2019 Community Health Needs Assessment

UCSF Benioff Children's Hospital Oakland

Prepared by the Department of Community Health and Engagement

Acknowledgments

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1. Executive Summary

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The Patient Protection and Affordable Care Act of 2010 (ACA), which was enacted on 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 include input from experts in public health, local health departments, and community members. Community members must include representatives of minority groups, low-income individuals, and medically underserved populations.[1] The CHNA must be completed by the last day of the hospital's taxable year, and the hospital must make the CHNA report widely available to the public.

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 shall not be limited to, a description of the activities that the hospital has undertaken within its mission and financial capacity to address identified community needs. Additionally, hospitals shall describe the process by which they involved community groups and local government officials in helping to identify and prioritize the community needs to be addressed. The community needs assessment shall be updated at least once every three years.[2]

The 2019 CHNA is the third of its kind completed since the ACA was enacted. It builds upon the information and understanding that resulted from previous assessments. The 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 federal 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.[1]

The 2019 CHNA meets both state (SB 697) and federal (ACA) requirements.

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

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

PROCESS AND METHODS

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

Secondary data were obtained from a variety of sources. (*See Attachment 1: Secondary Data Tables for a complete list.*) Secondary data were available for Alameda County as a whole, and, in many cases, also for the northern and southern parts of the hospital's service area separately; the northern part of the service area includes the cities of Hayward, San Leandro, San Lorenzo, and Union City, and the southern part includes the cities of Fremont and Newark.

In November 2018, community health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria.

For the purposes of this assessment, the Hospitals did not limit the definition of "community health" to traditional measures of health. Instead, this definition included indicators about the physical health of the county's residents, as well as the broader social and environmental determinants of health, such as access to health care, technology, affordable housing, child care, education, and employment. This more inclusive definition reflects the Hospitals' view that myriad factors affect community health and that community health cannot be adequately understood or addressed without wider consideration of those factors.

The health needs identified were then prioritized by a community benefits advisory group at UCSF Benioff Children's Hospital Oakland using this second set of criteria:

- **Community priority:** This criterion was ranked based on the frequency with which the community expressed concern about each health issue during the CHNA primary data collection (key informant interviews and focus groups).
- **Clear disparities or inequities:** This criterion refers to differences in health outcomes among subgroups. Subgroups may be based on geography, language, ethnicity, culture, citizenship, economic status, sexual orientation, age, gender, or other factors.
- **Magnitude:** This criterion refers to the number of people affected by the health need.
- **Prevention opportunity:** This criterion recognizes an opportunity to address the health issue by intervening at the prevention level.

The results of the prioritization appear in the table on the next page.

2019 PRIORITIZED COMMUNITY HEALTH NEEDS

The community health needs are listed in alphabetical order in their priority group, highest (1) to lowest (3).

PRIORITY 1	PRIORITY 2	PRIORITY 3
Behavioral Health	Accidents and Unintentional Injury	Asthma
Crime and Intentional Injury	Maternal/Infant Health	Cancer
Diet, Nutrition, and Food Access	Transportation and Traffic	Climate and Natural Environment
Economic Security		Communicable Diseases
Health Care Access and Delivery		Education and Literacy
Housing and Homelessness		Heart Disease and Stroke
		Physical Activity/ Access to Recreation

For additional details, including statistical data and citations, see the health needs descriptions in the Section 5: 2019 Prioritized Health Needs, as well as the data tables in Attachment 1: Secondary Data Tables.

NEXT STEPS

After making this CHNA report publicly available by June 30, 2019, UCSF Benioff Children's Hospital Oakland will solicit feedback (written comments) about the report until two subsequent CHNA reports have been posted on its website.[3] The hospital will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by November 15, 2019.

[3] https://www.childrenshospitaloakland.org/main/community-benefit-reports.aspx

2. Background

In 2018, UCSF Benioff Children's Hospital Oakland and 13 other hospitals in Alameda and Contra Costa counties ("the Hospitals") collaborated for the purpose of identifying critical health needs of the community. Together, the Hospitals conducted an extensive community health needs assessment (CHNA). The 2019 CHNA builds upon earlier assessments completed by the Hospitals.

PURPOSE OF THE CHNA REPORT AND AFFORDABLE CARE ACT REQUIREMENTS

Enacted on March 23, 2010, the Affordable Care Act (ACA) provides guidance at a national level for CHNAs for the first time. Federal requirements included in 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, the parties involved in the assessment, the process and methods used to conduct the assessment, and the community health needs that were identified and prioritized as a result of the assessment. Final ACA requirements were published in December 2014.

For the purposes of this assessment, the Hospitals went beyond the traditional measures of morbidity and mortality to define "community health" to consider broader social and environmental determinants of health, such as access to health care, affordable housing, child care, education, and employment. This more inclusive definition reflects the Hospitals' understanding that myriad factors affect community health. Children's Oakland is committed to supporting community health improvement through upstream (social determinants of health) and downstream (health condition) intervention.

In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, the ACA created more incentives for health care providers to focus on prevention of disease through lower or no co-payments for preventative screenings. Funding has also been established to support community-based primary and secondary prevention efforts.

SB 697 AND CALIFORNIA'S HISTORY OF ASSESSMENTS

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 shall not be limited to, a description of the activities that the hospital has undertaken, within its mission and financial capacity, to address identified community needs. Additionally, hospitals shall describe the process by which they involved community groups and

local government officials in helping identify and prioritize community needs to be addressed. The community needs assessment shall be updated at least once every three years.[4]

The 2019 CHNA meets both state (SB 697) and federal (ACA) requirements.

SUMMARY OF THE 2016 CHNA

In 2016, the hospital participated in a similarly collaborative assessment to identify significant community health needs and to meet the IRS and SB 697 requirements. During the 2016 CHNA, the health needs that were identified and prioritized (as primary or secondary needs, listed below by category in alphabetical order) were:

PRIMARY PRIORITY

- Economic Security
- Health Care Access and Delivery (including Primary and Specialty Care)
- Maternal and Infant Health

SECONDARY PRIORITY

- Mental Health
- Asthma
- Climate and Health
- Communicable Diseases (including STIs)
- Obesity, Diabetes, Nutrition
- Oral/Dental Health
- Substance Abuse (including Alcohol, Tobacco, and Other Drugs)
- Unintentional Injuries
- Violence/Injury Prevention

WRITTEN PUBLIC COMMENTS TO THE 2016 CHNA

UCSF Benioff Children's Hospital Oakland posted its 2016 CHNA report on its website[5] and gave the public an opportunity to submit written comments by providing a contact name and email. This channel of communication will continue to allow for feedback on the hospital's 2019 CHNA report. Comments and questions may be sent to Adam Davis, Managing Director, Department of Community Health and Engagement: AdDavis@mail.cho.org

At the time this report was completed, the hospital had not received any written comments about the 2016 CHNA. The hospital will continue to track submissions and make sure that all relevant comments are reviewed and addressed by appropriate hospital staff.

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[4] 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

[5] https://www.childrenshospitaloakland.org/main/community-benefit-reports.aspx

3. About UCSF Children's Hospital Oakland

The mission of UCSF Benioff Children's Hospital Oakland ("Children's Oakland") is to protect and advance the health and well-being of children through clinical care, teaching, and research. Children's Oakland offers a broad range of inpatient, outpatient, and community-based services, with experts in more than 30 distinct pediatric subspecialties.

Children's Oakland serves patients from across Northern California and beyond, but because of the hospital's location in the city of Oakland, a majority of patients comes from Alameda County. (*See Community Served, page 11.*) Children's Oakland is a pediatric safety-net hospital for both Alameda and neighboring Contra Costa County because neither has public hospital beds for children.

In 2018, Children's Oakland served a total of 79,113 patients through 9,159 inpatient and 209,413 outpatient visits. This number includes 44,723 visits to the Emergency Department. Children's Oakland offers multiple community programs and services. Its Federally Qualified Health Center is the largest pediatric primary care clinic in the Bay Area and includes two comprehensive school-based clinics and a clinic at the Juvenile Justice Center in San Leandro.

The Children's Hospital Oakland Research Institute is dedicated to translating basic and clinical research into health benefits for children. In 2018, the institute had more than 200 active grants and contracts, which included partnerships with private research organizations, corporations, universities, and government entities on local and national levels.

Since 2014, Children's Oakland has had an affiliation with UCSF. UCSF has representation on the Children's Oakland Board of Directors, and the hospital retains its identity as a private, nonprofit 501(c)(3) organization. The hospital's president is a voting member of the Board of Directors, as are the UCSF Medical Center CEO and the dean of the School of Medicine. The Regents of the University of California is the corporate "parent" of Children's Oakland.

COMMUNITY BENEFITS PROGRAM

With nearly $97 million in community benefits in 2017, Children's Oakland has one of the largest community benefits programs among all children's hospitals in California. Children's Oakland defines community benefit as "a planned, managed, organized, and measured approach to meeting documentable community needs intended to improve access to care, health status, and quality of life." It is generally accepted that a community benefit should meet one or more of these criteria:

- Respond to public health needs
- Respond to the needs of a vulnerable or at-risk population
- Improve access to care

- Generate no (or negative) profit margin
- Would likely be discontinued if the decision were made on a purely financial basis

In 2015, Children's Oakland created the Department of Community Health and Engagement (DCHE) in part to "house" and serve as a hub for community benefits programs and planning. The DCHE is responsible for coordinating the medical center's triennial community health needs assessment, and for writing its community benefits strategic plan and annual community benefits reports.

These reports are submitted to the Children's Oakland Board of Directors and made available to hospital staff and the general public through the hospital's website, the DCHE's quarterly newsletter, handouts at public events, and targeted mailings. The reports are also provided to community groups, donors, print media, and elected officials in the service area. Children's Oakland maintains public awareness of its community services through social media, traditional media coverage, DCHE's newsletter and website, and *Children's Handprints*, a hospital magazine sent out three times a year.

COMMUNITY SERVED

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

As noted previously in this report, Children's Oakland serves patients from across Northern California and beyond, but because of the hospital's location in the city of Oakland, a majority of patients comes from Alameda County. Oakland Children's collaborated on the 2019 CHNA with other hospitals in Alameda County.

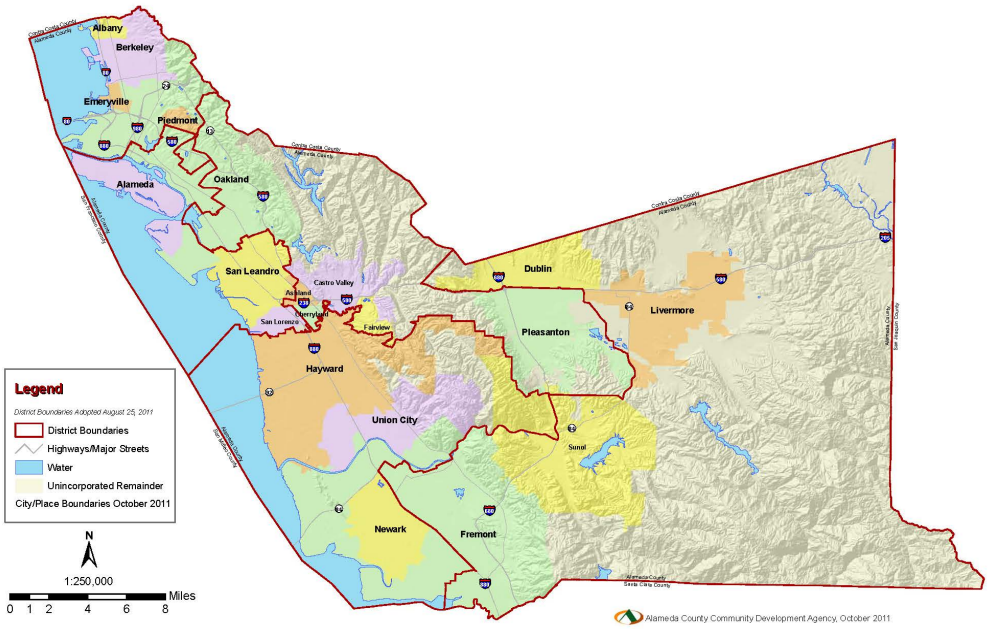
ALAMEDA COUNTY

Alameda County is located in the San Francisco Bay Area. The county's main cities and towns are Alameda, Albany, Berkeley, Emeryville, Fremont, Hayward, Newark, Oakland, Piedmont, San Leandro, San Lorenzo, and Union City. (*See county map, next page.*)

The U.S. Census estimates a population of about 1.63 million in Alameda County, including nearly 345,000 people under age 18. The community is highly diverse in socioeconomic status and ethnicity. The two largest ethnic subpopulations countywide are White and Asian (43 percent and 29 percent, respectively). Among children, the largest group is multiracial (nearly 44 percent), followed by Latinx (30 percent) and African ancestry (20 percent). Foreign-born residents account for 32 percent of the overall population.[6] (*See data table, next page.*)

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

Alameda County Map



Source: Alameda County, Board of Supervisors District Maps, ACgov.org

Ethnicity and Socioeconomic Data, Alameda County

ETHNICITY*			SOCIOECONOMIC DATA	
	Total Population	Child Population (Aged 0–17)		% of Total Population
Total population	1,629,615	344,912	Living in poverty (<100% Federal Poverty Level)	11.3%
White	42.6%	17.9%	Children in poverty	13.0%
Asian	28.9%	19.4%	Unemployment	3.1%
Latinx[7]	22.5%	30.0%	Uninsured population	6.9%
African ancestry[8]	11.1%	20.0%	Adults with no high school diploma	12.5%
Pacific Islander/ Native Hawaiian	0.8%	20.4%	Households with children	34.4%
Native American/ Alaska Native	0.6%	20.9%		
Some other race	9.5%	27.5%		
Multiple races	6.4%	43.5%		

**Percentages do not add up to 100 because they overlap. Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2013–2017; U.S. Department of Labor, Bureau of Labor Statistics, August 2018.*

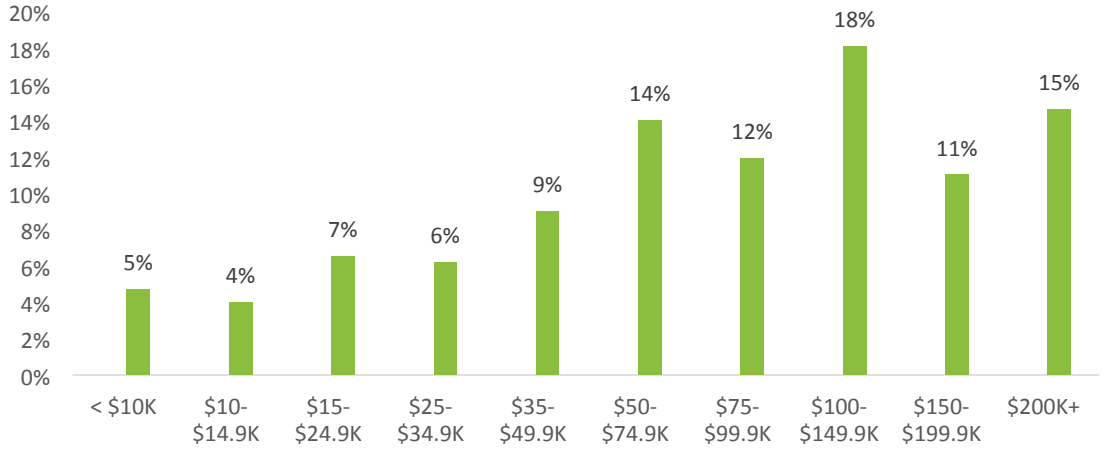
[7] The term Latinx is a gender-neutral way of referring to individuals of Hispanic or Latin American descent.
[8] In keeping with the *Status of African/African Ancestry Health* report, published in partnership with the Black Leadership Kitchen Cabinet of Silicon Valley, the term "African ancestry" refers to all people of African descent. The sources from which ethnicity data are provided may use the terms "Black" and/or "African-American" in their surveys and studies.

Two key social determinants, income and education, have a significant impact on health outcomes.

More than 40 percent of Alameda County residents live in households with incomes of $100,000 or more. More than 30 percent of the population has a household income below $50,000, and in the middle are over 25 percent that have household incomes between $50,000 and $100,000. By comparison, the 2018 Self-Sufficiency Standard for a two-adult family with two children was about $98,300 in Alameda County.[9]

Income disparities exist, as shown in the following chart.

Household Income Range, Alameda County



Percentage total exceeds 100% due to rounding. Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2013-2017. Table S1901.

Housing costs in Alameda County are high: In 2018, the median home price was about $881,000 and the median rent was $3,157.[10]

Despite the fact that more than a third of households in Alameda County earn over $100,000 per year, 11 percent of the total population and 13 percent of children live in poverty. Approximately 7 percent of all people in Alameda County are uninsured.

For 20 years, the U.S. Health Resources and Services Administration has used the Area Deprivation Index (ADI) to measure the lack of basic necessities in communities. The current ADI combines 17 indicators of income, education, employment, and housing quality from American Community Survey 5-year estimates, 2013–2017.

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[9] 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/

[10] Zillow, data through November 30, 2018: https://www.zillow.com/alameda-county-ca/home-values/

The ADI and percentile scores for Alameda County in the table below were calculated using Census Block Group[11] level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. The exceptions to that rule are median gross rent and median monthly home cost, where lower percentiles indicate higher rent and housing costs. Area percentiles and indicator values that are worse than the California benchmark are indicated in dark orange.

Area Deprivation Index, Alameda County

INDICATOR NAME	AC PERCENTILE	AC VALUE	CA PERCENTILE	CA VALUE
Area Deprivation Index	**29**	**88.6**	**49**	**98.1**
Families below poverty level	54	8.1%	64	11.9%
High school diploma/GED, adults ≥ age 25	60	87.3%	74	81.9%
Owner-occupied housing units	68	**52.6%**	68	54.1%
Households without a motor vehicle	**70**	**10.1%**	62	7.5%
Crowded households (>1 person per room)	86	6.9%	89	8.3%
Households without complete plumbing	**54**	**0.5%**	52	0.4%
Households without a telephone	56	2.0%	59	2.2%
Income disparity (log scale)	30	2.0	36	2.2
Median family income	19	$97,145	32	$74,913
Median gross rent	**12**	**$1,432**	17	$1,313
Median home value	7	$593,500	11	$441,468
Median monthly home cost	**13**	**$2,132**	20	$1,768
Population below 150% of poverty threshold	46	19.2%	59	25.9%
Single parent households with children < age 18	55	19.5%	67	23.8%
Less than high school education, adults ≥ age 25	74	6.9%	84	10.0%

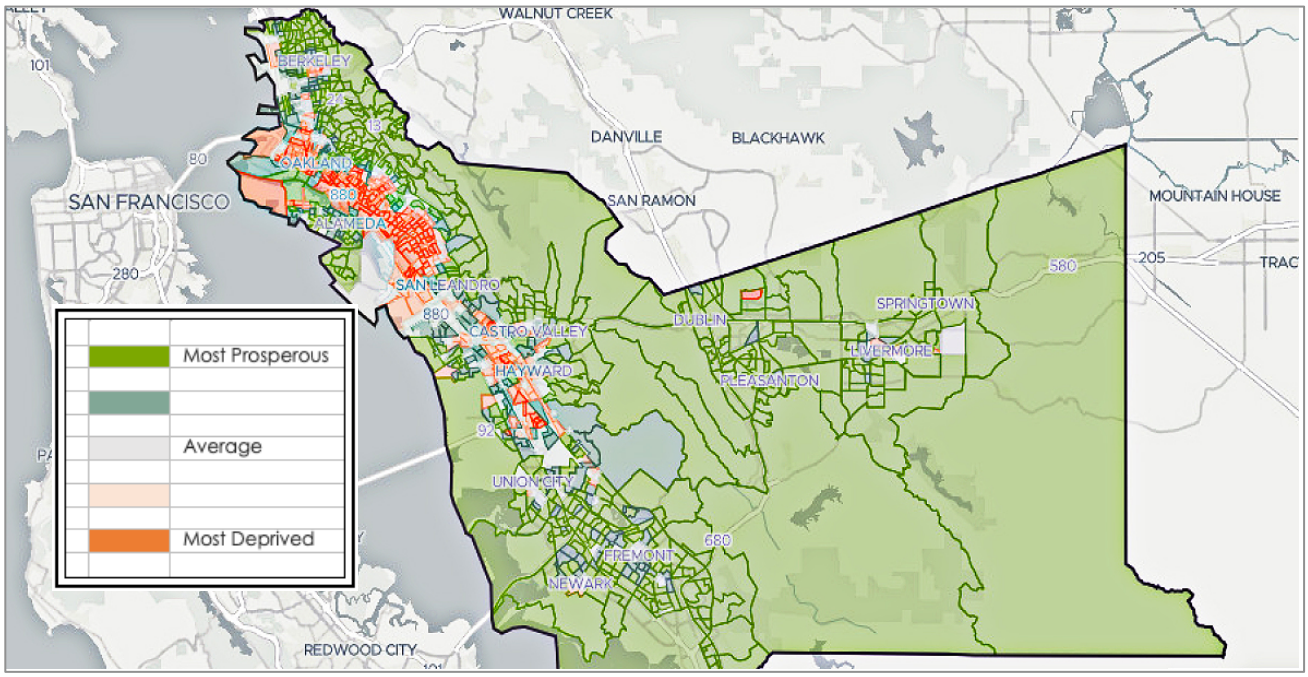
[11] A Census Block Group is smaller than a Census Tract, but larger than a Census Block. In urban areas, a Census Block is generally equivalent to a city block, but in suburban and rural areas may be defined by the Census in other ways. A Census Block Group encompasses multiple, usually contiguous,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

INDICATOR NAME	AC PERCENTILE	AC VALUE	CA PERCENTILE	CA VALUE
Unemployment, ≥ age 16	57	7.1%	68	8.9%
Employed in white collar occupations, ≥ age 16	31	68.6%	47	60.5%

Percentages of total population. Alameda County percentiles are generated in comparison to U.S. values.

The map below shows the ADI score by Census Block Group. Colors are used to differentiate block groups that are more prosperous from block groups that are more deprived. The most prosperous areas are green, and the most deprived areas are dark orange. Colors for the block groups are based on the percentile range into which the block group falls.

Area Deprivation Index Map, Alameda 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 14 hospitals in Alameda and Contra Costa Counties ("the Hospitals") contracted with Actionable Insights in 2018 to conduct the Community Health Needs Assessment in 2019:

- John Muir Health
- Kaiser Permanente – Diablo Area
  (Antioch and Walnut Creek Kaiser Foundation Hospitals)
- Kaiser Permanente – East Bay Area
  (Oakland and Richmond Kaiser Foundation Hospitals)
- Kaiser Permanente – Greater Southern Alameda Area
  (Fremont and San Leandro Kaiser Foundation Hospitals)
- St. Rose Hospital
- Stanford Health Care - ValleyCare
- Sutter Health Bay Area
  (Alta Bates Summit Medical Center and Herrick Campus,
  Delta Medical Center, and Eden Medical Center)
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

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 in a report. The project managers were Jennifer van Stelle, PhD, and Melanie Espino, co-founders and principals of Actionable Insights. They were assisted by Kelly Brown; Robin Dean, MA, MPH; Alexandra Fiona Dixon; Victoria Galbraith; Rebecca Smith Hurd; Franklin Hysten; Jenjii Hysten; Heather Imboden, MCP; Susana Morales, MA; Olivia Murillo; Kit Strong, MPH, MSW; and Margaret Tamisiea.

Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM education, youth development, and community collaboration efforts. AI has conducted community health needs assessments for over 25 hospitals during the 2018–2019 CHNA cycle. More information about Actionable Insights is available at http://actionablellc.com/.

5. 2019 Prioritized Health Needs

ACCIDENTS AND UNINTENTIONAL INJURY

What's the Issue?

The most common unintended injuries or accidents worldwide are road vehicle crashes, drowning, falls, fires and burns, and poisonings.[12] In 2016, unintentional injury was the third leading cause of death overall in the U.S.[13] The most common unintended injuries causing death in the U.S. are falls, traffic accidents, and poisonings, including overdose of prescription medications.[14, 15] Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.[16]

Common among older adults, falls are becoming a larger concern, because the percentage of the U.S. population aged 65 and older is projected to double between now and 2060, from 15 percent to nearly 24 percent (roughly 98 million people).[17] Likewise, unintentional injuries are the leading cause of death and hospitalization in California for children aged 16 and younger.[18]

Why Is It a Health Need?

Key informants 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 using car seats to prevent injuries to young children if collisions should occur.

Overall, Alameda County's rates of unintentional injury Emergency Department (ED) visits and deaths surpass benchmarks and are increasing. More specifically, the rate of traumatic injury hospitalizations (whether intentional or unintentional) among children and youth countywide is significantly higher than the benchmark. The rate of fatalities from firearms in Alameda County (whether intentional or unintentional) also significantly exceeds the state rate. The rates of

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[12] Norton, R., Hyder, A.A., Bishai, D., Peden, M., et al. (2007). Unintentional Injuries. *Disease Control Priorities in Developing Countries.*
[13] Centers for Disease Control and Prevention. (2017). *Mortality in the United States, 2016.*
[14] Centers for Disease Control and Prevention. (2017). *Accidents or Unintentional Injuries.*
[15] National Safety Council. (2018). *Unintentional Injuries Are the #1 Cause of Death from Infancy to Middle Age.*
[16] Office of Disease Prevention and Health Promotion. (2018). *Injury and Violence Prevention.*
[17] Population Reference Bureau. (2016). *Aging in the United States.*
[18] California Department of Public Health. (2018). *Child Passenger Safety (CPS) in California.*

bicycle-involved collisions and motor vehicle crash ED visits, respectively, are significantly higher than the California rates. The latter is rising.

Finally, alcohol retail density is suggestive of policy and environmental factors that affect excessive drinking, a factor in accidental injuries.[19] The number of stores per capita selling beer, wine, and liquor in the local area is significantly higher than the state average.

See also the Behavioral Health health need description.

"[Parents struggling to pay for housing] certainly don't have money to go out and purchase a car seat, even though it may seem inexpensive to some. It's not even what's on their mind. They don't have a safe place for their baby to sleep because they can't afford a crib. So, it's just — it's just a cycle." —Community health expert

ASTHMA

What's the Issue?

Asthma is a common of respiratory disorder that affects a person's ability to breathe. Inflammation causes airways to swell and narrow, characterized by episodes of reversible breathing problems.[20] Symptoms vary from mild to life-threatening. Asthma attacks can cause issues ranging from simple wheezing to extreme breathlessness.[21] 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."[22]

Why Is It a Health Need?

Community members identified poor air quality as a driver of asthma in Alameda County.

Asthma hospitalizations for children and youth separately are significantly worse in the county than the state benchmark. Asthma diagnoses for children/youth are significantly worse countywide than the benchmark — and increasing. Active asthma prevalence is also significantly worse than the benchmark, and the average cost of asthma hospitalization in the county is significantly higher than the state average.

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[19] Community Commons. https://www.communitycommons.org/chna/
[20] The Mayo Clinic. (2018). *Asthma Overview.*
[21] Centers for Disease Control and Prevention. (2018).
[22] American Lung Association. (2018). *Asthma Risk Factors.* 2018.

"The quality of the housing [can be tough]. We had one person whose child was asthmatic. They discovered there was nothing but mold underneath the carpets, and they just about had to rebuild that building or get that [child] somewhere else when there's no somewhere else." —Service provider

Asthma can be exacerbated by pollution. The respiratory hazard index in the San Leandro/ Hayward area significantly exceeds the state average. In Oakland, the overall (air, water, etc.) pollution burden in majority-Asian census tracts is significantly higher than the pollution burden in majority-White census tracts.

Tree canopy coverage is a protective factor against pollution and "heat island effects."[23] This indicator falls significantly below the state average in the Fremont/Newark area. Road network density contributes to greater traffic, which can increase air pollution.[24] The Fremont/Newark area has a significantly higher density of roads than the state average; particulates from traffic can contribute to asthma.

Among the various ethnic groups in Alameda County, asthma ED visits and hospitalizations are highest for African ancestry residents. In Oakland, asthma ED visits among children are more than 10 times higher in the African ancestry population, and nearly three times higher in the Latinx population, than in the White population. Certain other drivers of respiratory conditions, such as obesity and physical inactivity, are significantly higher among some ethnic populations.

See also the health needs descriptions for Diet, Nutrition, and Food Access; Physical Activity/Recreational Access; and Transportation and Traffic.

BEHAVIORAL HEALTH

What's the Issue?

Behavioral Health, including mental health and substance abuse, is one of the needs about which the community expressed the strongest concern.

Mental health—defined as 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.[25] Mental health and the maintenance of good physical health are closely related. Common mental health disorders like depression and anxiety can affect one's ability for self-care. Likewise, chronic diseases can lead to negative impacts on an individual's mental

[23] Insight Center for Community Economic Development. (2014). www.insightcced.org
[24] Community Commons. https://www.communitycommons.org/chna/
[25] Office of Disease Prevention and Health Promotion. (2018), *Mental Health and Mental Disorders*.

health.[26] Mental health issues affect a large number of Americans. The Mayo Clinic estimates that in 2015, roughly 20 percent of the adult U.S. population was coping with a mental illness.[27]

The use of substances such as alcohol, tobacco, and other drugs (both legal and illegal) impacts 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 causes a variety of diseases, including heart disease.[28] Exposure to secondhand smoke can create health problems for nonsmokers.[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?

In terms of mental health, depression and stress were the most common issues raised by the community. Focus group participants and key informants also expressed concern over the co-occurrence of mental health issues and substance use. They identified trauma and adverse childhood experiences (ACEs) as drivers of behavioral health problems. A number of participants described the impact of discrimination and institutionalized racism as generational trauma, which has contributed to inequitable health outcomes.

"A lot of these normal symptoms of trauma are interpreted in young black and brown men as social behavioral issues and not as very common mental health symptoms. And so, we're actually using the wrong method to even approach them."
—Youth-serving service provider

Mental health statistics for children and youth suggest a need. Mental health hospitalizations for children and youth in Alameda County are significantly higher than benchmarks, and both are trending up. Levels of school connectedness are significantly worse than state averages among Alameda County high schoolers (ninth and 11th graders). Children in foster care experience poor

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[26] Lando, J., & Williams, S. (2006). A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion. *Preventing Chronic Disease,* 2006 Apr; *3*(2): A61.
[27] Centers for Disease Control and Prevention. (2018). *Learn About Mental Health*.
[28] Centers for Disease Control and Prevention. (2018). *Health Effects of Cigarette Smoking.*
[29] American Lung Association. (2017). *Health Effects of Secondhand Smoke.*
[30] World Health Organization. (2018). *Management of Substance Abuse.*
[31] Office of Disease Prevention and Health Promotion. (2018). *Substance Abuse.*

mental health at a much higher rate than the general population.[32] Countywide, the rate of children in foster care and median time in foster care are both trending up. Moreover, the county's median number of days for children in foster care exceeds the state's median.

Domestic violence and homicide negatively affect the mental health of victims and/or their families; homicide can also impact the mental health of community members.[33] Domestic violence hospitalizations are significantly higher locally than the state average. In Oakland, rates are highest for the African ancestry population, followed by the Latinx population. Similarly, the county homicide rate is significantly higher than the state rate. In Oakland, rates are highest for residents of African ancestry, followed by Latinx residents.

"We need some sort of facility for that group [under age 12]. We have children as young as 3, with suicidal — I don't even know if that's the right term for a 3-year-old — but suicidal behavior. Right now, they're primarily just being boarded in Children's Emergency Department." —Behavioral health expert

Ethnic disparities exist across multiple mental health indicators for youth, 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 ancestry youth feel the least connected), and suicidal ideation (Native American youth fare the worst). Among the overall population in the county, the rate of suicide is higher than the benchmark for Whites only.

The rate of substance use-related Emergency Department visits is significantly higher in Alameda County than the state benchmark and trending up. Among 11th graders in the county, recent marijuana use is significantly higher than the state average. Marijuana use is highest among African ancestry youth. Alcohol and other drug use is highest among Latinx youth.

"I'm saying we're more at risk for having mental health issues and stuff like that, like alcohol and drug abuse and all of that. Then, you get stressed. And then, you don't know how to deal with it, and you don't have support. So, it's like, well, you go smoke or go drink." —Youth focus group participant

Alcohol retail density is suggestive of policy and environmental factors that affect binge drinking.[34] The number of stores per capita selling beer, wine, and liquor in the local area is significantly higher than the state average.

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[32] National Conference of State Legislatures. (2016), *Mental Health and Foster Care.*
[33] City of Oakland. (2018). *Equity Indicators Report*.
[34] Community Commons, https://www.communitycommons.org/chna/

CANCER

What's 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[35], it is the second leading cause of death in the U.S., following heart disease.[36] 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.[37]

Why Is It a Health Need?

Cancer mortality is much higher than the benchmark among the local area's African ancestry population, and somewhat higher among the local White population. Cervical cancer incidence significantly exceeds the benchmark among the Alameda County Latina population. Childhood cancer diagnoses have been slowly rising in Alameda County since 2003; they are highest among White children/youth. Research shows that delays in screening, as well as inadequate treatment, exacerbate cancer-related health outcomes among ethnic minorities and low-income patients.[38]

"For some groups of people, [cancer] screening needs to happen earlier. I think that following the generally accepted protocol for the general population hasn't always been good for some groups of people." —Public health expert

[35] Centers for Disease Control and Prevention. (2018). *How to Prevent Cancer or Find It Early*.
[36] Centers for Disease Control and Prevention. (2017). *Leading Causes of Death*.
[37] National Cancer Institute. (2018). *Cancer Disparities*.
[38] Fiscella, K., et al. (2011). Eliminating Disparities in Cancer Screening and Follow-up of Abnormal Results: What Will It Take? *Journal of Health Care for the Poor and Underserved*, *22*(1):83–100.

CLIMATE AND NATURAL ENVIRONMENT

What's the Issue?

Living in a healthy environment is critical to 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.[39] For people whose health is already compromised, exposure to negative environmental issues can compound their problems.[40] 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. The 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.[41]

Why Is It a Health Need?

Feedback from the community about the environment primarily concerned poor air quality, which was attributed to pollution. Community members identified poor air quality as a driver of asthma, noting that nearby freeways and traffic at the Port of Oakland contribute to air pollution. Key informants and focus group participants also pointed to climate change as the cause of severe weather events and wildfires.

The respiratory hazard index many parts of Alameda County exceeds the state average. Specifically, in the San Leandro/Hayward area, the index is significantly worse than the state average. The Fremont/Newark area has a significantly higher density of roads than the state average. This contributes to greater traffic, which can increase air pollution[42]; particulates from traffic can contribute to asthma. Tree canopy coverage is a protective factor against various health effects of climate change including pollution and "heat island effects." This indicator is significantly lower in the Fremont/Newark area than the state average.

"We live where there's nothing but liquor stores, and we got processed foods, we have insecticides, pesticides, fungicides. They got Trader Joe's up there in the hills. They got trees. We don't have that many trees, we don't have fresh oxygen."
—Youth focus group participant

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[39] Office of Disease Prevention and Health Promotion. (2018). *Environmental Health*.
[40] Morris, G., & Saunders, P. (2017). The Environment in Health and Well-Being. *Oxford Research Encyclopedias.*
[41] U.S. Global Change Research Program. (2018). *Fourth National Climate Assessment.*
[42] Community Commons. https://www.communitycommons.org/chna/

In Oakland, the overall (air, water, etc.) pollution burden in majority-Asian census tracts is significantly higher than the pollution burden in majority-White census tracts. Asthma prevalence in the local area is significantly worse than benchmarks. Asthma can be exacerbated by heat and pollution. Asthma hospitalizations are significantly worse for children and youth in Alameda County than the state average.

Finally, lead in the environment is of particular danger to children, whose bodies are still developing and thus more sensitive to such toxic substances.[43] Blood lead levels for children and youth are higher in Alameda County than the state average.

See also the Transportation and Traffic health need description.

COMMUNICABLE DISEASES

What's the Issue?

Despite the introduction and general availability of vaccines, infectious diseases such as viral hepatitis, influenza, and tuberculosis remain a major cause of illness, disability, and death in the U.S. These diseases are transmitted via contact with an infected person and that person's bodily fluids (blood, saliva, semen, etc.). Preventing infectious diseases (e.g., through education and/or vaccines) is significantly less costly than treating their related consequences. Various agencies monitor infectious diseases, identify outbreaks/epidemics, and distribute resources to combat them.[44]

As is the case with other infectious diseases, sexually transmitted infections (STIs) are spread through contact with an infected person or their bodily fluids (blood, semen, etc.). Left untreated, some STIs can be fatal (HIV) or affect fertility (syphilis, chlamydia, gonorrhea). The stigma of STIs such as genital herpes can lead to mental health issues.[45]

Why Is It a Health Need?

Infectious diseases were not prioritized by the community. But communicable diseases are a health need in Alameda County as evidenced by significantly higher rates of gonorrhea, HIV, and tuberculosis incidence compared to benchmarks. For youth aged 10–19, chlamydia and gonorrhea incidence rates are especially high, mainly among the African ancestry

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[43] California Environmental Health Tracking Program. (2015). *Costs of Environmental Health Conditions in California Children*. Public Health Institute.
[44] U.S. Government Accountability Office. (2004). *Emerging Infectious Diseases: Review of State and Federal Disease Surveillance Efforts.*
[45] Merin, A., & Pachankis, J. (2011). The Psychological Impact of Genital Herpes Stigma. *Journal of Health Psychology*, *16*(1):80–90.

population. Gonorrhea and syphilis incidence rates have both been trending up countywide since 2009. Influenza/pneumonia ranks among the top 10 causes of death in the county.[46]

The Alameda County public health expert noted an increase in STIs, especially HIV infections among males of African ancestry. Stigma and lack of specific health education were cited as possible barriers to preventing the spread of STIs. Northern Alameda County residents also identified the high costs of testing as a barrier.

"A lot of my high school and college students are talking about STDs, because when they're under the influence, a lot of times they're having sex without protection."
—Mental health service provider

CRIME AND INTENTIONAL INJURY

What's 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.[47] Crime in a neighborhood causes fear, stress, unsafe feelings, 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.[48] 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.[49] Additionally, exposure to violence has been linked to negative effects on an individual's mental health, including post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior themselves.[50]

Why Is It a Health Need?

Community and family safety was prioritized by the community in Alameda County. With regard to intentional injury, key informants and focus group participants most frequently talked about domestic violence. Participants also discussed violent crime in general. Residents reported seeing an increase in violence.

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[46] California Department of Public Health. (2018). Alameda County's Health Status Profile for 2018.
[47] 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.
[48] 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.
[49] World Health Organization. (2017). *10 Facts About Violence Prevention*.
[50] 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.

Human trafficking was mentioned as a community concern as well. Some participants described Oakland as a hub for human trafficking, including a large proportion of victims who are minors.

Mental health, including trauma, was often mentioned in relation to crime and intentional injury. A number of qualitative research participants described the impact of discrimination and racially motivated violence on mental health. Various participants mentioned police violence/ brutality as an important issue related to safety, especially for individuals of African ancestry.

"We have police who are supposed to serve and protect us, but they're the ones doing violence to us, so it confuses you. It doesn't give you the correct idea and safety that we're supposed to have, so we're not sure how we're supposed to feel safe."
—Youth/young adult focus group participant

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

The rate of violent crimes was significantly higher in the local area than the benchmark. Also, jail admission rates among teens/adults and juvenile felony arrest rates among youth were both significantly higher in Alameda County than the state average, although the two measures have been declining. The use of force by law enforcement in Oakland shows disparities by ethnicity, with African ancestry residents experiencing use of force at a rate nearly 25 times that of White residents, and Latinx residents experiencing use of force at a rate nearly seven times that of White residents.

Domestic violence hospitalization rates are significantly higher in Alameda County than the state average. In Oakland, rates are highest for the residents of African ancestry, followed by Latinx groups. Similarly, the county's homicide death rate is significantly than the state's rate. In Oakland, rates are highest for residents of African ancestry, followed by Latinx groups. A significantly greater proportion of high schoolers (11th graders) in the county perceive their schools as unsafe than their peers statewide.

The rate of Emergency Department visits for injuries from assaults is higher in Alameda County than the state average. Alcohol retail density is suggestive of policy and environmental factors that affect binge drinking, a factor in violence.[51] The number of stores per capita selling beer, wine, and liquor in the local area is significantly higher than the state average.

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

"I live in the Decoto area. I've been there all my life, I was born there. Things improved, but now things are getting worse. More gang violence, shootings, that kind of thing. Letting your kids out—I think that's one of the fears."
—Focus group participant

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

See also the Accidents and Unintentional Injury and Behavioral Health health needs descriptions.

DIET, NUTRITION, AND FOOD ACCESS

What's the Issue?

The benefits of a healthy diet include preventing high cholesterol and high blood pressure; reducing the risks of obesity, diabetes, and other diseases; and helping to reduce the risks of obesity.[52] For children and adolescents, a nutritious diet helps with growth and bone development and with improved cognitive function.[53]

Despite these well-known benefits, many people do not meet the recommended healthy food and exercise guidelines. Most significantly, a poor diet and lack of regular physical activity can lead to adult and childhood obesity, a serious and costly health concern in the U.S. that often results in some of the leading causes of preventable death.[54]

Consistent access to enough food to lead a healthy lifestyle is an issue for people with food insecurity, which means a "lack of available financial resources for food at the household level."[55, 56] Measurements of various levels of food insecurity, from marginal to low or very low,

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[52] United States Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*
[53] World Health Organization. (2018). *Early Child Development: Nutrition and the Early Years.*
[54] 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*.
[55] Feeding America. (2018). *What Is Food Insecurity?*
[56] U.S. Department of Agriculture, Economic Research Service. (2018). *Definitions of Food Security.*

include anxiety about food insufficiency, household food shortages, reduced "quality, variety, or desirability" of food, diminished nutritive intake, and "disrupted eating patterns."[56] In 2017, approximately one in eight Americans experienced food insecurity, more than one third of whom were children.[55]

Community elements that support good nutrition include the availability of and access to local stores with fresh produce. Residents are more likely to experience food insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and transportation/transit options are limited. Individuals with food insecurity may be more likely to experience poor health outcomes/health disparities, including obesity. Children who experience food insecurity are also at greater risk for developmental complications and/or delays compared to children with food security. In addition, food insecurity may have a detrimental impact on children's mental health.[57]

Food insecurity often co-exists with obesity because "both are consequences of economic and social disadvantage."[58] Nearly one in five children and nearly two in five adults in the U.S. are obese.[59] Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.[60]

Being overweight is also a risk factor for type 2 diabetes. The Centers for Disease Control and Prevention estimates that 30 million people in the U.S. are diabetic and an additional 84 million U.S. adults are pre-diabetic (have higher-than-normal blood glucose levels). The more serious health complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations. Certain ethnic groups (African ancestry, Latinx, Native American, and some Asian groups) are at a higher risk of type 2 diabetes than others.[61]

Why Is It a Health Need?

Alameda County has fewer grocery stores and produce vendors per capita than the state averages. The rate of diabetes hospitalization among children and youth is higher in Alameda County than the state benchmark — and rising. Obesity-related hospitalizations overall are also increasing countywide. Obesity rates are highest among Pacific Islander youth and African ancestry adults.

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[57] Healthy People 2020. (2018). *Food Insecurity.*
[58] Food Research and Action Center. (2015). *Food Insecurity and Obesity*.
[59] Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.
[60] The Mayo Clinic. (2018). *Obesity*.
[61] Centers for Disease Control and Prevention. (2018). *Diabetes Quick Facts.*

"I've heard is that obesity is the new face of hunger in America, and it's because people actually do have access to food. They're getting calories, but these calories are from processed food, from fast food that is affordable." —Service provider

Public health experts in Alameda County identified the lack of access to healthy food in certain areas (so-called "food deserts") as a driver of poor community health. Residents described difficulty accessing grocery stores that carry fresh food, a preponderance of fast food restaurants, and dismay with the unhealthy food served at schools and provided by food banks. It was noted that the relatively lower cost of unhealthy grocery items and fast food, paired with their convenience, makes buying and preparing fresh food less likely for busy families. The Latinx population was mentioned frequently as a population of particular concern for diet/nutrition-related conditions.

See also the Physical Activity and Recreational Access health need description.

ECONOMIC SECURITY

What's the Issue?

Our health-related behavior, physical environment, and access to quality health care are all determinants of how long and how well we live. The most important determinants of population health, however, are our social and economic environments.[62] Numerous research studies have found that access to economic security programs (i.e., SNAP — formerly referred to as food stamps) results in long-term better health and social outcomes.[63] As the World Health Organization notes, "the context of people's lives determine[s] their health." A link exists between higher income and/or social status and better health. Furthermore, a secure social support system — families, friends, communities — plays a significant role in healthier populations.[64]

Childhood poverty has long-term effects. Even when economic and social environments later improve, childhood poverty still results in poorer long-term health outcomes.[65] 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.[66]

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[62] County of Los Angeles Public Health. (2013). *Social Determinants of Health: How Social and Economic Factors Affect Health.*
[63] Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits*.
[64] World Health Organization (2018). *The Determinants of Health.*
[65] Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The Impact of Poverty on the Current and Future Health Status of Children. *Pediatric Child Health*. *12*(8): 667–672.
[66] 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 informants and focus group participants in all geographic areas discussed food insecurity, risk of homelessness, and employment. Residents emphasized that while there may be plenty of local jobs, those jobs do not pay enough considering the high cost of living. Although unemployment may appear to be low in northern Alameda County, rates by neighborhood show the population in several local areas continues to experience high unemployment, some experts noted.

"I think because of lack of access to employment and to financial support, it causes some young people at a very early age to make a difficult decision: Do I want to be engaged in this criminal activity, or do I want to just tough it out?" —Community expert

The community made the connection between poverty and poor health outcomes. Key informants and focus group participants suggested that people with lower incomes may have a harder time accessing care. A number of participants observed that individuals 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.

The population living in poverty in the local area exceeds the state average. Also, the cost of infant and preschool child care is significantly higher in the county than the state average.

"All the family members are working, but they're working like two or three part-time jobs. And they're still food insecure, have to go to the food bank. … They live really in, like, an emergency all of the time, from one situation to the next. So, they can't think about things like health and safety." —Community health expert

There are significant ethnic disparities in economic security among county residents:

- In southern Alameda County, the highest proportion of residents living in poverty, including children, are people of African ancestry. In northern Alameda County, the highest proportion of people living in poverty are Native American.
- More Native American residents in the Fremont/Newark area and more residents of "Other"[67] ethnicities in the San Leandro/Hayward area are uninsured than other racial groups in the area.

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

- Access to a vehicle is associated with better access to work and school. In Oakland, residents of African ancestry were more than three times less likely than White residents to have access to a car.

See also the Behavioral Health and Health Care Access and Delivery health needs descriptions.

EDUCATION AND LITERACY

What's 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, people living in households where English is not spoken, and individuals with minimal education.[68]

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.[69] 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 health care.

The relationship among educational attainment, employment, wages, and health have been well documented. People who have with at least a high school diploma fare better than high school dropouts on a number of measures, including income, health outcomes, life satisfaction, and self-esteem.[70] The National Poverty Center reports that increased education is associated with decreased rates of most acute and chronic diseases.[71] 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.[72] Finally, the majority of jobs in the U.S. require more than a high school education.[73]

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[68] Office of Disease Prevention and Health Promotion. (2018). *Language and Literacy.* www.healthypeople.gov
[69] Barnett, W.S., & Hustedt, J.T. (2003). Preschool: The Most Important Grade. *Educational Leadership*, *60*(7):54–57.
[70] Insight Center for Community Economic Development. (2014). www.insightcced.org
[71] Cutler, D.M., & Lleras-Muney, A. (2006). *Education and Health: Evaluating Theories and Evidence* (No. w12352). National Bureau of Economic Research.
[72] Gouskova, E., & Stafford, F. (2005). Trends in Household Wealth Dynamics, 2001–2003. *Panel Study of Income Dynamics. Technical Paper Series, 05–03.*
[73] Insight Center for Community Economic Development. (2014). www.insightcced.org

Why Is It a Health Need?

A wide variety of experts and community members expressed concerns about education issues. Academic achievement was discussed most often as a driver of economic security related to stable employment and sufficient wages. The county's public health expert emphasized that both K–12 and higher education often do not prepare residents for jobs that provide a living wage. Youth in northern Alameda County discussed inequities in the quality of K–12 education.

A larger proportion of children in the county live in linguistically isolated households[74] than the state average. That, combined with the comparatively high cost of preschool child care, suggests Alameda County children may have greater barriers to literacy than children elsewhere. The proportion of local fourth-graders reading at or above proficiency in northern Alameda County is on par with the state average, but in the San Leandro/Hayward area, it's significantly lower. Also, student suspensions (countywide) and expulsions (in southern Alameda County) exceed the state averages.

In Alameda County, the ratio of students to academic counselors is significantly higher (worse) than the overall ratio in the state. The student-teacher ratio has been increasing (worsening) since 2008. A smaller proportion of local students graduate high school on time compared to their peers statewide.

"How do we begin to look at what the root causes are for these young people not being able to go be successful academically and figure out a way in which we can provide them the resources and support they need so we can fill that gap?"
—Community expert

Ethnic disparities are evident in education and literacy-related indicators. African ancestry girls have significantly higher rates of teen pregnancy than girls of other ethnicities, which can interrupt or end their educational trajectory.

African ancestry youth are overrepresented among high school dropouts, while passing high school exit exams in lower proportions than youth of other ethnicities. In Alameda County, African ancestry youth are also underrepresented among high school graduates who had completed college prep courses. In Oakland, African ancestry youth are more than twice as likely, and Latinx youth almost twice as likely, as White youth to have never taken a high school Advanced Placement course. Furthermore, nearly four times as many African ancestry youth, and more than twice as many Latinx youth, as White youth are chronically absent from school.

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[74] Defined as a household in which no one aged 14 years or older speaks English "very well." U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016.

HEALTH CARE ACCESS AND DELIVERY

What's the Issue?

Access to comprehensive, quality health care is important to everyone's health and quality of life.[75] Limited access to care and/or its compromised delivery affects people's ability to reach their full potential. Components of access to care include insurance coverage, adequate numbers of primary and specialty care providers, and timeliness of services. Components of delivery of care include quality, transparency, and cultural competence/cultural humility.

As reflected in statistical and qualitative data, barriers to receiving quality care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. These barriers to accessing health services 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 concerns about health care access and delivery. Focus group participants and key informants discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists, especially for Medi-Cal patients. Access to behavioral health services was of particular concern to participants, who indicated that the behavioral health workforce was of insufficient size to adequately address the demand. Experts and others in southern Alameda County described a lack of health care services and resources in the southernmost areas (including Fremont and Newark) compared with Oakland and Hayward.

"Health care is unaffordable. With sexual health, if you are sexually assaulted, you can afford treatment because they will waive [the fees]. But it's just ridiculous to me as a sexual assault survivor that the only reason I was able to afford [treatment for] the STI I contracted was because I had been sexually assaulted."
—Youth/young adult focus group participant

Many focus group participants and key informants expressed alarm about health care access barriers faced by immigrants who are either ineligible for Medi-Cal due to their immigration status or fearful of being deported if they access services for which they are eligible. With regard to health care delivery, the community often identified the need for greater language support, culturally appropriate health care services, and whole-person care. Specifically, experts described the difficulty LGBTQ community members, especially transgender individuals, experience in finding medical professionals sensitive to their needs.

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

The ratio of students to school nurses and to school-based speech/language/hearing specialists are both much higher (worse) in the county than the state overall. Both ratios have been trending down since 2012.

A smaller proportion of the county's residents have a usual source for primary care and a larger proportion delayed or had difficulty obtaining care when compared to Healthy People 2020 aspirational goals. Also, the proportion of the county's population that has a usual source for health care has been declining since 2005. Although the local community has comparatively high rates of available primary care, dental, and mental health providers, access to primary care providers categorized as "other" (nurse practitioners, physician assistants, etc.) in Alameda County is significantly poorer than state benchmarks.

Good access to primary care can forestall the need for avoidable Emergency Department (ED) visits and hospitalizations, such as for asthma. The rate of asthma hospitalizations was significantly higher in the local community than the state rate. Also, the rate of avoidable ED visits has been rising in Alameda County.

More Native American residents in the Fremont/Newark area and more residents of "Other"[76] ethnicities in the San Leandro/Hayward area are uninsured than other groups locally. In regard to inequitable health outcomes, the index of premature death based on ethnicity (i.e., premature death for non-Whites versus Whites) was flagged as an issue in the local community. Preventable hospital events were highest for the local African ancestry population. In Alameda County, both acute and chronic preventable hospitalizations were highest for people of African ancestry.

Focus group facilitator: "Why are people not able to get health care, in your opinion?"
Youth focus group participant A: "Because they can't afford it."
Youth focus group participant B: "Because we black and brown."

Finally, access to a vehicle is associated with better access to medical appointments. In Oakland, residents of African ancestry were more than three times less likely than White residents to have access to a car.

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

HEART DISEASE AND STROKE

What's the Issue?

Nationally, some 84 million people suffer from a form of cardiovascular disease.[77] Heart disease is the No. 1 killer of both men and women,[78] while stroke is the fifth leading cause of death and a significant cause of serious disability for adults.[79] It is estimated that the current annual direct and indirect costs of cardiovascular disease and stroke are approximately $315 billion and are increasing annually.[77]

Recent research has established that disparities exist between minority and non-minority cardiovascular health outcomes across the U.S.[80] Although some risk factors for heart disease and stroke — age, race/ethnicity, gender — are not controllable, other risk factors — high blood pressure, high cholesterol, obesity, excessive alcohol consumption, smoking, an unhealthy diet, lack of physical activity — can be controlled.[78] 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.[81] Addressing risk factors early in life can help in preventing chronic cardiovascular disease.[82]

Why Is It a Health Need?

In Alameda County, congestive heart failure hospitalizations are higher than the state benchmark. In addition, stroke deaths in the local area exceed the benchmark. Local residents of African ancestry disproportionately die from stroke compared to residents of other ethnicities.

Substance use can negatively affect cardiovascular and cerebrovascular health. The rate of substance use Emergency Department (ED) visits in Alameda County is significantly higher than the state rate — and trending up.

See also the Diet, Nutrition, and Food Access and Physical Activity/Recreational Access health needs descriptions.

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

HOUSING AND HOMELESSNESS

What's the Issue?

The U.S. Department of Housing and Urban Development (HUD) defines affordable housing as that which costs no more than 30 percent of a household's annual income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care.[83] 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.[84] Furthermore, 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."[85]

Homelessness is correlated with poor health in that either poor health can lead to homelessness or homelessness can lead to poor health.[86] Individuals experiencing homelessness have been shown to have more health care issues, suffer from preventable illnesses at a greater rate, experience longer hospital stays, and have a greater risk of premature death than their peers with housing.[87] 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.[88]

Why Is It a Health Need?

Maintaining safe and healthy housing was a top community priority. Recent increases in housing costs especially affect renters and those with low and/or fixed incomes. Professionals and residents expressed concerns about the increasing number of unstably housed individuals and the displacement of families in the East Bay, including those with children.

Experts cited a lack of strong tenant protections — and a lack of knowledge about protections that may exist — in the community. Alameda County's public health expert expressed the need for strong tenant protections to keep residents from being displaced. In northern Alameda

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[83] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*
[84] Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis.* See also: The California Endowment. (2015). *Zipcode or Genetic Code: Which Is a Better Predictor of Health?*
[85] Children's Health Watch. (2011). *Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent*.
[86] National Health Care for the Homeless Council. (2011). *Care for the Homeless: Comprehensive Services to Meet Complex Needs*.
[87] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council.
[88] National Coalition for the Homeless. (2009). *Health Care and Homelessness.*

County, experts indicated that the housing crisis is worst in areas north of San Leandro. Some expressed specific concern about the declining African ancestry population due to displacement.

"It's so expensive now to live here that you're planning so much just to afford where you live, or where you rent, or where your mortgage is, how much of that is going to the extra child care. … It's, what, $2,200 to $2,400, [in] a decent complex? Yeah, it's pretty expensive. You've got like three or four families living in one apartment." —Focus group participant

The median rent in the county is significantly higher than the state average and has been increasing. Also, the proportion of Alameda County renters spending more than 30 percent of their household income on rent has been on the upswing since 2006. Possibly due to high rents, the proportion of children living in crowded housing has been rising in the county.

Poor housing quality (evidence of leaks, mold, pests, etc.) is associated with childhood asthma prevalence and asthma-related Emergency Department visits.[89] Child and youth asthma diagnoses and hospitalizations are significantly higher in the county than the state benchmarks. Finally, lead in the home environment is of particular danger to children, whose bodies are still developing and thus are more sensitive to such toxic substances.[90] Blood lead levels for children and youth are higher in Alameda County than the state average.

The number of individuals experiencing homelessness in Alameda County rose in 2017, and there was also specifically a rise in the number of unsheltered homeless children, youth, and young adults. The population experiencing homelessness in the county is disproportionately of African ancestry.

"A lot of times [the youth we serve] talk to us about living out of cars. Or they are sort of chronically homeless or semi-homeless, where they are staying like in relatives' garages maybe, or like the family will live in the living room of somebody's home for a couple of months and then they'll move on to the next space." —Youth service provider

[89] Urban Institute. (2017). *The Relationship Between Housing and Asthma Among School-Age Children.*
[90] California Environmental Health Tracking Program. (2015). *Costs of Environmental Health Conditions in California Children.* Public Health Institute.

MATERNAL/INFANT HEALTH

What's the Issue?

Good maternal and child health — the well-being of mothers, infants, and children — is an important public health goal. The health of these populations can determine the health of the next generation, and can help predict further public health issues, for families, communities, and the health care system as a whole. The need of maternal and child health includes a variety of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for women, children, and families. Data indicators that measure progress in this area include low birthweight, infant mortality, teen births, breastfeeding, and access to prenatal care.

The risk of pregnancy-related problems, complications, and disabilities, as well as both maternal and infant mortality, can be reduced through better access for mother and child to quality health care before, during, and after pregnancy. More specifically, the early identification of health issues in infants and children can aid in the prevention of disability or death, enabling them to achieve their full potential.[91]

Why Is It a Health Need?

Maternal/infant health is a need in Alameda County due to a significantly higher percentage of low birthweight babies in comparison to California overall. Additionally, infants and young children (aged 0–4) have much higher rates of asthma hospitalizations in the county than the state average. Finally, blood lead levels for infants and young children (aged 0–5) are higher than average in Alameda County.

Ethnic disparities exist in measures of maternal/infant health, including child mortality (significantly higher among African ancestry children in the community), teen births (disproportionately higher among Latinx and African ancestry residents of Alameda County), and children living in poverty (much higher among Native American and African ancestry children in the local area).

"Maternal depression is a significant issue in terms of thinking about the next generation of low-income kids moving out of poverty. I think it's something that is under address[ed], and I think a lot of people don't seek help." —Service provider

See also the Asthma and Housing and Homelessness health needs descriptions.

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[91] Office of Disease Prevention and Health Promotion. (2018). *Maternal, Infant, and Child Health.*

PHYSICAL ACTIVITY AND ACCESS TO RECREATION

What's the Issue?

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."[92] Getting regular exercise can help people of all ages combat obesity, reduce the risk of type 2 diabetes, and address a host of other physical issues.[93] Regular exercise can also help to strengthen bones and muscles and increase people's chances of living longer.[94]

Nearly one in five children and nearly two in five adults in the U.S. are obese. Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.[95]

The U.S. Surgeon General's "Vision for a Healthy and Fit Nation 2010" described how different elements of a community can support residents' healthy lifestyles. The components of the physical environment (sidewalks, bike paths, parks, fitness facilities, etc.) that are "available, accessible, attractive and safe" all contribute to the extent and type of residents' physical activities.[96, 97]

Why Is It a Health Need?

A greater proportion of youth in the San Leandro/Hayward area are physically inactive than the state average. Youth populations with the highest levels of physical inactivity in Alameda County are Pacific Islanders. Among the county's students, Latinx fifth-graders and Pacific Islander seventh- and ninth-graders are least likely to meet the fitness standards. The rate of diabetes hospitalization among children and youth is higher for the county than the state — and rising.

Public health experts in Alameda County identified the lack of access to recreation in certain areas as a driver of poor community health. Focus group participants cited a lack of safe public spaces and community centers where residents can engage in recreational activities and exercise. While 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

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[92] Centers for Disease Control and Prevention. (2018). *Physical Activity Basics.*
[93] The Mayo Clinic. (2016). *Exercise: 7 Benefits of Regular Physical Activity.*
[94] Harvard Health Publishing/Harvard Medical School. (2013). *Balance Training Seems to Prevent Falls, Injuries in Seniors.*
[95] Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.
[96] The Mayo Clinic. (2018). *Obesity*.
[97] Centers for Disease Control and Prevention. (2009). *Healthy Places*.

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.

"Parents are fearful to let their kids go out and just walk around and play in the street like I used to play on that same street. It's not the same anymore. It's pretty sad. … We used to play kickball, we used to play softball, we used to play army, we used to be running around the neighborhood. Now it's — no." —Community member

Experts discussed the fact that few people walk or bike to work because they have long commutes. Indeed, many workers in the local community have significantly longer commutes than the state average, driving more than 60 minutes each direction. Residents talked about the lack of motivation and lack of time to exercise (busy-ness), the expense of gym memberships and sports or exercise programs, and the inconvenient timing of exercise classes.

Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living in order to lose weight. The Latinx population was mentioned frequently as a population of particular concern for conditions related to inadequate physical activity. Key informants and focus group participants cited a need for more community health education to increase active living, which would prevent obesity, diabetes, high blood pressure, and other chronic diseases. Culturally appropriate approaches may be lacking, participants said.

See also the Diet, Nutrition, and Food Access health need description.

TRANSPORTATION AND TRAFFIC

What's 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 drunken driving, distracted driving, speeding, and not using seat belts.[98]

Increased road use is correlated with increased motor vehicle accidents,[99] while more traffic (road congestion) causes travel delays, greater fuel consumption, and higher greenhouse gas emissions from vehicle exhaust.[98] Vehicle exhaust is a known risk factor for heart disease,

[98] 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.
[99] Cohen, P. (2014, October 8). *Miles Driven and Fatality Rate: U.S. States, 2012. Sociological Images* [web log].

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.[100]

The benefits of eco-friendly alternative transport 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 environment. Combining alternative transport with traffic countermeasures can both improve health and reduce traffic-related injuries in communities.

Why Is It a Health Need?

Alameda County has a significantly higher density of roads than the state average. The rate of motor vehicle crash Emergency Department visits is significantly higher than the state rate and is increasing.

In southern Alameda County, a significantly greater proportion of area commuters drive alone to work over long distances (more than 60 minutes in each direction) than the state average, contributing to the traffic load on the roads. The pedestrian-accident death rate in the San Leandro/Hayward area is also higher than the state rate. The rate of bicycle-involved collisions in Alameda County overall is significantly higher than the state's. In Oakland, residents of African ancestry are more than three times less likely than White residents to have access to a car.

Many key informants 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 the expense of fares (especially for BART). Some participants discussed the fear of becoming a victim of a crime at BART stations. Others said that access for the disabled (working elevators) is unreliable at BART stations.

"We had a student last year [whose] fever was over 100 and something. … The parent was homeless going through a housing appointment. They didn't have transportation, and we're saying, 'We need you to come pick up your child. So, how do we work together? Can we call another relative? Can you get an Uber up here to be able to keep your child? Because, if not, then we're going to have to call 911, and that's another cost.' " —Service provider

For statistical data and sources, see Attachment 1: Secondary Data Tables.

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

6. Process and Methods

The 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 a report written for the Hospitals in spring of 2019. The phases of the process are depicted below.

SECONDARY DATA COLLECTION

AI analyzed over 200 quantitative health indicators to assist the Hospitals in understanding the health needs and assessing their priority in the community. They collected data from existing sources using the CHNA.org[101] 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 Hospitals. The 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 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 is an endeavor of the U.S. Department of Health and Human Services that has provided 10-year national objectives for improving the health of Americans based on scientific data spanning 30 years. Healthy People sets national objectives or targets for improvement. The most recent set of objectives are for the year 2020 (HP2020). Year 2030 objectives are currently under development.[102]

For details on specific sources and dates of the data used, see Attachment 1: Secondary Data Tables, and Attachment 2: Data Indicators List.

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[101] http://www.chna.org is a web-based resource funded by Kaiser Permanente as a way to support community health needs assessments and community collaboration. The platform offers 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 to state and national benchmarks.
[102] 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 the Coalition in its ability to assess some health issues that were identified as community needs. Statistical information related to these topics was scarce:

- Adequacy of community infrastructure (sewerage, electrical grid, etc.)
- Adult use of illegal drugs and misuse/abuse of prescription medications (e.g., opioids)
- Alzheimer's disease and dementia diagnoses
- Breastfeeding practices at home
- Data broken out by various Asian subgroups
- Diabetes among children
- Experiences of discrimination among vulnerable populations
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)
- Hepatitis C
- Mental health disorders
- Oral/dental health
- Suicide among LGBTQ youth

COMMUNITY INPUT

Actionable Insights conducted the primary research for this assessment. They 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 were based on facilitated discussion among the Hospitals members 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 health care 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 stand-alone piece of data. Recordings were transcribed, and then the team utilized 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 Hospitals used this tabulation to help assess community health priorities.

Across the key informant interviews and focus groups, AI solicited input from more than 100 community leaders and representatives of various organizations and sectors. These representatives either work in the health field or in community-based organizations that focus

on improving health and quality of life conditions by serving those from IRS-identified high-need target populations.[103]

See Attachment 3: Community Leaders, Representatives, and Members Consulted for the names, titles, and expertise of these leaders and representatives along with the date and mode of consultation (focus group or key informant interview). See Attachment 5: Qualitative Research Protocols for details about the protocols and questions.

KEY INFORMANT INTERVIEWS

Between June and August 2018, AI conducted primary research via key informant interviews with 26 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 health care 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

Eleven focus groups were conducted with a total of 78 professionals and community leaders from July to September 2018. The questions were the same as those used with key informants.

DETAILS OF FOCUS GROUPS WITH PROFESSIONALS

TOPIC OR POPULATION	FOCUS GROUP HOST/PARTNER	DATE	NUMBER OF PARTICIPANTS
Behavioral/mental health professionals (front-line staff)	Seneca	7/31/2018	8
Social determinants of health	South County Partnership	8/2/2018	4
Professionals who serve individuals experiencing homelessness	Alameda County Healthcare for the Homeless	8/21/2018	10
Adolescent health professionals and health promoters	Tri-City Health Center	8/24/2018	4
School health professionals who serve K–12 students	Oakland Unified School District	8/29/2018	8
Safety net clinic leaders	Kaiser Hospital Foundation–San Leandro	9/4/2018	4

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

TOPIC OR POPULATION	FOCUS GROUP HOST/PARTNER	DATE	NUMBER OF PARTICIPANTS
Professionals who serve undocumented individuals	Unity Council	9/13/2018	5
Safety net clinicians and related providers	Kaiser Permanente Northern California	9/14/2018	5
Health disparities and inequities	Kaiser Foundation Hospital – Oakland	9/21/2018	6
Professionals who serve youth	Kaiser Foundation Hospital – Oakland	9/21/2018	12
Mental health professionals	Kaiser Foundation Hospital – San Leandro	9/28/2018	12

Input from Residents

AI conducted five resident focus groups with a total of 70 residents in from July to September 2018. The discussions centered on the same five questions asked of the key informants. AI modified the questions appropriately for each audience.

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

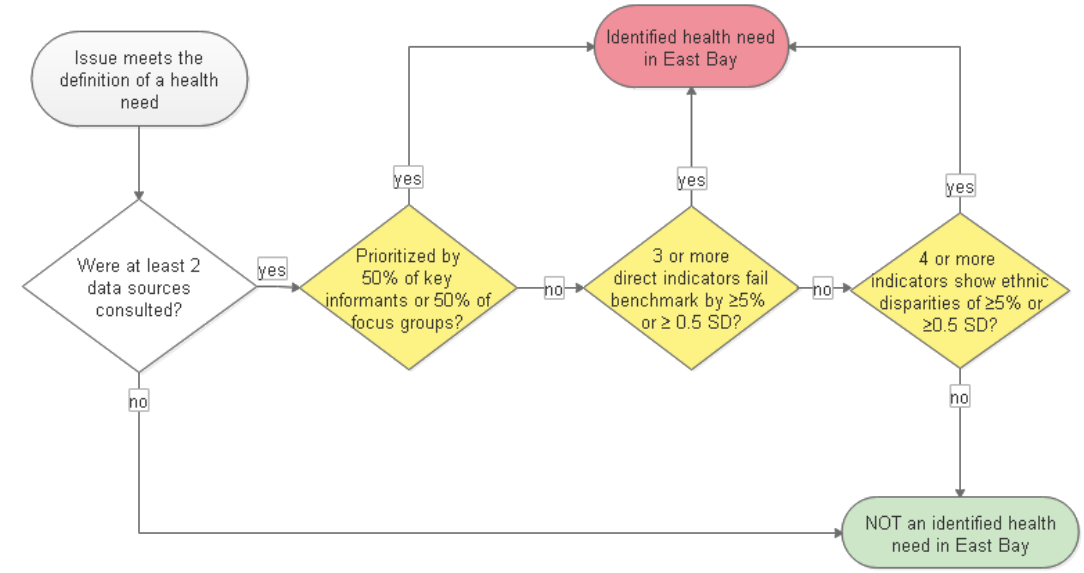
DETAILS OF FOCUS GROUPS WITH RESIDENTS

POPULATION	FOCUS GROUP HOST/PARTNER	DATE	NUMBER OF PARTICIPANTS
Spanish-speaking parents of middle- and high school-aged youth	La Familia Counseling	7/24/2018	12
Health coaches (peers of medically underserved individuals)	Alameda County Health Coach Program	8/2/2018	5
At-risk youth	St. Rose Hospital	8/3/2018	7
Immigrants and refugees	Mujeres Unidas y Activas	8/28/2018	15
Youth	Youth Radio	9/28/2018	31

PROCESS OF IDENTIFYING COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria (depicted in the diagram below). *See the next page for terms and definitions.*

What goes on the list?
Health needs list decision tree



- 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 Actionable Insights 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.
- A **benchmark** is either the California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

Criteria details:

1. Meets the definition of a "health need" (see sidebar).
2. At least two data sources were consulted.
3. a. Prioritized by at least half of key informants or focus groups.

   b. If not (a), three or more direct indicators were ≥5 percent or a ≥0.5 standard deviation worse than their respective benchmarks.

   c. If not (b), four or more indicators showed ethnic disparities of ≥5 percent or a ≥ 0.5 standard deviation worse than their respective benchmarks.

Actionable Insights (AI) analyzed data on a variety of issues, including secondary data and qualitative data from focus groups and key informant interviews. AI then synthesized these data for each issue and applied the criteria listed above to evaluate whether each issue qualified as a prioritized health need. In 2019, this process led to the identification of 16 community health needs that fit all three criteria. The list of needs, categorized in priority order, appears on page 49.

For further details about each of these health needs, including statistical data, see Attachment 1: Secondary Data Tables.

DEFINITIONS

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

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

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

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

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

PRIORITIZATION OF HEALTH NEEDS

The IRS CHNA requirements state that hospital facilities must identify and prioritize significant health needs of the community. As described on pages 45–47, AI solicited qualitative input from focus group and interview participants about which needs they thought were the highest priority (i.e., most pressing). The Hospitals used this input to identify the significant health needs listed in this report.

The Community Health Needs Assessment Advisory Group of UCSF Benioff Children's Hopsital Oakland met on March 25, 2019, at the hospital.[104] The advisory group was tasked with reviewing the CHNA results and further prioritizing the health needs to meet IRS requirements.

The advisory group members who participated in the prioritization process were:

- Thea Daniels, MA
- Adam Davis, MA, MPH
- Toby Eastman, LCSW
- Larissa Estes, DrPH
- Lacey Friedman
- Marsha Luster, MSW
- Nancy Shibata, MSN
- Marsha Treadwell, PhD
- Saun-Toy Trotter, MSW

Before beginning the prioritization process, the advisory group chose a set of criteria to use in ranking the list of health needs by responding to an online poll. The criteria were:

- **Community priority:** This criterion was ranked based on the frequency with which the community expressed concern about each health issue during the CHNA primary data collection (key informant interviews and focus groups).
- **Clear disparities or inequities:** This criterion refers to differences in health outcomes among subgroups. Subgroups may be based on geography, language, ethnicity, culture, citizenship, economic status, sexual orientation, age, gender, or other factors.
- **Magnitude:** This criterion refers to the number of people affected by the health need.
- **Prevention opportunity:** This criterion recognizes an opportunity to address the health issue by intervening at the prevention level.

Members used a worksheet to vote on their highest priorities based on the criteria above, and then categorized the 16 community health needs by priority, as shown in the table on the next page.

Health needs categorized as Priority 1 were voted as high priorities by half or more of the nine advisory group members. Health needs categorized as Priority 2 received priority votes from four of the nine members. Health needs categorized as Priority 3 were prioritized by three or fewer members.

[104] The advisory committee members who did not participate are Mary Jones, MD, MPH; Narin Noor, MD, MPH; Valerie Parker; and Daniel Won.

2019 Prioritized Community Health Needs

The community health needs are listed in alphabetical order in their priority group, highest (1) to lowest (3).

PRIORITY 1	PRIORITY 2	PRIORITY 3
Behavioral Health	Accidents and Unintentional Injury	Asthma
Crime and Intentional Injury	Maternal/Infant Health	Cancer
Diet, Nutrition, and Food Access	Transportation and Traffic	Climate and Natural Environment
Economic Security		Communicable Diseases
Health Care Access and Delivery		Education and Literacy
Housing and Homelessness		Heart Disease and Stroke
		Physical Activity/ Access to Recreation

See Section 5: 2019 Prioritized Health Needs for a summarized description of each health need.

7. Community Resources

Alameda County is home to various hospitals and partner clinics, community-based organizations, government departments and agencies, and other groups that work to address many of the community health needs identified by this assessment. Hospitals and clinics are listed below. Additional resources available to respond to local health needs can be found in Attachment 4: Community Assets and Resources.

HEALTH CARE FACILITIES

- Alameda County Behavioral Health Center
- Alameda Health System Alameda Hospital
- Alameda Health System Highland Hospital
- Alameda Health System John George Psychiatric
- Alameda Health System San Leandro Hospital
- John Muir Health
- Kaiser Permanente—Fremont
- Kaiser Permanente—Oakland
- Kaiser Permanente—San Leandro
- St. Rose Hospital
- Sutter Health Eden Medical Center
- Sutter Health Alta Bates Summit Medical Center
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

FEDERALLY QUALIFIED HEALTH CENTERS

- Asian Health Services
- La Clínica
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- UCSF Benioff Children's Hospital Oakland Claremont Clinic
- West Oakland Health

OTHER HEALTH CLINICS

- Brighter Beginnings CLINIC
- STOMP Mobile Clinic (Roots)
- Teen Health Clinic
- Tri-City Health Center (multiple sites and mobile clinic)
- Union City Clinic
- Washington on Wheels Mobile Health Clinic

8. Evaluation Findings from 2016–2018 Implemented Strategies

PURPOSE OF 2016 IMPLEMENTATION STRATEGY EVALUATION

A Community Health Needs Assessment (CHNA) for UCSF Benioff Children's Hospital Oakland was conducted in 2015–2016, according to guidelines proposed in the Affordable Care Act. Results of the CHNA revealed high-priority populations, geographic locations, diseases and conditions, and negative health drivers (i.e., risk factors). The methodology and results are described in detail in UCSF Benioff Oakland's 2016 CHNA Report.

UCSF Benioff Children's Hospital Oakland's 2016–2019 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA report describes and assesses the impact of these activities.

The 2016 CHNA health needs that were prioritized to be addressed by UCSF Benioff Children's Hospital Oakland in the Implementation Strategy Report were:

1. Mental Health
2. Economic Security
3. Maternal/Infant Health
4. Health Care Access and Delivery

UCSF Benioff Children's Hospital Oakland is monitoring and evaluating progress to date on its 2016 implementation strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made/received, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and Children's Oakland in-kind resources. In addition, Children's Oakland tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA report in April 2019, UCSF Benioff Children's Hospital Oakland had evaluation of impact information on activities from 2016, 2017, and 2018. Although not reflected in this report, Children's Oakland will continue to monitor impact for strategies implemented in 2016.

2016 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

According to the Affordable Care Act, the CHNA is intended to guide the hospital's community benefit programs. Since health needs of communities typically do not change dramatically within a few years, it is noteworthy that UCSF Benioff Oakland is already dedicating significant resources to many of the prioritized issues and populations identified in the CHNA. These issues

include preventable injuries, obesity, asthma, diabetes, child abuse and domestic violence, and dental care.

UCSF Benioff Oakland also has a substantial focus on specific subpopulations highlighted in the CHNA including youth, homeless children, foster children, the uninsured, and children living in poverty. With limited and in some cases declining funding for these efforts, UCSF Benioff Oakland's Community Benefit Implementation Plan includes the goal of sustaining key programs that are successfully addressing one or more of the prioritized community needs. Additionally, the CHNA has identified several community needs that represent opportunities to better serve children and families in its community.

CHNA Priorities, Strategies, and Outcomes (2016–2019)

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND 2016–2019 CHNA PRIORITIES

Mental Health

Severe mental illness emergencies, suicides, adolescent mental health, lack of trauma-informed care, lack of culturally diverse providers and social-emotional support

Economic Security

Addressing social determinants of health in health care settings, especially focusing on food insecurity, living wages, and housing

Maternal/Child Health

Infant mortality and breastfeeding in the African ancestry population, traumatic stress in children, low preschool enrollment

Health Care Access and Delivery

Specifically, transportation, experiences with providers, provider diversity and cultural sensitivity, linguistic issues, access to specialty care

MENTAL HEALTH PRIORITY

OBJECTIVE 1: INCREASE AWARENESS OF TRAUMA-INFORMED PRINCIPLES AMONG THE HOSPITAL AND COMMUNITY HEALTH CARE PROVIDERS.	
Strategy	**Outcomes**
Develop a trauma-informed learning community with representatives from different Children's Oakland departments.	Children's Oakland created the Trauma Informed Care Committee with 12 representatives from 10 hospital departments.
Identify a group of trauma-informed champions throughout the hospital that can support staff in implementing trauma-informed principles.	Children's Oakland identified trauma-informed champions through the Trauma Informed Care Committee.

Strategy	Outcomes
Provide two to three trainings per year to hospital and other community health providers on trauma-informed care.	Children's Oakland provided training to 11 attending physicians in primary care (September 2018), six residents (October 2018), and 13 members of hospital leadership (December 2018). Currently, the hospital is working to strategize how to train staff in primary care and behavioral health without disrupting prioritized initiatives and patient care.

OBJECTIVE 2: INCREASE THE NUMBER OF CULTURALLY DIVERSE MENTAL HEALTH PROVIDERS AS WELL AS THE AWARENESS AMONG ALL MENTAL HEALTH PROVIDERS OF THE NEEDS OF VARIOUS CULTURAL COMMUNITIES SERVED BY CHILDREN'S OAKLAND.	
Strategy	**Outcomes**
Develop and implement workforce development pathways for adolescents and new professionals who represent underserved cultural/ethnic communities.	Children's Oakland continued and grew its CHAMPS program, which aims to provide mentorship, shadowing, and training for low-income and minority high school students who may be interested in health care careers. Each cohort is in the program for three years. An additional $500,000 was raised to expand program services. Since 2016, 109 students have graduated, and 96 percent have gone on to post-secondary education.
Expand the hospital's cultural humility trainings.	Children's Oakland developed a curriculum that's now a mandatory part of all medical residents' training. To date, 126 residents have been trained.
Implement brown bag lunches focused on strengthening services to underserved cultural communities, in collaboration with representatives of those communities.	Children's Oakland has hosted a series of nine lunch meetings with representatives of various cultural communities to discuss improving services. More than 112 leaders attended these lunches.

OBJECTIVE 3: INCREASE THE HOSPITAL'S FOCUS ON PREVENTATIVE MENTAL HEALTH SERVICES RELATED TO ANTICIPATORY GUIDANCE.	
Strategy	**Outcomes**
Increase parent education and support group offerings for children, youth, and parents.	Children's Oakland initiated and sustained a biweekly parent support group for foster/adoptive parents within the Center for the Vulnerable Child, and started dialectical behavior therapy (DBT) groups as part of the Center for Child Protection.
Expand behavioral health/developmental integration in primary care through team-based care.	Children's Oakland started a behavioral health (BH) integration program to provide on-site BH services for underserved patients as part of primary care. The program has grown annually for the past three years, serving several hundred patients each year.
Develop and distribute written materials on the impact of trauma on children to Children's Oakland staff.	Members of the Trauma Informed Care Committee presented on this topic at Managers Forum (2018) and Grand Rounds (2019).

MATERNAL/CHILD HEALTH

OBJECTIVE 1: INCREASE EDUCATION/AWARENESS OF THE IMPACT OF TRAUMA ON CHILDREN.	
Strategy	**Outcomes**
Develop and market a broader trauma prevention-campaign throughout the hospital.	Children's Oakland secured Resilient Beginnings Collaborative funding from Center for Care Innovations; hosted trainings for 29 staff, including the hospital's leadership team.
Expand training and consultation to school based behavioral health care sites on trauma and impact on adolescents.	The hospital's school-based mental health care team started a series of multisession group consultation trainings for school staff at two high schools in Oakland to promote trauma-informed principles and practices.

OBJECTIVE 2: INCREASE THE NUMBER OF CHILDREN'S OAKLAND PATIENTS REFERRED TO PRESCHOOL/HEADSTART PROGRAMS.	
Strategy	**Outcomes**
Provide outreach throughout the hospital on the importance of preschool and how to access preschool slots for patients.	Not met due to lack of resources.

ECONOMIC SECURITY

OBJECTIVE 1: IMPROVE FOOD SECURITY WITH THE OVERARCHING GOAL OF BETTER HEALTH FOR CHILDREN'S OAKLAND PATIENTS AND THEIR FAMILIES.	
Strategy	**Outcomes**
Increase screening for food insecurity throughout the hospital.	Food insecurity screening questions were integrated into the hospital's online screening platform; food insecurity screening is now standard of care in the primary care and social services departments.
Provide pop-up Food Farmacies for patients.	Children's Oakland developed Food Farmacies, which take place twice per month. To date, 53 Food Farmacies have taken place, providing food to approximately 8,400 people.

OBJECTIVE 2: STRENGTHEN THE HOSPITAL'S ROLE IN IMPACTING THIRD GRADE READING LEVELS IN OAKLAND BY PARTNERING WITH SCHOOLS AND LIBRARIES TO BUILD UPON EXISTING EARLY LITERACY STRATEGIES.	
Strategy	**Outcomes**
Increase opportunities for read-a-thons, book fairs, and book giveaways.	Children's Oakland now partners with Tandem and East Bay Economic Development Agency and participates in events that target early learning and literacy. At these events, the hospital provides giveaways, including books.

Strategy	Outcomes
Partner with the library to increase library usage and library cards for Children's Oakland patients	The hospital has invited Oakland Public Library to host a library card sign-up table at primary care and early literacy events.

OBJECTIVE 3: CREATE A FRAMEWORK FOR INCLUDING FINANCIAL COACHING INTO HEALTH CARE VISITS.	
Strategy	**Outcomes**
Incorporate referrals to financial coaching/college savings accounts into primary care well visits for newborns and infants.	Children's Oakland initiated the Brilliant Baby program with the office of the mayor of Oakland in 2018. To date, 80 babies have been referred and have obtained college savings accounts; 25 parents/guardians have received financial coaching.
Evaluate the impact of financial coaching on children's health and development.	Children's Oakland has hired an evaluation firm and is in the process of evaluating the impact of the Brilliant Baby program.

HEALTH CARE ACCESS AND DELIVERY

OBJECTIVE 1: IMPROVE ACCESS TO GETTING TO MEDICAL APPOINTMENTS FOR CHILDREN AND FAMILIES.	
Strategy	**Outcomes**
Expand Telehealth options.	Children's Oakland secured funding and started planning a psychiatric "warm line" for children in the Bay Area, which meets a significant unmet need in the community. The telephone-based warm line will provide a single point of contact to provide brief counseling and navigation services.
Pilot FETCH transportation (ride sharing for patients with transportation challenges).	Children's Oakland has conducted two pilot projects with 123 families total and is currently conducting an evaluation to determine outcomes.

OBJECTIVE 2: STRENGTHEN FAMILY CENTERED CARE.	
Strategy	**Outcomes**
Expand FINDconnect platform and resource. FINDconnect is software developed to facilitate connecting families with basic needs to available resources.	Children's Oakland has made FINDconnect available to the entire hospital through the intranet and is now expanding the platform to other clinics throughout the community.

9. Conclusion

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

Next steps for UCSF Benioff Children's Hospital Oakland:

- CHNA adopted by the hospital's board and made publicly available on the hospital's website (by June 30, 2019).[105]
- 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 November 15, 2019).

[105] https://www.childrenshospitaloakland.org/main/community-benefit-reports.aspx

10. List of Attachments

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

Attachment 1. Secondary Data Tables, Alameda County

TABLE OF CONTENTS

INTRODUCTION

Health needs data found in the following tables were collected from the sources listed below. Each indicator in the tables has a footnote corresponding to its data source:

1. Alameda County 2017 Homeless Census & Survey Report based on the 2017 Point in Time (PIT) Count, accessed via http://everyonehome.org/wp-content/uploads/2016/02/2017-Alameda-County-8.1-2.pdf, pulled on July 31, 2018
2. 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
3. California Health Interview Survey (CHIS), accessed via http://ask.chis.ucla.edu/, pulled on August 5, 2018
4. California Healthy Kids Survey (CHKS), accessed via http://chks.wested.org/query-chks/, pulled on August 5, 2018
5. The new CHNA data platform (replacing Community Commons), accessed via http://chna.org/kp, pulled on May 17, 2018. Data updated September 4, 2018.
6. City of Oakland Equity Indicators (COEI) 2018 Report, accessed via https://www.oaklandca.gov/documents/equity-indicators-community-briefing-documents, pulled on November 10, 2018
7. County Health Rankings (CHR), accessed via http://www.countyhealthrankings.org/app/california/2018/rankings, pulled on July 30, 2018
8. The Healthy Alameda County (HAC.org) platform, accessed via http://www.healthyalamedacounty.org, pulled on July 21, 2018
9. KidsData.org, a program of the Lucile Packard Foundation for Children's Health, accessed via https://www.kidsdata.org, pulled on August 5, 2018
10. U.S. Department of Housing & 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
11. Vera Institute of Justice Incarceration Trends, accessed via http://trends.vera.org/rates/contra-costa-county-ca?incarcerationData=all, pulled on July 31, 2018

12. 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.

Geographic area indicators that are at least half a standard deviation (SD) or 5 percent or more worse than their benchmark have an asterisk, are **bold face**, and are highlighted in orange. Indicators that are otherwise within one SD of the benchmark are highlighted in gray, those at least one SD better than the benchmark are highlighted in light blue, and those at least two SDs better are highlighted in dark blue. 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.

Indicators are from CHNA.org unless otherwise noted. Some CHNA.org indicators have the notation "CA" after them; this merely means that the indicator is only available for service areas/counties in California and not elsewhere in the U.S. When the Healthy People 2020 benchmark is used instead of the state average, the notation (HP) appears in the "STATE AVG" column. Although community health needs were determined based on all available data, the subset of data presented in these tables are those which are most related to children and youth. The tables are presented alphabetically with the exception of "Overall Health," which is last.

ASTHMA

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Active Asthma Prevalence, All Ages[2] (AC)**	**2014**	**percent**	**10.0**	--	**8.3**	**20.5%**	**--**
***Asthma Deaths (per 1,000,000)[2] (AC)**	**2008–2010**	**rate**	**14.1**	--	**11.1**	**27.0%**	**--**
***Asthma Diagnoses, Children Age 1–17[9] (AC)**	**2015**	**percent**	**20.1%**	--	**15.2%**	**32.2%**	**--**
***Asthma ER Visits (per 100,000)[8] (AC)**	**2012–2014**	**rate**	**649.0**	--	**498.7**	**30.1%**	**--**
***Asthma Hospitalizations, Children Age 0–4 (per 10,000)[9] (AC)**	**2016**	**rate**	**36.9**	--	**19.6**	**88.3%**	**--**
***Asthma Hospitalizations, Children/Youth Age 5–17 (per 10,000)[9] (AC)**	**2016**	**rate**	**12.7**	--	**7.7**	**64.9%**	**--**
Average Charge per Asthma Hospitalization[2] (AC)	2014	dollars	**41,610**	**--**	39,860	4.4%	**--**
Childhood Asthma ED Visits (per 100,000 children)[6]	2013–2015	rate	--	1,658.0	--	--	--
Environmental Health-Pollution Burden[6]	2012–2017	score	--	36.9	--	--	--
Ozone Levels[5]	2008–2014	percent	31.8%	29.4%	42.0%	24.3%	30.0%
Particulate Matter 2.5 Levels[5]	2008–2014	percent	8.9%	9.5%	10.7%	16.8%	11.2%
***Respiratory Hazard Index[5]**	**2011**	**number**	**2.4**	**2.6**	**2.2**	**9.1%**	**18.2%**

TRENDS

Trend data are available on certain indicators.

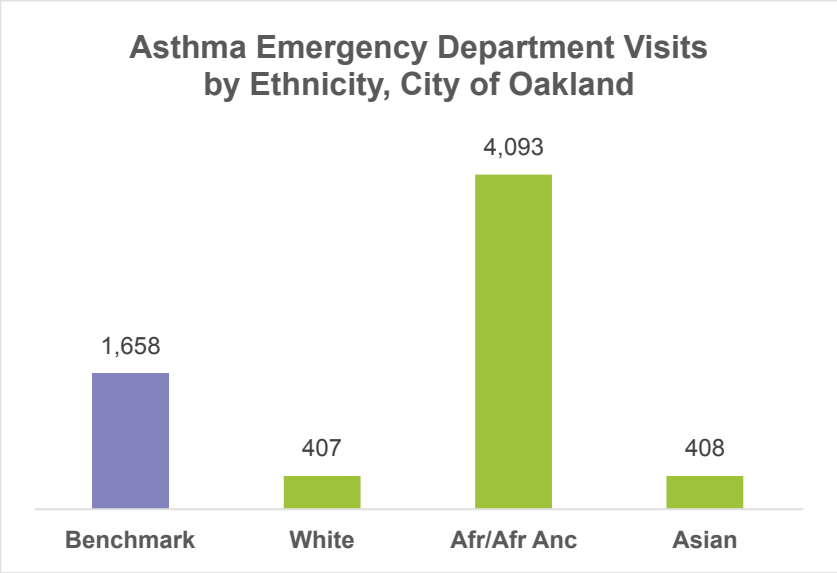
- Asthma Diagnoses, Children Age 1–179: Long-term trend mixed; trending up since 2009.
- Asthma ER Visits8: Generally trending down since 2009.
- Asthma Hospitalizations, Children Age 0–49: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Age 0–179: Long-term trend mixed, trending up since 2011.

Race & Ethnicity

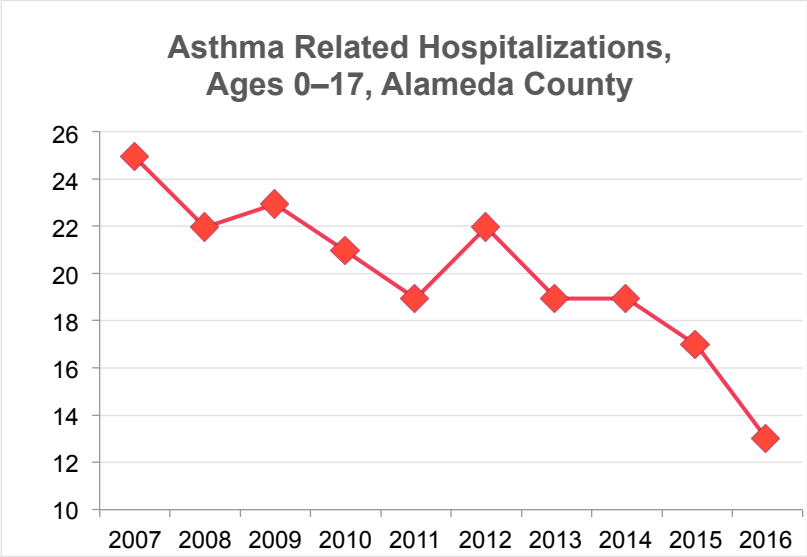
Certain indicators are available by ethnicity, which may show disparities in certain populations.

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANCESTRY	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Asthma ED Visits, All Ages[2] (AC)	49.5	32.7	**227.6**	20.5*					**57.0**
Asthma Hospitalizations, All Ages[2] (AC)	7.6	5.0	**31.2**	5.3*					**11.0**
Childhood Asthma ED Visits (per 100,000 children)[6] (Oak)°	1,658.0	407.4	**4,093.3**	408.0					1,134.0
Environmental Health-Pollution Burden[6] (Oak)°	36.9	31.8	**37.4**	**51.6**			**37.9**		**40.6**

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
* Indicates statistic is for Asian/Pacific Islander combined.



Rate per 100,000 children ages 0–17. Source: [City of Oakland, 2018 Oakland Equity Indicators Report, 2013–2015]



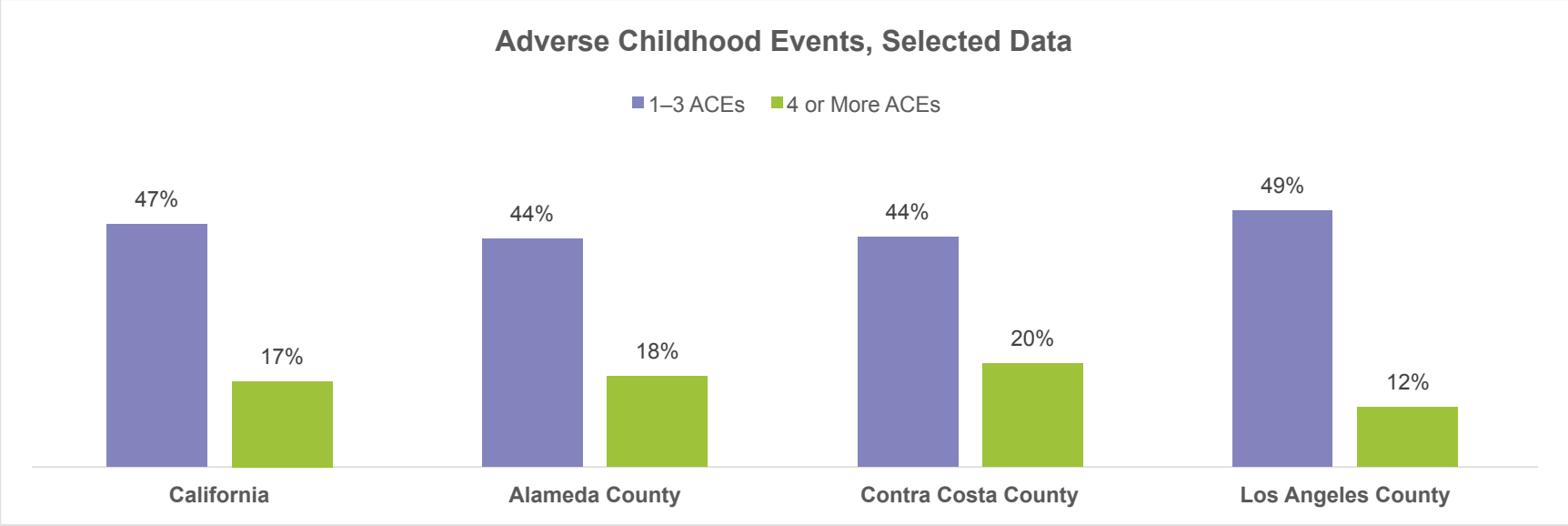
Rate per 10,000 children ages 0–17. CA Office of Statewide Health Planning and Development, 2017

BEHAVIORAL HEALTH

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC% DIFFERENT	OAKLAND % DIFFERENT
Alcohol Use (Youth)[8] (AC)	2011–2012	percent	22.6%	--	29.5%	23.4%	--
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.2**	**1.7**	**1.1**	**17.0%**	**54.5%**
Bullied at School, 7th Graders[4] (AC)	2011–2013	percent	40.6%	--	39.4%	3.0%	--
Bullied at School, 9th Graders[4] (AC)	2011–2013	percent	35.2%	--	34.4%	2.3%	--
Bullied at School, 11th Graders[4] (AC)	2011–2013	percent	27.9%	--	27.6%	1.1%	--
Caring Adults at School: Low, 7th Graders[4] (AC)	2011–2013	percent	11.7%	--	14.3%	18.2%	--
Caring Adults at School: Low, 9th Graders[4] (AC)	2011–2013	percent	14.0%	--	17.8%	21.3%	--
Caring Adults at School: Low, 11th Graders[4] (AC)	2011–2013	percent	12.8%	--	13.0%	1.5%	--
Children in Foster Care (per 1,000 under age 21)[9] (AC)	2015	rate	4.2	--	5.8	27.6%	--
Children Needing and Receiving Behavioral Health Care Services[9] (percentage of children ages 2–17) (AC)	2011–2012	percent	**64.3%**	--	62.7%	2.6%	--
Children with Two or More Adverse Experiences (Parent Reported)[9] (percentage of children ages 0–17) (AC)	2016	percent	14.3%	--	16.4%	12.8%	--
Chronic Liver Disease/Cirrhosis Deaths (per 100,000 population)[2] (AC)	2011–2016	rate	8.6	--	12.2	29.5%	--
Cyberbullied More than Once, 7th Graders[4] (AC)	2011–2013	percent	**9.7%**	--	9.4%	3.2%	--
Cyberbullied More than Once, 9th Graders[4] (AC)	2011–2013	percent	12.1%	--	12.4%	2.4%	--
Cyberbullied More than Once, 11th Graders[4] (AC)	2011–2013	percent	11.5%	--	12.4%	7.3%	--
Deaths by Suicide, Drug or Alcohol Poisoning (per 100,000 population)[5]	2011–2015	rate	28.4	28.4	34.2	17.0%	17.0%
Depression-Related Feelings, 7th Graders[4] (AC)	2013–2015	percent	33.3%	--	25.4%	8.3%	--
Depression-Related Feelings, 9th Graders[4] (AC)	2013–2015	percent	23.3%	--	31.5%	9.2%	--
Depression-Related Feelings, 11th Graders[4] (AC)	2013–2015	percent	28.6%	--	33.4%	0.3%	--
***Domestic Violence Hospitalizations** (females aged 10+ years per 100,000 population)[5]	**2013-2014**	**rate**	**5.6**	**5.7**	**4.9**	**14.3%**	**16.3%**
Heart Disease Deaths (per 100,000 population)[5]	2011–2015	rate	71.8	71.8	99.5	27.8%	27.8%
***Homicide[7] (per 100,000 population) (AC)**	**2010–2016**	**rate**	**8.0**	**--**	**5.0**	**60.0%**	**--**

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC% DIFFERENT	OAKLAND % DIFFERENT
Impaired Driving Deaths[5]	2011–2015	percent	**29.6%**	**29.6%**	29.0%	2.1%	2.1%
***Low Birth Weight (< 2500 grams)[5]**	**2008–2014**	**percent**	**7.2%**	**7.2%**	**6.8%**	**5.9%**	**5.9%**
Lung Cancer Deaths (per 100,000 population)[8] (AC)	2014–2016	rate	28.2	--	28.9	2.4%	--
Lung Cancer Incidence (per 100,000 population)[5]	2011–2015	rate	43.4	43.4	44.6	2.7%	2.7%
Meaningful Participation at School: Low, 7th Graders[4] (AC)	2011–2013	percent	28.6%	--	31.3%	8.6%	--
Meaningful Participation at School: Low, 9th Graders[4] (AC)	2011–2013	percent	34.9%	--	37.9%	7.9%	--
Meaningful Participation at School: Low, 11th Graders[4] (AC)	2011–2013	percent	**37.3%**	--	36.9%	1.1%	--
***Mental Health Hospitalization, Children Age 5–14 (per 1,000 children)[9] (AC)**	**2016**	**rate**	**2.8**	--	**2.5**	**12.0%**	--
***Mental Health Hospitalization, Youth Age 15–19 (per 1,000 children and youth)[9] (AC)**	**2016**	**rate**	**11.8**	--	**9.8**	**20.4%**	--
Mental Health Providers (per 100,000 population)[5]	2016	rate	515.5	513.4	288.7	78.6%	77.8%
Recent Alcohol/Drug Use, 7th Graders[4] (AC)	2013–2015	percent	7.5%	--	10.4%	27.9%	--
Recent Alcohol/Drug Use, 9th Graders[4] (AC)	2013–2015	percent	18.2%	--	23.2%	21.6%	--
Recent Alcohol/Drug Use, 11th Graders[4] (AC)	2013–2015	percent	33.2%	--	33.4%	0.6%	--
Recent Cigarette Use, 7th Graders[4] (AC)	2013–2015	percent	1.6%	--	2.0%	20.0%	--
Recent Cigarette Use, 9th Graders[4] (AC)	2013–2015	percent	2.7%	--	4.0%	32.5%	--
Recent Cigarette Use, 11th Graders[4] (AC)	2013–2015	percent	3.5%	--	6.7%	47.8%	--
Recent Marijuana Use, 7th Graders[4] (AC)	2013–2015	percent	3.6%	--	4.2%	14.3%	--
Recent Marijuana Use, 9th Graders[4] (AC)	2013–2015	percent	10.9%	--	12.3%	11.4%	--
***Recent Marijuana Use, 11th Graders[4] (AC)**	2013–2015	**percent**	**21.0%**	--	**18.0%**	**16.7%**	--
School Connectedness: Low, 7th Graders[4] (AC)	2011–2013	percent	9.4%	--	10.2%	7.8%	--
***School Connectedness: Low, 9th Graders[4] (AC)**	2011–2013	**percent**	**12.7%**	--	**11.5%**	**10.4%**	--
***School Connectedness: Low, 11th Graders[4] (AC)**	2011–2013	**percent**	**13.5%**	--	**12.5%**	**8.0%**	--
Self-Inflicted Injury ER Visits (per 100,000 population)[8] (AC)	2012–2014	rate	103.1	--	115.5	10.7%	--
Seriously Considered Suicide, 9th Graders[4] (AC)	2013–2015	percent	16.1%	--	19.0%	15.3%	--
Seriously Considered Suicide, 11th Graders[4] (AC)	2013–2015	percent	**18.7%**	--	18.1%	**3.3%**	--
***Severe Mental Illness ER Visits (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**489.3**	--	**320.0**	**52.9%**	--
Social Associations (per 10,000 population)[5]	2012–2015	rate	7.4	9.9	6.5	13.8%	52.3%
Students per School Psychologist[9] (AC)	2015	number	1,233	--	1,265	2.5%	--

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC% DIFFERENT	OAKLAND % DIFFERENT
***Substance Use ER Visits (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**1,642.7**	**--**	**1,275.4**	**28.8%**	**--**
Suicide Deaths (per 100,000 population)[5]	2011–2015	rate	8.8	9.0	10.2 (HP)	13.7%	11.8%
***Time in Foster Care (Median Months) (children under age 18)[9] (AC)**	**2013**	**number**	**17.6**	**--**	**15.6**	**12.8%**	**--**
Very Low Birth Weight (< 1500 grams)[9] (AC)	2013	percent	1.2%	--	1.2%	0.0%	--
Young People Not in School and Not Working (youth aged 16–19)[5]	2012–2016	percent	1.9%[8]	5.6%	7.7%	17.4%	27.3%



Percentage of adults who experienced adverse childhood events (ACEs), by ACEs level, selected counties versus the state of California.
Source: [Lucille Packard Foundation for Children's Health, Households with and without Children, by City, School District and County (10,000 Residents or More), 2016].

TRENDS

Trend data are available on certain indicators.

- Alcohol Use (Youth)[8]: Trending down since 2007.
- Children in Foster Care[9]: Downward trend since 2000, slight upward trend since 2012.
- Children without Secure Parental Employment[9]: Trending down since 2011.
- Lung Cancer Deaths[8]: Trending down since 2009.
- Mental Health Hospitalizations, Children Age 5–14[9]: Generally trending up since 2011.
- Mental Health Hospitalizations, Youth Age 15–19[9]: Long-term trend mixed, generally trending up since 2008.
- Mental Diseases & Disorders Hospitalizations, Children/Youth Age 0–17[7]: Trending up since 2007.
- Self-Inflicted Injury ER Visits[8]: Trend is mixed.
- Substance Use ER Visits[8]: Trending up since 2009.
- Time in Foster Care, Median Months[9]: Mixed trend, slightly upward since 2007.
- Very Low Birth Weight[9]: Trend is relatively flat since 1995.

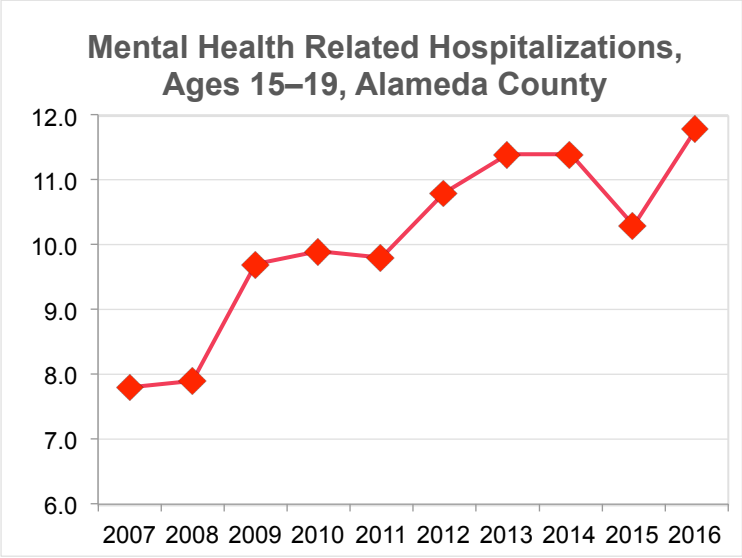
Race & Ethnicity

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

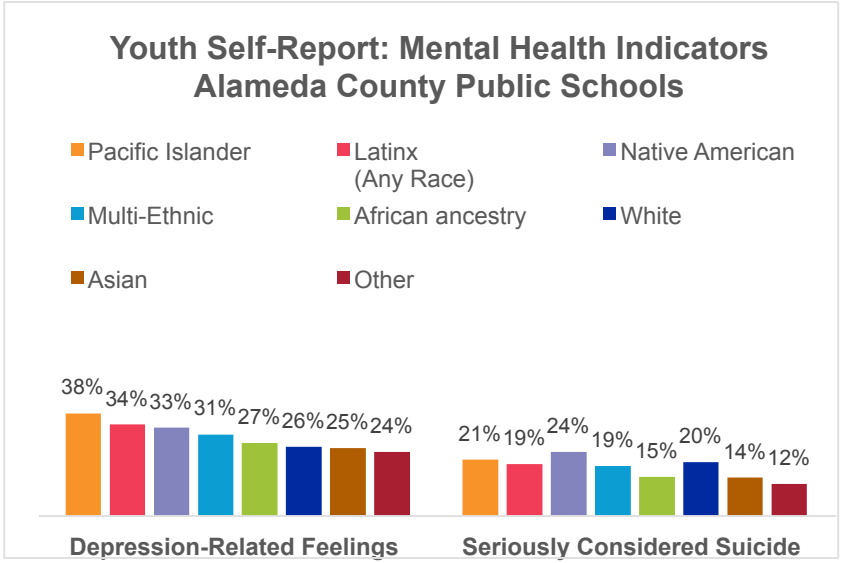
INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Caring Adults at School: Low[4]	#	10.0%	12.1%	10.9%	13.4%	15.0%	20.8%	12.8%	16.3%
Children in Foster Care[9]	5.8	2.7	20.2	0.7*					3.4
Community Stressors-Domestic Violence (per 100,000 people)[6] (Oak)°	n/a	321.8	2,111.8	223.6					835.4
Community Stressors-Homicide (per 100,000 people)[6] (Oak)°	n/a	3.4	55.7	1.5					10.9
Cyberbullied More than Once[4]	#	7.6%	9.3%	6.7%	14.0%	9.6%	11.5%	10.2%	11.4%
Depression-Related Feelings[4]	#	25.9%	27.2%	25.4%	38.4%	33.1%	23.9%	30.5%	34.2%
Heart Disease Deaths[5]	99.5	80.9	97.5	48.2		50.3			56.1

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Meaningful Participation at School: Low[4]	#	32.0%	**32.2%**	29.5%	31.1%	**32.2%**	28.3%	**32.2%**	**40.8%**
Recent Alcohol/Drug Use[4]	#	23.1%	**27.1%**	9.9%	20.3%	15.7%	16.4%	22.0%	**28.5%**
Recent Marijuana Use[4]	#	13.1%	**21.5%**	4.8%	12.8%	**13.3%**	10.6%	**15.2%**	**17.7%**
School Connectedness: Low[4]	#	6.9%	**14.1%**	**7.0%**	**7.9%**	**10.1%**	**11.4%**	**10.7%**	**12.0%**
Seriously Considered Suicide[4]	#	20.1%	14.6%	14.4%	**21.0%**	**24.0%**	12.0%	18.8%	19.4%
Suicide Deaths	10.2 (HP)	**14.1**	5.9	5.7					4.4

Blank cells indicate that data were unavailable.
Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.
* Indicates statistic is for Asian/Pacific Islander combined.
° Benchmark is for City of Oakland rather than county or state.



Rate per 10,000 children ages 15–19. https://www.kidsdata.org



Includes 7th, 9th, and 11th graders and nontraditional public school students. Source: WestEd, California Healthy Kids Survey. California Department of Education. 2013–2015.

CANCERS

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Cancer Deaths (per 100,000 population, per year)[5]	2011–2015	rate	140.5	140.6	147.3	4.6%	4.5%
Cervical Cancer Incidence (per 100,000 females)[8] (AC)	2011–2015	rate	6.5	--	7.3	11.0%	--
Childhood Cancer Diagnoses Ages 0-19 (per 100,000 children)[9] (AC)	2009–2013	rate	16.9	--	17.4	2.9%	--
Lung Cancer Deaths (per 100,000 population)[2] (AC)	2014–2016	rate	28.2	--	28.9	2.4%	--
Lung Cancer Incidence (per 100,000 population)[5]	2011–2015	rate	43.4	43.4	44.6	2.7%	2.7%

TRENDS

Trend data are available on certain indicators.

- Cervical Cancer Incidence[8]: Trending down since 2009.
- Childhood Cancer Diagnoses[9]: Slight upward trend since 2003.
- Lung Cancer Deaths[8]: Trending down since 2009.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Cancer Deaths[5]	147.3	**154.5**	**190.1**	102.8		75.8			112.6
Cervical Cancer Incidence[8]	7.3	6.9	7.0	5.1*					**9.9**
Childhood Cancer Diagnoses, Ages 0–19[9]	17.4	**19.4**	14.0	16.9*					15.1

Blank cells indicate that data were unavailable.
* Indicates statistic is for Asian/Pacific Islander combined.

CLIMATE/NATURAL ENVIRONMENT

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC% DIFFERENT	OAKLAND % DIFFERENT
***Active Asthma Prevalence, All Ages[2] (AC)**	**2014**	**percent**	**10.0**	**--**	**8.3**	**20.5%**	**--**
***Asthma Hospitalizations, Children Age 0–4 (per 10,000 population)[9] (AC)**	**2016**	**rate**	**36.9**	**--**	**19.6**	**88.3%**	**--**
***Asthma Hospitalizations, Children/Youth Age 5–17 (per 10,000 population)[9] (AC)**	**2016**	**rate**	**12.7**	**--**	**7.7**	**64.9%**	**--**
Climate-Related Mortality Impacts[5]	2016	percent	4.9%	4.8%	8.4%	41.7%	42.9%
Drinking Water Violations[5]	2015	number	0.0	0.0	0.8	100.0%	100.0%
Driving Alone to Work[5]	2012–2016	percent	62.6%	47.8%	73.5%	14.8%	35.0%
Driving Alone to Work, Long Distances[5]	2012–2016	percent	**44.4%**	38.8%	39.3%	**13.0%**	1.3%
Drought Severity (percentage of weeks in drought)[5]	2012–2014	percent	92.1%	87.6%	92.8%	0.8%	5.6%
Environmental Health-Abandoned Trash (illegal dumping service requests per 1,000 population)[6]	2012–2017	ratio	--	3.94	--	--	--
Environmental Health-Park Quality[6] (score out of 4)	2016	number	--	2.5	--	--	--
Environmental Health-Pollution Burden[6]	2012–2017	score	--	36.9	--	--	--
Flood Vulnerability (percentage of vulnerable housing units)[5]	2011	percent	1.9%	1.9%	3.7%	48.6%	48.6%
Heat Index (percentage of days per year above threshold)[5]	2006– 2013	percent	0.0%	0.0%	2.7%	100.0%	100.0%
Ozone Levels (percentage of days per year above threshold[5]	2008–2014	percent	31.8%	29.4%	42.0%	24.3%	30.0%
Particulate Matter 2.5 Levels (percentage of days per year above threshold)[5]	2008–2014	percent	8.9%	9.5%	10.7%	16.8%	11.2%
Public Transit Access (percentage of population living within 0.5 miles of a transit stop)[5]	2011	percent	20.5%	18.4%	16.8%	22.0%	9.5%
***Respiratory Hazard Index (likelihood of hazardous exposure per 1,000,000 population)[5]**	**2011**	**number**	**2.4**	**2.6**	**2.2**	**9.1%**	**18.2%**
***Road Network Density (road miles per square mile)[5]**	**2011**	**rate**	**6.5**	**21.6**	**2.0**	**225.0%**	**980.0%**
Tree Canopy Cover (percentage of land covered)[5]	2011	percent	9.1%	18.9%	8.3%	9.6%	127.7%

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.

TRENDS

- No trend data are available.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	NON WHITE/ MIXED	HISP / LAT (ANY RACE)
Environmental Health-Abandoned Trash (illegal dumping service requests per 1,000 population)[6] (Oak)°	66.9	26.1	**82.6**	**82.0**	--	--	--	**69.4**	**102.8**
Environmental Health-Pollution Burden[6] (Oak)°	36.9	31.8	**37.4**	**51.6**	--	--	--	**37.9**	**40.6**

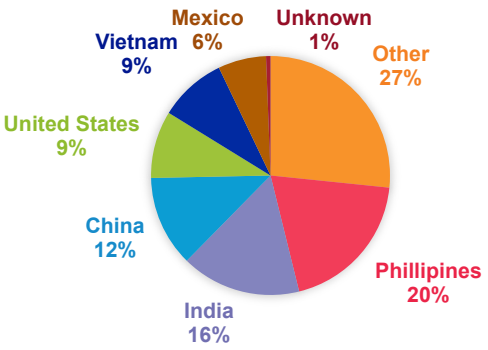
Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
* Indicates statistic is for Asian/Pacific Islander combined.

COMMUNICABLE DISEASES

TB Incidence in Alameda County is 9x the Healthy People 2020

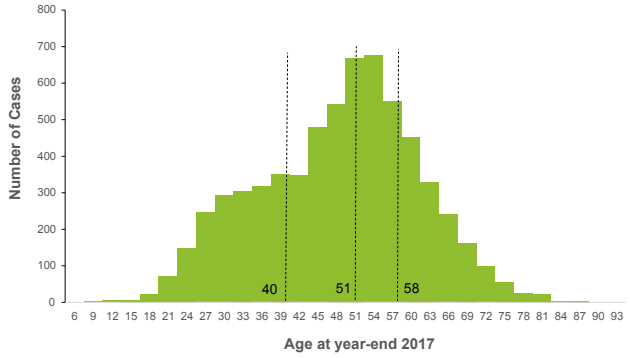
INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Children with Influenza Vaccination[3] (AC)	2013–2014	percent	65.9%	--	55.4%	19.0%	--
Chlamydia Incidence (per 100,000 population, per year)[5]	2016	rate	456.9	456.2	459.9	0.7%	0.8%
***Chlamydia Incidence Among Youth Age 10–19 (per 100,000 population)[2] (AC)**	**2015**	**rate**	**810.4**	--	**709.2**	**14.3%**	--
***Gonorrhea Incidence (per 100,000 population)2 (AC)**	**2017**	**rate**	**186.7**	--	**164.3**	**13.6%**	--
***Gonorrhea Incidence Among Youth Age 10–19 (per 100,000)[2] (AC)**	**2015**	**rate**	**203.5**	--	**121.2**	**67.9%**	--
***HIV Incidence (per 100,000 population)[2] (AC)**	**2015**	**rate**	**16.3**	--	**12.7**	**78.3%**	--
HIV/AIDS Deaths (per 100,000 population)[5]	2008–2014	rate	70.2	70.3	323.9	28.3%	78.3%
***HIV/AIDS Prevalence (per 100,000 population)[5]**	**2015**	**rate**	**406.9**	**405.0**	**374.6**	**8.6%**	**8.1%**
Influenza and Pneumonia Deaths (per 100,000 population)[2] (AC)	2014–2016	rate	12.6	--	14.3	11.9%	--
Influenza Vaccination (all ages) (vaccinated in last 12 months)[3] (AC)	2016	percent	56.6%	--	44.8%	26.3%	--
Kindergarteners with Required Immunizations[2] (AC)	2016	percent	95.9%	--	92.8%	3.3%	--
Syphilis Incidence (per 100,000 population)[2] (AC)	2017	rate	11.2	--	15.0	25.3%	--
***Tuberculosis Incidence (per 100,000 population)[2] (AC)**	**2014–2017**	**rate**	**8.9**	--	**1.0 (HP)**	**790%**	--

Incidence of Tuberculosis Cases by Place of Birth, Alameda County



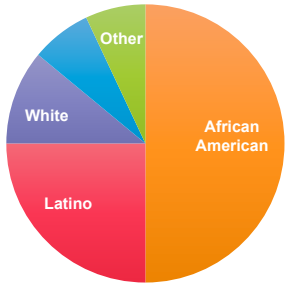
Source: Alameda County Public Health Department
http://www.acphd.org/media/537825/tb2018.pdf

Age of People Living with HIV, Alameda County



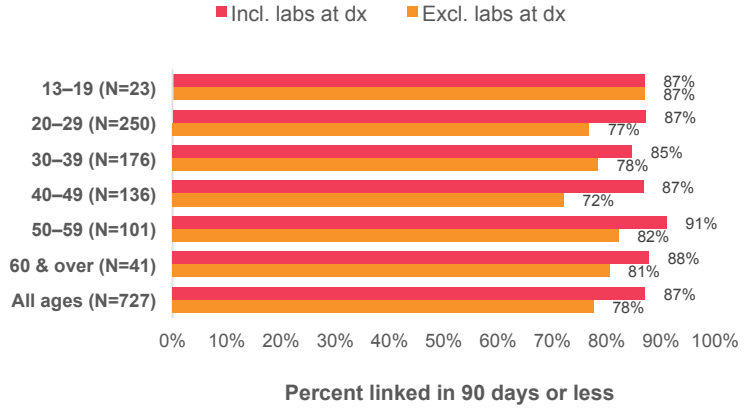
Note: Dashed lines indicate the 25th, 50th, and 75th percentile values for age among people living with HIV. Source: Alameda County Public Health Department, 2018 (data from year-end 2017).
http://www.acphd.org/media/532487/hiv2018_ac.pdf

Ethnic Distribution of Youth Ages 13–29 Living with HIV in Alameda County



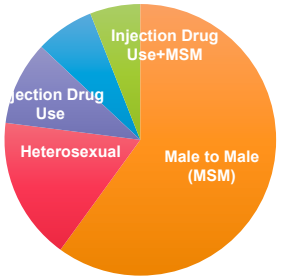
Source: Alameda County Public Health Department http://www.acphd.org/media/355858/alameda county hiv prevention plan.pdf

Linkage to HIV Care within 90 Days of Diagnosis, by Age, Alameda County



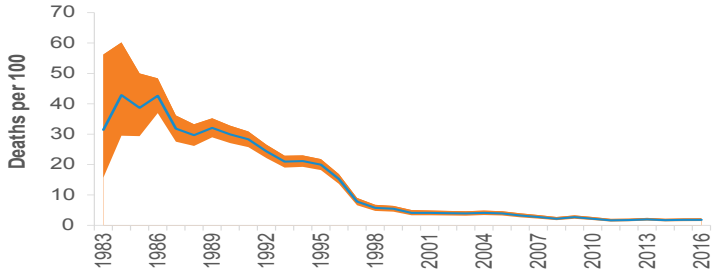
Source: Alameda County Public Health Department
http://www.acphd.org/media/532487/hiv2018_ac.pdf

Transmission Categories of Persons Living with HIV in Alameda County

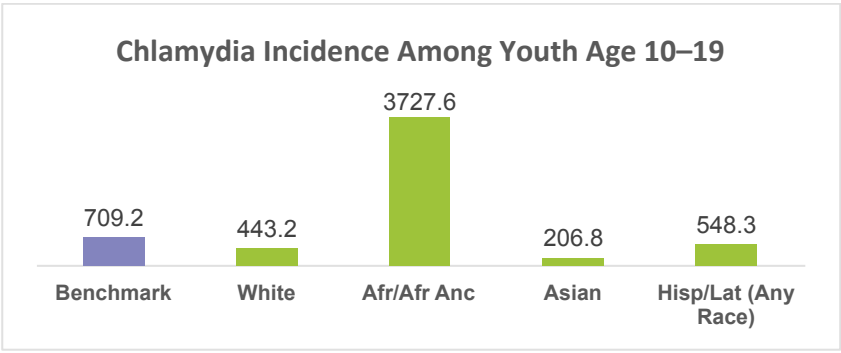


Source: [Oakland TGA Collaborative Community Planning Council & the Alameda County Office of AIDS Administration, Alameda County, California Comprehensive HIV Prevention Plan, 2014–2016].
http://www.acphd.org/media/355858/alameda%20county%20hiv%20prevention%20plan.pdf Page 13: "Transmission Categories of Persons Living with HIV in Alameda County."

Death Rates Among Residents Ever Diagnosed with AIDS, Alameda County



Deaths in people living with HIV without AIDS are not reported here. Source: Alameda County Public Health Department, 2018.
http://www.acphd.org/media/532487/hiv2018_ac.pdf Page 42: "Figure 3.9: Death Rate among Alameda County Residents Ever Diagnosed with AIDS, 1985–2016."



Rates are per 100,000 Alameda County youth age 10–19. Source: [California Department of Public Health, Alameda County's Health Status Profile for 2019, 2014].

TRENDS

Trend data are available on certain indicators.

- Influenza and Pneumonia Deaths[8]: Trending down since 2009.
- Kindergarteners with Required Immunizations[9]: Upward trend since 2013.
- Tuberculosis Incidence[8]: Generally trending down since 2010.
- Chlamydia Incidence Among Youth Age 10–19[9]: Trending down since 2010.
- Gonorrhea Incidence[9]: Generally trending up since 2009.
- Gonorrhea Incidence Among Youth Age 10–19[9]: Long-term trend mixed; flat since 2013.
- HIV Incidence[8]: Trend is mixed.
- Syphilis Incidence[8]: Trending up since 2009.

Race & Ethnicity

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

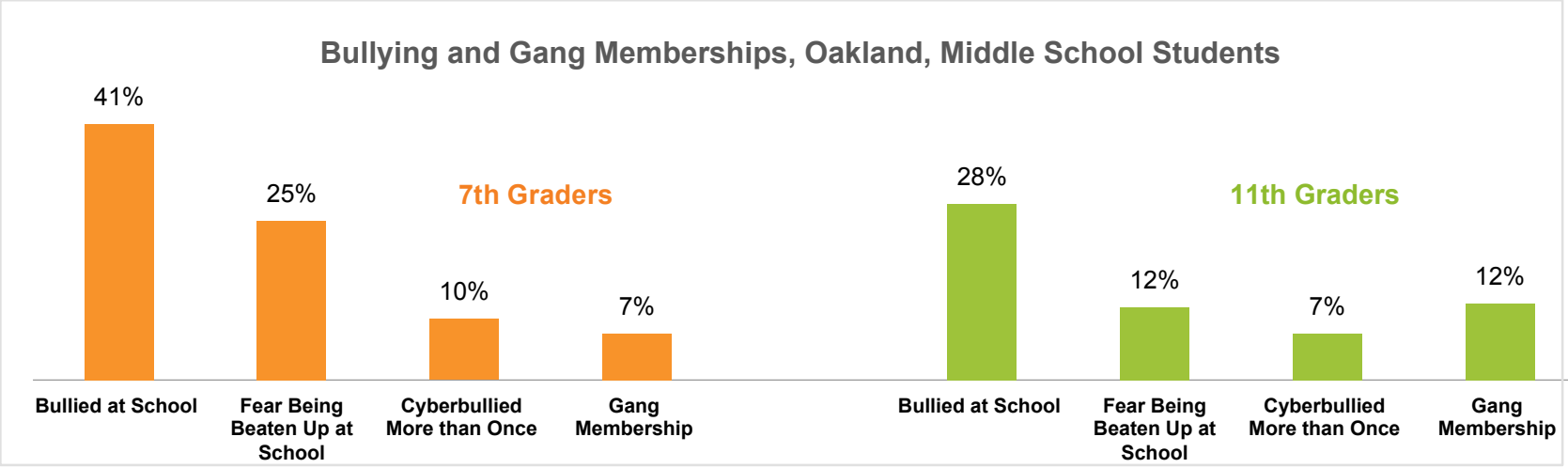
INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Chlamydia Incidence Among Youth Age 10–19[2]	709.2	443.2	3,727.6	206.8*					548.3
Gonorrhea Incidence Among Youth Age 10–19[2]	121.2	40.9	1,257.1	28.1*					84.0

Blank cells indicate that data were unavailable. * Indicates statistic is for Asian/Pacific Islander combined.

INTENTIONAL INJURY/CRIME

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Assault Injury ER Visits (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**422.2**	**--**	**322.6**	**30.9%**	**--**
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.24**	**1.7**	**1.1**	**17.0%**	**54.5%**
Built Environment-Long-Term Residential Vacancy (vacant for 2 or more years, by majority ethnicity census tracts)[6] (COEI)	2012–2017	percent	--	0.47%	--	--	--
Bullied at School, 7th Graders[4] (AC)	2011–2013	percent	**40.6%**	--	39.4%	3.0%	--
Bullied at School, 9th Graders[4] (AC)	2011–2013	percent	**35.2%**	--	34.4%	2.3%	--
Bullied at School, 11th Graders[4] (AC)	2011–2013	percent	**27.9%**	--	27.6%	1.1%	--
Cyberbullied More than Once, 7th Graders[4] (AC)	2011–2013	percent	**9.7%**	--	9.4%	3.2%	--
Cyberbullied More than Once, 9th Graders[4] (AC)	2011–2013	percent	12.1%	--	12.4%	2.4%	--
Cyberbullied More than Once, 11th Graders[4] (AC)	2011–2013	percent	11.5%	--	12.4%	7.3%	--
***Domestic Violence Hospitalizations, CA (per 100,000 females aged 10+)[5]**	**2013–2014**	**rate**	**5.6**	**5.7**	**4.9**	**14.3%**	**16.3%**
Fear Being Beaten Up at School, 7th Graders[4] (AC)	2011–2013	percent	25.2%	--	24.7%	2.0%	--
Fear Being Beaten Up at School, 9th Graders[4] (AC)	2011–2013	percent	18.4%	--	17.9%	2.8%	--
Fear Being Beaten Up at School, 11th Graders[4] (AC)	2011–2013	percent	**12.1%**	--	--	1.7%	--
***Firearm Assault Injury Hospitalization Rate, Ages 15-19[9] (AC)**	**2014**	**rate**	**34.4**	**--**	**14.5**	**137.2%**	**--**
***Firearm Assault Injury Hospitalization Rate, Ages 20-24[9] (AC)**	**2014**	**rate**	**42.1**	**--**	**16.2**	**159.9%**	**--**
***Firearm Fatalities (per 100,000 population)[7] (AC)**	**2012–2016**	**rate**	**9.0**	**--**	**8.0**	**12.5%**	**--**
Gang Membership, 11th Graders[4] (AC)	2011–2013	percent	7.4%	--	7.5%	1.3%	--
Gang Membership, 7th Graders[4] (AC)	2011–2013	percent	7.4%	--	8.1%	8.6%	--
Gang Membership, 9th Graders[4] (AC)	2011–2013	percent	**7.6%**	--	7.5%	1.3%	--
***Homicide (per 100,000 population)[7] (AC)**	**2010–2016**	**rate**	**8.0**	**--**	**5.0**	**60.0%**	**--**
Injury Deaths (per 100,000 population)[5]	2011–2015	rate	42.8	42.8	46.6	8.2%	8.2%
***Jail Admissions (annually per 100,000 residents aged 15-64)[11] (AC)**	**2015**	**rate**	**4,356.6**	**--**	**3,805.9**	**14.5%**	**--**
Jail Incarceration (per 100,000 residents aged 15-64)[11] (AC)	2015	rate	199.9	--	278.9	28.3%	--
***Juvenile Felony Arrests (per 1,000 youth aged 10-17)[9] (AC)**	**2015**	**rate**	**5.6**	**--**	**5.3**	**5.7%**	**--**
Law Enforcement-Use of Force (per 100,000 people)[6]	2016–2017	rate	--	84.1	--	--	--

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
(COEI)							
Prison incarceration (per 100,000 residents aged 15-64)[11] (AC)	2013	rate	331.3	--	--	--	--
***School Perceived as Unsafe/Very Unsafe, 11th Graders[4] (AC)**	**2011–2013**	**percent**	**7.3%**	**--**	**6.5%**	**12.3%**	**--**
School Perceived as Unsafe/Very Unsafe, 7th Graders[4] (AC)	2011–2013	percent	8.4%	--	9.3%	9.7%	--
School Perceived as Unsafe/Very Unsafe, 9th Graders[4] (AC)	2011–2013	percent	**8.0%**	--	7.7%	3.9%	--
Substantiated Child Abuse and Neglect (per 1,000 children under age 18)[9] (AC)	2015	rate	2.8	--	8.2	65.9%	--
***Traumatic Injury Hospitalizations, Children Age 0-17 (percentage of all child discharges, excluding newborns)[9] (AC)**	**2015**	**percent**	**1.6%**	**--**	**1.1%**	**45.5%**	**--**
***Violent Crimes (per 100,000 population)[5]**	**2012–2014**	**rate**	**720.3**	**716.8**	**402.7**	**78.9%**	**78.0%**



Source: [WestEd for the California Department of Education, Query California School Climate, Health, and Learning Surveys, 2011–2013]

TRENDS

Trend data are available on certain indicators.

- Assault Injury ER Visits[8]: Trending down since 2010.
- Juvenile Felony Arrest Rate[9]: Trending down since 2007.
- Prison Incarceration Rate[11]: Trending down since 1998.
- Substantiated Child Abuse and Neglect[9]: Generally trending down since 2001.
- Traumatic Injury Hospitalizations, Children Age 0–17[9]: Trend is mixed.

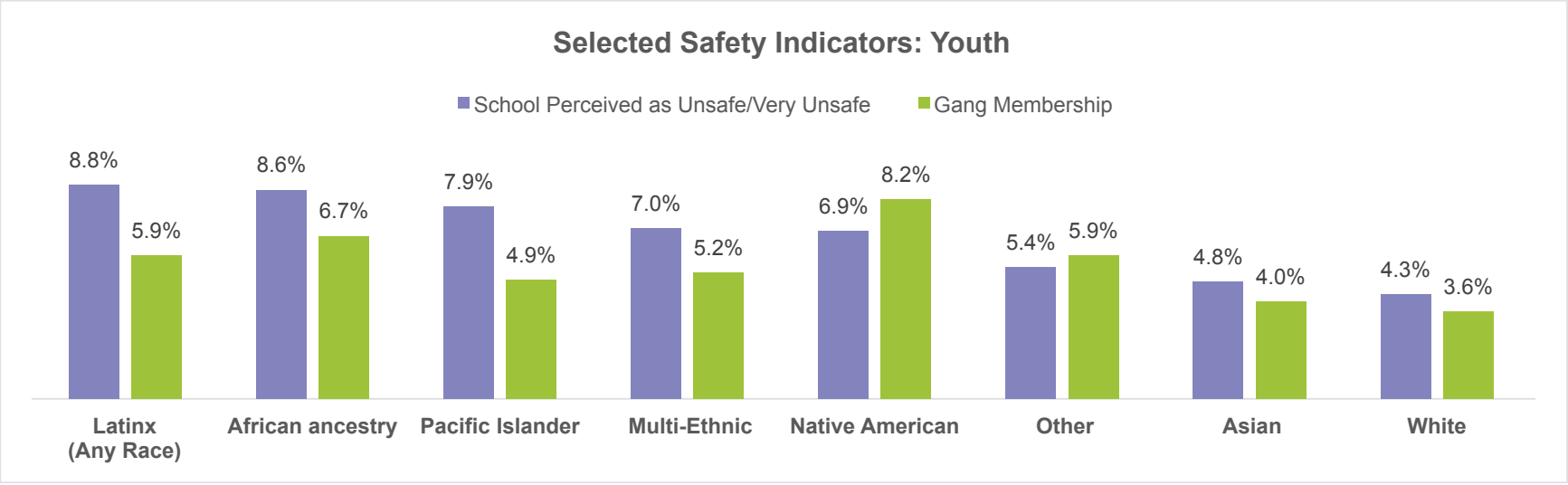
Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Built Environment-Long-Term Residential Vacancy (vacant for 2 or more years, by majority ethnicity census tracts)[6] (Oak)◦	0.47%	0.39%	**0.88%**	**0.66%**				**0.52%**	0.27%
Bullied at School[4]	#	37.5%	38.5%	33.0%	**46.4%**	**45.6%**	**37.8%**	**40.5%**	37.3%
Community Stressors- Domestic Violence (per 100,000 people)[6] (Oak)◦	n/a	321.8	**2,111.8**	223.6					**835.4**
Community Stressors- Homicide (per 100,000 people)[6] (Oak)◦	n/a	3.4	**55.7**	1.5					**10.9**
Community Stressors- Juvenile Felony Arrests (per 100,000)[6] (Oak)◦	n/a	17.5	**1,971.0**	**30.1**					**370.5**
Fear Being Beaten Up at School[4]	#	11.8%	11.1%	**12.3%**	**19.0%**	**18.8%**	**15.9%**	**15.7%**	**17.0%**
Gang Membership[4]	#	3.6%	**6.7%**	**4.0%**	**4.9%**	**8.2%**	**5.9%**	**5.2%**	**5.9%**

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Juvenile Felony Arrest Rate (per 1,000 youth aged 10-17)[9]	5.3	2.3	**25.0**				1.2		**5.4**
Law Enforcement-Use of Force (per 100,000 people)[6] (Oak)°	84.1	10.3	**244.4**	14.8					70.2
School Perceived as Unsafe/Very Unsafe[4]	#	4.3%	**8.6%**	**4.8%**	**7.9%**	**6.9%**	**5.4%**	**7.0%**	**8.8%**
Substantiated Child Abuse and Neglect (per 100,000 children under age 18)[9]	8.2	2.0	**10.3**	0.8*					2.8

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.
* Indicates statistic is for Asian/Pacific Islander combined.



Source: California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). 2011–2013.

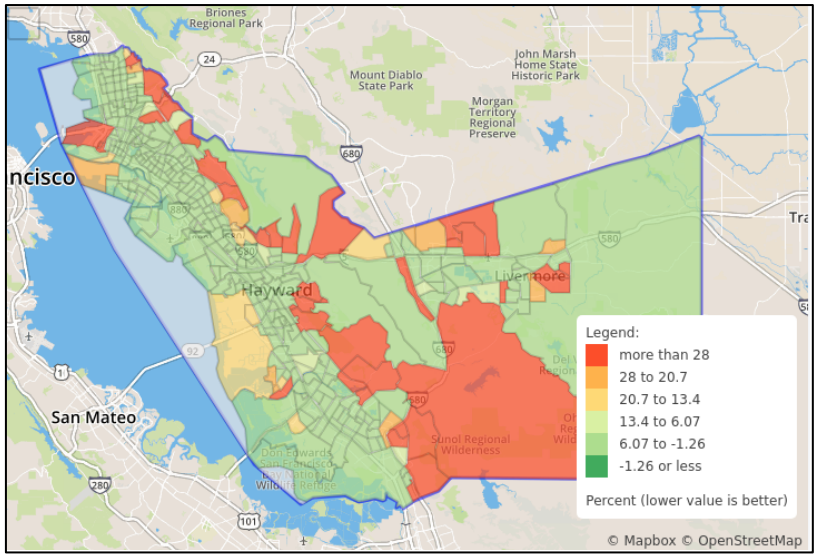
DIET, NUTRITION, AND FOOD ACCESS

16% of all children in Alameda County experience food insecurity at some point during the year.

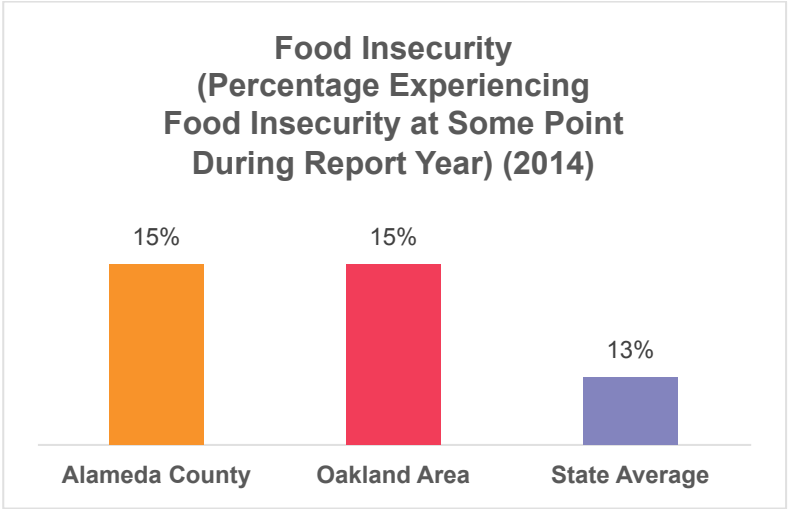
INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Adequate Fruit & Vegetable Consumption, Children Age 2-11[9] (AC)	2013–2014	percent	34.9%	--	32.0%	9.1%	--
Adequate Fruit & Vegetable Consumption, Children Age 12-17[9] (AC)	2013–2014	percent	30.5%	--	22.4%	36.2%	--
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.2**	**1.7**	**1.1**	**9.1%**	**54.5%**
Children Drinking ≥ 1 Sugar-Sweetened Beverage Daily[3] (AC)	2015–2016	percent	18.8%	--	40.4%	53.5%	--
Diabetes Deaths (per 100,000 population)[2] (AC)	2014–2016	rate	19.9	--	20.7	3.9%	--
Diabetes Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	879.6	--	1,017.7	13.6%	--
***Diabetes Hospitalizations, Children Age 0-17 (percentage of all child discharges, excluding newborns)[9] (AC)**	**2015**	**percent**	**1.6%**	**--**	**1.4%**	**14.3%**	**--**
Did Not Eat Breakfast, 7th Graders[4] (AC)	2011–2013	percent	30.5%	--	34.0%	10.3%	--
Did Not Eat Breakfast, 9th Graders[4] (AC)	2011–2013	percent	35.7%	--	38.3%	6.8%	--
Did Not Eat Breakfast, 11th Graders[4] (AC)	2011–2013	percent	37.5%	--	39.4%	4.8%	--
Food Environment Index (range is 1-10, measuring affordable, close, and nutritious food retailers)[5]	2014	number	**7.7**	**7.7**	7.8	1.3%	1.3%
***Food Insecure Children Ineligible for Assistance[8] (AC)**	**2016**	**percent**	**41%**	**--**	**33%**	**24.2%**	**--**
***Food Insecurity (percentage experiencing food insecurity at some point during report year)[5]**	**2014**	**percent**	**14.9%**	**14.9%**	**13.4%**	**11.2%**	**11.2%**
Food Insecurity, Child (percentage experiencing food insecurity at some point during report year[8] (AC)	2016	percent	15.9%	--	19.0%	16.3%	--
Free and Reduced Price Lunch[5]	2015–2016	percent	44.3%	52.4%	58.9%	24.8%	11.0%
Grocery Stores and Produce Vendors (per 10,000 population)[5]	2012–2015	rate	2.6	3.5	2.4	8.3%	45.8%
Heart Disease Deaths (per 100,000 population)[5]	2011–2015	rate	71.8	71.8	99.5	27.8%	27.8%
Lack of Healthy Food Stores[5]	2014	percent	7.6%	4.8%	13.4%	43.3%	64.2%
Obesity (Adult)[5]	2015	percent	21.2%	20.7%	26.5%	20.0%	21.9%

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Obesity (Youth) (children in grades 5, 7, and 9)[5]	2016–2017	percent	15.9%	16.4%	20.1%	20.9%	18.4%
Obesity Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	367.3	--	396.8	7.4%	--
SNAP Benefits[5]	2012–2016	percent	7.2%	7.6%	9.4%	23.4%	19.1%
SNAP Benefits – Households with Children[8] (AC)	2012–2016	percent	64.4%	--	69.8%	--	--
Stroke Deaths (per 100,000 population)[5]	2011–2015	rate	**36.4**	**36.4**	35.4	2.8%	2.8%
Youth Fruit Consumption[3] (AC)	2014–2015	percent	70.4%	--	64.3%	9.5%	--

Low Access to Healthy Food Stores, Alameda County



Percentage of the population that does not live in relatively close proximity to a supermarket or large grocery store, by census tract, compared to state average. Source: U.S. Census Bureau, American Community Survey, 2012–2016.



All ages experiencing food insecurity. Source: [Kaiser Permanente, Community Health Needs Assessment, 2014].

TRENDS

Trend data are available on certain indicators.

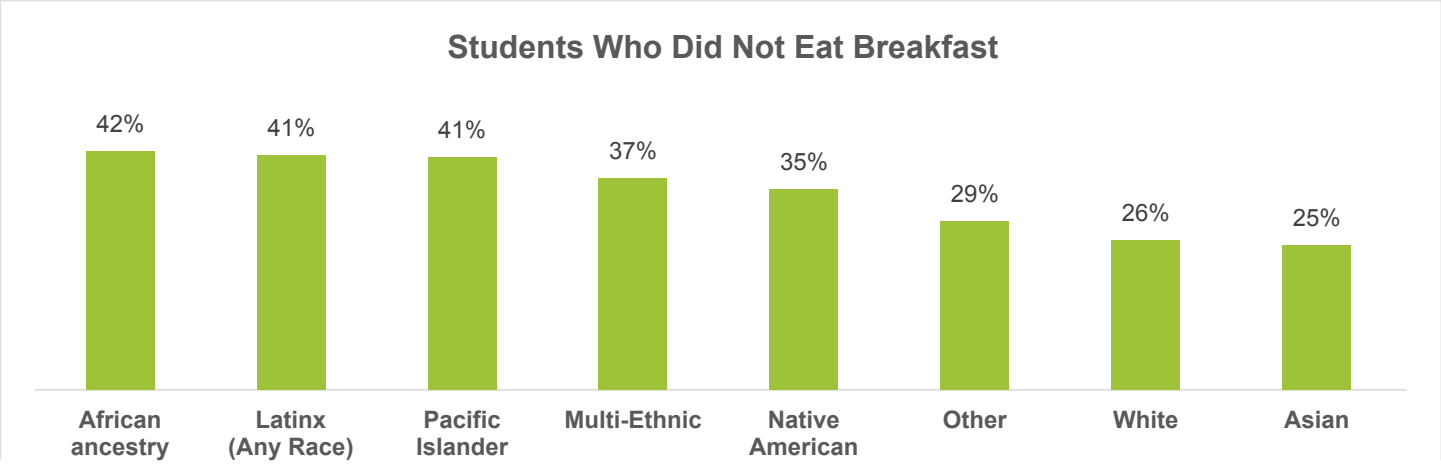
- Diabetes Deaths[2]: Trending down since 2012.
- Diabetes Hospitalizations[8]: Trending down since 2010.
- Diabetes Hospitalizations, Children Age 0–17[9]: Long-term trend mixed, trending up since 2011.
- Fast Food Consumption[3]: Long-term trend mixed, trending up since 2014.
- Food Insecure Children Ineligible for Assistance[8]: Generally trending down since 2012.
- Food Insecurity, Child[8]: Trending down since 2013.
- Obesity-Related Hospitalizations[8]: Trending up since 2009.
- Youth Fruit Consumption[3]: Generally trending up since 2012.

Race & Ethnicity

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

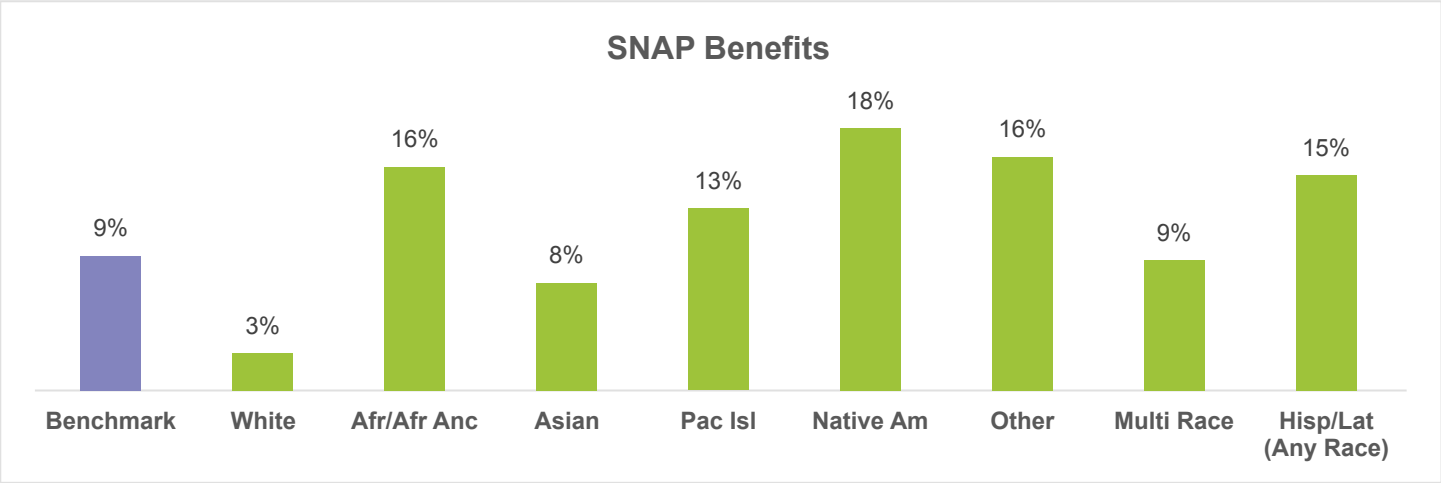
INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Did Not Eat Breakfast[4]	#	26.0%	**41.6%**	25.2%	**40.5%**	**34.9%**	**29.4%**	**36.8%**	**40.8%**
Heart Disease Deaths[5]	99.5	80.9	97.5	48.2		50.3			56.1
Obesity (Adult)[5]	26.5%	19.8%	**35.4%**	10.0%					**30.0%**
Obesity (Youth)[5]	20.1%	9.4%	**22.3%**	7.6%	**38.2%**	15.6%	14.7%†	8.8%	**24.5%**
SNAP Benefits[5]	9.4%	2.8%	**16.7%**	4.3%	**15.0%**	**15.0%**	**14.1%**	**9.7%**	**14.3%**
Stroke Deaths[5]	35.4	35.1	**52.5**	31.3					33.0

Blank cells indicate that 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 population.

Source: California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). 2011–2013.



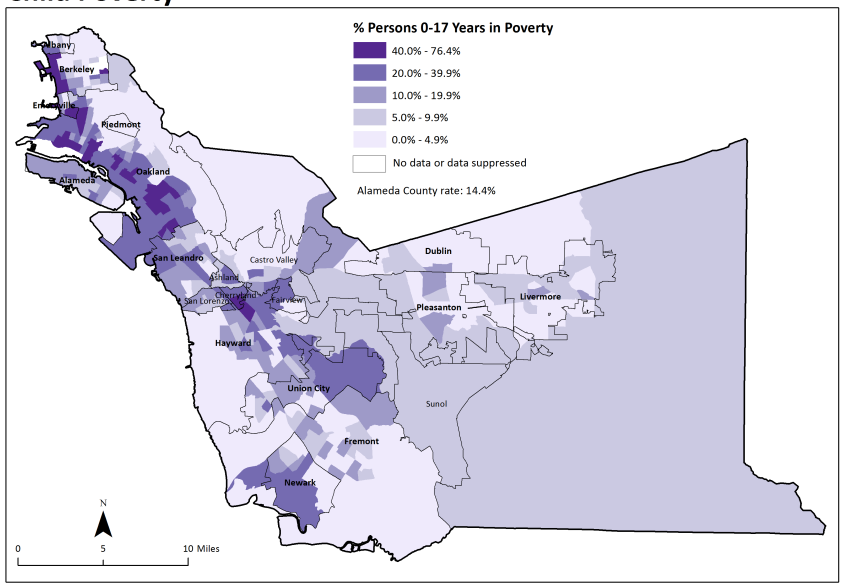
Households receiving SNAP benefits. Source: [Kaiser Permanente, Community Health Needs Assessment, 2014].

ECONOMIC SECURITY

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Banking Institutions (per 10,000 population)[5]	2012– 2015	rate	2.7	2.9	2.7	0.0%	7.4%
Childcare Availability (Licensed)[9] (AC)	2015	percent	31%	--	25.0%	24.0%	--
Children Below 100% FPL[5]	2012–2016	percent	14.4%	18.8%	21.9%	34.2%	14.2%
Children in Single-Parent Households[5]	2012–2016	percent	27.1%	31.8%	31.8%	14.8%	0.0%
Children without Secure Parental Employment[9] (AC)	2014	percent	27.8%	--	32.8%	15.2%	--
Cost Burdened Households[5]	2012–2016	percent	39.5%	41.7%	42.8%	7.7%	2.6%
***Cost of Infant Childcare, Annually, Child Care Center[9] (AC)**	**2014**	**dollars**	**15,435**	--	**13,327**	**15.8%**	--
***Cost of Preschool Childcare, Annually, Child Care Center[9] (AC)**	**2014**	**dollars**	**11,113**	--	**9,106**	**22.0%**	--
Free and Reduced Price Lunch[5]	2015–2016	percent	44.3%	52.4%	58.9%	24.8%	11.0%
High Speed Internet[5]	2016	percent	99.5%	98.9%	95.4%	4.3%	3.7%
Income Inequality - 80/20 Ratio[5]	2012–2016	number	**5.3**	4.2	5.1	3.9%	17.6%
Median Household Income[5]	2012–2016	dollars	79,831	79,831	65,812	21.3%	21.3%
Medicaid/Public Insurance Enrollment[5,8]	2012–2016	percent	22.1%[8]	18.9%	21.8%	1.4%	13.3%
Opportunity Index (range is 0–100)[5]	2017	number	58.4	58.5	51.9	12.5%	12.7%
***Population Below 100% FPL[5]**	**2012–2016**	**percent**	12.0%	**16.6%**	**15.8%**	**24.1%**	**5.1%**
SNAP Benefits[5]	2012–2016	percent	7.2%	7.6%	9.4%	23.4%	19.1%
SNAP Benefits – Households with Children[8] (AC)	2012–2016	percent	64.4%	--	69.8%	7.7%	--
Unemployment (population aged 16+ years)[5]	2018	percent	2.9%	2.9%	4.0%	27.5%	27.5%
Uninsured Children[5]	2012–2016	percent	8.9%	3.5%	10.4%	14.4%	66.3%
Uninsured Population[5]	2012–2016	percent	8.4%	9.0%	12.6%	33.3%	28.6%
Young People Not in School and Not Working (ages 16 to 19)[5,8]	2012–2016	percent	1.9%[8]	5.6%	7.7%	17.4%	27.3%

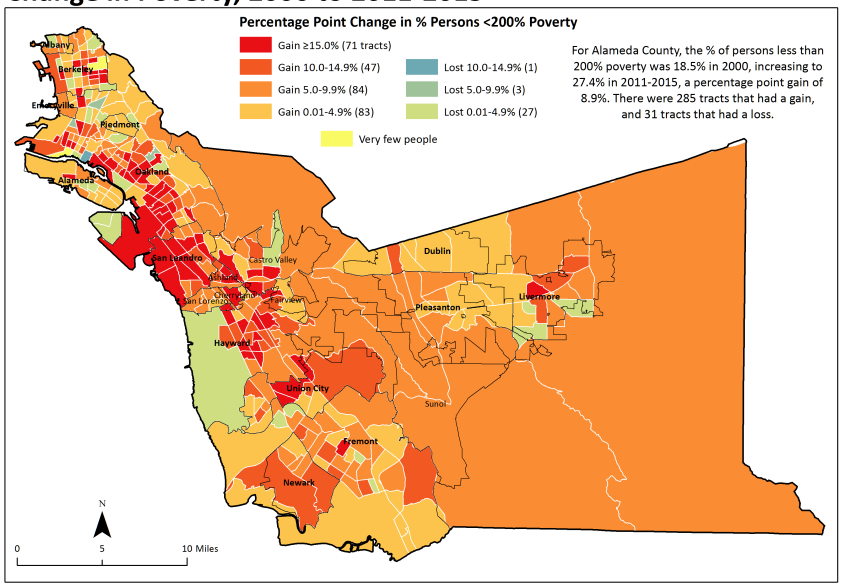
Poverty, Alameda County

Child Poverty



Source: CAPE, with data from American Community Survey 2016 5-year files.

Change in Poverty, 2000 to 2011-2015



Source: CAPE, with data from Census 2000 and American Community Survey 2015 five-year files.

Maps source: Alameda County Public Health Department, 2018.
http://www.acphd.org/media/500113/mapset2018.pdf Page 11: "Child Poverty."
http://www.acphd.org/media/500604/health,%20housing%20in%20oakland.pdf Page 26: "Figure 10: Change in Poverty, 2000 to 2011–2015, Alameda County."

TRENDS

Trend data are available on certain indicator.

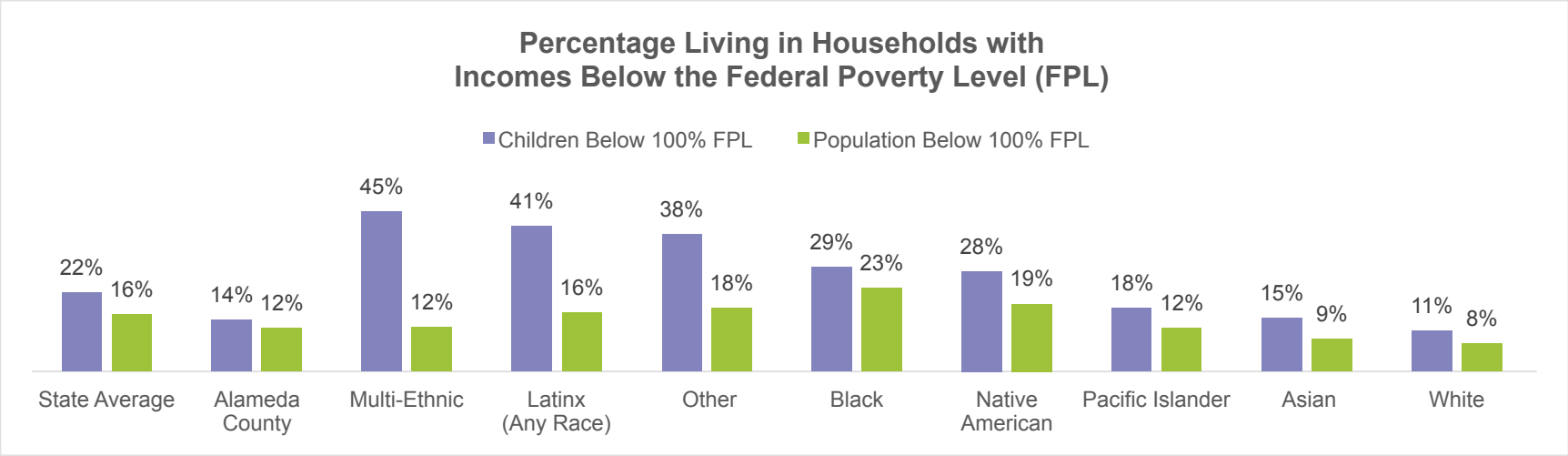
- Childcare Availability (Licensed)[9]: Relatively flat since 2000.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Access to a Car Lacking[6] (Oak)°	10.2%	6.1%	**18.7%**	10.0%			**14.2%**		7.6%
Children Below 100% FPL[5]	21.9%	11.4%	**29.0%**	14.9%	17.7%	**27.8%**	**38.0%**	**44.5%**	**40.5%**
Median Household Income ($)	65,812	95,331	**42,642**	101,544	73,467	**56,427**	**60,493**	71,043	**60,819**
Population Below 100% FPL[5]	15.8%	7.7%	**23.2%**	9.1%	12.1%	**18.8%**	**17.6%**	12.3%	**16.4%**
SNAP Benefits[5]	9.4%	2.8%	**16.7%**	4.3%	**15.0%**	**15.0%**	**14.1%**	**9.7%**	**14.3%**
Uninsured Children[5]	10.4%	2.0%	3.5%	2.0%	6.5%	4.2%	6.5%	3.2%	5.7%
Uninsured Population[5]	12.6%	4.7%	9.6%	6.3%	12.2%	**14.9%**	**17.8%**	7.5%	**15.6%**

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.

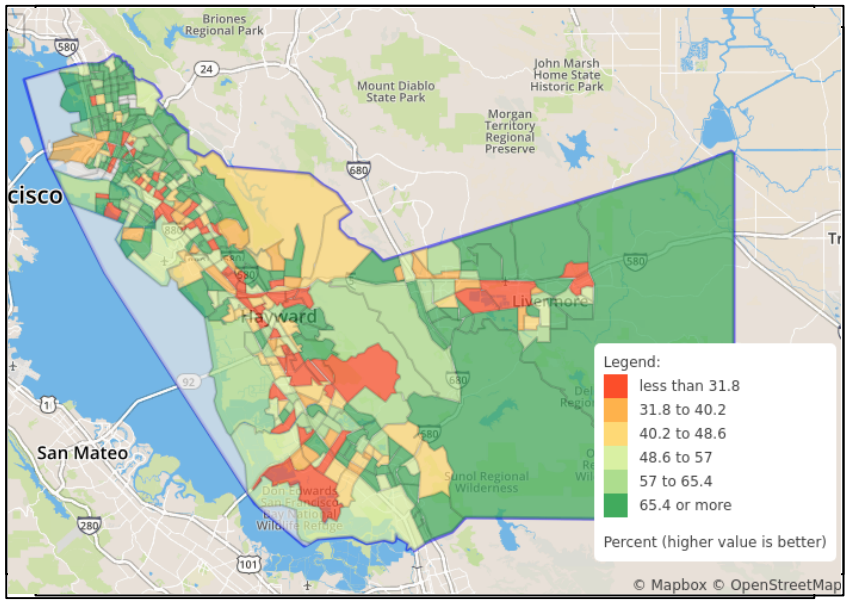


Source: U.S. Census Bureau, American Community Survey. 2012–2016.

EDUCATION AND LITERACY

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY VALUE	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Children in Linguistically Isolated Households[9] (AC)**	**2016**	**percent**	**11.5%**	**--**	**10.5%**	**9.5%**	**--**
Children in Single-Parent Households[5]	2012–2016	percent	27.1%	31.8%	31.8%	14.8%	0.0%
***Cost of Preschool Childcare, Annually, Child Care Center[9] (AC)**	**2014**	**dollars**	**11,113**	**--**	**9,106**	**22.0%**	**--**
***Expulsions, CA (per 100 enrolled students)[5]**	**2016–2017**	**rate**	0.06	**0.09**	**0.08**	25.0%	**12.5%**
High School Dropout (Adjusted)[9] (AC)	2015	percent	9.6%	--	10.7%	10.3%	--
High School Graduates Completing College Prep Courses[9] (AC)	2015	percent	54.5%	--	43.4%	25.6%	--
High Speed Internet[5]	2016	percent	99.5%	98.9%	95.4%	4.3%	3.7%
***Juvenile Felony Arrests (per 1,000 youth aged 10–17)[9] (AC)**	**2015**	**rate**	**5.6**	**--**	**5.3**	**5.7%**	**--**
***On-Time High School Graduation, CA[5]**	**2014–2015**	**percent**	85.0%	**77.2%**	**82.9%**	2.5%	**6.9%**
Passed High School Exit Exam, English[8] (AC)	2014–2015	percent	86.0%	--	85.0%	1.2%	--
Passed High School Exit Exam, Math[8] (AC)	2014–2015	percent	86.0%	--	85.0%	1.2%	--
Preschool Enrollment (population aged 3–4)[5]	2012–2016	percent	56.9%	65.4%	48.6%	17.1%	34.6%
Proficient in English/Language Arts—11th Graders[8] (AC)	2018	percent	64.0%	--	59.0%	8.5%	--
Proficient in Math—11th Graders[8] (AC)	2018	percent	43.0%	--	32.0%	34.4%	--
Reading at or Above Proficiency (grade 4)[5]	2014–2015	percent	50.0%	44.0%	43.9%	13.9%	0.2%
Student/Teacher Ratio[8] (AC)	2015–2016	number	23.0	--	23.7	3.0%	--
***Students per Academic Counselor[9] (AC)**	**2015**	**number**	**827**	**--**	**792**	4.4%	**--**
Suspensions, CA (per 100 enrolled students)[5]	2016–2017	rate	5.3	4.9	5.9	10.2%	16.9%
Teen Births (per 1,000 females aged 15–19)[5]	2008–2014	rate	19.6	19.6	29.3	33.1%	33.1%
Truancy (per 100 K–12 students)[9] (AC)	2015	rate	27.7	--	31.4	11.8%	--

Preschool Enrollment, Alameda County



Percentage of the population ages 3–4 years that is enrolled in preschool, by census tract, compared to the state average. Source: U.S. Census Bureau, American Community Survey, 2012–2016.

TRENDS

Trend data are available on certain indicators.

- Children in Linguistically Isolated Households[9]: Generally trending down since 2007.
- High School Dropout (Adjusted)[9]: Downward trend since 2010.
- High School Graduates Completing College Prep Courses[9]: Trending up since 1998.
- Passed High School Exit Exam, English[8]: Generally trending up since 2010.
- Passed High School Exit Exam, Math[8]: Trending up since 2010.
- Student/Teacher Ratio[8]: Trending up (worse) since 2008.
- Students Per Academic Counselor[9]: Trending down since 2013.
- Teen Births[9]: Generally trending down since 1995.
- Truancy[9]: Generally trending down since 2012.

Race & Ethnicity

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

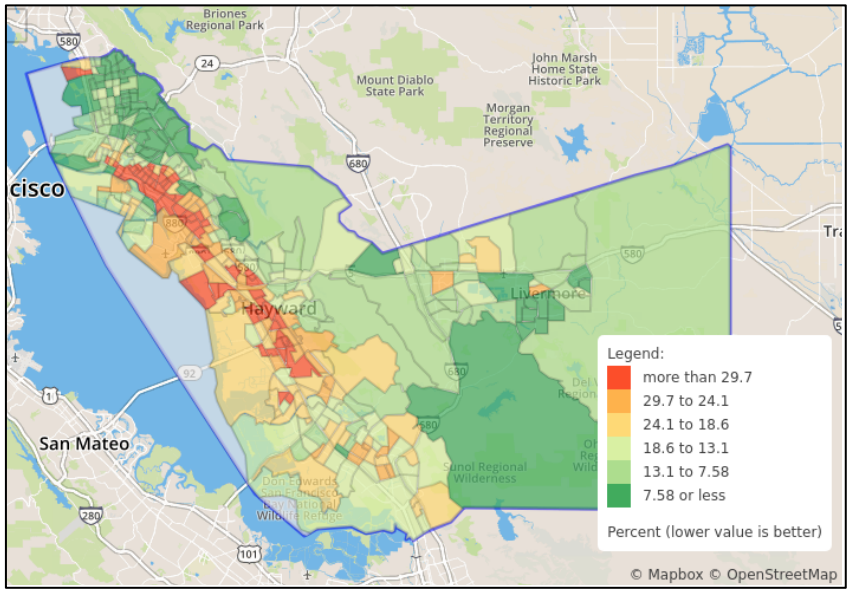
INDICATORS	BENCHMARK	WHITE	AFR ANC	AFR / AFR ANC & LATINO PRE DOMINANT	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
AP Course Enrollment (percentage of students never taking a single AP course throughout high school)[6] (Oak)°	n/a	29.6%	**73.7%**		**35.9%**					**58.1%**
Chronic Absenteeism[6] (Oak)°	n/a	5.6%	**22.2%**		5.2%					**12.6%**
High School Dropout (Adjusted)[9]	10.7%	5.8%	**18.3%**		3.9%	**13.6%**		3.6%†	7.4%	**13.5%**
High School Graduates Completing College Prep Courses[9]	43.4%	58.8%	**36.1%**		74.9%	**39.7%**	50.0%	56.8%†	56.3%	**42.5%**
Passed High School Exit Exam, English[8]	85%	94%	**74%**		93%	**80%**	**82%**	91%†	87%	**79%**
Passed High School Exit Exam, Math[8]	85%	95%	**69%**		96%	**77%**	**77%**	93%†	89%	**78%**
Teacher Experience (average percentage of teachers in their first five years of teaching, by majority ethnicity in student body)[6] (Oak)°	n/a	29.9%	**38.3%**	**48.9%**	20.3%				**32.5%**	**42.9%**
Teacher Turnover (average teacher turnover, by majority ethnicity in student body)[6] (Oak)°	n/a	10.2%	**38.3%**	**26.9%**	**14.6%**				**20.1%**	**34.5%**
Teen Births[9]	23.2	4.7	**28.3**		2.2*				11.4	**25.3**
Third-Grade ELA, Below Proficiency (percentage of students not meeting standard)[6] (Oak)°	n/a	11.9%	**60.9%**		**31.1%**					**61.6%**

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.
* Indicates statistic is for Asian/Pacific Islander combined.
† Indicates statistic is for Filipino.

HEALTH CARE ACCESS AND DELIVERY

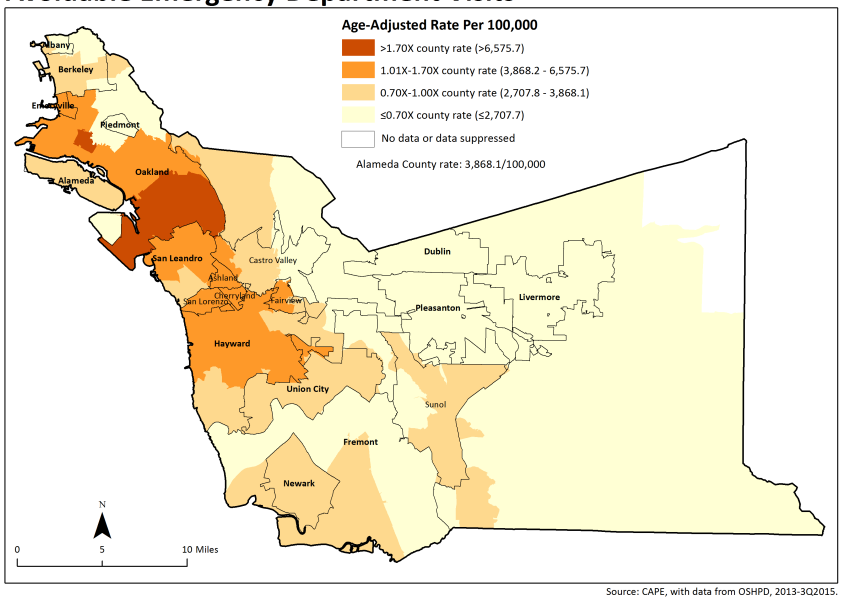
INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Access to a Car Lacking[6] (COEI)	2016	percent	--	10.2%	--	--	--
Acute Preventable Hospitalizations (per 100,000 population)[8] (AC)	2009–2011	rate	447.7	--	500.6	10.6%	--
Avoidable ER Visits (per 100,000 population)[8] (AC)	2012–2014	rate	3,740.6	--	3,950.2	5.3%	--
Chronic Preventable Hospitalizations (per 100,000 population)[8] (AC)	2009–2011	rate	**787.5**	--	787.0	0.1%	--
***Delayed/Did Not Receive 'Other Medical' Care[8] (AC)**	**2015–2016**	**percent**	**8.3%**	--	**4.2% (HP)**	**97.6%**	--
Dentists (per 100,000 population)[5]	2015	rate	89.4	89.4	80.3	11.3%	11.3%
Federally Qualified Health Centers (per 100,000 population)[5]	2018	rate	3.0	4.7	2.5	20.0%	88.0%
***Have Usual Source of Healthcare[3] (AC)**	**2015–2016**	**percent**	**87.5%**	--	**95.0% (HP)**	**7.9%**	--
Limited English Proficiency (AC)	2012–2016	**percent**	**18.4%**	--	**18.6%**		--
Medicaid/Public Insurance Enrollment[5,8]	2012–2016	percent	22.1%[8]	18.89%	21.8%	1.4%	13.3%
Mental Health Providers (per 100,000 population)[5]	2016	rate	515.5	513.4	288.7	78.6%	77.8%
***Non-Physician PCPs (per 100,000 population)[8] (AC)**	**2017**	**rate**	**47**	--	**52**	**9.6%**	--
***Premature Death, Racial/Ethnic Disparity Index[5]**	**2004–2010**	**number**	**50.2**	**50.1**	**36.8**	**36.4%**	**36.1%**
Preventable Hospital Events (per 1,000 population)[5]	2015	rate	33.1	33.1	35.9	7.8%	7.8%
Primary Care Physicians (per 100,000 population)[5]	2014	rate	106.8	106.8	78.1	36.7%	36.7%
Recent Dental Exam (Youth) (ages 2–11)[3]	2014	percent	89%	88.9%	86.7%	2.7%	2.5%
***Students per School Nurse[9] (AC)**	**2015**	**number**	**5,442**	--	**2,784**	**95.5%**	--
Students per School Psychologist[9] (AC)	2015	number	1,233	--	1,265	2.5%	--
***Students per School Speech/Language/Hearing Specialist[9] (AC)**	**2015**	**number**	**1,466**	--	**1,263**	**16.1%**	--
Uninsured Children[5]	2012–2016	percent	8.9%	3.5%	10.4%	14.4%	66.3%
Uninsured Population[5]	2012–2016	percent	8.4%	9.0%	12.6%	33.3%	28.6%

Linguistic Isolation, Alameda County



Percentage of the population ages 5 years and older that is considered linguistically isolated (speaks a language other than English at home and speaks English less than "very well"), by census tract, compared to the state average. Source: U.S. Census Bureau, American Community Survey, 2012-2016.

Avoidable Emergency Department Visits



Map source: Alameda County Public Health Department, 2018. http://www.acphd.org/media/500113/mapset2018.pdf Page 41: "Avoidable Emergency Department Visits."

TRENDS

Trend data are available on certain indicators.

- Avoidable ER Visits[8]: Trending up since 2010.
- Children with Health Insurance[8]: Trending up since 2013.
- Have Usual Source of Healthcare[3]: Generally trending down since 2005.
- Non-Physician PCPs[8]: Trending up since 2013.
- Students per School Nurse[9]: Generally trending down since 2012.
- Students per School Psychologist[9]: Trending down since 2012.
- Students per School Speech/Language/Hearing Specialist[9]: Trending down since 2012.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Access to a Car Lacking[6] (Oak)°	10.2%	6.1%	**18.7%**	10.0%			**14.2%**		7.6%
Acute Preventable Hospitalizations (per 100,000 population)[8]	500.6	489.4	**681.5**	274.3*		299.0			370.8
Chronic Preventable Hospitalizations (per 100,000 population)[8]	787.0	673.8	**2,055.1**	425.2*		684.6			632.2
Preventable Hospital Events (per 1,000 population)[5]	35.9	30.8	**53.5**						
Uninsured Children[5]	10.4%	2.0%	3.5%	2.0%	6.5%	4.2%	6.5%	3.2%	5.7%
Uninsured Population[5]	12.6%	4.7%	9.6%	6.3%	12.2%	**14.9%**	**17.8%**	7.5%	**15.6%**

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state. *Indicates statistic is for Asian/Pacific Islander combined.

HEART DISEASE/STROKE

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Congestive Heart Failure Hospitalizations (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**195.9**	--	**174.1**	**12.5%**	--
Exercise Opportunities (percentage of population living in close proximity to a park or recreational facility)[5]	2010, 2014	percent	99.7%	99.7%	93.6%	6.5%	6.5%
Heart Disease Deaths (per 100,000 population)[5]	2011–2015	rate	71.8	71.8	99.5	27.8%	27.8%
Hypertension Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	986.4	--	1,234.8	20.1%	--
Obesity (Adult)[5]	2015	percent	21.2%	20.7%	26.5%	20.0%	21.9%
Obesity (Youth) (children in grades 5, 7, and 9)[5]	2016–2017	percent	15.9%	16.4%	20.1%	20.9%	18.4%
Obesity Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	367.3	--	396.8	7.4%	--
Physical Inactivity (Youth) (grades 5, 7, and 9)[5]	2016–2017	percent	32.9%	**38.0%**	37.8%	13.0%	0.5%
Stroke Deaths (per 100,000 population)[5]	2011–2015	rate	**36.4**	**36.4**	35.4	2.8%	2.8%
Walkable Destinations (percentage of population living within close proximity to park, playground, library, museum, or other destination of interest)[5]	2012–2015	percent	56.5%	56.4%	29.0%	94.8%	94.5%

TRENDS

Trend data are available on certain indicator.

- Congestive Heart Failure Hospitalizations[8]: Generally trending down since 2009.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Heart Disease Deaths[5]	99.5	80.9	97.5	48.2		50.3			56.1
Obesity (Adult)[5]	26.5%	19.8%	**35.4%**	10.0%					**30.0%**
Obesity (Youth)[5]	20.1%	9.4%	**22.3%**	7.6%	**38.2%**	15.6%	14.7%†	8.8%	**24.5%**
Physical Inactivity (Youth)[5]	37.8%	21.6%	**48.6%**	20.0%	**51.3%**	35.5%	30.0%†	27.4%	**44.1%**
Stroke Deaths[5]	35.4	35.1	**52.5**	31.3					33.0

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

HOUSING AND HOMELESSNESS

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Asthma Diagnoses, Children Age 1–17[9] (AC)**	**2015**	**percent**	**20.1%**	**--**	**15.2%**	**32.2%**	**--**
***Asthma Hospitalizations, Children Age 0–4 (per 10,000 population)[9] (AC)**	**2016**	**rate**	36.9	**--**	**19.6**	**88.3%**	**--**
***Asthma Hospitalizations, Children/Youth Age 5–17 (per 10,000 population)[9] (AC)**	**2016**	**rate**	12.7	**--**	**7.7**	**64.9%**	**--**
Banking Institutions (per 10,000 population)[5]	2012–2015	rate	2.7	2.9	2.7	0.0%	7.4%
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.24**	**1.7**	**1.1**	**17.0%**	**54.5%**
Built Environment-Long-Term Residential Vacancy (vacant for 2 or more years, by majority ethnicity census tracts)[6] (COEI)	2012–2017	percent	**--**	0.47%	--	--	--
Children Living in Crowded Households[9] (AC)	2014	percent	23.5%	**--**	28.2%	16.7%	**--**
Cost Burdened Households[5]	2012–2016	percent	39.5%	41.7%	42.8%	7.7%	2.6%
***Elevated Blood Lead Levels in Children Age 0–5[2] (AC)**	**2013**	**percent**	**0.3%**	**--**	**0.2%**	**50.0%**	**50.0%**
***Elevated Blood Lead Levels in Children/Youth Age 6–20[2] (AC)**	**2013**	**percent**	**0.5%**	**--**	**0.3%**	**66.7%**	**--**
Home Ownership[3] (AC)	2016	percent	56.6%	**--**	55.2%	2.5%	**--**
Homeless Children Age 0-17 Who Are Unsheltered[9] (AC)	2017	percent	86.1%	**--**	88.0%	2.2%	**--**
Homeless Individuals[1]	2017	number	5,629	--	--	--	**--**
Homeless Individuals Who Are Unsheltered[1,10] (AC, CA)	2017	percent	69%	**--**	78%	11.5%	**--**
Homeless Public School Students[9] (AC)	2016	percent	1.8%	**--**	4.4%	59.1%	**--**
Homeless Young Adults Age 18–24 Who Are Unsheltered[1] (AC)	2017	percent	73.6%	**--**	81.8%	10.0%	**--**
Housing Burden – Rents[8] (AC)	2012–2016	percent	49.6%	**--**	56.%5	12.2%	**--**
Housing Problems[5]	2012–2016	percent	41.8%	43.2%	45.6%	8.3%	5.3%
Lack of Healthy Food Stores[5]	2014	percent	7.6%	4.8%	13.4%	43.3%	64.2%
***Median Rent, 2 Bedrooms[12] (AC)**	**2018**	**dollars**	**2,595**	**--**	**2,150**	**20.7%**	**--**
Segregation Index (range is 0–1)[5]	2010	number	0.40	0.43	0.43	7.0%	0.0%
Severe Housing Problems[5]	2011–2015	percent	24.5%	25.1%	27.3%	10.3%	8.1%

TRENDS

Trend data are available on certain indicators.

- Asthma Diagnoses, Children Age 1–17[9]: Long-term trend mixed; trending up since 2009.
- Asthma Hospitalizations, Children Age 0–4[9]: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Age 0–17[9]: Long-term trend mixed, trending up since 2011.
- Children Living in Crowded Households[9]: Generally trending up since 2008.
- Homeless Children Age 0–17 Who Are Unsheltered[9]: Up from zero in 2017.
- Homeless Population[1]: Increased in 2017.
- Homeless Young Adults Age 18–24 Who Are Unsheltered[1]: Was trending down, rose sharply in 2017.
- Housing Burden—Rents[8]: Generally trending up since 2006. Median Rent, 2 Bedrooms[12]: Increasing over past year.

Example of poor housing conditions

Photo source: Alameda County Department of Public Health

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Built Environment-Long-Term Residential Vacancy (percent vacant for 2 or more years, by majority ethnicity census tracts)[6] (Oak)°	0.47%	0.39%	**0.88%**	**0.66%**				**0.52%**	0.27%
Childhood Asthma ED Visits per 100,000 children[6] (Oak)°	1,658.0	407.4	**4,093.3**	408.0					1,134.0
Homeless Population[1]	#	30%	**49%**			3%		15%	17%

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
Benchmarks not available; comparison category is White.

MATERNAL AND CHILD HEALTH

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Asthma Hospitalizations, Children Age 0–4 (per 10,000 population)[9] (AC)**	**2016**	**rate**	**36.9**	**--**	**19.6**	**88.3%**	**--**
Breastfeeding[2] (AC)	2012	percent	97.4%	--	93.8%	3.8%	--
Child Mortality (per 100,000 population)[7] (AC)	2013–2016	rate	30	--	40	25.0%	--
Children Below 100% FPL[5]	2012–2016	percent	14.4%	18.8%	21.9%	34.2%	14.2%
Early Prenatal Care[2] (AC)	2014–2016	percent	89.9%	--	83.3%	7.9%	--
***Elevated Blood Lead Levels in Children Age 0–5[2] (AC)**	**2013**	**percent**	**0.3%**	**--**	**0.2%**	**50.0%**	**--**
Female Received Birth Control Information from Doctor[3] (AC)ǂ	2016	percent	37.1%	--	32.1%	15.6%	--
Infant Deaths (per 1,000 births)[5]	2006–2010	rate	4.4	4.4	5.0	12.0%	12.0%
Life Expectancy at Birth[5]	2014	number (years)	81.5	81.5	80.8	0.9%	0.9%
***Low Birth Weight (<2500 grams)[5]**	**2008–2014**	**percent**	**7.2%**	**7.2%**	**6.8%**	**5.9%**	**5.9%**
Preschool Enrollment (population aged 3–4 years)[5]	2012–2016	percent	56.9%	65.4%	48.6%	17.1%	34.6%
Pre-Term Births[5]	2012–2014	percent	8.9%	8.9%	9.0%	1.1%	1.1%
Teen Births (per 1,000 females aged 15–19)[5]	2008–2014	rate	19.6	19.6	29.3	33.1%	33.1%
Very Low Birth Weight (<1500 grams)[2] (AC)	2013	percent	1.2%	--	1.2%	0.0%	--

ǂ Male comparison not provided because data are statistically unstable.

TRENDS

Trend data are available on certain indicators.

- Asthma Hospitalizations, Children Age 0–4[9]: Generally trending downward since 2005.
- Breastfeeding[2]: Trending up since 2012.
- Early Prenatal Care[2]: Generally trending up since 2010.
- Teen Births[9]: Generally trending down since 1995.
- Very Low Birth Weight[2]: Trend is relatively flat since 1995.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Child Mortality[7]	40	30	**70**						30
Children Below 100% FPL[5]	21.9%	11.4%	**29.0%**	14.9%	17.7%	**27.8%**	**38.0%**	**44.5%**	**40.5%**
Infant Mortality (deaths per 1,000 live births)[6] (Oak)°	5.1	1.9	**11.7**	3.1			**11.2**		4.7
Teen Births[9]	23.2	4.7	**28.3**	2.2*				11.4	**25.3**

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.
* Indicates statistic is for Asian/Pacific Islander combined.

ORAL HEALTH

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Annual Dental Visit Among Denti-Cal Beneficiaries (ages 0–20)[8] (AC)**	**2015**	**percent**	**48.2%**	**48.2%**	**51.0%**	**5.5%**	**5.5%**
Children Drinking ≥ 1 Sugar-Sweetened Beverage Daily[3] (AC)	2015–2016	percent	18.8%	--	40.4%	53.5%	--
Dentists (per 100,000 population)[5]	2015	rate	89.4	89.4	80.3	11.3%	11.3%
Health Professional Shortage Area—Dental[5]	2016	percent	0.0%	0.0%	13.2%	100.0%	100.0%
Recent Dental Exam (Youth ages 2–11), CA[3]	2014	percent	89%	88.9%	86.7%	2.7%	2.5%

TRENDS

Trend data are available on certain indicator.

- Annual Dental Visit Among Denti-Cal Beneficiaries[8]: Trending down (i.e., getting worse) since 2013.

Race & Ethnicity

No indicators are available by ethnicity.

PHYSICAL ACTIVITY AND RECREATIONAL ACCESS

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
Children Walking or Biking to School[3]	2015–2016	percent	50.3%	50.1%	39.3%	28.0%	27.5%
Diabetes Deaths (per 100,000 population)[2] (AC)	2014–2016	rate	19.9	--	20.7	3.9%	--
Diabetes Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	879.6	--	1,017.7	13.6%	--
***Diabetes Hospitalizations, Children Age 0–17 (percentage of all child discharges, excluding newborns)[9] (AC)**	**2015**	**percent**	**1.6%**	--	**1.4%**	**14.3%**	--
Driving Alone to Work[5]	2012–2016	percent	62.6%	47.8%	73.5%	14.8%	35.0%
Driving Alone to Work, Long Distances[5]	2012–2016	percent	**44.4%**	38.8%	39.3%	**13.0%**	1.3%
Environmental Health-Park Quality[6] (Oak)° (highest score is 4)	2016	number	--	2.5	--	--	--
Exercise Opportunities (percentage of population living in close proximity to park or recreational facility)[5]	2010, 2014	percent	99.7%	99.7%	93.6%	6.5%	6.5%
Heart Disease Deaths (per 100,000 population)[5]	2011–2015	rate	71.8	71.8	99.5	27.8%	27.8%
Obesity (Adult)[5]	2015	percent	21.2%	20.7%	26.5%	43.3%	21.9%
Obesity (Youth) (children in grades 5, 7, and 9)[5]	2016–2017	percent	15.9%	16.4%	20.1%	20.0%	18.4%
Obesity Hospitalizations (per 100,000 population)[8] (AC)	2012–2014	rate	367.3	--	396.8	20.9%	--
Physical Inactivity (Youth) (grades 5, 7, and 9)[5]	**2016–2017**	**percent**	**32.9%**	**38.0%**	37.8%	**8.7%**	0.5%
Public Transit Access (percentage of population living within 0.5 miles of a transit stop)[5]	2011	percent	20.5%	18.4%	16.8%	22.0%	9.5%
Stroke Deaths (per 100,000 population)[5]	2011–2015	rate	**36.4**	**36.4**	35.4	2.8%	2.8%
Students Meeting Fitness Standards, 5th Graders[9] (AC)	2015	percent	30.4%	--	24.9%	15.2%	--
Students Meeting Fitness Standards, 7th Graders[9] (AC)	2015	percent	35.0%	--	31.4%	7.7%	--
Students Meeting Fitness Standards, 9th Graders[9] (AC)	2015	percent	**36.2%**	--	34.8%	**3.7%**	--
Walkable Destinations (percentage of population)[5]	2012–2015	percent	56.5%	56.4%	29.0%	94.8%	94.5%

TRENDS

Trend data are available on certain indicators.

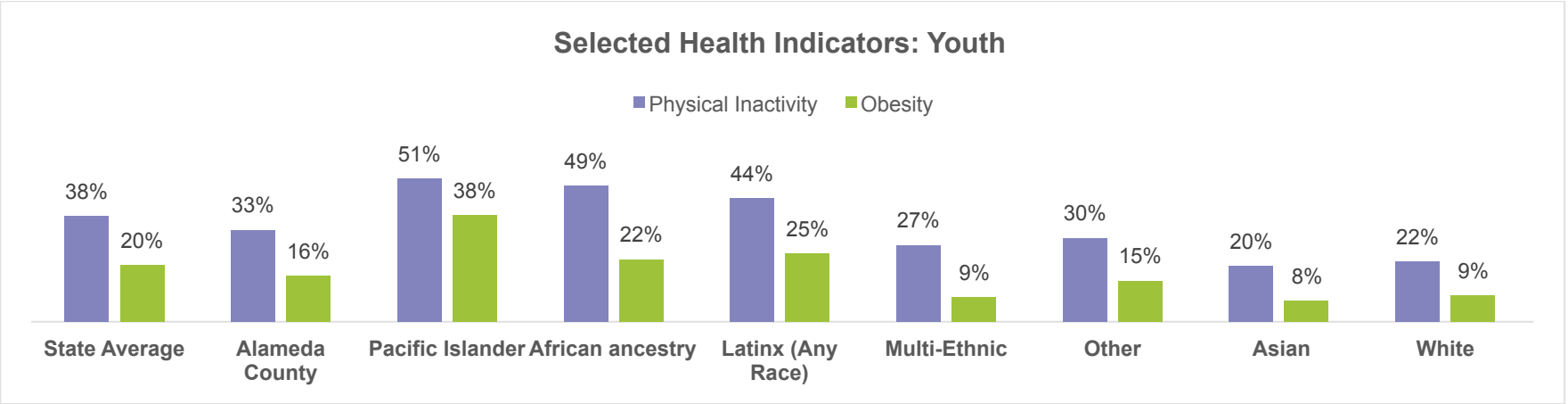
- Diabetes Deaths[2]: Trending down since 2012.
- Diabetes Hospitalizations[8]: Trending down since 2010.
- Diabetes Hospitalizations, Children Age 0–17[9]: Long-term trend mixed, trending up since 2011.
- Obesity-Related Hospitalizations[8]: Trending up since 2009.
- Students Meeting Fitness Standards, 5th Graders[9]: Trend is mixed.
- Students Meeting Fitness Standards, 7th Graders[9]: Generally trending upward since 2011.
- Students Meeting Fitness Standards, 9th Graders[9]: Trend is mixed.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Heart Disease Deaths[5]	99.5	80.9	97.5	48.2		50.3			56.1
Obesity (Adult)[5]	26.5%	19.8%	**35.4%**	10.0%					**30.0%**
Obesity (Youth)[5]	20.1%	9.4%	**22.3%**	7.6%	**38.2%**	15.6%	14.7%†	8.8%	**24.5%**
Physical Inactivity (Youth)[5]	37.8%	21.6%	**48.6%**	20.0%	**51.3%**	35.5%	30.0%†	27.4%	**44.1%**
Stroke Deaths[5]	35.4	35.1	**52.5**	31.3					33.0
Students Meeting Fitness Standards, 5th Graders[9]	24.9%	38.2%	**21.0%**	36.9%	**20.9%**		30.2%†	35.8%	**18.2%**
Students Meeting Fitness Standards, 7th Graders[9]	31.4%	42.7%	**23.3%**	45.7%	**17.2%**	34.2%	38.7%†	39.5%	**22.4%**
Students Meeting Fitness Standards, 9th Graders[9]	34.8%	45.8%	**22.6%**	45.5%	**16.3%**	34.9%	38.7%†	**33.7%**	**20.3%**

Blank cells indicate that 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 population.



Source: California Department of Education, Fitnessgram Physical Fitness Testing, 2016–2017.

TRANSPORTATION AND TRAFFIC

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.24**	**1.7**	**1.1**	**17.0%**	**54.5%**
***Bicycle-Involved Collisions (per 100,000 population)[8] (AC)**	**2015**	**rate**	**43.4**	**--**	**35.1**	**23.6%**	**--**
Driving Alone to Work[5]	2012–2016	percent	62.6%	47.8%	73.5%	14.8%	35.0%
Driving Alone to Work, Long Distances[5]	2012–2016	percent	**44.4%**	38.8%	39.3%	**13.0%**	1.3%
Impaired Driving Deaths[5]	2011–2015	percent	**29.6%**	**29.6%**	29.0%	2.1%	2.1%
Motor Vehicle Crash Deaths (per 100,000 population)[5]	2011–2015	rate	5.5	5.5	8.6	36.0%	36.0%
***Motor Vehicle Crash ER Visits (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**809.3**	**--**	**747.3**	**8.3%**	**--**
Pedestrian Accident Deaths (per 100,000 population)[5]	2011–2015	rate	1.8	2.0	2.3	21.7%	13.0%
Public Transit Access (percentage of population living within 0.5 miles of a transit stop)[5]	2011, 2013	percent	20.5%	18.4%	16.8%	22.0%	9.5%
***Road Network Density (road miles per square mile)[5]**	**2011**	**rate**	**6.5**	**21.6**	**2.0**	**225.0%**	**980.0%**
Walkable Destinations (percentage of population living within close proximity to park, playground, library, museum, or other destination of interest)[5]	2012-2015	percent	56.5%	56.4%	29.0%	94.8%	94.5%

TRENDS

Trend data are available on certain indicators.

- Bicycle-Involved Collisions[8]: Trending down since 2013.
- Motor Vehicle Crash ER Visits[8]: Trending up since 2009.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Access to a Car Lacking[6] (Oak)°	10.2%	6.1%	**18.7%**	10.0%			**14.2%**		7.6%
Motor Vehicle Crash Deaths (per 100,000 population)[5]	8.6	5.3	7.3	3.9					6.9

Blank cells indicate that data were unavailable.
° Benchmark is for City of Oakland rather than county or state.

UNINTENTIONAL INJURY/ACCIDENTS

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
***Beer, Wine, and Liquor Stores (per 10,000 population)[5]**	**2012–2015**	**rate**	**1.24**	**1.7**	**1.1**	**17.0%**	**54.5%**
***Bicycle-Involved Collisions (per 100,000 population)[8] (AC)**	**2015**	**rate**	**43.4**	**--**	**35.1**	**23.6%**	**--**
***Elevated Blood Lead Levels in Children Age 0–5[2] (AC)**	**2013**	**percent**	**0.3%**	**--**	**0.2%**	**50.0%**	**--**
***Elevated Blood Lead Levels in Children/Youth Age 6–20[2] (AC)**	**2013**	**percent**	**0.5%**	**--**	**0.3%**	**66.7%**	**--**
***Firearm Fatalities (per 100,000 population)[7] (AC)**	**2012–2016**	**rate**	**9.0**	**--**	**8.0**	**12.5%**	**--**
Impaired Driving Deaths[5]	2011–2015	percent	**29.6%**	**29.6%**	29.0%	2.1%	2.1%
Injury Deaths (per 100,000 population)[5]	2011–2015	rate	42.8	42.8	46.6	8.2%	8.2%
Motor Vehicle Crash Deaths (per 100,000 population)[5]	2011–2015	rate	5.5	5.5	8.6	36.0%	36.0%
***Motor Vehicle Crash ER Visits (per 100,000 population)[8] (AC)**	**2012–2014**	**rate**	**809.3**	**--**	**747.3**	**8.3%**	**--**
Pedestrian Accident Deaths (per 100,000 population)[5]	2011–2015	rate	1.8	2.0	2.3	21.7%	13.0%
Poisoning Hospitalizations, Children Age 0–17 (percentage of all child discharges, excluding newborns)[9] (AC)	2015	percent	0.6%	--	0.9%	33.3%	--
***Traumatic Injury Hospitalizations, Children Age 0–17 (percentage of all child discharges, excluding newborns)[9] (AC)**	**2015**	**percent**	**1.6%**	**--**	**1.1%**	**45.5%**	**--**
Unintentional Injury Deaths (per 100,000 population)[2] (AC)	2014–2016	rate	24.9	--	30.3	17.8%	--
Unintentional Injury ER Visits (per 100,000 population)[8] (AC)	2012–2014	rate	**6,749.6**	--	6,531.7	3.3%	--
Unintentional Injury Hospitalizations, Under Age 1 (per 100,000)[9] (AC)	2014	rate	**258.8**	--	248.4	4.2%	--
***Unintentional Injury Hospitalizations, Ages 1–4 (per 100,000)[9] (AC)**	**2014**	**rate**	**234.4**	**--**	**212.2**	**10.5%**	**--**
***Unintentional Injury Hospitalizations, Ages 5–12 (per 100,000)[9] (AC)**	**2014**	**rate**	**148.9**	**--**	**118.1**	**26.1%**	**--**
***Unintentional Injury Hospitalizations, Ages 13–15 (per 100,000)[9] (AC)**	**2014**	**rate**	**189.0**	**--**	**151.7**	**24.6%**	**--**
Unintentional Injury Hospitalizations, Ages 16–20 (per 100,000)[9] (AC)	2014	rate	**224.2**	--	222.2	0.9%	--

Race & Ethnicity

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

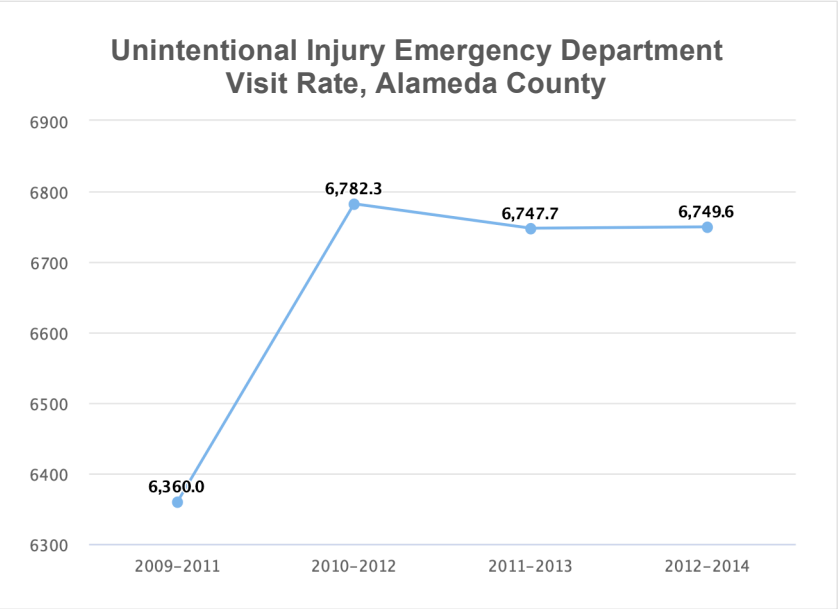
INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Motor Vehicle Crash Deaths (per 100,000 population)[5]	8.6	5.3	7.3	3.9					6.9

Blank cells indicate that data were unavailable.

TRENDS

Trend data are available on certain indicators.

- Bicycle-Involved Collisions[8]: Trending down since 2013.
- Elevated Blood Lead Levels in Children Age 0–5[2]: Downward trend since 2007.
- Elevated Blood Lead Levels in Children/Youth Age 6-20[2]: Trend is mixed.
- Motor Vehicle Crash ER Visits[8]: Trending up since 2009.
- Poisoning Hospitalizations, Children Age 0–17[9]: Long-term trend mixed, trending down since 2012.
- Traumatic Injury Hospitalizations, Children Age 0–17[9]: Trend is mixed.
- Unintentional Injury Deaths[2]: Generally trending up since 2010.
- Unintentional Injury ER Visits[8]: Generally trending up since 2009.



Source: Office of Statewide Health Planning and Development (OSHPD).

OVERALL HEALTH

Students per Social Worker
California: 12,870 **Alameda County:** 37,494

INDICATOR	YEAR(S)	INDICATOR TYPE	ALAMEDA COUNTY	OAKLAND AREA	STATE AVG	AC % DIFFERENT	OAKLAND % DIFFERENT
General Health (Self-Report): Good or Better[3] (AC)	2015	percent	86.4%	--	82.0%	5.4%	--
Life Expectancy at Birth[5]	2014	number (years)	81.5	81.5	80.8	0.9%	0.9%
Population with Any Disability[5]	2012–2016	percent	9.6%	11.0%	10.6%	9.4%	3.8%
Premature Death (per 100,000 population aged <75)[5]	2012–2014	rate	4,767	4,767	5,251	9.2%	9.2%
***Students per Social Worker[9] (AC)**	**2015**	**number**	**37,494**	--	**12,870**	**191.3%**	--

TRENDS

Trend data are available on certain indicators.

- General Health (Self-Report)[3]: Good or Better: Generally trending down since 2011.
- Students per Social Worker[9]: Generally trending down since 2011.

Race & Ethnicity

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

INDICATORS	BENCHMARK	WHITE	AFR / AFR ANC	ASIAN	PAC ISL	NATIVE AM	OTHER	MULTI RACE	HISP / LAT (ANY RACE)
Population with Any Disability[5]	10.6%	**11.1%**	**17.0%**	6.7%	9.5%	**17.1%**	6.5%	8.6%	7.4%

Blank cells indicate that data were unavailable.

Attachment 2. Secondary Data Indicators

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Access to a Car (COEI)	Health Care Access & Delivery	This indicator measures the percentage of individuals who live in housing units that do not have a car.	American Community Survey, 1-year PUMS.	2016
Active Asthma Prevalence	Asthma	Percentage of county residents reporting they currently have asthma.	Prepared by California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health using data from California Health Interview Survey.	2014
Acute Preventable Hospitalizations (HAC.org)	Health Care Access & Delivery	This indicator shows the number of preventable hospitalizations due to acute conditions per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2009-2011
Adequate Fruit & Vegetable Consumption, Children Age 12-17 (Kidsdata.org)	Obesity/HEAL/Diabetes	Estimated percentage of children aged 2-17 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 aged 12-17 ate at least five servings of fruits/vegetables daily).	UCLA Center for Health Policy Research, California Health Interview Survey	2013-2014
Adequate Fruit & Vegetable Consumption, Children Age 2-11 (Kidsdata.org)	Obesity/HEAL/Diabetes	Estimated percentage of children aged 2-17 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 aged 12-17 ate at least five servings of fruits/vegetables daily).	UCLA Center for Health Policy Research, California Health Interview Survey	2013-2014
Alcohol Use (Youth) (HAC.org)	Substance Use/Tobacco	This indicator shows the percentage of teens who answered yes to the question "Did you ever have more than a few sips of any alcoholic drink, like beer, wine, mixed drinks, or liquor?"	California Health Interview Survey	2011-2012

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Annual Dental Visit Among Denti-Cal Beneficiaries (HAC.org)	Oral Health	This indicator shows the percentage of Denti-Cal recipients aged 0-20 who had an annual dentist visit in the past year. This includes those with 90 days continuous eligibility in the fee-for-service (FFS) delivery system who received at least one dental visit within the given calendar year.	Annie E. Casey Foundation	2015
Assault Injury ER Visits (HAC.org)	Community & Family Safety	This shows the number of assault emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Asthma Deaths	Asthma	Age-adjusted rate of asthma mortality per 1,000,000 population	Prepared by California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health using data from California Death Statistical Master Files.	2008-2010
Asthma Diagnoses, Children Age 1-17[9]	Asthma	Percentage of children aged 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
Asthma ED Visits, All Ages (CDPH)	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 Dept. of Public Health using data from California Office of Statewide Health Planning and Development (OSHPD)	2014
Asthma ER Visits (HAC.org)	Asthma	This indicator shows the age-adjusted rate for asthma emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Asthma Hospitalizations, Children Age 0-4 (Kidsdata.org)	Asthma	Number of asthma hospitalizations per 10,000 population, by age group.	Prepared by California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Dept. of Finance, and the U.S. Census Bureau.	2016
Asthma Hospitalizations, Children/Youth Age 5-17 (Kidsdata.org)	Asthma	Number of asthma hospitalizations per 10,000 population, by age group.	Prepared by California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Dept. of Finance, and the U.S. Census Bureau.	2016
Average Charge per Asthma Hospitalizations	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 Dept. of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD)	2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Avoidable ER Visits (HAC.org)	Health Care Access & Delivery	This indicator shows the age-adjusted avoidable emergency department visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Banking Institutions	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 well-being.	County Business Patterns	2015, 2014, 2013, 2012
Beer, Wine, and Liquor Stores	Community & Family Safety; Economic Security; 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.	County Business Patterns	2015, 2012, 2014, 2013
Bicycle-Involved Collisions (HAC.org)	Community & Family Safety	This indicator shows the number of bicyclist-involved collisions resulting in bicyclist injury or death per 100,000 population.	California State Highway Patrol	2015
Breastfeeding (HAC.org)	Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of mothers who breastfed their new baby after delivery.	California Department of Public Health	2014-2016
Built Environment-Long-Term Residential Vacancy (COEI)	Crime/Intentional Injury	Percent of residential addresses that have been identified as “vacant” by the U.S. Postal Service for 2 or more years, aggregrated at the census tract level on a quarterly basis.	COEI: U.S. Department of Housing and Urban Development Aggregated USPS Administrative Data on Address Vacancies, Quarter 3 ending September 30, 2017; U.S. Census Bureau, American Community Survey, 5-year Estimates, 2012-2016.	2017 + 2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Bullied at School, 11th Graders (CHKS)	Community & Family Safety; Mental Health	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Community & Family Safety; Mental Health	Percentage of public school students in grade 7, and non-traditional 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 & Family Safety; Mental Health	Percentage of public school students in grade 9, and non-traditional 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
Cancer Deaths	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
Cervical Cancer Incidence (HAC.org)	Cancers	This indicator shows the age-adjusted incidence rate for cervical cancer in cases per 100,000 females.	National Cancer Institute	2011-2015
Child Mortality (CHR)	Maternal/Infant Health	Number of deaths among children under age 18 per 100,000.	CDC WONDER mortality data	2013-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Childhood Asthma ED Visits (COEI)	Asthma	Age-adjusted rate of asthma-related emergency department visits per 100,000 children under 5 years of age.	City of Oakland Equity Indicators (COEI) 2018 Report	2013-2015
Childhood Cancer Diagnoses (Kidsdata.org)	Cancers	Number of new cancer diagnoses per 100,000 children/youth aged 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	Economic Security; Overall Health	This indicator reports the percentage of children aged 0 to 17 years that live 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.	American Community Survey	2012-2016
Children Drinking ≥ 1 Sugar-Sweetened Beverage Daily[3] (AskCHIS)	Obesity/HEAL/Diabetes; Oral/Dental	Estimated percentage of children aged 2-17 who drink one or more sodas or other sugar-sweetened beverages per day.	California Health Interview Survey	2015-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Children in Foster Care (Kidsdata.org)	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 aged 0-17 living in households in which (i) no person age 14 or older speaks English only, and (ii) 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's American Community Survey microdata files (Dec. 2017).	2016
Children in Single-parent Households	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.	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's American Community Survey microdata files (Nov. 2015).	2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Children Needing and Receiving Behavioral Health Care Services (Kidsdata.org)	Mental Health	Percentage of children aged 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 American Community Survey* (Nov. 2016).	2011-2012
Children Walking or Biking to School, CA	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; 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 disease.	California Health Interview Survey	2015-2016
Children with Health Insurance (HAC.org)	Health Care Access & Delivery	This indicator shows the percentage of children aged 0-17 that have any type of health insurance coverage	American Community Survey	2016
Children with Influenza Vaccination (HAC.org)	Communicable Diseases (Not STIs)	This indicator shows the percentage of children aged 6 months to 11 years who received an influenza vaccination in the past year.	California Health Interview Survey	2013-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Children with Two or More Adverse Experiences (Parent Reported) (Kidsdata.org)	Mental Health	Estimated percentage of children aged 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 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's American Community Survey microdata files (Nov. 2015).	2014
Chlamydia Incidence (SAE)	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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	Sexually Transmitted Infections	Number of chlamydia infections per 100,000 youth aged 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Data; California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, 2010-2060; Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data & Statistics; U.S. Census Bureau, Population Estimates Program, Estimates of the Resident Population by Sex & Age for the United States, 2000-2010, 2010-2015 (Sept. 2016)	2015
Chronic Preventable Hospitalizations (HAC.org)	Health Care Access & Delivery	This indicator shows the number of preventable hospitalizations for chronic diseases per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2009-2011
Civic Engagement-Voter Turnout (registered voters not voting) (COEI)	Overall Health	Voter turnout is measured by the percentage of registered voters that voted in the general election. This indicator measures geographic disparities by City Council District.	COEI: Alameda County Registrar of Voters.	2016
Climate-Related Mortality Impacts	Climate & Health	This indicator reports the median estimated economic impacts from changes in all-cause mortality rates, across all age groups, as a percentage of county 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Community Stressors-Domestic Violence (COEI)	Mental Health	This indicator measures the rate of domestic violence victimization in Oakland by race/ethnicity. Rate is calculated as the number of domestic violence incidents per 100,000 people of the same race/ethnicity (of any age).	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates.	2017 + 2016
Community Stressors-Homicide (COEI)	Mental Health	This indicator measures the number of homicides in Oakland by race/ethnicity. Rate is calculated as the number of homicides per 100,000 people of the same race/ethnicity (of any age).	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates.	2017 + 2016
Congestive Heart Failure Hospitalizations (HAC.org)	CVD/Stroke	This indicator shows the number of congestive heart failure hospitalizations per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Cost Burdened Households	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 their basic needs for health care, child care, food, transportation and other costs.	American Community Survey	2012-2016
Cost of Infant Childcare, 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 & 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 Childcare, 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 & Referral Network, California Child Care Portfolio (Nov. 2015); cost data are from the Child Care Regional Market Rate Survey, 2014.	2014
Cyberbullied More than Once, 11th Graders (CHKS)	Community & Family Safety; Mental Health	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Community & Family Safety; Mental Health	Percentage of public school students in grade 7, and non-traditional 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 & Family Safety; Mental Health	Percentage of public school students in grade 9, and non-traditional 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
Deaths by Suicide, Drug or Alcohol Poisoning	Mental 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/Did Not Receive "Other Medical" Care (HAC.org)	Health Care Access & Delivery	This indicator shows the percentage of people who report having delayed or not received other medical care they felt they needed.	California Health Interview Survey	2015-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Dentists	Health Care Access & 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.	Area Health Resource File	2015
Depression-Related Feelings, 11th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 7, and non-traditional 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)	Mental Health	Estimated percentage of public school students in grade 9, and non-traditional 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 Deaths (HAC.org)	Obesity/HEAL/Diabetes	This indicator shows the age-adjusted death rate per 100,000 population due to diabetes.	California Department of Public Health	2014-2016
Diabetes Hospitalizations (HAC.org)	Obesity/HEAL/Diabetes	This is indicator shows the age-adjusted Diabetes hospitalization visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Diabetes Hospitalizations, Children Age 0-17 (Kidsdata.org)	Obesity/HEAL/Diabetes	Number hospital discharges among children aged 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Did Not Eat Breakfast, 11th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in grade 7, and non-traditional 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 grade 9, and non-traditional 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 Hospitalizations, CA	Community & Family Safety	This indicator reports the rate of non-fatal emergency department visits for domestic violence incidents among females aged 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	Climate & Health	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	Climate & Health; Obesity/HEAL/Diabetes	This indicator reports the percentage of the civilian non-institutionalized population aged 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.	American Community Survey	2012-2016
Driving Alone to Work, Long Distances	Climate & Health; 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.	American Community Survey	2012-2016
Drought Severity	Climate & Health	This indicator reports the population-weighted percentage of weeks in drought from January 1st, 2012 - December 31st, 2014. This indicator is relevant because it highlights communities vulnerable to the effects of drought, and associated health impacts.	US Drought Monitor	2012-2014
Early Prenatal Care (HAC.org)	Maternal/Infant Health	This indicator shows the percentage of births to mothers who began prenatal care in the first trimester of their pregnancy.	California Department of Public Health	2014-2016
Elevated Blood Lead Levels in Children Age 0-5 (Kidsdata.org)	Community & Family Safety	Percentage of children/youth aged 0-5 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group	California Dept. of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017).	2013
Elevated Blood Lead Levels in Children/Youth Age 6-20 (Kidsdata.org)	Community & Family Safety	Percentage of children/youth aged 6-20 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group.	California Dept. of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017).	2013
Environmental Health-Abandoned Trash (COEI)	Climate & Health	This indicator measures the number of service requests received by the Oakland Call Center for illegal dumping as a rate per 1,000 population in each census tract. The census tracts are grouped based on majority race/ethnicity. Service requests that were canceled were excluded from	COEI: Oakland Call Center, 2017; U.S. Census Bureau, American Community Survey, 2012-2016.	2017 + 2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
		the analysis.		
Environmental Health-Park Quality (COEI)	Climate & Health	Measures overall ratings for Oakland parks and compares average scores by City Council district. The overall ratings were based on an annual survey that assigned parks letter grades (A through F), which corresponded to scores (A=4, B=3, C=2, D=1, and F=0). In addition to Council District scores, the scores for parks surrounding Lake Merritt were reported as an average Lakeside score.	COEI: 2016 Community Report Card on the State of Maintenance in Oakland Parks, Oakland Parks and Recreation Foundation.	2016
Environmental Health-Pollution Burden (COEI)	Asthma; Climate & Health	Measure of pollution burden as a combined score that includes indicators of potential exposures to pollutants and environmental conditions (e.g., ozone, pesticides, toxic releases, traffic, hazardous waste). The pollution burden scores are averaged by majority race/ethnicity of Oakland census tracts.	COEI: Office of Environmental Health Hazard Assessment, CalEnviroScreen 3.0 Maps (2017); U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016.	2017 + 2012-2016
Exercise Opportunities	CVD/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, CA	Community & Family Safety; 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Fear Being Beaten Up at School, 11th Graders (AC, CCC) (CHKS)	Community & Family Safety	Percentage of public school students in grade 11, and non-traditional 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 Being Beaten Up at School, 7th Graders (CHKS)	Community & Family Safety	Percentage of public school students in grade 7, and non-traditional 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 Being Beaten Up at School, 9th Graders (AC, CCC) (CHKS)	Community & Family Safety	Percentage of public school students in grade 9, and non-traditional 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	Health Care Access & 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)	Maternal/Infant Health	Percentage of females who received birth control information from her doctor	California Health Interview Survey	2016
Firearm Assault Injury Hospitalization, by Age (KidsData.org)	Crime & Intentional Injury	Number of hospital discharges for non-fatal firearm-related assault injuries per 100,000 children and youth aged 0-24, by age group	Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data; California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; CDC, WISQARS.	2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Firearm Fatalities (CHR)	Crime & Intentional Injury; Unintentional Injuries/Accidents	Number of deaths due to firearms per 100,000 population.	CDC WONDER mortality data	2012-2016
Flood Vulnerability	Climate & Health	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
Food Environment Index	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 Insecure Children Ineligible for Assistance (HAC.org)	Economic Security; Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of food insecure children in households with incomes above 185% of the federal poverty level who are likely not income-eligible for federal nutrition assistance.	Feeding America	2016
Food Insecurity	Economic Security; 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
Food Insecurity, Child (HAC.org)	Economic Security; Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of children (under 18 years of age) living in households that experienced food insecurity at some point during the year.	Feeding America	2016
Free and Reduced Price Lunch	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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Gang Membership, 11th Graders (CHKS)	Community & Family Safety	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Community & Family Safety	Percentage of public school students in grade 7, and non-traditional 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 & Family Safety	Percentage of public school students in grade 9, and non-traditional 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
General Health (Self-Report): Good or Better (HAC.org)	Overall Health	This indicator shows the percentage of adults, teens, and children who answered good, very good, or excellent to: "How is your general health?"	California Health Interview Survey	2015
Gonorrhea Incidence (HAC.org)	Sexually Transmitted Infections	This indicator shows the gonorrhea incidence rate in cases per 100,000 population.	California Department of Public Health, STD Control Branch	2017

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	Sexually Transmitted Infections	Number of gonorrhea infections per 100,000 youth aged 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Data; California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, 2010-2060; Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data & Statistics; U.S. Census Bureau, Population Estimates Program, Estimates of the Resident Population by Sex & Age for the United States, 2000-2010, 2010-2015 (Sept. 2016)	2015
Grocery Stores and Produce Vendors	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.	County Business Patterns	2015, 2014, 2013, 2012
Have Usual Source of Health Care (HAC.org)	Health Care Access & Delivery	This indicator shows the percentage of people that report having a usual place to go to when sick or when health advice is needed.	California Health Interview Survey	2015-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Health Professional Shortage Area - Dental	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
Healthy Food Stores (Low Access)	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	CVD/Stroke; Obesity/HEAL/Diabetes; 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
Heat Index	Climate & Health	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 Dept. of Education, California Longitudinal Pupil Achievement Data System (CALPADS) (May 2016).	2015

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
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 Dept. of Education, California Basic Educational Data System (CBEDS) (Jun. 2016).	2015
High Speed Internet	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 Incidence (HAC.org)	Sexually Transmitted Infections	This indicator shows the HIV incidence rate in cases per 100,000 population.	California Department of Public Health	2015
HIV/AIDS Deaths	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 Prevalence	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	California Health Interview Survey	2016
Homeless Children Age 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 aged 0-17 were found to be homeless and unsheltered during the 2017 PIT count).	U.S. Dept. of Housing and Urban Development, PIT Estimates of Homelessness in the U.S 2014 & 2017 (Mar. 2018).	2017

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Homeless Individuals Who Are Unsheltered (AC, CCC, CA) (PIT; HUD)	Economic Security	The percentage of homeless individuals living in encampments, cars, parks, or abandoned buildings.	Applied Survey Research. (2017). Alameda County Homeless Census & Survey. Watsonville, CA; Contra Costa Council on Homelessness. (2017); 2017 Point in Time Count: A Snapshot of Contra Costa County; U.S. Dept. 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 Dept. of Education, Coordinated School Health and Safety Office custom tabulation & California Basic Educational Data System (May 2017).	2016
Homeless Young Adults Age 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 aged 0-17 were found to be homeless and unsheltered during the 2017 PIT count).	U.S. Dept. of Housing and Urban Development, PIT Estimates of Homelessness in the U.S 2014 & 2017 (Mar. 2018).	2017
Homicide (CHR)	Community & Family Safety	Number of deaths due to homicide per 100,000 population.	CDC WONDER mortality data	2010-2016
Housing Burden – Rents (HAC.org)	Economic Security	This indicator shows the percentage of renters who are spending 30% or more of their household income on rent.	American Community Survey	2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Housing Problems	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.	American Community Survey	2012-2016
Hypertension Hospitalizations (HAC.org)	CVD/Stroke	This shows the hypertension hospitalization visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Impaired Driving Deaths	Community & Family Safety; 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	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.	American Community Survey	2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Individuals Experiencing Homelessness (AC, CCC) (PIT)	Economic Security	The number of homeless individuals counted during the county's point-in-time count. The Point in Time Count includes only those that 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 and 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 camp ground.	Applied Survey Research. (2017). Alameda County Homeless Census & Survey. Watsonville, CA; Contra Costa Council on Homelessness. (2017). 2017 Point in Time Count: A Snapshot of Contra Costa County.	2017
Infant Deaths	Maternal/Infant Health	This indicator reports the rate of death among infants less than 1 year of age 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.	Area Health Resource File	2006-2010
Influenza and Pneumonia Deaths (HAC.org)	Communicable Diseases (Not STIs)	This indicator shows the age-adjusted death rate per 100,000 population due to influenza and pneumonia.	California Department of Public Health	2014-2016
Influenza Vaccination (all ages) (AskCHIS)	Communicable Diseases (Not STIs)	Percentage of the population who has had the flu vaccine in the last 12 months	California Health Interview Survey	2016
Injury Deaths	Community & Family Safety	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 aged 1 to 44 years; high injury mortality may signal broader issues in the community.	National Vital Statistics System	2011-2015

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Jail Admissions (Vera)	Community & Family Safety	Rate of annual admissions per 100,000 county residents age 15-64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates. Accessed 17 August 2018.	2015
Jail Incarceration (Vera)	Community & Family Safety	Rate of jail incarceration per 100,000 county residents age 15-64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates. Accessed 17 August 2018.	2015
Juvenile Felony Arrests (AC, CCC) (Kidsdata.org)	Community & Family Safety; Economic Security	Number of juvenile felony arrests per 1,000 youth aged 10-17	California Dept. of Justice, Arrest Data; California Dept. 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)	Communicable Diseases (Not STIs)	Percentage of children in kindergarten with all required immunizations.	California Dept. of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb. 2016).	2016
Law Enforcement-Use of Force (per 100,000 people) (COEI)	Crime/Intentional Injury	This indicator measures the rate of use of force on subjects per 100,000 people in Oakland by race/ethnicity.	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates, 2016.	2017 + 2016
Life Expectancy at Birth	Maternal/Infant Health; Overall 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Low Birth Weight	Maternal/Infant 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	2008-14
Lung Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 population due to lung cancer.	California Department of Public Health	2014-2016
Lung Cancer Incidence	Cancers; Substance Use/Tobacco	This indicator reports the age-adjusted incidence rate of lung cancer per 100,000 population. This indicator is relevant because it is a measure of the burden of lung cancer; this indicator 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
Meaningful Participation at School: Low, 11th Graders (CHKS)	Mental Health	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Mental Health	Percentage of public school students in grade 7, and non-traditional 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)	Mental Health	Percentage of public school students in grade 9, and non-traditional 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Median Income	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	Housing & Homelessness	This indicator reports median rent for a two-bedroom unit in October 2018.	Zilpy.com	2018
Medicaid/Public Insurance Enrollment	Economic Security; Health Care Access & 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.	American Community Survey	2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Mental Health Hospitalization, Children Age 5-14 (Kidsdata.org)	Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth aged 5-14, by age group.	California Office of Statewide Health Planning and Development special tabulation; California Dept. 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 Age 15-19 (Kidsdata.org)	Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth aged 15-19, by age group	California Office of Statewide Health Planning and Development special tabulation; California Dept. 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	Health Care Access & 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.	Area Health Resource File	2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Motor Vehicle Crash Deaths	Community & Family Safety	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
Motor Vehicle Crash ER Visits (HAC.org)	Community & Family Safety	This indicator shows the number of motor vehicle crash emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
Non-Physician PCPs (HAC.org)	Health Care Access & Delivery	This indicator shows the non-physician primary care provider rate per 100,000 population. Primary care providers who are not physicians include nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists.	County Health Rankings	2017
Obesity (Adult), CA	Asthma; Cancers; CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of adults aged 18 years and older that self-report having a Body Mass Index (BMI) greater than 30.0 (the threshold for obesity).	California Health Interview Survey	2014
Obesity (Youth), CA	Asthma; CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in grades 5, 7, and 9 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
Obesity Hospitalizations (HAC.org)	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator shows the age-adjusted obesity-related hospitalization rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
On-Time High School Graduation, CA	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
Opportunity Index	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
Oral Cancer Incidence (HAC.org)	Cancers	This indicator shows the age-adjusted incidence rate for oral cavity and pharynx cancer in cases per 100,000 population.	National Cancer Institute	2011-2015
Ozone Levels	Asthma; Climate & Health	This indicator reports the percentage of days per year with Ozone (O3) 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 O3 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	Asthma; Cancers; Climate & Health	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
Passed High School Exit Exam, English (HAC.org)	Economic Security	This indicator shows the percentage of 10th grade students passing the English-language arts portion of the California High School Exit Exam.	California Department of Education	2014-2015

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Passed High School Exit Exam, Math (HAC.org)	Economic Security	This indicator shows the percentage of 10th grade students passing the mathematics portion of the California High School Exit Exam.	California Department of Education	2014-2015
Pedestrian Accident Deaths	Community & Family Safety	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 (Youth), CA	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in grades 5, 7, and 9 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 Age 0-17 (Kidsdata.org)	Community & Family Safety	Number hospital discharges among children aged 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
Population Below 100% FPL	Economic Security; Overall 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.	American Community Survey	2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Population in Limited English Households	Economic Security	This indicator reports the percentage of the population aged 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."	American Community Survey	2012-2016
Population that is Linguistically Isolated	Economic Security	This indicator reports the percentage of the population aged 5 years and older that is considered linguistically isolated (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.	American Community Survey	2012-2016
Population with Any Disability	Overall 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.	American Community Survey	2012-2016
Pre-Term Births	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.	Area Health Resource File	2012-2014
Premature Death	Overall Health	This indicator reports the rate of death among those aged less than 75 years 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	Overall 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Preschool Enrollment	Economic Security; 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.	American Community Survey	2012-2016
Preventable Hospital Events	Health Care Access & Delivery; Overall 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	Health Care Access & 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.	Area Health Resource File	2014
Prison Incarceration (Vera	Community & Family Safety	Rate of individuals in state prison from county per 100,000 county residents age 15-64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates. Accessed 17 August 2018.	2013
Proficient in English/Language Arts-High School (HAC.org)	Economic Security	This indicator shows the percentage of eleventh grade students that are proficient or above in English/language arts. This value refers to student scores on the Smarter Balanced Assessment portion of California's statewide student assessment system, CAASPP.	California Department of Education	2018

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Proficient in Math-High School (HAC.org)	Economic Security	This indicator shows the percentage of eleventh grade students who are proficient or above in mathematics. This value refers to student scores on the Smarter Balanced Assessment portion of California's statewide student assessment system, CAASPP.	California Department of Education	2018
Prostate Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 males due to prostate cancer.	California Department of Public Health	2014-2016
Prostate Cancer Incidence	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
Public Transit Stops	Climate & Health; 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, CA	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, 11th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 11, and non-traditional 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Recent Alcohol/Drug Use, 7th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 7, and non-traditional 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)	Substance Use/Tobacco	Estimated percentage of public school students in grade 9, and non-traditional 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 Cigarette Use, 11th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 11, and non-traditional programs who have used cigarettes in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017).	2013-2015
Recent Cigarette Use, 7th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 7, and non-traditional programs who have used cigarettes in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017).	2013-2015
Recent Cigarette Use, 9th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 9, and non-traditional programs who have used cigarettes in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017).	2013-2015
Recent Dental Exam (Youth), CA	Health Care Access & 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.	California Health Interview Survey	2014
Recent Marijuana Use, 11th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 11, and non-traditional 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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Recent Marijuana Use, 7th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 7, and non-traditional 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)	Substance Use/Tobacco	Estimated percentage of public school students in grade 9, and non-traditional 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
Respiratory Hazard Index	Asthma; Climate & Health	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	Climate & Health	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, 11th Graders (CHKS)	Mental Health	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Mental Health	Percentage of public school students in grade 7, and non-traditional students by level of connectedness to school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011-2013

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
School Connectedness: Low, 9th Graders (CHKS)	Mental Health	Percentage of public school students in grade 9, and non-traditional 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, 11th Graders (CHKS)	Community & Family Safety	Percentage of public school students in grade 11, and non-traditional 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, 7th Graders (CHKS)	Community & Family Safety	Percentage of public school students in grade 7, and non-traditional 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 & Family Safety	Percentage of public school students in grade 9. and non-traditional 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
Segregation Index	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.	Decennial Census	2010
Self-Inflicted Injury ER Visits (HAC.org)	Mental Health	This indicator shows the number of self-inflicted injury emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Seriously Considered Suicide, 11th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 11, and non-traditional 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, 9th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 9, and non-traditional 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
Severe Housing Problems	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.	Consolidated Planning/CHAS Data	2011-2015
Severe Mental Illness ER Visits (AC) (HAC.org)	Mental Health	This indicator shows the number of severe mental illness related hospitalizations per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014
SNAP Benefits	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.	American Community Survey	2012-2016
SNAP Benefits – Households with Children (HAC.org)	Economic Security	This indicator shows the percentage of households participating in the Supplemental Nutrition Assistance Program (SNAP) with children under 18 years old.	American Community Survey	2012-2016

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Social Associations	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.	County Business Patterns	2015, 2014, 2013, 2012
Stroke Deaths	CVD/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
Student/Teacher Ratio (HAC.org)	Economic Security	This indicator shows the average number of public school students per teacher in the region. It does not measure class size.	National Center for Education Statistics	2015-2016
Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in grade 5 meeting 6 of 6 fitness standards	California Dept. 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 grade 7 meeting 6 of 6 fitness standards	California Dept. 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 grade 9 meeting 6 of 6 fitness standards	California Dept. 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 Dept. 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 Nurse (Kidsdata.org)	Health Care Access & 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 Dept. of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016);	2015
Students per School Psychologist (Kidsdata.org)	Health Care Access & Delivery; 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 Dept. 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)	Health Care Access & 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 Dept. of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016);	2015
Students per Social Worker (Kidsdata.org)	Overall 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 Dept. of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016);	2015
Substance Use ER Visits (HAC.org)	Substance Use/Tobacco	This indicator shows the age-adjusted substance use emergency department visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Substantiated Child Abuse and Neglect (KidsData.org)	Community & Family Safety	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	Community & Family Safety; 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 5-year time period is less than 10.	National Vital Statistics System	2011-2015
Suspensions, CA	Community & Family Safety; 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 (HAC.org)	Sexually Transmitted Infections	This indicator shows the infectious syphilis (primary and secondary) incidence rate in cases per 100,000 population.	California Department of Public Health, STD Control Branch	2017
Teen Births	Economic Security; Maternal/Infant Health	This indicator reports the number of births to women aged 15 to 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	2008-14

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Teen Births, by ethnicity (Kidsdata.org)	Economic Security; Maternal/Infant Health	Number of births per 1,000 young women aged 15-19.	California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & 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)	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
Traumatic Injury Hospitalizations, Children Age 0-17 (Kidsdata.org)	Community & Family Safety	Number hospital discharges among children aged 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	Climate & Health	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.	National Land Cover Database 2011	2011

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
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 Dept. of Education, DataQuest (Jun. 2016).	2015
Unemployment	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
Uninsured Children	Economic Security	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 health care access, including regular primary care, specialty care, and other health services, which contributes to poor health status and quality of health.	American Community Survey	2012-2016
Uninsured Population	Economic Security; Health Care Access & 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 health care access, including regular primary care, specialty care, and other health services, which contributes to poor health status and quality of life.	American Community Survey	2012-2016
Unintentional Injury Deaths (HAC.org)	Community & Family Safety	This indicator shows the age-adjusted death rate per 100,000 population due to unintentional injuries.	California Department of Public Health	2014-2016
Unintentional Injury ER Visits (HAC.org)	Community & Family Safety	This indicator shows the number of unintentional injury emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012-2014

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Unintentional Injury Hospitalizations (KidsData.org)	Community & Family Safety	This indicator shows the number of hospital discharges for non-fatal unintentional injuries per 100,000 children and youth, by age group	Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data; California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; CDC, WISQARS.	2014
Very Low Birth Weight (Kidsdata.org)	Maternal/Infant Health; Substance Use/Tobacco	Percentage of infants born at very low birthweight (less than 1,500 grams or about 3 lbs., 5 oz).	California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & 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	Community & Family Safety	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	2012-14
Walkable Destinations	CVD/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

INDICATOR	HEALTH NEEDS	DESCRIPTION	SOURCE	YEAR(S)
Young People Not in School and Not Working	Economic Security; Mental Health	This indicator reports the percentage of youth aged 16 to 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, well-being and quality of life.	American Community Survey	2012-2016

Attachment 3. Community Leaders, Representatives, and Members Consulted

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities, and the medically underserved. The group included leaders from the county health systems, local government employees, clinicians, and nonprofit organizations.

For a description of members of the community who participated in focus groups, please see Section 6: Process and Methods.

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Organizations							
C	Interview	Kathy Chiverton, Executive Director, Discovery Counseling Center	Mental health	1	Medically underserved	Leader	7/30/2018
C	Interview	Sandra Scherer, Executive Director, Monument Crisis Center	Needs of low-income population	1	Low-income	Leader	8/6/2018
C	Interview	Katherine Wutchiett, Attorney, Skadden Fellow, Legal Aid at Work	Low-income immigrant population needs	1	Low-income, Minority	Leader	8/13/2018
C, W	Interview	Debbie Toth, President & CEO, Choice in Aging	Older adult needs	1	Low-income, Medically underserved	Leader	8/15/2018
E	Interview	Diane Burgis, Supervisor, Contra Costa County, District III	Needs of Eastern Contra Costa County population	1	Low-income, Minority	Leader	6/27/2018
E	Interview	Ana Castro, Coordinator, Educational Services, Antioch Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	7/25/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
E	Interview	Bob Sanchez, Director of Student Services, Antioch Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	7/25/2018
E	Interview	Ken Carlson, Board Chair, John Muir Community Health Fund	Community health	1	Medically underserved	Leader	7/31/2018
E	Interview	Kirsten Rigsby, Executive Director, Village Community Resource Center	Latino population needs	1	Minority	Leader	8/14/2018
E	Interview	Barbara Hunt, Development Director, St. Vincent de Paul of Contra Costa County	Economic security	1	Low-income, Medically underserved	Leader	8/16/2018
E	Interview	Pam Di Franco, RN, MSN, PHN, Clinic Nurse Manager, Society of St. Vincent de Paul of Contra Costa County	Economic security	1	Low-income, Medically underserved	Leader	8/16/2018
E	Interview	Allison Staulcup Becwar, Chief Program Officer, Lincoln	Mental health needs	1	Medically underserved	Leader	8/17/2018
E	Interview	Hector J. Rojas, AICP, Senior Planner, City of Pittsburg	Community development	1	Low-income	Leader	8/17/2018
E, C	Interview	Kevin McAllister, Executive Director, Rainbow Community Center	LGBTQ population needs	1	Medically underserved, Minority	Leader	8/1/2018
E, C, W	Interview	Lavonna Martin, Director, Health, Housing, and Homeless Services, Contra Costa County Health Services	Needs of individuals experiencing homelessness	1	Low-income	Leader	7/13/2018
E, C, W	Interview	Dan Peddycord, Director of Public Health, Contra Costa County Health Services	Public health	1	Health department representative	Leader	7/23/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
E, KP-WC	Interview	Devorah Levine, Assistant Director, Contra Costa County Employment & Human Services	Medically underserved	1	Low-income, Medically underserved	Leader	8/2/2018
E, KP-WC	Interview	Rhonda James, Chief Executive Officer, STAND! for Families Free of Violence	Community & family safety	1	Low-income, Minority	Leader	8/17/2018
E, KP-WC	Interview	Kristin Connelly, President & Chief Executive Officer, East Bay Leadership Council	Economic security	1	Low-income	Leader	8/21/2018
E, W, KP-WC	Interview	Dr. Matthew P. White, Acting Director of Behavioral Health, Medical Director, Contra Costa County Health Services	Behavioral health	1	Medically underserved	Leader	7/31/2018
N	Interview	Leronne Armstrong, Deputy Chief, Oakland Police Department	Community & family safety (law enforcement)	1	Low-income, Minority	Leader	7/18/2018
N	Interview	Bonnie Lovette, RN MS PNP, Injury Prevention Coordinator, Trauma Services, UCSF Benioff Children's Hospital Oakland; Founder, Chair Childhood Injury Prevention Network, Bay Area (CIPN-BA); member, Alameda County Child Death Review Team	Injuries, children	1	Medically underserved	Leader	7/19/2018
N	Interview	Dr. Melanie Moore, Executive Director, All In Alameda County	Food insecurity	1	Low-income	Leader	7/19/2018
N	Interview	Ralph Silber, Executive Director, Alameda Health Consortium	Needs of medically underserved population	1	Medically underserved	Leader	7/25/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N	Interview	Anne Marks, Executive Director, Youth Alive	Community & family safety	1	Low-income, Minority	Leader	8/3/2018
N	Interview	Dr. Tony Iton, Senior Vice President, California Endowment	Social determinants of health	1	Low-income, Minority	Leader	8/8/2018
N	Interview	Gloria Bruce, Executive Director, East Bay Housing Organizations	Affordable housing	1	Low-income	Leader	8/8/2018
N	Interview	Leslie Ewing, Executive Director, Pacific Center	LGBTQ population needs	1	Medically underserved, Minority	Leader	8/16/2018
N, S	Interview	Dr. Kathleen Clanon, Medical Director, Alameda County Health Care Services	Whole person health	1	Medically underserved	Leader	6/29/2018
N, S	Interview	Dr. Erica Pan, Director, Division of Communicable Disease Control and Prevention, Alameda County Public Health Department	Infectious diseases	1	Health department representative	Leader	7/13/2018
N, S	Interview	Dr. Aaron Chapman, Medical Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018
N, S	Interview	James Wagner, Deputy Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018
N, S	Interview	Katherine Jones, Director, Adult & Older Adult System of Care, Behavioral Health Care Services of Alameda County	Behavioral health	1	Low-income, Medically underserved	Leader	8/13/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N, S	Interview	Colleen Chawla, Director, Alameda County Health Care Services	Healthcare access	1	Medically underserved	Leader	8/16/2018
N, S	Interview	Kristin Spanos, Chief Executive Officer, First 5 Alameda County	Needs of children aged 0-5	1	Low-income	Leader	8/20/2018
N, S, TV	Interview	Kimi Watkins-Tartt, Deputy Director, Public Health, Alameda County Public Health Department	Public health	1	Health department representative	Leader	7/23/2018
S	Interview	Dr. Laura Miller, Chief Medical Officer, Community Health Center Network	Access to primary care among individuals of low socioeconomic status	1	Low-income, Medically underserved	Leader	7/20/2018
S	Interview	Katie Sandoval-Clark, Program Manager, Fresh Lifelines for Youth (FLY)	At-risk youth needs	1	Low-income, Minority	Leader	7/30/2018
S (not KP-F)	Interview	Sharon McGrath, Rubicon	Economic security	1	Low-income, Minority	Leader	8/13/2018
S (not KP-SL)	Interview	Yasmine Safinya-Davies, Psy.D., Executive Director, Safe Alternatives to Violent Environments (SAVE)	Community & family safety	1	Low-income, Minority	Leader	7/20/2018
S (not KP-SL)	Interview	Taylor Johnson, Executive Director, Tri-City Volunteers	Food insecurity	1	Low-income	Leader	8/17/2018
S, TV	Interview	Denah Nunes, LCSW, Director of Health & Wellness Alameda County, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
S, TV	Interview	Louis Chicoine, Executive Director, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018
TV	Interview	Claudia Young, Human Services Programs Manager, Livermore Housing & Human Services	Government, health/human services	1	Low-income	Leader	7/26/2018
TV	Interview	Sue Compton, Chief Executive Officer, Axis Community Health	Needs of low-income population	1	Low-income	Leader	8/3/2018
TV	Interview	Robert Taylor, Executive Director, Senior Support Services of Tri-Valley	Older adult needs	1	Low-income	Leader	8/8/2018
TV	Interview	Cat Arthur, School Nurse, Livermore Valley Joint Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018
TV	Interview	Cindy Leung, District Community Liaison, Dublin Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	10/2/2018
TV	Interview	Scott Vernoy, Director of Student Services, Livermore Valley Joint Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018
TV	Interview	Vicki Fukumae, District Nurse, Dublin Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018
TV	Interview	Ed Diolazo, Assistant Superintendent of Student Support Services, Pleasanton Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	10/3/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
TV	Interview	Susan Han, RN, MSN, District Nurse, Pleasanton Unified School District	K-12 student health	1	Medically underserved	Leader	10/3/2018
W	Interview	Kanwarpal Dhaliwal, Associate Director, RYSE	Youth development and safety	1	Low-income, Minority	Leader	7/18/2018
W	Interview	Alvaro Fuentes, Executive Director, Community Clinic Consortium of Contra Costa and Solano Counties	Needs of medically underserved population	1	Medically underserved	Leader	7/27/2018
W	Interview	Sam Vaughn, Program Manager, Richmond's Office of Neighborhood Safety	Community & family safety	1	Low-income, Minority	Leader	7/30/2018
W	Interview	Alicia Gallo, Outreach Coordinator, Richmond Main Street Initiative	Economic insecurity	1	Low-income	Leader	8/3/2018
W	Interview	John Gioia, Supervisor, Western Contra Costa County	Needs of Western Contra Costa County population	1	Low-income, Minority	Leader	8/8/2018
W	Interview	Marin Trujillo, Community Engagement Interim-Director, West Contra Costa Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	8/14/2018
W	Interview	Roxanne Garza, Hub Manager, Healthy Richmond	Needs of medically underserved population	1	Medically underserved	Leader	8/22/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
TV	Focus Group	**Host:** Axis Community Health	Needs of Latinx low-income individuals	5	Low-income, Medically underserved, Minority	(see below)	8/7/2018
		Attendees:					
		Charon Emery, Enrollment, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Cindy Nava, BHCC, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Eileen Esparza, CDCC, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Maria Gonzalez, Clinic Manager, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Pam Alfaro, Community Health Worker, Axis Community Health	Needs of Latinx low-income individuals			Leader	
C, E, TV	Focus Group	**Host:** Kaiser Foundation Hospital-Walnut Creek	Needs of Central and Eastern Contra Costa County population	13	Low-income	(see below)	8/27/2018
		Attendees:					
		Dena Betti, Executive Director, #hersmile Nonprofit	Needs of Central and Eastern Contra Costa County population			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		John Jimno, Principal, Park Middle School, Antioch Unified School District	Needs of Central and Eastern Contra Costa County population			Leader	
		Catherine Stafford, Child Health & Nutrition Manager, CocoKids	Needs of Central and Eastern Contra Costa County population			Leader	
		Denise Milosevich, Contra Costa Health Services, Public Health Department	Needs of Central and Eastern Contra Costa County population			Leader	
		Caitlin Sly, Program Director, Food Bank of Contra Costa and Solano	Needs of Central and Eastern Contra Costa County population			Leader	
		Ali Uscilka, Program Director, Healthy & Active Before 5	Needs of Central and Eastern Contra Costa County population			Leader	
		Ray (Heracio) Harts, Executive Director, Healthy Hearts Institute	Needs of Central and Eastern Contra Costa County population			Leader	
		Amy Weiss, Director, Refugee & Immigrant Services, Jewish Family & Community Services/EB	Needs of Central and Eastern Contra Costa County population			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Jessica Rojas, Program Director, School Board Services of Contra Costa, Lincoln	Needs of Central and Eastern Contra Costa County population			Leader	
		Dave Thompson, Monument Impact	Needs of Central and Eastern Contra Costa County population			Leader	
		Helene Glaser, RN, MSN, Nurse, RotaCare Pittsburg Free Medical Clinic at St. Vincent de Paul	Needs of Central and Eastern Contra Costa County population			Leader	
		Carole Dorham-Kelly, Chief Program Officer, Rubicon Programs	Needs of Central and Eastern Contra Costa County population			Leader	
		Andrea Fati, Program Director, Shelter, Inc.	Needs of Central and Eastern Contra Costa County population			Leader	
C, E	Focus Group	**Host:** Multifaith Action Coalition	Needs of individuals living in poverty	7	Low-income	(see below)	8/14/2018
		Attendees:					
		Rev. Will McGarvey, Exec. Dir. of the Interfaith Council of CCC, Co-convener of Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		April Wise, Co-Chair, Health Care Task Force, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	

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		David Bressler, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Melody Howe Weintraub, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Pat Reyes, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Doug Leich, Racial Justice, Multi-Faith ACTION Coalition, Racial Justice Working Group	Needs of individuals living in poverty			Leader	
		Pamela Abbey, Retired United Methodist Clergy	Needs of individuals living in poverty			Leader	
E	Focus Group	**Host:** Kaiser Foundation Hospital-Antioch	Needs of Eastern Contra Costa County population	7	Low-income	(see below)	9/17/2018
		Attendees:					
		Mayra Preciado, Antioch Unified School District	Needs of Eastern Contra Costa County population			Leader	
		Robert Prinz, Education Director, Bike East Bay	Needs of Eastern Contra Costa County population			Leader	
		Wendy Escamilla, Brighter Beginnings	Needs of Eastern Contra Costa County population			Leader	
		Susun Kim, Executive Director, Family Justice Center	Needs of Eastern Contra Costa County population			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Alejandra Plascencia, Community Liaison – East and Central County, First 5 Contra Costa	Needs of Eastern Contra Costa County population			Leader	
		Brianna Robinson, Director of Programs, Opportunity Junction	Needs of Eastern Contra Costa County population			Leader	
		Darren Gapultos, Pittsburg Unified School District	Needs of Eastern Contra Costa County population			Leader	
N	Focus Group	**Host:** Seneca	Behavioral/mental health	8	Medically underserved	(see below)	7/31/2018
		Attendees:					
		Ilene Yasemsky, Clinical Director PHF, Seneca	Behavioral/mental health			Leader	
		Johanna Paillet-Growl, Willow Rock Crisis Stabilization Unit Supervisor, Seneca	Behavioral/mental health			Leader	
		Louisa Kornblatt, MSW Intern, PHF, Seneca	Behavioral/mental health			Leader	
		Melissa Lawton, CSU Assistant Director, Seneca	Behavioral/mental health			Leader	
		Amrit Sandhu, WRC PHF-RN Supervisor, Telecare	Behavioral/mental health			Leader	
		Jessica Eschman, LCSW, Program Director, Willow Rock Crisis Stabilization Unit (Seneca Family of Agencies)	Behavioral/mental health			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N	Focus Group	**Host:** Alameda County Healthcare for the Homeless	Needs of individuals experiencing homelessness	10	Low-income, Medically underserved	(see below)	8/21/2018
		Attendees:					
		Bonnie Wolf, Project Director, Alameda Senior Housing and Medical Respite Center, Alameda Point Collaborative	Needs of individuals experiencing homelessness			Leader	
		Doug Biggs, Executive Director, Alameda Point Collaborative	Needs of individuals experiencing homelessness			Leader	
		Jia Min Cheng, Staff Attorney/Project Manager, Bay Area Legal Aid	Needs of individuals experiencing homelessness			Leader	
		Steven Weiss, Bay Area Legal Aid	Needs of individuals experiencing homelessness			Leader	
		Ann Rubinstein, Managing Attorney, Homeless Action Center	Needs of individuals experiencing homelessness			Leader	
		Jamie Ramirez, Pop Up Care Village Program Director, Lava Mae	Needs of individuals experiencing homelessness			Leader	
		Brenda Goldstein, Lifelong Medical	Needs of individuals			Leader	

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			experiencing homelessness				
		Noha Aboelata, MD, Chief Executive Officer, Roots Community Health Center	Needs of individuals experiencing homelessness			Leader	
		Carol Johnson, Executive Director, St. Mary's Center	Needs of individuals experiencing homelessness			Leader	
N	Focus Group	**Host:** Oakland Unified School District	Health of K-12 students	8	Medically underserved	(see below)	8/29/2018
		Attendees:					
		Barbara Parker, Health Services Coordinator, Oakland Unified School District	Health of K-12 students			Leader	
		Coreen Steigerwald, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Eden Balde, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Edson Nunes da Silva, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Ozella Faison-Burns, BSN, RN, PHN, Credentialed School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Samantha Wong, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	

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		Sherry Kassenbrock, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
N	Focus Group	**Host:** Unity Council	Needs of undocumented individuals	5	Low-income, Medically underserved, Minority	(see below)	9/13/2018
		Attendees:					
		Edgar Salazar, Day Labor Employment Advocate, Oakland Workers Collective	Needs of undocumented individuals			Leader	
		Gabriela Galicia, Executive Director, Street Level Health Project	Needs of undocumented individuals			Leader	
N	Focus Group	**Host:** Kaiser Permanente Northern California	Needs of individuals utilizing safety net clinics	5	Low-income, Medically underserved	(see below)	9/14/2018
		Attendees:					
		Julia Liou, Chief Deputy of Administration, Development, Asian Health Services	Needs of individuals utilizing safety net clinics			Leader	
		Kendolyn Hindsman, Patient Services Manager, Lifelong Medical	Needs of individuals utilizing safety net clinics			Leader	
		Gale Taylor, West Oakland Health	Needs of individuals using safety net clinics			Leader	

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		Sara Rounsaville, West Oakland Health	Needs of individuals utilizing safety net clinics			Leader	
N	Focus Group	**Host:** Kaiser Foundation Hospital-Oakland	Health disparities and inequities	6	Low-income, Medically underserved, Minority	(see below)	9/21/2018
		Attendees:					
		Melissa Jones, BARHII	Health disparities and inequities			Leader	
		Anita Kumar, Manager, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Charise Fong, Chief Operating Officer, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Romi Hall, Associate Director, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Anthony Galace, Director of Health Equity, The Greenlining Institute	Health disparities and inequities			Leader	
		Ellen Wu, Urban Habitat	Health disparities and inequities			Leader	
N	Focus Group	**Host:** Kaiser Foundation Hospital-Oakland	Needs of youth	12	Low-income, Minority	(see below)	9/21/2018
		Attendees:					
		Rob Jackson, Beats Rhymes & Life	Needs of youth			Leader	

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		Jamal Mitchell, Care Champion, The Hidden Genius Project	Needs of youth			Leader	
		Kieran McMonagle, LMFT, Clinical Program Manager AC/SF, First Place for Youth	Needs of youth			Leader	
		Nedra Ginwright, MS, Chief Flourish Officer, Flourish Agenda	Needs of youth			Leader	
		Karen Bohlke, Martin Luther King Jr. Freedom Center	Needs of youth			Leader	
		JG Larochette, Founder & Executive Director, Mindful Life Project	Needs of youth			Leader	
		Wesley Hingano, Case Manager, Oakland High School	Needs of youth			Leader	
		Lailan Huen, API Student Achievement, Oakland Unified School District	Needs of youth			Leader	
		Eric Erhoff, Program Coordinator, Project Avary	Needs of youth			Leader	
		Tiffani Parrish, Case Manager, Youth Radio	Needs of youth			Leader	
		Shawana Booker, Director, Youth Uprising	Needs of youth			Leader	
S	Focus Group	**Host:** South County Partnership	Social determinants of health	4	Low-income, Minority	(see below)	8/2/2018
		Attendees:					
		Bronwyn Hogan, Director, Community Rel, Abode	Social deter-minants of health			Leader	

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		Suzanne Shenfil, Human Services Director, City of Fremont	Social determinants of health			Leader	
		Wil Lacro, VP of Business Development, Tiburcio Vasquez Health Center	Social determinants of health			Leader	
		Amy Hsieh, Development Manager, Tri-City Health Center	Social determinants of health			Leader	
S	Focus Group	**Host:** Tri-City Health Center	Needs of medically underserved individuals, especially adolescents	4	Medically underserved	(see below)	8/24/2018
		Attendees:					
		Jorge Hernandez, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	
		Karrisa Havlicek, School Health Services Supervisor, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	

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		Lisa Martin, Clinic Manager, Tri-City Health Center	Needs of medically underserved individuals, especially adolescents			Leader	
S	Focus Group	**Host:** Kaiser Foundation Hospital-San Leandro	Needs of individuals utilizing safety net clinics	4	Low-income, Medically underserved	(see below)	9/4/2018
		Attendees:					
		Sarah Timmons, MPH, Health Education Supervisor, School-Based Health Center Department, La Clinica de La Raza	Needs of individuals utilizing safety net clinics			Leader	
		Atziri Rodriguez, Senior Program Manager, SBHC, Native American Health Center	Needs of individuals utilizing safety net clinics			Leader	
		David B. Vliet, Chief Executive Officer, Tiburcio Vasquez Health Center	Needs of individuals utilizing safety net clinics			Leader	
		Phyllis Pei, Director of Clinical Services, Tri-City Health Center	Needs of individuals utilizing safety net clinics			Leader	

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S	Focus Group	**Host:** Kaiser Foundation Hospital-San Leandro	Mental health	12	Medically underserved	(see below)	9/28/2018
		Attendees:					
		Chet Dayal, Bay Area South Asian Network of Therapists	Mental health			Leader	
		Shalini Dayal, Bay Area South Asian Network of Therapists	Mental health			Leader	
		Kathy Kimberlin, Executive Director, Boldly Me	Mental health			Leader	
		Annie Bailey, City of Fremont, Youth & Family Services	Mental health			Leader	
		Yolanda Chavez, City of Fremont, Youth & Family Services	Mental health			Leader	
		Claudia P. Del Rio, Director, La Familia Counseling	Mental health			Leader	
		Leticia Vargas de Gonzalez, MH Educator, La Familia Counseling	Mental health			Leader	
		Lisa Jackson, Program Coordinator, Career Pathways Intervention & Prevention, San Leandro Unified School District	Mental health			Leader	
		Monica Zuniga, Mental Health Specialist, Tiburcio Vasquez Health Center	Mental health			Leader	
		Elizabeth Martin, Tri-City Health Center	Mental health			Leader	
		Nikhat Nazneen, DGO, MBBS, Physician - Pediatrics, Tri-City Health Center	Mental health			Leader	

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		Tam Nguyen, Tri-City Health Center	Mental health			Leader	
W	Focus Group	**Host:** Healthy Richmond Collaborative	Needs of individuals who are medically underserved	17	Medically underserved	(see below)	7/18/2018
		Attendees:					
		Sophia Cohn, Attorney, Bay Area Legal Aid	Needs of individuals who are medically underserved			Leader	
		Jennifer Turner, Brighter Beginnings	Needs of individuals who are medically underserved			Leader	
		Molly Baldridge, MPH, Project Director, California School-Based Health Alliance	Needs of individuals who are medically underserved			Leader	
		C. Sequoia Erasmus, Director of Community Engagement, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Gabino Arredondo, Management Analyst II, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Rodrigo Beteta, Schaeffer Government Service Fellow and Health Career Connection Intern, City of Richmond	Needs of individuals who are medically underserved			Leader	

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		Shasa Curl, Community and Economic Development Director, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Rachel K. Bell, Intern, Community Clinic Consortium	Needs of individuals who are medically underserved			Leader	
		Wanda Session, Assistant to Director, Contra Costa Health Services	Needs of individuals who are medically underserved			Leader	
		Dulce Galicia, Program Coordinator, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Noemi Corona, Summer Temporary Employee, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Roxanne Carrillo Garza, Hub Manager, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Kendolyn Hindsman, LifeLong Medical Care	Needs of individuals who are medically underserved			Leader	

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		Linda Collins, LifeLong Medical Care	Needs of individuals who are medically underserved			Leader	
		Yolanda Bolden, Wellness Coach, Rubicon Programs	Needs of individuals who are medically underserved			Leader	
		Sonia Bustamante, Office of Supervisor Gioia	Needs of individuals who are medically underserved			Leader	
W	Focus Group	**Host:** West Contra Costa Unified School District	K-12 student health	8	Medically underserved	(see below)	8/28/2018
		Attendees:					
		Joyce Synott, Social Worker, Bay Area Community Resources	K-12 student health			Leader	
		Megan White, Bay Area Community Resources	K-12 student health			Leader	
		Barbara Byrd, Student Welfare & Attendance, West Contra Costa Unified School District	K-12 student health			Leader	
		Nick Berger, Special Ed, West Contra Costa Unified School District	K-12 student health			Leader	
		Angelica Lara, Student Welfare & Attendance, West Contra Costa Unified School District	K-12 student health			Leader	

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		Jodi Couick, Coordinator, Educationally Related Mental Health Services, West Contra Costa Unified School District	K-12 student health			Leader	
		Eleazar Martinez, Community School Director, YMCA of the East Bay	K-12 student health			Leader	
Community Residents							
TV	Focus Group	**Host:** Open Heart Kitchen	Individuals experiencing homelessness or housing instability	7	Low-income, Medically underserved	Members	7/31/2018
TV	Focus Group	**Host:** Marylin Elementary School	Families with elementary-school-age children	11	Low-income	Members	9/6/2018
C	Focus Group	**Host:** First 5 Contra Costa County Regional Group	Parents children aged 0-5	13	Minority	Members	8/29/2018
C	Focus Group	**Host:** Diablo Valley College	Young adults, aged 18-25	7	Low-income	Members	9/5/2018
C	Focus Group	**Host:** Cambridge Elementary School	Families with elementary-school-age children	12	Minority	Members	9/14/2018
C, E	Focus Group	**Host:** Loaves & Fishes	Individuals experiencing homelessness or housing instability	9	Low-income, Medically underserved	Members	8/6/2018
E	Focus Group	**Host:** Rubicon Programs-	Individuals of	5	Low-income,	Members	8/29/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Antioch	minority, low-income, and/or re-entry status		Medically underserved, Minority		
E	Focus Group	**Host:** Los Medanos College	Young adults, aged 18-25	14	Low-income	Members	8/30/2018
E	Focus Group	**Host:** Stoneman Village	Older adults	9	Medically underserved	Members	9/17/2018
N	Focus Group	**Host:** Alameda County Health Coach Program	Health coaches – peers of medically underserved individuals	5	Medically underserved, Minority	Representatives, Members	8/2/2018
N	Focus Group	**Host:** Youth Radio	Youth	31	Low-income, Minority	Members	9/28/2018
S (NOT KP-F)	Focus Group	**Host:** La Familia Counseling	Parents of middle- and high-school-age youth	12	Minority	Members	7/24/2018
S	Focus Group	**Host:** St. Rose Hospital	At-risk youth	7	Low-income, Minority	Members	8/3/2018
S	Focus Group	**Host:** Mujeres Unidas y Activas	Immigrants and refugees	15	Low-income, Minority	Members	8/28/2018
W	Focus Group	**Host:** RYSE	Youth	6	Low-income, Minority	Members	7/24/2018
W	Focus Group	**Host:** Rubicon Programs-Richmond	Individuals of minority, low-income, and/or re-entry status	9	Low-income, Medically underserved, Minority	Members	8/13/2018
W	Focus Group	**Host:** LifeLong Medical Center	Health promoters —peers of low-income and/or medically under-served individuals	7	Low-income, Medically underserved	Representatives, Members	9/6/2018

Attachment 4. Assets and Resources

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HEALTH CARE FACILITIES AND AGENCIES

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

HOSPITAL FACILITIES

Hospitals	City/Region
Alameda County Behavioral Health Center	Oakland
Alameda Health System Alameda Hospital	Alameda
Alameda Health System Highland Hospital	Oakland
Alameda Health System John George Psychiatric	San Leandro
Alameda Health System San Leandro Hospital	San Leandro
John Muir Health	Berkeley
Kaiser Permanente	Fremont
Kaiser Permanente	Oakland
Kaiser Permanente	San Leandro
St. Rose Hospital	Hayward
Sutter Health Eden Medical Center	Castro Valley
Sutter Health Alta Bates Summit Medical Center	Oakland/Berkeley
UCSF Benioff Children's Hospital	Oakland
Washington Hospital Healthcare System	Fremont

FEDERALLY QUALIFIED HEALTH CENTERS

- Asian Health Services
- La Clínica
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- UCSF Benioff Children's Hospital Oakland Claremont Clinic
- West Oakland Health

OTHER CLINICS

- Brighter Beginnings CLINIC
- STOMP Mobile Clinic (Roots)
- Teen Health Clinic
- Tri-City Health Center (multiple sites and mobile clinic)
- Union City Clinic
- Washington on Wheels Mobile Health Clinic

ASSETS AND RESOURCES BY IDENTIFIED HEALTH NEED

Health Care Access and Delivery

- Abode Services
- Alameda County - South County Homeless Project- Hayward - Special Needs Housing
- Alameda County Health Care Services - School Health Services
- American Diabetes Association
- American Heart Association
- Ashland Free Medical Clinic
- Bay Area Communities for Health Education
- Birthright of San Lorenzo
- East Bay Agency for Children
- Eden I & R, Inc.
- Eden Youth and Family Center
- California Department of Healthcare Services
- Fremont Resource Center
- George Mark Children's Home
- Hayward Day Labor Center
- Hayward Medical Center
- Jewish Family & Community Services East Bay
- LIFE Eldercare, Inc. - VIP Rides Program
- New Start Tattoo Removal
- Operation Access
- Planned Parenthood Mar Monte
- Planned Parenthood Northern California
- Rubicon Programs
- Second Chance
- Serra Center
- South Hayward Parish- Hayward Community Action Network
- United Seniors of Oakland and Alameda County
- Washington Women's Center
- Winton Wellness Center

Behavioral Health

- 12-Step programs (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon/Alateen)
- Crisis Support Services of Alameda County 24-Hour Crisis Line
- Family Paths 24-Hour Parent Support Hotline
- Abode Services
- Alameda County Health Care Services
- Alameda County Health System
- Alameda County Housing and Community Development

- Alameda County Medical Center Substance Abuse program
- Alameda County Social Services Agency
- Alameda County Tri-City Children and Youth Service
- Ashland Youth Center
- Boldly Me
- Cherry Hill Detox
- City of Berkeley Health Department of Health Services
- CURA
- Davis Street
- East Bay Agency for Children- Child Assault Prevention Training Center
- Eden I&R, Inc.
- Family Education and Resource Center (FERC)
- Family Paths
- Fremont Senior Center
- George Mark Children's Home
- Girls Inc.
- HIV/AIDS Care and Treatment Program
- HOPE Project Mobile Health Clinic
- Jewish Family & Community Services East Bay
- John George Psychiatric Hospital
- Kaiser Behavioral Health classes (available to public)
- Kidango, Inc.
- La Clínica de la Raza, San Leandro
- Lincoln
- Mindful Life Project
- National Alliance on Mental Illness Alameda County South
- Niroga
- Partnership for Trauma Recovery
- Project Eden
- Project Independence
- REACH Ashland Youth Center
- Safe Alternative to Violent Environments (SAVE)
- St. Rose Hospital
- Second Chance, Inc.
- Seneca Center
- South Hayward Parish - Hayward Community Action Network
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- Victory Outreach - Prison Counseling and Services; Residential Rehab Program
- Washington Hospital Healthcare System - Health Connection
- West Oakland Health Council
- Willow Rock Center 23-Hour Crisis Stabilization Unit and Outpatient Services

- Women on the Way Recovery Center

Community and Family Safety

- A Safe Place
- Afghan Coalition
- Alameda County Family Justice Center
- Alameda Family Services
- Allen Temple Baptist Church Health and Social Services Ministries
- Alternatives in Action
- Bay Area Women Against Rape (BAWAR)
- Berkeley Youth Alternatives
- Beyond Violence
- Building Blocks for Kids Collaborative
- Building Futures
- Calico Center
- City of Berkeley Department of Health Services
- Community and Youth Outreach
- Community Violence Solutions
- Exonerated Nation
- First 5 Alameda County
- Fresh Lifelines for Youth
- Girls Inc.
- International Institute of the Bay Area
- La Familia Counseling Services
- Narika
- Oakland Unite!
- Project Avary
- REACH Ashland Youth Center
- Ruby's Place
- RYSE Youth Center
- Safe Alternatives to Violent Environments (SAVE)
- San Leandro Boys and Girls Club
- San Leandro Education Foundation
- Union City Family Center
- Youth Alive!

Economic Security

- Abode Services
- Alameda County Community Food Bank (searchable list)
- Alameda County Early Head Start and Head Start
- Alameda County Homeless Project- Hayward (including Special Needs Housing)

- Alameda County Nutrition Services -– Women, Infants, and Children (WIC)
- America Works
- Berkeley City College CalWORKS program
- Brighter Beginnings
- Building Blocks for Kids Collaborative
- Catholic Charities of the East Bay
- Centro de Servicios
- City of Berkeley Health, Housing and Community Services Department
- City of Oakland Department of Human Services
- Community Resources for Independent Living (CRIL)
- Contra Costa County Early Head Start and Head Start
- Contra Costa County Employment and Human Services
- East Bay Community Foundation
- East Bay Community Law Center
- East Bay Green Jobs Corps
- East Oakland Youth Development Center
- EBALDC - East Bay Asian Local Development Corporation
- Eden I&R, Inc.
- Fremont Resource Center
- HOPE Project Mobile Health Clinic
- One Stop Center
- OneChild
- South Hayward Parish: Emergency Food Pantry
- The Unity Council
- Tri-City One-Stop Career Center (Employment Development Department)
- Tri-City Volunteers Food Bank & Thrift Store
- Union City Family Center

Education and Literacy (School Districts)

- Alameda USD
- Albany USD
- Berkeley Public Schools
- Castro Valley USD
- Emeryville USD
- Fremont USD
- Hayward USD
- New Haven USD
- Newark USD
- Oakland USD
- Piedmont USD

- San Leandro USD
- San Lorenzo USD
- Sunol Glen USD

Climate and Natural Environment

- Alameda County Citizens' Climate Lobby
- Earth Team
- The Watershed Project

Healthy Eating/Active Living

See Economic Security for resources related to food insecurity.

- Abode Services
- Acta Non Verba: Youth Urban Farm Project
- Alameda County Community Food Bank (multiple sites)
- Alameda County Deputy Sheriffs' Activities League
- Alameda County Food Bank
- Alameda County Nutrition Services – Women, Infants, and Children (WIC)
- Alameda County Public Health Department
- Building Blocks Collaborative
- California State University, East Bay, Hayward Promise Neighborhood
- Centro de Servicios
- City Slicker Farms
- East Bay Agency for Children
- East Bay Regional Parks District
- Eden Youth and Family Center
- EdenFit Supervised Exercise Program
- Fremont Family Resource Center
- Fresh Approach
- LIFE Eldercare, Inc. - Meals on Wheels
- Meals on Wheels of Alameda County
- Public Health Institute
- REACH Ashland Youth Center
- Second Chance - Emergency Shelter
- St. Rose Hospital HE/AL classes
- Tri-City Volunteers Food Bank and Thrift Store
- Union City Family Center (Alameda County Food Bank)
- Viola Blythe Community Service Center of Newark
- Washington Hospital Healthcare System HE/AL classes
- Washington on Wheels Mobile Health Clinic nutritional information
- Washington Hospital Healthcare System Diabetes Education Center

Housing and Homelessness

- Alameda County Housing and Community Development
- Downtown Street Team
- East Bay Community Law Center Housing Program
- East Bay Housing Organizations
- Everyone Home
- MidPen Housing

Transportation and Traffic

- Alameda-Contra Costa Transit District (AC Transit)
- Bay Area Rapid Transit (BART)
- Drivers for Survivors
- Mobility Matters
- Paratransit

Attachment 5. Qualitative Research Protocols

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

TABLE 1: 2016 HEALTH NEEDS LIST

HEALTH NEED	EXAMPLES
Asthma	
Cancer	
Heart Disease & Stroke	
Obesity, Diabetes, Fitness & 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 & 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 & pedestrian accidents, falls, drownings
Behavioral Health	Stress, depression, suicide, drug/alcohol/tobacco addiction
Community & Family Safety	Child/partner abuse, bullying, violent crime, human trafficking
Economic Security	Income, employment, education
Housing & Homelessness	Safe, clean and affordable housing
Climate & Natural Environment	Extreme weather, environmental contaminants
Transportation & Traffic	Safe, reliable, accessible
Healthcare Access & Delivery (both primary & specialty care)	Health insurance, costs of medicine, availability of providers, quality of care, getting appointments, patients being treated with respect

Key Informant Protocol – Professionals

Introduction – 5 min.

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

Health Needs Prioritization – 6-10 min.

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

Thinking specifically about [geographic sub-area] …

1. **Are there any needs that should be added to the list?**
2. **Which three needs (2016 and others added) do you believe 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:] **You were invited to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

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

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

7. **Would you say that healthcare access [related to your specific expertise and/or population you serve] is sufficient or not? If not, what issues do you see?**

8. **What differences do you see, if any, among various groups in your work?**
   Prompts if needed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

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

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

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

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

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

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

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

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

[Time permitting] Additional comments

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

Closing

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

Focus Group Protocols

During focus groups, facilitators presented the 2016 CHNA List (**Table 1** of this attachment; note that at the recommendation of the Contra Costa County Public Health Officer, in focus groups with residents "Behavioral health" was called "Mental health"). Questions found in these protocols refer to that list.

Focus Groups with Professional or Community Representatives

Introduction – 6 min.

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

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

Health Needs Prioritization – 10 min.

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

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

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

1. **Are there any that you think should be added to the list?**
2. **Please think about the three from the list you believe the local people you serve feel are the most important to address here in the next 3-4 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 health care 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 & health care – specific offerings, specific social services

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

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

Closing – 5 min.

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

Focus Groups with Local Residents (90 min.)

Introduction – 6 min.

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

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Imagining a Healthy Community – 5 min.

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

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

   Prompt if needed: What makes a community healthy?

Health Needs Prioritization – 10 min.

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

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

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

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

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

Understanding the Needs – 15 min.

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

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

   - What impact do these barriers have on people's health?
   - When you think about this need, are any groups of people worse off than others? If so, which groups?

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

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

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

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

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

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

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

    a. **In your opinion, what are the specific mental health needs in our community?**

    Prompt if needed: Conditions like stress, depression, addiction; outcomes like suicide; concerns about stigma; access to mental health care

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

Equity & Cultural Humility – 15 min.

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

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about…

10. **What are some resources, services, or strategies that are working well in the community to address these needs?**
    Prompts if needed: Certain community-based organizations or their programs/ services, specific hospitals &/or health care programs/services, specific social services

11. **What types of resources, services, or strategies, if any, does the community need more of to address these needs?**
    Prompt if needed: Preventive care? Deep-end services? Workforce changes?

12. **What kinds of changes could those in charge here in the community make to help all of us stay healthy?**

Closing – 5 min.

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

Attachment 6. IRS Checklist

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

FEDERAL REQUIREMENTS CHECKLIST	REGULATION SECTION NUMBER	REPORT REFERENCE
A. Activities Since Previous CHNA(s)		
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Final draft Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(6)(F)	Section #8
B. Process & Methods		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section #4
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.	(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.		Section #3
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	

FEDERAL REQUIREMENTS CHECKLIST	REGULATION SECTION NUMBER	REPORT REFERENCE
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 1, 2 & 3
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Section #6
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #6
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #6
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 #6 & Attachment 3
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #6 & Attachment 3
I. Medically underserved populations	(b)(5)(i)(B)	Section #6 & Attachment 3
II. Low-income populations	(b)(5)(i)(B)	Section #6 & Attachment 3
III. Minority populations	(b)(5)(i)(B)	Section #6 & Attachment 3
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 #6 & Attachment 3
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #6 & Attachment 3
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #6 & Attachment 3
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section #6

FEDERAL REQUIREMENTS CHECKLIST	REGULATION SECTION NUMBER	REPORT REFERENCE
C. CHNA Needs Description & Prioritization		
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Section #5
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Section #5
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
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	Section #7 & Attachment 4
D. Finalizing the CHNA		
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Section #2
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	Section #9
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	**Date(s) on which a-f below were done:**
a. May not be a copy marked "Draft."	(b)(7)(ii)	
b. Posted conspicuously on website (either the hospital facility's website or a conspicuously located link to a web site established by another entity).	(b)(7)(i)(A)	
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

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

Made accessible
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