2022 Community Health Needs Assessment

Stanford HEALTH CARE
STANFORD MEDICINE

ValleyCare

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1. EXECUTIVE SUMMARY

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The Patient Protection and Affordable Care Act of 2010, which was enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) every three years.

The CHNA must be conducted by the last day of a hospital's taxable year, and the CHNA report must be made widely available to the public. The CHNA must also include input from public health experts, local health departments, and the community. The community must include representatives of high-need groups, such as minority, low-income, and medically underserved populations.[1]

The 2022 CHNA serves as the basis for implementation strategies that are required to be filed with the IRS as part of the hospital organization's 2022 Form 990, Schedule H, four and a half months into the next taxable year.[1]

PROCESS AND METHODS

This 2022 assessment is the fourth such assessment conducted since the Affordable Care Act was enacted. It builds upon the information and understanding that resulted from the 2019 CHNA. The CHNA process, completed in fiscal year 2022 and described in this report, was conducted collaboratively by Stanford Health Care - ValleyCare (SHC - VC) and 12 other hospitals in Alameda and Contra Costa counties ("the Hospitals") in compliance with federal requirements. In addition, Alameda County Public Health and Contra Costa Health Services were essential partners in collecting primary and secondary data.

Community Input and Secondary Data

Community input was obtained during the summer and fall of 2021 by the research firm Ad Lucem through key informant interviews with local health experts, community leaders, and community organizations, and by the Alameda and Contra Costa counties' public health departments through focus groups with community residents. Secondary data, culled from various sources, were available for our hospital's service area (the "Tri-Valley area"), as well as separate cities within the Tri-Valley area, and the Tri-Valley/Central Contra Costa County region. (See Attachment 1: Secondary Data Indicators List for a list of indicators and sources.)

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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 from https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf

Identification of Health Needs

In November 2021, our hospital identified community health needs by (1) synthesizing primary qualitative research and secondary data and (2) filtering those needs through a set of criteria.

The CHNA process applied a social determinants of health framework and examined social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the priority health needs for SHC - VC's service area. This CHNA report explored inequities and disparities and placed particular emphasis on the health issues and contributing factors that impact historically underserved populations that disproportionately have poorer health outcomes across multiple health needs. These analyses will inform intervention strategies to promote health equity.

Prioritization of Health Needs

SHC - VC's Community Benefit Advisory Group (CBAG) met on March 2, 2022 to review the health needs identified during the assessment and to participate in the prioritization process. (The CBAG members who participated are listed in the Process and Methods section of this report.)

The CBAG used these criteria to prioritize the list of health needs:

- **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process.
- **Clear disparities or inequities.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Lacking sufficient community assets and/or resources.** The IRS requires that hospitals take into consideration whether existing assets/ resources are available to address the issue.
- **Multiplier effect.** A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

Prioritized 2022 Health Needs

Based on those criteria, the CBAG members reached consensus in ranking nine community health needs. These needs are listed below in our hospital's priority order, from highest to lowest. Summarized descriptions of each need, including statistical data and community feedback, appear in the Community Health Needs section of this report.

1. Housing and Homelessness
2. Behavioral Health
3. Economic Stability
4. Healthy Eating/Active Living, Diabetes and Obesity

5. Health Care Access and Delivery
6. Community Safety
7. Heart Disease and Stroke
8. Cancer
9. Climate and Natural Environment

NEXT STEPS

After making this CHNA report publicly available on the Community Benefits page of its website by August 31, 2022, SHC - VC will solicit feedback and comments about the report until two subsequent CHNA reports have been posted.[2] The hospital will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by January 15, 2023.

[2] https://valleycare.com/about-us/community-benefits.html

2. INTRODUCTION

CHNA BACKGROUND AND FEDERAL REQUIREMENTS

In 2021, Stanford Health Care - ValleyCare (SHC - VC) and 12 other hospitals in Alameda and Contra Costa counties (subsequently referred to as "the Hospitals") collaborated for the purpose of identifying critical health needs of the community. Working together, the Hospitals conducted an extensive Community Health Needs Assessment (CHNA). The 2022 CHNA built upon earlier assessments conducted by the Hospitals.

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

The federal definition of community health needs includes social determinants of health in addition to morbidity and mortality. For the purposes of this assessment, the Hospitals went beyond traditional measures to define "community health," including indicators about the physical health of the county's residents, as well as 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 SHC - VC's understanding that myriad factors impact community health. SHC - VC is committed to supporting community health improvement through upstream (social determinants of health) and downstream (health condition) intervention.

Beyond providing a national set of standards and definitions related to community health needs, the Affordable Care Act has had an impact on upstream factors. For example, the Affordable Care Act created more incentives for health care providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

CALIFORNIA'S ASSESSMENT HISTORY AND STATE REQUIREMENTS

California Legislative Senate Bill 697, enacted in 1994, stipulates that each private nonprofit hospital submit an annual report to the Office of Statewide Health Planning and Development that shall include, but not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, the hospital shall describe the process by which it involved the community in identifying and prioritizing

needs to be addressed. This community needs assessment shall be updated at least once every three years.[3]

The 2022 CHNA meets federal and state requirements.

SUMMARY OF 2019 CHNA

In 2019, SHC - VC collaborated with 14 other hospitals (Alta Bates Summit Medical Center and Herrick Campus; Delta Medical Center; Eden Medical Center; Kaiser Foundation Hospitals in Antioch, Fremont, Oakland, Richmond, San Leandro, and Walnut Creek; John Muir Health and its joint venture partner San Ramon Regional Medical Center; St. Rose Hospital; UCSF Benioff Children's Hospital Oakland; and Washington Hospital Healthcare System) to assess community health needs and to meet the IRS and SB 697 requirements.
SHC - VC's 2019 CHNA report is publicly available online.[4]

The health needs identified and prioritized through the 2019 CHNA process were:

- Behavioral Health
- Health Care Access and Delivery
- Housing and Homelessness
- Healthy Eating/Active Living, Diabetes and Obesity
- Heart Disease and Stroke
- Economic Stability
- Community and Family Safety
- Oral/Dental Health
- Cancer
- Climate and Natural Environment
- Transportation and Traffic

WRITTEN PUBLIC COMMENTS TO 2019 CHNA

So that the public may provide written comments on 2019 CHNA report, SHC - VC maintains a Contact Us email link on the Community Benefits page of its website.[5] This link and page will allow for public comments on the 2022 CHNA report as well.

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

[4] https://valleycare.com/content/dam/valleycare/community-benefits/2019-Community-Health-Needs-Assessment-(CHNA).pdf

[5] https://valleycare.com/about-us/community-benefits.html

As of the time this CHNA report was written, SHC - VC has not received any written comments about the 2019 CHNA report. The hospital will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate hospital staff.

3. OUR HOSPITAL AND THE COMMUNITY

ABOUT STANFORD HEALTH CARE - VALLEYCARE

Stanford Health Care - ValleyCare (SHC - VC) has been dedicated to providing high-quality, nonprofit health care to the Tri-Valley and surrounding communities since 1961. Through state-of-the-art technology and highly skilled physicians, nurses, and staff, SHC - VC provides a wide range of health care services at its Livermore, Pleasanton, and Dublin medical facilities. SHC - VC has a total of 242 licensed beds and a medical staff of over 600, offering an array of inpatient and outpatient services to the community.

COMMUNITY BENEFITS

As a community-based organization, SHC - VC understands the value of continuously assessing the health needs of the community it serves. By doing so, the hospital is able to establish a systematic process for identifying community health needs that will guide thoughtful and effective community investment for years to come.

Mission Statement: To care, to educate, to discover.

Vision: Healing humanity through science and compassion, one patient at a time.

COMMUNITY SERVED

SHC - VC's primary service area is the Tri-Valley. The Tri-Valley encompasses the suburban cities of Livermore, Pleasanton, Dublin, and San Ramon in the three valleys from which it takes its name: Amador Valley, Livermore Valley, and San Ramon Valley. Dublin, Livermore, and Pleasanton are in Alameda County, and Danville and San Ramon are in Contra Costa County. SHC - VC operates facilities in Dublin, Livermore, and Pleasanton (see Map of the Community Served, next page). The Tri-Valley accounts for the majority of SHC - VC's inpatient discharges.

The U.S. Census estimates a population of about 379,000 in the Tri-Valley.[6] The area is highly diverse: The two largest ethnic subpopulations are white and Asian (51% and 28%, respectively).[6] The non-white population accounts for 49% of the population in the Tri-Valley area.[6]

[6] Esri Demographics, based on U.S. Census Bureau TIGER/Line geodatabases, using 2020 U.S. Census data.

Map of the Community Served

Demographics, Tri-Valley

Race/Ethnicity		Socioeconomic Data	
Total population	378,623	Median age	41
American Indian/ Alaskan Native	0.2%	People living in poverty (<100% federal poverty level)	4.3%

Race/Ethnicity		Socioeconomic Data	
Asian	28.0%	Children in poverty	4.0%
Black	2.5%	Uninsured population	2.3%
Hispanic/Latinx	13.1%	Uninsured children (ages 0-18)	0.9%
Pacific Islander/ Native Hawaiian	0.3%	Adults with no high school diploma	4.3%
White	51.3%	Unemployment	11.6%
Multiracial	4.3%	Limited English proficiency	5.4%
Some Other Race	0.2%	Neighborhood Deprivation Index	-1.4

Sources: Population, race/ethnicity, unemployment: Esri Demographics, based on U.S. Census Bureau TIGER/Line geodatabases, using 2020 census data. Age, poverty, insurance, education, English, Neighborhood Deprivation Index: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
*Percentages do not add to 100% because they overlap.

Housing costs are high. In the Tri-Valley, the median rent is $2,374. The 2021 median home price was about $1,050,000 in Alameda County and $800,000 in Contra Costa County.[7]

Two key social determinants, income and education, have a significant impact on health outcomes. The median household income in the Tri-Valley is $154,165, which is close to double that of California ($82,053).[8] As displayed in the chart on the next page, median incomes in the major cities in the Tri-Valley differ at the high and low ends from California. On average, 69% of people in Tri-Valley cities live in households with incomes of $100,000 or more, compared with only 41% in California overall. Only about 14% of the population in Tri-Valley cities have household incomes below $50,000, compared to more than double that proportion in California (32%). By comparison, the 2021 Self-

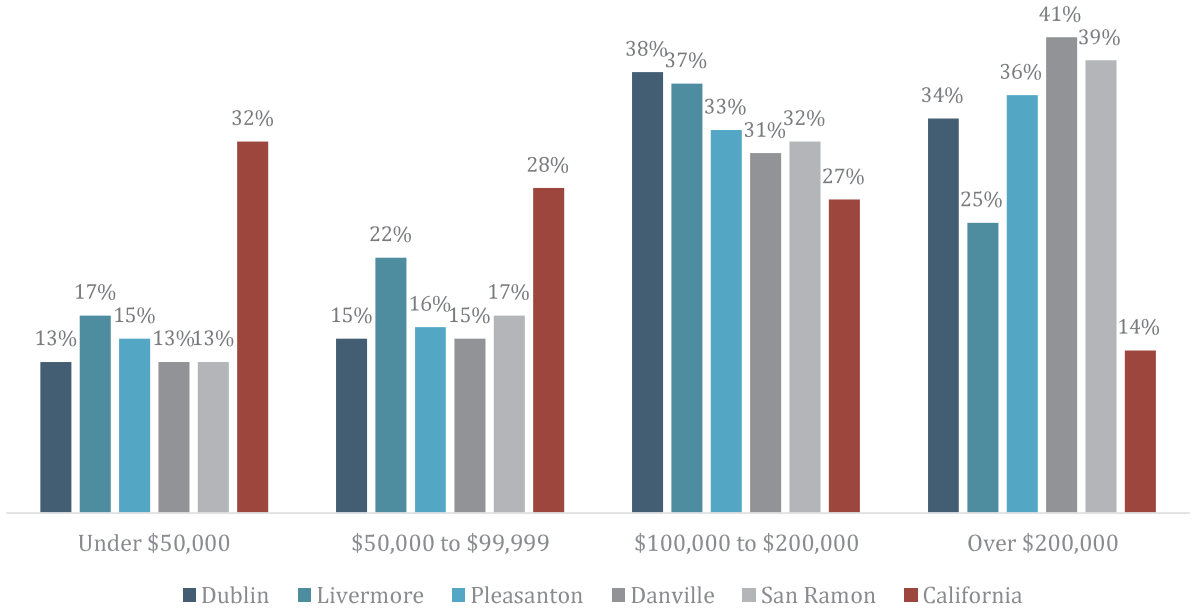
[7] Redfin. (2021.) *Alameda County Housing Market.* Retrieved from https://www.redfin.com/county/303/CA/Alameda-County/housing-market . Contra Costa County Housing Market. Retrieved from

[8] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.

Sufficiency Standard[9] for a two-adult family with two children was about $128,017 in Alameda County and about $132,360 in Contra Costa County.[10]

Despite the fact that over two-thirds of households in the Tri-Valley earn more than $100,000 per year, over 4% of Tri-Valley residents live below the federal poverty level.[11]
Similarly, over 4% of adults in the Tri-Valley do not have a high school diploma.[12] Just over 2% of people in the Tri-Valley are uninsured.[12]

Major Cities Median Household Income Ranges



Source: Census Reporter, https://censusreporter.org/profiles (American Community Survey, 2015–2019).

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the Tri-Valley's population overall is healthier than the national average.[13] Although the Tri-Valley is quite diverse and

[9] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

[10] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org/node/44

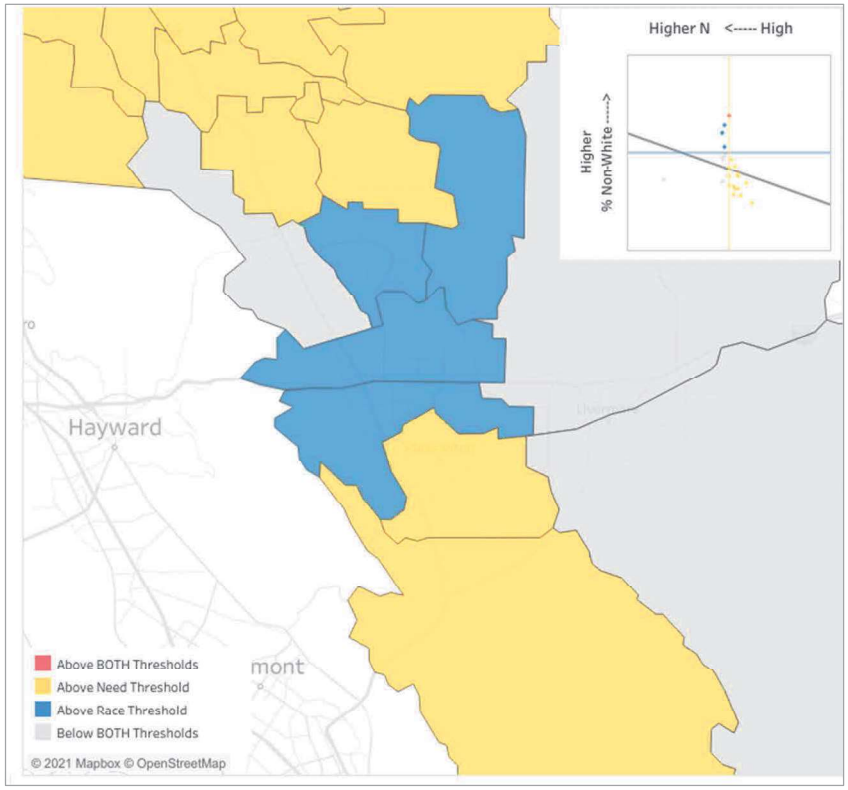
[11] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.

[12] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.

[13] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while the Tri-Valley is scored at -1.4. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. &

has substantial resources (see *Attachment 4: Assets and Resources*), there is significant inequality in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality[14], is higher in certain Zip Codes compared to others (see map below).

Correlation Between Income Inequality & Non-White Population, By Zip Code



Note: Parts of the Tri-Valley exhibit income inequality (yellow areas). "Need Threshold" is the U.S. Gini Index, 0.4. "Race Threshold" is 50% non-white. Source: Community Health Data Platform, 2021.

Certain areas also have poorer access to walkable neighborhoods (e.g., Zip Code 94551 in Livermore), or jobs (e.g., Zip Code 94582 in San Ramon). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

[14] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

4. ASSESSMENT TEAM

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

Stanford Health Care - ValleyCare collaborated with the following health systems and organizations to prepare the 2022 CHNA:

- Alameda County Public Health Department
- Applied Survey Research
- Contra Costa Health Services
- 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
- Sutter Health Bay Area
  (Alta Bates Summit Medical Center and Herrick Campus, Delta Medical Center, and Eden Medical Center)
- UCSF Benioff Children's Hospitals

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights, LLC, an independent local research firm, completed the 2022 Community Health Needs Assessment. To do so, Actionable Insights (AI) assisted SHC - VC with CHNA planning, collected secondary data, synthesized secondary data and key primary data insights, facilitated the processes of identifying community assets and health needs, assisted with determining the prioritization of community health needs, and documented the processes and findings in this report.

The project managers were Jennifer van Stelle, PhD, and Melanie Espino, the co-founders and principals of Actionable Insights. Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, housing, STEM (science, technology, engineering, and math) education, youth development and community collaboration. AI conducted community health needs assessments for seven hospitals during the 2021–2022 CHNA cycle.

More information about Actionable Insights is available on the company's website.[15]

[15] https://actionablellc.com/

Ad Lucem Consulting, a public health consulting firm, specializes in initiative design, strategic planning, grants management, and program evaluation, tailoring methods and strategies to each project and adapting to client needs and priorities, positioning clients for success. Ad Lucem Consulting works in close collaboration with clients, synthesizing complex information into easy-to-understand, usable formats, bringing a hands-on, down-to-earth approach to each project. Ad Lucem Consulting supports clients through a variety of services that can be applied to a range of issues.

Ad Lucem Consulting has developed CHNA reports and Implementation Plans for many hospitals, including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies. For SHC - VC during the 2021–2022 CHNA cycle, Ad Lucem conducted and analyzed key informant interviews and analyzed focus group data, providing key themes and quotes, and described the processes and methods it used in those efforts.

More information about Ad Lucem Consulting is available on the company's website.[16]

[16] www.adlucemconsulting.com

5. PROCESS AND METHODS

The Hospitals collaborated on the primary data requirements of the CHNA, updating and building on work done in prior years, including many of the themes identified in previous CHNA cycles. The 2022 CHNA process applied a social determinants of health framework and examined the Tri-Valley's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the area.

The CHNA data collection process took place over five months in 2021 and culminated in this report, written in late 2021 and early 2022. The phases of the process are depicted below.

CHNA PRINCIPLES

COVID-19: This assessment incorporates COVID-19 data in two ways: 1. Statistical data detailing the disease and associated health conditions and 2. Qualitative data provided by community experts and residents. As a novel virus, statistical data is limited at this time; however, community experts and residents offered ample qualitative data on the economic and social impacts of COVID-19 on local underserved communities. Among the statistical data that are available, below are the latest COVID-19 statistics for Alameda and Contra Costa counties, as of mid-March 2022:

- Alameda County[17, 18]
  - Cases:
    - Cumulative total cases[17]: 256,039
    - Seven-day average number of daily cases[18]: 135
    - Seven-day average rate of daily cases[18]: 8 per 100,000 people
    - Seven-day average number of people hospitalized daily[18]: 125
  - Infection and tests:
    - Rate of infection since January 2020[18]: 1 in 6 people

[17] Alameda County Health Care Services Agency, Public Health Department. (2022). *COVID-19 Data.* Data retrieved from https://covid-19.acgov.org/data.page? Data by ethnicity suggest that people of color in Alameda County are infected and dying at rates higher than the overall county averages. In the Alameda County part of the Tri-Valley, the county's data suggest that Livermore residents have the highest infection and death rates compared to Dublin and Pleasanton.

[18] The New York Times. (2022). California Coronavirus Tracker. *The New York Times.* Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html

        - Current rate of spread (R-eff[19]): 0.83 vs. 0.81 statewide[20]
        - 14-day average test positivity rate[18]: 2%
    - Deaths:
        - Rate of deaths since January 2020[18]: 1 in 923 people
        - Cumulative total deaths[17]: 1,810
        - Seven-day average number of daily deaths[18]: 3
        - Seven-day average rate of daily deaths[18]: 0.13 per 100,000 people
    - Vaccinations:
        - Fully vaccinated (all ages)[17]: 83%
            - Dublin: 84%
            - Livermore: 78%
            - Pleasanton: 87%
        - Fully vaccinated (age 5+)[18]: 86%
        - Fully vaccinated (age 65+)[18]: 93%

- Contra Costa County[18, 21]
    - Cases:
        - Cumulative total cases[21]: 189,751
        - Seven-day average number of daily cases[18]: 101
        - Seven-day average rate of daily cases[18]: 9 per 100,000 people
        - Seven-day average number of people hospitalized daily[18]: 90
    - Infection and tests:
        - Rate of infection since January 2020[18]: 1 in 6 people
        - Current rate of spread (R-eff[19]): 0.90 vs. 0.81 statewide[20]
        - 14-day average test positivity rate[18]: 3%
    - Deaths:
        - Rate of deaths since January 2020[18]: 1 in 911 people
        - Cumulative total deaths[21]: 1,275
        - Seven-day average number of daily deaths[18]: 1
        - Seven-day average rate of daily deaths[18]: 0.09 per 100,000 people
    - Vaccinations[18]:
        - Fully vaccinated (all ages): 81%
        - Fully vaccinated (age 5+): 86%
        - Fully vaccinated (age 65+): 95%

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[19] "R-eff is the average number of people an infected person will infect. … Value less than 1 means decreasing spread. Value greater than 1 means increasing spread." CalCAT. (2022). *California COVID Assessment Tool.*
[20] CalCAT. (2022). *California COVID Assessment Tool.* Data retrieved from https://calcat.covid19.ca.gov/cacovidmodels/
[21] Contra Costa Health Services. (2022). *COVID-19.* Data retrieved from https://www.coronavirus.cchealth.org/overview In the Contra Costa County part of the Tri-Valley, the county's data suggest that San Ramon residents have nearly the same cumulative case rate as Danville residents.

SHC - VC will continue to monitor and address the health effects, trends, and health care needs of COVID-19 as more is learned about the disease, its progression, and its short- and long-term impacts.

Racism: Racism, both structural and interpersonal, are fundamental causes of health inequities, health disparities and disease. The impact of these inequities on the health of Americans is severe, far-reaching, and unacceptable. Across the country and locally, racial and ethnic minority populations experience higher rates of poor health and disease in a range of health conditions, when compared to their white counterparts.[22] This assessment considers systemic racism as a root cause of racial and ethnic health inequities, which are detailed in the health need descriptions on pages 30-40 of this report.

SECONDARY DATA COLLECTION

Data sources were selected to understand the Tri-Valley population's health, including specific underserved and/or underrepresented populations, and to fill previously identified information gaps. Also, data on potential health disparities by geographic area and ethnicity were analyzed. These data were used to inform our health needs lists.

AI collected and analyzed over 300 quantitative health indicators from existing sources using the public Community Health Data Platform sponsored by Kaiser Permanente and other online sources, such as KidsData.com, the public Healthy Alameda County data platform, and the U.S. Census Bureau, as well as the two county public health departments. Findings from the previous community health needs assessment (2019) were also used whenever available to increase understanding of the health needs in the Tri-Valley area and to assess priorities in the community.

For the CNHA, local data were compared to state benchmarks (California averages and rates) to help determine the severity of a health problem and to identify disparities. The following questions were asked:

- How do these indicators perform against accepted benchmarks?
- What are the inequitable outcomes and conditions for people in our community?

For further details on the sources of data used, see Attachment 1: Secondary Data Indicators List.

PRIMARY DATA COLLECTION (COMMUNITY INPUT)

Consultants used two strategies for collecting community input: key informant interviews with health experts, and focus groups with residents. See Attachment 2: Community Leaders, Representatives,

[22] https://www.cdc.gov/healthequity/racism-disparities/index.html

and Members Consulted for more information on the participants. See Attachment 3: Qualitative Research Protocols for protocols and questions.

Key Informant Interview Methodology

Consulting firms Applied Survey Research (ASR) and Ad Lucem Consulting conducted a total of 10 key informant interviews relevant to the Tri-Valley area. Interviewees included organizations serving both Alameda and Contra Costa counties as well as organizations focused on the Tri-Valley. Interviewees represented diverse sectors including: public health, health care, mental health care, food assistance, homeless and social services, and education. The key informants were identified by members of the Alameda Contra Costa Hospital Council CHNA Collaborative and Stanford Health Care - ValleyCare staff.

All interviews were conducted by telephone in English and followed a standard set of interview questions and the interviewers took detailed notes during the call. At the beginning of the interview, confidentiality was assured.

Interview topics: Interview questions were developed by ASR. Questions addressed the following topics:

- Priority placed on 2019 health needs
- Other priority health needs
- Impact of COVID-19 on priority health needs
- Challenges to addressing priority health needs
- Sources of information on health needs
- Strategies to address priority health needs
- Health inequities and disparities
- Strategies to address inequities/disparities
- Existing community resources to address priority health needs

See Attachment 3, Qualitative Data Collection Protocols, for interview guide.

Data Analysis: ASR delivered to Ad Lucem Consulting a spreadsheet containing individual interviewee responses and key themes. Ad Lucem Consulting produced interview transcripts. First Ad Lucem Consulting identified themes and organized them into the health needs defined by the Kaiser Permanente Community Health Needs Assessment (CHNA) Data Platform. Next the number of mentions for all themes related to a particular health need were tallied to develop an interview data score. Health needs were assigned points based on the frequency of mentions of the health need by key informants. Points for each health need were tallied across interviewees to develop interview scores for health need priority, racial/ethnic disparities, geographic or other disparities and impact of the COVID-19 pandemic on the health need.

Focus Group Methodology

Five community resident focus groups were conducted; two in Alameda County and three in Central Contra Costa County. Three groups were conducted in English, two were conducted in Spanish. Participants were from underserved, low-income communities.[23]

In Alameda County, trained Public Health Department staff conducted the focus groups. Public Health staff recruited participants, organized logistics, and facilitated the focus groups. During each focus group, Public Health Department staff audio-recorded the focus group discussion for transcription.

Contra Costa Public Health Services/Public Health Community Ambassadors were trained by Ad Lucem Consulting to conduct focus groups with community residents. Health Services/Public Health publicized the focus groups widely to recruit participants. Contra Costa County focus groups were recorded for transcription.

The Public Health Departments collected focus group participant demographics through a screener survey; Ad Lucem Consulting was provided with analyzed screener survey results for inclusion in CHNA reports. Focus group recordings were translated into English as needed and all recordings were transcribed. Focus group transcripts were delivered to Ad Lucem Consulting for analysis. Participants received a small monetary gift as an incentive and thank you.

Focus group question guide: A focus group guide ensured consistency across groups. The focus group questions were developed by The Alameda Contra Costa Hospital Council CHNA Collaborative based on focus group questions designed by Ad Lucem Consulting for previous CHNAs. Questions were open-ended and additional probing questions were used as needed to elicit more in-depth responses and richer details. The questions were translated into Spanish. Focus group facilitators adjusted the questions as needed to ensure participant comprehension and maximize interaction.

At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses. An overview of the discussion was provided as well as a review of discussion ground rules. Questions addressed the following topics:

- Facilitators and barriers to health in the community
- Priority health needs facing community and why important
- Priority given to 2019 health needs
- COVID impact on health needs
- Strategies that are working to address health issues and new strategies needed
- Health inequities & disparities and strategies to reduce inequities & disparities

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

List of Focus Groups Conducted for CHNA 2022

Participants	Focus Group Host/Partner	Date	Number of Participants
Spanish-speaking Latinx Central Contra Costa County community members	Contra Costa Health Services	9/23/2021	10
Spanish-speaking older adult Livermore community members	La Familia	9/24/2021	11
Older adult Central Contra Costa County community members	Contra Costa Health Services	9/28/2021	9
Black Central Contra Costa County community members	Contra Costa Health Services	9/29/2021	2
Formerly unhoused Livermore community members	Goodness Village	10/6/2021	10

See Attachment 3, Qualitative Data Collection Protocols, for focus group discussion guide.

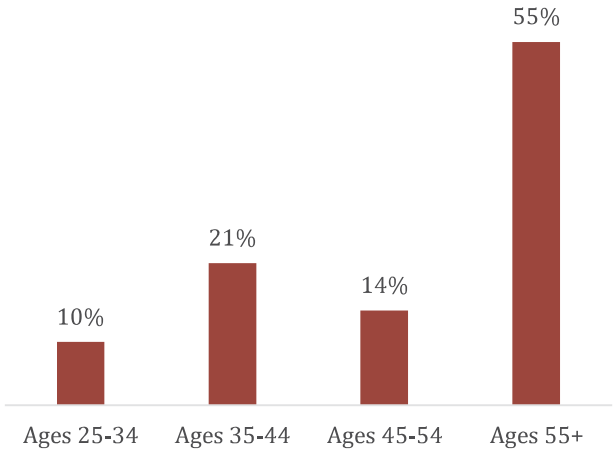
Data Analysis: Focus group transcripts were reviewed and coded to identify prominent themes. Health topics discussed by focus group participants were organized into the health need categories defined by the Kaiser Permanente CHNA Data Platform. Health needs were assigned points based on the frequency and importance given to the health need by focus group participants. Points for each health need were tallied across focus groups to develop scores for health need priority, racial/ethnic disparities, geographic or other disparities and impact of the COVID-19 pandemic on the health need.

CHNA Focus Group Participant Demographics

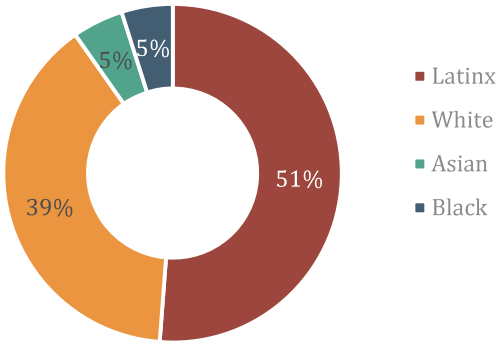
A total of 42 people participated in focus groups for the CHNA. Half (50%) lived in the Alameda County part of the Tri-Valley, and the other half lived in Contra Costa County.[24]

[24] City of residence was not collected from Central Contra Costa County focus group participants.

Participant Age Groups*



Participant Racial/Ethnic Groups



* The two Public Health Departments used different age ranges to gather data (e.g., 25-34 vs. 26-35); ranges in the chart are those representing the majority of focus groups.

The charts above show the age ranges of participants, as well as their race (N=41). Over half (51%) of participants were of Latinx ethnicity (N=41). More than three-quarters of participants (76%) identified as female, with the rest identifying as male (N=42). More than half (55%) of participants were over age 55 (N=42).

INFORMATION GAPS AND LIMITATIONS

A lack of data limited our ability to fully assess some health issues that were identified as community needs during the 2022 CHNA process. Conducting the 2022 CHNA presented unique challenges for data collection:

1. As was the case across the nation due to the COVID-19 pandemic, public health departments' epidemiologists lacked sufficient resources to conduct data analyses in the same way they had in years past. This affected our ability to assess data on infectious diseases, cancer, etc.
2. Our CHNA, as it has since 2012, employed data from the publicly available Kaiser Permanente Community Health Needs Dashboard. As of 2021, the platform no longer provides data breakdowns by race/ethnicity and instead simply offers correlations between race and poor health outcomes (which are presented in this report).

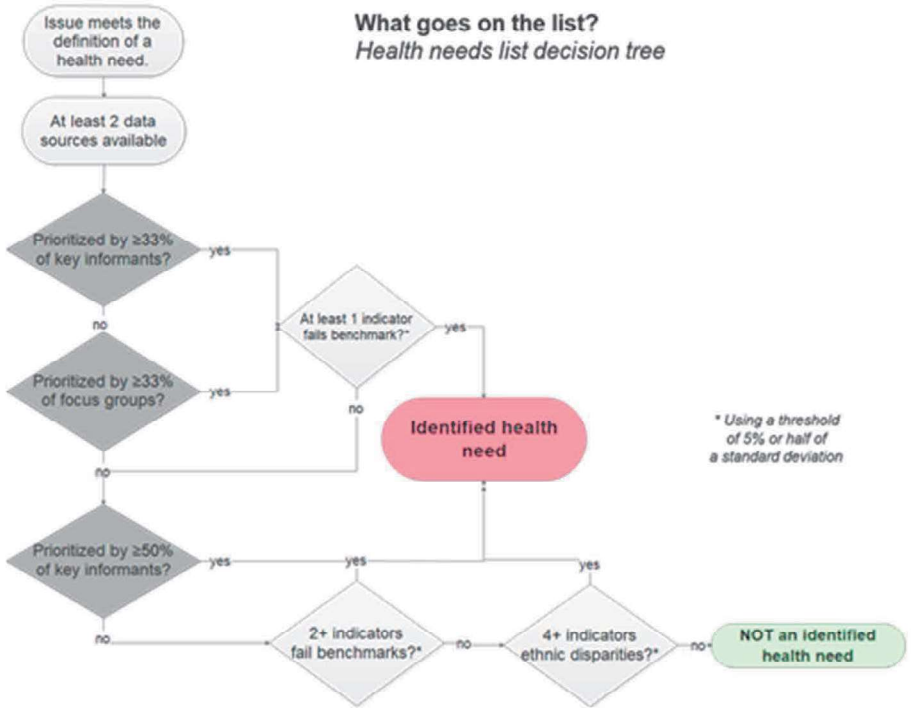
In both cases, when current data were lacking, Actionable Insights relied on data from our previous CHNA.

3. Lastly, some indicators are difficult to measure or are just emerging. Statistical information related to these topics was scarce:

- Impact of social media on adolescent mental health
- Youth cigarette and e-cigarette use
- Recent marijuana use and related behavioral health data
- Domestic violence and related community safety data
- Cognitive decline data, including Alzheimer's Disease prevalence rate and hospice admissions for dementia
- Caregiver impact data (unpaid care, health effects)
- Oral health data
- Experiences of discrimination
- Data breakdowns by income/socioeconomic status
- Economic inequities within key zip codes
- Health conditions associated with COVID-19 infection

DATA SYNTHESIS: IDENTIFICATION OF 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. These criteria are depicted in the diagram below; for terms and definitions, see Key Terms and Definitions on the next page.



Key Terms

- 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 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 the California state average.

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 need: A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
Health outcome: A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality.
Health indicator: A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

Details of Criteria

1. Meets the definition of a "health need" (see Definitions box above).
2. At least two data sources were consulted.
3. a. Prioritized by ≥ 33% of key informants or focus groups and at least one direct indicator fails the benchmark by ≥5%.
   b. If not (a), prioritized by ≥ 50% of key informants or focus groups.
   c. If not (b), two or more direct indicators fail the benchmark by ≥5%.
   d. If not (c), four or more indicators must show ethnic disparities that fail the benchmark by ≥5%.

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 2022, this process led to the identification of nine community health needs that fit all three criteria. The list of needs, in priority order, appears on page 29.

For further details about each health need see pages 30-40 or contact Stanford Health Care - ValleyCare.

PRIORITIZATION OF HEALTH NEEDS

SHC - VC's Community Benefit Advisory Group (CBAG) met virtually via Zoom on March 2, 2022 to review the health needs identified during the CHNA and to participate in the prioritization process.

The CBAG members who participated were:

- Tracey Lewis Taylor, Chief Operating Officer
- Monica Davila, Chief Nursing Officer
- David Svec, MD, Chief Medical Officer
- John Yee, MD, VP Clinical Initiatives
- Mino Sastry, VP Service Lines and Market Development
- Denise Bouillerce, Sr. Director, Government & Community Relations, PR/Marketing
- Marivic Paz, MBA, BSN, RN, Director of Utilization Management

The CBAG used these criteria to prioritize the list of health needs:

- **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process.
- **Clear disparities or inequities.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Lacking sufficient community assets and/or resources.** The IRS requires that hospitals take into consideration whether existing assets/ resources are available to address the issue.
- **Multiplier effect.** A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

Based on those criteria, the CBAG members reached consensus in ranking the nine community health needs as follows. (See the Community Health Needs section for a summarized description of each need.)

1. Housing and Homelessness
2. Behavioral Health
3. Economic Stability
4. Healthy Eating/Active Living, Diabetes and Obesity
5. Health Care Access and Delivery
6. Community Safety
7. Heart Disease and Stroke
8. Cancer
9. Climate and Natural Environment

6. COMMUNITY HEALTH NEEDS

SUMMARIZED DESCRIPTIONS OF 2022 PRIORITIZED COMMUNITY HEALTH NEEDS

Summary descriptions of each health need appear on the following pages.

Housing and Homelessness

Half of all key informants and three of five focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in the Tri-Valley are extremely high; the median home rental cost is more than 40% higher than the median state home rental cost. The qualitative data reflected this: key informants asserted that the Tri-Valley area is an expensive place to live, and that many families struggled to support themselves on an income that is inadequate compared to the cost of living. They said the COVID-19 pandemic made the existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food. Key informants noted that a lack of affordable housing in the Tri-Valley, made worse by the COVID-19 pandemic, has led to an increase in overcrowded homes. These housing struggles may cause anxiety, leading to mental/behavioral health difficulties and interpersonal issues, and sometimes escalating to domestic violence. Focus group participants also felt that the housing crisis was exacerbated by the COVID-19 pandemic. They also said that laws and resources that supported renters during the pandemic had been critically important.

> *"I do not have money to invest in a home. I have to pay bills and I am a single mother, I must choose between paying the rent, the bills, or the car."*
>
> *— Spanish-Speaking Focus Group Participant*

Key informants mentioned gentrification leaving families unable to afford living in their changing communities, yet simultaneously not having the means to move away. Focus group participants said that residents were moving from the Tri-Valley because of housing prices. Participants acknowledged that there is a significant need to develop more affordable housing.

> *"In East and West Dublin we have found more kids that are homeless, with families that have lost their jobs."*
>
> *— Education Expert*

Focus group participants felt that those experiencing homelessness are facing co-occurring issues and barriers to health, like food insecurity and mental and behavioral health issues. Participants said that community resources for homeless veterans in particular are insufficient or non-existent, and those needing help have to go out of the county to get it.

Behavioral Health

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need, being prioritized by nearly all key informants and two out of five focus groups.

According to key informants, mental health, which is already bad, is now at a critical level after the fear, anxiety, stress, job loss, isolation, and lack of trust that resulted from the COVID-19 pandemic. Focus group participants stated that the COVID-19 pandemic negatively impacted mental health due to fear of being out in public, using public transportation, and a stigma about mask-wearing. Key informants stated that mental health does not discriminate based on age, race, or socio-economic status. Especially after the trauma of the pandemic, mental health is a crisis across all populations. Informants did, however, note disparities based on geography, explaining that many mental health providers are centralized in Oakland and San Francisco and not in the Tri-Valley area. Participants corroborated this, explaining that there is often a long waiting list to see a mental health provider, specifically citing a shortage of Spanish-speaking therapists.

> *"How do you talk about mental health across racial and ethnic boundaries in addressing that stigma, in building trust with the mental health advocacy system?"*
>
> *— Public Health Expert*

Focus group participants felt that children faced significant stress and anxiety because of the pandemic. According to key informants, school systems do not adequately support students of color and need to make schools more welcoming, inclusive, and safe places for children. Key informants stated that the pandemic had a major impact on the mental health of youth, citing an increase in suicide attempts, suspensions, and behavioral issues. Youth mental health statistics bear out this concern: cyberbullying is experienced by greater percentages of Pacific Islander youth in both counties, and by Native American youth in Contra Costa County, than by all youth statewide. Pacific Islander youth in Alameda County also experience depression-related feelings in higher proportions than California youth overall. School-based bullying and harassment are greater for multi-ethnic youth and youth of "Other" ancestries[25] in Contra Costa County than all California youth. Finally, in Alameda County, the proportion of teens contemplating suicide is higher than teens statewide for Native American, Pacific Islander, multi-ethnic, and Other youth, while in Contra Costa County, it is higher than the state for Asian, Pacific Islander, and multi-ethnic youth. Experts note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive

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

needed care and are more likely to receive poor quality care when treated."[26] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues.[27]

> *"Everyone talks about the mental health of students in particular and has the idea that it has gotten more intense during COVID. This was a priority in the Tri-Valley area in particular. There were suicides that shocked the community."*
>
> *— Public Health Expert*

With regard to substance use, binge drinking is higher in Dublin, Livermore, and Pleasanton than it is statewide. The impaired driving mortality rate is higher in the Tri-Valley/Central Contra Costa County area than in California. In addition, the rate of visits to emergency departments for substance use has been trending up in Alameda County overall. Related to these statistics, focus group participants believed that drug and alcohol users made public spaces less safe for the community. Key informants mentioned a particular need to address substance use within the unhoused community.

> *"I have also seen people drinking [alcohol] and even breaking bottles. They were tossing them to the grass, and I told them not to because we bring our children, but they just laughed at me. I was very upset; I called the cops, but they just asked what my name was and at what park it was. I stayed there to wait for the cops, but they never showed. So… we also must put up with the cops not listening to us."*
>
> *— Spanish-Speaking Focus Group Participant*

Economic Stability

More than two-thirds of key informants and one focus group rated economic stability, including education, income, and employment, as a high community priority. Focus group participants believed there were not enough employment opportunities in the Tri-Valley area that paid enough to afford the expensive rents in the area. Key informants pointed to significant disparities in income in Pleasanton, Dublin, and Livermore, with many residents having significant means and others having little. They stated that many families are struggling to stay in the area for jobs and school, despite it being difficult to afford the cost of living. Our 2019 CHNA report described racial and ethnic disparities in

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[26] McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, 27(2), 393–403. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

[27] Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

income, with a larger proportion of the Black population in the Tri-Valley/Central Contra Costa area experiencing poverty than California's population overall.

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English-language arts standards compared to California 11th graders overall. Also, a smaller percentage of both counties' Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of Alameda County's Black and Pacific Islander high school graduates, and Contra Costa County's Black and Latinx high school graduates, completed college-preparatory courses compared to high school graduates statewide. The high school drop-out rate is particularly high among Alameda County's Latinx youth compared to all California youth. Building on these figures, in our 2019 CHNA report, we found a higher proportion of the Tri-Valley/Central Contra Costa County area's Latinxs, Pacific Islanders, and residents of Other ethnicities over ages 24 without a high school diploma compared to all Californian adults over age 24.

> *"There are students in this district who don't [have means]. Let's say a student has academic issues, some parents can afford tutoring outside our school system and some parents can't. There's a socioeconomic disparity that manifests into an equity issue for us."*
>
> *— Education Expert*

Qualitative data showed that COVID created more economic insecurity for those who lost work. Focus group participants said that small businesses struggled to survive the pandemic. This had a ripple effect throughout the economy, leading to loss of income and unemployment and subsequently housing. According to key informants, pandemic related job loss was a significant issue in the community that had broad effects including increased food insecurity, homelessness, and significant mental health issues. Key informants noted that parental job loss because of the COVID-19 pandemic had a trickle-down effect through families, citing students who withdrew from school due to stressors at home. Prior to the pandemic, a larger percentage of Dublin youth were not in school and not working than California youth overall.

> *"Wages of families may not be supporting families. Many have multiple families in one household, where COVID exposure is an issue that then impacts employment."*
>
> *— Education Expert*

In reference to school, key informants said the virtual learning environment left many students behind academically. Statistics from before the pandemic indicated greater proportions of Black students in both counties experienced low school connectedness than all California students. Greater proportions

of Latinx and Other students in Contra Costa County had low levels of meaningful participation in school than students statewide. Key informants also stated that access to childcare is a major issue. Affordable care is limited for low-income parents, and fear of exposure to COVID-19 has kept many parents wary of utilizing childcare services. Additionally, childcare facilities that can support children who have experienced homeless or other trauma were called out as a need.

Focus group participants specifically called out children, single parents, and people experiencing homelessness as populations that are experiencing significant food insecurity. Even before the pandemic, the proportion of Black children in Contra Costa County who went to school without having breakfast was higher than the proportion of all children statewide. According to key informants, food insecurity is on the rise in the Tri-Valley, especially among the Asian community in Pleasanton. The COVID-19 pandemic made an existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food.

> *"Oftentimes food ends up being the thing people are forced to cut back on when they can't cut back on other items (like rent and childcare)."*
>
> *— Food Insecurity Expert*

Healthy Eating/Active Living, Diabetes and Obesity

Two out of five focus groups and one key informant identified healthy eating and active living opportunities as top health needs. According to key informants, a significant increase in screen time during the pandemic has led to an increase in childhood obesity. Larger proportions of children in Alameda and Contra Costa counties do not meet fitness standards compared to children statewide.

The rate of adults with diabetes is trending up in Alameda County. Moreover, the proportion of the adult population in Livermore with obesity is higher than in Alameda County overall. Perhaps related to this, a smaller proportion of Livermore adults walk regularly than all adults in Alameda County. Both key informants and focus group participants discussed the need for more safe parks and outdoor spaces in the community to exercise and recreate. Focus group participants believed that existing outdoor parks and spaces had been taken over by groups that made the spaces feel unsafe (because of drug and alcohol use). Participants specifically stated that communities of color faced barriers to living a healthy lifestyle, citing the lack of parks in urban areas. In addition, focus group participants cited climate and environment issues (high temperatures and reduced air quality) as barriers to outdoor exercise opportunities.

> *"I'm always an advocate for open space, and more parks versus development. That's the big issue in terms of housing availability versus parks."*
>
> *— Older Adult Focus Group Participant*

In the Tri-Valley, a far larger percentage of workers drive alone, with long commutes, compared to all Californians. Related to this, focus group participants stated that long commutes to work negatively impacted their well-being. Also, in both Dublin and Livermore, the proportions of employed people who walk to work are substantially smaller than the statewide average.

Tri-Valley residents have lower access to grocery stores than their counterparts statewide. Similarly, data show that among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in the Tri-Valley than the state average. Key informants stated the need for medical providers to do a better job of linking nutrition with overall health for patients and connecting them with community resources that could help support healthier dietary patterns.

> *"Clientele who come in with diabetes and other health-related issues are healthier just from eating with us. Food is medicine."*
>
> *— Food Insecurity Expert*

Our 2019 CHNA report identified disparities in diabetes and obesity, with Tri-Valley/Central Contra Costa County Black adult and Latinx youth populations experiencing obesity at higher rates than the state. We also reported lower rates of diabetes management among Black people in the Tri-Valley/Central Contra Costa County area than the state. Some focus group participants in the 2022 CHNA said that "lifestyle diseases," like obesity and diabetes, were prevalent in the community and that this was a result of inequities in neighborhoods' built environment. Similarly, experts writing on behalf of the American Diabetes Association describe placing "socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations."[28]

> *"We are seeing a lot of people who are new to food insecurity. We are getting a lot of requests for specific foods that we haven't gotten before and are more mindful about what meats to include for community members' diet restrictions (like not using pork for some meals)."*
>
> *— Food Insecurity Expert*

Health Care Access and Delivery

Health care access and delivery, which affects various other community health needs, was identified as a top health need by almost all focus groups and over half of key informants. Focus group

[28] Ogunwole, S. M. & Golden, S. H. (2021). Social Determinants of Health and Structural Inequities—Root Causes of Diabetes Disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from https://care.diabetesjournals.org/content/44/1/11

participants cited a lack of providers and difficulty getting an appointment as issues contributing to access to care and mentioned specific communities facing inequities in accessing care: Latinx, undocumented people, veterans, seniors, and unhoused populations. Participants specifically believed that seniors and the uninsured face a disproportionate burden when it comes to income and paying for healthcare. Key informants pointed to an income gap impacting the ability of many to access care: those making too much to be eligible for Medi-Cal yet not enough to afford private insurance. Informants also highlighted inequities in access to care in low-income, underserved, Black, and LGBTQ+ populations and called for diverse and culturally competent providers. Key informants additionally mentioned a rapidly increasing Asian population in the Tri-Valley area. Access issues have arisen due to the multitude of languages spoken and a lack of providers and interpreters who speak these languages.

> *"Access …impacts our underserved populations, their ability to get to health care and mental health care, especially if parents aren't able to get their children to health care because they are working. Transportation and location of services are an issue. Special needs like specialty care is a barrier because services are in Dublin or Pleasanton and much of our population relies on public transportation, so it's been limited with COVID."*
>
> *— Education Expert*

Focus group participants linked transportation with health stating that traffic, road work, and a lack of cheap public transportation options made it difficult for them to access health care/get to their appointments. Key informants noted that many specialty services are located in Oakland or San Francisco. This is a barrier to access for many who do not have adequate means of transportation. As a result of the COVID-19 pandemic, informants noted patients gained expanded options to see providers out of their area via telehealth. Key informants also mentioned seeing increased collaboration among community entities to figure out solutions to provide care faster. However, informants also acknowledged disparities when it comes to telehealth, specifically among seniors who have difficulty utilizing new technologies and low-income residents who might not have reliable access to a computer or the internet. Key informants also called out issues in delayed dental care, specifically for children and unhoused populations, due to the pandemic. Additionally, informants noted a workforce shortage across all types of care.

> *"One of the emerging issues is access to technology. We've seen that be a significant concern with our senior patients. We worry about families living in poverty situations who may or may not have computer access. I think telehealth and access to technology as a whole is something we need to pay attention to."*
>
> *— Local Health Expert*

The COVID-19 pandemic exacerbated existing racial and health inequities, with people of color accounting for a disproportionate share of COVID-19 cases, hospitalizations, and deaths. Focus group participants agreed that the pandemic disproportionately impacted communities of color. Key informants mentioned that some communities are not accessing the vaccine because of their legal status. Informants pointed out the importance of considering the social determinants of health, and the need for providers to look at factors like housing, job stability, and food security, rather than a simple medical approach, to address structural racism's impact on health.

Multiple key informants pointed to a disparity in infant mortality in the Black community. They cited factors like a lack of culturally competent care, having to choose between significant others and doulas in the delivery room due to the pandemic, shortcomings in post-natal care, and racial tension and anxiety due to the pandemic. Statistics corroborate these observations: Infant mortality is higher among Alameda County's Black, Latinx, and multi-ethnic populations than in California overall. Low birth weight was a concern for the Alameda County Pacific Islander and multi-ethnic populations, as well as the Contra Costa County Asian population. Pre-term births are happening at higher rates for multi-ethnic babies in Contra Costa County than for all babies statewide. Teen births are higher for Contra Costa County Latinas than for young women across the state. Finally, breastfeeding rates are especially low among Pacific Islander mothers in both counties compared to mothers statewide.

Community and Family Safety

Key informants discussed fear and anxiety surrounding contracting COVID-19 as a threat to community safety. Informants said that residents had been afraid to send their children to school, visit their doctor to receive care, go into public spaces like the grocery stores, and to take public transportation. Key informants believed that the fear was subsiding, but trauma from these experiences remained.

Additionally, structural racism was mentioned by key informants as contributing to concerns of community safety. Comments and incidents of "Asian hate" were specifically mentioned, as well as students and parents of color not feeling like schools are safe and welcoming places for them. In Contra Costa County, larger proportions of Black, Latinx, and Pacific Islander students felt that their schools were very unsafe than California students overall. Perhaps because of this, gang membership levels among Black, Latinx, Native American, and Other youth are higher in both Alameda and Contra Costa counties than they are statewide.

> *"We have differences regarding how our kids and families of color feel within their school. I'm involved with Black and brown families seeing the school as not a place that is open and welcoming to them. Although the school sees themselves as open and welcoming to them. But there's always that trust issue – if you don't look like me how could you understand me?"*
>
> *— Education Expert*

Key informants discussed a lack of safe outdoor spaces to exercise and recreate as primary concerns about community safety. One focus group ranked community safety as a high priority. Several focus group participants believed that many community parks, particularly in Central Contra Costa County, had become places of illicit activities, specifically alcohol and drug use, that made their neighborhoods less safe. While many community safety statistics are better in the Tri-Valley than the state, the rate of violent crimes is higher.

> *"There is a lot of hate in the community right now that is being fanned by racist and homophobic comments."*
>
> *— Community Violence Expert*

Key informants also mentioned domestic violence, for which statistics show there are disparities: Black children ages 0-17 in Contra Costa County are more likely to be the subject of a substantiated child abuse case than children statewide. Researchers attribute these disparities to differences in family circumstances that put children at greater risk of abuse (e.g., being young and/or single parents, experiencing poverty).[29] Building on the differences in child abuse statistics, both Alameda and Contra Costa counties' Black children (ages 0-20) are also more likely to be in foster care than are California children on average. Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.[30] Statistics show that juvenile felony arrests (ages 10-17) are higher for Black youth in both counties. These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.[31]

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[29] Font, S. A., Berger, L. M., & Slack, K. S. (2012). Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review,* 34(11), 2188-2200. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3439815/. See also: Black Child Legacy Campaign. (2021). *Child Abuse and Neglect.* Retrieved from https://blackchildlegacy.org/resources/child-abuse-and-neglect/

[30] See, for example, Cutuli, J.J., Goerge, R.M., Coulton, C., Schretzman, M., Crampton, D., Charvat, B.J., Lalich, N., Raithel, J., Gacitua, C. and Lee, E.L., 2016. From foster care to juvenile justice: Exploring characteristics of youth in three cities. *Children and Youth Services Review*, 67, pp.84-94. Retrieved from https://www.aisp.upenn.edu/wp-content/uploads/2020/11/From-Foster-Care-to-Juvenile-Justice.pdf . And see Yi, Y., & Wildeman, C. (2018). Can foster care interventions diminish justice system inequality?. *The Future of Children*, 28(1), 37-58. Retrieved from https://files.eric.ed.gov/fulltext/EJ1179175.pdf

[31] Gallegos, A. H., & White, C. R. (2013). Preventing the School-Justice Connection for Youth in Foster Care. *Family Court Review*, 51(3), 460-468. And see: Foster, M. & Gifford, E. (2004). "The Transition to Adulthood for Youth Leaving Public Systems: Challenges to Policies and Research," in *On the Frontier of Adulthood: Theory, Research, and Public Policy*, eds. Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., & Rubén G. Rumbaut. Chicago: University of Chicago Press.

Heart Disease and Stroke

Cardiovascular disease is one of the leading causes of death in Alameda and Contra Costa counties. The proportions of adults with heart disease are higher in both Livermore and Pleasanton than in Alameda County overall. The rate of congestive heart failure hospitalizations is also higher in Livermore than California's rate.

Stroke is also among the top 10 causes of death in both counties. In particular, the rate of stroke deaths is higher in the Tri-Valley compared to the state rate and even compared to Alameda County's rate. Our 2019 CHNA report found that Black and white residents of the Tri-Valley/Central Contra Costa County area had higher stroke mortality rates than their statewide counterparts.

One key informant ranked chronic diseases such as heart disease and stroke as a high community priority. Key informants pointed to a growing population of seniors, and with that, more diagnoses of chronic diseases, co-morbidities, and disability.

Cancer

Cancer is one of the leading causes of death in both Alameda and Contra Costa counties. Indicators of concern include the breast cancer incidence rate among Tri-Valley/Central Contra Costa County women compared to California women overall, and the prostate cancer incidence rate among Tri-Valley/Central Contra Costa County men compared to California men overall.

Our 2019 CHNA report indicated that, compared to California residents, Black and white residents of both counties have a higher incidence of lung cancer and prostate cancer and a higher incidence of breast cancer in Contra Costa County. Black residents of both counties also have a higher incidence of colorectal cancer. Both Black and white residents of the Tri-Valley/Central Contra Costa County area experience a higher mortality rate due to all cancers than California residents overall. Finally, mammography screening levels, an early cancer detection measure, are lower for Black women in the Tri-Valley/Central Contra Costa County area than California's women overall.

The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, residents are more likely to be obese, which is a cancer risk factor). The Institute states, "Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and/or institutional inequalities."[32]

[32] National Cancer Institute. (2020). *Cancer Disparities.* Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

Climate and Natural Environment

Over the past three years, climate issues have risen to the forefront, including climbing temperatures, more extreme weather, flooding, and wildfires. The Tri-Valley is at significantly greater risk of drought and heat waves as well as river flooding than the state as a whole. Rising temperatures were also a concern among focus group participants who felt that, especially in the summer, going outside and participating in physical activity was limited by extreme heat on an increasing number of days.

> *"Climate makes a huge difference. It's difficult to go hiking when it's 100 degrees outside. During the summer it was really difficult; there were a lot of pretty hot days where you couldn't go out and exercise. It made it a health issue."*
>
> *— Older Adult Focus Group Participant*

One focus group ranked climate and the environment as a high community priority. However, smoke and ash from wildfires around the state were a big concern for many focus group participants, who explained that it impacted people with asthma and allergies and was a barrier to physical activity. Additionally, some participants felt that air quality was a silent threat to health and wanted better resources to know when they should stay inside due to reduced air quality. Asthma prevalence is higher among residents of the Tri-Valley than among Californians overall.

7. EVALUATION FINDINGS FROM IMPLEMENTED STRATEGIES

SHC - VC 2019 PRIORITIZED HEALTH NEEDS

In 2018–19, Stanford Health Care - ValleyCare participated in a Community Health Needs Assessment similar to our collaborative 2021 effort. (Our 2019 CHNA report is posted on the Community Benefits Page of our public website.[33]) In 2019, SHC - VC's Community Benefits Advisory Group prioritized the following health needs.

1. Behavioral Health
2. Health Care Access and Delivery
3. Housing and Homelessness
4. Healthy Eating/Active Living, Diabetes and Obesity
5. Heart Disease and Stroke
6. Economic Stability
7. Community and Family Safety
8. Oral/Dental Health
9. Cancer
10. Climate and Natural Environment
11. Transportation and Traffic

SHC - VC chose to address these needs in subsequent years through strategic initiatives:

- Behavioral Health
- Health Care Access and Delivery
- Healthy Lifestyles

SHC - VC and partner hospitals built upon the 2019 work for the 2022 Community Health Needs Assessment, using this list of identified needs and delving deeper into questions about inequities, barriers to care, and solutions.

IMPLEMENTATION STRATEGIES FOR FISCAL YEARS 2020 AND 2021

The 2019 CHNA formed the foundation for SHC - VC's implementation strategies for fiscal years 2020 through 2022, which were initiated in fiscal year 2020 (FY20). The IRS requires hospitals to report on the impact of implementation strategies. The following sections describe the evaluation of community benefit programs put forth in the implementation strategies. Due to timing constraints that require the adoption and public posting of this report by the end of the fiscal year, evaluation

[33] https://valleycare.com/about-us/community-benefits.html

results for FY22 (September 1, 2021–August 31, 2022) are not yet available for inclusion. For more information, see the Community Benefits Page of our public website.[34]

COMMUNITY BENEFIT INVESTMENTS IN FISCAL YEARS 2020 AND 2021

In FY20 and FY21, SHC - VC invested its community benefit funds in programs that help the larger community, such as health research, health education and training, serving vulnerable populations, charity care, and unreimbursed Medi-Cal and Medicare. These activities provide essential services for people in need in the Tri-Valley area. As part of our support for community partners and other community-based agencies, we conducted various activities for community members during FY20 and FY21, from education and support for people with chronic conditions.

EVALUATION FINDINGS FOR FISCAL YEARS 2020 AND 2021

This section describes the results of SHC - VC's community benefit investments in FY20 and FY21, based on its implementation strategies for the prioritized health needs of Behavioral Health, Health Care Access and Delivery, and Healthy Lifestyles.

Behavioral Health, FY20

Partner	Program	Program Details and FY20 Impact
Alameda County Behavioral Health Care Services	Santa Rita Mental Health Assessment, Referral and Drop-In Center	SHC – VC's grant supported the development of a new homeless mentally ill outreach and treatment program which opened in June 2020. The Drop-In Center is located on the grounds of Santa Rita Jail for people with mental illness, co-occurring conditions, and substance use disorders, assisting them with immediate needs as they are released from jail. The Drop-In Center provides a safe, comfortable, nonthreatening, temporary stop-over as next options are considered, and provides assistance/connection with: locating both immediate and long-term housing, medication, brief counseling and crisis counseling, referrals to further mental health and/or substance use services, connection to transportation (BART, bus, cab), refreshments and change of clothes, telephone and/or internet to line up transportation and other post-release necessities. Persons served: 218

[34] https://valleycare.com/about-us/community-benefits.html

Partner	Program	Program Details and FY20 Impact
Axis Community Health	Behavioral Health Program	The grant from SHC – VC supports a full-time licensed Marriage and Family Therapist (MFT), which increased capacity to serve uninsured Tri-Valley residents at Axis' clinical site. The additional counselor has helped to alleviate the dire need for more mental health services in the community. In addition, wait times for mental health services appointments at the clinic have been reduced. Persons served: 91 patients; 1,041 visits
Crisis Support Services of Alameda County	Healing Hearts 5K Walk/Run for Suicide Prevention	SHC – VC's funding supported this event, which is focused on raising awareness of the tragedy of suicide, reducing the stigma associated with depression and mental illness, educating the community about available services, supporting local suicide prevention programs, and providing a safe place to heal for those who have lost loved ones to suicide. Persons served: 370

Behavioral Health, FY21

Partner	Program	Program Details and FY21 Impact
Alameda County Behavioral Health Care Services	Santa Rita Mental Health Assessment, Referral and Drop-In Center	SHC – VC's grant supported the development of a new homeless mentally ill outreach and treatment program. The Drop-In Center is located on the grounds of Santa Rita Jail for people with mental illness, co-occurring conditions, and substance use disorders, assisting them with immediate needs as they are released from jail. The Drop-In Center provides a safe, comfortable, non-threatening, temporary stop-over as next options are considered, and provides assistance/connection with: locating both immediate and long-term housing, medication, brief counseling and crisis counseling, referrals to further mental health and/or substance use services, connection to transportation (BART, bus, cab), refreshments and change of clothes, telephone and/or internet to line up transportation and other post-release necessities. Persons served: 4,526

Partner	Program	Program Details and FY21 Impact
Axis Community Health	Behavioral Health Program	The grant from SHC – VC supports a full-time licensed Marriage and Family Therapist (MFT), which increased capacity to serve uninsured Tri-Valley residents at Axis' clinical site. Axis counseling staff continues seeing patients remotely using telehealth and conducts services via video or phone. They established several unique ways for patients to connect if they are unable to do so at home including drive up telehealth option, in addition to a clinic room set aside specifically for patients to connect with their counselors. Wait times for mental health services appointments at the clinic have been reduced. Persons served: 1,078 patient visits
Crisis Support Services of Alameda County	Healing Hearts 5K Walk/Run for Suicide Prevention	SHC – VC's funding supported this event, which is focused on raising awareness of the tragedy of suicide, reducing the stigma associated with depression and mental illness, educating the community about available services, supporting local suicide prevention programs, and providing a safe place to heal for those who have lost loved ones to suicide. Persons served: n/a

Health Care Access and Delivery, FY20

Partner	Program	Program Details and FY20 Impact
Senior Support Program of the Tri-Valley (SSPTV)	Senior Support Program of the Tri-Valley (SSPTV)	SHC – VC funded the provision of free, preventive health screenings and exams to low-income seniors. These screenings generally included blood pressure and diabetes checks, complete foot care, education about medication management, alcohol and drug education, as well as referrals, when appropriate. Some seniors also chose to receive colorectal cancer screenings and/or urine tests for infections and other toxicities. Persons served: 695

Partner	Program	Program Details and FY20 Impact
Tri-Valley Haven	Shelter	For incoming shelter residents, SHC – VC offered TB screening tests and provided initial patient evaluation and follow-up diagnostic testing for any positive TB tests at no charge. 77 tests
Sandra J. Wing Healing Therapies Foundation	Financial Assistance	SHC – VC gave funding to this foundation, which provides cancer patients with financial assistance during their treatment period for complementary healing services, such as acupuncture, acupressure, therapeutic massage, guided/visual imagery, and deep breathing meditation.
HERS Breast Cancer Foundation	Post-Surgical	Helps support women healing from breast cancer by providing post-surgical products and services, regardless of financial status. HERS stands for Hope, Empowerment, Renewal, and Support. SHC – VC provided office space to the foundation free of charge.
Multiple	Tri-Valley Health Initiative	This initiative, in which SHC – VC participates, serves as a gateway to make contact and engage with under-served communities, as well as to provide health screenings, linkages, and health care enrollment opportunities to youth and families in the Tri-Valley. The initiative aims to increase access to health care for youth and families, including culturally relevant prevention services, and strengthens the continuum of school-linked health supports throughout the Tri-Valley. Also, the initiative provides further opportunity to collaborate with school health officials in the local school districts regarding ongoing health concerns such as asthma and behavioral health.
Multiple	Tri-Valley Anti-Poverty Collaborative	This collective impact initiative to end poverty in the Tri-Valley area involves SHC – VC and partners from government, nonprofits, faith-based organizations, schools, philanthropic organizations, businesses, and individual community residents. The Collaborative supports a program in which struggling residents across the region can achieve a basic standard of living in housing, health care, nourishment, education, and sustainable financial resources.

Health Care Access and Delivery, FY21

Partner	Program	Program Details and FY21 Impact
Senior Support Program of the Tri-Valley (SSPTV)	Senior Support Program of the Tri-Valley (SSPTV)	SHC – VC funded the provision of free, preventive health screenings and exams to low-income seniors. These screenings generally included blood pressure and diabetes checks, complete foot care, education about medication management, alcohol and drug education, as well as referrals, when appropriate. Some seniors also chose to receive colorectal cancer screenings and/or urine tests for infections and other toxicities. Persons served: 695
Tri-Valley Haven	Shelter	For incoming shelter residents, SHC – VC offered TB screening tests and provided initial patient evaluation and follow-up diagnostic testing for any positive TB tests at no charge. 84 tests
HERS Breast Cancer Foundation	Post-Surgical	Helps support women healing from breast cancer by providing post-surgical products and services, regardless of financial status. HERS stands for Hope, Empowerment, Renewal, and Support. SHC – VC provided office space to the foundation free of charge.

Healthy Lifestyles, FY20

Partner	Program	Program Details and FY20 Impact
Meals on Wheels	Meals	This hot meal program provides local seniors with the nutrition critical to their health and well-being five days a week. Participating homebound seniors were located in Pleasanton, Livermore, Dublin, and Sunol. Some received several meals a day. SHC – VC's kitchen prepared the meals. Persons served: 800 people are served 34,420 meals (more than 90 meals per day, 5 days per week)

Partner	Program	Program Details and FY20 Impact
Spectrum	Administrative	SHC – VC provided office space to Spectrum, the nonprofit organization in charge of organizing the Meals on Wheels program in the Tri-Valley area.
CrossWinds Church Tri-Valley	Operation Cranberry Sauce	SHC – VC provided enough groceries to those in attendance to feed a family of five for a Thanksgiving meal. Each low-income family received one box of groceries that included staples and nonperishable items. In addition, SHC – VC staff provided reusable grocery bags, first aid kits, and nutrition information to event attendees; the nutrition information included healthy recipes, handouts on healthy eating, and healthy eating coloring books for children. Persons served: 830
Culinary Angels	Meals	SHC – VC provided funds to support culinary Angels, a volunteer, donation-based organization that provides nutrient-rich meals and nutrition education to people going through a serious health challenge. Meals are delivered free-of-charge throughout Livermore, Dublin and Pleasanton.
CAPE, Inc. (Community Association for Preschool Education)	Nutrition Services	CAPE, Inc.'s primary focus is providing the highest quality Early Childhood Development services that meet the needs of low-income children and their families including health and nutrition. SHC – VC supported CAPE's provision of meals for preschool-aged children by preparing all the meals. Persons served: 150 preschoolers
Open Heart Kitchen	Meals	This local nonprofit organization, which serves free meals to the hungry, stored food and assembled box lunches in space on SHC – VC's Livermore campus free of charge.
LARPD Children's Fair	Nutrition Education	At this free family event for the community, an SHC – VC health educator taught nutrition/healthy eating utilizing a spin wheel with nutrition questions, educational coloring books and had hands-on examples to demonstrate sugar content in foods.

Partner	Program	Program Details and FY20 Impact
Marylin Avenue Elementary School (Livermore)	Physical Education (PE)	SHC – VC funds an instructor to conduct PE classes for Marylin Avenue students during the school week. This project focused on improving scores for state testing, improving student physical health, educating the students on healthy living, and illustrating how to use exercise as a tool to help with focus in the classroom. Twice a week throughout the school year, students in fourth and fifth grades received 75 minutes of physical education. *Due to the COVID-19 pandemic, only mid-year evaluations were able to be completed due to the shelter-in-place and remote learning. 4th grade average results (54 students): ● Mile improved from 13:50 to 12:19. 5th grade average results (46 students): ● Mile improved from 13:49 to 11:75 minutes. ● Curl-ups improved from 14 to 24. ● Push-ups improved from 9 to 14. Overall, the students had better focus in class after PE. Most of the kids had an enjoyable experience with PE. Many students who were not physically active before showed a large amount of improvement. Many students were able to bring better problem-solving solutions and teamwork they learned from physical education to the classroom. Persons served: 105 students
Tri-Valley Haven	Food	SHC – VC donated 340 turkeys to the shelter over the Thanksgiving holiday.

Healthy Lifestyles, FY21

Partner	Program	Program Details and FY21 Impact
Meals on Wheels	Meals	This hot meal program provides local seniors with the nutrition critical to their health and well-being five days a week. Participating homebound seniors were located in Pleasanton, Livermore, Dublin, and Sunol. Some received several meals a day. SHC – VC's kitchen prepared the meals. Persons served: 800 people are served 34,420 meals (more than 90 meals per day, 5 days per week)
Spectrum	Administrative	SHC – VC provided office space to Spectrum, the nonprofit organization in charge of organizing the Meals on Wheels program in the Tri-Valley area.
CrossWinds Church Tri-Valley	Operation Cranberry Sauce	SHC – VC provided funding to support Operation Cranberry Sauce (OCS). OCS food packages feed a family of five for a Thanksgiving meal. Each low-income family received one box of groceries that included staples and nonperishable items and a frozen turkey. Persons served: 1500 packages fed approximately 9,000 family members
Culinary Angels	Meals	SHC – VC provided funds to support Culinary Angels, a volunteer, donation-based organization that provides nutrient-rich meals and nutrition education to people going through a serious health challenge. Meals are delivered free-of-charge throughout Livermore, Dublin and Pleasanton.
Head Start - CAPE, Inc. (Community Association for Preschool Education)	Nutrition Services	Head Start-CAPE, Inc.'s primary focus is providing the highest quality Early Childhood Development services that meet the needs of low-income children and their families including health and nutrition. SHC – VC supported CAPE's provision of meals for preschool- aged children by preparing all the meals. Persons served: 150 preschoolers

Partner	Program	Program Details and FY21 Impact
Open Heart Kitchen	Meals	This local nonprofit organization, which serves free meals to the hungry, stored food and assembled box lunches in space on SHC – VC's Livermore campus free of charge.

8. COMMUNITY RESOURCES

Various hospitals and clinics, community-based organizations, government departments and agencies, and other resources are available in the Stanford Health Care - ValleyCare service area to respond to the community health needs identified in this assessment. Hospitals and clinics are listed below.

EXISTING HEALTH CARE FACILITIES

San Ramon Regional Medical Center	San Ramon
Stanford Health Care - ValleyCare	Pleasanton
UCSF Benioff Children's Hospitals	Oakland
Axis Community Health (Federally Qualified Health Clinic)	Livermore and Pleasanton

Additional resources are listed in Attachment 4: Community Assets and Resources.

9. CONCLUSION

Stanford Health Care - ValleyCare worked with 12 other hospitals, pooling expertise and resources, to conduct the 2022 Community Health Needs Assessment. By conducting new primary research as a team, the Hospitals were able to understand the community's perception of health needs. By gathering secondary data specific to the Tri-Valley area, SHC - VC was able to prioritize health needs with consideration for how each compares against benchmarks. SHC - VC further prioritized health needs in its service area based on a set of defined criteria.

The 2022 CHNA meets federal and state requirements.

Next steps for SHC - VC:

- 2022 CHNA adopted by SHC - VC board and made publicly available on the hospital's website by August 31, 2022.[35]
- Monitor community comments on CHNA reports (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs (independently and/or by partnering with other local hospitals).
- Ensure strategies are adopted by the hospital board and filed with the IRS by January 15, 2023.

[35] https://valleycare.com/about-us/community-benefits.html

10. LIST OF ATTACHMENTS

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

ATTACHMENT 1: SECONDARY DATA INDICATORS LIST

Category	Indicator	Repository	Source
Behavioral Health	Adults with 4 or More Adverse Childhood Experiences	KidsData	UC Davis Violence Prevention Research Program, tabulation of data from the California Behavioral Risk Factor Surveillance System and American Community Survey. Apr. 2020.
Behavioral Health	Children Ages 0-17 with 2 or More Adverse Experiences (Parent Reported)	KidsData	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the American Community Survey. Jan. 2021.
Behavioral Health	Ratio of Students to School Psychologists	KidsData	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).
Behavioral Health	Ratio of Students to School Social Workers	KidsData	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Behavioral Health	Students Bullied or Harassed at School in the Previous Year (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Students Cyberbullied 4 or More Times in the Previous Year (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Students Who Had Depression-Related Feelings in the Previous Year (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Aug. 2020.
Behavioral Health	Students Who Have Consumed Alcohol 7 or More Times in Their Lifetimes (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Students Who Seriously Considered Attempting Suicide in the Previous Year (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education. Aug. 2020.
Behavioral Health	Students Who Used Alcohol or Drugs in the Previous Month (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.

Category	Indicator	Repository	Source
Behavioral Health	Students Who Used Marijuana 20-30 Days in the Previous Month (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Students with a Low Level of Caring Relationships with Adults at School (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Students with a Low Level of School Connectedness (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Behavioral Health	Adults with 1-3 Adverse Childhood Experiences	KidsData	UC Davis Violence Prevention Research Program, tabulation of data from the California Behavioral Risk Factor Surveillance System and American Community Survey. Apr. 2020.
Behavioral Health	Mental Health Hospitalizations among Children and Youth (Ages 5-14, 15-19)	KidsData	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. May 2020.
Cancer	Cancer Incidence among Children Ages 0-19	KidsData	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool. Jun. 2018.
Community & Family Safety	Children Ages 0-17 with Substantiated Cases of Abuse or Neglect	KidsData	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. Jul. 2019.
Community & Family Safety	Children Ages 0-20 in Foster Care	KidsData	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. Jul. 2019.
Community & Family Safety	Domestic Violence-Related Calls for Assistance among Adults Ages 18-69	KidsData	California Dept. of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (Jul. 2019); California Dept. of Finance, Population Estimates and Projections (May 2019).
Community & Family Safety	Median Length of Stay in Foster Care among Children Ages 0-17 Entering Foster Care	KidsData	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. Jul. 2019.
Community & Family Safety	Students Who Consider Themselves Gang Members (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.

Category	Indicator	Repository	Source
Community & Family Safety	Students Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Community & Family Safety	Students Who Feel Very Unsafe at School (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Community & Family Safety	Felony Arrests among Juveniles Ages 10-17	KidsData	California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. May 2019.
COVID-19	14-day average test positivity rate		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Cumulative total cases		Alameda County: Alameda County Health Care Services Agency, Public Health Department. (2022). COVID-19 Data. Data retrieved from https://covid-19.acgov.org/data.page? Contra Costa County: Contra Costa Health Services. (2022). COVID-19. Data retrieved from https://www.coronavirus.cchealth.org/overview California: The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 17, 2022.
COVID-19	Cumulative total deaths		Alameda County: Alameda County Health Care Services Agency, Public Health Department. (2022). COVID-19 Data. Data retrieved from https://covid-19.acgov.org/data.page? Contra Costa County: Contra Costa Health Services. (2022). COVID-19. Data retrieved from https://www.coronavirus.cchealth.org/overview California: The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from

Category	Indicator	Repository	Source
			https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 17, 2022.
COVID-19	Current rate of spread (R-eff)[36]		CalCAT. (2022). California COVID Assessment Tool. Data retrieved from https://calcat.covid19.ca.gov/cacovidmodels/ March 17, 2022.
COVID-19	Fully vaccinated (age 5+)		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Fully vaccinated (age 65+)		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Fully vaccinated (all ages)		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022. Alameda County: Alameda County Health Care Services Agency, Public Health Department. (2022). COVID-19 Data. Data retrieved from https://covid-19.acgov.org/data.page? March 17, 2022.
COVID-19	Seven-day average number of daily cases		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Seven-day average number of daily deaths		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from

[36] Average number of people an infected person will infect. Value less than 1 means decreasing spread. Value greater than 1 means increasing spread.

Category	Indicator	Repository	Source
			https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Seven-day average number of people hospitalized daily		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Seven-day average rate of daily cases		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Seven-day average rate of daily deaths		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 17, 2022.
COVID-19	Rate of deaths since January 2020		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 17, 2022.
COVID-19	Rate of infection since January 2020		The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 17, 2022.
Economic Stability	Children Ages 0-17 Living in Food Insecure Households	KidsData	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. May 2019.
Economic Stability	Children Ages 0-17 without Secure Parental Employment	KidsData	Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files. Dec. 2017.

Category	Indicator	Repository	Source
Economic Stability	High School Graduates Completing College Preparatory Courses	KidsData	California Dept. of Education, Graduates by Race and Gender. May 2018.
Economic Stability	Students Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts (11th Grade)	KidsData	California Dept. of Education, Test Results for California's Assessments. Jan. 2020.
Economic Stability	Students Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics (11th Grade)	KidsData	California Dept. of Education, Test Results for California's Assessments. Jan. 2020.
Economic Stability	Students Not Completing High School	KidsData	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data. Feb. 2019.
Economic Stability	Students Who Did Not Eat Breakfast in the Previous Day (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.
Economic Stability	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	KidsData	California Child Care Resource and Referral Network, California Child Care Portfolio. Feb. 2020.
Economic Stability	Children Ages 0-12 in Working Families for Whom Licensed Childcare is Available	KidsData	California Child Care Resource and Referral Network, California Child Care Portfolio (Apr. 2020); U.S. Census Bureau, American Community Survey public use microdata (Oct. 2020).
Economic Stability	Annual Cost of Childcare for Preschoolers Ages 3-5 in a childcare Center	KidsData	California Child Care Resource and Referral Network, California Child Care Portfolio. Feb. 2020.
Education	Children Ages 0-17 Living in Limited English-Speaking Households	KidsData	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata. Dec. 2019.
Education	Ratio of Students to School Counselors	KidsData	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Education	Students Truant from School	KidsData	California Dept. of Education, Truancy Data. Dec. 2017.
Education	Students with a Low Level of Meaningful Participation at School (7th, 9th, 11th Grade)	KidsData	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. Mar. 2019.

Category	Indicator	Repository	Source
General	Deaths among Children and Youth Ages 1-24	KidsData	California Dept. of Public Health, Death Statistical Master Files; California Dept. of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 1990-2009; Population Reference Bureau, Population Estimates 2010-2016; CDC WONDER Online Database, Underlying Cause of Death 1999-2016. Feb. 2019.
Healthcare Access & Delivery	Children Ages 0-18 with Health Insurance Coverage	KidsData	U.S. Census Bureau, American Community Survey Summary Files and Public Use Microdata. Oct. 2018.
Healthcare Access & Delivery	Ratio of Students to School Nurses	KidsData	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).
Healthcare Access & Delivery	Ratio of Students to School Speech/Language/Hearing Specialists	KidsData	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Healthy Eating/Active Living, Diabetes and Obesity	Children Who Ate 5 or More Servings of Fruits and Vegetables in the Previous Day (Ages 2-11, 12-17)	KidsData	UCLA Center for Health Policy Research, California Health Interview Survey. Mar. 2018.
Healthy Eating/Active Living, Diabetes and Obesity	Share of Hospitalizations among Children Ages 0-17 for Diabetes	KidsData	California Office of Statewide Health Planning and Development custom tabulation. Sept. 2019.
Healthy Eating/Active Living, Diabetes and Obesity	Students Meeting All Fitness Standards (5^{th}, 7^{th}, 9^{th} Grade)	KidsData	California Dept. of Education, Physical Fitness Testing Research Files. Dec. 2018.

Category	Indicator	Repository	Source
Housing & Homelessness	Children Ages 0-17 Living in Crowded Households	KidsData	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata. Dec. 2019.
Housing & Homelessness	Point-in-Time Count of Homeless Children and Youth (Ages 0-17, 18-24)	KidsData	U.S. Dept. of Housing and Urban Development, Point-In- Time Estimates of Homelessness in the U.S. Apr. 2021.
Housing & Homelessness	Point-in-Time Count of Homeless, Unsheltered Children and Youth (Ages 0-17, 18-24)	KidsData	U.S. Dept. of Housing and Urban Development, Point-In- Time Estimates of Homelessness in the U.S. Apr. 2021.
Housing & Homelessness	Students Recorded as Homeless at Some Point during the School Year	KidsData	California Dept. of Education, Coordinated School Health and Safety Office custom tabulation & California Basic Educational Data System. Oct. 2019.
Housing & Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (Ages 0-5, 6-20)	KidsData	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. Jun. 2020.
Housing & Homelessness	Children with (Worst) Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (Ages 0-5, 6-20)	KidsData	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. Jun. 2020.
Infectious Disease-COVID	Kindergarteners with All Required Immunizations	KidsData	California Dept. of Public Health, Immunization Branch, Kindergarten Data and Reports. Jun. 2019.
Maternal/Infant	Babies Born at Very Low Birthweight	KidsData	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data. Feb. 2019.
Maternal/Infant	Babies Born to Mothers Who Received Prenatal Care in the First Trimester	KidsData	California Dept. of Public Health, Birth Statistical Master Files. Feb. 2019.
Maternal/Infant	Babies Breastfed Exclusively in Hospital	KidsData	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. Oct. 2019.
Maternal/Infant	Babies Breastfed in Hospital	KidsData	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data (Oct. 2019.

Category	Indicator	Repository	Source
Maternal/Infant	Births among Teens Ages 15-19	KidsData	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data (Feb. 2019.
Respiratory	Children Ages 1-17 Ever Diagnosed with Asthma	KidsData	UCLA Center for Health Policy Research, California Health Interview Survey. Aug. 2020.
Respiratory	Asthma Hospitalizations among Children (Ages 0-4, 5-17)	KidsData	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. Jul. 2020.
STIs	Chlamydia Incidence among Youth Ages 10-19	KidsData	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018).
STIs	Gonorrhea Incidence among Youth Ages 10-19	KidsData	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018).
Unintended Injuries	Share of Hospitalizations among Children Ages 0-17 for Poisoning	KidsData	California Office of Statewide Health Planning and Development custom tabulation. Sept. 2019.
Unintended Injuries	Share of Hospitalizations among Children Ages 0-17 for Traumatic Injuries	KidsData	California Office of Statewide Health Planning and Development custom tabulation. Sept. 2019.

ATTACHMENT 2: COMMUNITY LEADERS, REPRESENTATIVES, AND MEMBERS CONSULTED

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

ID#	Data Collection Method	Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Organizations							
1	Interview	Leadership, Open Heart Kitchen	Homelessness, food insecurity	1	Low-income, older adults, youth	Leader	7/22/2021
2	Interview	Leader, Alameda County Community Food Bank	Food insecurity	1	Low-income	Leader	7/27/2021
3	Interview	Leadership & Director level, Tri-Valley Haven	Food insecurity	2	Low-income	Leader	8/4/2021
4	Interview	Program Manager, Alameda County Public Health Department	Public health	1	Low-income, medically underserved, minority	Leader	8/9/2021

ID#	Data Collection Method	Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
5	Interview	Leadership & Nurse, Livermore Valley Joint Unified School District	Education	2	Medically underserved, youth	Leader	8/27/2021
6	Interview	Co-Founder, Z-Cares Foundation	Youth mental health	1	Youth	Leader	9/21/2021
7	Interview	CEO & Chief Development Officer, Axis Community Health	Access to care	2	Medically underserved	Leader	9/21/2021
8	Interview	Director of Student Services, Dublin Unified School District	Education	1	Youth	Leader	10/19/2021
9	Interview	Assistant Superintendent, Pleasanton Unified School District	Education	1	Youth	Leader	10/20/2021
10	Interview	Epidemiologist/Biostatistician & Public Health Accreditation Coordinator, Contra Costa Health Services	Public health	2	Low-income, medically underserved	Leader	11/5/2021
Community Residents							

ID#	Data Collection Method	Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
11	Focus Group	Host: Contra Costa Health Services	Spanish-speaking Latinx residents	10	Minority	Member	9/23/2021
12	Focus Group	Host: La Familia	Spanish-speaking Latinx older adults	9	Low-income, minority, older adults	Member	9/24/2021
13	Focus Group	Host: Contra Costa Health Services	Older adults	9	Low-income, older adults	Member	9/28/2021
14	Focus Group	Host: Contra Costa Health Services	Black residents	2	Minority	Member	9/29/2021
15	Focus Group	Host: Goodness Village	Formerly homeless residents	9	Low-income	Member	10/6/2021

Community Health Needs Assessment 2021

Focus Group Questions

Virtual: As participants get onto the Zoom say hello and tell them we are waiting for everyone to arrive. At 3 minutes past the start time put up the Focus Group Survey poll and ask everyone to complete it. Don't start the Welcome and Introductions until everyone has completed the Focus Group Survey poll.

In Person: As participants gather say hello and tell them we are waiting for everyone to arrive. Don't start the Welcome and Introductions until everyone has completed the Focus Group Survey.

Welcome and Introductions (*Say each of these points)*

- Hello everyone, thank you for joining our focus group today.
- My name is (Leader).
    - ***a.*** **Leader Note:** *Let the group know your name and why you wanted to do this focus group. Share your interest in the focus group discussion.*
- As the focus group leader, I'll be asking you questions, asking follow up questions and keeping track of time and keeping the discussion moving so we can get through all of the questions.
- This is (Notetaker) who will be taking notes during our conversation.
- Our discussion today will take about 1 ½ hours.
- We want you to know that your participation is voluntary and you can leave the group at any time.
- We are recording the session today so we do not miss any of your thoughts. During the focus group, feel free to ask that we turn off the recording if you do not want to be recorded for a specific comment. Is anyone NOT OK to start recording?
    a. **Leader Note: *START RECORDING***
    IN PERSON – start recording on iPad using the VoiceMemo app.
    VIRTUAL – press the Zoom record button.
- Now I'd like to have each of you introduce yourself. IN PERSON: Please introduce yourself by telling us your first name. VIRTUAL: I'll call on you by your first name and please wave and say hi so the group knows who you are.

Notetaker Note: *Write down the name of each participant.*

- Thanks for these introductions, now we will talk about the purpose of the focus group.

Purpose of Focus Group (*Read to the group*)

Public Health is conducting focus groups to learn more about what you, as a community member, feel are the most important health issues in [region of county]. Public Health is conducting these focus groups with nonprofit hospitals in the area, which are required by the IRS to conduct a Community Health Needs Assessment -- which we call the CHNA -- every three years. Hospitals working together on the East Bay CHNA include: John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care -- ValleyCare, Sutter Health, and UCSF Benioff Children's Hospital-Oakland.

Public Health, nonprofit hospitals, and others will use the information gathered during the focus group to identify important health issues in our community and come up with a plan to address the major

health issues affecting people in the County. We are interested in hearing your thoughts about what makes it easy or difficult to be healthy in your community and what services and resources are available and needed in the community to promote health.

Ground Rules (*Say each of these points*)

Now I would like to share the ground rules we'll use to make sure our discussion is meaningful and comfortable for everyone. (*Read the list of ground rules to the group.*)

1. There are no right or wrong answers because we're interested in everyone's thoughts and opinions and people often have different opinions.
    - Please, feel free to share your opinions even though it's not what others have said.
    - If there are topics you don't know about or a question you are not comfortable answering, feel free to not answer.
    - All input will be welcomed and valued.
2. Next, we want to have a group discussion, but we'd like only one person to talk at a time because we want to make sure everyone has a chance to share their opinion.
    - Please speak loudly and clearly since we are recording and we don't want to miss anything you say.
    - Let's also remember to turn off or silence our cell phones.
    - If you absolutely must take an urgent call, please step away from the focus group.
3. The last guideline is about protecting your privacy.
    - Your name will not be used in any reports, and your name will not be linked to comments you make.
    - Transcripts will go to the hospitals and the consultants working with the hospitals.
    - When we are finished with all of the focus groups, the transcripts will be read by the consultants, who will then summarize the things we learn. Some quotes will be used so that the hospitals can read your own words. Your name will not be used when we use quotes.
    - I'd also like for all of us to agree that what is said in this focus group stays in this focus group.
4. VIRTUAL - Stay on video the whole time so you can fully participate.
5. Are there other ground rules you would like us to add?

Consent and Incentive

- Before we start, we would like to get your consent to participate in this focus group (***say the consent statement provided by Public Health***).
  Leader Note: *Ask for a thumbs up to signal consent. If someone doesn't agree to the consent nicely ask them to leave the focus group.*
- As a thank you for your participation, we will be providing a $25 gift card.

Discussion Questions

Facilitators and barriers to health in the community

We would like to discuss what is healthy and not so healthy about your community. Things that make a community healthy can include the environment -- examples are sidewalks, clean streets, parks; social/emotional factors -- examples include feeling safe, access to behavioral or mental health services; opportunities for healthy behaviors -- for example, places to buy healthy food, places to exercise;

community services and events such as low cost or free activities for families; and access to health care services.

1. Think about how your community is right now. What is healthy about your community?

2. What makes it difficult to be healthy in your community?

Leader Note: *if examples are needed, you can say this* - For example, lack of access to health services, few grocery stores with healthy, affordable food, unsafe neighborhoods, lack of access to transportation, lots of pollution in the air, no safe places to be active, no affordable dental care.

Three most important health issues facing the community and why important (asking about behavioral health, economic security, and access to care, if not addressed)

Part of our task today is to find out which health issues you think are most important. We have a list of the health issues, many of which the community came up with when the hospitals did the Community Health Needs Assessment in this area in 2019.

Leader Note: *Read all of the issues aloud and define where needed (e.g., "Healthcare Access and Delivery" means insurance, having a primary care physician, preventive care instead of emergency room, being treated with dignity and respect, wait times, etc.).*

- Climate/Natural Environment
- Community and Family Safety
- Economic Security
- Education and Literacy
- Healthcare Access and Delivery
- Healthy Eating/Active Living
- Housing and Homelessness
- Behavioral Health (includes Mental Health and Substance Use)
- Transportation and Traffic

3. Please think about the **three health issues** on the list you personally believe are the most important to address here in the next few years.

IN PERSON – What we would like you to do is vote for **three health issues** that you think are the most important to address in the next few years. Make a check mark next to each of the three health needs you think are most important. 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.

VIRTUAL – What we would like you to do is vote for **three health issues** that you think are the most important to address in the next few years. We will put up a poll that lists the health issues and select only 3 you think are most important. We really want your personal perspective and opinion; it's totally OK if it's different from others'. Then we will discuss the results of your votes.

If there is a tie:

IN PERSON and VIRTUAL – If there is a tie for the third health need, ask participants to think about which of the tied health needs is most important. Read off the first health need and ask participants

to raise their hand if that is the health need they select. Read off the second health need and count the number of raised hands.

Leader Note: *Write down and then say the three health issues with the most votes. Explain that we will spend the rest of our time reflecting on the three top priorities. You will need to bring up each of the three top health issues during the following questions.*
Notetaker Note: Write down the top 3 health issues.

4. When you think about [health issue 1]…
    a. What makes this an important health issue? An issue can be a top priority because it impacts lots of people in the County, impacts vulnerable populations such as kids or older adults, or impacts County residents' ability to have a high quality of life.
    b. In your opinion, what are the specific needs related to [health issue 1] in our community?

5. When you think about [health issue 2]…
    a. What makes this an important health issue?
    b. In your opinion, what are the specific needs related to [health issue 2] in our community?

6. When you think about [health issue 3]…
    a. What makes this an important health issue?
    b. In your opinion, what are the specific needs related to [health issue 3] in our community?

[Only If *Not* Voted a Top Need: Behavioral Health (includes Mental Health and Substance use]
    a. What about behavioral health? This was one of the top health issues last time.
    b. In your opinion, what are the specific behavioral health needs in our community? *Prompt, if needed:* Conditions like stress, depression, addiction, suicide; concerns about stigma; access to behavioral health care or substance use treatment.

[Only If *Not* Voted a Top Need: Economic Security]
    a. What about economic security? This was another top health issue last time.
    b. In your opinion, what are the specific economic security needs in our community? *Prompt, if needed:* job training, financial education or coaching, support with accessing financial assistance

[Only If *Not* Voted a Top Need: Healthcare Access & Delivery]
    a. What about healthcare access and delivery? This was also a top health issue last time.
    b. In your opinion, what are the specific healthcare access and delivery issues in our community? *Prompt, if needed:* access to affordable health services and medications, access to a primary care doctor or specialists

<u>Anything about top health issues that changed due to COVID</u>
7. Is there anything about the most important health issues you mentioned that changed because of the COVID-19 pandemic? If so, in what ways did COVID change these important health issues?
    a. Let's start with [Health issue 1].
    b. In what ways, if any, did COVID change [Health issue 2]?
    c. In what ways, if any, did COVID change [Health issue 3]?

Strategies that are working well and new strategies that are needed

8. What are some available resources, services, or strategies that are working well in the community to address the 3 most important health issues? *Prompts, if needed:* We are looking for your ideas on specific community-based organizations or their programs/ services, specific social services, or health care programs/services.

9. Thinking about the health issues you said are most important, what are new resources, services, or strategies that are needed to address these issues? Some examples could be new or more services or services available in your preferred language or changes in your neighborhood (for example, more parks, more markets for fresh, healthy foods, or more economic opportunities).

Health inequities/disparities and strategies to reduce inequities/disparities

10. Which groups, if any, are experiencing these important health issues more than other groups? For example, are there certain ethnic/racial groups, residents living in specific neighborhoods, age or gender groups that are more impacted by these health issues than others?

    a. Let's start with [Health issue 1]. Which groups, if any, are experiencing [Health issue 1] more than other groups? In what ways?
    b. Which groups, if any, are experiencing [Health issue 2] more than other groups? In what ways?
    c. Which groups, if any, are experiencing [Health issue 3] more than other groups? In what ways?

11. What resources, services, or strategies would help address these important health issues for the groups just mentioned?
    a. Let's start with [Health issue 1].
    b. What would help address [Health issue 2] for [the group(s) discussed]?
    c. What would help address [Health issue 3] for [the group(s) discussed]?

Anything else important to know about health in the community

13. We're just about ready to wrap up. Are there any other health issues that you think are of high importance that we haven't talked about?

14. Is there anything else you feel is important for us to know about health in your community?

Wrap Up and Gift Cards

Thank you so much for joining the focus group today. That was a really good discussion and gave us lots of information.

IN PERSON: Now we will hand out gift cards as our thank you for taking the time to join the focus group. Please stick around for a few more minutes to get your gift card.

Leader Note: *Hand one gift card to each participant.*

VIRTUAL: You will be receiving your $25 gift card shortly by (describe how the participants will get gift cards for example in the mail or by email).

CHNA 2021 Interview Questions

INTRODUCTION

Thank you for agreeing to do this interview today. My name is **[NAME]** with Applied Survey Research (ASR). I will be conducting the interview today on behalf of Kaiser Permanente and additional partner hospitals, **[NAME PARTNER HOSPITALS].** I am leading the Community Health Needs Assessment process for Kaiser in Alameda and Contra Costa Counties.

Kaiser Permanente is conducting a Community Health Needs Assessment. It is a systematic examination of health indicators in a Kaiser Permanente area that will be used to identify key problems and assets in a community and develop strategies to address community health needs. You are an important contributor to this assessment because of your knowledge of the needs in the community you serve or represent. We greatly value your input.

We expect this interview to last approximately 60 minutes. The information you provide today will not be reported in a way that would identify you.

[Optional: To improve the accuracy of our notes and any quotes that might be used for reporting purposes, we would like to record the interview.

Do we have your permission to record the interview? YES / NO

Do you have any questions before we get started?

KEY INFORMANT BACKGROUND INFORMATION

Ms./Mr./Dr. [KEY INFORMANT NAME], how would you like me to address you [first name, full name, nickname]? Now, I would like to ask a few questions about you.

1. **What is your role at [organization] and how long have you been there?**

2. **Tell me in a few sentences what [organization] does and how it serves the community?**

3. **How would you describe the geographic areas and populations you serve or represent?**

HEALTH NEEDS

Next, I would like to ask a few questions about the health needs and strategies to address them in your community. This will be followed by questions about inequities in your community that have an impact on these health needs.

4. **In 2019, Kaiser Permanente and its hospital partners identified access to health, economic security (such as jobs and housing), and mental/behavioral health as priority health needs in the Community Health Needs Assessment (CHNA) in** [service area/region]**. Are these health needs still a priority? If no, what changed? If yes, what does it mean to experience** [insert health need] **in** [service area/region]**?**

5. **Are there any other health-related needs that were not identified in the 2019 CHNA that are of growing concern in your community??**

6. **Is there anything about these significant health needs you mentioned that changed due to the COVID-19 pandemic? If so, in what ways?**

7. **You indicated that** [RESTATE THE significant health needs mentioned above, either those identified as still a need or those identified as a new need area] **are significant health needs in your community. What are one or two of the biggest challenges to addressing each of these needs?**

8. **Has your organization conducted any recent surveys or written any reports that can speak more to the significant health needs in your community? Have you come across any other surveys or reports in your area further demonstrating those health needs? If so, can you please share those with us?**

9. **How would you like to see health care organizations invest in community health programs or strategies to address these needs? What would those investments be?**

EQUITY

Now I have a few questions to ask you about inequities in your community that have an impact on the important health needs you mentioned. This could be racial inequity as well as inequities related to gender, age, and other factors.

10. **Are there certain people or geographic areas that have been affected by these issues we've been talking about more than others? If so, in what ways?** [Probe: Are there any subgroups of the population we should focus on to reduce disparities and inequities (racism or other factors)?]

11. **What are effective strategies to reduce health disparities and inequities in your community? [Probe: Is there work underway that is promising?]**

COMMUNITY RESOURCES

12. **What are key community resources, assets, or partnerships can you think of that can help address the significant health needs we talked about today?**

CLOSING

13. **Are there any other thoughts or comments you would like to share that we have not discussed?**

Thank you **<KEY INFORMANT NAME>.** That is all that I have for you today. Kaiser Permanente

will be developing their implementation strategy for investing resources to address critical health needs in your community over the next year. A final report of the community health needs assessment will be made available in 2022.

ATTACHMENT 4: COMMUNITY ASSETS AND RESOURCES

Tri-Valley programs and resources available to meet identified community health needs are listed on the following pages.

BEHAVIORAL HEALTH

- Adobe Services—HOPE Project Mobile Health Clinic
- Alameda County Health Care Services Agency
- Axis Bridge Mental Health Urgent Care
- Axis Community Health Behavioral Health Services
- Contra Costa Health Services
- Crisis Support Services of Alameda County
- Hume Center
- La Familia Counseling
- National Alliance on Mental Illness (NAMI)

CANCER

- American Cancer Society
- American Lung Association
- Sandra J. Wing Foundation

CLIMATE AND NATURAL ENVIRONMENT

- Alameda County Department of Environmental Health
- Bay Area Air Quality Management District Climate Protection Planning Program
- City of Livermore Environmental Services Division
- City of Pleasanton Environmental Services Division
- Contra Costa Health Services Environmental Health Division
- Dublin San Ramon Services District Environmental Health & Safety Program
- Sierra Club Tri-Valley Group

COMMUNITY SAFETY

- First 5 Alameda County

ECONOMIC STABILITY

- Abode Services
    - HOPE Project Mobile Health Clinic
    - Project Independence
- Alameda County Early Head Start and Head Start
- Alameda County Housing and Community Development Shelter and Care
- Alameda County Office of Education

- Alameda County Social Services Department
- America Works (ex-convicts)
- Axis Community Health WIC Program
- City of Dublin Senior Center
- Community Resources for Independent Living (CRIL)
- Contra Costa County Employment & Human Services
- Contra Costa County Early Head Start and Head Start
- Dublin Unified School District
- East Bay Community Foundation
- Ensuring Opportunity Contra Costa
- First 5 Alameda
- Friends of Alameda County Court Appointed Special Advocates
- Livermore Valley Joint Union School District
- Monument Impact
- Pleasanton Union School District
- San Ramon Valley Unified School District

HEALTH CARE ACCESS AND DELIVERY

- Adobe Services—HOPE Project Mobile Health Clinic
- Alameda County Health Care Services Agency
- American Diabetes Association
- American Heart Association
- American Lung Association
- Axis Community Health
- Every Woman Counts
- Planned Parenthood
- Regional Asthma Management Program
- Alameda–Contra Costa Transit District (AC Transit)
- Bay Area Rapid Transit (BART)
- CountyConnection.com—trip planning
- Mobility Matters
- Paratransit

HEALTHY EATING/ACTIVE LIVING, DIABETES AND OBESITY

- Axis Community Health—WIC Program
- City of Dublin Parks and Community Services
- City of Livermore Recreation and Park District
- City of Pleasanton Community Services Department & Parks and Recreation Commission
- City of San Ramon Parks and Community Services

- East Bay Regional Parks
- Open Heart Kitchen
- Meals on Wheels of Alameda County
- Senior Support Program of the Tri-Valley
- Spectrum Community Services—Meals on Wheels, Senior Nutrition and Activities Program
- Town of Danville Recreation, Arts & Community Services
- Town of Danville Senior Center
- Tri-Valley Haven for Women—food pantry

HEART DISEASE/STROKE

- Alameda County Health Care Services Agency
- American Heart Association
- American Lung Association

HOUSING AND HOMELESSNESS

- CityServe of the Tri-Valley
- Goodness Village
- Shepherd's Gate
- Tri-Valley Haven

ATTACHMENT 5: IRS CHECKLIST

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

Federal Requirements Checklist	Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)		
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(6)(F)	Section #7
B. Process & Methods		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section #4
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.	(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.		Section #3
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 1 & 2

Federal Requirements Checklist	Regulation Section Number	Report Reference
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Section #5
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #5
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section #5 & Attachment 2
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #5 & Attachment 2
I. Medically underserved populations	(b)(5)(i)(B)	Section #5 & Attachment 2
II. Low-income populations	(b)(5)(i)(B)	Section #5 & Attachment 2
III. Minority populations	(b)(5)(i)(B)	Section #5 & Attachment 2
c. Additional sources (optional) – (e.g., healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(ii)	Section #5 & Attachment 2
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #5 & Attachment 2
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #5 & Attachment 2
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section #5 & Attachment 2

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 #6
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Section #6
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Section #5
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	Section #8 & 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)	By 8/31/2022
a. May not be a copy marked "Draft".	(b)(7)(ii)	By 8/31/2022
b. Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	By 8/31/2022
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	By 8/31/2022
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	By 8/31/2022
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	By 8/31/2022

Federal Requirements Checklist			Regulation Section Number	Report Reference
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	By 8/31/2022

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