Social Worker (Kidsdata.org)	Other Health	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Social Worker. Smaller numbers indicate that students have greater access to support service personnel	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Substantiated Child Abuse and Neglect (KidsData.org)	Community and Family Safety: Crime/Intentional Injury	Number of substantiated cases of abuse and neglect per 1,000 children under age 18	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016); Annie E. Casey Foundation, KIDS COUNT (Jul. 2016)	2015
Suicide Mortality (CHNA.org)	Community and Family Safety: Crime/Intentional Injury; Behavioral Health: Mental Health	This indicator reports the age-adjusted rate of death due to intentional self-harm (suicide) per 100,000 population. This indicator is relevant because it is a measure of burden of suicide, a leading cause of death in the U.S. Values are suppressed when the number of suicide deaths over the five-year time period is less than 10.	National Vital Statistics System	2011–2015

Indicator	Health Needs	Description	Source	Year(s)
Suspensions (CHNA.org)	Community and Family Safety: Crime/Intentional Injury; Economic Security	This indicator reports the rate of suspensions per 100 enrolled students. This indicator is relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcome, including experiences of stress and trauma.	California Department of Education	2016–2017
Syphilis Incidence (Male) (CCC) (CDPH)	Healthcare Access and Delivery: Sexually Transmitted Infections	This indicator shows the infectious syphilis (primary and secondary) incidence rate in male cases per 100,000 population.	California Department of Public Health, STD Control Branch	2014–2016
Teen Births (CHNA.org)	Economic Security; Healthcare Access and Delivery: Maternal/Infant Health	This indicator reports the number of births to women ages 15–19 years per 1,000 population. This indicator is relevant because social determinants such as low education and low income are associated with teen pregnancies, and it highlights communities in need of prevention and support services.	National Vital Statistics System	2008–2014
Teen Births by Ethnicity (Kidsdata.org)	Economic Security; Healthcare Access and Delivery: Maternal/Infant Health	Number of births per 1,000 young women ages 15–19	California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990–1999, 2000–2010, 2010–2060; California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control and Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015)	2013
Time in Foster Care (Median Months) (Kidsdata.org)	Behavioral Health: Mental Health	Median length of stay in foster care, in months, for children under age 18	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016)	2013

Indicator	Health Needs	Description	Source	Year(s)
Traumatic Injury Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Community and Family Safety: Crime/Intentional Injury; Community and Family Safety: Unintentional Injuries/ Accidents	Number hospital discharges among children ages 0–17 for traumatic injury diagnoses, as a percentage of all child discharges, excluding newborns	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015
Tree Canopy Cover (CHNA.org)	Climate/Natural Environment	This indicator reports the percentage of land within the report area that is covered by tree canopy. This indicator is relevant as a measure of resilience against the health impacts of climate change; tree canopy coverage protects against air pollution, reduces heat island effects, reduces noise pollution, and provides ecosystem services.	U.S. Department of the Interior, U.S. Geological Survey, Earth Resources Observation and Science Center, National Land Cover Database 2011	2011
Truancy (Kidsdata.org)	Economic Security	Number of K–12 public school students reported as being truant at least once during the school year per 100 students	California Department of Education, DataQuest (Jun. 2016)	2015
Tuberculosis Incidence (CCC) (CDPH)	Healthcare Access and Delivery: Communicable Diseases (Not STIs)	This indicator shows the tuberculosis incidence rate per 100,000 population.	California Department of Public Health, Tuberculosis Control Branch, Data request, September 2017	2014–2016, 2017
Unemployment (CHNA.org)	Economic Security	This indicator reports the percentage of the civilian non-institutionalized population aged 16 years and older that is unemployed but seeking work (non-seasonally adjusted). This indicator is relevant because unemployment is a measure of community stability and regional economic dynamism; at the individual level, unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status and quality of life.	Bureau of Labor Statistics	2018

Indicator	Health Needs	Description	Source	Year(s)
Uninsured Children (CHNA.org)	Economic Security; Healthcare Access and Delivery	This indicator reports the percentage of children aged less than 18 years of age without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access, including regular primary care, specialty care, and other health services, which contributes to poor health status and quality of health.	U.S. Census Bureau, American Community Survey	2012–2016
Uninsured Population (CHNA.org)	Economic Security; Healthcare Access and Delivery	This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access, including regular primary care, specialty care, and other health services, which contributes to poor health status and quality of life.	U.S. Census Bureau, American Community Survey	2012–2016
Very Low Birth Weight (Kidsdata.org)	Healthcare Access and Delivery: Maternal/Infant Health; Behavioral Health: Substance Use/Tobacco	Percentage of infants born at very low birthweight (less than 1,500 grams or about 3 lbs., 5 oz.)	California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control and Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015)	2013
Violent Crimes (CHNA.org)	Community and Family Safety: Crime/Intentional Injury	This indicator reports the rate of violent crime offenses (including homicide, rape, robbery and aggravated assault) reported by law enforcement per 100,000 population. This indicator is relevant as a measure of community safety.	FBI Uniform Crime Reports	2012–2014

Indicator	Health Needs	Description	Source	Year(s)
Walkable Destinations (CHNA.org)	Healthcare Access and Delivery: Heart Disease/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of the population that live in close proximity to a park, playground, library, museum or other destinations of interest. This indicator is relevant because good access to walkable destination promotes physical activity and is associated long-term physical and mental health benefits.	Center for Applied Research and Environmental Systems (CARES)	2012–2015
Young People Not in School and Not Working (CHNA.org)	Economic Security; Behavioral Health: Mental Health	This indicator reports the percentage of youth ages 16–19 years who are not currently enrolled in school or employed. This indicator is relevant as a measure of youth disconnection which has short- and long-term implications for health, wellbeing and quality of life.	U.S. Census Bureau, American Community Survey	2012–2016

Attachment 7. Impact of Implemented Strategies 2017–2018

This section is based on the 2016–2018 Implementation Strategy that described how Sutter Delta Medical Center planned to address significant health needs identified in its 2016 Community Health Needs Assessment (CHNA).

The 2016 CHNA identified eight community health needs. Working within its mission and capabilities, Sutter Delta Medical Center selected these needs to address in its Implementation Strategy:

- Access to Quality Primary Care Health Services
- Access to Basic Needs, Such as Housing and Employment
- Access to Mental, Behavioral, and Substance Abuse Services
- Health Education and Health Literacy
- Access to Transportation and Mobility

The Implementation Strategy provided details of actions the hospital intended to take, including programs and resources it planned to commit. The tables below highlight the 2017 and 2018 impacts achieved by the programs that Sutter Delta Medical Center featured in its 2016–2018 Implementation Strategy.

Access to Quality Primary Health Care Services Impact

Name of Program, Activity, or Initiative	**Care Transitions**
Description	Sutter Delta Medical Center worked with partner La Clínica, a Federally Qualified Health Center (FQHC), to improve care transitions for targeted individuals.
2017–2018 Impact	1,782 people served 1,832 primary care physician appointments scheduled 86.25% of follow-up appointments kept

Name of Program, Activity, or Initiative	**Save a Life Sister**
Description	Save a Life Sister provides breast cancer screening and diagnostic services to all adult residents of East Contra Costa County who, due to low income or lack of health coverage, do not have access to these services. If cancer is detected, a nurse navigator links women to appropriate treatment services. Education and support are provided as well.
2017–2018 Impact	Save a Life Sister is now part of the Department of Health Services Cancer Detection and Treatment Branches program, Every Woman Counts (EWC); therefore, Sutter Delta Medical Center does not have any metrics to report.

Access to Basic Needs, Such Housing and Employment, Impact

Name of Program, Activity, or Initiative	**Interim Care Program**
Description	Sutter Delta Medical Center partnered with the Phillip Dorn Respite Center to provide patients experiencing homelessness with temporary housing after their hospital discharge. This allowed patients to recuperate in a clean, stable environment with nursing care, meals, and other social services provided. The program includes transportation to the respite center for patients who need it.
2017-2018 Impact	3,342 people served 2,737 connected to social services 880 placed in shelter and received case management

Access to Mental, Behavioral, and Substance Abuse Services Impact

Name of Program, Activity, or Initiative	**Sobering Center**
Description	Develop a pilot project in collaboration with neighboring hospitals and nursing schools to address the need for access to substance abuse treatment services.
2017–2018 Impact	Program not developed at this time

Health Education and Health Literacy Impact

Name of Program, Activity, or Initiative	**Asthma Resource Center**
Description	The Asthma Resource Center is designed to help individuals control their asthma and improve their quality of life by providing education and tools for asthma management with a focus on the uninsured or underinsured. Individuals learned about basic asthma facts, medications and techniques, environmental controls, and asthma action plans. Efforts were made to also assist individuals who lacked follow-up medical care in locating ongoing care in the community.
2017–2018 Impact	287 people served 19 inpatient clinic visits 35 people provided with educational sessions via phone

Access to Transportation and Mobility Impact

Name of Program, Activity, or Initiative	**Taxi Voucher Program**
Description	This program provided a transportation voucher to patients who had no means to return home when they were discharged from Sutter Delta Medical Center.
2017–2018 Impact	1,984 transportation vouchers distributed to discharged patients

Attachment 8. IRS Checklist

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

Federal Requirements Checklist	Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)		
Describes the written public comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Section 2, Page 10
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's prior CHNA(s).	(b)(6)(F)	Section 9 and Attachment 7, Pages 60 and 169–170
B. Process and Methods		
Background Information		
Identifies any parties with whom the hospital collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section 4, Page 17
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section 4, Page 17
Defines the community the hospital serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Section 3, Pages 11–12 (including map)
Describes how the community was determined.	(b)(6)(i)(A)	Section 3, Pages 12–16
Describes demographics and other descriptors of the hospital service area.	(b)(6)(i)(A)	Section 3, Pages 13–16
Health Needs Data Collection		
Describes data and other information used in the assessment:	(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 4, 5, and 6, Pages 89–168
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Sections 5 and 6, Pages 18–24
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves 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)	Sections 5 and 6, Pages 18–24

		Federal Requirements Checklist	Regulation Section Number	Report Reference
		Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section 5, Pages 18–21, and Attachment 2, Pages 72–75
		a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section 5, Pages 18–21, and Attachment 2, Pages 72–75
		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 are not required.)	(b)(5)(i)(B)	Section 5, Page 19, and Attachment 2, Pages 72–75
		I. Medically underserved populations	(b)(5)(i)(B)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
		II. Low-income populations	(b)(5)(i)(B)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
		III. Minority populations	(b)(5)(i)(B)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
		c. Additional sources (optional) (e.g., healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers, and community health centers)	(b)(5)(ii)	Section 5, Pages 20–21, and Attachment 2, Pages 72–75
		Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
		Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
		Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section 5, Pages 19–21, and Attachment 2, Pages 72–75
C. CHNA Needs Description and Prioritization				
		Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Section 6, Pages 22–24

Federal Requirements Checklist			Regulation Section Number	Report Reference
	Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.		(b)(6)(i)(D)	Section 6, Pages 22–24
	Prioritized description of significant health needs identified.		(b)(6)(i)(D)	Section 7, Pages 25–58
	Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.		(b)(4) (b)(6)(E)	Section 8, Page 59, and Attachment 3, Pages 76–88
D. Finalizing the CHNA				
	CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.		(a)1	Section 2, Page 9
	CHNA is a written report that is adopted for the hospital by an authorized body of the hospital facility [authorized body defined in §1.501(r)-1(b)(4)].		(b)(iv)	Section 10, Page 61
	Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a website" is defined in §1.501(r)-1(b)(29).		(b)(7)(i)(A)	Date(s) on which a-f below were done:
		a. May not be a copy marked "Draft."	(b)(7)(ii)	12/31/19
		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)	12/31/19
		c. Instructions for accessing the CHNA report are clear.	(b)(7)(i)(A)	12/31/19
		d. Individuals with Internet access can access and print reports without special software, without paying a fee, and without creating an account.	(b)(7)(i)(A)	12/31/19
		e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	12/31/19
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital.	(b)(7)(i)(B)	12/31/19

Further IRS requirements available:

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