

2019

Community Health Needs Assessment



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- Melanie Espino, co-founder and principal
- Jennifer van Stelle, PhD, co-founder and principal

Actionable Insights thanks the following individuals for their collaboration on this report:

- Stephanie Rivera Merrell, MPH, director, Community Health Improvement, John Muir Health
- Jamie Elmasu, MPH, manager, Community Health Improvement, John Muir Health
- Molly Bergstrom, MS, community benefit manager, Kaiser Permanente–Diablo and East Bay
- Susanna Osorno-Crandall, MPA, community benefit manager, Kaiser Permanente–East Bay
- Tim Traver, associate administrator, San Ramon Regional Medical Center
- Christine Donohoe, marketing manager, San Ramon Regional Medical Center
- Denise Bouillercce, public relations and marketing director, Stanford Health Care - ValleyCare
- Shelby Salonga, public relations and marketing manager, Stanford Health Care - ValleyCare
- Mindy Landmark, community health manager, Sutter Health Bay Area
- Bryden Johnston, MPH, community health coordinator, Sutter Health Bay Area
- Adam Davis, MPH, MA, managing director, Center for Community Health and Engagement, UCSF Benioff Children’s Hospital Oakland


John Muir Health thanks the following individuals for their contributions to this report:

- Daniel Peddycord, MA, public health director, Contra Costa Health Services
- Lorena Martinez-Ochoa, director, Family, Maternal and Child Health Programs, Contra Costa Health Services
- Dana Williamson, MPH, lead consultant, Community Benefit Programs, Kaiser Permanente–Northern California Region
- Katrina Noelle, president, KNow Research
- Katy Carew, research manager, KNow Research
- Leann Donovan, marketing manager, KNow Research

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1. Executive Summary

Overview

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

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

The 2019 CHNA is the third such assessment completed since the Affordable Care Act was enacted. It builds upon the information and understanding that resulted from the 2016 CHNA. The CHNA process, completed in fiscal year 2019 and described in this report, was conducted collaboratively by 12 health systems in Alameda and Contra Costa counties ("the Health Systems") in compliance with current federal requirements. The 2019 CHNA will serve as the basis for implementation strategies that are required to be filed with the IRS as part of 2019 Form 990, Schedule H, four and a half months into the next taxable year.¹

Process and Methods

The Health Systems began the third CHNA cycle in 2018 with the goal of collectively gathering community feedback, understanding existing data about health status, and prioritizing local health needs. Community input was gathered during the summer and fall of 2018 through key informant interviews with local health experts, focus groups with community leaders and representatives, and focus groups with community members. Secondary data were collected from Alameda and Contra Costa counties and, in many cases, also for John Muir Health's service area separately. Secondary qualitative data were obtained from a report on low-acuity

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

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

use of our Concord facility’s Emergency Department as well as other sources. (See Attachment 2: Secondary Data Sources for a complete list.)

In November 2018, the Health Systems identified community health needs by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then prioritized by community experts using a second set of criteria. The results of the prioritization are summarized in the table below.

For the purposes of this assessment, the Health Systems did not limit the definition of “community health” to traditional measures. They also considered the broader social and environmental determinants of health, such as access to health care, technology, affordable housing, childcare, education, and employment. This reflects the Health Systems’ view that myriad factors affect community health, and thus community health cannot be adequately understood or addressed without considering these factors.

2019 Prioritized Health Needs

Based on the process outlined above, a list of the most pressing health needs for John Muir Health emerged. These needs appear below in priority order, starting with the top-ranked need. For further details, including statistical data and citations, please consult the health needs descriptions in Section 6: Identification and Prioritization of Health Needs, as well as the data tables in Attachments 4 A–D: Secondary Data Tables.

Health Need	What Is the Issue?	Why Is It a Health Need?
<p>Housing and Homelessness</p>	<p>The U.S. government defines housing as affordable when it costs no more than 30% of a household’s annual income. Spending more than that makes a household less able to afford other necessities. The condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the well-being of those who live inside.</p> <p>Poor health can lead to homelessness, and homelessness can lead to poor health. People without a home suffer from preventable illnesses at a higher rate, require longer hospital stays, and have a greater risk of premature death than their peers with a home. The average life expectancy for a person who lacks permanent housing is at least 25 years shorter than the national average.</p>	<p>Concerns about housing and homelessness—particularly the impact that high costs have on people’s mental and physical health—are prevalent in the community. The median rent in Alameda and Contra Costa counties is significantly higher than the state average and has been increasing. The proportion of Alameda County renters who spend more than 30% of their household income on rent has been rising since 2006. Poor housing quality (evidence of leaks, mold, pests, etc.) may also be an issue. Indicators that housing quality is sub-par: In both counties, child and youth asthma diagnoses and hospitalizations are significantly higher than the state benchmarks. Blood lead levels for children and youth in Alameda County are higher than average too.</p>

Health Need	What Is the Issue?	Why Is It a Health Need?
<p>Behavioral Health</p>	<p>Emotional and psychological well-being are important to every person’s capacity to maintain healthy relationships and function in society. “Well-being” generally means having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing satisfaction and fulfillment in life.</p> <p>Roughly one in five adults in the U.S. is coping with a mental illness. Common disorders such as depression and anxiety can affect self-care. Likewise, chronic diseases can negatively affect mental health. So too can substance use. Substance use can lead or contribute to other social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, car accidents, and HIV/AIDS.</p>	<p>Behavioral health, including mental health and substance use, is one of the community’s top priorities. In Alameda County, the proportion of adults needing help for behavioral health issues, and the rates of Emergency Department visits for both substance use and severe mental illness, exceed state averages. In Contra Costa County, a significantly higher than average percentage of adults has recently taken regular prescription medication for an emotional or mental health issue. Opioid prescription drug claims are higher in Eastern Contra Costa County than the benchmark.</p> <p>In Alameda County, mental health hospitalizations for children and youth are significantly higher than state average—and both are trending up. Levels of school connectedness are significantly worse than benchmarks for 9th and 11th graders in both counties compared to their peers statewide. In Contra Costa County, school bullying among 7th graders is significantly worse than average, as is recent marijuana use among 11th graders.</p>
<p>Economic Security</p>	<p>Economic security is one of the most widely recognized social determinants of health. Higher incomes and a secure social support system—families, friends, communities—play a significant role in people’s overall well-being. Access to economic security programs such as SNAP (Supplemental Nutrition Assistance Program, formerly referred to as food stamps) results in better long-term health outcomes. Despite this, childhood poverty has lasting effects: Even after conditions improve, it results in poorer health outcomes over time.</p>	<p>With regard to this health need, the community was especially concerned about food insecurity, the risk of homelessness, and the stressors of economic instability. They also connected poverty with poor health outcomes. In Northern Alameda County, the population living below the Federal Poverty Level surpasses the state average. In Alameda and Contra Costa counties, the percentage of older adults living in poverty has been increasing. In Eastern Contra Costa County, the percentages of people enrolled in government assistance programs,</p>

Health Need	What Is the Issue?	Why Is It a Health Need?
		<p>including SNAP, are substantially above the state averages. The proportion of children eligible for free or reduced-price lunch, a proxy for low income, is significantly higher than average in eastern and Western Contra Costa County. Also, the proportion of young people (ages 16–19) who aren't attending school or working is higher in Western Contra Costa County than the state average.</p>
<p>Health Care Access and Delivery</p>	<p>Access to comprehensive health care is important for everyone's well-being and quality of life. "Access" generally means a patient has a sufficient number of health care providers available locally, reliable transportation to medical appointments, and adequate insurance (or can otherwise afford services and medications). "Delivery" refers to the timeliness, standards, transparency, and appropriateness with which providers render services.</p> <p>Too often, common medical conditions that could be controlled through preventive care and proper management—such as asthma, cancer, and heart disease/stroke—are instead exacerbated by barriers to access and/or delivery. This can lead to premature death.</p>	<p>Health care access and delivery, particularly the affordability of care/insurance and the lack of access to specialists (including dentists and behavioral health practitioners), greatly concern the community. Interviews with patients and staff at John Muir Health Concord Medical Center identified various patient groups with barriers to access—poverty, lack of understanding of the health care system, poor access to transportation, etc.—using the Emergency Department (ED) in place of more appropriate forms of care. Meanwhile, the proportion of Alameda County's population with a usual source of health care has been decreasing, and the rate of avoidable ED visits (such as those associated with substance use) has been increasing.</p> <p>Good access to primary care can forestall avoidable ED visits and hospitalizations. Data show that the rates of asthma and congestive heart failure hospitalizations in Northern Alameda County are higher than the state rate. Stroke hospitalizations in John Muir Health's service area, as well as stroke deaths across the Tri-Valley area and Contra Costa County exceed state benchmarks. The percentage of recent ED visits in countywide is significantly higher than</p>

Health Need	What Is the Issue?	Why Is It a Health Need?
		<p>the state's. In Eastern Contra Costa County, the percentage of people enrolled in Medicaid or other public insurance is substantially greater than the state average.</p> <p>Finally, barriers to access can mean that people go without routine cancer screenings. Incidence rates for certain cancers (breast, colorectal, lung, and prostate) are worse in Contra Costa County than the state averages. Childhood cancer diagnoses have been slowly rising in Alameda County since 2003.</p>
<p>Community and Family Safety</p>	<p>Crime, violence, and intentional injury are related to poorer physical and mental health for victims, perpetrators, and communities. Crime in a neighborhood causes fear, stress, and mental health issues. Beyond physical injury, victims of violence have a higher risk of depression, substance use, anxiety, reproductive health problems, and suicidal behavior than other people. Exposure to violence also has been linked to post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior oneself.</p> <p>Unintentional injury—accidents involving falls, traffic, overdoses of prescription medications, and more—was the third leading cause of death in the U.S. in 2016. Unintentional injuries are the leading cause of death and hospitalization in California for children ages 16 and younger. Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.</p>	<p>With regard to intentional injury, the community most frequently talked about domestic violence. They also discussed violent crime in general and reported an increase in violence. The rate of Emergency Department (ED) visits for injuries from assaults is higher in Alameda County than the state average. The rate of traumatic injury hospitalizations (intentional and unintentional) among children and youth in Alameda County is significantly higher than the benchmark, as is the case in Contra Costa County. Domestic violence hospitalization rates also significantly exceed the average in the John Muir Health service area. Similarly, homicide death rates are significantly above the state benchmark in Alameda and Contra Costa counties.</p> <p>Concerns were expressed over the impact of discrimination and racially motivated violence on mental health. The use of force by police in Oakland shows disparities by ethnicity, with African Americans experiencing use of force at a rate nearly 25 times that of Whites. Youth and young adult community members in particular expressed fear of the police. In Northern Alameda County and the</p>

Health Need	What Is the Issue?	Why Is It a Health Need?
		<p>Tri-Valley/Central Contra Costa County, the rates of violent crime overall are significantly higher than the benchmark. Also, jail admission rates among adults, and juvenile felony arrest rates among youth, are significantly higher in Alameda County than average. Other issues of concern for youth and children include online and in-person bullying, victimization, and acting out (externalizing) trauma.</p> <p>With regard to unintentional injuries, the rates of bicycle-involved collisions, motor vehicle crash ED visits, other unintentional-injury ED visits, and unintentional deaths in Alameda County exceed the state averages. Deaths attributed to traffic collisions in Contra Costa County are experienced disproportionately by African Americans.</p>
<p>Education and Literacy</p>	<p>Literacy generally means “the ability to read and write,” although it also involves skills related to listening, speaking, and working with numbers. Limited literacy reflects low levels of education, which is associated with poor health outcomes. People at risk for low English literacy include immigrants, those living in households where English is not spoken, and individuals with inadequate schooling. Adults who have at least a high school diploma do better than dropouts when it comes to health, income, life satisfaction, and self-esteem.</p> <p>The National Poverty Center associates increased education with decreased rates of most acute and chronic diseases. This may be because they’re better able to afford health care: Research shows that families in which the head of household has a high school diploma are 10 times wealthier than those in</p>	<p>The community discussed academic achievement most often as a driver of economic security. Data show that a larger proportion of children in Alameda County live in linguistically isolated households than the state average. Combined with the comparatively high cost of preschool childcare, Alameda County children may have greater barriers to literacy than children elsewhere. In western and Eastern Contra Costa County, the proportion of 4th graders reading at or above proficiency level is significantly lower than the state average. Student truancy is higher in Contra Costa County than the benchmark. In Alameda County, the ratio of students to academic counselors exceeds the state average—a trend that’s been increasing since 2008. A smaller proportion of Northern Alameda County students graduate high school on time compared to peers statewide.</p>

Health Need	What Is the Issue?	Why Is It a Health Need?
	<p>which the head of household dropped out. Many jobs in the U.S. require more than a high school education.</p>	<p>Meanwhile, ethnic disparities are evident. African American girls in both counties and Latina girls in Contra Costa County have significantly higher rates of teen pregnancy than girls of other ethnicities, which can interrupt or end their educational trajectory. African American youth in both counties are overrepresented among high school dropouts and pass high school exit exams in lower proportions than youth of other ethnicities.</p>
<p>Healthy Eating/Active Living</p>	<p>Nearly two in five adults and one in five children in the U.S. are obese. Being obese or overweight raises the risk for diabetes, hypertension, stroke, and cardiovascular disease—some of the leading causes of preventable death. Obesity also can contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Risk factors of obesity include an unhealthy diet, a sedentary lifestyle, underlying medical issues, family models, and social and economic factors. Obesity often co-exists with food insecurity (a lack of available financial resources for food at the household level) because “both are consequences of economic and social disadvantage.”</p> <p>Getting regular exercise can help reduce the risk of obesity and Type 2 diabetes, as well as cardiovascular disease, some cancers, and other physical issues. It also can help strengthen bones and muscles, prevent falls for older adults, and promote a longer life. Similarly, maintaining a healthy diet can help prevent high cholesterol and high blood pressure and lower the risks of obesity, osteoporosis, and dental cavities. For children and adolescents, a nutritious diet</p>	<p>This health need comprises access to food and recreation, food insecurity, diet and nutrition, fitness, diabetes, and obesity. Data show that access to healthy food stores is significantly lower than the state average in Contra Costa County as well as the Tri-Valley area. Fewer than average grocery stores and produce vendors exist per capita in these locales. This is true in Northern Alameda County as well, where the number of stores per capita selling beer, wine, and liquor is significantly higher than average. Also, the smoking incidence rate is significantly higher in western and Eastern Contra Costa County than the benchmark.</p> <p>Fast food consumption is trending up in Alameda County. In the county's northern region, food insecurity is higher than the state average. (<i>For more about food insecurity, see Economic Security.</i>)</p> <p>The diabetes hospitalization rate among children and youth is higher in both Alameda and Contra Costa counties than the state average—and is rising. The rate of diabetes management in both counties is lowest among African Americans.</p> <p>A larger proportion of youth in western and Eastern Contra Costa</p>

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	<p>contributes to growth, bone development, and cognitive function. Yet many people do not follow the recommended food and exercise guidelines.</p>	<p>County are physically inactive than the state average. Countywide, a significantly smaller proportion of children and youth walk or bike to school. Also, the percentage of 9th graders in Contra Costa County who meet fitness standards has been declining.</p> <p>In Western Contra Costa County, community members may limit their physical activity due to concerns about air quality. Youth in the area were concerned about potential contamination of the water supply near oil refineries. Lack of access to clean drinking water affects physical health in various ways, including the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay.</p> <p>Obesity-related hospitalizations are increasing in Alameda County. Youth obesity is significantly higher in western and Eastern Contra Costa County than the state average. In all but the Tri-Valley and Central Contra Costa County, obesity is highest among Pacific Islander youth and among African American adults. Latinx youth and African American adults have the highest rates of obesity in the Tri-Valley/Central Contra Costa County area.</p>
<p>Transportation and Traffic</p>	<p>Motor vehicle crashes killed over 35,000 people and injured 2.5 million more across the U.S. in 2015. The major contributors to this type of bodily harm—drunken driving, distracted driving, speeding, and not using seat belts—are preventable. Increases in road use and motor vehicle collisions go hand in hand. Greater traffic congestion causes travel delays, more fuel consumption, and higher greenhouse gas emissions from vehicle exhaust. Vehicle exhaust</p>	<p>For some community members, transportation is a barrier to seeing a doctor and getting to work. Public transportation to East Bay locations can be difficult, they said, because of poor reliability, limited bus and BART lines, long public transit travel times, and the expense.</p> <p>Traffic is also an issue. The John Muir Health service area has a significantly higher density of roads than the state’s benchmark. Compared to the state average, a</p>

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	<p>is a known risk factor for heart disease, stroke, asthma, and cancer. The benefits of alternative transport, such as walking or riding a bicycle, include improving health. Combining alternative transport with traffic countermeasures can also reduce traffic-related injuries and deaths.</p>	<p>significantly greater proportion of eastern and Central Contra Costa County and Tri-Valley commuters drive alone to work more than 60 minutes in each direction, contributing to the traffic load on the roads. A significantly smaller proportion of Eastern Contra Costa County community members live within half a mile of a public transit stop compared to other state residents.</p>
<p>Climate/Natural Environment</p>	<p>A healthy environment is critical to everyone’s physical health and quality of life. Nearly 25% of all deaths and diseases worldwide can be attributed to environmental issues such as air, water, food, and soil contamination. A poor environment can compound the problems of people whose health is already compromised. Therefore, any effort to improve overall health must consider environmental factors that may increase the likelihood of illness and disease. This includes climate change, which is projected to have an increasing impact on air quality, the spread of infectious diseases, and the severity of fires, floods, droughts, and other natural disasters. In 2017 and 2018, smoke from Northern California wildfires contributed to the number of days when air quality reached unhealthy levels. The long-term effects of prolonged exposure to poor air quality can be severe: Air pollution is linked to premature death from lung cancer, chronic obstructive pulmonary disorder, and acute respiratory infections.</p>	<p>Feedback from the community about the environment primarily focused on poor air quality. The respiratory hazard index in Northern Alameda County is significantly worse than the state average. Road network density contributes to greater traffic, which can increase air pollution. Eastern Contra Costa County has a significantly higher density of roads compared to the state average; particulates from traffic can contribute to asthma. While air quality measures are better than the state benchmark, asthma prevalence in the local area is significantly worse. Asthma can be exacerbated by heat and pollution. Asthma hospitalizations are significantly worse for children in both counties and for youth in Alameda County compared to the state.</p> <p>Finally, drinking water violations in the service area’s community water systems were flagged as an issue. Lead in the environment is of particular danger to children, whose bodies are still developing and thus more sensitive to such toxic substances. Blood lead levels for children and youth are higher in Alameda County compared to the state average.</p>

John Muir Health Selected Priority Areas

As a result of these selected needs, John Muir Health will focus Community Benefit 2020-2022 programming on the following:

1. Access to care, including primary and specialty care
2. Behavioral and mental health services
3. Economic Security, to include:
 - a. Housing
 - b. Food
 - c. Community and family safety

Next Steps

After making this CHNA report publicly available by December 31, 2019, on the Community Commitment page of our website,³ John Muir Health will solicit feedback about the report until two subsequent CHNA reports have been posted. The public may email comments to community.benefit@johnmuirhealth.com. Our Health System will also develop a community health implementation strategy based on the CHNA results, which will be filed with the IRS by May 15, 2020.

³ <https://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html>

2. Introduction

In 2018, 12 health systems in Alameda and Contra Costa counties (referred to collectively as “the Health Systems”) collaborated for the purpose of identifying critical health needs of the community. John Muir Health worked with these partners to conduct an extensive community health needs assessment (CHNA). The 2019 CHNA builds upon earlier assessments conducted by the Health Systems, and this report—which is available to the public for review and comment—provides details of the results.

Purpose of the CHNA Report and Affordable Care Act Requirements

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

The federal description of “community health needs” goes beyond morbidity and mortality to include social determinants of health, such as access to care, affordable housing, childcare, education, and economic security. This broad scope presents opportunities for nonprofit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, ACA created more incentives for health care providers to focus on disease prevention by including lower (or no) co-payments for preventive screenings.

SB 697 and California’s History of Assessments

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals shall describe the process by which they involved the community groups and local government officials in helping identify and prioritize community needs to be addressed. This community needs assessment shall be updated at least once every three years.⁴

The 2019 CHNA meets current state and federal requirements.

⁴ California Office of Statewide Health Planning and Development. (1998). Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697), Report to the Legislature. Retrieved November 2019 from <https://oshpd.ca.gov/wp-content/uploads/2018/07/SB-697-Report-to-the-Legislature-Community-Benefit.pdf>

Summary of the 2016 CHNA

In 2016, John Muir Health participated in a collaborative process to identify significant community health needs and to meet the IRS and SB 697 requirements. The 2016 CHNA report (PDF) is available to the public for review and comment on the Community Commitment page of our website.⁵

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

1. Obesity, Diabetes, Healthy Eating, and Active Living
2. Economic Security
3. Health Care Access and Delivery, including Primary and Specialty Care
4. Oral/Dental Health
5. Mental Health
6. Substance Abuse, Including Alcohol, Tobacco, and Other Drugs
7. Unintentional Injuries
8. Violence and Injury Prevention

Written Public Comments on the 2016 CHNA

At the time this CHNA report was completed, John Muir Health had not received any written comments about its 2016 CHNA report. Our hospital will continue to accept feedback and make sure all relevant submissions are reviewed and addressed by appropriate hospital staff.

John Muir Health offers the public an ongoing means to provide written comments on our CHNA reports by maintaining a specific email address (community.benefit@johnmuirhealth.com) as well as a general comment form on the Contact Us page of our website.⁶

This 2019 Community Health Needs Assessment was adopted by John Muir Health's Board of Directors on December 11, 2019.

⁵ https://www.johnmuirhealth.com/content/dam/jmh/Documents/Community/2016_Community_Health_Needs_Assessment.pdf

⁶ <https://www.johnmuirhealth.com/secure/contact-us.html>

3. About John Muir Health

John Muir Health is a tax-exempt organization that owns and operates John Muir Medical Center-Walnut Creek, John Muir Medical Center-Concord, and John Muir Behavioral Health (JMBH). JMBH is also a tax-exempt organization that owns and operates the Behavioral Health Center. John Muir Health, JMBH, and affiliates collectively constitute an integrated health delivery system.

John Muir Health is a private, nationally recognized, community-based, not-for-profit health care organization serving patients in Contra Costa, eastern Alameda, and southern Solano counties. The health system comprises a network of over 1,000 primary care and specialty physicians, more than 6,000 employees, medical centers in Concord and Walnut Creek (including Contra Costa County's only trauma center), and a behavioral health center. John Muir Health also has partnerships with San Ramon Regional Medical Center, Stanford Children's Health, and UCSF Medical Center to expand our capabilities, increase access to services, and better serve patients.

The health system offers a full-range of medical services, including primary care, outpatient services, and imaging services. John Muir Health is widely recognized as a leader in many specialties—neuroscience, orthopedics, cancer, cardiovascular, trauma, emergency, pediatrics, and high-risk obstetrics care. More information is available on our website.⁷

Mission, Vision, and Values

John Muir Health is guided by our charitable mission, which serves as the foundation for directing the organization's community benefit activities. We are dedicated to improving the health of the communities we serve with quality and compassion.

John Muir Health's eight core values that guide our board of directors, management, and employees in all efforts are: Excellence, Honesty and Integrity, Mutual Respect and Teamwork, Caring and Compassion, Commitment to Patient Safety, Continuous Improvement, Stewardship of Resources, and Access to Care.

Community Commitment

John Muir Health's mission reflects community health efforts as a corporate leader and community partner. Our community health leadership role is rooted in our excellence as a health care provider and our commitment to building partnerships with organizations that also exemplify excellence.

We view our commitment to community service initiatives as core to our mission. This commitment is seen through every facet of the organization from volunteers to physicians and in

⁷ <https://www.johnmuirhealth.com/>

our emergency departments and outpatient centers. Most clinical service lines lead and operate a community service initiative. For example, our Cancer Institute leads the La Clínica Specialty Care and Every Woman Counts programs. John Muir Health received Magnet® recognition honoring our nursing services and quality nursing care, the highest recognition in nursing, and we are leaders in community services through our initiatives to promote health and wellness outside the hospital. Employees contribute when they participate in departmental programs, volunteer for John Muir Health–sponsored community events and programs, or volunteer in their own communities to make them better places to live and work.

Community Benefit

The Community Health Improvement Department serves as a steward for John Muir Health's charitable purposes by assisting the community in achieving optimal health through education, collaboration, and health/wellness programs and services. Community Health Improvement works in partnership with local communities, other health systems, public health providers, community clinics, community-based organizations, and school districts to identify and address unmet health needs among vulnerable populations. Community Health Improvement's main role is to coordinate the John Muir Health community benefit planning process and to act as the liaison to the community-at-large, which enables John Muir Health to align resources and strategies to better impact the goal of creating healthy communities.

The Community Benefit Oversight Committee (CBOC) provides governance for all community benefit activities. The CBOC is composed of executive leaders from across the health system and key community leaders. Additionally, John Muir Health's administration and board of directors oversee community benefit investments through frequent reporting. The Community Benefit Guiding Principles, approved by the board of directors in 2015, include John Muir Health's vision for creating healthy communities. The principles also provide a framework for current and future community health priorities and initiatives, as follows:

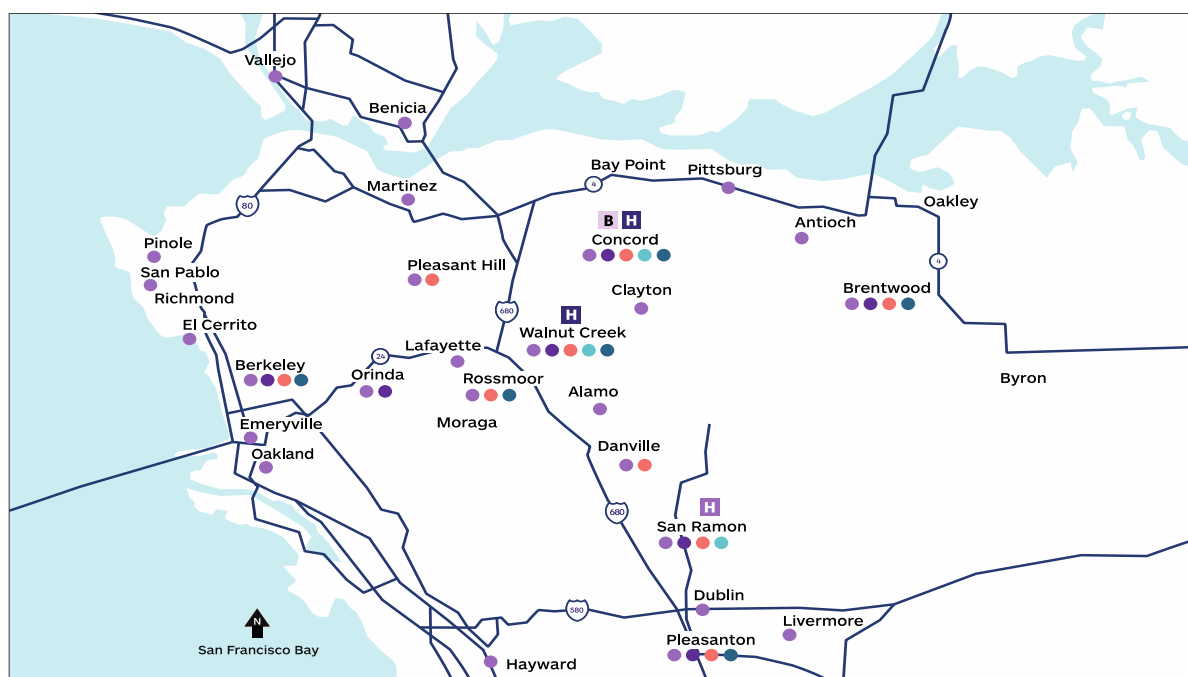
- Provide subsidized care to patients served at John Muir Health facilities, according to the Patient Assistance/Charity Care Program Policy.
- Engage in activities that align with John Muir Health Community Benefit focus areas as defined in the triennial Community Health Improvement Plan.
- Focus investments in the John Muir Health community benefit service area.
- Engage in and create activities targeted to vulnerable populations, defined as those meeting one or more of the following characteristics: economically disadvantaged, evidenced-based disparities in health outcomes, significant barriers to care.
- Conduct long-term sustained activities with trusted partners.
- Partner with organizations that have expertise and specific capabilities to better leverage John Muir Health resources.
- Invest in activities with demonstrated outcomes in achieving community health improvement.
- Invest in activities that emphasize quality and continuity of care.
- Engage the community to gain broad support of activities.

In addition to our direct delivery of care and community benefit programs, John Muir Health provides broad financial and technical support to promote community wellness. John Muir Health contributes \$1 million each year to the John Muir/Mt. Diablo Community Fund, which works to bring systemic change that improves the health of people in central and east Contra Costa County who are most likely to experience health care disparities.

Community Served

The Internal Revenue Service defines the “community served” as individuals residing within the hospital’s service area. A hospital service area comprises all the inhabitants of a defined geographic area and does not exclude low-income or underserved populations. John Muir Health collaborated on the 2019 CHNA with other hospitals in Alameda and Contra Costa counties.

John Muir Health Locations



- H** John Muir Health Medical Centers
- H** San Ramon Regional Medical Center, a John Muir Health Partner
- B** Behavioral Health Center
- Physician Offices
- Urgent Care Centers
- Other Outpatient Services
- Emergency Services
- Outpatient Centers

Additional physician offices available in Fairfield and Fremont.

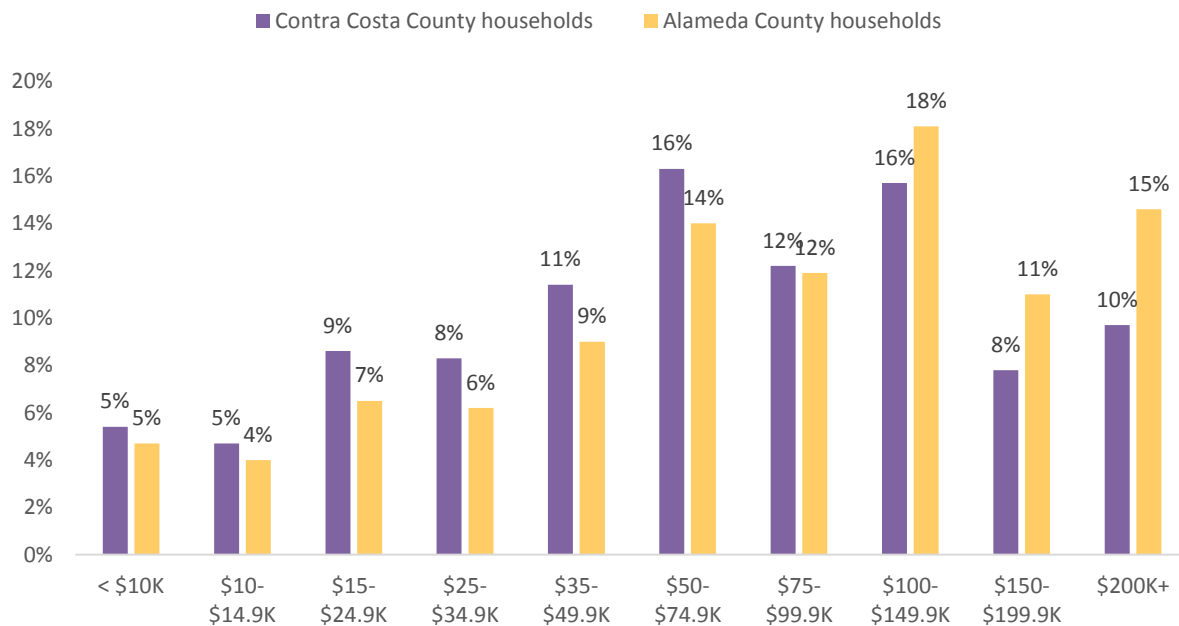
John Muir Health’s primary and secondary service area extends from southern Solano County into Eastern Contra Costa County and south to San Ramon in Contra Costa County. John Muir Health’s Trauma Center serves all of Contra Costa County, Solano County, and Marin County. It is also the backup trauma center for Alameda County. John Muir Health also serves eastern Alameda County in joint venture with San Ramon Regional Medical Center and serves northern Alameda County in joint venture with University of California, San Francisco.

John Muir Health’s Community Benefit programs primarily focus on the needs of vulnerable populations in Contra Costa County, the Tri-Valley, and Northern Alameda County. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care, and economic disadvantages.

Community Demographics

The areas John Muir Health serves are highly diverse in socioeconomic status and ethnicity. Two key social determinants, income and education, have a significant impact on health outcomes. The median household income in Alameda County (about \$80,000) is higher than California overall (about \$66,000) but lower than neighboring Contra Costa County (\$83,000).⁸ Median incomes in Alameda and Contra Costa counties show some differences in those with high incomes and low incomes, as displayed in the following chart.

Household Income Range by County



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

More than four in 10 people in Alameda County live in households with incomes of \$100,000 or more, compared with about three in 10 in Contra Costa County. More than 30% of the population in both counties has a household income below \$50,000, and over 25% that have household incomes between \$50,000 and \$100,000.³ By comparison, the 2018 Self-Sufficiency

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

Standard for a two-adult family with two children was about \$98,300 in Alameda County and about \$102,900 in Contra Costa County.⁹

Housing costs are high. In 2018, the median home price was about \$881,000 and the median rent is \$3,157 in Alameda County, and the median home price was about \$624,000 and median rent is \$2,749 in Contra Costa County.¹⁰

Tri-Valley/Central Contra Costa County

The U.S. Census estimates a population of about 750,000 in the Tri-Valley/Central Contra Costa County (TV/C-CCC) area. The two largest ethnic subpopulations are White and Asian (60% and 18%, respectively). About 14% of the community has Latinx heritage. Foreign-born individuals comprise 25% of the population in Contra Costa County.¹¹

TV/C-CCC Ethnicity and Socioeconomic Data

Ethnicity		Socioeconomic Data	
Total population	750,746	Living in poverty (<100% Federal Poverty Level)	6.2%
White	59.8%	Children in poverty	6.3%
Asian	18.2%	Unemployment	3.0%
Hispanic/Latinx	14.5%	Uninsured population	5.5%
African American	2.4%	Adults with no high school diploma	5.8%
Pacific Islander/Native Hawaiian	0.4%		
Native American/Alaska Native	0.2%		
Some other race	0.2%		
Multiple races	4.2%		

Percentages do not add to 100% because people could choose more than one ethnicity. Source: U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

Despite the fact that more than a third of households in each county earn more than \$100,000 per year, 6% of the total population and 6% of children in TV/C-CCC are living in poverty, much smaller proportions than in either Alameda or Contra Costa County overall.¹¹ More than 5% of people in TV/C-CCC are uninsured.

⁹ The Insight Center for Community Economic Development. (2018). *Self-Sufficiency Standard Tool*. Retrieved December 2018 from <https://insightccd.org/tools-metrics/self-sufficiency-standard-tool-for-california/>

¹⁰ Zillow, data through November 30, 2018: <https://www.zillow.com/contra-costa-county-ca/home-values/>

¹¹ U.S. Census Bureau. (2017). American Community Survey, 5-Year Estimates, 2013–2017.

TV/C-CCC Area Deprivation Index

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

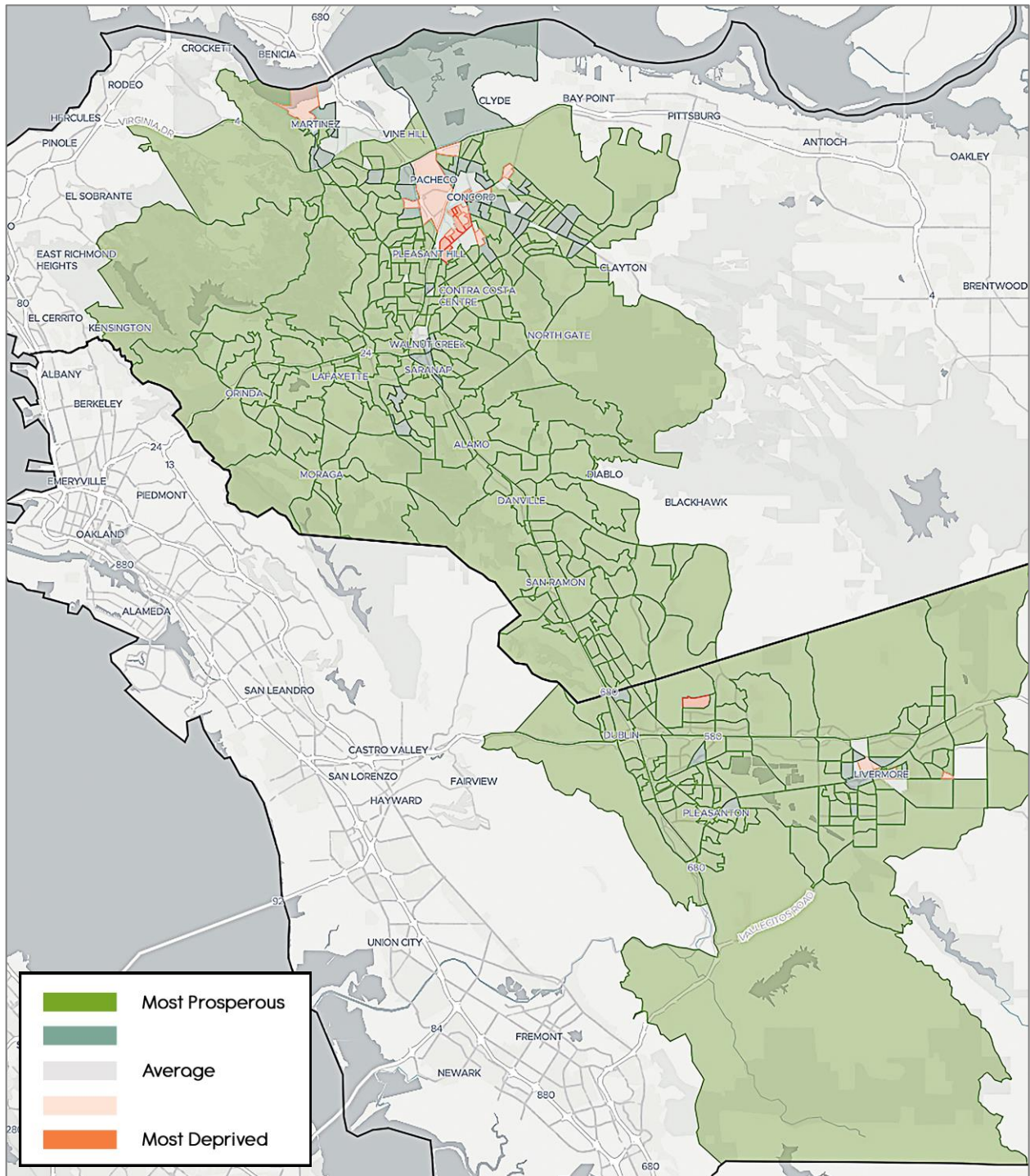
The ADI score of 72.6 for the Tri-Valley/Central Contra Costa County¹² was calculated using Census Block Group level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. The exceptions to that rule are housing costs (e.g., rent), where lower percentiles indicate higher housing costs. Area percentiles and indicator values that are worse than California are indicated in **bold red**.

Indicator Name	TV/C-CCC Percentile	TV/C-CCC Value	CA Percentile	CA Value
Area Deprivation Index	7	72.6	49	98.1
Families below poverty level	35	3.9%	64	11.9%
High school diploma/GED, adults ≥ age 25	31	94.2%	74	81.9%
Owner-occupied housing units	50	68.8%	68	54.1%
Households without a motor vehicle	49	4.7%	62	7.5%
Crowded households (>1 person per room)	68	2.8%	89	8.3%
Households without complete plumbing	34	0.3%	52	0.4%
Households without a telephone	47	1.3%	59	2.2%
Income disparity (log scale)	20	1.2	36	2.2
Median family income	7	\$132,288	32	\$74,913
Median gross rent	7	\$1,846	17	\$1,313
Median home value	3	\$706,007	11	\$441,468
Median monthly home cost	5	\$2,492	20	\$1,768
Population below 150% of poverty threshold	24	10.4%	59	25.9%
Single parent households with children < age 18	49	18.5%	67	23.8%
Less than high school education, adults ≥ age 25	48	2.7%	84	10.0%
Unemployment, ≥ age 16	46	5.6%	68	8.9%
Employed in white collar occupations, ≥ age 16	16	76.9%	47	60.5%

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

¹² For the ADI and percentile scores only, the Tri-Valley/Central Contra Costa County area comprises the cities/towns of Alamo, Concord, Danville, Dublin, Lafayette, Livermore, Martinez, Moraga, Orinda, Pacheco, Pleasant Hill, Pleasanton, San Ramon, and Walnut Creek, and includes the following ZIP codes: 94506, 94507, 94517, 94518, 94519, 94520, 94521, 94523, 94526, 94528, 94549, 94550, 94551, 94552, 94553, 94556, 94563, 94566, 94568, 94575, 94582, 94583, 94586, 94588, 94595, 94596, 94597, 94598, 94611.

TV/C-CCC Area Deprivation Index Map



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

Eastern Contra Costa County

The U.S. Census estimates a population of 318,900 in the Eastern Contra Costa County (E-CCC) area. The two largest ethnic subpopulations are White and Latinx in the E-CCC area (36% and 35%, respectively). Approximately 35% of residents have Latinx heritage and 13% are African American.

E-CCC Ethnicity and Socioeconomic Data

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

Percentages do not add to 100% because people could choose more than one ethnicity. Source: U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

Despite the fact that one third of households in the county earn more than \$100,000 per year, close to 13% of people in the E-CCC area live in poverty, a higher proportion than in Contra Costa County overall. In addition, 18% of children in the E-CCC area live below the poverty line, again exceeding the county statistic.¹³ Nearly 10% of individuals in E-CCC are uninsured.

¹³ U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

E-CCC Area Deprivation Index

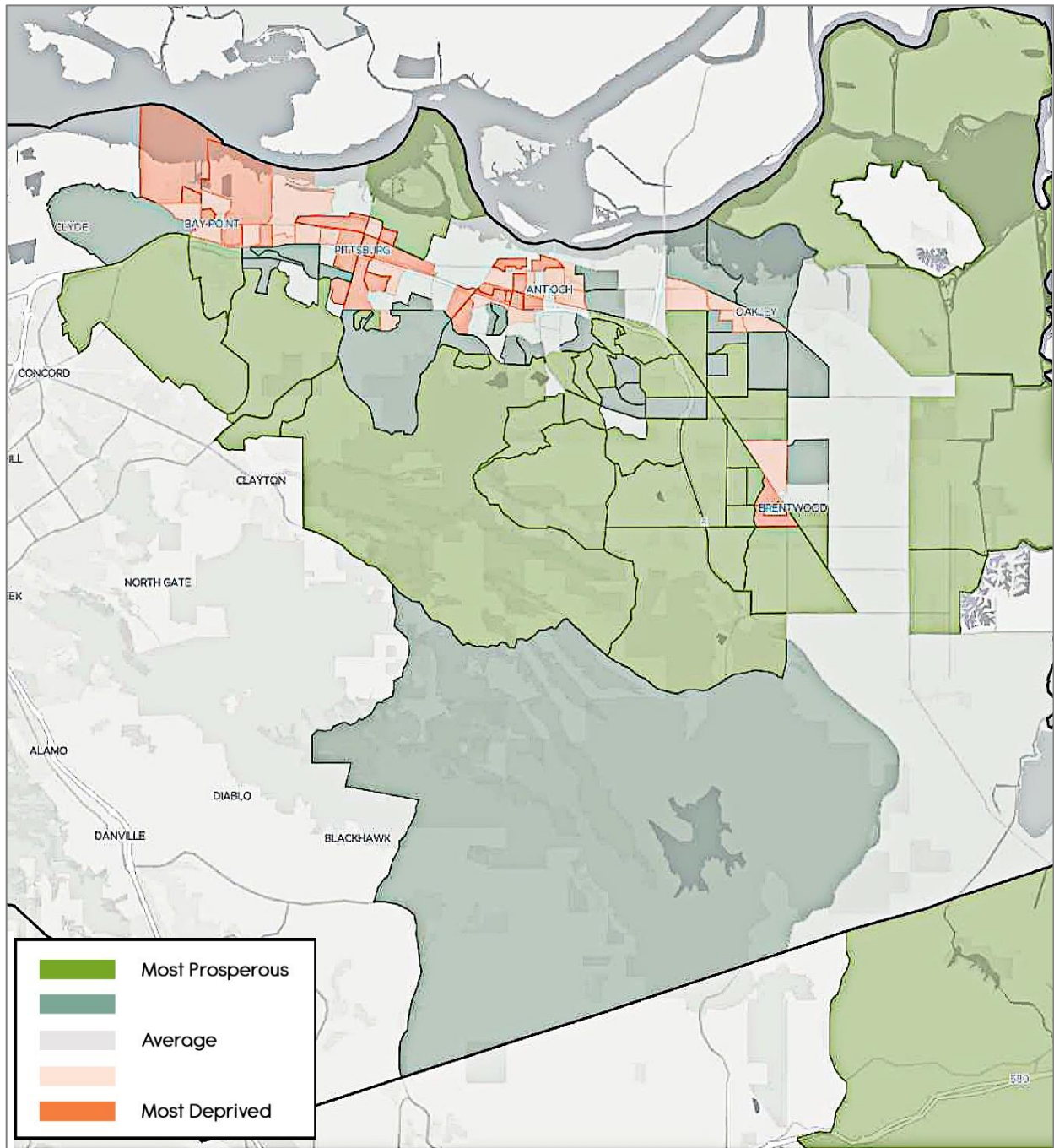
The ADI score of 95.1 for Eastern Contra Costa County¹⁴ was calculated using Census Block Group level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. The exceptions to that rule are housing costs (e.g., rent), where lower percentiles indicate higher housing costs. Area percentiles and indicator values that are worse than California are indicated in **bold red**. (For general details about the Area Deprivation Index, see page 22.)

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

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

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

E-CCC Area Deprivation Index Map



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

Western Contra Costa County

The U.S. Census estimates a population of 254,267 in the Western Contra Costa County (W-CCC) area. The two largest ethnic subpopulations are Latinx and White (35% and 23%, respectively).

W-CCC Ethnicity and Socioeconomic Data

Ethnicity		Socioeconomic Data	
Total population	254,267	Living in poverty (<100% Federal Poverty Level)	14.0%
Hispanic/Latinx	35.2%	Children in poverty	19.7%
White	23.4%	Unemployment	3.1%
Asian	20.1%	Uninsured population	12.9%
African American	15.5%	Adults with no high school diploma	18.2%
Pacific Islander/Native Hawaiian	0.4%		
Native American/Alaska Native	0.3%		
Some other race	0.6%		
Multiple races	4.7%		

Percentages do not add to 100% because people could choose more than one ethnicity. Source: U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

Despite the fact that over one third of all households in the county earn more than \$100,000 per year, about 14% of residents in the W-CCC area are living in poverty, a higher proportion of residents than in Contra Costa County overall. In addition, more than one in five children in the W-CCC area is living in poverty, again exceeding the proportion in the county.¹⁵ Approximately 13% of people in W-CCC are uninsured.

¹⁵ U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

W-CCC Area Deprivation Index

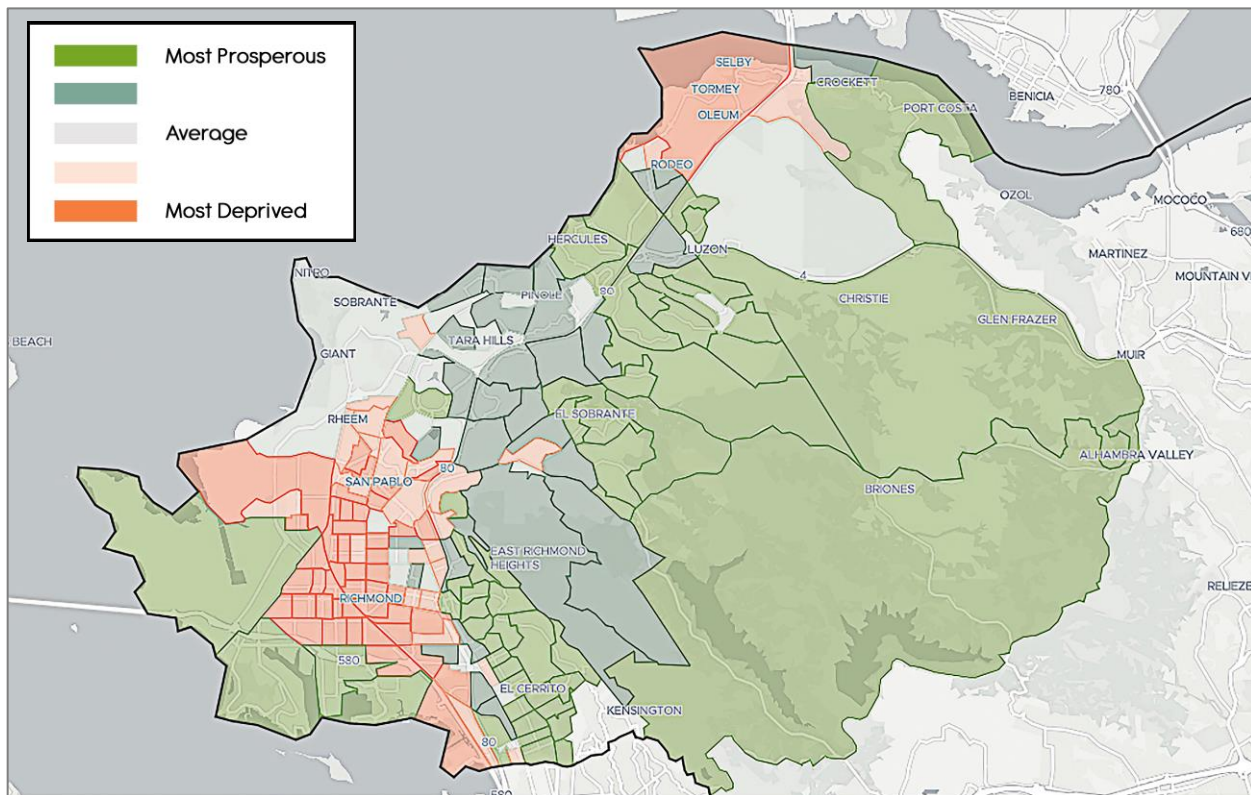
The ADI score of 99.3 for Western Contra Costa County¹⁶ was calculated using Census Block Group level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. The exceptions to that rule are housing costs (e.g., rent), where lower percentiles indicate higher housing costs. Area percentiles and indicator values that are worse than California are indicated in **bold red**. (For general details about the Area Deprivation Index, see page 22.)

Indicator Name	W-CCC Percentile	W-CCC Value	CA Percentile	CA Value
Area Deprivation Index	52	99.3	49	98.1
Families below poverty level	63	11.7%	64	11.9%
High school diploma/GED, adults ≥ age 25	75	81.2%	74	81.9%
Owner-occupied housing units	67	55.5%	68	54.1%
Households without a motor vehicle	65	8.2%	62	7.5%
Crowded households (>1 person per room)	88	7.8%	89	8.3%
Households without complete plumbing	55	0.4%	52	0.4%
Households without a telephone	51	1.6%	59	2.2%
Income disparity (log scale)	31	2.1	36	2.2
Median family income	34	\$73,361	32	\$74,913
Median gross rent	19	\$1,337	17	\$1,313
Median home value	19	\$352,411	11	\$441,468
Median monthly home cost	24	\$1,600	20	\$1,768
Population below 150% of poverty threshold	55	23.7%	59	25.9%
Single parent households with children < age 18	64	23.7%	67	23.8%
Less than high school education, adults ≥ age 25	86	11.2%	84	10.0%
Unemployment, ≥ age 16	65	8.4%	68	8.9%
Employed in white collar occupations, ≥ age 16	55	56.5%	47	60.5%

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

¹⁶ For the ADI and percentile scores only, the Western Contra Costa County area comprises the cities/towns of Bayview, Crockett, East Richmond Heights, El Cerrito, El Sobrante, Hercules, Kensington, Montalvin Manor, North Richmond, Pinole, Richmond, Rodeo, Rollingwood, San Pablo, and Tara Hills, and includes the following ZIP codes: 94525, 94530, 94547, 94564, 94572, 94801, 94803, 94804, 94805, and 94806.

W-CCC Area Deprivation Index Map



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

Northern Alameda County

The U.S. Census estimates a population of 587,090 in the Northern Alameda County area. The two largest ethnic subpopulations are White and Asian (40% and 20%, respectively). Some 17% of residents have Latinx heritage and just over 16% are African American. Foreign-born residents account for 32% of the population in Alameda County overall.¹³

N-AC Ethnicity and Socioeconomic Data

Ethnicity		Socioeconomic Data	
Total population	587,090	Living in poverty (<100% Federal Poverty Level)	16.6%
White	40.0%	Children in poverty	18.8%
Asian	20.3%	Unemployment	2.9%
Hispanic/Latinx	17.0%	Uninsured population	9.0%
African American	16.2%	Adults with no high school diploma	12.1%
Native American/Alaska Native	0.3%		
Pacific Islander/Native Hawaiian	0.5%		
Some other race	0.4%		
Multiple races	5.3%		

Percentages do not add to 100% because people could choose more than one ethnicity. Source: U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

Despite the fact that 44% of households countywide earn \$100,000 or more per year, nearly 17% of people in Northern Alameda County live in poverty, a greater proportion than the county overall. Almost one in five children in Northern Alameda County lives in poverty, again exceeding the county overall.¹⁷ Approximately 9% of people in Northern Alameda County are uninsured.

¹⁷ U.S. Census Bureau. (2016). American Community Survey, 5-Year Estimates, 2012–2016.

N-AC Area Deprivation Index

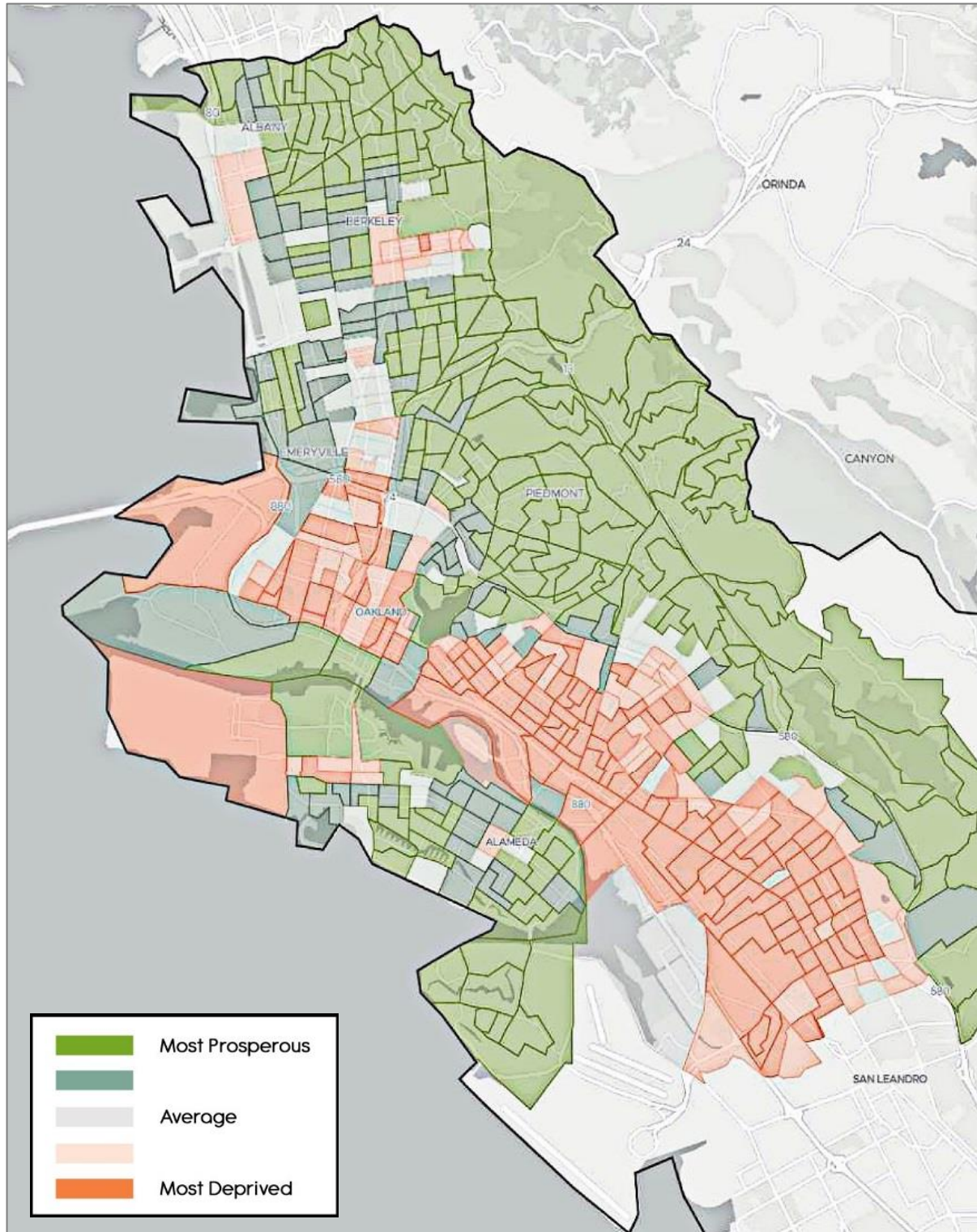
The ADI score of 96.3 for Northern Alameda County¹⁸ was calculated using Census Block Group level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. The exceptions to that rule are housing costs (e.g., rent), where lower percentiles indicate higher housing costs. Area percentiles and indicator values that are worse than California are indicated in **bold red**. (For general details about the Area Deprivation Index, see page 22.)

Indicator Name	N-AC Percentile	N-AC Value	CA Percentile	CA Value
Area Deprivation Index	45	96.3	49	98.1
Families below poverty level	66	12.5%	64	11.9%
High school diploma/GED, adults ≥ age 25	66	85.6%	74	81.9%
Owner-occupied housing units	79	42.0%	68	54.1%
Households without a motor vehicle	83	16.2%	62	7.5%
Crowded households (>1 person per room)	86	6.6%	89	8.3%
Households without complete plumbing	72	0.8%	52	0.4%
Households without a landline or mobile phone	64	2.5%	59	2.2%
Income disparity (log scale)	46	2.5	36	2.2
Median family income	26	\$84,138	32	\$74,913
Median gross rent	20	\$1,317	17	\$1,313
Median home value	7	\$597,914	11	\$441,468
Median monthly home cost	18	\$2,054	20	\$1,768
Population below 150% of poverty threshold	61	26.8%	59	25.9%
Single parent households with children < age 18	48	16.6%	67	23.8%
Less than high school education, adults ≥ age 25	79	8.0%	84	10.0%
Unemployment, ≥ age 16	66	8.3%	68	8.9%
Employed in white collar occupations, ≥ age 16	31	69.5%	47	60.5%

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

¹⁸ For the ADI and percentile scores, the Northern Alameda County area comprises only the cities/towns of Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont.

N-AC Area Deprivation Index Map



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

4. Assessment Team

Hospital Partners

Community benefit representatives from 12 health systems in Alameda and Contra Costa counties (“the Health Systems”) contracted with Actionable Insights in 2018 to conduct the 2019 Community Health Needs Assessment (CHNA). The Health Systems were:

- John Muir Health (Walnut Creek, Concord, and Behavioral Health Medical Centers)
- Kaiser Permanente–Diablo (Antioch and Walnut Creek Kaiser Foundation Hospitals)
- Kaiser Permanente–East Bay (Oakland and Richmond Kaiser Foundation Hospitals)
- St. Rose Hospital
- San Ramon Regional Medical Center
- Stanford Health Care - ValleyCare
- Sutter Health Bay Area (Alta Bates Summit Medical Center and Herrick Campus and Sutter Delta Medical Center)
- UCSF Benioff Children’s Hospital Oakland

Identity and Qualifications of Consultants

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

Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI has conducted community health needs assessments for over 25 hospitals during the 2018–19 CHNA cycle. More information about AI is available on its website.¹⁹

¹⁹ <http://actionablellc.com/>

5. Process and Methods

The Health Systems collaborated on the primary and secondary data requirements of the CHNA, and John Muir Health subsequently worked with Kaiser Permanente, Sutter Health, and local community experts on the prioritization of the needs. The CHNA data collection process took place over seven months and culminated in separate reports written for each of the health systems in spring of 2019. The phases of the process are depicted below.



Secondary Data Collection

AI analyzed over 200 quantitative health indicators to assist the Health Systems in understanding the health needs and assessing their priority in the community. They gathered data from existing sources using the CHNA.org²⁰ data platform and other online sources, such as the California Department of Public Health and the U.S. Census Bureau. The decision to include these additional data was made, and these data were collected, by the Health Systems. The Health Systems, as a group, determined that these additional data would bring greater depth to the CHNA in their community. When trend data and/or data by ethnicity were available, they were reviewed to enhance understanding of the issue(s).

- As a further framework for the assessment, the Health Systems requested that AI address these questions in its analysis: How do these indicators perform against accepted benchmarks (Healthy People 2020 objectives and statewide averages)?
- Are there disparate outcomes and conditions for people in the community?

Healthy People is an endeavor of the U.S. Department of Health and Human Services that has provided 10-year national objectives for improving the health of Americans based on scientific data spanning 30 years. Healthy People sets national objectives or targets for improvement. The most recent set of objectives are for the year 2020 (HP2020). Year 2030 objectives are currently under development.²¹

In addition to the secondary quantitative data that were collected for the Health Systems, secondary qualitative research was conducted by KNow Research, a San Francisco-based market research firm, on behalf of John Muir Health. This qualitative research focused on better understanding use of John Muir Medical Center-Concord's Emergency Department. KNow

²⁰ <http://www.chna.org> is a web-based resource funded by Kaiser Permanente as a way to support community health needs assessments and community collaboration. The platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in certain neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand ethnic disparities and compare local indicators with state and national benchmarks.

²¹ U.S. Department of Health and Human Services. Healthy People 2020. <http://www.healthypeople.gov>.

Research interviewed a total of 11 patients and eight staff of the Concord campus. The research was reviewed by John Muir Health and summarized by Actionable Insights.

For further details, see Attachment 2: Secondary Data Sources, Attachment 3: Secondary Data Indicators List.

Information Gaps and Limitations

A lack of secondary data limited Actionable Insights and the Health Systems in their ability to fully assess some of the identified community health needs. Such limitations included:

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

Community Input

Actionable Insights (AI), LLC, conducted the primary research for this assessment. AI used three strategies for collecting community input: key informant interviews with health experts, focus groups with service providers, and focus groups with community members.

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

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

Across the key informant interviews and focus groups, the team solicited input from 164 community leaders and representatives of various organizations and sectors. These representatives either work in the health field or in community-based organizations that focus on improving health and quality of life conditions by serving those from IRS-identified high-need target populations.²² The team also convened focus groups with community members/users of the health systems in Alameda and Contra Costa counties. Contra Costa Health Services (the public health department) provided input into the protocols and facilitated the focus groups in Contra Costa County.

Key Informant Interviews

Between June and October 2018, AI conducted primary research via key informant interviews with 54 local and/or regional experts from various organizations. These experts included individuals from the public health department, community health center managers, community based organization representatives and clinicians. Interviews were conducted in person or by telephone. For approximately one hour, AI asked informants to: identify and discuss the top needs of their constituencies, including barriers to health; give their perceptions of access to health care and mental health needs; and share which solutions may improve health, including services and policies. AI asked five questions:

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

²² The IRS requires that community input include the low-income, minority, and medically underserved populations.

Focus Groups

Service Providers and Community Leaders

Thirteen focus groups were conducted with a total of 110 service providers and community leaders from July to September 2018. The questions were the same as those used with key informants.

Details of Focus Groups With Service Providers

Topic or Population	Focus Group Host/Partner	Date	Number of Participants
Professionals who serve individuals who are medically underserved	Healthy Richmond Collaborative	7/18/2018	17
Behavioral/mental health professionals (front-line staff)	Seneca	7/31/2018	8
Professionals who serve Latinx low-income individuals	Axis Community Health	8/7/2018	5
Professionals who serve individuals living in poverty	Multifaith Action Coalition	8/14/2018	7
Professionals who serve individuals experiencing homelessness	Alameda County Healthcare for the Homeless	8/21/2018	10
Representatives of Central and Eastern Contra Costa County community-based organizations	Kaiser Foundation Hospital–Walnut Creek	8/27/2018	13
School health professionals who serve K–12 students	West Contra Costa Unified School District	8/28/2018	7
School health professionals who serve K–12 students	Oakland Unified School District	8/29/2018	8
Professionals who serve undocumented individuals	Unity Council	9/13/2018	5
Safety net clinicians and related providers	Kaiser Permanente Northern California	9/14/2018	5
Health disparities and inequities	Kaiser Foundation Hospital–Oakland	9/21/2018	6
Professionals who serve youth	Kaiser Foundation Hospital–Oakland	9/21/2018	12
Representatives of Eastern Contra Costa County community-based organizations	Kaiser Foundation Hospital–Antioch	9/17/2018	7

Community Members

Fourteen resident focus groups were conducted with a total of 145 residents between July and September 2018. The discussions centered around the same five questions as the key informants, which were modified appropriately for each audience. Nonprofit hosts, such as Open Heart Kitchen in Livermore, recruited participants for the groups. To provide a voice to the community it serves, and in alignment with IRS regulations, the focus groups targeted residents who are medically underserved, low-income, or of a minority population.

Details of Focus Groups With Community Members

Population	Focus Group Host/Partner	Date	Number of Participants
Youth	RYSE	7/24/2018	6
Individuals experiencing homelessness or housing instability	Open Heart Kitchen	7/31/2018	7
Health coaches—peers of medically underserved individuals	Alameda County Health Coach Program	8/2/2018	5
Individuals experiencing homelessness or housing instability	Loaves & Fishes	8/6/2018	9
Individuals of minority, low-income, and/or re-entry status	Rubicon Programs-Richmond	8/13/2018	9
Spanish-speaking parents of children ages 0–5	First 5 Contra Costa County Regional Group	8/29/2018	13
Individuals of minority, low-income, and/or re-entry status	Rubicon Programs-Antioch	8/29/2018	5
Young adults, ages 18–25	Los Medanos College	8/30/2018	14
Young adults, ages 18–25	Diablo Valley College	9/5/2018	7
Families with elementary school-aged children	Marylin Elementary School	9/6/2018	11
Health promoters—peers of low-income and/or medically underserved individuals	LifeLong Medical Center	9/6/2018	7
Spanish-speaking families with elementary school-aged children	Cambridge Elementary School	9/14/2018	12
Older adults	Stoneman Village	9/17/2018	9
Youth	Youth Radio	9/28/2018	31

2019 TV/C-CCC Resident Participant Demographics

A total of 59 community members participated in the focus group discussions in Tri-Valley/Central Contra Costa County. Facilitators asked all participants to fill out an anonymous demographic survey, the results of which are as follows (note that not all completed the survey):

- 85% of respondents were female, while 15% were male.
- 91% of respondents were between ages 25 and 64.
- 70% of respondents were Latinx, 15% were White, 6% were Asian, 6% were Native American, and the rest reported “Other” or more than one race (or did not respond).
- 50% resided in Livermore, 35% in Concord, while almost all of the rest lived in other Central Contra Costa locations.
- 88% had some form of medical insurance; of these, less than 10% had Medicare. In addition, 47% of insureds had Medi-Cal, 17% had employer-based insurance, 10% had HealthPAC, and the rest were covered through private insurance, the Veterans’ Administration, Covered California, Contra Costa Cares, or other plans.
- Among adult participants, 90% had a high school diploma or less. Only one participant had a four-year college degree (BA/BS) or higher.
- 88% reported having an annual household income of under \$49,000 per year, which is below the 2014 California Self-Sufficiency Standard²³ for Alameda County for two adults with no children (\$50,478). Fifty-three percent were low-income (i.e., Medi-Cal eligible²⁴ or earning less than \$25,000). This demonstrates a relatively high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

2019 E-CCC Resident Participant Demographics

A total of 37 community members participated in the focus group discussions in Eastern Contra Costa County. Facilitators asked all participants to fill out an anonymous demographic survey, the results of which are as follows (note that not all completed the survey):

- 64% of respondents were female, while 36% were male.
- 42% of respondents were older adults (65+), 15% were young adults (19–24), and the rest were ages 25–64.
- 59% of respondents were White, 22% were African American, 7% were Asian, 7% were Latinx, and the rest were of multiple ethnicities (or did not respond).
- 41% lived in Pittsburg, 37% lived in Martinez, while almost all of the rest lived in other Eastern or Central Contra Costa locations.
- 100% had some form of medical insurance; of these, 64% had Medicare. In addition, 48% of insureds had Medi-Cal, 19% had employer-based insurance, 14% had private

²³ The Insight Center for Community Economic Development. (2015). *Self-Sufficiency Standard Tool for California*. Retrieved from <http://www.insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california/>

²⁴ Earned below 138% of the Federal Poverty Level (\$16,753 for an individual, \$22,108 for two adults, \$34,638 for a family of four). California Department of Health Services. *Medi-Cal Eligibility*. 2018. Retrieved from <https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx>

insurance, and the rest were covered through the Veterans' Administration, Covered California, Contra Costa Cares, or other plans.

- Among adult participants, more than half (56%) had a two-year college degree (AA/AS) or higher, while the rest had high school diploma or less.
- 96% reported having an annual household income of under \$49,000 per year, which is below the 2014 California Self-Sufficiency Standard²⁵ for the county for two adults with no children (\$54,882). Eighty-one percent were low-income (i.e., Medi-Cal eligible²⁶ or earning less than \$25,000). This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

2019 W-CCC Resident Participant Demographics

A total of 21 community members participated in the focus group discussions in Western Contra Costa County. Facilitators asked all participants to fill out an anonymous demographic survey, the results of which are as follows (note that not all completed the survey):

- 52% of respondents were female, while 48% were male.
- 34% of respondents were youth or young adults (under age 25), 48% were ages 25–54, and the rest were 55 or older.
- 67% of respondents were African American, 19% were Latinx, and the rest reported being of multiple ethnicities (or did not respond).
- 86% lived in Richmond, while the rest lived in other Western Contra Costa locations.
- 95% had some form of medical insurance; of these, 20% had Medicare. In addition, 60% of insureds had Medi-Cal, while the rest were split relatively evenly among private insurance, employer-based insurance, and Covered California.
- Among adult participants, the highest level of education for more than half (53%) was high school diploma or GED. Only 12% had a four-year college degree (BA/BS) or higher.
- 90% reported having an annual household income of under \$49,000 per year, which is below the 2014 California Self-Sufficiency Standard for the county for two adults with no children (\$54,882).²⁷ Two thirds were low-income (i.e., Medi-Cal eligible²⁸ or earning less than \$25,000). This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

²⁵ The Insight Center for Community Economic Development. (2015). *Self-Sufficiency Standard Tool for California*. Retrieved from <http://www.insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california/>

²⁶ Earned below 138% of the Federal Poverty Level (\$16,753 for an individual, \$22,108 for two adults, \$34,638 for a family of four). California Department of Health Services. *Medi-Cal Eligibility*. 2018. Retrieved from <https://www.dhcs.ca.gov/services/medical/Pages/DoYouQualifyForMedi-Cal.aspx>

²⁷ The Insight Center for Community Economic Development. (2015). *Self-Sufficiency Standard Tool for California*. Retrieved from <http://www.insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california/>

²⁸ Earned below 138% of the Federal Poverty Level (\$16,753 for an individual, \$22,108 for two adults, \$34,638 for a family of four). California Department of Health Services. *Medi-Cal Eligibility*. (2018). Retrieved from <https://www.dhcs.ca.gov/services/medical/Pages/DoYouQualifyForMedi-Cal.aspx>

2019 N-AC Resident Participant Demographics

Participant demographics were not available for Northern Alameda County because too few focus group participants completed the survey.

For more information, see Attachment 1: Community Leaders, Representatives, and Members Consulted and Attachment 6: Qualitative Research Protocols.

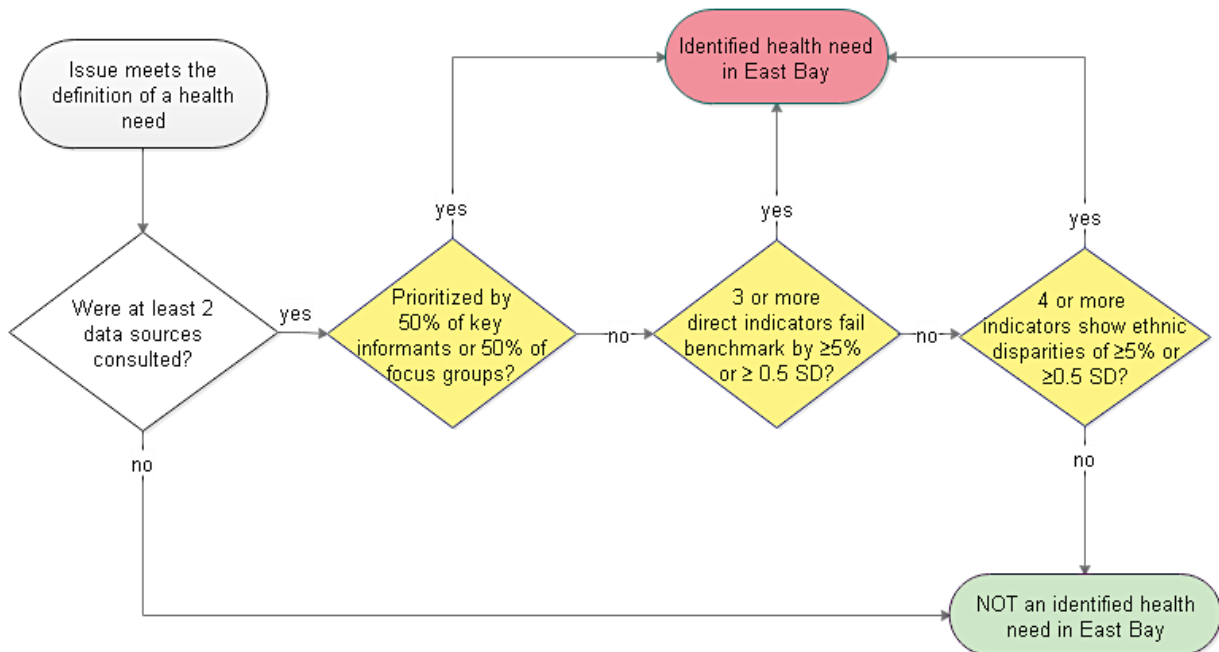
6. Identification and Prioritization of Health Needs

Identification of Health Needs

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

What goes on the list?

Health needs list decision tree



Legend

- A **data source** is either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, 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 either the California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

Criteria

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

Actionable Insights (AI) analyzed secondary data along with qualitative data from focus groups and key informant interviews. AI then synthesized these data for each issue and applied the criteria described above to evaluate whether each issue qualified as a prioritized health need. This process led to the identification of nine community health needs that fit all three criteria. The list of needs, in priority order, can be found on the next page.

For further details about each of these health needs, including statistical data, see Attachments 4 A–D: Secondary Data Tables.

Prioritization of Health Needs

The IRS CHNA requirements state that hospital facilities must identify and prioritize significant health needs of the community. As described in the Process and Methods section, focus group and interview participants were asked which needs they thought were the highest priority (most pressing). Therefore, the health needs list itself reflects the health priorities of the community. The Health Systems used this input as well as additional input described below to identify the significant health needs listed in this report.

John Muir Health, Kaiser Permanente, and Sutter Health collaboratively convened meetings with key leaders in Alameda and Contra Costa counties, including representatives from each county’s Office of Education, Clinic Consortium, the Bay Area Regional Health Inequities Initiative, and the East Bay Community Foundation. At the county-specific meetings, Actionable

DEFINITIONS

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

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

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

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

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

Insights presented the results of the hospitals' 2019 Community Health Needs Assessment and facilitated the prioritization of the health needs by meeting participants.

Participants considered a set of criteria in prioritizing the list of health needs. The criteria, which were chosen by the Health Systems before beginning the prioritization process, were:

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

Participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs. For John Muir Health, Northern Alameda County, the Tri-Valley, and western, central, and Eastern Contra Costa County scores were averaged together to obtain a single, final combined ranking of nine health needs. Those needs, in priority order, are:

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

Summary descriptions of each health need appear on subsequent pages of this report.

Descriptions of 2019 Prioritized Community Health Needs

Housing and Homelessness

What Is the Issue?

The U.S. Department of Housing and Urban Development (HUD) defines affordable housing as that which costs no more than 30% of a household's annual income. Spending greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care.²⁹ The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.³⁰ Further, a 2011 study by Children's Health Watch found that "[c]hildren in families that have been behind on rent within the last year are more likely to be in poor health and have an increased risk of developmental delays than children whose families are stably housed."³¹

Homelessness is correlated with poor health in that either poor health can lead to homelessness or homelessness can lead to poor health.³² Individuals experiencing homelessness have been shown to have more health care issues than people with housing: They suffer from preventable illnesses at a greater rate, experience longer hospital stays, and have a greater risk of premature death.³³ A National Health Care for the Homeless study found that the average life expectancy for a person without permanent housing is at least 25 years shorter than that of the average U.S. citizen.³⁴

Why Is It a Health Need?

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

²⁹ U.S. Department of Housing and Urban Development. (2018). *Affordable Housing*.

³⁰ Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis*. See also: The California Endowment. (2015). *Zip Code or Genetic Code: Which Is a Better Predictor of Health?*

³¹ Children's Health Watch. (2011). *Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent*.

³² National Health Care for the Homeless Council. (2011). *Care for the Homeless: Comprehensive Services to Meet Complex Needs*.

³³ O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council.

³⁴ National Coalition for the Homeless. (2009). *Health Care and Homelessness*.

“When you have a physical roof over your head, you’re reducing victimization, which reduces your incidence of trauma.” —Community Expert, Interviewee

Service providers and community members described concerns about the increasing number of unstably housed individuals and the displacement of families in the East Bay. Experts cited a lack of strong tenant protections (and a lack of knowledge about protections that may exist) in the community. Alameda County’s public health expert expressed the need for strong tenant protections to keep residents from being displaced. Focus group participants suggested that the imbalance of jobs and housing (i.e., many new jobs but few new housing units) was a major driver of the housing crisis. In Northern Alameda County, experts indicated that the housing crisis is worst in areas north of San Leandro. Some expressed specific concern about the declining African American population due to displacement.

“They can make \$20 or \$18, but they don’t have a safe place where they can go call home every single night. They will be moving around. They will be living in the car. They will be living on somebody’s couch and everything. So, it doesn’t matter how much money they make sometimes. It is so hard to afford rent right now in Contra Costa [County] that we’ve seen a lot of people having more than one job. Making \$25 per hour, even more—they are really not able to sustain or be self-sufficient either.” —SERVICE PROVIDER, FOCUS GROUP PARTICIPANT

The median rent in both Alameda and Contra Costa counties is significantly higher than the state average and has been increasing. Also, the proportion of Alameda County renters who spend more than 30% of their household income on rent has been increasing since 2006. Possibly due to high rents, the proportion of children living in crowded housing has been rising in both counties.

Poor housing quality (e.g., evidence of leaks, mold, and pests) is associated with childhood asthma prevalence and asthma-related Emergency Department visits.³⁵ In both counties, child and youth asthma diagnoses and hospitalizations are significantly higher than the state benchmarks. Lead in the home environment is of particular danger to children, whose bodies are still developing and thus are more sensitive to such toxic substances. Blood lead levels for children and youth in Alameda County are higher than the state average.

The number of individuals experiencing homelessness in Alameda County rose in 2017, and there was also specifically an increase in the number of unsheltered homeless children, teens, and young adults in the county. The number of unsheltered homeless individuals has risen in Central Contra Costa County. The population experiencing homelessness is disproportionately White in Contra Costa County and disproportionately African American in Alameda County.

³⁵ Urban Institute. (2017). The Relationship Between Housing and Asthma Among School-Age Children.

Behavioral Health

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

Mental Health

What Is the Issue?

While there is no single definition, researchers agree that the minimum elements of well-being include: having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing life satisfaction, fulfillment, and “positive function.” Well-being looks beyond happiness to include one’s ability to:³⁶

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

Mental health—emotional and psychological well-being, along with the ability to cope with normal, daily life—is key to personal well-being, healthy relationships, and the ability to function in society.³⁷ Mental health and the maintenance of good physical health are closely related. Common mental health disorders such as depression and anxiety can affect one’s ability for self-care. Likewise, chronic diseases can lead to negative impacts on an individual’s mental health.³⁸ Mental health issues affect a large number of Americans. The Mayo Clinic estimates that in 2015, roughly 20% of the adult U.S. population was coping with a mental illness.³⁹

Why Is It a Health Need?

Behavioral health is one of the needs about which the community expressed the strongest concern. Depression and stress were the most common issues raised in all geographic areas. Focus group participants and key informants across the counties discussed the co-occurrence of mental health and substance use. Community members in each local area identified trauma and adverse childhood experiences (ACEs) as drivers of behavioral health problems. A number

³⁶ Centers for Disease Control and Prevention. (2016). *Health-Related Quality of Life: Well-Being Concepts*.

³⁷ Office of Disease Prevention and Health Promotion. (2018). *Mental Health and Mental Disorders*.

³⁸ Lando, J., & Williams, S. (2006). A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion. *Preventing Chronic Disease*. 2006 Apr; 3(2): A61.

³⁹ Centers for Disease Control and Prevention. (2018). *Learn About Mental Health*.

of participants described the impact of discrimination and institutionalized racism as generational trauma, which has contributed to inequitable health outcomes.

Mental health statistics for adults are of concern. A significantly larger proportion of adults in the county, compared to the state, need help for behavioral health issues. Also, a significantly higher percentage of adults in Contra Costa County, compared to the state, have recently taken regular prescription medication for an emotional/mental health issue. The emergency room visit rate for severe mental illness is significantly higher in Alameda County than the state.

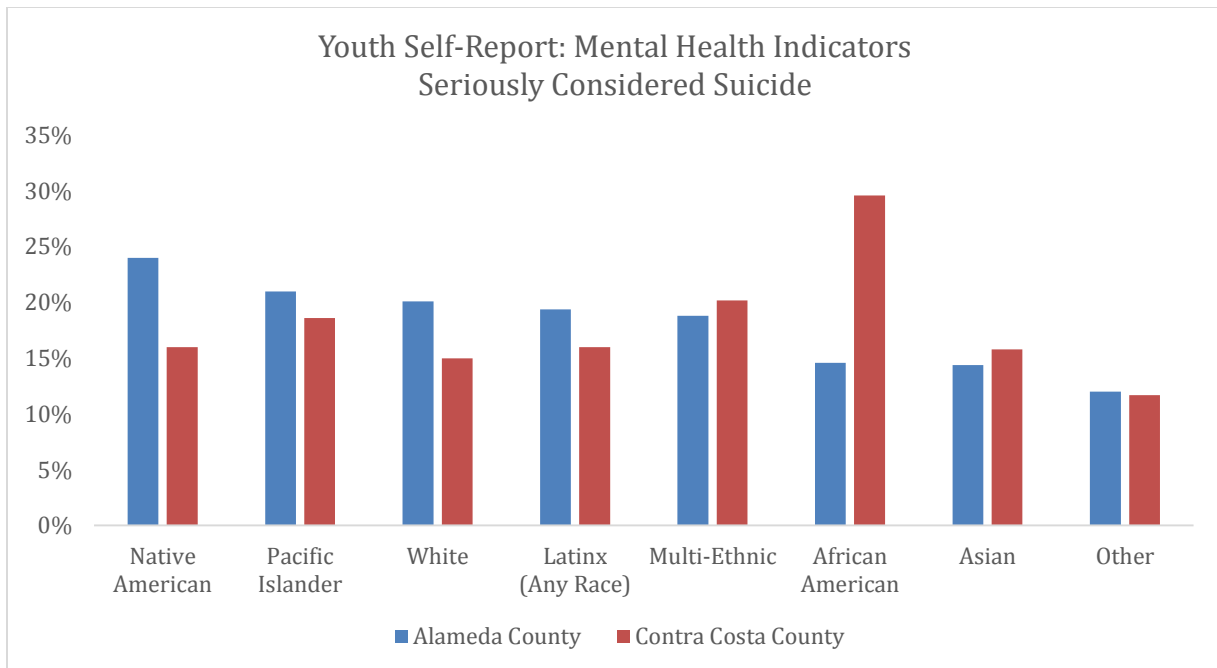
Additionally, social isolation may be a driver for poor mental health; statistics indicate that a larger percentage of older adults live alone in Alameda County compared to the state average, and the number of social associations per capita in the local area is worse than the benchmark.

Mental health statistics for children and youth suggest a need. Mental health hospitalizations for children and youth in Alameda County are significantly higher than benchmarks, and both are trending up. Levels of school connectedness are significantly worse than benchmarks for Alameda County high schoolers (9th and 11th graders) compared to state averages. Among 7th graders, school bullying is significantly worse in Contra Costa County than the state average. Children in foster care experience poor mental health at a much higher rate than the general population.⁴⁰ In the county, the rate of children in foster care and median time in foster care are both trending up. Moreover, median days in foster care for children is higher in the county than the state median figure.

Domestic violence and homicide negatively impact mental health for victims and their families; homicide can also impact the mental health of community members. Domestic violence hospitalizations are significantly higher in Northern Alameda County and the Tri-Valley/Central Contra Costa County than the state average. In Oakland, domestic violence rates are highest for African Americans (2,111.8 per 100,000 people), followed by Latinx community members (835.4 per 100,000 people). Similarly, the homicide death rate is significantly higher in the counties than the state rate. In Oakland, rates are highest for the African Americans (55.7 per 100,000 people), followed by Latinx community members (10.9 per 100,000 people).

Ethnic disparities exist across multiple mental health indicators for youth, including cyberbullying (Pacific Islander youth fare the worst), depression-related feelings (the highest proportion of youth experiencing such feelings are Latinxs and Pacific Islanders in Alameda County, and Latinxs and African Americans in Contra Costa County), school connectedness (African American youth feel the least connected), and suicidal ideation (African American youth also fare the worst in Contra Costa County, while Native American youth fare the worst in Alameda County). Among adults, the rate of suicide in the local area is higher than the benchmark for Whites only.

⁴⁰ National Conference of State Legislatures. (2016). *Mental Health and Foster Care*.



Surveyed public school students in 9th and 11th grades, and nontraditional students. Source: California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd), 2013–2015.

Substance Use

What Is the Issue?

The use of substances such as alcohol, tobacco, and other drugs (both legal and illegal) impacts not only the individuals using them but also their families and communities. Smoking cigarettes, for instance, can harm nearly every organ in the body and causes a variety of diseases, including heart disease.⁴¹ Exposure to secondhand smoke can create health problems for nonsmokers.⁴² Substance use can lead or contribute to other costly social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, auto accidents, and HIV/AIDS.⁴³

In recent years, advances in research have resulted in a variety of effective evidence-based strategies to treat various addictions. Brain-imaging technology and the development of targeted medications have helped to shift the perspective of the research community with respect to substance use.⁴⁴ More and more, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.⁴⁴

⁴¹ Centers for Disease Control and Prevention, (2018). *Health Effects of Cigarette Smoking*.

⁴² American Lung Association. (2017). *Health Effects of Secondhand Smoke*.

⁴³ World Health Organization. (2018). *Management of Substance Abuse*.

⁴⁴ Office of Disease Prevention and Health Promotion. (2018). *Substance Abuse*.

Why Is It a Health Need?

Behavioral health is one of the needs about which the community expressed the strongest concern. Focus group participants and key informants across the counties discussed the co-occurrence of mental health and substance use.

“There’s definitely a stigma with mental health and substance abuse. I don’t think the general population knows a lot about that. So, you need to understand and accept someone for who they are, and give them a break.”—COMMUNITY MEMBER, FOCUS GROUP PARTICIPANT

The rate of substance use ED visits is significantly higher in Alameda County than the average rate for California and is trending up. Among 11th graders in the county, recent marijuana use is significantly higher than the state average. Marijuana, alcohol, and other drug use is highest among Latinx youth in Contra Costa County; statistics are similar in Alameda County, with the difference being that marijuana usage is highest among African American youth. Smoking and lung cancer incidence rates are both significantly higher than benchmarks in western and Eastern Contra Costa County.

Additionally, opioid prescription drug claims are higher in Eastern Contra Costa County than the benchmark. In Northern Alameda County, alcohol retail density is suggestive of policy and environmental factors that affect binge drinking. Although binge drinking is lower in this area than the state benchmark, the number of stores per capita selling beer, wine, and liquor in the area is significantly higher.

Economic Security

What Is the Issue?

Our health-related behavior, physical environment, and access to quality health care are all determinants of how long and how well we live. The most important determinants of population health, however, are our social and economic environments.⁴⁵ Numerous studies have found that access to economic security programs (e.g., the Supplemental Nutrition Assistance Program or SNAP, formerly referred to as food stamps) results in better long-term health and social outcomes.⁴⁶ As the World Health Organization notes, “the context of people’s lives determine[s] their health.” A link exists between higher income and/or social status and better health. Further, a secure social support system (families, friends, communities) plays a significant role in healthier populations.⁴⁷ Childhood poverty has long-term effects: Even when economic and social environments later improve, childhood poverty still results in poorer long-

⁴⁵ County of Los Angeles Public Health. (2013). *Social Determinants of Health: How Social and Economic Factors Affect Health*.

⁴⁶ Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits*.

⁴⁷ World Health Organization. (2018). *The Determinants of Health*.

term health outcomes.⁴⁸ Setting policies that positively influence economic and social conditions can improve health for many people in a sustainable way over time.⁴⁹

Why Is It a Health Need?

In addition to housing, overall economic security was one of the top priorities of the community. With regard to this need, key informants and focus group participants in all geographic areas discussed food insecurity, risk of homelessness, and employment. Community members emphasized that although there may be plenty of jobs in the area, they do not pay enough considering the high cost of living. Some experts noted that although unemployment may appear to be low in Northern Alameda County overall, rates by neighborhood show that there are still local areas where the population is experiencing high unemployment.

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

“When low-income folks can never afford to own and are perpetually locked into being a renter, you’ve locked them into a life of poverty.” —HEALTH EXPERT, INTERVIEWEE

The population living in poverty in Northern Alameda County exceeds the state average. Additionally, the percentage of older adults living in poverty has been increasing in both counties. Individuals receiving government assistance must meet low-income thresholds. The percentages of the Eastern Contra Costa County population enrolled government assistance programs such as SNAP benefits and Medicaid or other public insurance are substantially higher than the state average. The proportion of children eligible for free or reduced-price lunch, a proxy for low income, is significantly higher in both eastern and Western Contra Costa County compared to the state average. The percentage of children in single-parent households in Western Contra Costa County is also significantly higher.

“There’s been a demographic shift in Antioch in particular. It’s much more racially diverse than it used to be. And ... social supports and family supports and institutional supports don’t exist in the suburbs [as] they do in larger cities. And so ... the economic security challenge facing residents of Antioch, I think if you look at sort of a wealth gap and an income gap, comparing Eastern Contra Costa to central and south county, you’ll see some of the differences because Contra Costa in particular is a microcosm of California.” —COMMUNITY EXPERT, INTERVIEWEE

⁴⁸ Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The Impact of Poverty on the Current and Future Health Status of Children. *Pediatric Child Health*. 12(8): 667–672.

⁴⁹ Office of Disease Prevention and Health Promotion. (2018). *Social Determinants of Health*.

Single-parent households, by virtue of the fact that they generally contain only one potential breadwinner, are more at risk for economic instability than dual-parent households. The cost of infant and preschool childcare is significantly higher in both counties than the state average. Also, the proportion of young people (ages 16–19) not in school and not working is higher in Western Contra Costa County than the state average. When youth are neither employed nor being educated, their future chances for economic stability are reduced.

There are far fewer banking institutions per capita in eastern and Western Contra Costa County than in the state overall. Having sufficient financial institutions in the community represents a measure of financial inclusion, offering everyone access to the tools and services needed to realize economic stability.⁵⁰ As noted above, educational attainment is correlated with income. The proportion of adults with at least some post-secondary education, and those with an associate's degree or higher are both significantly lower in Eastern Contra Costa County than the benchmark.

There are significant ethnic disparities in economic security in the community. For example, the highest proportions of adults without a high school diploma in Northern Alameda County and western and Eastern Contra Costa counties exist among the Latinx population, while in the Tri-Valley/Central Contra Costa County, the disparities are worst for the Pacific Islander population; in all areas, educational disparities are also very high for individuals of “Other” ethnicities.⁵¹

For various age groups (children, older adults, overall), the greatest proportion of people living in poverty in the Tri-Valley/Central Contra Costa County and Eastern Contra Costa County are African Americans, while in Western Contra Costa county poverty is highest for Pacific Islanders, and in Northern Alameda County poverty is highest for Native Americans. In all but Western Contra Costa County, more individuals of “Other” ethnicities⁴⁸ than any other group in the local area are uninsured; in Western Contra Costa County, the Pacific Islander population has the highest proportion of uninsured individuals.

Health Care Access and Delivery

Health care access and delivery was a high priority of the community. This need is associated with many different health conditions, including asthma, cancer, oral health, maternal/infant health, sexually transmitted infections, and heart disease/stroke.

What Is the Issue?

Access to comprehensive, quality health care is important for health and for increasing the quality of life for everyone.⁵² Components of access to care include insurance coverage,

⁵⁰ Community Commons. <https://www.communitycommons.org/chna/>

⁵¹ “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

⁵² Office of Disease Prevention and Health Promotion. (2015). <http://www.healthypeople.gov>

adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include quality, transparency, and cultural competence/cultural humility. Limited access to health care and compromised health care delivery impact a person's ability to reach their full potential, negatively affecting quality of life. As reflected in statistical and qualitative data, barriers to receiving quality care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, and an inability to attain preventive services.

Why Is It a Health Need?

Across all geographic areas, the community expressed strong concern about health care access and delivery. Focus group participants and key informants discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists (including geriatric care), especially for Medi-Cal patients. Access to behavioral health services was of particular concern; the community in all geographic areas indicated that the behavioral health workforce was of insufficient size to adequately address the demand. Lack of access to oral health services was also identified in Contra Costa County and the Tri-Valley area, including the need for more facilities in Western Contra Costa County. The health care workforce overall was a topic frequently addressed by service providers, who cited low reimbursement rates for clinicians as a barrier to offering services to Medi-Cal patients.

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

Interviews with patients and staff at JMMC-Concord identified a variety of patient groups using the Emergency Department (ED) in place of more appropriate forms of care. These groups include low-income individuals, the uninsured, immigrants, older adults, individuals with serious behavioral health issues, and individuals with pain management issues. Each of these groups have specific barriers to accessing care. Some of the common barriers include poverty, lack of understanding of the health care system, poor access to transportation and other support, and the over-impacted state of existing services available to them. Patients use the ED because they can receive “immediate and high-quality care” and can get all their care in one place.⁵³

⁵³ KNow Research & John Muir Health. (2018). Patient Access to Care and the Resulting Use of the ED.

“The price of the rent is a barrier, because instead of paying to see a doctor, they use that money to pay the rent. You pay the dentist, the doctor, or the rent.” —COMMUNITY MEMBER, FOCUS GROUP PARTICIPANT

A smaller proportion of both counties’ residents have a usual source for primary care and a larger proportion delayed or had difficulty obtaining care when compared to the Healthy People 2020 aspirational goals. While the community in Northern Alameda County has higher rates of available primary care, dental, and mental health providers than the state benchmarks, there is significantly poorer access to “other” primary care providers (nurse practitioners, physician assistants, etc.). The ratio of students-to-school nurses in Alameda and Contra Costa counties is much higher than the state overall, which means each nurse cares for a greater number of students. This is also true of school-based speech, language, and hearing specialists in Alameda County.

Good access to primary care can forestall the need for avoidable ED visits and hospitalizations, such as for asthma. The proportion of the Alameda County’s population that has a usual source for health care has been declining since 2005. The rate of avoidable ED visits has been rising in Alameda County. The rate of asthma hospitalizations is significantly higher in Northern Alameda County than the state rate. In Contra Costa County, the percentage of recent ED visits is significantly higher than the state, both overall and specifically for older adults.

“Asthma hospitalization rates are really high ... not only because of the five refineries and two power plants ... but because some of the people that live in East [Contra Costa County], where the rates are highest, don’t have access to more affordable, ongoing care for their asthma.” —COMMUNITY EXPERT, FOCUS GROUP PARTICIPANT

In terms of specialty care, Federally Qualified Health Centers (FQHCs) are the only organizations that receive a higher reimbursement rate for dental services. Statistics show, however, that the ratio of FQHCs to residents is significantly worse in Contra Costa County than the state. The percentage of the Eastern Contra Costa County population enrolled in Medicaid or other public insurance is substantially higher than the state average. In all but Western Contra Costa County, more individuals of “Other” ethnicities⁵⁴ than any other group in the local area are uninsured; in Western Contra Costa County, the Pacific Islander population has the highest proportion of uninsured individuals.

In regard to inequitable health outcomes, the index of premature death based on ethnicity (i.e., premature death for non-Whites versus Whites) is significantly worse in the local community compared to the state. The rate of diabetes management in the county is lowest among African American patients. Preventable hospital events were highest for the local African American population. In Alameda County, both acute and chronic preventable hospitalizations were highest for the African American population.

⁵⁴ “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

Access to a car is associated with better access to health care. In Oakland, African Americans were more than three times less likely than Whites to have access to a car.

Asthma/Respiratory Conditions

What Is the Issue?

Respiratory disorders affect the ability of the individual to breathe. Asthma, chronic obstructive pulmonary disorder (COPD), pneumonia, and lung cancer — each of which is chronic — are among the most common of respiratory disorders.⁵⁵ Asthma is an inflammation of the airways that causes them to swell and narrow, characterized by episodes of reversible breathing problems.⁵⁶ Symptoms range from mild to life-threatening. Asthma attacks can cause a range of issues from simple wheezing to extreme breathlessness.⁵⁷ According to the American Lung Association, “the most common risk factors for developing asthma [are] having a parent with asthma, having a severe respiratory infection as a child, having an allergic condition, or being exposed to certain chemical irritants or industrial dusts in the workplace.”⁵⁸

Why Is It a Health Need?

Across John Muir Health’s service area, community members identified poor air quality as a driver of asthma.

Asthma hospitalizations overall, and for children separately, are significantly worse in both counties compared to the state. In Alameda County, asthma hospitalizations for youth are also worse than the state. In both counties, asthma diagnoses for children/youth are worse than the benchmark, and in Alameda County this figure is increasing. Among various ethnic groups in both counties, asthma ED visits and hospitalization are highest for African Americans. In Oakland, asthma ED visits among children are over 10 times higher in the African American population, and nearly three times higher in the Latinx population, than in the White population. Finally, the average cost of asthma hospitalization is significantly higher in the county than the state.

“Recent research [shows] a very direct correlation around the social determinants of health and how it impacts a chronic condition like asthma. In addition ... these factors trigger asthma. So, that’s ... inequity, too.” —SERVICE PROVIDER, FOCUS GROUP PARTICIPANT

Asthma can be exacerbated by pollution. The respiratory hazard index in Northern Alameda County significantly surpasses (is worse than) the state average. Specifically, in Oakland, the overall (air, water, etc.) pollution burden in majority-Asian census tracts is significantly higher than the pollution burden in majority-White census tracts. Road network density contributes to

⁵⁵ U.S. National Library of Medicine. (2018). *Lung Disease*.

⁵⁶ The Mayo Clinic. (2018). *Asthma Overview*.

⁵⁷ Centers for Disease Control and Prevention. (2018).

⁵⁸ American Lung Association. (2018). *Asthma Risk Factors*.

greater traffic, which can increase air pollution.⁵⁹ Eastern Contra Costa County has a significantly higher density of roads compared to the state average; particulates from traffic can contribute to asthma. While air quality measures are better than the state in Eastern Contra Costa County, asthma prevalence in both that area and Northern Alameda County is significantly worse than benchmarks.

The percentage of residents in eastern and Western Contra Costa County who smoke tobacco, which can aggravate asthma, is higher than the state average. Certain other drivers of respiratory conditions, such as obesity and physical inactivity, are significantly higher among certain ethnic populations (see *Healthy Eating/Active Living* section for further information).

Cancer

What Is the Issue?

Cancer is a generic term used to describe a condition in which abnormal cells divide uncontrollably, invading and killing healthy tissue. These abnormal cells can metastasize to other parts of the body via the blood and lymph systems. With more than 100 kinds of cancer,⁶⁰ it is the second leading cause of death in the U.S., following heart disease.⁶¹ High-quality screening can serve to reduce cancer rates; however, a variety of complex factors contribute to disparities in cancer incidence and death rates among different ethnic, socioeconomic, and otherwise vulnerable groups. While personal, behavioral, and environmental factors are significant (e.g., smoking, exposure to known carcinogens), the most important risk factors for cancer are lack of health insurance and low socioeconomic status.⁶²

Why Is It a Health Need?

Incidence rates for certain cancers (breast, colorectal, lung, and prostate) are worse than the state in Contra Costa County and the Tri-Valley. Also, childhood cancer diagnoses have been slowly rising in Alameda County since 2003; they are highest among White children and youth. Across the John Muir Health service area, cancer mortality is much higher than the benchmark in the African American population and somewhat higher among the White population. In Alameda County, cervical cancer incidence significantly exceeds the benchmark Latina population.

Across the service area, the African American population is less likely to have been screened for breast cancer (i.e., have had a mammogram) than the White population. In Alameda County, the multi-ethnic population is the least likely group to have been screened for colorectal cancer, followed by the Asian population.

⁵⁹ Community Commons. <https://www.communitycommons.org/chna/>

⁶⁰ Centers for Disease Control and Prevention. (2018). *How to Prevent Cancer or Find It Early*.

⁶¹ Centers for Disease Control and Prevention. (2017). *Leading Causes of Death*.

⁶² National Cancer Institute. (2018). *Cancer Disparities*.

Heart Disease and Stroke

What Is the Issue?

Nationally, some 84 million people suffer from a form of cardiovascular disease.⁶³ Heart disease is the number one killer for both men and women,⁶⁴ while stroke is the fifth leading cause of death and a significant cause of serious disability for adults.⁶⁵ It is estimated that the current annual direct and indirect costs of cardiovascular disease and stroke are approximately \$315 billion and are increasing annually.⁶³ Recent research has established that disparities exist between minority and non-minority cardiovascular health outcomes across the U.S.⁶⁶ While some risk factors for heart disease and stroke are not controllable — age, race/ethnicity, gender — some risk factors can be controlled: high blood pressure, high cholesterol, obesity, excessive alcohol consumption, smoking, an unhealthy diet, lack of physical activity.⁶⁴ Left untreated, these risk factors can lead to changes in the heart and blood vessels. Over time, those changes can lead to heart attacks, heart failure, strokes, and other forms of cardiovascular disease.⁶⁷ Addressing risk factors early in life can help in preventing chronic cardiovascular disease.⁶⁸

Why Is It a Health Need?

In Alameda County, congestive heart failure hospitalizations fail against the state benchmark. In addition, stroke hospitalizations in all the local areas and stroke deaths in Contra Costa County and the Tri-Valley exceed the benchmarks. In all of the local areas, African American residents disproportionately die from stroke compared to residents of other ethnicities.

Substance use, including smoking, can negatively affect cardiovascular and cerebrovascular health. The rate of substance use ED visits is significantly higher in Alameda County than the average rate for California and is trending up. The percentage of residents in western and Eastern Contra Costa County who smoke tobacco is higher than the state average. For information on other drivers of heart disease and stroke, see the Healthy Eating/Active Living health need description.

⁶³ Johns Hopkins Medicine. (2018). *Cardiovascular Disease Statistics*.

⁶⁴ Centers for Disease Control and Prevention. (2017). *Heart Disease Facts*.

⁶⁵ Centers for Disease Control and Prevention. (2018). *Stroke*.

⁶⁶ Graham, G. (2015). Disparities in Cardiovascular Disease Risk in the United States. *Current Cardiology Reviews*, 11(3): 238–245.

⁶⁷ American Heart Association. (2017). *What is Cardiovascular Disease?*

⁶⁸ The Mayo Clinic. (2016). *Strategies to Prevent Heart Disease*.

Maternal/Infant Health

What Is the Issue?

Good maternal and child health — the well-being of mothers, infants, and children — is an important public health goal. The health of these populations can determine the health of the next generation, and can help predict further public health issues, for families, communities, and the health care system as a whole.⁶⁹ The need of maternal and child health includes a variety of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for women, children, and families.⁶⁹ Data indicators that measure progress in this area include low birthweight, infant mortality, teen births, breastfeeding, and access to prenatal care. The risk of pregnancy-related problems, complications, and disabilities, as well as both maternal and infant mortality, can be reduced through better access for both mother and child to quality health care before, during, and after pregnancy.⁶⁹ More specifically, the early identification of health issues in infants and children can aid in the prevention of disability or death, enabling them to achieve their full potential.⁶⁹

Why Is It a Health Need?

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

“When you look at the disparities amongst the African American women and maternal and child health, that’s an impact of all of these things manifesting in ... a concrete barrier to raising a family here in Oakland for specific communities ... because their environment isn’t conducive to raising a family or childbearing.” —SERVICE PROVIDER, FOCUS GROUP PARTICIPANT

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

⁶⁹ Office of Disease Prevention and Health Promotion. (2018). *Maternal, Infant, and Child Health*.

Oral/Dental Health

What Is the Issue?

A healthy smile can indicate more than a good mood. Oral/dental health promotes overall well-being by allowing a person to taste, chew, swallow, and speak, as well as to express feelings and emotions through facial expressions.⁷⁰ Maintaining oral/dental health depends on routine self-care, such as brushing teeth with a fluoride-based toothpaste, flossing, and receiving professional dental treatment.⁷¹ Unhealthy behaviors, such as poor dietary choices, substance use (nicotine, methamphetamines, other drugs), and inconsistent hygiene, can result in conditions from cavities to cancer.⁷² As with other health needs, a variety of factors can create barriers to accessing dental services for different ethnic, socioeconomic, and otherwise vulnerable groups. The primary access factors are lack of insurance, low socioeconomic status, and fear of dental treatment.⁷³

Why Is It a Health Need?

Lack of access to oral health services was identified as a health need by the community in the Tri-Valley.

The proportion of Denti-Cal beneficiaries who had an annual dental visit was lower in Alameda County than it was the statewide, and has been dropping (i.e., getting worse) over time. Federally Qualified Health Centers (FQHCs) are the only organizations that receive a higher reimbursement rate for dental services. Statistics show, however, that the ratio of FQHCs to residents is significantly worse in the Tri-Valley/Central Contra Costa County area than the state.

“It’s definitely our low-income folks. ... My understanding is that occasionally you may have somebody who owns a private practice who may do some pro bono or reduced rates. But it’ll be a one-off case. We don’t have any dental providers here [in the Tri-Valley] that will take Medi-Cal, that’s definitely a big barrier.” —COMMUNITY EXPERT, INTERVIEWEE

⁷⁰ National Institute of Dental and Craniofacial Research. (2000). *Oral Health in America: A Report of the Surgeon General*.

⁷¹ Mayo Clinic. (2016). Oral Health: Brush Up on Dental Care Basics.

⁷² Office of Disease Prevention and Health Promotion. (2018). *Oral Health*.

⁷³ Centers for Disease Control and Prevention. (2017). *Disparities in Preventive Dental Care Among Children in Georgia*. See also: Harvard Health Publishing/Harvard Medical School. (2015). *Dental Fear? Our Readers Suggest Coping Techniques*.

Sexually Transmitted Infections (STIs)

What Is the Issue?

As is the case with other infectious diseases, sexually transmitted infections (STIs) are spread via contact with an infected person or his or her discharge (blood, semen, etc.). Left untreated, some STIs can be fatal (HIV) or can affect fertility (syphilis, chlamydia, gonorrhea). The stigma of STIs such as genital herpes can lead to mental health issues.⁷⁴ Again, as is the case with other infectious diseases, a variety of agencies monitor STIs, identify outbreaks/epidemics, and provide vaccines and education programs.⁷⁵ This proactive approach is less costly than treating STIs and their related consequences.

Why Is It a Health Need?

The Alameda County public health expert noted there had been an increase in STIs, especially HIV infections among African American males. Stigma and lack of specific health education was cited as a possible barrier to preventing the spread of STIs. In Northern Alameda County, residents identified the lack of health education about STIs and the high costs of testing as barriers to preventing the spread of STIs. An expert in the Tri-Valley area expressed concern about the rising rates of STIs, especially for LGBTQ individuals. Stigma and lack of attention among health care professionals was identified as a possible barrier to preventing the spread of STIs.

“Health care is unaffordable. If you are sexually assaulted, you can afford treatment because they will waive treatment [fees]. It’s just ridiculous to me as a sexual assault survivor that the only reason I was able to afford [treatment for] the STI I contracted was because I had been sexually assaulted.” —COMMUNITY MEMBER, FOCUS GROUP PARTICIPANT

There are significantly higher rates of gonorrhea among females in Contra Costa County compared to the state. There are significantly higher rates of both gonorrhea and HIV/AIDS in Alameda County compared to the state. The incidence rates of chlamydia and gonorrhea among youth are also worse in Alameda County than the state. Finally, rates of syphilis have been trending upward in the county since 2009. The incidence rates of chlamydia and gonorrhea for African American youth are between four and ten times higher in the counties, respectively, than the benchmarks.

⁷⁴ Merin, A., & Pachankis, J. (2011). *The Psychological Impact of Genital Herpes Stigma*. *Journal of Health Psychology*; 16(1):80–90.

⁷⁵ U.S. Government Accountability Office. (2004). *Emerging Infectious Diseases: Review of State and Federal Disease Surveillance Efforts*.

Community and Family Safety

Crime and Intentional Injury

What Is the Issue?

Crime, violence, and intentional injury are related to poorer physical and mental health for the victims, the perpetrators, and the community at large.⁷⁶ Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. In one study, individuals who reported feeling unsafe to go out during the day were much more likely to experience poor mental health.⁷⁷ As reported by the World Health Organization, even apart from any direct physical injury, victims of violence have been shown to suffer from a higher risk of depression, substance use, anxiety, reproductive health problems, and suicidal behavior.⁷⁸ Additionally, exposure to violence has been linked to negative effects on an individual's mental health, including post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior themselves.⁷⁹

Why Is It a Health Need?

Community and family safety was one of the top health needs prioritized by the community in Northern Alameda County and Western Contra Costa County. With regard to intentional injury, key informants and focus group attendees most frequently talked about domestic violence. Qualitative research participants also discussed violent crime in general. Residents reported they have seen an increase in violence. The rate of Emergency Department (ED) visits for injuries from assaults was higher in Alameda County than the state average.

“In my community, domestic violence from men to women is very common. In my personal case I have suffered violence from my children. They are men towards me, already grown up. And I see how my uncles sometimes use violence against women. It's men against women, gender-based violence, domestic violence.”—COMMUNITY MEMBER, FOCUS GROUP PARTICIPANT

Human trafficking was mentioned as a community concern as well in all areas except the Tri-Valley. Some participants indicated that human trafficking is a growing problem in Antioch, while others described Oakland as a hub for human trafficking, including a large proportion of victims who are minors.

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

⁷⁶ Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The World Report on Violence and Health. *The Lancet*, 360(9339), 1083–1088.

⁷⁷ Guite, H. F., Clark, C., & Ackrill, G. (2006). The Impact of the Physical and Urban Environment on Mental Well-Being. *Public Health*, 120(12), 1117–1126.

⁷⁸ World Health Organization. (2017). *10 Facts About Violence Prevention*.

⁷⁹ Ozer, E. J., & McDonald, K. L. (2006). Exposure to Violence and Mental Health Among Chinese American Urban Adolescents. *Journal of Adolescent Health*, 39(1), 73–79.

mentioned police violence/brutality as an important issue related to safety, especially for African American individuals.

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

Children and youth were the populations about which participants expressed the most concern. Issues identified for these populations included online and in-person bullying, being victims of violence, and acting out trauma. Finally, the community recognized the connection between unsafe neighborhoods and the lack of outdoor play or other physical activities.

“Some of our patients also don’t live in the greatest communities or neighborhoods. So, I think even taking a walk outside might be dangerous for them.” —HEALTH EXPERT, FOCUS GROUP PARTICIPANT

A significantly greater proportion of high schoolers (9th and 11th graders in Contra Costa County, 11th graders in Alameda County), compared to the state, perceive their schools as unsafe. Among 7th graders, school bullying is significantly worse in Contra Costa County than the state average. Additionally, gang membership among high schoolers (9th and 11th graders) in the county significantly exceeds the state average.

Domestic violence hospitalization rates are significantly higher in Northern Alameda County and the Tri-Valley/Central Contra Costa County area than the state average. In Oakland, rates are highest for the African American population, followed by the Latinx population. Similarly, homicide death rates are significantly higher in both counties than the state rate. In Oakland, rates are highest for African Americans, followed by Latinx residents.

Alcohol retail density is suggestive of policy and environmental factors that affect binge drinking, a factor in violence. Although binge drinking in Northern Alameda County is lower than the benchmark, the number of stores per capita selling beer, wine, and liquor in the local area is significantly higher than the state average.

Ethnic disparities exist across multiple crime and intentional injury indicators for children and youth, including:

- cyberbullying (Pacific Islander youth fare the worst across both counties)
- in-person bullying at school (African American youth fare the worst in Contra Costa County, while Pacific Islander youth fare the worst in Alameda County)

- fear of being beaten up at school (the highest proportion who experience this fear are Native American and African American youth in Contra Costa County and Pacific Islander youth in Alameda County)
- gang membership (the highest proportion of gang members are among multi-ethnic and Pacific Islander youth in Contra Costa County and Native American and African American youth in Alameda County)
- school climate (Latinx and African American youth in both counties are most likely to attend schools they perceive as unsafe)
- juvenile felony arrests (African American youth are arrested in much higher proportion than others across both counties), and
- substantiated child abuse and neglect (again, African American children and youth fare the worst in both counties).

Among adults in Contra Costa County, jail incarceration rates are highest among African Americans.

Unintended Injuries/Accidents

What Is the Issue?

The most common unintended injuries or accidents worldwide are road vehicle crashes, drowning, falls, fires and burns, and poisonings.⁸⁰ In 2016, unintentional injury was the third leading cause of death overall in the U.S.⁸¹ The most common unintended injuries causing death in the U.S. are falls, traffic accidents, and poisonings, including overdose of prescription medications.^{82, 83} Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.⁸⁴

“Fall is the number one leading cause of emergency departments visits and death in the aging population. ... [I]njuries, hospitalizations, and death. There are your outcomes. And the trend is you have a population that is increasing in size. And so, you have an increasing number of those bad outcomes.” —SERVICE PROVIDER, INTERVIEWEE

Common among older adults, falls are a growing concern, because the percentage of the U.S. population 65 years old and older is projected to double—from 46 million to 98 million people—between now and 2060, which means nearly one in every four Americans will be a senior citizen.⁸⁵ Likewise, unintentional injuries are the leading cause of death and hospitalization in California for children 16 and younger.⁸⁶

⁸⁰ Norton, R., Hyder, A. A., Bishai, D., Peden, M., et al. (2007). Unintentional Injuries. *Disease Control Priorities in Developing Countries*.

⁸¹ Centers for Disease Control and Prevention. (2017). *Mortality in the United States, 2016*.

⁸² Centers for Disease Control and Prevention. (2017). *Accidents or Unintentional Injuries*.

⁸³ National Safety Council. (2018). *Unintentional Injuries Are the #1 Cause of Death From Infancy to Middle Age*.

⁸⁴ Office of Disease Prevention and Health Promotion. (2018). *Injury and Violence Prevention*.

⁸⁵ Population Reference Bureau. (2016). *Aging in the United States*.

⁸⁶ California Department of Public Health. (2018). *Child Passenger Safety (CPS) in California*.

Why Is It a Health Need?

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

Overall, Alameda County's rates of unintentional injury ED visits and deaths surpass state benchmarks and are increasing. More specifically, the rate of traumatic injury hospitalizations (whether intentional or unintentional) among children and youth in Alameda County is significantly higher than the benchmark, as is the case in Contra Costa County. Similarly, the rate of children and youth being hospitalized for poisoning in Contra Costa County is significantly higher than the state average.

The rate of fatalities from firearms in the county (whether intentional or unintentional) also significantly exceeds the state's. The rate of bicycle-involved collisions in Alameda County is significantly higher than the state average. Additionally, the rate of motor vehicle crash ED visits in Alameda County is significantly higher than the California rate and is rising, and motor vehicle crash deaths in Contra Costa County are disproportionately experienced by African Americans.

Alcohol retail density is suggestive of policy and environmental factors that affect excessive drinking, a factor in accidental injuries. Although binge drinking in Northern Alameda County is lower than the state average, the number of stores per capita selling beer, wine, and liquor in the local area is significantly higher.

Education and Literacy

What Is the Issue?

Literacy is generally understood to mean the ability to read and write, although the term also includes skills related to listening, speaking, and using numbers (numeracy). Limited literacy is correlated with low educational attainment, which is associated with poor health outcomes. Individuals at risk for low English literacy include immigrants, those living in households where English is not spoken, and individuals with minimal education.⁸⁷

Pre-school education is positively associated with readiness for and success in school, as well as long-term economic benefits for individuals and society, including greater educational

⁸⁷ Office of Disease Prevention and Health Promotion. (2018). *Language and Literacy*. www.healthypeople.gov

attainment, higher income, and lower engagement in delinquency and crime.⁸⁸ Educational attainment, along with employment rates and household income, are key indicators that show the economic vitality of an area and the buying power of individuals, including their ability to afford basic needs such as housing and health care.

The interrelationship of educational attainment, employment, wages, and health is well documented. Individuals with at least a high school diploma do better on a number of measures than high school dropouts, including income, health outcomes, life satisfaction, and self-esteem.⁸⁹ The National Poverty Center reports that increased education is associated with decreased rates of most acute and chronic diseases.⁹⁰ Additionally, research has found that wealth among families in which the head of household has a high school diploma is 10 times higher than that of families in which the head of household dropped out of high school.⁹¹ Finally, the majority of jobs in the U.S. require more than a high school education.⁸⁸

Why Is It a Health Need?

A wide variety of experts and community members discussed concerns regarding education and academic achievement. Academic achievement was discussed most often as a driver of economic security related to stable employment and sufficient wages. The Contra Costa County Public Health Officer described educational attainment as a gateway to self-sufficiency, and a major contributing factor to homeownership. The Alameda County public health expert emphasized that both K–12 education and higher education often do not prepare residents for jobs that provide a living wage. Youth in Northern Alameda County discussed inequities in the quality of K–12 education.

“Educational attainment in this nation is still one of the most important gateways to self-sufficiency.” —HEALTH EXPERT, INTERVIEWEE

A larger proportion of children in Alameda County live in linguistically isolated households than the state average. Combined with the comparatively high cost of preschool childcare, Alameda County children may have greater barriers to literacy than children elsewhere.

The proportion of local 4th-graders in western and Eastern Contra Costa County who are reading at or above proficiency is significantly lower than the state average, while in Northern Alameda County the proportion is no better than the state’s. Also, student suspensions in these areas exceed the state average, as do expulsions in Northern Alameda County. Additionally, student truancy is higher in Contra Costa County than the state average. In Alameda County, the ratio of students to academic counselors is significantly higher than the overall ratio in the state. The student-teacher ratio has been increasing (i.e., worsening) since 2008. A smaller

⁸⁸ Barnett, W. S., & Hustedt, J. T. (2003). Preschool: The Most Important Grade. *Educational Leadership*, 60(7):54–57.

⁸⁹ Insight Center for Community Economic Development. (2014). <http://www.insightcced.org>

⁹⁰ Cutler, D. M., & Lleras-Muney, A. (2006). *Education and Health: Evaluating Theories and Evidence* (No. w12352). National Bureau of Economic Research.

⁹¹ Gouskova, E., & Stafford, F. (2005). Trends in Household Wealth Dynamics, 2001–2003. *Panel Study of Income Dynamics. Technical Paper Series*, 05–03.

proportion of Northern Alameda County students graduate high school on time when compared to their statewide peers.

“If a student cannot get adequate health care and the student cannot get adequate education, then they’re trapped in a cycle of poverty and they can’t make it out.” —HEALTH EXPERT, FOCUS GROUP PARTICIPANT

Ethnic disparities are evident in education and literacy-related indicators. African American girls in both counties and Latina girls in eastern and Western Contra Costa County have significantly higher rates of teen pregnancy than girls of other ethnicities, which can interrupt or end their educational trajectory. In both counties, African American youth are also overrepresented among high school dropouts, while passing high school exit exams in lower proportions than youth of other ethnicities. African American youth are also underrepresented among Alameda County high school graduates who had completed college prep courses. Specifically, in Oakland, African American youth are more than twice as likely, and Latinx youth almost twice as likely, as White youth to have never taken a high school Advanced Placement course. Furthermore, nearly four times the proportion of African American youth, and more than twice as many Latinx youth, as White youth are chronically absent from school.

Healthy Eating/Active Living

Healthy eating/active living is a need in the East Bay that was prioritized (identified as a top health need) by the community. This need includes concerns about access to food and recreation, food insecurity, diabetes, nutrition, diet, fitness, and obesity.

Access to Food and Recreation

What Is the Issue?

The U.S. Surgeon General’s “Vision for a Healthy and Fit Nation 2010” described how different elements of a community can support residents’ healthy lifestyles. The various components of the physical environment, including sidewalks, bike paths, parks, and fitness facilities that are “available, accessible, attractive and safe,” all contribute to the extent and type of residents’ physical activities.⁹² Other community elements that support healthy lifestyles include local stores with fresh produce. Residents are more likely to experience food insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and there are limited transportation/transit options.⁹³

The CDC recommends policies and environments that support behaviors aimed at achieving and maintaining healthy weight in settings such as workplaces, educational institutions, health care facilities, and communities.⁹⁴ For example, the availability of healthy and affordable food in

⁹² Centers for Disease Control and Prevention. (2009). *Healthy Places*.

⁹³ Healthy People 2020. (2018). *Food Insecurity*.

⁹⁴ Healthy People 2020. (2015). *Nutrition and Weight Status*.

retail and cafeteria-style settings allows individuals to make better food choices throughout the day. Otherwise, people may settle for caloric foods of low nutritional value.⁹⁵

Why Is It a Health Need?

Public health experts in Alameda County identified the lack of access to recreation and healthy food in certain areas (“food deserts”) as drivers of poor community health. Focus group participants in all areas cited a lack of safe public spaces and community centers where residents can engage in recreational activities and exercise. While some neighborhoods have parks, many of them are not used because residents fear becoming victims of crime. In Central Contra Costa County, concern about the safety of public parks keeps children from playing there. Other parks lacked appropriate exercise equipment, while others offered no programs to encourage or teach residents to exercise.

“We work a lot with ... John Muir and with Kaiser, it’s all about healthy eating, active living. But I don’t think I can stress enough that if [people] aren’t getting the appropriate food for their family and for their mind and their body, you can forget about playing, active living, and doing exercise, and starting to do all the other things. For our population, which is just so extreme low income, ... those are the things that they need first.” —SERVICE PROVIDER, INTERVIEWEE

Parents in all geographic areas specifically mentioned the lack of free exercise and sports programs as a barrier to physical activity for children. One key informant drew a connection between the long commutes experienced by many working residents in Eastern Contra Costa County and the lack of time to exercise; together, these may have contributed to the low local demand for exercise programs. Immigrants living in Central Contra Costa County specifically stated their desire for sports programs.

With regard to the food supply, residents described difficulty accessing grocery stores that carry fresh food, the preponderance of fast food restaurants, and their dismay with the unhealthy food served at schools and provided by food banks. Local experts mentioned that there may be a lack of knowledge among families about how to access healthy, affordable food in Western Contra Costa County.

Compared to the state average, access to healthy food stores is significantly lower in eastern, western, and Central Contra Costa County as well as the Tri-Valley area. There are fewer grocery stores and produce vendors per capita in these locales compared to the state. This is true in Northern Alameda County as well, while the number of stores per capita selling beer, wine, and liquor is significantly higher locally than at the state level.

⁹⁵ Centers for Disease Control and Prevention. (2015). *Healthy Food Environments*.

Food Insecurity

What Is the Issue?

Food insecurity is defined as the “lack of consistent access to enough food for an active, healthy life.”⁹⁶ Hunger and food insecurity are related but distinct concepts; hunger is the physical discomfort related to “prolonged, involuntary lack of food,” while food insecurity refers to a “lack of available financial resources for food at the household level.”^{97, 98} Measurements of various levels of food insecurity, from marginal to low or very low, include anxiety about food insufficiency, household food shortages, reduced “quality, variety, or desirability” of food, diminished nutritive intake, and “disrupted eating patterns.”⁹⁸ In 2017, approximately one in eight Americans experienced food insecurity, of which more than one third were children.⁹⁷

Individuals who are food-insecure may be more likely to experience various poor health outcomes/health disparities, including obesity. Children who experience food insecurity are also at greater risk for developmental complications and/or delays compared to children who are food-secure. In addition, food insecurity may have a detrimental impact on children’s mental health.⁹⁹

Why Is It a Health Need?

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

“Good healthy food is so expensive; the costs of good healthy organic raspberries are \$5 for a little tiny pint. [Low income populations] are not going to buy this food because they don’t have that kind of money to spend on food. So, they’re making short-term decisions about their lives, not long-term health decisions.” —SERVICE PROVIDER, INTERVIEWEE

Overall, food insecurity is higher in Northern Alameda County compared to the state. Additionally, the percentage of food-insecure children in Alameda County who are ineligible for government assistance surpasses the benchmark. The percentage of the Eastern Contra Costa County population receiving SNAP benefits is substantially higher than the state average. The proportion of children eligible for free or reduced-price lunch in both western and Eastern Contra Costa County is significantly higher compared to the state average. Of all students in both counties, African Americans are least likely to have eaten breakfast.

⁹⁶ U.S. Department of Agriculture, Economic Research Service. (2018). *Food Security in the U.S.*

⁹⁷ Feeding America. (2018). *What Is Food Insecurity?*

⁹⁸ U.S. Department of Agriculture, Economic Research Service. (2018). *Definitions of Food Security.*

⁹⁹ Healthy People 2020. (2018). *Food Insecurity.*

Nutrition, Diet, and Fitness

What Is the Issue?

The benefits of fitness and a healthy, nutritious diet are commonly known and well-documented.

As noted by the Centers for Disease Control and Prevention, “physical activity fosters normal growth and development, can reduce the risk of various chronic diseases, and can make people feel better, function better, and sleep better.”¹⁰⁰ Getting regular exercise can help people of all ages combat obesity, reduce the risk of cardiovascular disease, Type 2 diabetes, some cancers, and a host of other physical issues.¹⁰¹ Regular exercise can also help to strengthen bones and muscles, prevent falls for older adults, and increase an individual’s chances of living longer.^{101, 102} Likewise, the benefits of a healthy diet include preventing high cholesterol and high blood pressure, reducing the risks of developing diseases including cancer and diabetes, and helping to reduce the risks of obesity, osteoporosis, and dental cavities.¹⁰³ For children and adolescents, a nutritious diet helps with growth and bone development, as well as improved cognitive function.¹⁰⁴

In spite of these well-known benefits most people, young and old alike, do not meet the recommended healthy food and exercise guidelines. Most significantly, a poor diet and lack of regular exercise can lead to adult and childhood obesity, a serious and costly health concern in the U.S. that often results in some of the leading causes of preventable death.¹⁰⁵

Why Is It a Health Need?

The community connected healthy eating and active living to good mental health. Residents, however, noted that the relatively lower cost of unhealthy grocery items and fast food, together with their convenience, makes buying and preparing fresh food less likely for busy families. Experts discussed the fact that few people walk or bike to work because they have long commutes. The Latinx population was mentioned frequently as a population of particular concern for HEAL-related conditions. Residents talked about the lack of motivation and lack of time to exercise the expense of gym memberships and sports or exercise programs, and the inconvenient timing of exercise classes. Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living in order to lose weight. Regarding physical activity, the community in the Tri-Valley and in eastern and Central Contra Costa County identified the increased use of screens, including video games, among youth as a driver of sedentary lifestyles.

¹⁰⁰ Centers for Disease Control and Prevention. (2018). *Physical Activity Basics*.

¹⁰¹ The Mayo Clinic. (2016). Exercise: 7 Benefits of Regular Physical Activity.

¹⁰² Harvard Health Publishing/Harvard Medical School. (2013). *Balance Training Seems to Prevent Falls, Injuries in Seniors*.

¹⁰³ United States Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*

¹⁰⁴ World Health Organization. (2018). Early Child Development: Nutrition and the Early Years.

¹⁰⁵ Centers for Disease Control and Prevention. (2016). *Childhood Obesity Causes and Consequences*. See also: Centers for Disease Control and Prevention. (2018). *Adult Obesity Causes and Consequences*.

With the exception of Northern Alameda County, workers in John Muir Health’s service area have significantly longer commutes than the state average, driving over 60 minutes each direction. This can affect the time individuals have available for engaging in physical activity and healthy cooking/eating. Fast food consumption is trending up in Alameda County. Also, the smoking incidence rate is significantly higher in western and Eastern Contra Costa County than the benchmark.

A greater proportion of western and Eastern Contra Costa County youth are physically inactive compared to the state average. Youth populations with the highest levels of physical inactivity in most communities across both counties are Pacific Islanders, while Latinx youth are the least physically active in the Tri-Valley/Central Contra Costa County area. More specifically, in all but Northern Alameda County, a significantly smaller proportion of local area children/youth walk or bike to school, compared to the state average. Also, the percentage of 9th graders in Contra Costa County who meet fitness standards has been declining. Among Contra Costa County’s 5th, 7th, and 9th graders, Latinx students are least likely to meet fitness standards. Among Alameda County’s students, 5th graders who are Latinx, and 7th and 9th graders who are Pacific Islander, are least likely to meet the fitness standards.

In Western Contra Costa County, local residents may voluntarily limit their physical activity due to concerns about air quality. Residents indicated that local refineries were a cause of air pollution (e.g., refinery fires). Additionally, community members noted that the nearby freeways and traffic at the Port of Oakland contributed to poor air quality.

Youth in Western Contra Costa County were concerned about potential contamination of the water supply near oil refineries. A key informant in Eastern Contra Costa County expressed concern that mobile home parks are using wells that may be contaminated. Lack of access to clean drinking water affects physical health in a variety of ways, including the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay.

Diabetes

What Is the Issue?

Diabetes refers to a category of diseases that affects how the body uses glucose (blood sugar), the body’s primary source of fuel. Type 1 diabetes and Type 2 diabetes are chronic,¹⁰⁶ with Type 2 diabetes accounting for roughly 90% of all diagnosed cases and Type 1 diabetes accounting for approximately 5%. Gestational diabetes accounts for the rest. The Centers for Disease Control and Prevention (CDC) estimates that 30 million people in the U.S. have diabetes, and that an additional 84 million U.S. adults are pre-diabetic. The more serious health complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations.¹⁰⁷

¹⁰⁶ The Mayo Clinic. (2018). *Diabetes Overview*.

¹⁰⁷ Centers for Disease Control and Prevention. (2018). *Diabetes Quick Facts*.

While Type 1 diabetes is generally believed to be caused by a combination of genetic and environmental factors¹⁰⁶ and cannot be prevented, Type 2 diabetes and pre-diabetes (higher-than-normal blood glucose levels) are the result of the body losing its ability to generate sufficient insulin to maintain and regulate a healthy blood sugar level. Risk factors for Type 2 diabetes include being physically inactive, being overweight, being age 45 or older, having a close family member with Type 2 diabetes, and having pre-diabetes. Additionally, certain ethnic groups (African American, Latinx, Native American, Pacific Islanders, and some Asian groups) are at a higher risk of Type 2 diabetes.¹⁰⁷

As the seventh leading cause of death in the U.S., diabetes is costly. The CDC estimates the annual medical costs and lost work/wages attributable to diabetes is in excess of \$300 billion annually, and overall medical costs for those diagnosed with diabetes are twice as high as for those who do not have diabetes.¹⁰⁷

Why Is It a Health Need?

In all but Northern Alameda County, the community prioritized conditions related to healthy eating and active living. In all areas, most focus group and key informant feedback related the need for more community health education in order to increase healthy eating and active living, which would prevent obesity, diabetes, high blood pressure, and other chronic diseases. Culturally appropriate health education may be lacking, according to participants.

The rate of diabetes hospitalization among children and youth is higher for both counties than the state and is rising in Alameda County. The rate of diabetes management in both counties is lowest among African American patients.

“In the traditional health needs space, I think diabetes/obesity is number one, because it’s kind of a composite disease that reflects a lot of social drivers. So, for populations that struggle to understand how to attack the social determinants of health, I tend to try to encourage them to focus on diabetes and obesity, because it takes you to the social determinants of health.”

—HEALTH EXPERT, INTERVIEWEE

Obesity

What Is the Issue?

Taking in more calories than are burned through normal activity and exercise causes the excess calories to be stored as fat.¹⁰⁸ When one's weight is higher than the healthy standard for one's height, an individual is described as overweight or obese. Both conditions are measured by body mass index (BMI), a metric ratio of weight divided by the square of height.¹⁰⁹ Risk factors of obesity, in addition to unhealthy diet and inactivity, include genetic factors, underlying medical issues, family models, social and economic factors, and hormonal changes due to lack of sleep, pregnancy, or age. Smoking cessation and the side effects of certain medications can also contribute to obesity.¹⁰⁸ Further, food insecurity and obesity often co-exist because “both are consequences of economic and social disadvantage.”¹¹⁰

Nearly one in five children and nearly two in five adults in the U.S. are obese.¹⁰⁹ Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.^{108, 109}

Why Is It a Health Need?

In all but Northern Alameda County, the community prioritized conditions related to healthy eating and active living. Most focus group and key informant feedback related to the need for more community health education in order to increase healthy eating and active living, which would help prevent obesity, diabetes, high blood pressure, and other chronic diseases. Culturally appropriate health education may be lacking, according to participants. Parents specifically discussed having difficulty encouraging their children to practice healthy eating and active living in order to lose weight.

“I've heard ... that obesity is the new face of hunger in America, and it's because people ...are getting calories, but these calories are from processed food, from fast food that is affordable.”
—COMMUNITY EXPERT, INTERVIEWEE

Obesity-related hospitalizations are increasing in Alameda County. Youth obesity is significantly higher in western and Eastern Contra Costa County compared to the state average. In all but the Tri-Valley and Central Contra Costa County, obesity is highest among Pacific Islander youth and African American adults. Latinx youth and African American adults have the highest rates of obesity in the Tri-Valley/Central Contra Costa County.

¹⁰⁸ The Mayo Clinic. (2018). *Obesity*.

¹⁰⁹ Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.

¹¹⁰ Food Research & Action Center. (2015). *Food Insecurity and Obesity*.

Transportation and Traffic

What Is the Issue?

In the U.S. in 2010, 13.6 million motor vehicle crashes killed nearly 33,000 people and injured 3.9 million more, at an estimated cost to the U.S. economy of \$242 billion. The major contributors to motor vehicle crashes include drunk driving, distracted driving, speeding, and not using seat belts.¹¹¹ Increased road use is correlated with increased motor vehicle accidents,¹¹² while more traffic (road congestion) causes travel delays, greater fuel consumption, and higher greenhouse gas emissions via vehicle exhaust.¹¹¹ Vehicle exhaust is a known risk factor for heart disease, stroke, asthma, and cancer. Thus, it is important to monitor the miles traveled by vehicles over time to better understand the various potentially adverse health consequences.¹¹³

The benefits of eco-friendly alternative transport such as walking or riding a bicycle include improving health, saving money by not having to purchase a car or gasoline, and reducing impact on the environment. Combining alternative transport with traffic countermeasures can both improve health and reduce traffic-related injuries in communities.

Why Is It a Health Need?

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

“My children won’t ride BART. They used to ride BART. There’s no way I would let them get on BART. I mean, there were five murders in 30 days. Between the murders and sitting on needles... .” —COMMUNITY MEMBER, FOCUS GROUP PARTICIPANT

All regions of the John Muir Health service area have a significantly higher density of roads than the state’s benchmark. Compared to the state average, a significantly greater proportion of Eastern Contra Costa County and Tri-Valley commuters drive alone to work more than 60 minutes in each direction, which contributes to the traffic load on the roads. However, in Oakland, African American community members were over three times less likely than White

¹¹¹ U.S. Department of Transportation, National Highway and Traffic Safety Administration. (2015). *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised)*, DOT HS 812 013. 2015 (revised). See also: Centers for Disease Control and Prevention. (2017). *Motor Vehicle Safety: Cost Data and Prevention Policies*, which suggests that the figures have not changed significantly since 2010.

¹¹² Cohen, P. (2014, October 8). Miles Driven and Fatality Rate: U.S. States, 2012. Sociological Images [web log].

¹¹³ Health Matters in San Francisco. (2008). *Heavy Traffic Can Be Heartbreaking*.

residents to have access to a car. A significantly smaller proportion of Eastern Contra Costa County residents live within half a mile of a public transit stop compared to other state residents.

The rate of bicycle-involved collisions in Alameda County is significantly higher than the state average. The rate of motor vehicle crash ED visits in Alameda County is significantly higher than the state rate—and rising. Motor vehicle crash deaths in Contra Costa County are disproportionately experienced by African Americans.

Climate/Natural Environment

What Is the Issue?

Living in a healthy environment is critical to quality of life and physical health. The Office of Disease Prevention and Health Promotion reports that globally nearly 25% of all deaths and diseases can be attributed to environmental issues. Those environmental issues include air, water, food, and soil contamination, as well as natural and technological disasters.¹¹⁴ For those whose health is already compromised, exposure to negative environmental issues can compound their problems.¹¹⁵

Therefore, it follows that any effort to improve overall health must include consideration of those societal and environmental factors that increase the likelihood of exposure and disease. The recent reports on climate change highlight the importance of considering environmental health in the context of climate health, which is projected to have an increasing impact on sea levels, air quality, patterns of infectious diseases, and the severity of natural disasters, such as fires, floods, and droughts.¹¹⁶

Why Is It a Health Need?

Feedback from the community about the environment primarily concerned poor air quality, which was attributed to pollution. Across all geographies, community members identified poor air quality as a driver of asthma. Key informants and focus group participants in each local area also pointed to climate change as the cause of severe weather events and wildfires. In Eastern Contra Costa County, community members indicated that local refineries were a cause of air pollution (e.g., refinery fires). In Northern Alameda County, community members noted that the nearby freeways and traffic at the Port of Oakland contributed to air pollution.

“The consequences [of climate] on the health side of the fence are not just more people dying of heatstroke. It’s going to be the exacerbation of chronic diseases. ... You’re going to start to see this ripple effect of extreme heat.” —HEALTH EXPERT, INTERVIEWEE

¹¹⁴ Office of Disease Prevention and Health Promotion. (2018). *Environmental Health*.

¹¹⁵ Morris, G., & Saunders, P. (2017). The Environment in Health and Well-Being, *Oxford Research Encyclopedias*.

¹¹⁶ U.S. Global Change Research Program. (2018). *Fourth National Climate Assessment*.

A key informant in Eastern Contra Costa County expressed concern that mobile home parks are using wells that may be contaminated. Lack of access to clean drinking water affects physical health in a variety of ways, including the potential for acquiring communicable diseases and the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay.

The respiratory hazard index in Northern Alameda County significantly surpasses (i.e., is worse than) the state average. Specifically, in Oakland, the overall (air, water, etc.) pollution burden in majority-Asian census tracts is significantly higher than the pollution burden in majority-White census tracts. Road network density contributes to greater traffic, which can increase air pollution.¹¹⁷ Eastern Contra Costa County has a significantly higher density of roads compared to the state average; particulates from traffic can contribute to asthma. While air quality measures are better than the state, asthma prevalence in the local area is significantly worse than benchmarks. Asthma can be exacerbated by heat and pollution. Asthma hospitalizations are significantly worse for children in both counties and for youth in Alameda County compared to the state.

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

For further details, including statistical data and sources, please consult the data tables in Attachments 4 A–D: Secondary Data Tables.

¹¹⁷ Community Commons. <https://www.communitycommons.org/chna/>

7. Community Resources

Various hospitals and clinics, community-based organizations, government departments and agencies, and other resources are available in the John Muir Health service area to respond to the community health needs identified in this assessment. Hospitals and clinics are identified below. *Additional resources are listed in Attachment 5: Community Assets and Resources.*

Hospitals

- Alameda County Behavioral Health Center
- Alameda Health System (Alameda and Highland Hospitals)
- Contra Costa Regional Medical Center
- John Muir Behavioral Health Center
- John Muir Medical Center Concord
- John Muir Medical Center Walnut Creek
- Kaiser Permanente–Diablo (Antioch and Walnut Creek)
- Kaiser Permanente–East Bay (Oakland and Richmond)
- San Ramon Regional Medical Center
- Stanford Health Care - ValleyCare
- Sutter Health Alta Bates Summit Medical Center
- Sutter Delta Medical Center
- UCSF Benioff Children’s Hospital
- Veterans Affairs Medical Center/Concord Vet Center

Federally Qualified Health Centers

- Asian Health Services
- Axis Community Health
- Brighter Beginnings
- Community Clinics
- La Clínica (multiple locations)
- LifeLong Medical Care (multiple locations)
- Native American Health Center
- Planned Parenthood (multiple locations)
- RotaCare (multiple locations)
- West Oakland Health

8. Evaluation of Implemented Strategies

This section describes the outcomes of John Muir Health’s implemented strategies based on the 2016 CHNA. The Community Health Improvement Plan includes initiatives and community-based programs operated or substantially supported by John Muir Medical Center, Walnut Creek; John Muir Medical Center, Concord; and John Muir Health Behavioral Health Center.

Programs were developed in response to the 2016 Community Health Needs Assessment, internal data, and community partner input.

	
Community Health Improvement Plan 2016–2018 Evaluation Outcomes	
<p>The following year-end results are outlined by each of three identified community health needs, their associated long-term and intermediate goals.</p> <p>Select program outcomes from 2016 to 2018 (inclusive) are provided in the color-coded tables on subsequent pages.</p>	
Community Health Needs	
1. Health care access and delivery, including primary and specialty care	
2. Behavioral Health, including mental health and substance abuse	
3. Obesity, diabetes, healthy eating and active living	
Community Health Need:	Health care access and delivery, including primary and specialty care
Long-Term Goal:	Increase access to appropriate health care and health care support services for low-income children, adults, and seniors.
Intermediate Goals:	1. Increase access to comprehensive primary care for vulnerable adults.
	2. Increase access to specialty care services for vulnerable adults.
	3. Increase access to health care support services for vulnerable children and adults.

Program	Outcome
<p>Mobile Health Clinic: Provide comprehensive primary care for vulnerable adults who are unable to access care due to inadequate insurance coverage, availability of services, timeliness of appointments or accessibility.</p>	<p>Total patients served during Saturday Clinic and JMH Family Residency Clinic = 1,224</p> <p>The Mobile Health Clinic served 6,695 patients through partnership programs (RotaCare and Healthcare for the Homeless).</p> <p>80% of patients were non-English speaking and 100% of services met their linguistic needs (primarily Spanish).</p> <p>On average, 29% of patients report that they would have received health care services in the Emergency Department had they not had access to the MHC.</p>
<p>Community Nurse Program: Provide health care support services for children in schools that serve low-income families.</p>	<p>Community Nurse services were provided at Cambridge, Meadow Homes, Foothill, Highlands, and Willow Cove elementary schools.</p> <p>Total individuals served to include students, parents, and school staff = 19,244</p> <p>Total clinical interventions = 8,257</p> <p>Total support service interventions = 716</p> <p>Total health education interventions = 1,099</p>
<p>Mobile Dental Clinic: Provide health care support services for children in schools that serve low-income families through the Dental Collaborative of Contra Costa County.</p>	<p>Mobile Dental Clinic provided oral health services to 12,040 children for a total of 14,115 visits.</p> <p>The Dental Collaborative of Contra Costa County includes Ronald McDonald House Charities, the County's Children's Oral Health Program, La Clínica de La Raza, Lifelong Community Health Center, and John Muir Health.</p> <p>The Dental Collaborative provided the following in schools: 33,875 dental education encounters; 11,137 assessments; 11,364 fluoride; 2,216 sealants.</p>
<p>La Clínica Specialty Care Program: Provide specialty care services through the La Clínica Specialty Care program for vulnerable adults who are unable to access care due to lack of coverage.</p>	<p>Providers were recruited to meet the needs of referred patients, which included gynecological oncologist, gynecologist, medical oncologist, radiation oncologist, diagnostic imaging, gastroenterologist, surgeon, cancer geneticist, urologist, and others.</p> <p>Total patients served = 728</p> <p>Total encounters = 2,178</p> <p>Total cancer diagnoses = 13</p> <p>96% of patients completed treatment or received/scheduled for follow-up.</p>
<p>Operation Access (OA): Provide specialty care services through Operation Access for vulnerable adults who are unable to access care due to lack of coverage.</p>	<p>Total patients who received surgical services = 345</p> <p>Total active volunteer physicians from John Muir Health who provided at least one surgical service = 55 providers</p> <p>Prior to using OA services, 22% of patients reported that they visited the Emergency Room.</p>
<p>Every Woman Counts Program: Provide free breast cancer screening for low-income women who are unable to access care due to lack of coverage.</p>	<p>Total patients served = 1,199</p> <p>98% of breast cancer patients were provided with same day, "one stop" services, including breast exams, diagnostic mammograms, ultrasounds, and biopsies.</p>

Program	Outcome
	Total cancer diagnoses = 14 100% of diagnoses were enrolled in the Breast and Cervical Cancer Treatment Program.
Lung Cancer Screening Program: Provide screening programs for low-income adults who are unable to access care due to lack of coverage.	Total screenings conducted = 532 Total cancer diagnoses = 8 100% of scan results provided within 10 working days.
Medication Assistance Program: Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency.	Total seniors served = 413 Total medications provided = 2,115 Estimate value of medications = \$2.75 million
Geriatric Care Coordination (GCC) and Patient Navigator (PN) Program: Enable older adults, families and caregivers to access all medical, health and community services that may assist in promoting best quality of life.	Case Managers and Patient Navigators received a total of 12,829 referrals from the health system and community, and 100% were provided assistance. Total older adults provided linkages to health care and health education = 7,458 Case Managers assisted 3,270 “walk-in” seniors who inquired about a variety of health and support services.
Fall Prevention Program (FPP): Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency through fall prevention safety trainings, home assessments and modifications, and education through Meals on Wheels of Mt. Diablo Region.	Total seniors served = 1,945 Total home modifications = 486 FPP conducted 83 education presentations, reaching 1,459 seniors and 150 caregivers. 99% of seniors who received a home modification reported feeling a positive difference in their daily life and 82% have not fallen 90 days post home modification.
Caring Hands Volunteer Caregivers & Senior Transportation Program (STP): Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency through transportation assistance.	Total seniors served = 1,163 Total volunteers = 910 Caring Hands volunteers provided 11,640 rides for a total of 15,427 hours. Caring Hands volunteers provided 3,292 friendly visits for a total of 6,191 hours. Caring Hands volunteers provided 1,547 respite visits for a total of 3,474 hours. Caring Hands volunteers provided 5,559 assisted outings for a total of 14,965 hours. Caring Hands volunteers provided 83 household tasks for a total of 160 hours.

Community Health Need:	Behavioral Health, including mental health and substance abuse
Long Term Goal:	Increase access to behavioral health support for vulnerable communities.
Intermediate Goals:	1. Increase access to mental health prevention and intervention support for vulnerable adults. 2. Reduce youth community violence in vulnerable communities.
Program	Outcome
Beyond Violence Program: Provide intervention and referrals to trauma victims ages 15–25 in order to prevent recidivism and retaliation.	Total clients = 162 Total support service interventions provided = 827 % remained alive = 100% % avoided re-injury = 97% % did not retaliate = 99%
Complex Community Care Coordination Program: Provide comprehensive case management and support services for individuals who frequent the Emergency Department, have excessive hospitalizations and meet criteria related to social determinants of health.	Total clients served = 246 Provided interventions related to benefits, appointment, care plan, case management, communications, housing, mental health, site visit, transportation or other.
Putnam Clubhouse: Support and/or provide behavioral health intervention services to vulnerable adults with severe mental health illness through education and vocational rehabilitation support services.	Total members = 1,008 Total hours spent participating in activities = 167,697 Total members who secured employment = 127 Total members who returned to school = 63 % improved emotional well-being = 85% John Muir Health provided health education materials and workshops on the following topics: nutrition, diabetes, smoking cessation, exercise, and managing medications.
Respite Care Center: Connect homeless patients discharged from hospital to Respite Care Center to provide recuperative care and on-site comprehensive case management and support services to medically fragile homeless adults.	Total patients approved for respite = 342 Total patients placed in respite = 120 Total patients placed in county shelter = 55
Mentes Positivas en Acción (Positive Minds in Action) Promotores Program: Support the prevention and/or improvement in the levels of stress and depression in vulnerable communities through the Positive Minds in Action Promotores program offered by Monument Impact.	Total trainers for Mentes Positivas en Acción 1 = 18 Total trainers for Mentes Positivas en Acción 2 = 13 Total programs delivered = 43 programs of MPA1 and 11 of MPA2 were completed for a total of 54 programs. Total community participants = 363

Community Health Need:	Obesity, diabetes, healthy eating and active living
Long-Term Goal:	Decrease the number of residents who suffer from negative health outcomes as a result of obesity, diabetes, poor nutrition and lack of exercise.
Intermediate Goals:	1. Reduce the incidence of diabetes in vulnerable adults. 2. Increase access to healthy food and exercise for low-income families.
Program	Outcome
<p><u>Diabetes Services:</u> Provide diabetes prevention programs to vulnerable adults who are identified as pre-diabetic.</p>	John Muir Health in collaboration with La Clínica de la Raza launched the DEEP program in 2017, and since have trained a total participation of 26 people for six weeks.
	The DEEP program was conducted in Spanish.
	100% of participants were uninsured.
	Biometrics were tracked by La Clínica staff.
<p><u>Healthy and Active Before 5 (HAB45):</u> Support HAB45 to prevent obesity in children ages 0–5 by addressing barriers to healthy eating and active play.</p>	HAB45 convenes biannual Leadership Council meetings to educate, share best practices, and inspire progress in implementing the HAB45 policy agenda among local organizations serving young children in Contra Costa County.
	HAB45 supported the adoption of new organization-wide policies that create healthier environments for children through the Pledge the Practice, Pass the Policy Initiative. These policies reach approximately 14,776 children and adults.
	The parks partnership focused efforts in Antioch, Bay Point and Richmond. Community members actively engaged to assess twelve parks and conduct community surveys.
<p><u>Food Bank of Contra Costa and Solano County’s Community Produce Program:</u> Support the Food Bank to provide access to fresh produce for low-income families in Contra Costa County.</p>	The Community Produce Program served 26,000 people and distributed over 10.2 million pounds of fresh fruits and vegetables.
	Clients overall reported increased consumption of fresh fruits and vegetables and having more balanced diets since receiving food from the program.

9. Conclusion

John Muir Health collaborated with other local health systems (“the Health Systems”) to meet the requirements of the federally required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and conducting new primary research as a team, the Health Systems were able to collectively understand the community’s perception of health needs.

By presenting the findings to local experts for input, the Health Systems were able to prioritize health needs based on not only how each one compared to state benchmarks, but also how each one ranked in importance to the community compared to other needs.

Next Steps for John Muir Health:

- CHNA adopted by our board and made publicly available on our website by December 31, 2019.¹¹⁸
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs (independently or with partner hospitals).
- Ensure strategies are adopted by the hospital board and filed with the IRS (by May 15, 2020).

¹¹⁸ <https://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html>

10. List of Attachments

1. Community Leaders, Representatives, and Members Consulted
2. Secondary Data Sources
3. Secondary Data Indicators List
4. Secondary Data Tables
 - A. Tri-Valley and Central Contra Costa County
 - B. Eastern Contra Costa County
 - C. Western Contra Costa County
 - D. Northern Alameda County
5. Community Assets and Resources
6. Qualitative Research Protocols
7. IRS Checklist

Attachment 1. Community Leaders, Representatives, and Members Consulted

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups, including low-income, minority, and medically underserved populations. The group included leaders from the county health systems, local government employees, clinicians, and nonprofit organizations. For a description of members of the community who participated in focus groups, please see Section 5: Process and Methods. The names of some focus group participants were withheld upon request.

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
<i>Community Leaders and Representatives</i>							
E-CCC	Interview	Diane Burgis, Supervisor, Contra Costa County, District III	Needs of Eastern Contra Costa County population	1	Low-income, Minority	Leader	6/27/2018
E-CCC	Interview	Ana Castro, Coordinator, Educational Services, Antioch Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	7/25/2018
E-CCC	Interview	Bob Sanchez, Director of Student Services, Antioch Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	7/25/2018
E-CCC	Interview	Ken Carlson, Board Chair, John Muir Community Health Fund	Community health	1	Medically underserved	Leader	7/31/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
E-CCC	Interview	Devorah Levine, Assistant Director, Contra Costa County Employment and Human Services	Medically underserved	1	Low-income, Medically underserved	Leader	8/2/2018
E-CCC	Interview	Kirsten Rigsby, Executive Director, Village Community Resource Center	Latinx population needs	1	Minority	Leader	8/14/2018
E-CCC	Interview	Pam Di Franco, RN, MSN, PHN, Clinic Nurse Manager, Society of St. Vincent de Paul of Contra Costa County	Economic security	1	Low-income, Medically underserved	Leader	8/16/2018
E-CCC	Interview	Barbara Hunt, Development Director, St. Vincent de Paul of Contra Costa County	Economic security	1	Low-income, Medically underserved	Leader	8/16/2018
E-CCC	Interview	Rhonda James, Chief Executive Officer, STAND! for Families Free of Violence	Community and family safety	1	Low-income, Minority	Leader	8/17/2018
E-CCC	Interview	Allison Staulcup Becwar, Chief Program Officer, Lincoln	Mental health needs	1	Medically underserved	Leader	8/17/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
E-CCC	Interview	Hector J. Rojas, AICP, Senior Planner, City of Pittsburg	Community development	1	Low-income	Leader	8/17/2018
E-CCC	Interview	Kristin Connelly, President and Chief Executive Officer, East Bay Leadership Council	Economic security	1	Low-income	Leader	8/21/2018
E-CCC, TV/C-CCC	Interview	Kevin McAllister, Executive Director, Rainbow Community Center	LGBTQ population needs	1	Medically underserved, Minority	Leader	8/1/2018
E-CCC, TV/C-CCC, W-CCC	Interview	Lavonna Martin, Director, Health, Housing, and Homeless Services, Contra Costa County Health Services	Needs of individuals experiencing homelessness	1	Low-income	Leader	7/13/2018
E-CCC, TV/C-CCC, W-CCC	Interview	Dan Peddycord, Director of Public Health, Contra Costa County Health Services	Public health	1	Health department representative	Leader	7/23/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
E-CCC, W-CCC	Interview	Dr. Matthew P. White, Acting Director of Behavioral Health, Medical Director, Contra Costa County Health Services	Behavioral health	1	Medically underserved	Leader	7/31/2018
N-AC	Interview	Leronne Armstrong, Deputy Chief, Oakland Police Department	Community and family safety (law enforcement)	1	Low-income, Minority	Leader	7/18/2018
N-AC	Interview	Bonnie Lovette, RN MS PNP, Injury Prevention Coordinator, Trauma Services, UCSF Benioff Children's Hospital Oakland; Founder, Chair, Childhood Injury Prevention Network, Bay Area (CIPN-BA); member, Alameda County Child Death Review Team	Injuries, children	1	Medically underserved	Leader	7/19/2018
N-AC	Interview	Dr. Melanie Moore, Executive Director, All In Alameda County	Food insecurity	1	Low-income	Leader	7/19/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Interview	Ralph Silber, Executive Director, Alameda Health Consortium	Needs of medically underserved population	1	Medically underserved	Leader	7/25/2018
N-AC	Interview	Anne Marks, Executive Director, Youth Alive	Community and family safety (community)	1	Low-income, Minority	Leader	8/3/2018
N-AC	Interview	Dr. Tony Iton, Senior Vice President, California Endowment	Social determinants of health	1	Low-income, Minority	Leader	8/8/2018
N-AC	Interview	Gloria Bruce, Executive Director, East Bay Housing Organizations	Affordable housing	1	Low-income	Leader	8/8/2018
N-AC	Interview	Leslie Ewing, Executive Director, Pacific Center	LGBTQ population needs	1	Medically underserved, Minority	Leader	8/16/2018
N-AC	Interview	Dr. Kathleen Clanon, Medical Director, Alameda County Health Care Services	Whole person health	1	Medically underserved	Leader	6/29/2018
N-AC	Interview	Dr. Erica Pan, Director, Division of Communicable Disease Control and Prevention, Alameda County Public Health Department	Infectious diseases	1	Health department representative	Leader	7/13/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Interview	Dr. Aaron Chapman, Medical Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018
N-AC	Interview	James Wagner, Deputy Director, Behavioral Health Care Services of Alameda County	Behavioral health	1	Medically underserved	Leader	8/13/2018
N-AC	Interview	Katherine Jones, Director, Adult and Older Adult System of Care, Behavioral Health Care Services of Alameda County	Behavioral health	1	Low-income, Medically underserved	Leader	8/13/2018
N-AC	Interview	Colleen Chawla, Director, Alameda County Health Care Services	Healthcare access	1	Medically underserved	Leader	8/16/2018
N-AC	Interview	Kristin Spanos, Chief Executive Officer, First 5 Alameda County	Needs of children age 0-5	1	Low-income	Leader	8/20/2018
N-AC, TV/C-CCC	Interview	Kimi Watkins-Tartt, Deputy Director, Public Health, Alameda County Public Health Department	Public health	1	Health department representative	Leader	7/23/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
TV/C-CCC	Interview	Claudia Young, Human Services Programs Manager, Livermore Housing and Human Services	Government, health/human services	1	Low-income	Leader	7/26/2018
TV/C-CCC	Interview	Kathy Chiverton, Executive Director, Discovery Counseling Center	Mental health	1	Medically underserved	Leader	7/30/2018
TV/C-CCC	Interview	Sue Compton, Chief Executive Officer, Axis Community Health	Needs of low-income population	1	Low-income	Leader	8/3/2018
TV/C-CCC	Interview	Sandra Scherer, Executive Director, Monument Crisis Center	Needs of low-income population	1	Low-income	Leader	8/6/2018
TV/C-CCC	Interview	Denah Nunes, LCSW, Director of Health and Wellness Alameda County, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018
TV/C-CCC	Interview	Louis Chicoine, Executive Director, Abode Services	Needs of individuals experiencing homelessness	1	Low-income, Medically underserved	Leader	8/7/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
TV/C-CCC	Interview	Robert Taylor, Executive Director, Senior Support Services of Tri-Valley	Older adult needs	1	Low-income	Leader	8/8/2018
TV/C-CCC	Interview	Katherine Wutchiett, Attorney, Skadden Fellow, Legal Aid at Work	Low-income immigrant population needs	1	Low-income, Minority	Leader	8/13/2018
TV/C-CCC, W-CCC	Interview	Debbie Toth, President and CEO, Choice in Aging	Older adult needs	1	Low-income, Medically underserved	Leader	8/15/2018
TV/C-CCC	Interview	Cat Arthur, School Nurse, Livermore Valley Joint Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018
TV/C-CCC	Interview	Cindy Leung, District Community Liaison, Dublin Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	10/2/2018
TV/C-CCC	Interview	Scott Vernoy, Director of Student Services, Livermore Valley Joint Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
TV/C-CCC	Interview	Vicki Fukumae, District Nurse, Dublin Unified School District	K-12 student health	1	Medically underserved	Leader	10/2/2018
TV/C-CCC	Interview	Ed Diolazo, Assistant Superintendent of Student Support Services, Pleasanton Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	10/3/2018
TV/C-CCC	Interview	Susan Han, RN, MSN, District Nurse, Pleasanton Unified School District	K-12 student health	1	Medically underserved	Leader	10/3/2018
W-CCC	Interview	Kanwarpal Dhaliwal, Associate Director, RYSE	Youth development and safety	1	Low-income, Minority	Leader	7/18/2018
W-CCC	Interview	Alvaro Fuentes, Executive Director, Community Clinic Consortium of Contra Costa and Solano Counties	Needs of medically underserved population	1	Medically underserved	Leader	7/27/2018
W-CCC	Interview	Sam Vaughn, Program Manager, Richmond's Office of Neighborhood Safety	Community and family safety	1	Low-income, Minority	Leader	7/30/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
W-CCC	Interview	Alicia Gallo, Outreach Coordinator, Richmond Main Street Initiative	Economic insecurity	1	Low-income	Leader	8/3/2018
W-CCC	Interview	John Gioia, Supervisor, Western Contra Costa County	Needs of Western Contra Costa County population	1	Low-income, Minority	Leader	8/8/2018
W-CCC	Interview	Marin Trujillo, Community Engagement Interim-Director, West Contra Costa Unified School District	K-12 student health and education	1	Low-income, Minority	Leader	8/14/2018
W-CCC	Interview	Roxanne Garza, Hub Manager, Healthy Richmond	Needs of medically underserved population	1	Medically underserved	Leader	8/22/2018
TV/C-CCC	Focus Group	Host: Axis Community Health	Needs of Latinx low-income individuals	5	Low-income, Medically underserved, Minority	(see below)	8/7/2018
		Attendees:					
		Charon Emery, Enrollment, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Cindy Nava, BHCC, Axis Community Health	Needs of Latinx low-income individuals			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Eileen Esparza, CDCC, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Maria Gonzalez, Clinic Manager, Axis Community Health	Needs of Latinx low-income individuals			Leader	
		Pam Alfaro, Community Health Worker, Axis Community Health	Needs of Latinx low-income individuals			Leader	
E-CCC, TV/C-CCC	Focus Group	Host: Kaiser Foundation Hospital-Walnut Creek	Needs of Central and Eastern Contra Costa County population	13	Low-income	(see below)	8/27/2018
		Attendees:					
		Dena Betti, Executive Director, #hersmile Nonprofit	Needs of Central and Eastern Contra Costa County population			Leader	
		John Jimno, Principal, Park Middle School, Antioch Unified School District	Needs of Central and Eastern Contra Costa County population			Leader	
		Catherine Stafford, Child Health and Nutrition Manager, CocoKids	Needs of Central and Eastern Contra Costa County population			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Denise Milosevich, Contra Costa Health Services, Public Health Department	Needs of Central and Eastern Contra Costa County population			Leader	
		Caitlin Sly, Program Director, Food Bank of Contra Costa and Solano	Needs of Central and Eastern Contra Costa County population			Leader	
		Ali Uscilka, Program Director, Healthy and Active Before 5	Needs of Central and Eastern Contra Costa County population			Leader	
		Ray (Heracio) Harts, Executive Director, Healthy Hearts Institute	Needs of Central and Eastern Contra Costa County population			Leader	
		Amy Weiss, Director, Refugee and Immigrant Services, Jewish Family and Community Services/EB	Needs of Central and Eastern Contra Costa County population			Leader	
		Jessica Rojas, Program Director, School Board Services of Contra Costa, Lincoln	Needs of Central and Eastern Contra Costa County population			Leader	

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

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		April Wise, Co-Chair, Health Care Task Force, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		David Bressler, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Melody Howe Weintraub, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Pat Reyes, Multi-Faith ACTION Coalition	Needs of individuals living in poverty			Leader	
		Doug Leich, Racial Justice, Multi-Faith ACTION Coalition, Racial Justice Working Group	Needs of individuals living in poverty			Leader	
		Pamela Abbey, Retired United Methodist Clergy	Needs of individuals living in poverty			Leader	
E-CCC	Focus Group	Host: Kaiser Foundation Hospital-Antioch	Needs of Eastern Contra Costa County population	7	Low-income	(see below)	9/17/2018
		Attendees:					
		Mayra Preciado, Antioch Unified School District	Needs of Eastern Contra Costa County population			Leader	

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		Robert Prinz, Education Director, Bike East Bay	Needs of Eastern Contra Costa County population			Leader	
		Wendy Escamilla, Brighter Beginnings	Needs of Eastern Contra Costa County population			Leader	
		Susun Kim, Executive Director, Family Justice Center	Needs of Eastern Contra Costa County population			Leader	
		Alejandra Plascencia, Community Liaison – East and Central County, First 5 Contra Costa	Needs of Eastern Contra Costa County population			Leader	
		Brianna Robinson, Director of Programs, Opportunity Junction	Needs of Eastern Contra Costa County population			Leader	
		Darren Gapultos, Pittsburg Unified School District	Needs of Eastern Contra Costa County population			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Focus Group	Host: Seneca	Behavioral/mental health	8	Medically underserved	(see below)	7/31/2018
		Attendees:					
		Ilene Yasemsky, Clinical Director PHF, Seneca	Behavioral/mental health			Leader	
		Johanna Paillet-Growl, Willow Rock Crisis Stabilization Unit Supervisor, Seneca	Behavioral/mental health			Leader	
		Louisa Kornblatt, MSW Intern, PHF, Seneca	Behavioral/mental health			Leader	
		Melissa Lawton, CSU Assistant Director, Seneca	Behavioral/mental health			Leader	
		Amrit Sandhu, WRC PHF-RN Supervisor, Telecare	Behavioral/mental health			Leader	
		Jessica Eschman, LCSW, Program Director, Willow Rock Crisis Stabilization Unit (Seneca Family of Agencies)	Behavioral/mental health			Leader	

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

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Jamie Ramirez, Pop Up Care Village Program Director, Lava Mae	Needs of individuals experiencing homelessness			Leader	
		Brenda Goldstein, Lifelong Medical	Needs of individuals experiencing homelessness			Leader	
		Noha Aboelata, MD, Chief Executive Officer, Roots Community Health Center	Needs of individuals experiencing homelessness			Leader	
		Carol Johnson, Executive Director, St. Mary's Center	Needs of individuals experiencing homelessness			Leader	
N-AC	Focus Group	Host: Oakland Unified School District	Health of K-12 students	8	Medically underserved	(see below)	8/29/2018
		Attendees:					
		Barbara Parker, Health Services Coordinator, Oakland Unified School District	Health of K-12 students			Leader	
		Coreen Steigerwald, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Eden Balde, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Edson Nunes da Silva, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Ozella Faison-Burns, BSN, RN, PHN, Credentialed School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Samantha Wong, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
		Sherry Kassenbrock, School Nurse, Oakland Unified School District	Health of K-12 students			Leader	
N-AC	Focus Group	Host: Unity Council	Needs of undocumented individuals	5	Low-income, Medically underserved, Minority	(see below)	9/13/2018
		Attendees:					
		Edgar Salazar, Day Labor Employment Advocate, Oakland Workers Collective	Needs of undocumented individuals			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Gabriela Galicia, Executive Director, Street Level Health Project	Needs of undocumented individuals			Leader	
N-AC	Focus Group	Host: Kaiser Permanente Northern California	Needs of individuals utilizing safety net clinics	5	Low-income, Medically underserved	(see below)	9/14/2018
		Attendees:					
		Julia Liou, Chief Deputy of Administration, Development, Asian Health Services	Needs of individuals utilizing safety net clinics			Leader	
		Kendolyn Hindsman, Patient Services Manager, Lifelong Medical	Needs of individuals utilizing safety net clinics			Leader	
		Gale Taylor, West Oakland Health	Needs of individuals utilizing safety net clinics			Leader	
		Sara Rounsaville, West Oakland Health	Needs of individuals utilizing safety net clinics			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Focus Group	Host: Kaiser Foundation Hospital-Oakland	Health disparities and inequities	6	Low-income, Medically underserved, Minority	(see below)	9/21/2018
		Attendees:					
		Melissa Jones, BARHII	Health disparities and inequities			Leader	
		Anita Kumar, Manager, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Charise Fong, Chief Operating Officer, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Romi Hall, Associate Director, East Bay Asian Local Development Corporation	Health disparities and inequities			Leader	
		Anthony Galace, Director of Health Equity, The Greenlining Institute	Health disparities and inequities			Leader	
		Ellen Wu, Urban Habitat	Health disparities and inequities			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Focus Group	Host: Kaiser Foundation Hospital-Oakland	Needs of youth	12	Low-income, Minority	(see below)	9/21/2018
		Attendees:					
		Rob Jackson, Beats Rhymes and Life	Needs of youth			Leader	
		Jamal Mitchell, Care Champion, The Hidden Genius Project	Needs of youth			Leader	
		Kieran McMonagle, LMFT, Clinical Program Manager AC/SF, First Place for Youth	Needs of youth			Leader	
		Nedra Ginwright, MS, Chief Flourish Officer, Flourish Agenda	Needs of youth			Leader	
		Karen Bohlke, Martin Luther King Jr. Freedom Center	Needs of youth			Leader	
		JG Larochette, Founder and Executive Director, Mindful Life Project	Needs of youth			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Wesley Hingano, Case Manager, Oakland High School	Needs of youth			Leader	
		Lailan Huen, API Student Achievement, Oakland Unified School District	Needs of youth			Leader	
		Eric Erhoff, Program Coordinator, Project Avary	Needs of youth			Leader	
		Tiffani Parrish, Case Manager, Youth Radio	Needs of youth			Leader	
		Shawana Booker, Director, Youth Uprising	Needs of youth			Leader	
W-CCC	Focus Group	Host: Healthy Richmond Collaborative	Needs of individuals who are medically underserved	17	Medically underserved	(see below)	7/18/2018
		Attendees:					
		Sophia Cohn, Attorney, Bay Area Legal Aid	Needs of individuals who are medically underserved			Leader	
		Jennifer Turner, Brighter Beginnings	Needs of individuals who are medically underserved			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Molly Baldrige, MPH, Project Director, California School-Based Health Alliance	Needs of individuals who are medically underserved			Leader	
		C. Sequoia Erasmus, Director of Community Engagement, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Gabino Arredondo, Management Analyst II, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Rodrigo Beteta, Schaeffer Government Service Fellow and Health Career Connection Intern, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Shasa Curl, Community and Economic Development Director, City of Richmond	Needs of individuals who are medically underserved			Leader	
		Rachel K. Bell, Intern, Community Clinic Consortium	Needs of individuals who are medically underserved			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Wanda Session, Assistant to Director, Contra Costa Health Services	Needs of individuals who are medically underserved			Leader	
		Dulce Galicia, Program Coordinator, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Noemi Corona, Summer Temporary Employee, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Roxanne Carrillo Garza, Hub Manager, Healthy Richmond	Needs of individuals who are medically underserved			Leader	
		Kendolyn Hindsman, LifeLong Medical Care	Needs of individuals who are medically underserved			Leader	
		Linda Collins, LifeLong Medical Care	Needs of individuals who are medically underserved			Leader	
		Yolanda Bolden, Wellness Coach, Rubicon Programs	Needs of individuals who are medically underserved			Leader	
		Sonia Bustamante, Office of Supervisor Gioia	Needs of individuals who are medically underserved			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
W-CCC	Focus Group	Host: West Contra Costa Unified School District	K-12 student health	7	Medically underserved	(see below)	8/28/2018
		Attendees:					
		Joyce Synott, Social Worker, Bay Area Community Resources	K-12 student health			Leader	
		Megan White, Bay Area Community Resources	K-12 student health			Leader	
		Barbara Byrd, Student Welfare and Attendance, West Contra Costa Unified School District	K-12 student health			Leader	
		Nick Berger, Special Ed, West Contra Costa Unified School District	K-12 student health			Leader	
		Angelica Lara, Student Welfare and Attendance, West Contra Costa Unified School District	K-12 student health			Leader	

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Jodi Couick, Coordinator, Educationally Related Mental Health Services, West Contra Costa Unified School District	K-12 student health			Leader	
		Eleazar Martinez, Community School Director, YMCA of the East Bay	K-12 student health			Leader	
Community Residents							
E-CCC	Focus Group	Host: Rubicon Programs-Antioch	Individuals of minority, low-income, and/or re-entry status	5	Low-income, Medically underserved, Minority	Members	8/29/2018
E-CCC	Focus Group	Host: Los Medanos College	Young adults, ages 18–25	14	Low-income	Members	8/30/2018
E-CCC	Focus Group	Host: Stoneman Village	Older adults	9	Low-income	Members	9/17/2018
E-CCC, TV/C-CCC	Focus Group	Host: Loaves and Fishes	Individuals experiencing homelessness or housing instability	9	Low-income, Medically underserved	Members	8/6/2018
N-AC	Focus Group	Host: Alameda County Health Coach Program	Health coaches – peers of medically underserved individuals	5	Medically underserved, Minority	Representatives, Members	8/2/2018

AREA(S)	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC OR POPULATION	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
N-AC	Focus Group	Host: Youth Radio	Youth	31	Low-income, Minority	Members	9/28/2018
TV/C-CCC	Focus Group	Host: Open Heart Kitchen	Individuals experiencing homelessness or housing instability	7	Low-income, Medically underserved	Members	7/31/2018
TV/C-CCC	Focus Group	Host: First 5 Contra Costa County Regional Group	Parents children ages 0–5	13	Minority	Members	8/29/2018
TV/C-CCC	Focus Group	Host: Diablo Valley College	Young adults, ages 18–25	7	Low-income	Members	9/5/2018
TV/C-CCC	Focus Group	Host: Marilyn Elementary School	Families with elementary-school-age children	11	Low-income	Members	9/6/2018
TV/C-CCC	Focus Group	Host: Cambridge Elementary School	Families with elementary-school-age children	12	Minority	Members	9/14/2018
W-CCC	Focus Group	Host: RYSE	Youth	6	Low-income, Minority	Members	7/24/2018
W-CCC	Focus Group	Host: Rubicon Programs-Richmond	Individuals of minority, low-income, and/or re-entry status	9	Low-income, Medically underserved, Minority	Members	8/13/2018
W-CCC	Focus Group	Host: LifeLong Medical Center	Health promoters – peers of low-income and/or medically underserved individuals	7	Low-income, Medically underserved	Representatives, Members	9/6/2018

Attachment 2. Secondary Data Sources

The sources of data in the list below were consulted to compile the data tables that underlie this 2019 Community Health Needs Assessment.

Source	Year(s)
American Housing Survey	2011–2013
Annie E. Casey Foundation, KIDS COUNT Data Center (Jul. 2016).	2015
Applied Survey Research. (2017). Alameda County Homeless Census and Survey. Watsonville, CA	2017
Area Health Resource File	2006–2010, 2012–2014, 2015, 2015, 2016
Bureau of Labor Statistics	2016, 2018
California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau.	2016
California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015)	2014
California Department of Education	2014–2015, 2014–2017, 2015–2016, 2016–2017, 2018
California Department of Education, California Healthy Kids Survey (WestEd)	2011–2013, 2013–2015
California Department of Public Health	2014–2016, 2015, 2017
California Department of Public Health, Birth Profiles by ZIP code	2011
California Department of Public Health, Breastfeeding Statistics	2012
California Department of Public Health, Death Public Use Data	2010–2012
California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section	2010–2012, 2013–2015
California Department of Public Health, STD Control Branch	2014–2016, 2017
California Department of Public Health, STD Control Branch, Data Request, September 2017. Gonorrhea data.	2014–2016
California Department of Public Health, Tuberculosis Control Branch, Data request, September 2017.	2014–2016, 2016
California Department of Public Health: 2011–2016 Death Records.	2011–2016
California Department of Education, California Basic Educational Data System (CBEDS) (Jun. 2016).	2015
California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS) (May 2016).	2015
California Department of Education, Coordinated School Health and Safety Office custom tabulation and California Basic Educational Data System (May 2017).	2016
California Department of Education, DataQuest (Jun. 2016).	2015
California Department of Education, Physical Fitness Testing Research Files (Dec. 2015).	2015
California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009	2016

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

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

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

Attachment 3. Secondary Data Indicators List

Indicator	Health Needs	Description	Source	Year(s)
30-Day Readmissions	Healthcare Access and Delivery	This indicator reports the percentage of Medicare fee-for-service beneficiaries readmitted to a hospital within 30 days of an initial hospitalization discharge. This indicator is relevant as a measure of quality of care.	Dartmouth Atlas of Health Care	2014, 2013, 2012, 2011, 2010
Access to a Car (COEI)	Healthcare Access and Delivery	This indicator measures the percentage of individuals who live in housing units that do not have a car.	American Community Survey, 1-year PUMS.	2016
Active Asthma Prevalence	Asthma	Percentage of county residents reporting they currently have asthma.	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from California Health Interview Survey.	2014
Acute Preventable Hospitalizations (HAC.org)	Healthcare Access and Delivery	This indicator shows the number of preventable hospitalizations due to acute conditions per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2009–2011
Adequate Fruit and Vegetable Consumption, Children Ages 12–17 (Kidsdata.org)	Obesity/HEAL/Diabetes	Estimated percentage of children ages 2–17 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily, by age group (e.g., in 2013–2014, an estimated 22.4% of California youth ages 12–17 ate at least five servings of fruits/vegetables daily).	UCLA Center for Health Policy Research, California Health Interview Survey	2013–2014
Adequate Fruit and Vegetable Consumption, Children Ages 2–11 (Kidsdata.org)	Obesity/HEAL/Diabetes	Estimated percentage of children ages 2–17 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily, by age group (e.g., in 2013–2014, an estimated 22.4% of California youth ages 12–17 ate at least five servings of fruits/vegetables daily).	UCLA Center for Health Policy Research, California Health Interview Survey	2013–2014

Indicator	Health Needs	Description	Source	Year(s)
Adults 18+ with Influenza Vaccination (AskCHIS)	Communicable Diseases (Not STIs)	Percentage of adults 18+ reporting they have had the flu vaccine in the past 12 months	California Health Interview Survey	2016
Adults Needing and Receiving Behavioral Health Care Services (HAC.org)	Mental Health	This indicator shows the percentage of adults needing care for emotional or mental health or substance abuse issues who stated that they did obtain help for those issues in the past year.	UCLA Center for Health Policy Research, California Health Interview Survey	2015–2016
Adults Needing Help for Behavioral Health Issue (AskCHIS)	Mental Health	Percentage of adults needing help for emotional/mental health problems or use of alcohol/drugs	California Health Interview Survey	2016
Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)	Mental Health	This indicator reports the percentage of adults who self-report that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs.	California Health Interview Survey	2016
Adults with an Associate's Degree or Higher	Economic Security	This indicator reports the percentage of the population aged 25 years and older with an Associate's degree or higher. This indicator is relevant because educational attainment is an important determinant of health, influencing health knowledge and behaviors, employment and income, and social standing and social networks.	American Community Survey	2012–2016
Adults with Any Adverse Childhood Experiences (Kidsdata.org)	Mental Health	Estimated percentage of adults 18 and older exposed to adverse childhood experiences before age 18, by household type.	Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008, 2009, 2011, and 2013. Public Health Institute, Survey Research Group.	2008, 2009, 2011, and 2013

Indicator	Health Needs	Description	Source	Year(s)
Adults with Four or More Adverse Childhood Experiences (Kidsdata.org)	Mental Health	Estimated percentage of adults 18 and older exposed to four or more adverse childhood experiences before age 18, by household type.	Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008, 2009, 2011, and 2013. Public Health Institute, Survey Research Group.	2008, 2009, 2011, and 2013
Adults with No High School Diploma (SAE)	Economic Security	This indicator reports the percentage of the population aged 25 years and older without at least a high school diploma or equivalent. This indicator is relevant as a measure of educational attainment, an important determinant of health and opportunity across a lifespan.	American Community Survey	2012–2016
Adults with Some Post-secondary Education	Economic Security	This indicator reports the percentage of adults aged 25 to 44 years with at least some post-secondary education. This indicator is relevant because educational attainment is an important determinant of health, influencing health knowledge and behaviors, employment and income, and social standing and social networks.	American Community Survey	2012–2016
Alcohol Use (Youth) (HAC.org)	Substance Use/Tobacco	This indicator shows the percentage of teens who answered yes to the question "Did you ever have more than a few sips of any alcoholic drink, like beer, wine, mixed drinks, or liquor?"	California Health Interview Survey	2011–2012
Alzheimer's Disease Deaths (AC, CCC) (CDPH)	Overall Health	Age-adjusted rate of death due to Alzheimer's per 100,000 population per year	California Department of Public Health: 2011–2016 Death Records.	2011–2016
Alzheimer's Disease or Dementia Among Medicare Beneficiaries (HAC.org)	Overall Health	This indicator shows the percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia.	Centers for Medicare and Medicaid Services	2015

Indicator	Health Needs	Description	Source	Year(s)
Annual Dental Visit Among Denti-Cal Beneficiaries (HAC.org)	Oral Health	This indicator shows the percentage of Denti-Cal recipients ages 0–20 who had an annual dentist visit in the past year. This includes those with 90 days continuous eligibility in the fee-for-service (FFS) delivery system who received at least one dental visit within the given calendar year.	Annie E. Casey Foundation	2015
Arthritis Among Medicare Beneficiaries (HAC.org)	Overall Health	This indicator shows the percentage of Medicare beneficiaries who were treated for rheumatoid arthritis or osteoarthritis.	Centers for Medicare and Medicaid Services	2015
Assault Injury ER Visits (HAC.org)	Community and Family Safety	This shows the number of assault emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
Asthma Deaths	Asthma	Age-adjusted rate of asthma mortality per 1,000,000 population	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from California Death Statistical Master Files.	2008–2010
Asthma Diagnoses, Children Ages 1–17 ⁹	Asthma	Percentage of children ages 1–17 whose parents report that their child has ever been diagnosed with asthma.	UCLA Center for Health Policy Research, California Health Interview Survey	2015
Asthma ED Visits, All Ages (CDPH)	Asthma	Age-adjusted rate of asthma emergency department visits per 10,000 residents, by age and overall	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from California Office of Statewide Health Planning and Development (OSHPD)	2014

Indicator	Health Needs	Description	Source	Year(s)
Asthma ER Visits (HAC.org)	Asthma	This indicator shows the age-adjusted rate for asthma emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
Asthma Hospitalizations	Asthma; Climate and Health; Healthcare Access and Delivery	This indicator reports the patient discharge rate per 10,000 total population for asthma and related complications. This indicator is relevant This indicator reports the patient discharge rate among Medicare-fee-for-service per 10,000 population for asthma and related complications. This indicator is relevant because it is a measure of the burden of asthma, a significant cause of morbidity among children and adults in the U.S. that is often exacerbated by poor air quality and other environmental conditions.	CMS_MMD Mapping Medicare Disparities Tool	2015
Asthma Hospitalizations, Children Age 0–4 (Kidsdata.org)	Asthma	Number of asthma hospitalizations per 10,000 population, by age group.	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau.	2016

Indicator	Health Needs	Description	Source	Year(s)
Asthma Hospitalizations, Children/Youth Ages 5–17 (Kidsdata.org)	Asthma	Number of asthma hospitalizations per 10,000 population, by age group.	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Department of Finance, and the U.S. Census Bureau.	2016
Asthma Prevalence, CA	Asthma; Climate and Health	This indicator reports the percentage of the population aged 18 years and older with asthma. This indicator is relevant because it is a measure of the burden of asthma, a significant cause of morbidity in the U.S. that is often exacerbated by poor air quality and other environmental conditions.	California Health Interview Survey	2014
Atrial Fibrillation Among Medicare Beneficiaries (HAC.org)	CVD/Stroke	This indicator shows the percentage of Medicare beneficiaries who were treated for atrial fibrillation.	Centers for Medicare and Medicaid Services	2015
Average Charge per Asthma Hospitalizations	Asthma	Average charge for hospitalization for asthma. Charges for asthma hospitalizations are the only type of data available to assess the costs of asthma in California counties. However, there are many other costs associated with asthma, including other types of health care utilization, medications, and indirect costs due to factors such as school and work missed.	Prepared by California Breathing, Environmental Health Investigations Branch, California Department of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD)	2014
Avoidable ER Visits (HAC.org)	Healthcare Access and Delivery	This indicator shows the age-adjusted avoidable emergency department visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014

Indicator	Health Needs	Description	Source	Year(s)
Banking Institutions	Economic Security	This indicator reports the number of banking institutions (commercial banks, savings institutions and credit unions) per 10,000 population. This indicator is relevant because an adequate supply of financial institutions enables financial inclusion, empowering people with tools and services to realize financial health and well-being.	County Business Patterns	2015, 2014, 2013, 2012
Beer, Wine, and Liquor Stores	Community and Family Safety; Economic Security; Substance Use/Tobacco	This indicator reports the number of beer, wine, and liquor stores per 10,000 population. This indicator is relevant because it measures alcohol outlet density which helps characterize policy and environmental factors that affect excessive alcohol use, a leading cause of preventable death in the U.S.	County Business Patterns	2015, 2012, 2014, 2013
Bicycle-Involved Collisions (HAC.org)	Community and Family Safety	This indicator shows the number of bicyclist-involved collisions resulting in bicyclist injury or death per 100,000 population.	California State Highway Patrol	2015
Breast Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 females due to breast cancer.	California Department of Public Health	2014–2016
Breast Cancer Incidence	Cancers	This indicator reports the age-adjusted incidence rate of breast cancer among females per 100,000 population per year. This indicator is relevant because it is a measure of the burden of breast cancer and may be useful for targeting interventions to prevent, screen for and treat breast cancer which is among the most common cancers affecting women.	State Cancer Profiles	2010–2014
Breast Cancer Screening (Mammogram)	Cancers; Healthcare Access and Delivery	This indicator reports the percentage of female Medicare enrollees, aged 67 and older, who have received one or more mammograms in the past two years. This indicator is relevant because breast cancer screening enables early detection and treatment; low levels of screening may suggest a lack of access to preventive care, lack of health knowledge, insufficient provider outreach, and existence of other barriers to utilization of services.	Dartmouth Atlas of Health Care	2014

Indicator	Health Needs	Description	Source	Year(s)
Breastfeeding (HAC.org)	Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of mothers who breastfed their new baby after delivery.	California Department of Public Health	2014–2016
Built Environment-Long-Term Residential Vacancy (COEI)	Crime/Intentional Injury	Percent of residential addresses that have been identified as “vacant” by the U.S. Postal Service for 2 or more years, aggregated at the census tract level on a quarterly basis.	COEI: U.S. Department of Housing and Urban Development Aggregated USPS Administrative Data on Address Vacancies, Quarter 3 ending September 30, 2017; U.S. Census Bureau, American Community Survey, 5-year Estimates, 2012–2016.	2017 + 2012–2016
Bullied at School, 7 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 7, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Bullied at School, 9 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 9, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Bullied at School, 11 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 11, and nontraditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Cancer Deaths	Cancers	This indicator reports the age-adjusted rate of death due to malignant neoplasm (cancer) per 100,000 population per year. This indicator is relevant as a measure of the burden of cancer, a leading cause of death in the U.S.	National Vital Statistics System	2011–2015
Cervical Cancer Incidence (HAC.org)	Cancers	This indicator shows the age-adjusted incidence rate for cervical cancer in cases per 100,000 females.	National Cancer Institute	2011–2015
Child Mortality (CHR)	Maternal/Infant Health	Number of deaths among children under age 18 per 100,000.	CDC WONDER mortality data	2013–2016

Indicator	Health Needs	Description	Source	Year(s)
Childhood Asthma ED Visits (COEI)	Asthma	Age-adjusted rate of asthma-related emergency department visits per 100,000 children under 5 years of age.	City of Oakland Equity Indicators (COEI) 2018 Report	2013–2015
Childhood Cancer Diagnoses (Kidsdata.org)	Cancers	Number of new cancer diagnoses per 100,000 children/youth ages 0–19 over a five-year period, by race/ethnicity and age group.	National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program, Research data, 1973–2013 (Nov. 2015)	2009–2013
Children Below 100% FPL	Economic Security; Overall Health	This indicator reports the percentage of children aged 0 to 17 years that live in households with incomes below the Federal Poverty Level (FPL). This indicator is relevant as a measure for the concentration of poverty, and because it highlights a group requiring special consideration, targeted services and outreach by providers.	American Community Survey	2012–2016
Children in Foster Care (Kidsdata.org)	Mental Health	Number of children and youth under age 21 in foster care per 1,000 on July 1 of each year	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016); Annie E. Casey Foundation, KIDS COUNT Data Center (Jul. 2016).	2015
Children in Linguistically Isolated Households (Kidsdata.org)	Economic Security	Estimated percentage of children ages 0–17 living in households in which (1) no person age 14 or older speaks English only, and (2) no person age 14 or older who speaks a language other than English speaks English very well	Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Dec. 2017).	2016

Indicator	Health Needs	Description	Source	Year(s)
Children in Single-Parent Households	Economic Security	This indicator reports the percentage of children that live in households with only one parent present. This indicator is relevant because children from single-parent households are at increased risk for presenting emotional and behavioral problems, developing depression, using tobacco, alcohol and other substances, and for all-cause morbidity and mortality.	American Community Survey	2012–2016
Children Living in Crowded Households (Kidsdata.org)	Economic Security	Estimated percentage of children under age 18 living in households with more than one person per room of the house. “Rooms” include living rooms, dining rooms, kitchens, bedrooms, finished recreation rooms, enclosed porches, and lodger’s rooms.	Population Reference Bureau, analysis of data from the U.S. Census Bureau’s American Community Survey microdata files (Nov. 2015).	2014
Children Needing and Receiving Behavioral Health Care Services (Kidsdata.org)	Mental Health	Percentage of children ages 2–17 who need mental health treatment or counseling and who have received mental health services in the past 12 months.	Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health, <i>Advancing data-in-action partnerships for children and children with special health care needs in California counties and cities using synthetic estimation from the 2011/12 National Survey of Children’s Health and 2008–2012 American Community Survey</i> (Nov. 2016).	2011–2012

Indicator	Health Needs	Description	Source	Year(s)
Children Walking or Biking to School, CA	Obesity/HEAL/Diabetes	This indicator reports the percentage of children walk, bike or skate to school at least occasionally, according to their parent/guardian. This indicator is relevant as a measure of quality of the physical/built environment and active transportation systems, and because active commuting to school promotes regular physical activity; regular physical activity in children can help improve fitness, build strong bones and muscles, control weight, reduce depression and anxiety, and reduce risk for chronic disease.	California Health Interview Survey	2015–2016
Children with Health Insurance (HAC.org)	Healthcare Access and Delivery	This indicator shows the percentage of children ages 0–17 that have any type of health insurance coverage	American Community Survey	2016
Children with Influenza Vaccination (HAC.org)	Communicable Diseases (Not STIs)	This indicator shows the percentage of children ages 6 months to 11 years who received an influenza vaccination in the past year.	California Health Interview Survey	2013–2014
Children with Two or More Adverse Experiences (Parent Reported) (Kidsdata.org)	Mental Health	Estimated percentage of children ages 0–17 who have experienced two or more adverse experiences.	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the American Community Survey (Mar. 2018).	2016
Children Without Secure Parental Employment (Kidsdata.org)	Economic Security	Estimated percentage of children under age 18 living in families where no resident parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey	Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Nov. 2015).	2014
Chlamydia Incidence (SAE)	Sexually Transmitted Infections	This indicator reports incidence rate of chlamydia cases per 100,000 population per year. This indicator is relevant because it is a measure of the burden of chlamydia, a common sexually transmitted infection for which effective interventions for prevention and treatment exist.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2016

Indicator	Health Needs	Description	Source	Year(s)
Chlamydia Incidence Among Youth Ages 10–19 (Kidsdata.org)	Sexually Transmitted Infections	Number of chlamydia infections per 100,000 youth ages 10–19	California Department of Public Health, Sexually Transmitted Diseases Data; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2010, 2010–2060; Centers for Disease Control and Prevention, Sexually Transmitted Diseases Data and Statistics; U.S. Census Bureau, Population Estimates Program, Estimates of the Resident Population by Sex and Age for the United States, 2000–2010, 2010–2015 (Sept. 2016)	2015
Chronic Kidney Disease Among Medicare Beneficiaries (HAC.org)	Overall Health	This indicator shows the percentage of Medicare beneficiaries who were treated for chronic kidney disease.	Centers for Medicare and Medicaid Services	2015
Chronic Liver Disease/Cirrhosis Deaths (CDPH)	Substance Use/Tobacco	Chronic liver disease and cirrhosis age-adjusted death rate per 100,000 population	California Department of Public Health: 2011–2016 Death Records.	2011–2016
Chronic Preventable Hospitalizations (HAC.org)	Healthcare Access and Delivery	This indicator shows the number of preventable hospitalizations for chronic diseases per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2009–2011
Civic Engagement-Voter Turnout (registered voters not voting) (COEI)	Overall Health	Voter turnout is measured by the percentage of registered voters that voted in the general election. This indicator measures geographic disparities by City Council District.	COEI: Alameda County Registrar of Voters	2016

Indicator	Health Needs	Description	Source	Year(s)
Climate-Related Mortality Impacts	Climate and Health	This indicator reports the median estimated economic impacts from changes in all-cause mortality rates, across all age groups, as a percentage of county GDP. This indicator is relevant because climate-change is a significant threat to public health for which interventions may exist to prevent or mitigate climate-related health impacts.	Climate Impact Lab	2016
Colon and Rectum Cancer Incidence (SAE)	Cancers	This indicator reports the age-adjusted incidence rate of colon and rectum cancer cases per 100,000 population per year. This indicator is relevant because it is a measure of the burden of colon and rectum cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat colorectal cancers.	State Cancer Profiles	2010–2014
Colon Cancer Screening (HAC.org)	Cancers; Healthcare Access and Delivery	This indicator shows the percentage of adults aged 50 and over who are compliant with recommended screening practices for colorectal cancer.	California Health Interview Survey	2009
Colorectal Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 population due to colorectal cancer.	California Department of Public Health	2014–2016
Community Stressors-Domestic Violence (COEI)	Mental Health	This indicator measures the rate of domestic violence victimization in Oakland by race/ethnicity. Rate is calculated as the number of domestic violence incidents per 100,000 people of the same race/ethnicity (of any age).	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates.	2017 + 2016
Community Stressors-Homicide (COEI)	Mental Health	This indicator measures the number of homicides in Oakland by race/ethnicity. Rate is calculated as the number of homicides per 100,000 people of the same race/ethnicity (of any age).	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates.	2017 + 2016
Condition of Teeth (Adults): Less Than Good (AskCHIS)	Oral Health	Percentage of adults with fair or poor teeth condition	California Health Interview Survey	2016

Indicator	Health Needs	Description	Source	Year(s)
Congestive Heart Failure Hospitalizations (HAC.org)	CVD/Stroke	This indicator shows the number of congestive heart failure hospitalizations per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
Cost-Burdened Households	Economic Security	This indicator reports the percentage of households for which housing costs exceed 30% of total household income. This indicator is relevant because it offers a measure of housing affordability; affordable housing helps ensure individuals can financially meet their basic needs for health care, child care, food, transportation and other costs.	American Community Survey	2012–2016
Cost of Infant Childcare, Annually, Child Care Center (Kidsdata.org)	Economic Security	Average annual cost of licensed childcare, by facility type and age group of children	California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015); cost data are from the Child Care Regional Market Rate Survey, 2014.	2014
Cost of Preschool Childcare, Annually, Child Care Center (Kidsdata.org)	Economic Security	Average annual cost of licensed childcare, by facility type and age group of children	California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2015); cost data are from the Child Care Regional Market Rate Survey, 2014.	2014
Current Smokers, CA	Cancers; CVD/Stroke; Obesity/HEAL/Diabetes; Oral Health; Substance Use/Tobacco	This indicator reports the percentage of adults aged 18 years and older that self-report smoking cigarettes some days, most days or every day, or that self-reporting having smoked at least 100 cigarettes in their lifetime. This indicator is relevant because current behaviors are determinants of future health; the leading cause of preventable death in the U.S., tobacco use can cause long-term health impacts, including cardiovascular diseases, respiratory diseases, and cancers.	California Health Interview Survey	2014

Indicator	Health Needs	Description	Source	Year(s)
Cyberbullied More Than Once, 7 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 7, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Cyberbullied More Than Once, 9 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 9, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Cyberbullied More Than Once, 11 th Graders (CHKS)	Community and Family Safety; Mental Health	Percentage of public school students in grade 11, and nontraditional students reporting the number of times in the past 12 months other students spread mean rumors or lies about them on the internet.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Deaths by Suicide, Drug or Alcohol Poisoning	Mental Health; Substance Use/Tobacco	This indicator reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses per 100,000 population. This indicator is relevant because high rates of death of despair may signal broader issues in the community related to mental health, and substance use.	National Vital Statistics System	2011–2015
Delayed/Didn't Get Care (AskCHIS)	Healthcare Access and Delivery	Percentage of adults reporting they had delayed or did not get medical care	California Health Interview Survey	2016
Delayed/Had Difficulty Obtaining "Other Medical" Care (HAC.org)	Healthcare Access and Delivery	This indicator shows the percentage of people who report having delayed or not received other medical care they felt they needed.	California Health Interview Survey	2015–2016
Lack Dental Insurance Coverage, CA	Oral Health	This indicator reports the percentage of adults aged 18 and older who self-report that they do not have dental insurance (at the time of the interview). This indicator is relevant because having insurance enables access to dental care, a prerequisite for good oral health and overall health.	California Health Interview Survey	2015–2016

Indicator	Health Needs	Description	Source	Year(s)
Dentists	Healthcare Access and Delivery; Oral Health	This indicator reports the number of licensed dentists (including DDSs and DMDs) per 100,000 population. This indicator is relevant because an inadequate supply of dentists may limit access to dental care, a prerequisite for good oral health and overall health.	Area Health Resource File	2015
Depression Among Medicare Beneficiaries	Mental Health	This indicator reports the percentage of the Medicare fee-for-service population with depression. This indicator is relevant as a measure of the burden of depression, a leading cause of disability in the U.S.; depression both influences and is influenced by physical health, affecting individuals' participation in health-promoting behaviors and presenting with multiple chronic comorbidities.	Centers for Medicare and Medicaid Services	2015
Depression-Related Feelings, 7 th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 7, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Depression-Related Feelings, 9 th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 9, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Depression-Related Feelings, 11 th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 11, and nontraditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Diabetes Deaths (HAC.org)	Obesity/HEAL/Diabetes	This indicator shows the age-adjusted death rate per 100,000 population due to diabetes.	California Department of Public Health	2014–2016
Diabetes Hospitalizations (HAC.org)	Obesity/HEAL/Diabetes	This indicator shows the age-adjusted Diabetes hospitalization visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014

Indicator	Health Needs	Description	Source	Year(s)
Diabetes Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Obesity/HEAL/Diabetes	Number hospital discharges among children ages 0–17 for diabetes, as a percentage of all child discharges, excluding newborns.	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015
Diabetes Management (Hemoglobin A1c Test) (SAE)	CVD/Stroke; Healthcare Access and Delivery; Obesity/HEAL/Diabetes	This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test of blood sugar levels administered by a health care professional in the past year. This indicator is relevant because blood sugar monitoring enables disease management and treatment of diabetes complications; low levels of testing may suggest a lack of access to preventive care, lack of health knowledge, insufficient provider outreach, and existence of other barriers to utilization of services.	Dartmouth Atlas of Health Care	2015
Diabetes Prevalence	Obesity/HEAL/Diabetes	This indicator reports the percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes.	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	2013
Did Not Eat Breakfast, 7 th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in grade 7, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Did Not Eat Breakfast, 9 th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in grade 9, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Did Not Eat Breakfast, 11 th Graders (CHKS)	Economic Security; Obesity/HEAL/Diabetes	Percentage of students in grade 11, and nontraditional students in public schools reporting whether they ate breakfast on the day of the survey.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Domestic Violence Calls for Assistance (KidsData.org)	Community and Family Safety	Number of domestic violence calls for assistance per 1,000 adults ages 18–69.	California Department of Justice, Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance Database (1998–2003) and Online Query System (Aug. 2015)	2014
Domestic Violence Hospitalizations, CA	Community and Family Safety	This indicator reports the rate of nonfatal emergency department visits for domestic violence incidents among females aged 10 years and older per 100,000 population. This indicator is relevant as a proxy measure of intimate partner and domestic violence, and may signal broader issues in the community, such as economic insecurity and substance misuse.	EPICENTER California EpiCenter	2013–2014
Drinking Water Violations	Climate and Health	This indicator reports the presence or absence of health-based violations in community water systems over a specified time frame. This indicator is relevant as a measure of drinking water safety, a prerequisite for good health.	Safe Drinking Water Information System	2015
Driving Alone to Work	Climate and Health; Obesity/HEAL/Diabetes	This indicator reports the percentage of the civilian non-institutionalized population ages 16 years and older that commute alone to work by motor vehicle. This indicator is relevant as a measure of quality of the physical/built environment, and public transportation and active transportation systems.	American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Driving Alone to Work, Long Distances	Climate and Health; Obesity/HEAL/Diabetes	This indicator reports the percentage of the civilian non-institutionalized population with long commutes to work, over 60 minutes each direction. This indicator is relevant as a measure of quality of the physical/built environment, regional employment trends, and public transportation and active transportation systems.	American Community Survey	2012–2016
Drought Severity	Climate and Health	This indicator reports the population-weighted percentage of weeks in drought from January 1, 2012–December 31, 2014. This indicator is relevant because it highlights communities vulnerable to the effects of drought, and associated health impacts.	U.S. Drought Monitor	2012–2014
Early Prenatal Care (HAC.org)	Maternal/Infant Health	This indicator shows the percentage of births to mothers who began prenatal care in the first trimester of their pregnancy.	California Department of Public Health	2014–2016
Elevated Blood Lead Levels in Children Ages 0–5 (Kidsdata.org)	Community and Family Safety	Percentage of children/youth ages 0–5 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group	California Department of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017).	2013
Elevated Blood Lead Levels in Children/Youth Ages 6–20 (Kidsdata.org)	Community and Family Safety	Percentage of children/youth ages 6–20 with blood lead levels at or above 9.5 micrograms per deciliter, among those screened, by age group.	California Department of Public Health, Childhood Lead Poisoning Prevention Branch (Aug. 2017).	2013
Environmental Health-Abandoned Trash (COEI)	Climate and Health	This indicator measures the number of service requests received by the Oakland Call Center for illegal dumping as a rate per 1,000 population in each census tract. The census tracts are grouped based on majority race/ethnicity. Service requests that were canceled were excluded from the analysis.	COEI: Oakland Call Center, 2017; U.S. Census Bureau, American Community Survey, 2012–2016.	2017 + 2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Environmental Health-Park Quality (COEI)	Climate and Health	Measures overall ratings for Oakland parks and compares average scores by City Council district. The overall ratings were based on an annual survey that assigned parks letter grades (A through F), which corresponded to scores (A=4, B=3, C=2, D=1, and F=0). In addition to Council District scores, the scores for parks surrounding Lake Merritt were reported as an average Lakeside score.	COEI: 2016 Community Report Card on the State of Maintenance in Oakland Parks, Oakland Parks and Recreation Foundation.	2016
Environmental Health–Pollution Burden (COEI)	Asthma; Climate and Health	Measure of pollution burden as a combined score that includes indicators of potential exposures to pollutants and environmental conditions (e.g., ozone, pesticides, toxic releases, traffic, hazardous waste). The pollution burden scores are averaged by majority race/ethnicity of Oakland census tracts.	COEI: Office of Environmental Health Hazard Assessment, CalEnviroScreen 3.0 Maps (2017); U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016.	2017 + 2012– 2016
Excessive Drinking, CA	Cancers; Community and Family Safety; CVD/Stroke; Substance Use/Tobacco	This indicator reports the percentage of adults aged 18 years and older that self-report heavy alcohol consumption. This indicator is relevant as a proxy measure of alcohol use; a leading cause of preventable death in the U.S., excessive alcohol use can cause short- and long-term health impacts, including injuries, violence, risky sexual behavior, pregnancy complications and fetal alcohol spectrum disorders, certain cancers, heart and liver disease, and mental health, substance dependency and social problems.	California Health Interview Survey	2015– 2016
Exercise Opportunities	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of the population that live in close proximity to a park or recreational facility. This indicator is relevant because good access to parks and recreational facilities promotes physical activity and is associated long-term physical and mental health benefits.	County Health Rankings	2010; 2014

Indicator	Health Needs	Description	Source	Year(s)
Expulsions, CA	Community and Family Safety; Economic Security	This indicator reports the rate of expulsions per 100 enrolled students. This indicator is relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcome, including experiences of stress and trauma.	California Department of Education	2016–2017
Fast Food Consumption (HAC.org)	Obesity/HEAL/Diabetes	This indicator shows the percentage of adults who consumed fast food at least one time in the last week.	California Health Interview Survey	2016
Fear Being Beaten Up at School, 7 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 7, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Fear Being Beaten Up at School, 9 th Graders (AC, CCC) (CHKS)	Community and Family Safety	Percentage of public school students in grade 9, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Fear Being Beaten Up at School, 11 th Graders (AC, CCC) (CHKS)	Community and Family Safety	Percentage of public school students in grade 11, and nontraditional students reporting the number of times in the past 12 months they have been afraid of being beaten up at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Federally Qualified Health Centers	Healthcare Access and Delivery	This indicator reports the rate of Federally Qualified Health Centers (FQHCs) per 100,000 total population within the service area. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations, and receive federal funding to promote access to ambulatory care in medically underserved areas.	Provider of Services File	2016

Indicator	Health Needs	Description	Source	Year(s)
Female Received Birth Control Information from Doctor (AskCHIS)	Maternal/Infant Health	Percentage of females who received birth control information from her doctor	California Health Interview Survey	2016
Firearm Fatalities (CHR)	Community and Family Safety	Number of deaths due to firearms per 100,000 population.	CDC WONDER mortality data	2012–2016
Flood Vulnerability	Climate and Health	This indicator reports the estimated percentage of housing units within the special flood hazard area (SFHA) per county. This indicator is relevant because it highlights communities vulnerable to flooding and associated health impacts.	National Flood Hazard Layer	2011
Food Environment Index	Obesity/HEAL/Diabetes	This indicator reports the food environment index score, a measure of affordable, close, and nutritious food retailers in a community, for which scores range between 0 (poorest food environment) and 10 (optimum food environment). This indicator is relevant because it highlights communities with lower access to healthy foods; good access to healthy food retailers promotes healthier eating behaviors and associated health benefits, including lower risk for obesity and related chronic diseases.	Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America)	2014
Food Insecure Children Ineligible for Assistance (HAC.org)	Economic Security; Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of food insecure children in households with incomes above 185% of the federal poverty level who are likely not income-eligible for federal nutrition assistance.	Feeding America	2016
Food Insecurity	Economic Security; Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the report year.	Feeding America	2014
Food Insecurity, Child (HAC.org)	Economic Security; Maternal/Infant Health; Obesity/HEAL/Diabetes	This indicator shows the percentage of children (under 18 years of age) living in households that experienced food insecurity at some point during the year.	Feeding America	2016

Indicator	Health Needs	Description	Source	Year(s)
Free and Reduced Price Lunch	Economic Security; Obesity/HEAL/Diabetes	This indicator reports the percentage of public school students eligible for free or reduced price lunches. This indicator is relevant because it provides a proxy measure for the concentration of low-income students within a school.	CCD NCES – Common Core of Data	2015– 2016
Frequent Mental Distress (HAC.org)	Mental Health	This indicator shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was not good for 14 or more of the past 30 days.	County Health Rankings	2016
Frequent Physical Distress (HAC.org)	Overall Health	This indicator shows the percentage of adults who stated that their physical health, which includes physical illness and injury, was not good for 14 or more of the past 30 days.	County Health Rankings	2016
Gang Membership, 7 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 7, and nontraditional students reporting whether they currently consider themselves a member of a gang.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011– 2013
Gang Membership, 9 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 9, and nontraditional students reporting whether they currently consider themselves a member of a gang.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011– 2013
Gang Membership, 11 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 11, and nontraditional students reporting whether they currently consider themselves a member of a gang.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011– 2013
General Health (Self-Report): Good or Better (HAC.org)	Overall Health	This indicator shows the percentage of adults, teens, and children who answered good, very good, or excellent to: "How is your general health?"	California Health Interview Survey	2015
Gonorrhea Incidence (HAC.org)	Sexually Transmitted Infections	This indicator shows the gonorrhea incidence rate in cases per 100,000 population.	California Department of Public Health, STD Control Branch	2017

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

Indicator	Health Needs	Description	Source	Year(s)
Have Usual Source of Healthcare (HAC.org)	Healthcare Access and Delivery	This indicator shows the percentage of people that report having a usual place to go to when sick or when health advice is needed.	California Health Interview Survey	2015–2016
Health Professional Shortage Area – Dental	Oral Health	This indicator reports the percentage of the population that lives in a designated Health Professional Shortage Area, defined as having a shortage of dental health professionals. This indicator is relevant because an inadequate supply of dental health professionals may limit access to dental care, a prerequisite for good oral health and overall health.	Health Resources and Services Administration	2016
Healthy Food Stores (Low Access)	Economic Security; Obesity/HEAL/Diabetes	This indicator reports the percentage of the population that do not live in close proximity to a large grocery store or supermarket. This indicator is relevant because it highlights communities with lower access to healthy foods; good access to healthy food retailers promotes healthier eating behaviors and associated health benefits, including lower risk for obesity and related chronic diseases.	USDA – Food Access Research Atlas	2014
Heart Disease Deaths	CVD/Stroke; Obesity/HEAL/Diabetes; Substance Use/Tobacco	This indicator reports the age-adjusted rate of death due to coronary heart disease per 100,000 population. This indicator is relevant because it is a measure of the burden of heart disease, the leading cause of death in the U.S.	National Vital Statistics System	2011–2015
Heart Disease Hospitalizations	CVD/Stroke; Obesity/HEAL/Diabetes; Substance Use/Tobacco	This indicator reports the hospitalization rate for coronary heart disease among Medicare beneficiaries aged 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population. This indicator is relevant because it is a measure of the burden of heart disease, the leading cause of death in the U.S.	Interactive Atlas of Heart Disease and Stroke	2012–2014
Heart Disease Prevalence (Medicare Population)	CVD/Stroke; Obesity/HEAL/Diabetes; Substance Use/Tobacco	This indicator reports the percentage of the Medicare-fee-for-service population that self-report having been diagnosed with heart disease by a doctor.	Centers for Medicare and Medicaid Services	2015

Indicator	Health Needs	Description	Source	Year(s)
Heat Index	Climate and Health	This indicator reports the percentage of days per year with recorded heat index values (a measure of temperature and humidity) of over 100 degrees Fahrenheit. This indicator is relevant because it is a measure of exposure to extreme heat events which can trigger heat stress conditions and respiratory symptoms, increase death rates, and increase the risk of foodborne illness.	North America Land Data Assimilation System (NLDAS)	2013, 2012, 2011, 2010, 2009, 2008, 2007, 2006
High Blood Pressure Prevalence (HAC.org)	CVD/Stroke	This indicator shows the percentage of adults who have been told they have high blood pressure. Normal blood pressure should be less than 120/80 mm Hg for an adult. Blood pressure above this level (140/90 mm Hg or higher) is considered high (hypertension).	California Health Interview Survey	2016
High School Dropout (Adjusted) (Kidsdata.org)	Economic Security	Percentage of public high school students who do not complete high school, based on the four-year adjusted cohort dropout rate.	California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS) (May 2016).	2015
High School Graduates Completing College Prep Courses (Kidsdata.org)	Economic Security	Percentage of public school 12th grade graduates completing courses required for University of California (UC) and/or California State University (CSU) entrance, with a grade of "C" or better (e.g., in 2015, 43.4% of 12th grade graduates in California completed courses required for UC and/or CSU entrance).	California Department of Education, California Basic Educational Data System (CBEDS) (Jun. 2016).	2015
High-Speed Internet	Economic Security	This indicator reports the percentage of population with access to high-speed internet. This indicator is relevant because internet access opens up opportunities for employment and education.	FCC Fixed Broadband Deployment Data	2016
HIV Incidence (HAC.org)	Sexually Transmitted Infections	This indicator shows the HIV incidence rate in cases per 100,000 population.	California Department of Public Health	2015

Indicator	Health Needs	Description	Source	Year(s)
HIV/AIDS Deaths	Sexually Transmitted Infections	This indicator reports the rate of death due to HIV and AIDS per 100,000 population. This indicator is relevant because it is a measure of the burden of HIV/AIDS, and may suggest the existence of barriers to accessing care.	National Vital Statistics System	2008–2014
HIV/AIDS Incidence (CCC) (CDPH)	Sexually Transmitted Infections	This indicator shows the HIV incidence rate in individuals age 13 and over per 100,000 population.	California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section reporting periods are: Current Period 2013–2015, Previous Period 2010–2012	2013–2015
HIV/AIDS Prevalence	Sexually Transmitted Infections	This indicator reports prevalence of HIV infection per 100,000 population. This indicator is relevant because it is a measure of the burden of HIV/AIDS, a life-threatening chronic disease for which effective interventions for treatment and prevention exist.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013
Home Ownership (AskCHIS)	Economic Security	Percentage of adults who own their home	California Health Interview Survey	2016
Homeless Children Ages 0–17 Who Are Unsheltered (Kidsdata.org)	Economic Security	Number of unaccompanied children found to be homeless during the national point-in-time (PIT) count of homeless individuals, by age group and shelter status (e.g., 1,451 California children ages 0–17 were found to be homeless and unsheltered during the 2017 PIT count).	U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S 2014 and 2017 (Mar. 2018)	2017

Indicator	Health Needs	Description	Source	Year(s)
Homeless Individuals Who Are Unsheltered (AC, CCC, CA) (PIT; HUD)	Economic Security	The percentage of homeless individuals living in encampments, cars, parks, or abandoned buildings.	Applied Survey Research. (2017). Alameda County Homeless Census and Survey. Watsonville, CA; Contra Costa Council on Homelessness. (2017); 2017 Point in Time Count: A Snapshot of Contra Costa County; U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S	2017
Homeless Public School Students (Kidsdata.org)	Economic Security	Percentage of public school students recorded as being homeless at any point during a school year (e.g., 4.4% of California students were recorded as being homeless at some point during the 2016 school year).	California Department of Education, Coordinated School Health and Safety Office custom tabulation and California Basic Educational Data System (May 2017)	2016
Homeless Young Adults Ages 18–24 Who Are Unsheltered (Kidsdata.org)	Economic Security	Number of unaccompanied young adults found to be homeless during the national point-in-time (PIT) count of homeless individuals, by age group and shelter status (e.g., 1,451 California children ages 0–17 were found to be homeless and unsheltered during the 2017 PIT count).	U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S 2014 and 2017 (Mar. 2018)	2017
Homicide (CHR)	Community and Family Safety	Number of deaths due to homicide per 100,000 population.	CDC WONDER mortality data	2010–2016
Housing Burden – Rents (HAC.org)	Economic Security	This indicator shows the percentage of renters who are spending 30% or more of their household income on rent.	American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Housing Problems	Economic Security	This indicator reports the percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Housing unit is severely overcrowded (>1 person per room); or Household is severely cost burdened (all housing costs represent over >30% of monthly income). This indicator is relevant because it highlights communities wherein housing or quality of life is considered substandard.	American Community Survey	2012–2016
Hyperlipidemia Among Medicare Beneficiaries (HAC.org)	CVD/Stroke	This indicator shows the percentage of Medicare beneficiaries who were treated for hyperlipidemia.	Centers for Medicare and Medicaid Services	2015
Hypertension Among Medicare Beneficiaries (HAC.org)	CVD/Stroke	This indicator shows the percentage of Medicare beneficiaries who were treated for hypertension.	Centers for Medicare and Medicaid Services	2015
Hypertension Hospitalizations (HAC.org)	CVD/Stroke	This shows the hypertension hospitalization visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
Impaired Driving Deaths	Community and Family Safety; Substance Use/Tobacco	This indicator reports the percentage of motor vehicle crash deaths in which alcohol played a role. This indicator is relevant because alcohol is a leading cause of preventable death in the U.S., and impaired driving is the leading cause of alcohol-related deaths.	Fatality Analysis Reporting System	2011–2015
Income Inequality - 80/20 Ratio	Economic Security	This indicator reports the ratio of household income at the 80th percentile to household income at the 20th percentile. This indicator is relevant because it highlights communities with greater disparities between low- and high-income households; income inequality is a strong predictor of health status, health disparities, and social and environmental vulnerabilities.	American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Individuals Experiencing Homelessness (AC, CCC) (PIT)	Economic Security	The number of homeless individuals counted during the county's point-in-time count. The Point in Time Count includes only those that fit the HUD definition of homelessness: 1) an individual or family living in a supervised publicly or privately operated shelter; designated to provide temporary living arrangement (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals), or 2) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camp ground.	Applied Survey Research. (2017). Alameda County Homeless Census and Survey. Watsonville, CA; Contra Costa Council on Homelessness. (2017). 2017 Point in Time Count: A Snapshot of Contra Costa County.	2017
Infant Deaths	Maternal/Infant Health	This indicator reports the rate of death among infants less than 1 year of age per 1,000 births. This indicator is relevant because infant mortality is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	Area Health Resource File	2006–2010
Influenza and Pneumonia Deaths (HAC.org)	Communicable Diseases (Not STIs)	This indicator shows the age-adjusted death rate per 100,000 population due to influenza and pneumonia.	California Department of Public Health	2014–2016
Influenza Vaccination (All Ages) (AskCHIS)	Communicable Diseases (Not STIs)	Percentage of the population who has had the flu vaccine in the last 12 months	California Health Interview Survey	2016
Injury Deaths	Community and Family Safety	This indicator reports the number of deaths from intentional and unintentional injuries per 100,000 population. This indicator is relevant because death from injury is a leading cause of death in the U.S., and the leading cause of death among those ages 1 to 44 years; high injury mortality may signal broader issues in the community.	National Vital Statistics System	2011–2015

Indicator	Health Needs	Description	Source	Year(s)
Insufficient Sleep (HAC.org)	Overall Health	This indicator shows the percentage of adults who report fewer than 7 hours of sleep on average.	County Health Rankings	2016
Insufficient Social and Emotional Support	Mental Health	This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health and Human Services, Health Indicators Warehouse	2006–2012
Jail Admissions (Vera)	Community and Family Safety	Rate of annual admissions per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates . Accessed 17 August 2018	2015
Jail Incarceration (Vera)	Community and Family Safety	Rate of jail incarceration per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates . Accessed 17 August 2018	2015
Juvenile Felony Arrests (AC, CCC) (Kidsdata.org)	Community and Family Safety; Economic Security	Number of juvenile felony arrests per 1,000 youth ages 10–17	California Department of Justice, Arrest Data; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990–1999, 2000–2010, 2010–2060 (Oct. 2016)	2015
Kindergarteners with Required Immunizations (Kidsdata.org)	Communicable Diseases (Not STIs)	Percentage of children in kindergarten with all required immunizations.	California Department of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb. 2016)	2016

Indicator	Health Needs	Description	Source	Year(s)
Law Enforcement-Use of Force (per 100,000 people) (COEI)	Crime/Intentional Injury	This indicator measures the rate of use of force on subjects per 100,000 people in Oakland by race/ethnicity.	COEI: Oakland Police Department; U.S. Census Bureau, American Community Survey, 1-year Estimates, 2016	2017 + 2016
Life Expectancy at Birth	Maternal/Infant Health; Overall Health	This indicator reports the average life expectancy at birth in years. This indicator is relevant as a measure of overall mortality across a population.	IHME_LE Institute for Health Metrics and Evaluation	2014
Low Birth Weight	Maternal/Infant Health; Substance Use/Tobacco	This indicator reports the percentage of total births that are low birthweight (under 2500 grams). This indicator is relevant because low birthweight is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	National Vital Statistics System	2008–2014
Lung Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 population due to lung cancer.	California Department of Public Health	2014–2016
Lung Cancer Incidence	Cancers; Substance Use/Tobacco	This indicator reports the age-adjusted incidence rate of lung cancer per 100,000 population. This indicator is relevant because it is a measure of the burden of lung cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat lung cancer which is the leading cause of cancer deaths.	State Cancer Profiles	2010–2014
Meaningful Participation at School: Low, 7 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 7, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Meaningful Participation at School: Low, 9 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 9, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school..	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
Meaningful Participation at School: Low, 11 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 11, and nontraditional students reporting low level of agreement that they have opportunities for meaningful participation at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
Median Income	Economic Security	This indicator reports median inflation-adjusted household income. Median Household Income is the income where half of households in a county earn more and half of households earn less	U.S. Census Bureau, American Community Survey.	2012–2016
Median Rent	Housing and Homelessness	This indicator reports median rent for a two-bedroom unit in October 2018.	Zilpy.com	2018
Medicaid/Public Insurance Enrollment	Economic Security; Healthcare Access and Delivery	This indicator reports the percentage of the population that is enrolled in Medicaid or another public health insurance program. This indicator is relevant because Medicaid provides insurance coverage for groups with special health needs, including low-income children, adults and people with disabilities; when combined with poverty data, this indicator may help identify gaps in coverage and barriers access.	American Community Survey	2012–2016
Medicare Healthcare Costs, Dollars per Capita (HAC.org)	Healthcare Access and Delivery	This indicator shows the dollar amount of price-adjusted Medicare reimbursements per enrollee and includes Medicare Parts A and B.	County Health Rankings	2015
Mental Health Hospitalization, Children Ages 5–14 (Kidsdata.org)	Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5–14, by age group.	California Office of Statewide Health Planning and Development special tabulation; California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009; Population Reference Bureau, Population Estimates 2010–2016 (Aug. 2017)	2016

Indicator	Health Needs	Description	Source	Year(s)
Mental Health Hospitalization, Youth Ages 15–19 (Kidsdata.org)	Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth ages 15–19, by age group	California Office of Statewide Health Planning and Development special tabulation; California Department of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000–2009; Population Reference Bureau, Population Estimates 2010–2016 (Aug. 2017)	2016
Mental Health Providers	Healthcare Access and Delivery	This indicator reports the number of mental health care providers (including psychiatrists, psychologists, clinical social workers, and counsellors) per 100,000 population. This indicator is relevant because an inadequate supply of providers may limit access to mental health care.	Area Health Resource File	2016
Motor Vehicle Crash Deaths	Community and Family Safety	This indicator reports the age-adjusted rate of death due to motor vehicle crashes per 100,000 population. This indicator is relevant because motor vehicle crashes are a leading cause of death in the U.S., and the leading cause of death among teens, despite being preventable.	National Vital Statistics System	2011–2015
Motor Vehicle Crash ER Visits (HAC.org)	Community and Family Safety	This indicator shows the number of motor vehicle crash emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHDP)	2012–2014
Non-Physician PCPs (HAC.org)	Healthcare Access and Delivery	This indicator shows the non-physician primary care provider rate per 100,000 population. Primary care providers who are not physicians include nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists.	County Health Rankings	2017
Obesity (Adult), CA	Asthma; Cancers; CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of adults aged 18 years and older that self-report having a Body Mass Index (BMI) greater than 30.0 (the threshold for obesity).	California Health Interview Survey	2014

Indicator	Health Needs	Description	Source	Year(s)
Obesity (Youth), CA	Asthma; CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category for body composition on the Fitnessgram physical fitness test. This indicator is relevant because it is a proxy measure of the burden of obesity among children; childhood obesity is linked with short- and long-term implications for health, including social and mental health impacts, diabetes, and heart disease.	Fitnessgram Physical Fitness Testing	2016– 2017
Obesity Hospitalizations (HAC.org)	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator shows the age-adjusted obesity-related hospitalization rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHDP)	2012– 2014
Older Adults Below 100% FPL (HAC.org)	Economic Security	This indicator shows the percentage of people aged 65 years and over living below the federal poverty level.	American Community Survey	2012– 2016
Older Adults Living Alone (HAC.org)	Mental Health	This indicator shows the percentage of people aged 65 years and over who live alone.	American Community Survey	2012– 2016
On-Time High School Graduation, CA	Economic Security	This indicator reports the on-time high school graduation rate per cohort. This indicator is relevant as a measure of educational attainment, an important determinant of health and opportunity across the lifespan.	California Department of Education	2014– 2015
Opioid Prescription Drug Claims	Substance Use/Tobacco	This indicator reports the number of Medicare Part D prescription claims for opiates as a percentage of total Medicare Part D prescription drug claims. This indicator is relevant as a proxy measure of opiate prescription drug use.	Centers for Medicare and Medicaid Services	2015
Opportunity Index	Economic Security	This indicator reports the opportunity index score, a measure of community well-being, for which scores range between 0 (indicating no opportunity) and 100 (indicating maximum opportunity). This indicator is relevant as a measure of economic, education, health and community factors that affect opportunity and well-being.	Opportunity Nation	2017

Indicator	Health Needs	Description	Source	Year(s)
Oral Cancer Incidence (HAC.org)	Cancers	This indicator shows the age-adjusted incidence rate for oral cavity and pharynx cancer in cases per 100,000 population.	National Cancer Institute	2011–2015
Osteoporosis Among Medicare Beneficiaries (HAC.org)	Overall Health	This indicator shows the percentage of Medicare beneficiaries who were treated for osteoporosis.	Centers for Medicare and Medicaid Services	2015
Ozone Levels	Asthma; Climate and Health	This indicator reports the percentage of days per year with Ozone (O ₃) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb). This indicator is relevant because it is a measure of exposure to O ₃ which can cause and exacerbate respiratory health issues, including onset of respiratory symptoms, decreased lung function, and aggravated asthma and lung diseases.	National Environmental Public Health Tracking Network	2014, 2013, 2012, 2011, 2010, 2009, 2008
Particulate Matter 2.5 Levels	Asthma; Cancers; Climate and Health	This indicator reports the percentage of days per year with fine particulate matter 2.5 (PM _{2.5}) levels above the National Ambient Air Quality Standard of 35 micrograms per cubic meter. This indicator is relevant because it is a measure of exposure to PM _{2.5} which is linked with respiratory and cardiovascular health issues, including onset of respiratory symptoms, decreased lung function, and aggravated asthma, and heart and lung diseases.	National Environmental Public Health Tracking Network	2014, 2013, 2012, 2011, 2010, 2009, 2008
Passed High School Exit Exam, English (HAC.org)	Economic Security	This indicator shows the percentage of 10 th grade students passing the English-language arts portion of the California High School Exit Exam.	California Department of Education	2014–2015
Passed High School Exit Exam, Math (HAC.org)	Economic Security	This indicator shows the percentage of 10 th grade students passing the mathematics portion of the California High School Exit Exam.	California Department of Education	2014–2015

Indicator	Health Needs	Description	Source	Year(s)
Pedestrian Accident Deaths	Community and Family Safety	This indicator reports the rate of death due to pedestrian accident per 100,000 population. This indicator is relevant because high pedestrian mortality may signal issues within communities affecting the safety of streets and pedestrian infrastructure.	Fatality Analysis Reporting System	2011–2015
Physical Inactivity (Adult)	Cancers; CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of adults aged 20 years and older that self-report not participating in physical activities or exercise. This indicator is relevant because current behaviors are determinants of future health; physical inactivity increases risk for many adverse health conditions, including heart disease, diabetes, and certain cancers, and shortens life expectancy.	National Center for Chronic Disease Prevention and Health Promotion	2013
Physical Inactivity (Youth), CA	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of children in grades 5, 7, and 9 ranking within the “High Risk” or “Needs Improvement” zones for aerobic capacity on the Fitnessgram physical fitness test. This indicator is relevant as a proxy measure of physical activity levels among children; regular physical activity in children can help improve fitness, build strong bones and muscles, control weight, reduce depression and anxiety, and reduce risk for chronic diseases.	Fitnessgram Physical Fitness Testing	2016–2017
Poisoning Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Community and Family Safety	Number hospital discharges among children ages 0–17 for the poisoning diagnoses as a percentage of all child discharges, excluding newborns.	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015
Poor Mental Health Days	Mental Health; Substance Use/ Tobacco; Overall Health	This indicator reports the age-adjusted average number of self-reported mentally unhealthy days per month among adults. This indicator is relevant because it provides a measure of mental health status and quality of life.	Behavioral Risk Factor Surveillance System	2015

Indicator	Health Needs	Description	Source	Year(s)
Poor or Fair Health	Healthcare Access and Delivery; Overall Health	This indicator reports the percentage of adults that self-report having poor or fair health. This indicator is relevant because it is a measure of general poor health status and quality of life.	Behavioral Risk Factor Surveillance System	2015
Poor Physical Health Days	Healthcare Access and Delivery; Overall Health	This indicator reports the age-adjusted, average number of self-reported physically unhealthy days per month among adults. The indicator is relevant because it provides a measure of general physical health status and quality of life.	Behavioral Risk Factor Surveillance System	2015
Population Below 100% FPL	Economic Security; Overall Health	This indicator reports the percentage of the population living in households with incomes below the Federal Poverty Level (FPL). This indicator is relevant as a measure for the concentration of poverty, and because it highlights a group requiring special consideration, targeted services and outreach by providers.	American Community Survey	2012–2016
Population in Limited English Households	Economic Security	This indicator reports the percentage of the population aged 5 and older living in Limited English speaking households. A “Limited English speaking household” is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English “Very well.”	American Community Survey	2012–2016
Population That Is Linguistically Isolated	Economic Security	This indicator reports the percentage of the population aged 5 years and older that is considered linguistically isolated (1) speak a language other than English at home, and 2) speak English less than “very well.” This indicator is relevant because it highlights communities requiring special consideration, targeted services and outreach by providers.	American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Population with Any Disability	Overall Health	This indicator reports the percentage of the total non-institutionalized civilian population with a disability. This indicator is relevant as a measure of the burden due to disability, and because disabled individuals comprise a population with certain needs for targeted services and outreach by providers.	American Community Survey	2012–2016
Pre-Term Births	Maternal/Infant Health	This indicator reports the percentage of total births that are pre-term (occurring before 37 weeks of pregnancy). This indicator is relevant because preterm birth is a proxy measure for community health status, poverty and socioeconomic status, and access to care.	Area Health Resource File	2012–2014
Premature Death	Overall Health	This indicator reports the rate of death among those aged less than 75 years per 100,000 population. This indicator is relevant as a measure of the extent of premature mortality.	County Health Rankings	2012–2014
Premature Death, Racial/Ethnic Disparity Index	Overall Health	This indicator reports a summary measure of disparity (Index of Disparity) in premature death on the basis of race and ethnicity. This indicator is relevant as a measure of the extent to which premature mortality varies between racial and ethnic background groups.	National Vital Statistics System	2004–2010
Preschool Enrollment	Economic Security; Maternal/Infant Health	This indicator reports the percentage of the population ages 3 to 4 years that is enrolled in preschool. This indicator is relevant because early childhood education improves cognitive and social development of children, is a protective factor against disease and disability in adulthood, and may minimize gaps in school readiness between lesser and more economically advantaged children.	American Community Survey	2012–2016

Indicator	Health Needs	Description	Source	Year(s)
Preventable Hospital Events	Healthcare Access and Delivery; Overall Health	This indicator reports the patient discharge rate for conditions that are ambulatory care sensitive (e.g., pneumonia, dehydration, asthma, diabetes) per 1,000 population. This indicator is relevant as a measure of preventable hospital events, and demonstrates a possible 'return on investment' from interventions that reduce admissions, such as those that improve access to primary care resources.	Dartmouth Atlas of Health Care	2014
Primary Care Physicians	Healthcare Access and Delivery	This indicator reports the number of primary care physicians (including MDs and DOs practicing general family medicine and general practice, and MDs practicing general internal medicine and general pediatrics) per 100,000 population. This indicator is relevant because an inadequate supply of primary care physicians may limit access to preventive health care services.	Area Health Resource File	2014
Prison Incarceration (Vera)	Community and Family Safety	Rate of individuals in state prison from county per 100,000 county residents ages 15–64	Vera Institute of Justice, Incarceration Trends. Retrieved from http://trends.vera.org/rates . Accessed 17 August 2018	2013
Proficient in English/ Language Arts-High School (HAC.org)	Economic Security	This indicator shows the percentage of eleventh grade students that are proficient or above in English/language arts. This value refers to student scores on the Smarter Balanced Assessment portion of California's statewide student assessment system, CAASPP.	California Department of Education	2018
Proficient in Math-High School (HAC.org)	Economic Security	This indicator shows the percentage of eleventh grade students who are proficient or above in mathematics. This value refers to student scores on the Smarter Balanced Assessment portion of California's statewide student assessment system, CAASPP.	California Department of Education	2018
Prostate Cancer Deaths (HAC.org)	Cancers	This indicator shows the age-adjusted death rate per 100,000 males due to prostate cancer.	California Department of Public Health	2014– 2016

Indicator	Health Needs	Description	Source	Year(s)
Prostate Cancer Incidence	Cancers	This indicator reports the age-adjusted incidence rate of prostate cancer among males per 100,000 population per year. This indicator is relevant because it is a measure of the burden of prostate cancer; this indicator may be useful for targeting interventions to prevent, screen for and treat prostate cancer which is among the most common cancers affecting men.	State Cancer Profiles	2010–2014
Public Transit Stops	Climate and Health; Obesity/HEAL/Diabetes	This indicator measures the percentage of the population living within 0.5 miles of a transit stop. This indicator is relevant because it is a measure of access to public transportation. Data are available only for population living within cities that report transit data using General Transit Feed Specification (GTFS) standards.	Environmental Protection Agency, EPA Smart Location Database	2013
Reading at or Above Proficiency, CA	Economic Security	This indicator reports the percentage of children in grade 4 whose reading skills tested at or above the "proficient" level for the English Language Arts portion of the state-specific standardized test.	US Department of Education, EDFacts. Accessed via DATA.GOV.	2015–2016
Recent Alcohol/Drug Use, 7 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 7, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Alcohol/Drug Use, 9 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 9, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Alcohol/Drug Use, 11 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 11, and nontraditional programs who have used alcohol or drugs (excluding tobacco) in the previous 30 days.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015

Indicator	Health Needs	Description	Source	Year(s)
Recent Dental Exam (Youth), CA	Healthcare Access and Delivery; Oral Health	This indicator reports the percentage of children ages 2 to 11 years with teeth that have visited a dentist in the past year. This indicator is relevant because it measures preventive dental care services utilization which contributes to good oral and overall health.	California Health Interview Survey	2014
Recent Dental Visit (Adults) (AskCHIS)	Healthcare Access and Delivery; Oral Health	Percentage of adults who had a dental visit up to 1 year ago.	California Health Interview Survey	2016
Recent ER Visit (AskCHIS)	Healthcare Access and Delivery	Percentage of adults who had visited an emergency room in the past 12 months	California Health Interview Survey	2016
Recent ER Visit, Adults 65+ (AskCHIS)	Healthcare Access and Delivery	Percentage of adults ages 65 and older who had visited an emergency room in the past 12 months	California Health Interview Survey	2016
Recent Formal Community Engagement (Volunteer Work) (Adult) (AskCHIS)†	Mental Health	Percentage of adults who engaged in formal volunteer work for community problems within the past year	California Health Interview Survey	2016
Recent Informal Community Engagement (Met with Others) (Adult) (AskCHIS)	Mental Health	Percentage of adults who met informally with others about community problems within the past year	California Health Interview Survey	2016
Recent Marijuana Use, 7 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 7, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Marijuana Use, 9 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 9, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Marijuana Use, 11 th Graders (CHKS)	Substance Use/Tobacco	Estimated percentage of public school students in grade 11, and nontraditional programs who have used marijuana in the previous 30 days, by grade level and frequency.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Recent Primary Care Visit, CA	Healthcare Access and Delivery	This indicator reports the percentage of adults aged 18 years and older that visited a primary care clinician at least once within the past year.	California Health Interview Survey	2015–2016

Indicator	Health Needs	Description	Source	Year(s)
Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (AskCHIS)	Mental Health	Percentage of adults who have taken prescription medicine for an emotional/mental health issue for at least 2 weeks within the past year	California Health Interview Survey	2016
Respiratory Hazard Index	Asthma; Climate and Health	This indicator reports the respiratory hazard index, for which scores greater than 1.0 mean respiratory pollutants are likely to increase risk of non-cancer adverse health effects over a lifetime. This indicator is relevant because it is a measure of exposure to respiratory hazards and risk for associated health impacts.	EPA National Air Toxics Assessment	2011
Road Network Density	Climate and Health	This indicator reports road network density, or road miles per square mile. This indicator is relevant as a measure of connectivity, but also traffic density, vehicle emissions and air quality.	EPA Smart Location Database	2011
School Connectedness: Low, 7 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 7, and nontraditional students by level of connectedness to school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Connectedness: Low, 9 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 9, and nontraditional students by level of connectedness to school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Connectedness: Low, 11 th Graders (CHKS)	Mental Health	Percentage of public school students in grade 11, and nontraditional students by level of connectedness to school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Perceived as Unsafe/Very Unsafe, 7 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 7, and nontraditional students reporting the level of safety they feel at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013

Indicator	Health Needs	Description	Source	Year(s)
School Perceived as Unsafe/Very Unsafe, 9 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 9. and nontraditional students reporting the level of safety they feel at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd)	2011–2013
School Perceived as Unsafe/Very Unsafe, 11 th Graders (CHKS)	Community and Family Safety	Percentage of public school students in grade 11, and nontraditional students reporting the level of safety they feel at school.	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).	2011–2013
Segregation Index	Economic Security	This indicator reports the segregation index score, a measure of the spatial distribution or evenness of population demographic groups, for which index values range between 0.0 (indicating even distribution) and 1.0 (indicating maximum segregation). This indicator is relevant as a measure of residential segregation with implications affecting spatial and socioeconomic mobility.	Decennial Census	2010
Self-Inflicted Injury ER Visits (HAC.org)	Mental Health	This indicator shows the number of self-inflicted injury emergency department visits per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
Seriously Considered Suicide, 9 th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 9, and nontraditional programs who seriously considered attempting suicide in the previous year, by grade level.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Seriously Considered Suicide, 11 th Graders (CHKS)	Mental Health	Estimated percentage of public school students in grade 11, and nontraditional programs who seriously considered attempting suicide in the previous year, by grade level.	WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)	2013–2015
Seriously Considered Suicide, CA	Community and Family Safety; Mental Health	This indicator reports the percentage of adults aged 18 years and older that self-report having seriously thought about committing suicide. This indicator is relevant because suicide is a leading cause of preventable death among young people in the U.S.	California Health Interview Survey	2015–2016

Indicator	Health Needs	Description	Source	Year(s)
Severe Housing Problems	Economic Security	This indicator reports the percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Housing unit is severely overcrowded (> 2 persons per room); or Household is severely cost burdened (all housing costs represent >50% of monthly income). This indicator is relevant because it highlights communities wherein housing or quality of life is considered substandard.	Consolidated Planning/CHAS Data	2011–2015
Severe Mental Illness ER Visits (AC) (HAC.org)	Mental Health	This indicator shows the number of severe mental illness related hospitalizations per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014
SNAP Benefits	Economic Security	This indicator reports the estimated percentage of households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant as a proxy measure for community food security, poverty and socioeconomic status; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.	American Community Survey	2012–2016
SNAP Benefits – Households with Children (HAC.org)	Economic Security	This indicator shows the percentage of households participating in the Supplemental Nutrition Assistance Program (SNAP) with children under 18 years old.	American Community Survey	2012–2016
Social Associations	Mental Health	This indicator reports the number of social associations (e.g. civic organizations, recreational clubs and facilities, political organizations, labor organizations, business associations, professional organizations) per 10,000 population. This indicator is relevant as a measure of community vitality.	County Business Patterns	2015, 2014, 2013, 2012

Indicator	Health Needs	Description	Source	Year(s)
Soft Drink Consumption, CA	Obesity/HEAL/Diabetes; Oral Health	This indicator reports the percentage of adults that self-report drinking a soda or sugar sweetened beverage at least once daily. This indicator is relevant as a measure of soft drink consumption; drinking soft drinks increases risk for diabetes, heart disease, and other chronic diseases.	California Health Interview Survey	2014
Stroke Deaths	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the age-adjusted rate of death due to cerebrovascular disease (stroke) per 100,000 population. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	National Vital Statistics System	2011– 2015
Stroke Hospitalizations	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the hospitalization rate for Ischemic stroke among Medicare beneficiaries aged 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	Interactive Atlas of Heart Disease and Stroke	2012– 2014
Stroke Prevalence	CVD/Stroke; Obesity/HEAL/Diabetes	This indicator reports the percentage of the Medicare fee-for-service population diagnosed with stroke. This indicator is relevant because it is a measure of the burden of stroke, a leading cause of death and disability in the U.S.	Centers for Medicare and Medicaid Services	2015, 2014, 2013, 2012, 2011, 2010
Student/Teacher Ratio (HAC.org)	Economic Security	This indicator shows the average number of public school students per teacher in the region. It does not measure class size.	National Center for Education Statistics	2015– 2016
Students Meeting Fitness Standards, 5 th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in grade 5 meeting six of six fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015
Students Meeting Fitness Standards, 7 th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in grade 7 meeting six of six fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015).	2015

Indicator	Health Needs	Description	Source	Year(s)
Students Meeting Fitness Standards, 9 th Graders (Kidsdata.org)	Obesity/HEAL/Diabetes	Percentage of public school students in grade 9 meeting six of six fitness standards	California Department of Education, Physical Fitness Testing Research Files (Dec. 2015)	2015
Students per Academic Counselor (Kidsdata.org)	Economic Security	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Academic Counselor. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per School Nurse (Kidsdata.org)	Healthcare Access and Delivery	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by School Nurse. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per School Psychologist (Kidsdata.org)	Healthcare Access and Delivery; Mental Health	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by School Psychologist. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per School Speech/Language/Hearing Specialist (Kidsdata.org)	Healthcare Access and Delivery	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Speech/Language/Hearing Specialist. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Students per Social Worker (Kidsdata.org)	Overall Health	Ratio of public school students to full-time equivalent (FTE) pupil support service personnel, by Social Worker. Smaller numbers indicate that students have greater access to support service personnel.	California Department of Education, California Basic Educational Data System (CBEDS), Staff Assignment and Course Data (Mar. 2016)	2015
Substance Use ER Visits (HAC.org)	Substance Use/Tobacco	This indicator shows the age-adjusted substance use emergency department visit rate per 100,000 population.	Office of Statewide Health Planning and Development (OSHPD)	2012–2014

Indicator	Health Needs	Description	Source	Year(s)
Substantiated Child Abuse and Neglect (KidsData.org)	Community and Family Safety	Number of substantiated cases of abuse and neglect per 1,000 children under age 18.	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016); Annie E. Casey Foundation, KIDS COUNT (Jul. 2016)	2015
Suicide Mortality	Community and Family Safety; Mental Health	This indicator reports the age-adjusted rate of death due to intentional self-harm (suicide) per 100,000 population. This indicator is relevant because it is a measure of burden of suicide, a leading cause of death in the U.S. Values are suppressed when the number of suicide deaths over the 5-year time period is less than 10.	National Vital Statistics System	2011–2015
Suspensions, CA	Community and Family Safety; Economic Security	This indicator reports the rate of suspensions per 100 enrolled students. This indicator is relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcome, including experiences of stress and trauma.	California Department of Education	2016–2017
Syphilis Incidence (HAC.org)	Sexually Transmitted Infections	This indicator shows the infectious syphilis (primary and secondary) incidence rate in cases per 100,000 population.	California Department of Public Health, STD Control Branch	2017
Syphilis Incidence (Male) (CCC) (CDPH)	Sexually Transmitted Infections	This indicator shows the infectious syphilis (primary and secondary) incidence rate in male cases per 100,000 population.	California Department of Public Health, STD Control Branch	2014–2016

Indicator	Health Needs	Description	Source	Year(s)
Teen Births	Economic Security; Maternal/Infant Health	This indicator reports the number of births to women ages 15 to 19 years per 1,000 population. This indicator is relevant because social determinants such as low education and low income are associated with teen pregnancies, and it highlights communities in need of prevention and support services.	National Vital Statistics System	2008–2014
Teen Births by Ethnicity (Kidsdata.org)	Economic Security; Maternal/Infant Health	Number of births per 1,000 young women ages 15-19.	California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control and Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015)	2013
Time in Foster Care (Median Months) (Kidsdata.org)	Mental Health	Median length of stay in foster care, in months, for children under age 18.	Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016)	2013
Traumatic Injury Hospitalizations, Children Ages 0–17 (Kidsdata.org)	Community and Family Safety	Number hospital discharges among children ages 0-17 for traumatic injury diagnoses, as a percentage of all child discharges, excluding newborns.	Special tabulation by California Office of Statewide Health Planning and Development (Sept. 2016)	2015

Indicator	Health Needs	Description	Source	Year(s)
Tree Canopy Cover	Climate and Health	This indicator reports the percentage of land within the report area that is covered by tree canopy. This indicator is relevant as a measure of resilience against the health impacts of climate change; tree canopy coverage protects against air pollution, reduces heat island effects, reduces noise pollution, and provides ecosystem services.	National Land Cover Database 2011	2011
Truancy (Kidsdata.org)	Economic Security	Number of K-12 public school students reported as being truant at least once during the school year per 100 students.	California Department of Education, DataQuest (Jun. 2016).	2015
Tuberculosis Incidence (CCC) (CDPH)	Communicable Diseases (Not STIs)	This indicator shows the tuberculosis incidence rate per 100,000 population.	California Department of Public Health, Tuberculosis Control Branch, Data request, September 2017.	2014–2016, 2017
Unemployment	Economic Security	This indicator reports the percentage of the civilian non-institutionalized population aged 16 years and older that is unemployed but seeking work (non-seasonally adjusted). This indicator is relevant because unemployment is a measure of community stability and regional economic dynamism; at the individual level, unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status and quality of life.	Bureau of Labor Statistics	2018
Uninsured Children	Economic Security	This indicator reports the percentage of children aged less than 18 years of age without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access, including regular primary care, specialty care, and other health services, which contributes to poor health status and quality of health.	American Community Survey	2012–2016

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

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

Attachment 4A. Secondary Data, Tri-Valley/Central Contra Costa County

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INTRODUCTION

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

- Alameda County 2017 Homeless Census and Survey Report based on the 2017 Point in Time (PIT) Count, accessed via <http://everyonehome.org/wp-content/uploads/2016/02/2017-Alameda-County-8.1-2.pdf>, pulled on July 31, 2018
- California Department of Public Health (CDPH) county health status profiles, accessed via <https://www.cdph.ca.gov/Programs/CHSI/Pages/Individual-County-Data-Sheets.aspx>, pulled on July 24, 2018
- California Health Interview Survey (CHIS), accessed via <http://ask.chis.ucla.edu/>, pulled on August 5, 2018
- California Healthy Kids Survey (CHKS), accessed via <http://chks.wested.org/query-chks/>, pulled on August 5, 2018
- The new CHNA data platform (replacing Community Commons), accessed via <http://chna.org/kp>, pulled on May 17, 2018¹
- Contra Costa County 2017 Point in Time (PIT) Count, accessed via <https://cchealth.org/h3/coc/pdf/PIT-report-2017.pdf>, pulled on July 31, 2018
- County Health Rankings (CHR), accessed via <http://www.countyhealthrankings.org/app/california/2018/rankings/contra-costa/county/factors/overall/snapshot>, pulled on July 30, 2018
- KidsData.org, a program of the Lucile Packard Foundation for Children's Health, accessed via <https://www.kidsdata.org>, pulled on August 5, 2018
- U.S. Department of Housing and Urban Development (HUD) 2017 Annual Homeless Assessment Report to Congress, accessed via <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>, pulled on July 31, 2018
- Vera Institute of Justice Incarceration Trends, accessed via <http://trends.vera.org/rates/contra-costa-county-ca?incarcerationData=all>, pulled on July 31, 2018
- Zilpy, accessed via <http://www.zilpy.com/>, pulled on November 12, 2018

Statistical data tables compare local data to California state benchmarks or national goals, whichever is more stringent.

Geographic area indicators that are at least two standard deviations (SD) or 5% or more worse than their benchmark have an asterisk, are in **bold type**, and are highlighted in **orange**. Those that are at least one SD worse have an asterisk, are in **bold type**, and are highlighted in **light orange**. Those that are at least a half SD worse have an asterisk, are in **bold type**, and are highlighted in **gray**. When indicators are worse than their benchmark by less than 5% or by less than 0.5 SDs, only their statistic is in **bold type**.

¹ Data updated September 4, 2018.

Indicators that are otherwise within one SD of the benchmark are merely highlighted in gray, those at least one SD better than the benchmark are highlighted in light blue, and those at least two SDs better are highlighted in dark blue. All indicators are rounded to the nearest tenth decimal point except when their values are less than one; then they are rounded to the nearest hundredth.

Indicators are from CHNA.org unless otherwise noted. Some CHNA.org indicators have the notation “CA” after them; this merely means that the indicator is only available for service areas/counties in California and not elsewhere in the U.S. CHNA.org indicators are for the combined Tri-Valley/Central Contra Costa County (TV/C-CCC) area only, when available. Other indicators are county-wide unless otherwise noted. When the Healthy People 2020 benchmark is used instead of the state average, the notation (HP) appears in the “State avg” column. The tables are presented alphabetically with the exception of “Overall Health,” which is last.

ASTHMA

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Active Asthma Prevalence, All Ages (AC, CCC) (CDPH)	percent		10.6	10.0	8.3	N/A		27.7%	20.5%
*Asthma Deaths (AC) (CDPH)	rate			14.1	11.1	N/A			27.0%
*Asthma Diagnoses, Children Age 1-17 (AC, CCC) (Kidsdata.org)	percent		16.9	20.1	15.2	N/A		11.2%	32.2%
*Asthma ER Visits (AC) (HAC.org)	rate			649.0	498.7	N/A			30.1%
*Asthma ED Visits, All Ages (per 10,000) (AC, CCC) (CDPH)	rate		64.6	64.5	49.5	N/A		30.5%	30.3%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0			2.4	0.7	16.7%		
*Asthma Hospitalizations, All Ages (per 10,000) (AC, CCC) (Kidsdata.org)	rate		8.5	10.5	7.6	N/A		11.8%	38.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		22.7	36.9	19.6	N/A		15.8%	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		7.9	12.7	7.7	N/A		2.6%	64.9%
Asthma Prevalence, Adults, CA	percent	15.3			14.8	-0.2	3.4%		
*Average Charge per Asthma Hospitalization (AC, CCC) (CDPH)	dollars		45,784	41,610	39,860	N/A		14.9%	4.4%
Ozone Levels	percent	35.2			42.0	1.1	16.2%		
Particulate Matter 2.5 Levels	percent	8.8			10.7	1.0	17.8%		
Respiratory Hazard Index	number	1.8			2.2	0.6	18.2%		

Trends

Trend data are available on certain indicators.

- Asthma Diagnoses, Children Age 1-17:
 - AC: Long-term trend mixed; trending up since 2009.
 - CCC: Long-term trend mixed; trending down since 2009.
- Asthma ER Visits: AC: Generally trending down since 2009.

- Asthma Hospitalizations, Children Age 0-4:
 - AC: Generally trending downward since 2005.
 - CCC: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Age 0-17:
 - AC: Long-term trend mixed, trending up since 2011.
 - CCC: Long-term trend mixed, trending up since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Asthma ED Visits, All Ages (per 10,000) (CDPH)	49.5	32.7	227.6	20.5*					57.0
(CCC) Asthma ED Visits, All Ages (per 10,000) (CDPH)	49.5	38.6	233.0	25.3*					65.1
(AC) Asthma Hospitalizations, All Ages (per 10,000) (CDPH)	7.6	5.0	31.2	5.3*					11.0
(CCC) Asthma Hospitalizations, All Ages (per 10,000) (CDPH)	7.6	6.3	26.0	4.8*					8.1

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

BEHAVIORAL HEALTH

Mental Health

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Adults Needing and Receiving Behavioral Health Care Services (AC) (HAC.org)	percent			62.2	60.5	N/A			2.8%
*Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)†	percent		16.5		13.4	N/A		23.1%	
*Adults Needing Help for Behavioral Health Issue (AC, CCC) (AskCHIS)	percent		18.9	18.5	16.4	N/A		15.2%	12.8%
Adults with Any Adverse Childhood Experiences (AC, CCC) (Kidsdata.org)	percent		58.4	57.0	61.0	N/A		4.3%	6.6%
Adults with Four or More Adverse Childhood Experiences (AC, CCC) (Kidsdata.org)	percent		15.2	12.5	15.9	N/A		4.4%	21.4%
*Bullied at School, 7th Graders (AC, CCC) (CHKS)	percent		42.3	40.6	39.4	N/A		7.4%	3.0%
Bullied at School, 9 th Graders (AC, CCC) (CHKS)	percent		35.0	35.2	34.4	N/A		1.7%	2.3%
Bullied at School, 11 th Graders (AC, CCC) (CHKS)	percent		28.8	27.9	27.6	N/A		4.3%	1.1%
Children in Foster Care (AC, CCC) (Kidsdata.org)	rate		3.7	4.2	5.8	N/A		36.2%	27.6%
Children Needing and Receiving Behavioral Health Care Services (AC, CCC) (Kidsdata.org)	percent		62.5	64.3	62.7	N/A		0.3%	2.6%
Children with Two or More Adverse Experiences (Parent Reported) (AC, CCC) (Kidsdata.org)	percent		14.7	14.3	16.4	N/A		10.4%	12.8%
Cyberbullied More than Once, 7 th Graders (AC, CCC) (CHKS)	percent		9.8	9.7	9.4	N/A		4.3%	3.2%
Cyberbullied More than Once, 9 th Graders (AC, CCC) (CHKS)	percent		12.5	12.1	12.4	N/A		0.8%	2.4%
Cyberbullied More than Once, 11 th Graders (AC, CCC) (CHKS)	percent		12.6	11.5	12.4	N/A		1.6%	7.3%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	29.2			34.2	0.5	14.6%		
Depression Among Medicare Beneficiaries	percent	13.9			14.3	0.3	2.8%		
Depression-Related Feelings, 7 th Graders (AC, CCC) (CHKS)	percent		21.9	23.3	25.4	N/A		13.8%	8.3%
Depression-Related Feelings, 9 th Graders (AC, CCC)	percent		28.0	28.6	31.5	N/A		11.1%	9.2%

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
(CHKS)									
Depression-Related Feelings, 11 th Graders (AC, CCC) (CHKS)	percent		31.8	33.3	33.4	N/A		4.8%	0.3%
*Domestic Violence Hospitalizations, CA	rate	6.1			4.9	-0.3	24.5%		
Frequent Mental Distress (AC, CCC) (HAC.org, CHR)	percent		10.0	9.5	10.6	N/A		5.7%	10.4%
*Homicide (AC, CCC) (CHR)	rate		6.0	8.0	5.0	N/A		20.0%	60.0%
Insufficient Sleep (AC) (HAC.org)	percent			33.5	34.5	N/A			2.9%
Insufficient Social and Emotional Support	percent	22.2			24.7	0.7	10.1%		
Meaningful Participation at School: Low, 7 th Graders (AC) (CHKS)	percent		27.6	28.6	31.3	N/A		11.8%	8.6%
Meaningful Participation at School: Low, 9 th Graders (AC) (CHKS)	percent		34.9	34.9	37.9	N/A		7.9%	7.9%
Meaningful Participation at School: Low, 11 th Graders (AC) (CHKS)	percent		35.0	37.3	36.9	N/A		5.1%	1.1%
*Mental Health Hospitalization, Children Age 5-14 (AC, CCC) (Kidsdata.org)	rate		2.2	2.8	2.5	N/A		12.0%	12.0%
*Mental Health Hospitalization, Youth Age 15-19 (AC, CCC) (Kidsdata.org)	rate		8.7	11.8	9.8	N/A		11.2%	20.4%
Mental Health Providers	rate	362.7			288.7	0.6	25.6%		
*Older Adults Living Alone (AC) (HAC.org)	percent			24.3	23.1	N/A			5.2%
Poor Mental Health Days	number	3.4			3.7	0.8	8.1%		
Recent Formal Community Engagement (Volunteer Work) (Adult) (AC) (AskCHIS)†	percent			13.8	11.2	N/A			23.2%
Recent Informal Community Engagement (Met with Others) (Adult) (AC, CCC) (AskCHIS)	percent		15.9	21.3	16.5	N/A		3.6%	29.1%
*Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (AC, CCC) (AskCHIS)	percent		16.0	8.0	11.1	N/A		44.1%	27.9%
School Connectedness: Low, 7 th Graders (AC, CCC) (CHKS)	percent		9.0	9.4	10.2	N/A		11.8%	7.8%
*School Connectedness: Low, 9th Graders (AC, CCC) (CHKS)	percent		11.0	12.7	11.5	N/A		4.3%	10.4%
*School Connectedness: Low, 11th Graders (AC, CCC) (CHKS)	percent		12.8	13.5	12.5	N/A		2.4%	8.0%
Self-Inflicted Injury ER Visits (AC) (HAC.org)	rate			103.1	115.5	N/A			10.7%
Seriously Considered Suicide, Adults, CA	percent	7.7			10.0	0.8	23.0%		
Seriously Considered Suicide, 9 th Graders (AC, CCC)	percent		16.7	16.1	19.0	N/A		12.1%	15.3%

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
(CHKS)									
Seriously Considered Suicide, 11 th Graders (AC, CCC) (CHKS)	percent		18.3	18.7	18.1	N/A		1.1%	3.3%
*Severe Mental Illness ER Visits (AC) (HAC.org)	rate			489.3	320.0	N/A			52.9%
Social Associations (per 10,000)	rate	8.6			6.5	1.4	32.3%		
Students per School Psychologist (AC, CCC) (Kidsdata.org)	number		959	1,233	1,265	N/A		24.2%	2.5%
Suicide Deaths	rate	9.4			10.2 (HP)	N/A	7.8%		
*Time in Foster Care (Median Months) (AC, CCC) (Kidsdata.org)	number		17.5	17.6	15.6	N/A		12.2%	12.8%
Young People Not in School and Not Working	percent	4.6			7.7	1.4	40.3%		

‡ AskCHIS data on adults needing and receiving behavioral health care in Alameda County not provided because it is statistically unstable.

† AskCHIS data on volunteering in Contra Costa County not provided because it is statistically unstable.

Trends

Trend data are available on certain indicators.

- Adults Needing and Receiving Behavioral Health Care Services: AC: Generally trending down since 2009.
- Adults Needing Help for Behavioral Health Issue:
 - AC: Trend is mixed.
 - CCC: Trend is mixed.
- Children in Foster Care:
 - AC: Downward trend since 2000, slight upward trend since 2012.
 - CCC: Downward trend since 2000, slight upward trend since 2010.
- Mental Health Hospitalizations, Children Age 5-14:
 - AC: Generally trending up since 2011.
 - CCC: Long-term trend mixed, trending down since 2011.
- Mental Health Hospitalizations, Youth Age 15-19:
 - AC: Long-term trend mixed, generally trending up since 2008.

- CCC: Long-term trend mixed, trending slightly up since 2014.
- Mental Diseases and Disorders Hospitalizations, Children/Youth Age 0-17:
 - AC: Trending up since 2007.
 - CCC: Trend is mixed.
- Older Adults Living Alone: AC: Trending down since 2006.
- Self-Inflicted Injury ER Visits: AC: Trend is mixed.
- Time in Foster Care, Median Months:
 - AC: Mixed trend, slightly upward since 2007.
 - CCC: Mixed trend, slightly upward since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Caring Adults at School: Low (CHKS)	#	10.0%	12.1%	10.9%	13.4%	15.0%	20.8%	12.8%	16.3%
(CCC) Caring Adults at School: Low (CHKS)	#	10.3%	18.9%	10.5%	10.8%	28.0%	12.6%	12.9%	16.9%
(AC) Children in Foster Care (Kidsdata.org)	5.8	2.7	20.2	0.7*					3.4
(CCC) Children in Foster Care (Kidsdata.org)	5.8	3.0	17.3	0.9*					2.5
(AC) Cyberbullied More than Once (CHKS)	#	7.6%	9.3%	6.7%	14.0%	9.6%	11.5%	10.2%	11.4%
(CCC) Cyberbullied More than Once (CHKS)	#	8.5%	7.7%	6.8%	10.8%	8.1%	9.6%	10.2%	9.9%

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(CCC) Depression- Related Feelings (CHKS)	#	23.4%	31.6%	24.8%	31.2%	19.2%	20.2%	28.5%	31.4%
(AC) Meaningful Participation at School: Low (CHKS)	#	32.0%	32.2%	29.5%	31.1%	32.2%	28.3%	32.2%	40.8%
(CCC) Meaningful Participation at School: Low (CHKS)	#	27.3%	28.5%	25.9%	29.5%	55.1%	40.7%	32.6%	40.4%
(AC) School Connectedness: Low (CHKS)	#	6.9%	14.1%	7.0%	7.9%	10.1%	11.4%	10.7%	12.0%
(CCC) School Connectedness: Low (CHKS)	#	6.5%	20.5%	6.4%	10.4%	8.0%	11.3%	12.0%	12.0%
(AC) Seriously Considered Suicide (CHKS)	#	20.1%	14.6%	14.4%	21.0%	24.0%	12.0%	18.8%	19.4%
(CCC) Seriously Considered Suicide (CHKS)	#	15.0%	29.6%	15.8%	18.6%	16.0%	11.7%	20.2%	16.0%
Suicide Deaths	10.2 (HP)	13.3	6.6	5.6					5.4

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Substance Use/Tobacco

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C- CCC SDs	TV/C- CCC % different	CCC % different	AC % different
*Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)‡	percent		16.5		13.4	N/A		23.1%	
*Adults Needing Help for Behavioral Health Issue (AC,	percent		18.9	18.5	16.4	N/A		15.2%	12.8%

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
CCC) (AskCHIS)									
Alcohol Use (Youth) (AC) (HAC.org)	percent			22.6	29.5	N/A			23.4%
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.79			1.06	0.8	25.5%		
Chronic Liver Disease/Cirrhosis Deaths (AC, CCC) (CDPH)	rate		8.6	8.6	12.2	N/A		29.5%	29.5%
Current/Former Smokers, Adults, CA	percent	12.2			13.7	0.4	10.9%		
Deaths by Suicide, Drug or Alcohol Poisoning	rate	29.2			34.2	0.5	14.6%		
Excessive Drinking, CA	percent	31.3			33.4	0.7	6.3%		
Heart Disease Deaths	rate	69.9			99.5	1.4	29.7%		
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.9			10.5	0.3	5.7%		
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	6.3			7.0	0.4	10.0%		
Impaired Driving Deaths	percent	28.6			29.0	0.1	1.4%		
Low Birth Weight	percent	6.9			6.8	-0.3	1.5%		
Lung Cancer Incidence	rate	46.3			44.6	-0.3	3.8%		
Opioid Prescription Drug Claims	percent	5.8			7.0	0.7	17.1%		
Poor Mental Health Days	number	3.4			3.7	0.8	8.1%		
Recent Alcohol/Drug Use, 7 th Graders (AC, CCC) (CHKS)	percent		7.8	7.5	10.4	N/A		25.0%	27.9%
Recent Alcohol/Drug Use, 9 th Graders (AC, CCC) (CHKS)	percent		20.7	18.2	23.2	N/A		10.8%	21.6%
Recent Alcohol/Drug Use, 11 th Graders (AC, CCC) (CHKS)	percent		31.7	33.2	33.4	N/A		5.1%	0.6%
Recent Marijuana Use, 7 th Graders (AC, CCC) (CHKS)	percent		2.7	3.6	4.2	N/A		35.7%	14.3%
Recent Marijuana Use, 9 th Graders (AC, CCC) (CHKS)	percent		11.0	10.9	12.3	N/A		10.6%	11.4%
*Recent Marijuana Use, 11th Graders (AC, CCC) (CHKS)	percent		18.6	21.0	18.0	N/A		3.3%	16.7%
*Substance Use ER Visits (AC) (HAC.org)	rate			1,642.7	1,275.4	N/A			28.8%
Very Low Birth Weight (AC, CCC) (Kidsdata.org)	percent		1.1	1.2	1.2	N/A		8.3%	0.0%

Trends

Trend data are available on certain indicators.

- Adults Needing and Receiving Behavioral Health Care Services: AC: Generally trending down since 2009.
- Adults Needing Help for Behavioral Health Issue:
 - AC: Trend is mixed.

- CCC: Trend is mixed.
- Alcohol Use (Youth): AC: Trending down since 2007.
- Lung Cancer Deaths: AC: Trending down since 2009.
- Substance Use ER Visits: AC: Trending up since 2009.
- Very Low Birth Weight:
 - AC: Trend is relatively flat since 1995.
 - CCC: Trend is relatively flat since 1995.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Heart Disease Deaths	99.5	73.5	103.6	47.4		50.3			54.1
(AC) Recent Alcohol/Drug Use - Youth (CHKS)	#	23.1%	27.1%	9.9%	20.3%	15.7%	16.4%	22.0%	28.5%
(CCC) Recent Alcohol/Drug Use - Youth (CHKS)	#	23.1%	17.5%	8.0%	18.1%	12.1%	12.8%	20.9%	24.2%
(AC) Recent Marijuana Use - Youth (CHKS)	#	13.1%	21.5%	4.8%	12.8%	13.3%	10.6%	15.2%	17.7%
(CCC) Recent Marijuana Use - Youth (CHKS)	#	11.6%	12.3%	3.6%	10.0%	5.3%	5.9%	12.4%	13.1%

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.

CANCERS

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Breast Cancer Deaths, Females (AC, CCC) (HAC.org, CDPH)	rate		19.0	17.8	19.1	N/A		0.5%	6.8%
*Breast Cancer Incidence, Females	rate	127.9			120.7	-0.8	6.0%		
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	63.0			59.7	0.7	5.5%		
Cancer Deaths	rate	144.9			147.3	0.2	1.6%		
Cervical Cancer Incidence (AC) (HAC.org)	rate			6.5	7.3	N/A			11.0%
Childhood Cancer Diagnoses Ages 0-19 (AC, CCC) (Kidsdata.org)	rate		15.7	16.9	17.4	N/A		9.8%	2.9%
*Colon and Rectum Cancer Incidence	rate	38.8			37.2	-0.7	4.3%		
Colon Cancer Screening, Adults Age 50+ (AC) (HAC.org)	percent			71.3	68.1	N/A			4.7%
Colorectal Cancer Deaths (AC, CCC) (HAC.org, CDPH)	rate		12.9	12.1	12.8	N/A		0.8%	5.5%
Current/Former Smokers, Adults, CA	percent	12.2			13.7	0.4	10.9%		
Lung Cancer Deaths (AC, CCC) (HAC.org, CDPH)	rate		29.2	28.2	28.9	N/A		1.0%	2.4%
Lung Cancer Incidence	rate	46.3			44.6	-0.3	3.8%		
Oral Cancer Incidence (AC) (HAC.org)	rate			9.6	10.3	N/A			6.8%
Prostate Cancer Deaths (AC, CCC) (HAC.org, CDPH)	rate		20.1	17.2	19.6	N/A		2.6%	12.2%
*Prostate Cancer Incidence	rate	122.2			109.2	-1.6	11.9%		

Trends

Trend data are available on certain indicators.

- Breast Cancer Deaths: AC: Trending down since 2009.
- Cervical Cancer Incidence: AC: Trending down since 2009.
- Childhood Cancer Diagnoses:
 - AC: Slight upward trend since 2003.
 - CCC: Mixed in earlier years, relatively flat since 2006.

- Colon Cancer Screening: AC: Trending up since 2003.
- Colorectal Cancer Deaths: AC: Generally trending down since 2009.
- Lung Cancer Deaths: AC: Trending down since 2009.
- Oral Cancer Incidence: AC: Generally trending down since 2004.
- Prostate Cancer Deaths: AC: Generally trending down since 2008.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	63.7%	56.1%						
Cancer Deaths	147.3	155.7	196.3	97.9		81.1			116.0
(AC) Cervical Cancer Incidence (HAC.org)	7.2	6.9	7.0	5.1*					9.9
(AC) Childhood Cancer Diagnoses, Ages 0-19 (Kidsdata.org)	17.4	19.4	14.0	16.9*					15.1
(CCC) Childhood Cancer Diagnoses, Ages 0-19 (Kidsdata.org)	17.4	16.4		10.4*					16.9
(AC) Colon Cancer Screening, Adults Age 50+	68.1%	72.2%	76.0%	62.3%*		65.7%		50.4%	81.2%
(AC) Oral Cancer Incidence	10.3	10.4	7.9	7.4*					5.8

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

CLIMATE/NATURAL ENVIRONMENT

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Active Asthma Prevalence, All Ages (AC, CCC) (CDPH)	percent		10.6	10.0	8.3	N/A		27.7%	20.5%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0			2.4	0.7	16.7%		
*Asthma Hospitalizations, All Ages (per 10,000) (AC, CCC) (Kidsdata.org)	rate		8.5	10.5	7.6	N/A		11.8%	38.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		22.7	36.9	19.6	N/A		15.8%	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		7.9	12.7	7.7	N/A		2.6%	64.9%
Asthma Prevalence, Adults, CA	percent	15.3			14.8	-0.2	3.4%		
Climate-Related Mortality Impacts	percent	1.7			8.4	0.8	79.8%		
*Drinking Water Violations	number	1.0			0.8	-0.5	25.0%		
Driving Alone to Work	percent	71.4			73.5	0.3	2.9%		
*Driving Alone to Work, Long Distances	percent	43.9			39.3	-0.6	11.7%		
Drought Severity	percent	93.6			92.8	-0.1	0.9%		
Flood Vulnerability	percent	3.2			3.7	0.2	13.5%		
Heat Index	percent	0			2.7	0.6	100.0%		
Ozone Levels	percent	35.2			42.0	1.1	16.2%		
Particulate Matter 2.5 Levels	percent	8.8			10.7	1.0	17.8%		
Public Transit Stops Within 0.5 Mile	percent	31.3			16.8	1.9	86.3%		
Respiratory Hazard Index	number	1.8			2.2	0.6	18.2%		
*Road Network Density	rate	3.7			2.0	-1.2	85.0%		
Tree Canopy Cover	percent	18.7			8.3	1.6	125.3%		

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

COMMUNICABLE DISEASES (NOT STIS)

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Adults 18+ with Influenza Vaccination (AC, CCC) (AskCHIS)†	percent		55.9	53.0	43.4	N/A		28.8%	22.1%
Children with Influenza Vaccination (AC) (HAC.org)	percent			65.9	55.4	N/A			19.0%
Influenza and Pneumonia Deaths (AC, CCC) (HAC.org, CDPH)	rate		10.0	12.6	14.3	N/A		30.1%	11.9%
Influenza Vaccination, All Ages (AC, CCC) (AskCHIS)	percent		55.5	56.6	44.8	N/A		23.9%	26.3%
Kindergarteners with Required Immunizations (AC, CCC) (Kidsdata.org)	percent		95.1	95.9	92.8	N/A		2.5%	3.3%
*Tuberculosis Incidence (AC, CCC) (HAC.org, CDPH)	rate		4.0	8.9	1.0 (HP)	N/A		300%	790%

† AskCHIS data on influenza vaccination for children 0-17 and older adults (65+) not provided because it is statistically unstable.

Trends

Trend data are available on certain indicators.

- Influenza and Pneumonia Deaths: AC: Trending down since 2009.
- Kindergarteners with Required Immunizations:
 - AC: Upward trend since 2013.
 - CCC: Relatively flat since 2002.
- Tuberculosis Incidence: AC: Generally trending down since 2010.

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(CCC) Adults 18+ with Influenza Vaccination (AskCHIS)	43.4%	53.7%							56.9%

Blank cells indicate that data were unavailable.

COMMUNITY AND FAMILY SAFETY

Crime/Intentional Injury

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Assault Injury ER Visits (AC) (HAC.org)	rate			422.2	322.6	N/A			30.9%
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.79			1.06	0.8	25.5%		
*Bullied at School, 7th Graders (AC, CCC) (CHKS)	percent		42.3	40.6	39.4	N/A		7.4%	3.0%
Bullied at School, 9 th Graders (AC, CCC) (CHKS)	percent		35.0	35.2	34.4	N/A		1.7%	2.3%
Bullied at School, 11 th Graders (AC, CCC) (CHKS)	percent		28.8	27.9	27.6	N/A		4.3%	1.1%
Cyberbullied More than Once, 7 th Graders (AC, CCC) (CHKS)	percent		9.8	9.7	9.4	N/A		4.3%	3.2%
Cyberbullied More than Once, 9 th Graders (AC, CCC) (CHKS)	percent		12.5	12.1	12.4	N/A		0.8%	2.4%
Cyberbullied More than Once, 11 th Graders (AC, CCC) (CHKS)	percent		12.6	11.5	12.4	N/A		1.6%	7.3%
Domestic Violence Calls for Assistance (AC, CCC) (KidsData.org)	rate		4.6	5.7	6.0	N/A		23.3%	5.0%
*Domestic Violence Hospitalizations, CA	rate	6.1			4.9	-0.3	24.5%		
Fear Being Beaten Up at School, 7 th Graders (AC, CCC) (CHKS)	percent		23.3	25.2	24.7	N/A		5.7%	2.0%
Fear Being Beaten Up at School, 9 th Graders (AC, CCC) (CHKS)	percent		16.9	18.4	17.9	N/A		5.6%	2.8%
Fear Being Beaten Up at School, 11 th Graders (AC, CCC) (CHKS)	percent		10.9	12.1	11.9	N/A		8.4%	1.7%
*Firearm Fatalities (AC, CCC) (CHR)	rate		9.0	9.0	8.0	N/A		12.5%	12.5%
Gang Membership, 7 th Graders (AC, CCC) (CHKS)	percent		7.0	7.4	8.1	N/A		13.6%	8.6%
*Gang Membership, 9th Graders (AC, CCC) (CHKS)	percent		8.7	7.6	7.5	N/A		16.0%	1.3%
*Gang Membership, 11th Graders (AC, CCC) (CHKS)	percent		8.0	7.4	7.5	N/A		6.7%	1.3%
*Homicide (AC, CCC) (CHR)	rate		6.0	8.0	5.0	N/A		20.0%	60.0%
Injury Deaths	rate	43.9			46.6	0.2	5.8%		
*Jail Admissions, Age 15-64 (AC, CCC) (Vera)	rate		3,534.8	4,356.6	3,805.9	N/A		7.1%	14.5%
Jail Incarceration, Age 15-64 (AC, CCC) (Vera)	rate		161.0	199.9	278.9	N/A		42.3%	28.3%
*Juvenile Felony Arrests, Age 10-17 (per 1,000) (AC, CCC) (Kidsdata.org)	rate		4.3	5.6	5.3	N/A		18.9%	5.7%
School Perceived as Unsafe/Very Unsafe, 7 th Graders	percent		9.1	8.4	9.3	N/A		2.2%	9.7%

Indicator (AC, CCC) (CHKS)	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*School Perceived as Unsafe/Very Unsafe, 9th Graders (AC, CCC) (CHKS)	percent		8.7	8.0	7.7	N/A		13.0%	3.9%
*School Perceived as Unsafe/Very Unsafe, 11th Graders (AC, CCC) (CHKS)	percent		8.4	7.3	6.5	N/A		29.2%	12.3%
Substantiated Child Abuse and Neglect (per 1,000 under age 18) (AC, CCC) (KidsData.org)	rate		4.3	2.8	8.2	N/A		47.6%	65.9%
*Traumatic Injury Hospitalizations, Children Age 0-17 (AC, CCC) (Kidsdata.org)	percent		1.5	1.6	1.1	N/A		36.4%	45.5%
*Violent Crimes	rate	467.0			402.7	-0.4	16.0%		

Data without Benchmarks

Certain indicators have no state or national comparison.

- The prison incarceration rate was 331.3 per 100,000 residents age 15-64 in Alameda County in 2013 (Vera).
- The prison incarceration rate was 241.3 per 100,000 residents age 15-64 in Contra Costa County in 2013 (Vera).

Trends

Trend data are available on certain indicators.

- Assault Injury ER Visits: AC: Trending down since 2010.
- Domestic Violence Calls for Assistance:
 - AC: Downward trend since 2005.
 - CCC: Downward trend since 1998.
- Jail Incarceration:
 - AC: Trending down since 2006.
 - CCC: Generally trending down since 2003.
- Juvenile Felony Arrest Rate:
 - AC: Trending down since 2007.
 - CCC: Trending down since 2007.

- **Prison Incarceration Rate:**
 - AC: Trending down since 1998.
 - CCC: Trending down since 1998.
- **Substantiated Child Abuse and Neglect:**
 - AC: Generally trending down since 2001.
 - CCC: Generally trending down since 2001.
- **Traumatic Injury Hospitalizations, Children Age 0-17:**
 - AC: Trend is mixed.
 - CCC: Trend is mixed.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Bullied at School (CHKS)	#	37.5%	38.5%	33.0%	46.4%	45.6%	37.8%	40.5%	37.3%
(CCC) Bullied at School (CHKS)	#	32.8%	43.2%	36.7%	38.4%	23.4%	31.8%	36.8%	31.8%
(AC) Fear Being Beaten Up at School (CHKS)	#	11.8%	11.1%	12.3%	19.0%	18.8%	15.9%	15.7%	17.0%
(CCC) Fear Being Beaten Up at School (CHKS)	#	11.3%	14.5%	11.6%	16.0%	36.7%	11.2%	12.7%	14.5%
(AC) Gang Membership (CHKS)	#	3.6%	6.7%	4.0%	4.9%	8.2%	5.9%	5.2%	5.9%
(CCC) Gang Membership (CHKS)	#	5.9%	7.9%	4.1%	9.1%	2.9%	6.3%	9.4%	7.2%
(AC) Jail Incarceration (Vera)	278.9	110.8	962.0	32.6*		296.4			261.1
(CCC) Jail Incarceration (Vera)	278.9	98.1	616.0	9.8*					250.5

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Juvenile Felony Arrests (per 1,000) (Kidsdata.org)	5.3	2.3	25.0				1.2		5.4
(CCC) Juvenile Felony Arrests (per 1,000) (Kidsdata.org)	5.3	2.1	22.0				1.3		3.6
(AC) School Perceived as Unsafe/Very Unsafe (CHKS)	#	4.3%	8.6%	4.8%	7.9%	6.9%	5.4%	7.0%	8.8%
(CCC) School Perceived as Unsafe/Very Unsafe (CHKS)	#	4.2%	10.0%	5.3%	6.3%	3.5%	8.4%	8.6%	9.6%
(AC) Substantiated Child Abuse and Neglect (per 1,000 under age 18) (Kidsdata.org)	8.2	2.0	10.3	0.8*					2.8
(CCC) Substantiated Child Abuse and Neglect (per 1,000 under age 18) (Kidsdata.org)	8.2	3.6	13.4	1.8*					4.2

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Unintended Injury/Accidents

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C- CCC SDs	TV/C- CCC % different	CCC % different	AC % different
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.79			1.06	0.8	25.5%		
*Bicycle-Involved Collisions (AC) (HAC.org)	rate			43.4	35.1	N/A			23.6%
*Elevated Blood Lead Levels in Children Age 0-5 (AC,	percent		0.1	0.3	0.2	N/A		50.0%	50.0%

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
CCC (Kidsdata.org)									
*Elevated Blood Lead Levels in Children/Youth Age 6-20 (AC, CCC) (Kidsdata.org)	percent		0.2	0.5	0.3	N/A		33.3%	66.7%
*Firearm Fatalities (AC, CCC) (CHR)	rate		9.0	9.0	8.0	N/A		12.5%	12.5%
Impaired Driving Deaths	percent	28.6			29.0	0.1	1.4%		
Injury Deaths	rate	43.9			46.6	0.2	5.8%		
Motor Vehicle Crash Deaths	rate	6.1			8.6	0.8	29.1%		
*Motor Vehicle Crash ER Visits (AC) (HAC.org)	rate			809.3	747.3	N/A			8.3%
Pedestrian Accident Deaths	rate	1.4			2.3	1.8	39.1%		
*Poisoning Hospitalizations, Children Age 0-17 (AC, CCC) (Kidsdata.org)	percent		1.3	0.6	0.9	N/A		44.4%	33.3%
*Traumatic Injury Hospitalizations, Children Age 0-17 (AC, CCC) (Kidsdata.org)	percent		1.5	1.6	1.1	N/A		36.4%	45.5%
Unintentional Injury Deaths (AC, CCC) (HAC.org, CDPH)	rate		26.1	24.9	30.3	N/A		13.9%	17.8%
Unintentional Injury ER Visits (AC) (HAC.org)	rate			6,749.6	6,531.7	N/A			3.3%

Trends

Trend data are available on certain indicators.

- Bicycle-Involved Collisions: AC: Trending down since 2013.
- Elevated Blood Lead Levels in Children Age 0-5:
 - AC: Downward trend since 2007.
 - CCC: Relatively flat since 2007.
- Elevated Blood Lead Levels in Children/Youth Age 6-20:
 - AC: Trend is mixed.
 - CCC: Relatively flat since 2009.
- Motor Vehicle Crash ER Visits: AC: Trending up since 2009.
- Poisoning Hospitalizations, Children Age 0-17:
 - AC: Long-term trend mixed, trending down since 2012.
 - CCC: Trend is mixed.
- Traumatic Injury Hospitalizations, Children Age 0-17:

- AC: Trend is mixed.
- CCC: Trend is mixed.
- Unintentional Injury Deaths: AC: Generally trending up since 2010.
- Unintentional Injury ER Visits: AC: Generally trending up since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	6.8	9.2	3.2					5.7

Blank cells indicate that data were unavailable.

ECONOMIC SECURITY

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Adults with an Associate's Degree or Higher, Age 25+	percent	61.7			39.8	2.3	55.0%		
Adults with No High School Diploma, Age 25+	percent	5.8			17.9	2.2	67.6%		
Adults with Some Post-secondary Education, Age 25-44	percent	82.5			63.6	2.1	29.7%		
Banking Institutions (per 10,000)	rate	4.4			2.7	2.6	63.0%		
Childcare Availability (Licensed) (AC, CCC) (Kidsdata.org)	percent		30	31	25	N/A		20.0%	24.0%
Children Below 100% FPL	percent	6.3			21.9	2.3	71.2%		
Children in Single-parent Households	percent	17.6			31.8	2.8	44.7%		
Children without Secure Parental Employment (AC, CCC) (Kidsdata.org)	percent		27.2	27.8	32.8	N/A		17.1%	15.2%
Cost Burdened Households	percent	36.1			42.8	1.8	15.7%		
*Cost of Infant Childcare, Annually, Child Care Center (AC, CCC) (Kidsdata.org)	dollars		14,979	15,435	13,327	N/A		12.4%	15.8%
*Cost of Preschool Childcare, Annually, Child Care Center (AC, CCC) (Kidsdata.org)	dollars		10,895	11,113	9,106	N/A		19.6%	22.0%
Free and Reduced Price Lunch	percent	16.3			58.9	3.0	72.3%		
High Speed Internet	percent	99.2			95.4	0.5	4.0%		
Income Inequality - 80/20 Ratio	number	3.5			5.1	3.0	31.4%		
Medicaid/Public Insurance Enrollment	percent	9.5	23.1	22.1	21.8	2.2	56.4%	6.0%	1.4%
Older Adults Below 100% FPL (AC) (HAC.org)	percent			9.5	10.3	N/A			7.8%
Opportunity Index	number	59.5			51.9	0.9	14.7%		
Population Below 100% FPL	percent	6.2			15.8	2.2	60.8%		
SNAP Benefits	percent	2.9			9.4	1.6	69.1%		
SNAP Benefits – Households with Children (AC) (HAC.org)	percent			64.4	69.8	N/A			7.7%
Unemployment	percent	3.0			4.0	0.6	25.0%		
Uninsured Children	percent	2.4			10.4	3.0	76.9%		
Uninsured Population	percent	5.5			12.6	2.4	56.3%		
Young People Not in School and Not Working	percent	4.6			7.7	1.4	40.3%		

Trends

Trend data are available on certain indicators.

- Childcare Availability (Licensed):
 - AC: Relatively flat since 2000.
 - CCC: Relatively flat since 2000.
- Older Adults Below 100% FPL: AC: Generally trending up since 2006.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults with No High School Diploma	17.9%	2.7%	8.9%	4.8%	31.1%	13.9%	29.0%	6.8%	22.4%
Children Below 100% FPL	21.9%	4.1%	27.3%	3.5%	5.2%	9.1%	17.0%	6.7%	12.5%
(AC) Older Adults Below 100% FPL (HAC.org)	10.3%	6.1%	13.0%	13.6%	10.8%	14.8%	10.5%	11.6%	10.5%
Population Below 100% FPL	15.8%	4.9%	18.8%	4.7%	9.0%	15.0%	15.3%	7.8%	11.3%
SNAP Benefits	9.4%	2.0%	8.0%	1.0%	19.7%	13.5%	12.4%	8.0%	9.0%
Uninsured Children	10.4%	1.9%	4.3%	2.0%	6.5%	10.8%	6.6%	1.5%	4.4%
Uninsured Population	12.6%	3.8%	9.9%	4.2%	18.1%	8.6%	20.2%	3.2%	13.9%

Blank cells indicate that data were unavailable.

EDUCATION AND LITERACY

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Adults with an Associate's Degree or Higher, Age 25+	percent	61.7			39.8	2.3	55.0%		
Adults with No High School Diploma, Age 25+	percent	5.8			17.9	2.2	67.6%		
Adults with Some Post-secondary Education, Age 25-44	percent	82.5			63.6	2.1	29.7%		
*Children in Linguistically Isolated Households (AC, CCC) (Kidsdata.org)	percent		8.0	11.5	10.5	N/A		23.8%	9.5%
*Cost of Preschool Childcare, Annually, Child Care Center (AC, CCC) (Kidsdata.org)	dollars		10,895	11,113	9,106	N/A		19.6%	22.0%
Expulsions, CA (per 100 enrolled students)	rate	0.03			0.08	0.8	62.5%		
High School Dropout (Adjusted) (AC, CCC) (Kidsdata.org)	percent		5.8	9.6	10.7	N/A		45.8%	10.3%
High School Graduates Completing College Prep Courses (AC, CCC) (Kidsdata.org)	percent		48.9	54.5	43.4	N/A		12.7%	25.6%
High Speed Internet	percent	99.2			95.4	0.5	4.0%		
*Juvenile Felony Arrests, Age 10-17 (per 1,000) (AC, CCC) (Kidsdata.org)	rate		4.3	5.6	5.3	N/A		18.9%	5.7%
On-Time High School Graduation, CA	rate	93.0			82.9	1.8	12.2%		
Passed High School Exit Exam, English (AC) (HAC.org)	percent			86.0	85.0	N/A			1.2%
Passed High School Exit Exam, Math (AC) (HAC.org)	percent			86.0	85.0	N/A			1.2%
Preschool Enrollment	percent	66.4			48.6	2.1	36.6%		
Proficient in English/Language Arts-High School (AC) (HAC.org)	percent			64.0	59.0	N/A			8.5%
Proficient in Math-High School (AC) (HAC.org)	percent			43.0	32.0	N/A			34.4%
Reading at or Above Proficiency, CA	percent	68.0			43.9	3.0	54.9%		
Student/Teacher Ratio (AC) (HAC.org)	number			23.0	23.7	N/A			3.0%
*Students per Academic Counselor (AC, CCC) (Kidsdata.org)	number		1,014	827	792	N/A		28.0%	4.4%
Suspensions, CA (per 100 enrolled students)	rate	3.6			5.9	0.8	39.0%		
Teen Births (per 1,000 females age 15-19)	rate	18.4			29.3	1.2	37.2%		
*Truancy (per 100 students) (AC, CCC) (Kidsdata.org)	rate		37.8	27.7	31.4	N/A		20.4%	11.8%

Trends

Trend data are available on certain indicators.

- **Children in Linguistically Isolated Households:**
 - AC: Generally trending down since 2007.
 - CCC: Mixed.
- **High School Dropout (Adjusted):**
 - AC: Downward trend since 2010.
 - CCC: Downward trend since 2010.
- **High School Graduates Completing College Prep Courses:**
 - AC: Trending up since 1998.
 - CCC: Trending up since 2008.
- **Passed High School Exit Exam, English: AC: Generally trending up since 2010.**
- **Passed High School Exit Exam, Math: AC: Trending up since 2010.**
- **Student/Teacher Ratio: AC: Trending up (worse) since 2008.**
- **Students Per Academic Counselor:**
 - AC: Trending down since 2013.
 - CCC: Trending down since 2013.
- **Teen Births:**
 - AC: Generally trending down since 1995.
 - CCC: Generally trending down since 1996.
- **Truancy:**
 - AC: Generally trending down since 2012.
 - CCC: Trend is mixed.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) High School Dropout (Adjusted) (Kidsdata.org)	10.7%	5.8%	18.3%	3.9%	13.6%		3.6%†	7.4%	13.5%
(CCC) High School Dropout (Adjusted) (Kidsdata.org)	10.7%	3.7%	11.3%	1.7%				5.7%	8.5%
(AC) High School Graduates Completing College Prep Courses (Kidsdata.org)	43.4%	58.8%	36.1%	74.9%	50.0%	39.7%	56.8%†	56.3%	42.5%
(CCC) High School Graduates Completing College Prep Courses (Kidsdata.org)	43.4%	57.6%	26.1%	71.8%	26.7%		57.6%†	51.8%	34.9%
(AC) Passed High School Exit Exam, English (HAC.org)	85%	94%	74%	93%	80%	82%	91%†	87%	79%
(AC) Passed High School Exit Exam, Math (HAC.org)	85%	95%	69%	96%	77%	77%	93%†	89%	78%
(AC) Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.7	28.3	2.2*				11.4	25.3
(CCC) Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.6	21.9					10.1	24.3

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

HEALTH CARE ACCESS AND DELIVERY

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
30-Day Readmissions	percent	13.9			14.4	0.5	3.5%		
Acute Preventable Hospitalizations (AC) (HAC.org)	rate			447.7	500.6	N/A			10.6%
*Adults Delayed/Didn't Get "Other Medical" Care (AC) (AskCHIS)	percent		11.0	7.0	9.8	N/A		12.2%	28.6%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0			2.4	0.7	16.7%		
Avoidable ER Visits (AC) (HAC.org)	rate			3,740.6	3,950.2	N/A			5.3%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	63.0			59.7	0.7	5.5%		
Children with Health Insurance (AC) (HAC.org)	percent			98.2	100 (HP)	N/A			1.8%
Chronic Preventable Hospitalizations (AC) (HAC.org)	rate			787.5	787.0	N/A			0.1%
Dentists	rate	84.5			80.3	0.2	5.2%		
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.4			81.8	-0.2	0.5%		
*Federally Qualified Health Centers	rate	0.7			2.5	-1.0	72.0%		
*Have Usual Source of Health Care (AC) (HAC.org)	percent			87.5	95 (HP)	N/A			7.9%
Lack of Dental Insurance Coverage, CA	percent	31.4			38.5	1.0	18.4%		
Medicaid/Public Insurance Enrollment	percent	9.5	23.1	22.1	21.8	2.2	56.4%	6.0%	1.4%
Medicare Health Care Costs, Dollars per Capita (AC) (HAC.org)	rate			8,707	9,100	N/A			4.3%
Mental Health Providers	rate	362.7			288.7	0.6	25.6%		
*Non-Physician PCPs (AC) (HAC.org)	rate			47	52	N/A			9.6%
*People Delayed/Did Not Receive "Other Medical" Care (AC) (HAC.org)	percent			8.3	4.2 (HP)	N/A			97.6%
Poor or Fair Health, Adults	percent	11.8			17.2	1.4	31.4%		
Poor Physical Health Days, Adults	number	3.2			3.7	1.1	13.5%		
*Premature Death, Racial/Ethnic Disparity Index	number	48.0			36.8	-1.3	30.4%		
Preventable Hospital Events	rate	33.6			35.9	0.3	6.4%		
Primary Care Physicians	rate	100.8			78.1	1.0	29.1%		
Recent Dental Exam (Youth), CA	percent	87.0			86.7	0.2	0.3%		
Recent Dental Visit (Adults) (AC, CCC) (AskCHIS)	percent		74.2	78.4	70.3	N/A		5.5%	11.5%
*Recent ER Visit, Adults (AC, CCC) (AskCHIS)	percent		24.2	15.6	21.4	N/A		13.1%	27.1%
*Recent ER Visit, Adults 65+ (CCC) (AskCHIS)‡	percent		30.4		22.0	N/A		38.2%	

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Recent Primary Care Visit, CA	percent	73.5			72.4	0.3	1.5%		
*Students per School Nurse (AC, CCC) (Kidsdata.org)	number		5,393	5,442	2,784	N/A		93.7%	95.5%
Students per School Psychologist (AC, CCC) (Kidsdata.org)	number		959	1,233	1,265	N/A		24.2%	2.5%
*Students per School Speech/Language/Hearing Specialist (AC, CCC) (Kidsdata.org)	number		1,359	1,466	1,263	N/A		7.6%	16.1%
Uninsured Children	percent	2.4			10.4	3.0	76.9%		
Uninsured Population	percent	5.5			12.6	2.4	56.3%		

‡ AskCHIS data on recent ER visit for children 0-17 in both counties and for older adults (65+) in Alameda County not provided because it is statistically unstable.

Trends

Trend data are available on certain indicators.

- Avoidable ER Visits: AC: Trending up since 2010.
- Children with Health Insurance: AC: Trending up since 2013.
- Colon Cancer Screening: AC: Trending up since 2003.
- Have Usual Source of Health Care: AC: Generally trending down since 2005.
- Medicare Health Care Costs, Dollars per Capita: AC: Trend is mixed.
- Non-Physician PCPs: AC: Trending up since 2013.
- Students per School Nurse:
 - AC: Generally trending down since 2012.
 - CCC: Generally trending down since 2011.
- Students per School Psychologist:
 - AC: Trending down since 2012.
 - CCC: Trending down since 2012.
- Students per School Speech/Language/Hearing Specialist:
 - AC: Trending down since 2012.
 - CCC: Trending down since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Acute Preventable Hospitalizations (HAC.org)	500.6	489.4	681.5	274.3*		299.0			370.8
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	63.7%	56.1%						
(AC) Chronic Preventable Hospitalizations	787.0	673.8	2,055.1	425.2*		684.6			632.2
(AC) Colon Cancer Screening, Adults Age 50+	68.1%	72.2%	76.0%	62.3%*		65.7%		50.4%	81.2%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.5%	74.2%						
Preventable Hospital Events	35.9	32.1	50.4						
Uninsured Children	10.4%	1.9%	4.3%	2.0%	6.5%	10.8%	6.6%	1.5%	4.4%
Uninsured Population	12.6%	3.8%	9.9%	4.2%	18.1%	8.6%	20.2%	3.2%	13.9%

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

HEALTHY EATING/ACTIVE LIVING

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Adequate Fruit and Vegetable Consumption, Children Age 2-11 (AC, CCC) (Kidsdata.org)	percent		36.0	34.9	32.0	N/A		12.5%	9.1%
Adequate Fruit and Vegetable Consumption, Children Age 12-17 (AC, CCC) (Kidsdata.org)	percent		Data suppressed	30.5	22.4	N/A			36.2%
*Children Walking or Biking to School, CA	percent	30.9			39.3	-0.9	21.4%		
Current/Former Smokers, Adults, CA	percent	12.2			13.7	0.4	10.9%		
Diabetes Deaths (AC, CCC) (HAC.org, CDPH)	rate		17.6	19.9	20.7	N/A		15.0%	3.9%
Diabetes Hospitalizations (AC) (HAC.org)	rate			879.6	1,017.7	N/A			13.6%
*Diabetes Hospitalizations, Children Age 0-17 (AC, CCC) (Kidsdata.org)	percent		1.5	1.6	1.4	N/A		7.1%	14.3%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.4			81.8	-0.2	0.5%		
Diabetes Prevalence, CA	percent	6.0			8.4	1.1	28.6%		
Did Not Eat Breakfast, 7 th Graders (AC, CCC) (CHKS)	percent		29.2	30.5	34.0	N/A		14.1%	10.3%
Did Not Eat Breakfast, 9 th Graders (AC, CCC) (CHKS)	percent		32.5	35.7	38.3	N/A		15.1%	6.8%
Did Not Eat Breakfast, 11 th Graders (AC, CCC) (CHKS)	percent		35.1	37.5	39.4	N/A		10.9%	4.8%
Driving Alone to Work	percent	71.4			73.5	0.3	2.9%		
*Driving Alone to Work, Long Distances	percent	43.9			39.3	-0.6	11.7%		
Exercise Opportunities	percent	97.0			93.6	0.4	3.6%		
Fast Food Consumption (AC) (HAC.org)	percent			58.3	65.6	N/A			11.1%
Food Environment Index	number	8.0			7.8	0.3	2.6%		
*Food Insecure Children Ineligible for Assistance (AC) (HAC.org)	percent			41	33	N/A			24.2%
Food Insecurity	percent	13.2			13.4	0.1	1.5%		
Food Insecurity, Child (AC) (HAC.org)	percent			15.9	19.0	N/A			16.3%
Free and Reduced Price Lunch	percent	16.3			58.9	3.0	72.3%		
*Grocery Stores and Produce Vendors	rate	1.9			2.4	-0.7	20.8%		
*Low Access to Healthy Food Stores	percent	26.0			13.4	-1.7	94.0%		
Heart Disease Deaths	rate	69.9			99.5	1.4	29.7%		
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.9			10.5	0.3	5.7%		
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	6.3			7.0	0.4	10.0%		
Obesity (Adult), CA	percent	17.7			26.5	1.2	33.2%		

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Obesity (Youth), CA	percent	10.4			20.1	2.7	48.3%		
Obesity Hospitalizations (AC) (HAC.org)	rate			367.3	396.8	N/A			7.4%
Physical Inactivity (Adult)	percent	17.2			17.3	0.1	0.6%		
Physical Inactivity (Youth), CA	percent	21.7			37.8	2.8	42.6%		
Public Transit Stops Within 0.5 Mile	percent	31.3			16.8	1.9	86.3%		
SNAP Benefits	percent	2.9			9.4	1.6	69.1%		
Soft Drink Consumption, CA	percent	12.5			18.1	1.0	30.9%		
*Stroke Deaths	rate	39.0			35.4	-0.7	10.2%		
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9			7.4	-0.6	6.8%		
Stroke Prevalence, Medicare Beneficiaries	percent	3.8			3.7	-0.3	2.7%		
Students Meeting Fitness Standards, 5 th Graders (AC, CCC) (Kidsdata.org)	percent		30.6	30.4	26.4	N/A		15.9%	15.2%
Students Meeting Fitness Standards, 7 th Graders (AC, CCC) (Kidsdata.org)	percent		34.2	35.0	32.5	N/A		5.2%	7.7%
Students Meeting Fitness Standards, 9 th Graders (AC, CCC) (Kidsdata.org)	percent		38.9	36.2	37.6	N/A		3.5%	3.7%
Walkable Destinations	percent	44.2			29.0	0.9	52.4%		

Trends

Trend data are available on certain indicators.

- Diabetes Deaths: AC: Trending down since 2012.
- Diabetes Hospitalizations: AC: Trending down since 2010.
- Diabetes Hospitalizations, Children Age 0-17:
 - AC: Long-term trend mixed, trending up since 2011.
 - CCC: Trend is mixed.
- Fast Food Consumption: AC: Long-term trend mixed, trending up since 2014.
- Food Insecure Children Ineligible for Assistance: AC: Generally trending down since 2012.
- Food Insecurity, Child: AC: Trending down since 2013.

- Obesity-Related Hospitalizations: AC: Trending up since 2009.
- Students Meeting Fitness Standards, 5th Graders:
 - AC: Trend is mixed.
 - CCC: Trend is mixed.
- Students Meeting Fitness Standards, 7th Graders:
 - AC: Generally trending upward since 2011.
 - CCC: Trend is mixed.
- Students Meeting Fitness Standards, 9th Graders:
 - AC: Trend is mixed.
 - CCC: Trending down since 2014.
- Youth Fruit Consumption: AC: Generally trending up since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	26.4%	38.2%	21.0%	36.9%	20.9%		30.2%†	35.8%	18.2%
(CCC) Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	26.4%	39.8%	19.7%	41.0%	26.4%		26.6%†	29.5%	15.5%
(AC) Students Meeting Fitness Standards, 7th Graders (Kidsdata.org)	32.5%	42.7%	23.3%	45.7%	17.2%	34.2%	38.7%†	39.5%	22.4%

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(CCC) Students Meeting Fitness Standards, 7th Graders (Kidsdata.org)	32.5%	40.9%	23.2%	35.1%	21.6%		31.3%†	30.8%	21.2%
(AC) Students Meeting Fitness Standards, 9th Graders (Kidsdata.org)	37.6%	45.8%	22.6%	45.5%	16.3%	34.9%	38.7%†	33.7%	20.3%
(CCC) Students Meeting Fitness Standards, 9th Graders (Kidsdata.org)	37.6%	42.3%	26.8%	43.0%		32.4%	42.1%†	30.9%	23.6%
(AC) Did Not Eat Breakfast (CHKS)	#	26.0%	41.6%	25.2%	40.5%	34.9%	29.4%	36.8%	40.8%
(CCC) Did Not Eat Breakfast (CHKS)	#	25.7%	43.1%	23.1%	34.2%	35.3%	40.1%	34.0%	38.7%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.5%	74.2%						
Obesity (Adult), CA	26.5%	17.7%	33.3%	8.2%					26.1%
Obesity (Youth), CA	20.1%	8.0%	14.9%	5.2%	20.7%	9.8%	9.6%†	12.6%	21.6%
Physical Inactivity (Youth), CA	37.8%	17.9%	33.4%	14.8%	30.3%	24.6%	21.6%†	27.3%	36.2%

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

HEART/STROKE

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Atrial Fibrillation Among Medicare Beneficiaries (AC) (HAC.org)	percent			6.2	7.3	N/A			15.1%
*Congestive Heart Failure Hospitalizations (AC) (HAC.org)	rate			195.9	174.1	N/A			12.5%
Current/Former Smokers, Adults, CA	percent	12.2			13.7	0.4	10.9%		
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.4			81.8	-0.2	0.5%		
Exercise Opportunities	percent	97.0			93.6	0.4	3.6%		
Heart Disease Deaths	rate	69.9			99.5	1.4	29.7%		
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.9			10.5	0.3	5.7%		
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	6.3			7.0	0.4	10.0%		
High Blood Pressure Prevalence (AC) (HAC.org)	percent			25.5	26.9 (HP)	N/A			5.2%
Hyperlipidemia Among Medicare Beneficiaries (AC) (HAC.org)	percent			38.6	41.5	N/A			7.0%
Hypertension Among Medicare Beneficiaries (AC) (HAC.org)	percent			50.0	49.6	N/A			0.8%
Hypertension Hospitalizations (AC) (HAC.org)	rate			986.4	1,234.8	N/A			20.1%
Obesity (Adult), CA	percent	17.7			26.5	1.2	33.2%		
Obesity (Youth), CA	percent	10.4			20.1	2.7	48.3%		
Obesity Hospitalizations (AC) (HAC.org)	rate			367.3	396.8	N/A			7.4%
Physical Inactivity (Adult)	percent	17.2			17.3	0.1	0.6%		
Physical Inactivity (Youth), CA	percent	21.7			37.8	2.8	42.6%		
*Stroke Deaths	rate	39.0			35.4	-0.7	10.2%		
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9			7.4	-0.6	6.8%		
Stroke Prevalence, Medicare Beneficiaries	percent	3.8			3.7	-0.3	2.7%		
Walkable Destinations	percent	44.2			29.0	0.9	52.4%		

Trends

Trend data are available on certain indicators.

- Atrial Fibrillation Among Medicare Beneficiaries: AC: Trending down since 2013.
- Congestive Heart Failure Hospitalizations: AC: Generally trending down since 2009.
- High Blood Pressure Prevalence: AC: Generally trending down since 2012.
- Hyperlipidemia Among Medicare Beneficiaries: AC: Long-term trend is mixed, trending down since 2013.
- Hypertension Among Medicare Beneficiaries: AC: Generally trending down since 2011.
- Hypertension Hospitalizations: AC: Trending down since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.5%	74.2%						
Heart Disease Deaths	99.5	73.5	103.6	47.4		50.3			54.1
Obesity (Adult), CA	26.5%	17.7%	33.3%	8.2%					26.1%
Obesity (Youth), CA	20.1%	8.0%	14.9%	5.2%	20.7%	9.8%	9.6%†	12.6%	21.6%
Physical Inactivity (Youth), CA	37.8%	17.9%	33.4%	14.8%	30.3%	24.6%	21.6%†	27.3%	36.2%
Stroke Deaths	35.4	39.0	53.2	32.4					34.3

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

HOUSING AND HOMELESSNESS

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Asthma Diagnoses, Children Age 1-17 (AC, CCC) (Kidsdata.org)	percent		16.9	20.1	15.2	N/A		11.2%	32.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		22.7	36.9	19.6	N/A		15.8%	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		7.9	12.7	7.7	N/A		2.6%	64.9%
Banking Institutions (per 10,000)	rate	4.4			2.7	2.6	63.0%		
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.79			1.06	0.8	25.5%		
Children Living in Crowded Households (AC, CCC) (Kidsdata.org)	percent		16.7	23.5	28.2	N/A		40.8%	16.7%
Cost Burdened Households	percent	36.1			42.8	1.8	15.7%		
*Elevated Blood Lead Levels in Children Age 0-5 (AC, CCC) (Kidsdata.org)	percent		0.1	0.3	0.2	N/A		50.0%	50.0%
*Low Access to Healthy Food Stores	percent	26.0			13.4	-1.7	94.0%		
Home Ownership (AC, CCC) (AskCHIS)	percent		62.3	56.6	55.2	N/A		12.9%	2.5%
Homeless Children Age 0-17 Who Are Unsheltered (AC, CCC) (Kidsdata.org)	percent		0	86.1	88.0	N/A		100%	2.2%
Homeless Individuals Who Are Unsheltered (AC, CCC, CA) (PIT; HUD)	percent		57	69	78	N/A		26.9%	11.5%
Homeless Public School Students (AC, CCC) (Kidsdata.org)	percent		1.5	1.8	4.4	N/A		65.9%	59.1%
Homeless Young Adults Age 18-24 Who Are Unsheltered (AC, CCC) (Kidsdata.org)	percent		50.8	73.6	81.8	N/A		37.9%	10.0%
Housing Burden – Rents (AC) (HAC.org)	percent			49.6	56.5	N/A			12.2%
Housing Problems	percent	36.1			45.6	2.1	20.8%		
*Median Rent, 2 Bedrooms (AC, CCC) (Zilpy)	dollars		2,390	2,595	2,150	N/A		11.2%	20.7%
Segregation Index	number	0.28			0.43	1.5	34.9%		
Severe Housing Problems	percent	18.1			27.3	2.2	33.7%		

Data without Benchmarks

Certain indicators have no state or national comparison.

- A total of 5,629 individuals experienced homelessness in Alameda County in 2017 (PIT).
- A total of 1,607 individuals experienced homelessness in Contra Costa County in 2017 (PIT).

Trends

Trend data are available on certain indicators.

- Children Living in Crowded Households:
 - AC: Generally trending up since 2008.
 - CCC: Generally trending up since 2007.
- Homeless Children Age 0-17 Who Are Unsheltered:
 - AC: Up from zero in 2017.
 - CCC: Zero since 2015.
- Homeless Population:
 - AC: Increased in 2017.
 - CCC: Decreasing since 2015.
 - Unsheltered population rose in Central County in 2017.
- Homeless Young Adults Age 18-24 Who Are Unsheltered:
 - AC: Was trending down, rose sharply in 2017.
 - CCC: Trending down since 2015.
- Housing Burden – Rents: AC: Generally trending up since 2006.
- Median Rent, 2 Bedrooms:
 - AC: Increasing over past year.
 - CCC: Increasing over past year.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Homeless Population (PIT)	#	30%	49%			3%		15%	17%
(CCC) Homeless Population (PIT)	#	48%	33%	4%*					22%

Blank cells indicate that data were unavailable. # Benchmarks not available; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined. Statistics add to more than 100% because individuals may be both ethnically Hispanic/Latino and of another race.

MATERNAL/INFANT HEALTH

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C- CCC SDs	TV/C- CCC % different	CCC % different	AC % different
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC, CCC) (Kidsdata.org)	rate		22.7	36.9	19.6	N/A		15.8%	88.3%
Breastfeeding (AC, CCC) (HAC.org, CDPH)	percent		96.7	97.4	93.8	N/A		3.1%	3.8%
Child Mortality (AC, CCC) (CHR)	rate		30	30	40	N/A		25.0%	25.0%
Early Prenatal Care (AC, CCC) (HAC.org, CDPH)	percent		86.9	89.9	83.3	N/A		4.3%	7.9%
*Elevated Blood Lead Levels in Children Age 0-5 (AC, CCC) (Kidsdata.org)	percent		0.1	0.3	0.2	N/A		50.0%	50.0%
Female Received Birth Control Information from Doctor (AC) (AskCHIS)‡	percent			37.1	32.1	N/A			15.6%
Infant Deaths	rate	4.3			5.0	0.9	14.0%		
Life Expectancy at Birth	number	81.4			80.8	0.4	0.7%		
Low Birth Weight	percent	6.9			6.8	-0.3	1.5%		
Pre-Term Births	percent	8.9			9.0	0.1	1.1%		
Preschool Enrollment	percent	66.4			48.6	2.1	36.6%		
Teen Births (per 1,000 females age 15-19)	rate	18.4			29.3	1.2	37.2%		
Very Low Birth Weight (AC, CCC) (Kidsdata.org)	percent		1.1	1.2	1.2	N/A		8.3%	0.0%

‡ AskCHIS data for this indicator for Contra Costa County not provided because it is statistically unstable. Male comparisons for both counties not provided because they are statistically unstable.

Trends

Trend data are available on certain indicators.

- Asthma Hospitalizations, Children Age 0-4:
 - AC: Generally trending downward since 2005.
 - CCC: Generally trending downward since 2005.
- Breastfeeding: AC: Trending up since 2012.
- Early Prenatal Care: AC: Generally trending up since 2010.
- Teen Births:
 - AC: Generally trending down since 1995.
 - CCC: Generally trending down since 1996.
- Very Low Birth Weight:
 - AC: Trend is relatively flat since 1995.
 - CCC: Trend is relatively flat since 1995.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Child Mortality (CHR)	40	30	70						30
(CCC) Child Mortality (CHR)	40	20	70						30
Children Below 100% FPL	21.9%	4.1%	27.3%	3.5%	5.2%	9.1%	17.0%	6.7%	12.5%
(AC) Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.7	28.3	2.2*				11.4	25.3
(CCC) Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.6	21.9					10.1	24.3

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

ORAL HEALTH

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Annual Dental Visit Among Denti-Cal Beneficiaries, Age 0-20 (AC) (HAC.org)	percent			48.2	51.0	N/A			5.5%
Condition of Teeth (Adults): Less than Good (AC, CCC) (AskCHIS)	percent		24.0	22.4	29.3	N/A		18.1%	23.5%
Current/Former Smokers, Adults, CA	percent	12.2			13.7	0.4	10.9%		
Dentists	rate	84.5			80.3	0.2	5.2%		
Health Professional Shortage Area - Dental	percent	0			13.2	0.5	100.0%		
Lack of Dental Insurance Coverage, CA	percent	31.4			38.5	1.0	18.4%		
Oral Cancer Incidence (AC) (HAC.org)	rate			9.6	10.3	N/A			6.8%
Recent Dental Exam (Youth), CA	percent	87.0			86.7	0.2	0.3%		
Recent Dental Visit (Adults) (AC, CCC) (AskCHIS)	percent		74.2	78.4	70.3	N/A		5.6%	11.5%
Soft Drink Consumption, CA	percent	12.5			18.1	1.0	30.9%		

Trends

Trend data are available on certain indicators.

- Annual Dental Visit Among Denti-Cal Beneficiaries: AC: Trending down (i.e., getting worse) since 2013.
- Oral Cancer Incidence: AC: Generally trending down since 2004.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Oral Cancer Incidence	10.3	10.4	7.9	7.4*					5.8

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

SEXUALLY TRANSMITTED INFECTIONS

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Chlamydia Incidence	rate	407.9			459.9	0.4	11.3%		
*Chlamydia Incidence Among Youth Age 10-19 (AC, CCC) (Kidsdata.org)	rate		702.7	810.4	709.2	N/A		0.9%	14.3%
*Gonorrhea Incidence (AC) (HAC.org)	rate			186.7	164.3	N/A			13.6%
*Gonorrhea Incidence, Females (CCC) (CDPH)	rate		246.0		218.0	N/A		12.8%	
Gonorrhea Incidence, Males (CCC) (CDPH)	rate		295.6		372.6	N/A		20.7%	
*Gonorrhea Incidence Among Youth Age 10-19 (AC, CCC) (Kidsdata.org)	rate		123.5	203.5	121.2	N/A		1.9%	67.9%
HIV/AIDS Deaths	rate	75.5			323.9	3.0	76.7%		
HIV Incidence (AC) (HAC.org)	rate			16.3	12.7	N/A			28.3%
HIV/AIDS Incidence (CCC) (CDPH)	rate		247.2		391.7	N/A		36.9%	
HIV/AIDS Prevalence	rate	272.3			374.6	0.3	27.3%		
Syphilis Incidence (AC) (HAC.org)	rate			11.2	15.0	N/A			25.3%
Syphilis Incidence (Male) (CCC) (CDPH)†	rate		13.4		22.5	N/A		40.4%	

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

Trends

Trend data are available on certain indicators.

- Chlamydia Incidence Among Youth Age 10-19:
 - AC: Trending down since 2010.
 - CCC: Slight upward trend since 2012.
- Gonorrhea Incidence: AC: Generally trending up since 2009.
- Gonorrhea Incidence Among Youth Age 10-19:
 - AC: Long-term trend mixed; flat since 2013.
 - CCC: Long-term trend mixed; flat since 2012.
- HIV Incidence: AC: Trend is mixed.
- Syphilis Incidence: AC: Trending up since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
(AC) Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	709.2	443.2	3,727.6	206.8*					548.3
(CCC) Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	709.2	495.5	3,028.0	143.2*					531.1
(AC) Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	121.2	40.9	1,257.1	28.1*					84.0
(CCC) Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	121.2	53.4	712.1	13.4*					84.0

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

TRANSPORTATION AND TRAFFIC

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.79			1.06	0.8	25.5%		
*Bicycle-Involved Collisions (AC) (HAC.org)	rate			43.4	35.1	N/A			23.6%
Driving Alone to Work	percent	71.4			73.5	0.3	2.9%		
*Driving Alone to Work, Long Distances	percent	43.9			39.3	-0.6	11.5%		
Impaired Driving Deaths	percent	28.6			29.0	0.1	1.4%		
Motor Vehicle Crash Deaths	rate	6.1			8.6	0.8	29.1%		
*Motor Vehicle Crash ER Visits (AC) (HAC.org)	rate			809.3	747.3	N/A			8.3%
Pedestrian Accident Deaths	rate	1.4			2.3	1.8	39.1%		
Public Transit Stops Within 0.5 Mile	percent	31.3			16.8	1.9	86.3%		
*Road Network Density	rate	3.7			2.0	-1.2	85.0%		
Walkable Destinations	percent	44.2			29.0	0.9	52.4%		

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	6.8	9.2	3.2					5.7

Blank cells indicate that data were unavailable.

OVERALL HEALTH

Indicator	Indicator type	TV/C-CCC Value	CCC Value	AC Value	State avg	TV/C-CCC SDs	TV/C-CCC % different	CCC % different	AC % different
*Alzheimer's Disease Deaths (AC, CCC) (CDPH)	rate		37.2	32.0	34.2	N/A		8.8%	6.4%
*Alzheimer's Disease or Dementia Among Medicare Beneficiaries (AC) (HAC.org)	percent			10.0	9.3	N/A			7.5%
Arthritis Among Medicare Beneficiaries (AC) (HAC.org)	percent			23.1	27.6	N/A			16.3%
Chronic Kidney Disease Among Medicare Beneficiaries (AC) (HAC.org)	percent			18.6	17.9	N/A			3.9%
Frequent Physical Distress (AC, CCC) (HAC.org, CHR)	percent		9.0	9.1	10.9	N/A		17.4%	16.5%
General Health (Self-Report): Good or Better (AC) (HAC.org)	percent			86.4	82.0	N/A			5.4%
Life Expectancy at Birth	number	81.4			80.8	0.4	0.7%		
Osteoporosis Among Medicare Beneficiaries (AC) (HAC.org)	percent			5.9	6.7	N/A			11.9%
Poor or Fair Health, Adults	percent	11.8			17.2	1.4	31.4%		
Poor Physical Health Days, Adults	number	3.2			3.7	1.1	13.5%		
Population with Any Disability	percent	8.9			10.6	0.8	16.0%		
Premature Death	rate	4,727			5,251	0.5	10.0%		
*Students per Social Worker (AC, CCC) (Kidsdata.org)	number		34,960	37,494	12,870	N/A		171.6%	191.3%

Trends

Trend data are available on certain indicators.

- Alzheimer's Disease or Dementia Among Medicare Beneficiaries: AC: Trending down since 2010.
- Arthritis Among Medicare Beneficiaries: AC: Trending up since 2012.
- Chronic Kidney Disease Among Medicare Beneficiaries: AC: Trending up since 2010.
- General Health (Self-Report): Good or Better: AC: Generally trending down since 2011.
- Osteoporosis Among Medicare Beneficiaries: AC: Generally trending down since 2011.

- **Students per Social Worker:**
 - AC: Generally trending down since 2011.
 - CCC: Generally trending down since 2011.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Population with Any Disability	10.6%	10.2%	14.0%	5.1%	13.1%	21.4%	9.6%	6.4%	8.2%

Blank cells indicate that data were unavailable.

Attachment 4B. Secondary Data, Eastern Contra Costa County

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INTRODUCTION

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

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

Statistical data tables compare local data to California state benchmarks or national goals, whichever is more stringent.

Geographic area indicators that are at least two standard deviations (SD) or 5% or more worse than their benchmark have an asterisk, are in **bold type**, and are highlighted in **orange**. Those that are at least one SD worse have an asterisk, are in **bold type**, and are highlighted in **light orange**. Those that are at least a half SD worse have an asterisk, are in **bold type**, and are highlighted in **gray**. When indicators are worse than their benchmark by less than 5% or by less than 0.5 SDs, only their statistic is in **bold type**.

Indicators that are otherwise within one SD of the benchmark are merely highlighted in **gray**, those at least one SD better than the benchmark are highlighted in **light blue**, and those at least two SDs better are highlighted in **dark blue**. All indicators are rounded to the nearest tenth decimal point except when their values are less than one; then they are rounded to the nearest hundredth.

Indicators are from CHNA.org unless otherwise noted. Some CHNA.org indicators have the notation “CA” after them; this merely means that the indicator is only available for service areas/counties in California and not elsewhere in the U.S. CHNA.org indicators are for the

¹ Data updated September 4, 2018.

Eastern Contra Costa County area only, when available. Other indicators are countywide unless otherwise noted. When the Healthy People 2020 benchmark is used instead of the state average, the notation (HP) appears in the “State avg” column. The tables are presented alphabetically with the exception of “Overall Health,” which is last.

BEHAVIORAL HEALTH

Mental Health

Indicator	Indicator type	Value	State avg	SDs	% difference
*Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)	percent	18.9	16.4	N/A	15.2%
*Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)	percent	16.5	13.4	N/A	23.1%
Adults with Any Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	58.4	61.0	N/A	4.3%
Adults with Four or More Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	15.2	15.9	N/A	4.4%
*Bullied at School, 7th Graders (CCC) (CHKS)	percent	42.3	39.4	N/A	7.4%
Bullied at School, 9 th Graders (CCC) (CHKS)	percent	35.0	34.4	N/A	1.7%
Bullied at School, 11 th Graders (CCC) (CHKS)	percent	28.8	27.6	N/A	4.3%
Children in Foster Care (CCC) (Kidsdata.org)	rate	3.7	5.8	N/A	36.2%
Children Needing and Receiving Behavioral Health Care Services (CCC) (Kidsdata.org)	percent	62.5	62.7	N/A	0.3%
Children with Two or More Adverse Experiences (Parent Reported) (CCC) (Kidsdata.org)	percent	14.7	16.4	N/A	10.4%
Cyberbullied More than Once, 7 th Graders (CCC) (CHKS)	percent	9.8	9.4	N/A	4.3%
Cyberbullied More than Once, 9 th Graders (CCC) (CHKS)	percent	12.5	12.4	N/A	0.8%
Cyberbullied More than Once, 11 th Graders (CCC) (CHKS)	percent	12.6	12.4	N/A	1.6%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	29.5	34.2	0.5	13.7%
Depression Among Medicare Beneficiaries	percent	14.1	14.3	0.1	1.4%
Depression-Related Feelings, 7 th Graders (CCC) (CHKS)	percent	21.9	25.4	N/A	13.8%
Depression-Related Feelings, 9 th Graders (CCC) (CHKS)	percent	28.0	31.5	N/A	11.1%
Depression-Related Feelings, 11 th Graders (CCC) (CHKS)	percent	31.8	33.4	N/A	4.8%
Domestic Violence Calls for Assistance (CCC) (KidsData.org)	rate	4.6	6.0	N/A	23.3%
Domestic Violence Hospitalizations, CA	rate	6.3	4.9	-0.4	28.6%
Frequent Mental Distress (CCC) (CHR)	percent	10.0	10.6	N/A	5.7%
*Homicide (CCC) (CHR)	rate	6.0	5.0	N/A	20.0%
Insufficient Social and Emotional Support	percent	20.9	24.7	1.1	15.4%
Meaningful Participation in School: Low, 7 th Graders (CCC) (CHKS)	percent	27.6	31.3	N/A	11.8%
Meaningful Participation in School: Low, 9 th Graders (CCC) (CHKS)	percent	34.9	37.9	N/A	7.9%
Meaningful Participation in School: Low, 11 th Graders (CCC) (CHKS)	percent	35.0	36.9	N/A	5.1%
Mental Health Hospitalization, Children Age 5-14 (CCC) (Kidsdata.org)	rate	2.2	2.5	N/A	12.0%
Mental Health Hospitalization, Youth Age 15-19 (CCC) (Kidsdata.org)	rate	8.7	9.8	N/A	11.2%
Mental Health Providers	rate	301.1	288.7	0.1	4.3%
Poor Mental Health Days	number	3.5	3.7	0.5	5.4%
Recent Informal Community Engagement (Met with Others) (Adult) (CCC) (AskCHIS)	percent	15.9	16.5	N/A	3.6%
*Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (CCC) (AskCHIS)	percent	16.0	11.1	N/A	44.1%
School Connectedness: Low, 7 th Graders (CCC) (CHKS)	percent	9.0	10.2	N/A	11.8%
School Connectedness: Low, 9 th Graders (CCC) (CHKS)	percent	11.0	11.5	N/A	4.3%

Indicator	Indicator type	Value	State avg	SDs	% difference
School Connectedness: Low, 11 th Graders (CCC) (CHKS)	percent	12.8	12.5	N/A	2.4%
Seriously Considered Suicide, 9 th Graders (CCC) (CHKS)	percent	16.7	19.0	N/A	12.1%
Seriously Considered Suicide, 11 th Graders (CCC) (CHKS)	percent	18.3	18.1	N/A	1.1%
Seriously Considered Suicide, Adults, CA	percent	7.0	10.0	1.1	30.0%
*Social Associations (per 10,000)	rate	3.9	6.5	-1.9	40.0%
Students per School Psychologist (CCC) (Kidsdata.org)	number	959	1,265	N/A	24.2%
Suicide Deaths	rate	9.7	10.2 (HP)	0.2	4.9%
*Time in Foster Care (Median Months) (CCC) (Kidsdata.org)	number	17.5	15.6	N/A	12.2%
Young People Not in School and Not Working	percent	6.7	7.7	0.4	13.0%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.

Substance Use/Tobacco

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

CLIMATE AND HEALTH

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

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

COMMUNITY AND FAMILY SAFETY

Crime/Intentional Injury

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

Data without Benchmarks

Certain indicators have no state or national comparison.

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Unintended Injury/Accidents

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	7.2	10.2	2.7					5.2

Blank cells indicate that data were unavailable.

ECONOMIC SECURITY

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

Trends

Trend data are available on certain indicators.

- **Childcare Availability (Licensed):** Relatively flat since 2000.

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable.

EDUCATION AND LITERACY

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

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

HEALTH CARE ACCESS AND DELIVERY

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

Access to and Delivery of Health Care

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

Trends

Trend data are available on certain indicators.

- Students per School Nurse: Generally trending down since 2011.
- Students per School Psychologist: Trending down since 2012.
- Students per School Speech/Language/Hearing Specialist: Trending down since 2012.

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable.

Asthma

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Asthma ED Visits, All Ages (per 10,000) (CDPH)	49.5	38.6	233.0	25.3*					65.1
Asthma Hospitalizations, All Ages (per 10,000) (CDPH)	7.6	6.3	26.0	4.8*					8.1

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

Cancers

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

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

Communicable Diseases (Not STIs)

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

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

Trends

Trend data are available on certain indicators.

- **Kindergarteners with Required Immunizations: Relatively flat since 2002.**

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults 18+ with Influenza Vaccination (AskCHIS)	43.4%	53.7%							56.9%

Blank cells indicate that data were unavailable.

Heart/Stroke

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

Trends

No trend data are available.

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.2%	77.2%						
Heart Disease Deaths	99.5	71.3	106.7	46.9					53.4
Obesity (Adult), CA	26.5%	21.6%	35.6%	10.7%					29.7%
Obesity (Youth), CA	20.1%	15.8%	22.6%	10.9%	42.4%	0.0%	18.1%†	17.0%	27.5%
Physical Inactivity (Youth), CA	37.8%	32.6%	46.0%	30.6%	57.3%	0.0%	36.4%†	38.1%	45.0%
Stroke Deaths	35.4	40.1	53.6	33.1					34.8

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

Maternal/Infant Health

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Child Mortality (CHR)	40	20	70						30
Children Below 100% FPL	21.9%	8.2%	27.4%	12.4%	20.5%	14.1%		16.0%	21.6%
Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.6	21.9					10.1	24.3

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

Oral Health

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

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

Sexually Transmitted Infections

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

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	709.2	495.5	3,028.0	143.2*					531.1
Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	121.2	53.4	712.1	13.4*					84.0

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

HEALTHY EATING/ACTIVE LIVING

Includes access to food and recreation, food insecurity, diabetes, nutrition, diet, fitness, and obesity.

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

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

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

HOUSING AND HOMELESSNESS

Indicator	Indicator type	Value	State avg	SDs	% difference
*Asthma Diagnoses, Children Age 1-17 (CCC) (Kidsdata.org)	percent	16.9	15.2	N/A	11.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (CCC) (Kidsdata.org)	rate	22.7	19.6	N/A	15.8%
Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	7.9	7.7	N/A	2.6%
*Banking Institutions (per 10,000)	rate	1.9	2.7	-1.1	29.6%
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.54	1.06	1.6	49.1%
Children Living in Crowded Households (CCC) (Kidsdata.org)	percent	16.7	28.2	N/A	40.8%
Cost Burdened Households	percent	43.1	42.8	-0.1	0.7%
* Low Access to Healthy Food Stores	percent	19.8	13.4	-0.9	47.8%
High School Dropout (Adjusted) (CCC) (Kidsdata.org)	percent	5.8	10.7	N/A	45.8%
Home Ownership (CCC) (AskCHIS)	percent	62.3	55.2	N/A	12.9%
Homeless Children Age 0-17 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	0	88.0	N/A	100%
Homeless Individuals Who Are Unsheltered (CCC) (PIT; HUD)	percent	57	78.0	N/A	26.9%
Homeless Public School Students (CCC) (Kidsdata.org)	percent	1.5	4.4	N/A	65.9%
Homeless Young Adults Age 18-24 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	50.8	81.8	N/A	37.9%
Housing Problems	percent	44.8	45.6	0.2	1.8%
*Median Rent, 2 Bedrooms (CCC) (Zilpy)	dollars	2,390	2,150	N/A	11.2%
Segregation Index	number	0.32	0.43	1.1	25.6%
Severe Housing Problems	percent	24.4	27.3	0.7	10.6%

Data without Benchmarks

Certain indicators have no state or national comparison.

- A total of 1,607 individuals experienced homelessness in Contra Costa County in 2017 (PIT).

Trends

Trend data are available on certain indicators.

- Children Living in Crowded Households: Generally trending up since 2007.
- Homeless Children Age 0-17 Who Are Unsheltered: Zero since 2015.
- Homeless Population: Decreasing since 2015.
 - Unsheltered population dropping in West County since 2015.
- Homeless Young Adults Age 18-24 Who Are Unsheltered: Trending down since 2015.
- Median Rent, 2 Bedrooms: Increasing over past year.

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Homeless Population (PIT)	#	48%	33%	4%*					22%

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

TRANSPORTATION AND TRAFFIC

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

Trends

No trend data are available.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	7.2	10.2	2.7					5.2

Blank cells indicate that data were unavailable.

OVERALL HEALTH

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

Trends

Trend data are available on certain indicators.

- Students per Social Worker: Generally trending down since 2011.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Population with Any Disability	10.6%	14.1%	16.3%	9.3%	9.7%	19.6%	9.3%	11.9%	9.8%

Blank cells indicate that data were unavailable.

Attachment 4C. Secondary Data, Western Contra Costa County

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INTRODUCTION

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

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

Statistical data tables compare local data to California state benchmarks or national goals, whichever is more stringent.

Geographic area indicators that are at least two standard deviations (SD) or 5% or more worse than their benchmark have an asterisk, are in **bold type**, and are highlighted in **orange**. Those that are at least one SD worse have an asterisk, are in **bold type**, and are highlighted in **light orange**. Those that are at least a half SD worse have an asterisk, are in **bold type**, and are highlighted in **gray**. When indicators are worse than their benchmark by less than 5% or by less than 0.5 SDs, only their statistic is in **bold type**.

Indicators that are otherwise within one SD of the benchmark are merely highlighted in **gray**, those at least one SD better than the benchmark are highlighted in **light blue**, and those at least two SDs better are highlighted in **dark blue**. All indicators are rounded to the nearest tenth decimal point except when their values are less than one; then they are rounded to the nearest hundredth.

Indicators are from CHNA.org unless otherwise noted. Some CHNA.org indicators have the notation “CA” after them; this merely means that the indicator is only available for service

¹ Data updated September 4, 2018.

areas/counties in California and not elsewhere in the U.S. CHNA.org indicators are for the Western Contra Costa County area only, when available. Other indicators are county-wide unless otherwise noted. When the Healthy People 2020 benchmark is used instead of the state average, the notation (HP) appears in the “State avg” column. The tables are presented alphabetically with the exception of “Overall Health,” which is last.

BEHAVIORAL HEALTH

Mental Health

Indicator	Indicator type	Value	State avg	SDs	% difference
*Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)	percent	18.9	16.4	N/A	15.2%
*Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)	percent	16.5	13.4	N/A	23.1%
Adults with Any Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	58.4	61.0	N/A	4.3%
Adults with Four or More Adverse Childhood Experiences (CCC) (Kidsdata.org)	percent	15.2	15.9	N/A	4.4%
*Bullied at School, 7th Graders (CCC) (CHKS)	percent	42.3	39.4	N/A	7.4%
Bullied at School, 9 th Graders (CCC) (CHKS)	percent	35.0	34.4	N/A	1.7%
Bullied at School, 11 th Graders (CCC) (CHKS)	percent	28.8	27.6	N/A	4.3%
Children in Foster Care (CCC) (Kidsdata.org)	rate	3.7	5.8	N/A	36.2%
Children Needing and Receiving Behavioral Health Care Services (CCC) (Kidsdata.org)	percent	62.5	62.7	N/A	0.3%
Children with Two or More Adverse Experiences (Parent Reported) (CCC) (Kidsdata.org)	percent	14.7	16.4	N/A	10.4%
Cyberbullied More than Once, 7 th Graders (CCC) (CHKS)	percent	9.8	9.4	N/A	4.3%
Cyberbullied More than Once, 9 th Graders (CCC) (CHKS)	percent	12.5	12.4	N/A	0.8%
Cyberbullied More than Once, 11 th Graders (CCC) (CHKS)	percent	12.6	12.4	N/A	1.6%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	29.5	34.2	0.5	13.7%
Depression Among Medicare Beneficiaries	percent	14.1	14.3	0.1	1.4%
Depression-Related Feelings, 7 th Graders (CCC) (CHKS)	percent	21.9	25.4	N/A	13.8%
Depression-Related Feelings, 9 th Graders (CCC) (CHKS)	percent	28.0	31.5	N/A	11.1%
Depression-Related Feelings, 11 th Graders (CCC) (CHKS)	percent	31.8	33.4	N/A	4.8%
Domestic Violence Calls for Assistance (CCC) (KidsData.org)	rate	4.6	6.0	N/A	23.3%
*Domestic Violence Hospitalizations, CA	rate	6.3	4.9	-0.4	28.6%
Frequent Mental Distress (CCC) (CHR)	percent	10.0	10.6	N/A	5.7%
*Homicide (CCC) (CHR)	rate	6.0	5.0	N/A	20.0%
Insufficient Social and Emotional Support	percent	20.9	24.7	1.1	15.4%
Meaningful Participation in School: Low, 7 th Graders (CCC) (CHKS)	percent	27.6	31.3	N/A	11.8%
Meaningful Participation in School: Low, 9 th Graders (CCC) (CHKS)	percent	34.9	37.9	N/A	7.9%
Meaningful Participation in School: Low, 11 th Graders (CCC) (CHKS)	percent	35.0	36.9	N/A	5.1%
Mental Health Hospitalization, Children Age 5-14 (CCC) (Kidsdata.org)	rate	2.2	2.5	N/A	12.0%
Mental Health Hospitalization, Youth Age 15-19 (CCC) (Kidsdata.org)	rate	8.7	9.8	N/A	11.2%
Mental Health Providers	rate	301.1	288.7	0.1	4.3%
Poor Mental Health Days	number	3.5	3.7	0.5	5.4%
Recent Informal Community Engagement (Met with Others) (Adult) (CCC) (AskCHIS)	percent	15.9	16.5	N/A	3.6%
*Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (CCC) (AskCHIS)	percent	16.0	11.1	N/A	44.1%
School Connectedness: Low, 7 th Graders (CCC) (CHKS)	percent	9.0	10.2	N/A	11.8%

Indicator	Indicator type	Value	State avg	SDs	% difference
School Connectedness: Low, 9 th Graders (CCC) (CHKS)	percent	11.0	11.5	N/A	4.3%
School Connectedness: Low, 11 th Graders (CCC) (CHKS)	percent	12.8	12.5	N/A	2.4%
Seriously Considered Suicide, 9 th Graders (CCC) (CHKS)	percent	16.7	19.0	N/A	12.1%
Seriously Considered Suicide, 11 th Graders (CCC) (CHKS)	percent	18.3	18.1	N/A	1.1%
Seriously Considered Suicide, Adults, CA	percent	7.0	10.0	1.1	30.0%
*Social Associations (per 10,000)	rate	4.7	6.5	-1.2	27.7%
Students per School Psychologist (CCC) (Kidsdata.org)	number	959	1,265	N/A	24.2%
Suicide Deaths	rate	9.7	10.2 (HP)	N/A	4.9%
*Time in Foster Care (Median Months) (CCC) (Kidsdata.org)	number	17.5	15.6	N/A	12.2%
*Young People Not in School and Not Working	percent	9.0	7.7	-0.7	16.9%

Trends

Trend data are available on certain indicators.

- Adults Needing Help for Behavioral Health Issue: Trend is mixed.
- Children in Foster Care: Downward trend since 2000, slight upward trend since 2010.
- Domestic Violence Calls for Assistance: Downward trend since 1998.
- Mental Health Hospitalizations, Children Age 5-14: Long-term trend mixed, trending down since 2011.
- Mental Health Hospitalizations, Youth Age 15-19: Long-term trend mixed, trending slightly up since 2014.
- Mental Diseases and Disorders Hospitalizations, Children/Youth Age 0-17: Trend is mixed.
- Time in Foster Care, Median Months: Mixed trend, slightly upward since 2009.

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.

Substance Use/Tobacco

Indicator	Indicator type	Value	State avg	SDs	% difference
*Adults Needing Help for Behavioral Health Issue (CCC) (AskCHIS)	percent	18.9	16.4	N/A	15.2%
*Adults Seeing Health Care Provider for Behavioral Health Services (CCC) (AskCHIS)	percent	16.5	13.4	N/A	23.1%
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.94	1.06	0.4	11.3%
Chronic Liver Disease/Cirrhosis Deaths (CCC) (CDPH)	rate	8.6	12.2	N/A	29.5%
*Current/Former Smokers, Adults, CA	percent	16.0	13.7	-0.6	16.8%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	29.5	34.2	0.5	13.7%
Excessive Drinking, CA	percent	31.7	33.4	0.5	5.1%
Heart Disease Deaths	rate	69.2	99.5	1.5	30.4%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.5	7.0	1.0	21.4%
Impaired Driving Deaths	percent	28.1	29.0	0.2	3.1%
Low Birth Weight	percent	6.7	6.8	0.1	1.5%
*Lung Cancer Incidence	rate	47.4	44.6	-0.5	6.3%
Opioid Prescription Drug Claims	percent	5.8	7.0	0.7	17.1%
Poor Mental Health Days	number	3.5	3.7	0.5	5.4%
Recent Alcohol/Drug Use, 7 th Graders (CCC) (CHKS)	percent	7.8	10.4	N/A	25.0%
Recent Alcohol/Drug Use, 9 th Graders (CCC) (CHKS)	percent	20.7	23.2	N/A	10.8%
Recent Alcohol/Drug Use, 11 th Graders (CCC) (CHKS)	percent	31.7	33.4	N/A	5.1%
Recent Marijuana Use, 7 th Graders (CCC) (CHKS)	percent	2.7	4.2	N/A	35.7%
Recent Marijuana Use, 9 th Graders (CCC) (CHKS)	percent	11.0	12.3	N/A	10.6%
Recent Marijuana Use, 11 th Graders (CCC) (CHKS)	percent	18.6	18.0	N/A	3.3%
Very Low Birth Weight (CCC) (Kidsdata.org)	percent	1.1	1.2	N/A	8.3%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White.

CLIMATE/NATURAL ENVIRONMENT

Indicator	Indicator type	Value	State avg	SDs	% difference
*Active Asthma Prevalence, All Ages (CCC) (CDPH)	percent	10.6	8.3	N/A	27.7%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0	2.4	0.7	16.7%
*Asthma Hospitalizations, All Ages (per 10,000) (CCC) (Kidsdata.org)	rate	8.5	7.6	N/A	11.8%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (CCC) (Kidsdata.org)	rate	22.7	19.6	N/A	15.8%
Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	7.9	7.7	N/A	2.6%
Asthma Prevalence, Adults, CA	percent	14.2	14.8	0.2	4.1%
Climate-Related Mortality Impacts	percent	0.4	8.4	1.0	95.2%
Drinking Water Violations	number	0	0.8	2.0	100.0%
Driving Alone to Work	percent	61.8	73.5	1.5	15.9%
*Driving Alone to Work, Long Distances	percent	48.2	39.3	-1.1	22.6%
Drought Severity	percent	90.8	92.8	0.3	2.2%
Flood Vulnerability	percent	3.7	3.7	0.0	0.0%
Heat Index	percent	0	2.7	0.6	100.0%
Ozone Levels	percent	30.3	42.0	1.9	27.9%
Particulate Matter 2.5 Levels	percent	10.2	10.7	0.3	4.7%
Public Transit Stops Within 0.5 Mile	percent	26.6	16.8	1.3	58.3%
Respiratory Hazard Index	number	2.2	2.2	-0.1	0.0%
*Road Network Density	rate	8.7	2.0	-3.0	335.0%
Tree Canopy Cover	percent	20.5	8.3	1.8	147.0%

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

COMMUNITY AND FAMILY SAFETY

Crime/Intentional Injury

Indicator	Indicator type	Value	State avg	SDs	% difference
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.94	1.06	0.4	11.3%
*Bullied at School, 7th Graders (CCC) (CHKS)	percent	42.3	39.4	N/A	7.4%
Bullied at School, 9 th Graders (CCC) (CHKS)	percent	35.0	34.4	N/A	1.7%
Bullied at School, 11 th Graders (CCC) (CHKS)	percent	28.8	27.6	N/A	4.3%
Cyberbullied More than Once, 7 th Graders (CCC) (CHKS)	percent	9.8	9.4	N/A	4.3%
Cyberbullied More than Once, 9 th Graders (CCC) (CHKS)	percent	12.5	12.4	N/A	0.8%
Cyberbullied More than Once, 11 th Graders (CCC) (CHKS)	percent	12.6	12.4	N/A	1.6%
Domestic Violence Calls for Assistance (CCC) (KidsData.org)	rate	4.6	6.0	N/A	23.3%
*Domestic Violence Hospitalizations, CA	rate	6.3	4.9	-0.4	28.6%
Fear Being Beaten Up at School, 7 th Graders (CCC) (CHKS)	percent	23.2	24.7	N/A	6.1%
Fear Being Beaten Up at School, 9 th Graders (CCC) (CHKS)	percent	16.9	17.9	N/A	5.6%
Fear Being Beaten Up at School, 11 th Graders (CCC) (CHKS)	percent	10.9	11.9	N/A	8.4%
*Firearm Fatalities (CCC) (CHR)	rate	9.0	8.0	N/A	12.5%
Gang Membership, 7 th Graders (CCC) (CHKS)	percent	7.0	8.1	N/A	13.6%
*Gang Membership, 9th Graders (CCC) (CHKS)	percent	8.7	7.5	N/A	16.0%
*Gang Membership, 11th Graders (CCC) (CHKS)	percent	8.0	7.5	N/A	6.7%
*Homicide (CCC) (CHR)	rate	6.0	5.0	N/A	20.0%
Injury Deaths	rate	44.3	46.6	0.2	4.9%
Jail Admissions, Age 15-64 (CCC) (Vera)	rate	3,534.8	3,805.9	N/A	7.1%
Jail Incarceration, Age 15-64 (CCC) (Vera)	rate	161.0	278.9	N/A	42.3%
Juvenile Felony Arrests, Age 10-17 (per 1,000) (CCC) (Kidsdata.org)	rate	4.3	5.3	N/A	18.9%
School Perceived as Unsafe/Very Unsafe, 7 th Graders (CCC) (CHKS)	percent	9.1	9.3	N/A	2.2%
*School Perceived as Unsafe/Very Unsafe, 9th Graders (CCC) (CHKS)	percent	8.7	7.7	N/A	13.0%
*School Perceived as Unsafe/Very Unsafe, 11th Graders (CCC) (CHKS)	percent	8.4	6.5	N/A	29.2%
Substantiated Child Abuse and Neglect (per 1,000 under age 18) (CCC) (KidsData.org)	rate	4.3	8.2	N/A	47.6%
*Traumatic Injury Hospitalizations, Children Age 0-17 (CCC) (Kidsdata.org)	percent	1.5	1.1	N/A	36.4%
Violent Crimes	rate	366.0	402.7	0.3	9.1%

Data without Benchmarks

Certain indicators have no state or national comparison.

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Unintended Injury/Accidents

Indicator	Indicator type	Value	State avg	SDs	% difference
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.94	1.06	0.4	11.3%
Elevated Blood Lead Levels in Children Age 0-5 (CCC) (Kidsdata.org)	percent	0.1	0.2	N/A	50.0%
Elevated Blood Lead Levels in Children/Youth Age 6-20 (CCC) (Kidsdata.org)	percent	0.2	0.3	N/A	33.3%
*Firearm Fatalities (CCC) (CHR)	rate	9.0	8.0	N/A	12.5%
Impaired Driving Deaths	percent	28.1	29.0	0.2	3.0%
Injury Deaths	rate	44.3	46.6	0.2	4.8%
Motor Vehicle Crash Deaths	rate	6.4	8.6	0.7	25.3%
Pedestrian Accident Deaths	rate	1.5	2.3	1.7	34.8%
*Poisoning Hospitalizations, Children Age 0-17 (CCC) (Kidsdata.org)	percent	1.3	0.9	N/A	44.4%
*Traumatic Injury Hospitalizations, Children Age 0-17 (CCC) (Kidsdata.org)	percent	1.5	1.1	N/A	36.4%
Unintentional Injury Deaths (CCC) (CDPH)	rate	26.1	30.3	N/A	13.9%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	7.2	10.2	2.7					5.2

Blank cells indicate that data were unavailable.

ECONOMIC SECURITY

Indicator	Indicator type	Value	State avg	SDs	% difference
Adults with an Associate's Degree or Higher, Age 25+	percent	38.5	39.8	-0.1	3.3%
Adults with No High School Diploma, Age 25+	percent	18.2	17.9	-0.1	1.7%
*Adults with Some Post-secondary Education, Age 25-44	percent	59.4	63.6	-0.5	6.6%
*Banking Institutions (per 10,000)	rate	1.8	2.7	-1.2	33.3%
Childcare Availability (Licensed) (CCC) (Kidsdata.org)	percent	30	25	N/A	20.0%
Children Below 100% FPL	percent	19.7	21.9	0.3	10.0%
*Children in Single-parent Households	percent	35.4	31.8	-0.7	11.3%
Children without Secure Parental Employment (CCC) (Kidsdata.org)	percent	27.2	32.8	N/A	17.1%
Cost Burdened Households	percent	41.1	42.8	0.5	4.0%
*Cost of Infant Childcare, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	14,979	13,327	N/A	12.4%
*Cost of Preschool Childcare, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	10,895	9,106	N/A	19.6%
*Free and Reduced Price Lunch	percent	72.0	58.9	-1.1	22.2%
High Speed Internet	percent	99.2	95.4	0.4	4.0%
Income Inequality - 80/20 Ratio	number	3.9	5.1	2.2	23.5%
Median Household Income	dollars	82,881	65,812	1.2	25.9%
*Medicaid/Public Insurance Enrollment	percent	23.1	21.8	-0.2	6.0%
Opportunity Index	number	60.0	51.9	1.0	15.6%
Population Below 100% FPL	percent	14.0	15.8	0.4	11.4%
SNAP Benefits	percent	9.5	9.4	0.0	1.1%
Unemployment	percent	3.1	4.0	0.5	22.5%
Uninsured Children	percent	5.9	10.4	2.4	43.3%
Uninsured Population	percent	12.9	12.6	-0.1	2.4%
*Young People Not in School and Not Working	percent	9.0	7.7	-0.7	16.9%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults with No High School Diploma	17.9%	5.4%	10.9%	14.8%	38.1%	31.5%	39.8%	9.7%	39.3%
Children Below 100% FPL	21.9%	13.4%	28.4%	8.3%	58.3%	13.2%	24.2%	13.3%	22.4%
Median Household Income	65,812	96,220	52,917	102,276		58,507	57,053	72,339	61,038
Population Below 100% FPL	15.8%	8.6%	19.6%	8.8%	37.5%	12.6%	19.1%	14.3%	17.6%
SNAP Benefits	9.4%	4.8%	16.0%	4.5%	26.5%	4.9%	13.0%	13.6%	13.7%
Uninsured Children	10.4%	6.4%	3.3%	3.9%	5.4%	6.6%	8.5%	4.5%	7.5%
Uninsured Population	12.6%	7.1%	9.2%	10.8%	23.5%	15.2%	20.8%	11.1%	19.6%

Blank cells indicate that data were unavailable.

EDUCATION AND LITERACY

Indicator	Indicator type	Value	State avg	SDs	% difference
Adults with an Associate's Degree or Higher, Age 25+	percent	38.5	39.8	-0.1	3.3%
Adults with No High School Diploma, Age 25+	percent	18.2	17.9	-0.1	1.7%
*Adults with Some Post-secondary Education, Age 25-44	percent	59.4	63.6	-0.5	6.6%
Children in Linguistically Isolated Households (CCC) (Kidsdata.org)	percent	8.0	10.5	N/A	23.8%
*Cost of Preschool Childcare, Annually, Child Care Center (CCC) (Kidsdata.org)	dollars	10,895	9,106	N/A	19.6%
*Expulsions, CA (per 100 enrolled students)	rate	0.38	0.08	-3.0	375.0%
High School Dropout (Adjusted) (CCC) (Kidsdata.org)	percent	5.8	10.7	N/A	45.8%
High School Graduates Completing College Prep Courses (CCC) (Kidsdata.org)	percent	48.9	43.4	N/A	12.7%
High Speed Internet	percent	99.2	95.4	0.4	4.0%
Juvenile Felony Arrests, Age 10-17 (per 1,000) (CCC) (Kidsdata.org)	rate	4.3	5.3	N/A	18.9%
On-Time High School Graduation, CA	rate	85.1	82.9	0.4	2.7%
Preschool Enrollment	percent	52.0	48.6	0.4	7.0%
*Reading at or Above Proficiency, CA	percent	32.0	43.9	-1.6	27.1%
*Students per Academic Counselor (CCC) (Kidsdata.org)	number	1,014	792	N/A	28.0%
*Suspensions, CA (per 100 enrolled students)	rate	11.0	5.9	-1.9	86.4%
Teen Births (per 1,000 females age 15-19)	rate	17.9	29.3	1.2	38.9%
*Truancy (per 100 students) (CCC) (Kidsdata.org)	rate	37.8	31.4	N/A	20.4%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults with No High School Diploma	17.9%	5.4%	10.9%	14.8%	38.1%	31.5%	39.8%	9.7%	39.3%
High School Dropout (Adjusted) (Kidsdata.org)	10.7%	3.7%	11.3%	1.7%				5.7%	8.5%
High School Graduates Completing College Prep Courses (Kidsdata.org)	43.4%	57.6%	26.1%	71.8%	26.7%		57.6%†	51.8%	34.9%
Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.6	21.9					10.1	24.3

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

HEALTH CARE ACCESS AND DELIVERY

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

Access to and Delivery of Health Care

Indicator	Indicator type	Value	State avg	SDs	% difference
30-Day Readmissions	percent	13.6	14.4	0.8	5.6%
*Adults Delayed/Didn't Get "Other Medical" Care (CCC) (AskCHIS)	percent	11.0	9.8	N/A	12.2%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0	2.4	0.7	16.7%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	63.6	59.7	0.8	6.5%
Dentists	rate	82.4	80.3	0.1	2.6%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.6	81.8	-0.1	0.2%
*Federally Qualified Health Centers	rate	2.1	2.5	-0.3	16.0%
Lack of Dental Insurance Coverage, CA	percent	32.3	38.5	0.9	16.1%
*Medicaid/Public Insurance Enrollment	percent	23.1	21.8	-0.2	6.0%
Mental Health Providers	rate	301.1	288.7	0.1	4.3%
Poor or Fair Health, Adults	percent	12.1	17.2	1.4	29.7%
Poor Physical Health Days, Adults	number	3.3	3.7	0.9	10.8%
*Premature Death, Racial/Ethnic Disparity Index	number	46.6	36.8	-1.2	26.6%
Preventable Hospital Events	rate	33.8	35.9	0.3	5.8%
Primary Care Physicians	rate	98.3	78.1	0.9	25.9%
Recent Dental Exam (Youth), CA	percent	86.0	86.7	-0.4	0.8%
Recent Dental Visit (Adults) (CCC) (AskCHIS)	percent	74.2	70.3	N/A	5.5%
*Recent ER Visit, Adults (CCC) (AskCHIS)	percent	24.2	21.4	N/A	13.1%
*Recent ER Visit, Adults 65+ (CCC) (AskCHIS)‡	percent	30.4	22.0	N/A	38.2%
Recent Primary Care Visit, CA	percent	73.2	72.4	0.2	1.1%
*Students per School Nurse (CCC) (Kidsdata.org)	number	5,393	2,784	N/A	93.7%
Students per School Psychologist (CCC) (Kidsdata.org)	number	959	1,265	N/A	24.2%
*Students per School Speech/Language/Hearing Specialist (CCC) (Kidsdata.org)	number	1,359	1,263	N/A	7.6%
Uninsured Children	percent	5.9	10.4	2.4	43.3%
Uninsured Population	percent	12.9	12.6	-0.1	2.4%

Trends

Trend data are available on certain indicators.

- Students per School Nurse: Generally trending down since 2011.
- Students per School Psychologist: Trending down since 2012.
- Students per School Speech/Language/Hearing Specialist: Trending down since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	64.2%	56.3%						
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.2%	77.2%						
Preventable Hospital Events	35.9	32.5	48.5						
Uninsured Children	10.4%	6.4%	3.3%	3.9%	5.4%	6.6%	8.5%	4.5%	7.5%
Uninsured Population	12.6%	7.1%	9.2%	10.8%	23.5%	15.2%	20.8%	11.1%	19.6%

Blank cells indicate that data were unavailable.

Asthma

Indicator	Indicator type	Value	State avg	SDs	% difference
*Active Asthma Prevalence, All Ages (CCC) (CDPH)	percent	10.6	8.3	N/A	27.7%
*Asthma Diagnoses, Children Age 1-17 (CCC) (Kidsdata.org)	percent	16.9	15.2	N/A	11.2%
*Asthma ED Visits, All Ages (per 10,000) (CCC) (CDPH)	rate	64.6	49.5	N/A	30.5%
Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	2.0	2.4	0.7	16.7%
*Asthma Hospitalizations, All Ages (per 10,000) (CCC) (Kidsdata.org)	rate	8.5	7.6	N/A	11.8%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (CCC) (Kidsdata.org)	rate	22.7	19.6	N/A	15.8%
Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	7.9	7.7	N/A	2.6%
Asthma Prevalence, Adults, CA	percent	14.2	14.8	0.2	4.1%
*Average Charge per Asthma Hospitalization (CCC) (CDPH)	dollars	45,784	39,860	N/A	14.9%
Ozone Levels	percent	30.3	42.0	1.9	27.9%
Particulate Matter 2.5 Levels	percent	10.2	10.7	0.3	4.7%
Respiratory Hazard Index	number	2.2	2.2	-0.1	0.0%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

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

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

Cancers

Indicator	Indicator type	Value	State avg	SDs	% difference
Breast Cancer Deaths, Females (CCC) (CDPH)	rate	19.0	19.1	N/A	0.5%
*Breast Cancer Incidence, Females	rate	130.6	120.7	-1.1	8.2%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	63.6	59.7	0.8	6.5%
Cancer Deaths	rate	146.7	147.3	0.1	0.4%
Childhood Cancer Diagnoses Age 0-19 (CCC) (Kidsdata.org)	Rate	15.7	17.4	N/A	9.8%
*Colon and Rectum Cancer Incidence	rate	40.0	37.2	-1.2	7.5%
Colorectal Cancer Deaths (CCC) (CDPH)	rate	12.9	12.8	N/A	0.8%
*Current/Former Smokers, Adults, CA	percent	16.0	13.7	-0.6	16.8%
Lung Cancer Deaths (CCC) (CDPH)	rate	29.2	28.9	N/A	1.0%
*Lung Cancer Incidence	rate	47.4	44.6	-0.5	6.3%
Prostate Cancer Deaths (CCC) (CDPH)	rate	20.1	19.6	N/A	2.6%
*Prostate Cancer Incidence	rate	126.5	109.2	-2.2	15.8%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	64.2%	56.3%						
Cancer Deaths	147.3	156.0	199.5	94.6		83.6			117.2
Childhood Cancer Diagnoses, Ages 0-19 (Kidsdata.org)	17.4	16.4		10.4*					16.9

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

Communicable Diseases (Not STIs)

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

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

Trends

Trend data are available on certain indicators.

- **Kindergarteners with Required Immunizations: Relatively flat since 2002.**

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults 18+ with Influenza Vaccination (AskCHIS)	43.4%	53.7%							56.9%

Blank cells indicate that data were unavailable.

Heart/Stroke

Indicator	Indicator type	Value	State avg	SDs	% difference
*Current/Former Smokers, Adults, CA	percent	16.0	13.7	-0.6	16.8%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.6	81.8	-0.1	0.2%
Exercise Opportunities	percent	95.9	93.6	0.3	2.5%
Heart Disease Deaths	rate	69.2	99.5	1.5	30.5%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.5	7.0	1.0	21.4%
Obesity (Adult), CA	percent	24.1	26.5	0.3	9.1%
*Obesity (Youth), CA	percent	22.5	20.1	-0.7	11.9%
Physical Inactivity (Adult)	percent	17.8	17.3	-0.2	2.9%
*Physical Inactivity (Youth), CA	percent	50.7	37.8	-2.2	34.1%
*Stroke Deaths	rate	40.1	35.4	-1.0	13.3%
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9	7.4	-0.6	6.8%
Stroke Prevalence, Medicare Beneficiaries	percent	3.8	3.7	-0.3	2.7%
Walkable Destinations	percent	39.3	29.0	0.6	35.5%

Trends

No trend data are available.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.2%	77.2%						
Heart Disease Deaths	99.5	71.3	106.7	46.9					53.4
Obesity (Adult), CA	26.5%	20.6%	35.6%	9.8%					30.0%
Obesity (Youth), CA	20.1%	14.4%	25.0%	16.3%	39.1%		14.8%†	18.2%	25.6%
Physical Inactivity (Youth), CA	37.8%	37.6%	56.5%	36.0%	65.2%		28.0%†	49.2%	55.5%
Stroke Deaths	35.4	40.1	53.6	33.1					34.8

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

Maternal/Infant Health

Indicator	Indicator type	Value	State avg	SDs	% difference
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (CCC) (Kidsdata.org)	rate	22.7	19.6	N/A	15.8%
Breastfeeding (CCC) (CDPH)	percent	96.7	93.8	N/A	3.1%
Child Mortality (CCC) (CHR)	rate	30	40	N/A	25.0%
Early Prenatal Care (CCC) (CDPH)	percent	86.9	83.3	N/A	4.3%
Elevated Blood Lead Levels in Children Age 0-5 (CCC) (Kidsdata.org)	percent	0.1	0.2	N/A	50.0%
Infant Deaths	rate	4.2	5.0	1.0	16.0%
Life Expectancy at Birth	number	81.4	80.8	0.4	0.7%
Low Birth Weight	percent	6.7	6.8	0.1	1.5%
Preschool Enrollment	percent	52.0	48.6	0.4	7.0%
Pre-Term Births	percent	8.9	9.0	0.1	1.1%
Teen Births (per 1,000 females age 15-19)	rate	17.9	29.3	1.2	38.9%
Very Low Birth Weight (CCC) (Kidsdata.org)	percent	1.1	1.2	N/A	8.3%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Child Mortality (CHR)	40	20	70						30
Children Below 100% FPL	21.9%	13.4%	28.4%	8.3%		13.2%		13.3%	22.4%
Teen Births (per 1,000 females age 15-19) (Kidsdata.org)	23.2	4.6	21.9					10.1	24.3

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

Oral Health

Indicator	Indicator type	Value	State avg	SDs	% difference
*Current/Former Smokers, Adults, CA	percent	16.0	13.7	-0.6	16.8%
Condition of Teeth (Adults): Less than Good (CCC) (AskCHIS)	percent	24.0	29.3	N/A	18.1%
Dentists	rate	82.4	80.3	0.1	2.6%
*Health Professional Shortage Area - Dental	percent	40.2	13.2	-1.1	204.5%
Lack of Dental Insurance Coverage, CA	percent	32.3	38.5	0.9	16.1%
Recent Dental Exam (Youth), CA	percent	86.0	86.7	-0.4	0.8%
Recent Dental Visit (Adults) (CCC) (AskCHIS)	percent	74.2	70.3	N/A	5.5%
Soft Drink Consumption, CA	percent	17.7	18.1	0.1	2.2%

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

Sexually Transmitted Infections

Indicator	Indicator type	Value	State avg	SDs	% difference
Chlamydia Incidence	rate	388.4	459.9	0.6	15.5%
Chlamydia Incidence Among Youth Age 10-19 (CCC) (Kidsdata.org)	rate	702.7	709.2	N/A	0.9%
*Gonorrhea Incidence, Females Age 15-44 (CCC) (CDPH)	rate	246.0	218.0	N/A	12.8%
Gonorrhea Incidence, Males Age 15-44 (CCC) (CDPH)	rate	295.6	372.6	N/A	20.7%
Gonorrhea Incidence Among Youth Age 10-19 (CCC) (Kidsdata.org)	rate	123.5	121.2	N/A	1.9%
HIV/AIDS Deaths	rate	77.7	323.9	3.0	76.0%
HIV/AIDS Incidence Age 13+ (CCC) (CDPH)	rate	247.2	391.7	N/A	36.9%
HIV/AIDS Prevalence	rate	217.8	374.6	0.5	41.9%
Syphilis Incidence (Male) (CCC) (CDPH)‡	rate	13.4	22.5	N/A	40.4%

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	709.2	495.5	3,028.0	143.2*					531.1
Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	121.2	53.4	712.1	13.4*					84.0

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

HEALTHY EATING/ACTIVE LIVING

Includes access to food and recreation, food insecurity, diabetes, nutrition, diet, fitness, and obesity.

Indicator	Indicator type	Value	State avg	SDs	% difference
Adequate Fruit and Vegetable Consumption, Children Age 2-11 (AC, CCC) (Kidsdata.org)‡	percent	36.0	32.0	N/A	12.5%
*Children Walking or Biking to School, CA	percent	18.7	39.3	-2.2	52.4%
*Current/Former Smokers, Adults, CA	percent	16.0	13.7	-0.6	16.8%
Diabetes Deaths (CCC) (CDPH)	rate	17.6	20.7	N/A	15.0%
*Diabetes Hospitalizations, Children Age 0-17 (CCC) (Kidsdata.org)	percent	1.5	1.4	N/A	7.1%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	81.6	81.8	-0.1	0.2%
Diabetes Prevalence, CA	percent	8.6	8.4	-0.1	2.4%
Did Not Eat Breakfast, 7 th Graders (CCC) (CHKS)	percent	29.2	34.0	N/A	14.1%
Did Not Eat Breakfast, 9 th Graders (CCC) (CHKS)	percent	32.5	38.3	N/A	15.1%
Did Not Eat Breakfast, 11 th Graders (CCC) (CHKS)	percent	35.1	39.4	N/A	10.9%
Driving Alone to Work	percent	61.8	73.5	1.5	15.9%
*Driving Alone to Work, Long Distances	percent	48.2	39.3	-1.1	22.6%
Exercise Opportunities	percent	95.9	93.6	0.3	2.5%
Food Environment Index	number	8.1	7.8	0.5	3.8%
Food Insecurity	percent	12.5	13.4	0.5	6.7%
*Free and Reduced Price Lunch	percent	72.0	58.9	-1.1	22.2%
Grocery Stores and Produce Vendors	rate	3.2	2.4	1.4	33.3%
*Low Access to Healthy Food Stores	percent	16.5	13.4	-0.4	23.1%
Heart Disease Deaths	rate	69.2	99.5	1.5	30.5%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	9.8	10.5	0.3	6.7%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.5	7.0	1.0	21.4%
Obesity (Adult), CA	percent	24.1	26.5	0.3	9.1%
*Obesity (Youth), CA	percent	22.5	20.1	-0.7	11.9%
Physical Inactivity (Adult)	percent	17.8	17.3	-0.2	2.9%
*Physical Inactivity (Youth), CA	percent	50.7	37.8	-2.2	34.1%
Public Transit Stops Within 0.5 Mile	percent	26.6	16.8	1.3	58.3%
SNAP Benefits	percent	9.5	9.4	0.0	1.1%
Soft Drink Consumption, CA	percent	17.7	18.1	0.1	2.2%
*Stroke Deaths	rate	40.1	35.4	-1.0	13.3%
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9	7.4	-0.6	6.8%
Stroke Prevalence, Medicare Beneficiaries	percent	3.8	3.7	-0.3	2.7%
Students Meeting Fitness Standards, 5 th Graders (CCC) (Kidsdata.org)	percent	30.6	26.4	N/A	15.9%
Students Meeting Fitness Standards, 7 th Graders (CCC) (Kidsdata.org)	percent	34.2	32.5	N/A	5.2%
Students Meeting Fitness Standards, 9 th Graders (CCC) (Kidsdata.org)	percent	38.9	37.6	N/A	3.5%
Walkable Destinations	percent	39.3	29.0	0.6	35.5%

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

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Did Not Eat Breakfast (CHKS)	#	25.7%	43.1%	23.1%	34.2%	35.3%	40.1%	34.0%	38.7%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	82.2%	77.2%						
Heart Disease Deaths	99.5	71.3	106.7	46.9					53.4
Obesity (Adult), CA	26.5%	20.6%	35.6%	9.8%					30.0%
Obesity (Youth), CA	20.1%	14.4%	25.0%	16.3%	39.1%		14.8%†	18.2%	25.6%
Physical Inactivity (Youth), CA	37.8%	37.6%	56.5%	36.0%	65.2%		28.0%†	49.2%	55.5%
SNAP Benefits	9.4%	4.8%	16.0%	4.5%	26.5%	4.9%	13.0%	13.6%	13.7%
Stroke Deaths	35.4	40.1	53.6	33.1					34.8
Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	26.4%	39.8%	19.7%	41.0%	26.4%		26.6%†	29.5%	15.5%
Students Meeting Fitness Standards, 7th Graders (Kidsdata.org)	32.5%	40.9%	23.2%	35.1%	21.6%		31.3%†	30.8%	21.2%
Students Meeting Fitness Standards, 9th Graders (Kidsdata.org)	37.6%	42.3%	26.8%	43.0%		32.4%	42.1%†	30.9%	23.6%

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

HOUSING AND HOMELESSNESS

Indicator	Indicator type	Value	State avg	SDs	% difference
*Asthma Diagnoses, Children Age 1-17 (CCC) (Kidsdata.org)	percent	16.9	15.2	N/A	11.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (CCC) (Kidsdata.org)	rate	22.7	19.6	N/A	15.8%
Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (CCC) (Kidsdata.org)	rate	7.9	7.7	N/A	2.6%
*Banking Institutions (per 10,000)	rate	1.8	2.7	-1.2	33.3%
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.94	1.06	0.4	11.3%
Children Living in Crowded Households (CCC) (Kidsdata.org)	percent	16.7	28.2	N/A	40.8%
Cost Burdened Households	percent	41.1	42.8	0.5	4.0%
*Low Access to Healthy Food Stores	percent	16.5	13.4	-0.4	23.1%
Home Ownership (CCC) (AskCHIS)	percent	62.3	55.2	N/A	12.9%
Homeless Children Age 0-17 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	0	88.0	N/A	100%
Homeless Individuals Who Are Unsheltered (CCC) (PIT; HUD)	percent	57	78.0	N/A	26.9%
Homeless Public School Students (CCC) (Kidsdata.org)	percent	1.5	4.4	N/A	65.9%
Homeless Young Adults Age 18-24 Who Are Unsheltered (CCC) (Kidsdata.org)	percent	50.8	81.8	N/A	37.9%
Housing Problems	percent	44.3	45.6	0.3	2.9%
Median Household Income	dollars	82,881	65,812	1.2	25.9%
*Median Rent, 2 Bedrooms (CCC) (Zilpy)	dollars	2,390	2,150	N/A	11.2%
Segregation Index	number	0.42	0.43	0.2	2.3%
Severe Housing Problems	percent	25.6	27.3	0.4	6.2%

Data without Benchmarks

Certain indicators have no state or national comparison.

- A total of 1,607 individuals experienced homelessness in Contra Costa County in 2017 (PIT).

Trends

Trend data are available on certain indicators.

- Asthma Diagnoses, Children Age 1-17: Long-term trend mixed; trending down since 2009.
- Asthma Hospitalizations, Children Age 0-4: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Age 0-17: Long-term trend mixed, trending up since 2012.
- Children Living in Crowded Households: Generally trending up since 2007.
- Homeless Children Age 0-17 Who Are Unsheltered: Zero since 2015.

- Homeless Population: Decreasing since 2015.
 - Unsheltered population dropping in West County since 2015.
- Homeless Young Adults Age 18-24 Who Are Unsheltered: Trending down since 2015.
- Median Rent, 2 Bedrooms: Increasing over past year.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Homeless Population (PIT)	#	48%	33%	4%*					22%

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

TRANSPORTATION AND TRAFFIC

Indicator	Indicator type	Value	State avg	SDs	% difference
Beer, Wine, and Liquor Stores (per 10,000)	rate	0.94	1.06	0.4	11.3%
Driving Alone to Work	percent	61.8	73.5	1.5	15.9%
*Driving Alone to Work, Long Distances	percent	48.2	39.3	-1.1	22.6%
Impaired Driving Deaths	percent	28.1	29.0	0.2	3.1%
Motor Vehicle Crash Deaths	rate	6.4	8.6	0.7	25.6%
Pedestrian Accident Deaths	rate	1.5	2.3	1.7	34.8%
Public Transit Stops Within 0.5 Mile	percent	26.6	16.8	1.3	58.3%
*Road Network Density	rate	8.7	2.0	-3.0	335.0%
Walkable Destinations	percent	39.3	29.0	0.6	35.5%

Trends

No trend data are available.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	7.2	10.2	2.7					5.2

Blank cells indicate that data were unavailable.

OVERALL HEALTH

Indicator	Indicator type	Value	State avg	SDs	% difference
*Alzheimer's Disease Deaths (CCC) (CDPH)	rate	37.2	34.2	N/A	8.8%
Frequent Physical Distress (CCC) (CHR)	percent	9.0	10.9	N/A	17.4%
Life Expectancy at Birth	number	81.4	80.8	0.4	0.7%
Poor or Fair Health, Adults	percent	12.1	17.2	1.4	29.7%
Poor Physical Health Days, Adults	number	3.3	3.7	0.9	10.8%
*Population with Any Disability	percent	12.2	10.6	-0.9	15.1%
Premature Death	rate	4,712	5,251	0.5	10.3%
*Students per Social Worker (CCC) (Kidsdata.org)	number	34,960	12,870	N/A	171.6%

Trends

Trend data are available on certain indicators.

- Students per Social Worker: Generally trending down since 2011.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Population with Any Disability	10.6%	15.5%	17.9%	10.0%	13.7%	16.6%	6.0%	13.1%	8.9%

Blank cells indicate that data were unavailable.

Attachment 4D. Secondary Data, Northern Alameda County

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INTRODUCTION

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

- Alameda County 2017 Homeless Census and Survey Report based on the 2017 Point in Time (PIT) Count, accessed via <http://everyonehome.org/wp-content/uploads/2016/02/2017-Alameda-County-8.1-2.pdf>, pulled on July 31, 2018
- California Department of Public Health (CDPH) county health status profiles, accessed via <https://www.cdph.ca.gov/Programs/CHSI/Pages/Individual-County-Data-Sheets.aspx>, pulled on July 24, 2018
- California Health Interview Survey (CHIS), accessed via <http://ask.chis.ucla.edu/>, pulled on August 5, 2018
- California Healthy Kids Survey (CHKS), accessed via <http://chks.wested.org/query-chks/>, pulled on August 5, 2018
- The new CHNA data platform (replacing Community Commons), accessed via <http://chna.org/kp>, pulled on May 17, 2018¹
- City of Oakland Equity Indicators (COEI) 2018 Report, accessed via <https://www.oaklandca.gov/documents/equity-indicators-community-briefing-documents>, pulled on November 10, 2018
- County Health Rankings (CHR), accessed via <http://www.countyhealthrankings.org/app/california/2018/rankings>, pulled on July 30, 2018
- The Healthy Alameda County (HAC.org) platform, accessed via <http://www.healthyalamedacounty.org>, pulled on July 21, 2018
- KidsData.org, a program of the Lucile Packard Foundation for Children's Health, accessed via <https://www.kidsdata.org>, pulled on August 5, 2018
- U.S. Department of Housing and Urban Development (HUD) 2017 Annual Homeless Assessment Report to Congress, accessed via <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>, pulled on July 31, 2018
- Vera Institute of Justice Incarceration Trends, accessed via <http://trends.vera.org/rates/contra-costa-county-ca?incarcerationData=all>, pulled on July 31, 2018
- Zilpy, accessed via <http://www.zilpy.com/>, pulled on November 12, 2018

Statistical data tables compare local data to California state benchmarks or national goals, whichever is more stringent.

Geographic area indicators that are at least two standard deviations (SD) or 5% or more worse than their benchmark have an asterisk, are in **bold type**, and are highlighted in **orange**. Those that are at least one SD worse have an asterisk, are in **bold type**, and are highlighted in **light orange**. Those that are at least a half SD worse have an asterisk, are in **bold type**, and are

¹ Data updated September 4, 2018.

highlighted in **gray**. When indicators are worse than their benchmark by less than 5% or by less than 0.5 SDs, only their statistic is in **bold type**.

Indicators that are otherwise within one SD of the benchmark are merely highlighted in **gray**, those at least one SD better than the benchmark are highlighted in **light blue**, and those at least two SDs better are highlighted in **dark blue**. All indicators are rounded to the nearest tenth decimal point except when their values are less than one; then they are rounded to the nearest hundredth.

Indicators are from CHNA.org unless otherwise noted. Some CHNA.org indicators have the notation “CA” after them; this merely means that the indicator is only available for service areas/counties in California and not elsewhere in the U.S. CHNA.org indicators are for the Northern Alameda County area only, when available. Other indicators are countywide unless otherwise noted. When the Healthy People 2020 benchmark is used instead of the state average, the notation (HP) appears in the “State avg” column. The tables are presented alphabetically with the exception of “Overall Health,” which is last.

ASTHMA

Indicator	Indicator type	Value	State avg	SDs	% different
*Active Asthma Prevalence, All Ages (AC) (CDPH)	percent	10.0	8.3	N/A	20.5%
*Asthma Deaths (AC) (CDPH)	rate	14.1	11.1	N/A	27.0%
*Asthma Diagnoses, Children Age 1-17 (AC) (Kidsdata.org)	percent	20.1	15.2	N/A	32.2%
*Asthma ER Visits (AC) (HAC.org)	rate	649.0	498.7	N/A	30.1%
*Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	3.0	2.4	-1.0	25.0%
*Asthma Hospitalizations, All Ages (per 10,000) (AC) (Kidsdata.org)	rate	10.5	7.6	N/A	38.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC) (Kidsdata.org)	rate	36.9	19.6	N/A	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC) (Kidsdata.org)	rate	12.7	7.7	N/A	64.9%
*Asthma Prevalence, Adults, CA	percent	16.1	14.8	-0.4	8.8%
Average Charge per Asthma Hospitalization (AC) (CDPH)	dollars	41,610	39,860	N/A	4.4%
Ozone Levels	percent	29.4	42.0	2.1	30.0%
Particulate Matter 2.5 Levels	percent	9.5	10.7	0.6	11.2%
*Respiratory Hazard Index	number	2.6	2.2	-0.8	18.2%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- Childhood Asthma ED Visits (COEI):** Childhood asthma and related ED visits are associated with poor housing conditions, as well as child absences from school and parents' absences from work. The rate of asthma-related emergency visits among all children in Oakland was 1,658.0 per 100,000 population. By ethnicity, the following are rates of asthma-related emergency visits among children:
 - African American: 4,093.3
 - Asian: 408.0
 - Latino: 1,134.0
 - White: 407.4
- Environmental Health-Pollution Burden (COEI):** Pollution negatively impacts health in multiple ways, from physical health to food and water supply. Overall, the average pollution burden score in Oakland was 36.9. By majority ethnicity census tract, the average pollution burden scores are as follows:
 - Asian: 51.6
 - Latino: 40.6
 - Non-White/Mixed: 37.9
 - African American: 37.4
 - White: 31.8

Trends

Trend data are available on certain indicators.

- Asthma Diagnoses, Children Age 1-17: Long-term trend mixed; trending up since 2009.
- Asthma ER Visits: Generally trending down since 2009.
- Asthma Hospitalizations, Children Age 0-4: Generally trending downward since 2005.
- Asthma Hospitalizations, Children/Youth Age 0-17: Long-term trend mixed, trending up since 2011.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Asthma ED Visits, All Ages (per 10,000) (CDPH)	49.5	32.7	227.6	20.5*					57.0
Asthma Hospitalizations, All Ages (per 10,000) (CDPH)	7.6	5.0	31.2	5.3*					11.0

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

BEHAVIORAL HEALTH

Mental Health

Indicator	Indicator type	Value	State avg	SDs	% different
Adults Needing and Receiving Behavioral Health Care Services (AC) (HAC.org)	percent	62.2	60.5	N/A	2.8%
*Adults Needing Help for Behavioral Health Issue (AC) (AskCHIS)	percent	18.5	16.4	N/A	12.8%
Adults with Any Adverse Childhood Experiences (AC) (Kidsdata.org)	percent	57.0	61.0	N/A	6.6%
Adults with Four or More Adverse Childhood Experiences (AC) (Kidsdata.org)	percent	12.5	15.9	N/A	21.4%
Bullied at School, 7 th Graders (AC) (CHKS)	percent	40.6	39.4	N/A	3.0%
Bullied at School, 9 th Graders (AC) (CHKS)	percent	35.2	34.4	N/A	2.3%
Bullied at School, 11 th Graders (AC) (CHKS)	percent	27.9	27.6	N/A	1.1%
Caring Adults at School: Low, 7 th Graders (AC) (CHKS)	percent	11.7	14.3	N/A	18.2%
Caring Adults at School: Low, 9 th Graders (AC) (CHKS)	percent	14.0	17.8	N/A	21.3%
Caring Adults at School: Low, 11 th Graders (AC) (CHKS)	percent	12.8	13.0	N/A	1.5%
Children in Foster Care (AC) (Kidsdata.org)	rate	4.2	5.8	N/A	27.6%
Children Needing and Receiving Behavioral Health Care Services (AC) (Kidsdata.org)	percent	64.3	62.7	N/A	2.6%
Children with Two or More Adverse Experiences (Parent Reported) (AC) (Kidsdata.org)	percent	14.3	16.4	N/A	12.8%
Cyberbullied More than Once, 7 th Graders (AC) (CHKS)	percent	9.7	9.4	N/A	3.2%
Cyberbullied More than Once, 9 th Graders (AC) (CHKS)	percent	12.1	12.4	N/A	2.4%
Cyberbullied More than Once, 11 th Graders (AC) (CHKS)	percent	11.5	12.4	N/A	7.3%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	28.4	34.2	0.6	17.0%
Depression Among Medicare Beneficiaries	percent	13.2	14.3	0.8	7.7%
Depression-Related Feelings, 7 th Graders (AC) (CHKS)	percent	23.3	25.4	N/A	8.3%
Depression-Related Feelings, 9 th Graders (AC) (CHKS)	percent	28.6	31.5	N/A	9.2%
Depression-Related Feelings, 11 th Graders (AC) (CHKS)	percent	33.3	33.4	N/A	0.3%
Domestic Violence Calls for Assistance (AC) (KidsData.org)	rate	5.7	6.0	N/A	5.0%
*Domestic Violence Hospitalizations, CA	rate	5.7	4.9	-0.2	16.3%
Frequent Mental Distress (AC) (HAC.org)	percent	9.5	10.6	N/A	10.4%
*Homicide (AC) (CHR)	rate	8.0	5.0	N/A	60.0%
Insufficient Sleep (AC) (HAC.org)	percent	33.5	34.5	N/A	2.9%
Insufficient Social and Emotional Support	percent	25.5	24.7	-0.2	3.2%
Meaningful Participation at School: Low, 7 th Graders (AC) (CHKS)	percent	28.6	31.3	N/A	8.6%
Meaningful Participation at School: Low, 9 th Graders (AC) (CHKS)	percent	34.9	37.9	N/A	7.9%
Meaningful Participation at School: Low, 11 th Graders (AC) (CHKS)	percent	37.3	36.9	N/A	1.1%
*Mental Health Hospitalization, Children Age 5-14 (AC) (Kidsdata.org)	rate	2.8	2.5	N/A	12.0%
*Mental Health Hospitalization, Youth Age 15-19 (AC) (Kidsdata.org)	rate	11.8	9.8	N/A	20.4%

Indicator	Indicator type	Value	State avg	SDs	% different
Mental Health Providers	rate	513.4	288.7	1.8	77.8%
*Older Adults Living Alone (AC) (HAC.org)	percent	24.3	23.1	N/A	5.2%
Poor Mental Health Days	number	3.2	3.7	1.5	13.5%
Recent Formal Community Engagement (Volunteer Work) (Adult) (AC) (AskCHIS)	percent	13.8	11.2	N/A	23.2%
Recent Informal Community Engagement (Met with Others) (Adult) (AC) (AskCHIS)	percent	21.3	16.5	N/A	29.1%
Recently Taken Prescription Medicine Regularly for Emotional/Mental Health Issue (Adults) (AC) (AskCHIS)	percent	8.0	11.1	N/A	27.9%
School Connectedness: Low, 7 th Graders (AC) (CHKS)	percent	9.4	10.2	N/A	7.8%
*School Connectedness: Low, 9th Graders (AC) (CHKS)	percent	12.7	11.5	N/A	10.4%
*School Connectedness: Low, 11th Graders (AC) (CHKS)	percent	13.5	12.5	N/A	8.0%
Self-Inflicted Injury ER Visits (AC) (HAC.org)	rate	103.1	115.5	N/A	10.7%
Seriously Considered Suicide, 9 th Graders (AC) (CHKS)	percent	16.1	19.0	N/A	15.3%
Seriously Considered Suicide, 11 th Graders (AC) (CHKS)	percent	18.7	18.1	N/A	3.3%
Seriously Considered Suicide, Adults, CA	percent	9.2	10.0	0.3	8.0%
*Severe Mental Illness ER Visits (AC) (HAC.org)	rate	489.3	320.0	N/A	52.9%
Social Associations (per 10,000)	rate	9.9	6.5	2.4	52.3%
Students per School Psychologist (AC) (Kidsdata.org)	number	1,233	1,265	N/A	2.5%
Suicide Deaths	rate	9.0	10.2 (HP)	N/A	11.8%
*Time in Foster Care (Median Months) (AC) (Kidsdata.org)	number	17.6	15.6	N/A	12.8%
Young People Not in School and Not Working	percent	5.6	7.7	1.0	27.3%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Community Stressors-Domestic Violence (COEI):** While often under-reported, instances of domestic violence negatively impact long-term physical and emotional health. By ethnicity, the following are domestic violence rates per 100,000 people:
 - African American: 2,111.8
 - Latino: 835.4
 - White: 321.8
 - Asian: 223.6
- **Community Stressors-Homicides (COEI):** Homicides negatively impact victims and their families, but also the surrounding communities. By ethnicity, the following are homicide rates per 100,000 people:
 - African American: 55.7
 - Latino: 10.9
 - White: 3.4
 - Asian: 1.5

Trends

Trend data are available on certain indicators.

- Adults Needing and Receiving Behavioral Health Care Services: Generally trending down since 2009.
- Adults Needing Help for Behavioral Health Issue: Trend is mixed.
- Children in Foster Care: Downward trend since 2000, slight upward trend since 2012.
- Children without Secure Parental Employment: Trending down since 2011.
- Domestic Violence Calls for Assistance: Downward trend since 2005.
- Mental Health Hospitalizations, Children Age 5-14: Generally trending up since 2011.
- Mental Health Hospitalizations, Youth Age 15-19: Long-term trend mixed, generally trending up since 2008.
- Mental Diseases and Disorders Hospitalizations, Children/Youth Age 0-17: Trending up since 2007.
- Older Adults Living Alone: Trending down since 2006.
- Self-Inflicted Injury ER Visits: Trend is mixed.
- Time in Foster Care, Median Months: Mixed trend, slightly upward since 2007.

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Caring Adults at School: Low (CHKS)	#	10.0%	12.1%	10.9%	13.4%	15.0%	20.8%	12.8%	16.3%
Children in Foster Care (Kidsdata.org)	5.8	2.7	20.2	0.7*					3.4
Cyberbullied More than Once (CHKS)	#	7.6%	9.3%	6.7%	14.0%	9.6%	11.5%	10.2%	11.4%
Depression-Related Feelings (CHKS)	#	25.9%	27.2%	25.4%	38.4%	33.1%	23.9%	30.5%	34.2%
Meaningful Participation at School: Low (CHKS)	#	32.0%	32.2%	29.5%	31.1%	32.2%	28.3%	32.2%	40.8%
School Connectedness: Low (CHKS)	#	6.9%	14.1%	7.0%	7.9%	10.1%	11.4%	10.7%	12.0%
Seriously Considered Suicide (CHKS)	#	20.1%	14.6%	14.4%	21.0%	24.0%	12.0%	18.8%	19.4%
Suicide Deaths	10.2 (HP)	14.1	5.9	5.7					4.4

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Substance Use/Tobacco

Indicator	Indicator type	Value	State avg	SDs	% different
Adults Needing and Receiving Behavioral Health Care Services (AC) (HAC.org)	percent	62.2	60.5	N/A	2.8%
*Adults Needing Help for Behavioral Health Issue (AC) (AskCHIS)	percent	18.5	16.4	N/A	12.8%
Alcohol Use (Youth) (AC) (HAC.org)	percent	22.6	29.5	N/A	23.4%
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
Chronic Liver Disease/Cirrhosis Deaths (AC) (CDPH)	Rate	8.6	12.2	N/A	29.5%
Current/Former Smokers, Adults, CA	percent	11.8	13.7	0.5	13.9%
Deaths by Suicide, Drug or Alcohol Poisoning	rate	28.4	34.2	0.6	17.0%
Excessive Drinking, CA	percent	30.6	33.4	0.9	8.4%
Heart Disease Deaths	rate	71.8	99.5	1.4	27.8%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	10.3	10.5	0.1	1.9%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.6	7.0	0.9	20.0%
Impaired Driving Deaths	percent	29.6	29.0	-0.1	2.1%
*Low Birth Weight	percent	7.2	6.8	-1.0	5.9%
Lung Cancer Deaths (AC) (HAC.org)	rate	28.2	28.9	N/A	2.4%
Lung Cancer Incidence	rate	43.4	44.6	0.2	2.7%
Opioid Prescription Drug Claims	percent	5.9	7.0	0.6	15.7%
Poor Mental Health Days	number	3.2	3.7	1.5	13.5%
Recent Alcohol/Drug Use, 7 th Graders (AC) (CHKS)	percent	7.5	10.4	N/A	27.9%
Recent Alcohol/Drug Use, 9 th Graders (AC) (CHKS)	percent	18.2	23.2	N/A	21.6%
Recent Alcohol/Drug Use, 11 th Graders (AC) (CHKS)	percent	33.2	33.4	N/A	0.6%
Recent Marijuana Use, 7 th Graders (AC) (CHKS)	percent	3.6	4.2	N/A	14.3%
Recent Marijuana Use, 9 th Graders (AC) (CHKS)	percent	10.9	12.3	N/A	11.4%
*Recent Marijuana Use, 11th Graders (AC) (CHKS)	percent	21.0	18.0	N/A	16.7%
*Substance Use ER Visits (AC) (HAC.org)	rate	1,642.7	1,275.4	N/A	28.8%
Very Low Birth Weight (AC) (Kidsdata.org)	percent	1.2	1.2	N/A	0.0%

Trends

Trend data are available on certain indicators.

- Adults Needing and Receiving Behavioral Health Care Services: Generally trending down since 2009.
- Adults Needing Help for Behavioral Health Issue: Trend is mixed.
- Alcohol Use (Youth): Trending down since 2007.
- Lung Cancer Deaths: Trending down since 2009.
- Substance Use ER Visits: Trending up since 2009.
- Very Low Birth Weight: Trend is relatively flat since 1995.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Heart Disease Deaths	99.5	80.8	97.6	48.2		50.3			56.1
Recent Alcohol/Drug Use (CHKS)	#	23.1%	27.1%	9.9%	20.3%	15.7%	16.4%	22.0%	28.5%
Recent Marijuana Use (CHKS)	#	13.1%	21.5%	4.8%	12.8%	13.3%	10.6%	15.2%	17.7%

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

CANCERS

Indicator	Indicator type	Value	State avg	SDs	% different
Breast Cancer Deaths, Females (AC) (HAC.org)	rate	17.8	19.1	N/A	6.8%
Breast Cancer Incidence, Females	rate	120.6	120.7	0.0	0.1%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	61.3	59.7	0.3	2.7%
Cancer Deaths	rate	140.6	147.3	0.6	4.5%
Cervical Cancer Incidence (AC) (HAC.org)	rate	6.5	7.3	N/A	11.0%
Childhood Cancer Diagnoses Ages 0-19 (AC) (Kidsdata.org)	rate	16.9	17.4	N/A	2.9%
Colon and Rectum Cancer Incidence	rate	35.6	37.2	0.6	4.3%
Colon Cancer Screening, Adults Age 50+ (AC) (HAC.org)	percent	71.3	68.1	N/A	4.7%
Colorectal Cancer Deaths (AC) (HAC.org)	rate	12.1	12.8	N/A	5.5%
Current/Former Smokers, Adults, CA	percent	11.8	13.7	0.5	13.9%
Lung Cancer Deaths (AC) (HAC.org)	rate	28.2	28.9	N/A	2.4%
Lung Cancer Incidence	rate	43.4	44.6	0.2	2.7%
Oral Cancer Incidence (AC) (HAC.org)	rate	9.6	10.3	N/A	6.8%
Prostate Cancer Deaths (AC) (HAC.org)	rate	17.2	19.6	N/A	12.2%
Prostate Cancer Incidence	rate	110.9	109.2	-0.2	1.6%

Trends

Trend data are available on certain indicators.

- **Breast Cancer Deaths:** Trending down since 2009.
- **Cervical Cancer Incidence:** Trending down since 2009.
- **Childhood Cancer Diagnoses:** Slight upward trend since 2003.
- **Colon Cancer Screening:** Trending up since 2003.
- **Colorectal Cancer Deaths:** Generally trending down since 2009.
- **Lung Cancer Deaths:** Trending down since 2009.
- **Oral Cancer Incidence:** Generally trending down since 2004.
- **Prostate Cancer Deaths:** Generally trending down since 2008.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	62.1%	55.6%						
Cancer Deaths	147.3	154.5	190.2	102.8		75.9			112.7
Cervical Cancer Incidence (HAC.org)	7.3	6.9	7.0	5.1*					9.9
Childhood Cancer Diagnoses, Ages 0-19 (Kidsdata.org)	17.4	19.4	14.0	16.9*					15.1
Colon Cancer Screening, Adults Age 50+ (AC) (HAC.org)	68.1%	72.2%	76.0%	62.3%*		65.7%		50.4%	81.2%
Oral Cancer Incidence (AC) (HAC.org)	10.3	10.4	7.9	7.4*					5.8

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

CLIMATE/NATURAL ENVIRONMENT

Indicator	Indicator type	Value	State avg	SDs	% different
*Active Asthma Prevalence, All Ages (AC) (CDPH)	percent	10.0	8.3	N/A	20.5%
*Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	3.0	2.4	-1.0	25.0%
*Asthma Hospitalizations, All Ages (per 10,000) (AC) (Kidsdata.org)	rate	10.5	7.6	N/A	38.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC) (Kidsdata.org)	rate	36.9	19.6	N/A	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC) (Kidsdata.org)	rate	12.7	7.7	N/A	64.9%
*Asthma Prevalence, Adults, CA	percent	16.1	14.8	-0.4	8.8%
Climate-Related Mortality Impacts	percent	4.8	8.4	0.4	42.9%
Drinking Water Violations	number	0.0	0.8	2.0	100.0%
Driving Alone to Work	percent	47.8	73.5	3.0	35.0%
Driving Alone to Work, Long Distances	percent	38.8	39.3	0.1	1.3%
Drought Severity	percent	87.6	92.8	0.8	5.6%
Flood Vulnerability	percent	1.9	3.7	0.5	48.6%
Heat Index	percent	0.0	2.7	0.6	100.0%
Ozone Levels	percent	29.4	42.0	2.1	30.0%
Particulate Matter 2.5 Levels	percent	9.5	10.7	0.6	11.2%
Public Transit Stops Within 0.5 Miles	percent	18.4	16.8	0.2	9.5%
*Respiratory Hazard Index	number	2.6	2.2	-0.8	18.2%
*Road Network Density	rate	21.6	2.0	-3.0	980.0%
Tree Canopy Cover	percent	18.9	8.3	1.6	127.7%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Environmental Health-Abandoned Trash (COEI):** Abandoned trash reduces neighborhood quality and pose health and fire risks. Overall, the rate of illegal dumping service requests in Oakland was 66.9 requests per 1,000 population. By majority ethnicity census tract, the rates of illegal dumping service requests are as follows:
 - Latino: 102.8
 - African American: 82.6
 - Asian: 82.0
 - Non-White/Mixed: 69.4
 - White: 26.1
- **Environmental Health-Park Quality (COEI):** Park quality impacts park use and community benefit. The average park quality score for the City of Oakland was 2.5 out of 4 on an annual community survey by City Council District.
- **Environmental Health-Pollution Burden (COEI):** Pollution negatively impacts health in multiple ways, from physical health to food and water supply. Overall, the average

pollution burden score in Oakland was 36.9. By majority ethnicity census tract, the average pollution burden scores are as follows:

- Asian: 51.6
- Latino: 40.6
- Non-White/Mixed: 37.9
- African American: 37.4
- White: 31.8

Trends

No trend data are available.

Race and Ethnicity

No indicators are available by ethnicity.

COMMUNICABLE DISEASES (NOT STIS)

Indicator	Indicator type	Value	State avg	SDs	% different
Adults 18+ with Influenza Vaccination (AC) (AskCHIS)†	percent	53.0	43.4	N/A	22.1%
Children with Influenza Vaccination (AC) (HAC.org)	percent	65.9	55.4	N/A	19.0%
Influenza and Pneumonia Deaths (AC) (HAC.org)	rate	12.6	14.3	N/A	11.9%
Influenza Vaccination, All Ages (AC) (AskCHIS)	percent	56.6	44.8	N/A	26.3%
Kindergarteners with Required Immunizations (AC) (Kidsdata.org)	percent	95.9	92.8	N/A	3.3%
*Tuberculosis Incidence (AC) (HAC.org)	rate	8.9	1.0 (HP)	N/A	790.0%

† AskCHIS data on influenza vaccination for older adults (65+) not provided because it is statistically unstable.

Trends

Trend data are available on certain indicators.

- Influenza and Pneumonia Deaths: Trending down since 2009.
- Kindergarteners with Required Immunizations: Upward trend since 2013.
- Tuberculosis Incidence: Generally trending down since 2010.

Race and Ethnicity

No indicators are available by ethnicity.

COMMUNITY AND FAMILY SAFETY

Crime/Intentional Injury

Indicator	Indicator type	Value	State avg	SDs	% different
*Assault Injury ER Visits (AC) (HAC.org)	rate	422.2	322.6	N/A	30.9%
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
Bullied at School, 7 th Graders (AC) (CHKS)	percent	40.6	39.4	N/A	3.0%
Bullied at School, 9 th Graders (AC) (CHKS)	percent	35.2	34.4	N/A	2.3%
Bullied at School, 11 th Graders (AC) (CHKS)	percent	27.9	27.6	N/A	1.1%
Cyberbullied More than Once, 7 th Graders (AC) (CHKS)	percent	9.7	9.4	N/A	3.2%
Cyberbullied More than Once, 9 th Graders (AC) (CHKS)	percent	12.1	12.4	N/A	2.4%
Cyberbullied More than Once, 11 th Graders (AC) (CHKS)	percent	11.5	12.4	N/A	7.3%
Domestic Violence Calls for Assistance (AC) (KidsData.org)	rate	5.7	6.0	N/A	5.0%
*Domestic Violence Hospitalizations, CA	rate	5.7	4.9	-0.2	16.3%
Fear Being Beaten Up at School, 7 th Graders (AC) (CHKS)	percent	25.2	24.7	N/A	2.0%
Fear Being Beaten Up at School, 9 th Graders (AC) (CHKS)	percent	18.4	17.9	N/A	2.8%
*Firearm Fatalities (AC) (CHR)	rate	9.0	8.0	N/A	12.5%
Gang Membership, 11 th Graders (AC) (CHKS)	percent	7.4	7.5	N/A	1.3%
Gang Membership, 7 th Graders (AC) (CHKS)	percent	7.4	8.1	N/A	8.6%
Gang Membership, 9 th Graders (AC) (CHKS)	percent	7.6	7.5	N/A	1.3%
*Homicide (AC) (CHR)	rate	8.0	5.0	N/A	60.0%
Injury Deaths	rate	42.8	46.6	0.3	8.2%
*Jail Admissions, Age 15-64 (AC) (Vera)	rate	4,356.6	3,805.9	N/A	14.5%
Jail Incarceration, Age 15-64 (AC) (Vera)	rate	199.9	278.9	N/A	28.3%
*Juvenile Felony Arrests, Age 10-17 (per 1,000) (AC) (Kidsdata.org)	rate	5.6	5.3	N/A	5.7%
*School Perceived as Unsafe/Very Unsafe, 11th Graders (AC) (CHKS)	percent	7.3	6.5	N/A	12.3%
School Perceived as Unsafe/Very Unsafe, 7 th Graders (AC) (CHKS)	percent	8.4	9.3	N/A	9.7%
School Perceived as Unsafe/Very Unsafe, 9 th Graders (AC) (CHKS)	percent	8.0	7.7	N/A	3.9%
Substantiated Child Abuse and Neglect (per 1,000 under age 18) (AC) (KidsData.org)	rate	2.8	8.2	N/A	65.9%
*Traumatic Injury Hospitalizations, Children Age 0-17 (AC) (Kidsdata.org)	percent	1.6	1.1	N/A	45.5%
*Violent Crimes	rate	716.8	402.7	-2.2	78.0%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Built Environment-Long-Term Residential Vacancy (COEI):** Long-term residential vacancies are correlated with decreased safety and neighborhood quality. Overall, the

percent of residential addresses in Oakland that have been vacant for 2 or more years was 0.47%. By majority ethnicity census tracts, the percent of residential vacancies for 2 or more years are as follows:

- African American: 0.88%
 - Asian: 0.66%
 - Non-White/Mixed: 0.52%
 - White: 0.39%
 - Latino: 0.27%
- **Community Stressors-Domestic Violence (COEI):** While often under-reported, instances of domestic violence negatively impact long-term physical and emotional health. By ethnicity, the following are domestic violence rates per 100,000 people:
 - African American: 2,111.8
 - Latino: 835.4
 - White: 321.8
 - Asian: 223.6
 - **Community Stressors-Homicides (COEI):** Homicides negatively impact victims and their families, but also the surrounding communities. By ethnicity, the following are homicide rates per 100,000 people:
 - African American: 55.7
 - Latino: 10.9
 - White: 3.4
 - Asian: 1.5
 - **Community Stressors-Juvenile Felony Arrests (COEI):** Juvenile arrest increases the likelihood of adult re-arrest and incarceration. By ethnicity, the following are juvenile felony arrest rates per 100,000:
 - African American: 1,971.0
 - Latino: 370.5
 - Asian: 30.1
 - White: 17.5
 - **Law Enforcement-Use of Force (COEI):** Use of force by law enforcement impacts individuals disparately by race and ethnicity. Among all individuals in Oakland, the rate of use of force was 84.1 per 100,000 people. By ethnicity, the following are use of force rates per 100,000 people:
 - African American: 244.4
 - Latino: 70.2
 - Asian: 14.8
 - White: 10.3
 - **Prison Incarceration (Vera):** The prison incarceration rate was 331.3 per 100,000 residents age 15-64 in Alameda County in 2013.

Trends

Trend data are available on certain indicators.

- Assault Injury ER Visits: Trending down since 2010.
- Domestic Violence Calls for Assistance: Downward trend since 2005.
- Juvenile Felony Arrest Rate: Trending down since 2007.
- Prison Incarceration Rate: Trending down since 1998.
- Substantiated Child Abuse and Neglect: Generally trending down since 2001.
- Traumatic Injury Hospitalizations, Children Age 0-17: Trend is mixed.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Bullied at School (CHKS)	#	37.5%	38.5%	33.0%	46.4%	45.6%	37.8%	40.5%	37.3%
Fear Being Beaten Up at School (CHKS)	#	11.8%	11.1%	12.3%	19.0%	18.8%	15.9%	15.7%	17.0%
Gang Membership (CHKS)	#	3.6%	6.7%	4.0%	4.9%	8.2%	5.9%	5.2%	5.9%
Jail Incarceration (Vera)	278.9	110.8	962.0	32.6*		296.4			261.1
Juvenile Felony Arrests (per 1,000) (Kidsdata.org)	5.3	2.3	25.0				1.2		5.4
School Perceived as Unsafe/Very Unsafe (CHKS)	#	4.3%	8.6%	4.8%	7.9%	6.9%	5.4%	7.0%	8.8%
Substantiated Child Abuse and Neglect (per 1,000) (Kidsdata.org)	8.2	2.0	10.3	0.8*					2.8

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined.

Unintentional Injuries/Accidents

Indicator	Indicator type	Value	State avg	SDs	% different
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
*Bicycle-Involved Collisions (AC) (HAC.org)	rate	43.4	35.1	N/A	23.6%
*Elevated Blood Lead Levels in Children Age 0-5 (AC) (Kidsdata.org)	percent	0.3	0.2	N/A	50.0%
*Elevated Blood Lead Levels in Children/Youth Age 6-20 (AC) (Kidsdata.org)	percent	0.5	0.3	N/A	66.7%
*Firearm Fatalities (AC) (CHR)	rate	9.0	8.0	N/A	12.5%
Impaired Driving Deaths	percent	29.6	29.0	-0.1	2.1%
Injury Deaths	rate	42.8	46.6	0.3	8.2%
Motor Vehicle Crash Deaths	rate	5.5	8.6	1.0	36.0%
*Motor Vehicle Crash ER Visits (AC) (HAC.org)	rate	809.3	747.3	N/A	8.3%
Pedestrian Accident Deaths	rate	2.0	2.3	0.6	13.0%
Poisoning Hospitalizations, Children Age 0-17 (AC) (Kidsdata.org)	percent	0.6	0.9	N/A	33.3%
*Traumatic Injury Hospitalizations, Children Age 0-17 (AC) (Kidsdata.org)	percent	1.6	1.1	N/A	45.5%
Unintentional Injury Deaths (AC) (HAC.org)	rate	24.9	30.3	N/A	17.8%
Unintentional Injury ER Visits (AC) (HAC.org)	rate	6,749.6	6,531.7	N/A	3.3%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	5.3	7.3	3.9					6.9

Blank cells indicate that data were unavailable.

ECONOMIC SECURITY

Indicator	Indicator type	Value	State avg	SDs	% different
Adults with an Associate's Degree or Higher, Age 25+	percent	58.6	39.8	2.0	47.2%
Adults with No High School Diploma, Age 25+	percent	12.1	17.9	1.1	32.4%
Adults with Some Post-secondary Education, Age 25-44	percent	80.0	63.6	1.8	25.8%
Banking Institutions (per 10,000)	rate	2.9	2.7	0.3	7.4%
Childcare Availability (Licensed) (AC) (Kidsdata.org)	percent	31.0	25.0	N/A	24.0%
Children Below 100% FPL	percent	18.8	21.9	0.5	14.2%
Children in Single-Parent Households	percent	31.8	31.8	0.0	0.0%
Children without Secure Parental Employment (AC) (Kidsdata.org)	percent	27.8	32.8	N/A	15.2%
Cost Burdened Households	percent	41.7	42.8	0.3	2.6%
*Cost of Infant Childcare, Annually, Child Care Center (AC) (Kidsdata.org)	dollars	15,435	13,327	N/A	15.8%
*Cost of Preschool Childcare, Annually, Child Care Center (AC) (Kidsdata.org)	dollars	11,113	9,106	N/A	22.0%
Free and Reduced Price Lunch	percent	52.4	58.9	0.5	11.0%
High Speed Internet	percent	98.9	95.4	0.4	3.7%
Income Inequality - 80/20 Ratio	number	4.2	5.1	1.6	17.6%
Median Household Income	dollars	79,831	65,812	1.0	21.3%
Medicaid/Public Insurance Enrollment	percent	18.9	21.8	0.5	13.3%
Older Adults Below 100% FPL (AC) (HAC.org)	percent	9.5	10.3	N/A	7.8%
Opportunity Index	number	58.5	51.9	0.8	12.7%
*Population Below 100% FPL	percent	16.6	15.8	-0.2	5.1%
SNAP Benefits	percent	7.6	9.4	0.4	19.1%
SNAP Benefits – Households with Children (AC) (HAC.org)	percent	64.4	69.8	N/A	7.7%
Unemployment	percent	2.9	4.0	0.7	27.5%
Uninsured Children	percent	3.5	10.4	3.0	66.3%
Uninsured Population	percent	9.0	12.6	1.2	28.6%
Young People Not in School and Not Working	percent	5.6	7.7	1.0	27.3%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Access to a Car (COEI):** Access to a car is correlated with increased access to work, school, appointment, social events, and other critical resources. Overall, 10.2% of individuals living in housing units in Oakland do not have a car. By ethnicity, the following are percentages of individuals who do not have access to a car:
 - African American: 18.7%
 - Other: 14.2%
 - Asian: 10.0%
 - Latino: 7.6%
 - White: 6.1%

Trends

Trend data are available on certain indicators.

- **Childcare Availability (Licensed):** Relatively flat since 2000.
- **Older Adults Below 100% FPL:** Generally trending up since 2006.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults with No High School Diploma	17.9%	2.3%	11.2%	21.5%	10.1%	17.4%	39.4%	7.6%	31.7%
Children Below 100% FPL	21.9%	5.0%	34.0%	18.1%	13.9%	44.9%	32.9%	13.2%	28.4%
Older Adults Below 100% FPL (HAC.org)	10.3%	6.1%	13.0%	13.6%	10.8%	14.8%	10.5%	11.6%	10.5%
Population Below 100% FPL	15.8%	9.3%	24.9%	20.1%	20.8%	30.2%	24.9%	14.8%	22.0%
SNAP Benefits	9.4%	2.6%	15.6%	7.5%	12.7%	18.3%	16.3%	9.1%	15.0%
Uninsured Children	10.4%	1.1%	4.4%	3.5%	4.8%	4.6%	7.3%	2.9%	6.4%
Uninsured Population	12.6%	4.9%	10.5%	8.3%	10.5%	18.9%	21.3%	8.1%	18.3%

Blank cells indicate that data were unavailable.

EDUCATION AND LITERACY

Indicator	Indicator type	Value	State avg	SDs	% different
Adults with an Associate's Degree or Higher, Age 25+	percent	58.6	39.8	2.0	47.2%
Adults with No High School Diploma, Age 25+	percent	12.1	17.9	1.1	32.4%
Adults with Some Post-secondary Education, Age 25-44	percent	80.0	63.6	1.8	25.8%
*Children in Linguistically Isolated Households (AC) (Kidsdata.org)	percent	11.5	10.5	N/A	9.5%
*Cost of Preschool Childcare, Annually, Child Care Center (AC) (Kidsdata.org)	dollars	11,113	9,106	N/A	22.0%
*Expulsions, CA (per 100 enrolled students)	rate	0.09	0.08	-0.1	12.5%
High School Dropout (Adjusted) (AC) (Kidsdata.org)	percent	9.6	10.7	N/A	10.3%
High School Graduates Completing College Prep Courses (AC) (Kidsdata.org)	percent	54.5	43.4	N/A	25.6%
High Speed Internet	percent	98.9	95.4	0.4	3.7%
*Juvenile Felony Arrests, Age 10-17 (per 1,000) (AC) (Kidsdata.org)	rate	5.6	5.3	N/A	5.7%
*On-Time High School Graduation, CA	rate	77.2	82.9	-1.0	6.9%
Passed High School Exit Exam, English (AC) (HAC.org)	percent	86.0	85.0	N/A	1.2%
Passed High School Exit Exam, Math (AC) (HAC.org)	percent	86.0	85.0	N/A	1.2%
Preschool Enrollment	percent	65.4	48.6	2.0	34.6%
Proficient in English/Language Arts-11th Graders (AC) (HAC.org)	percent	64.0	59.0	N/A	8.5%
Proficient in Math-11th Graders (AC) (HAC.org)	percent	43.0	32.0	N/A	34.4%
Reading at or Above Proficiency, CA	percent	44.0	43.9	0.0	0.2%
Student/Teacher Ratio (AC) (HAC.org)	number	23.0	23.7	N/A	3.0%
*Students per Academic Counselor (AC) (Kidsdata.org)	number	827	792	N/A	4.4%
Suspensions, CA (per 100 enrolled students)	rate	4.9	5.9	0.3	16.9%
Teen Births (per 1,000 females age 15-19)	rate	19.6	29.3	1.0	33.1%
Truancy (per 100 students) (AC) (Kidsdata.org)	rate	27.7	31.4	N/A	11.8%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **AP Course Enrollment (COEI):** AP course enrollment in high school is correlated with academic success in college. By ethnicity, the following proportion of students never took a single AP course throughout high school:
 - African American: 73.7%
 - Latino: 58.1%
 - Asian: 35.9%
 - White: 29.6%
- **Chronic Absenteeism (COEI):** School absenteeism negatively impacts children's academic success. By ethnicity, the following proportions of students were chronically absent:
 - African American: 22.2%
 - Latino: 12.6%
 - White: 5.6%

- Asian: 5.2%
- **Community Stressors-Juvenile Felony Arrests (COEI):** Juvenile arrest increases the likelihood of adult re-arrest and incarceration. By ethnicity, the following are juvenile felony arrest rates per 100,000:
 - African American: 1,971.0
 - Latino: 370.5
 - Asian: 30.1
 - White: 17.5
- **Teacher Experience (COEI):** Increased teacher experience is positively correlated with student academic outcomes. By majority ethnicity in the student body, the following represent the average percentage of teachers in their first five years of teaching:
 - African American and Latino predominant: 48.9%
 - Latino: 42.9%
 - African American: 38.3%
 - Mixed: 32.5%
 - White: 29.9%
 - Asian: 20.3%
- **Teacher Turnover (COEI):** High teacher turnover is negatively correlated with student achievement. By majority ethnicity in the student body, the following percentages represent the average teacher turnover:
 - African American: 38.3%
 - African American and Latino predominant: 26.9%
 - Latino: 34.5%
 - Asian: 14.6%
 - White: 10.2%
 - Mixed: 20.1%
- **Third-Grade ELA, Below Proficiency (COEI):** Proficiency is correlated with high school graduation rates. By ethnicity, the following proportions of students did not meet the standard:
 - Latino: 61.6%
 - African ancestry: 60.9%
 - Asian: 31.1%
 - White: 11.9%

Trends

Trend data are available on certain indicators.

- **Children in Linguistically Isolated Households:** Generally trending down since 2007.
- **High School Dropout (Adjusted):** Downward trend since 2010.
- **High School Graduates Completing College Prep Courses:** Trending up since 1998.
- **Juvenile Felony Arrest Rate:** Trending down since 2007.
- **Passed High School Exit Exam, English:** Generally trending up since 2010.
- **Passed High School Exit Exam, Math:** Trending up since 2010.
- **Student/Teacher Ratio:** Trending up (worse) since 2008.

- Students Per Academic Counselor: Trending down since 2013.
- Teen Births: Generally trending down since 1995.
- Truancy: Generally trending down since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Adults with No High School Diploma	17.9%	2.3%	11.2%	21.5%	10.1%	17.4%	39.4%	7.6%	31.7%
High School Dropout (Adjusted) (Kidsdata.org)	10.7%	5.8%	18.3%	3.9%	13.6%		3.6%†	7.4%	13.5%
High School Graduates Completing College Prep Courses (Kidsdata.org)	43.4%	58.8%	36.1%	74.9%	39.7%	50.0%	56.8%†	56.3%	42.5%
Jail Incarceration (Vera)	278.9	110.8	962.0	32.6*		296.4			261.1
Juvenile Felony Arrests (per 1,000) (Kidsdata.org)	5.3	2.3	25.0				1.2		5.4
Passed High School Exit Exam, English (HAC.org)	85%	94%	74%	93%	80%	82%	91%†	87%	79%
Passed High School Exit Exam, Math (HAC.org)	85%	95%	69%	96%	77%	77%	93%†	89%	78%
Teen Births (per 1,000) (Kidsdata.org)	23.2	4.7	28.3	2.2*				11.4	25.3

Blank cells indicate that data were unavailable. # Benchmarks only available by grade, while ethnicity data only available in the aggregate; comparison category is White. * Indicates statistic is for Asian/Pacific Islander combined. † Indicates statistic is for Filipino.

HEALTH CARE ACCESS AND DELIVERY

Indicator	Indicator type	Value	State avg	SDs	% different
30-Day Readmissions	percent	14.8	14.4	-0.4	2.8%
Acute Preventable Hospitalizations (AC) (HAC.org)	rate	447.7	500.6	N/A	10.6%
*Asthma Hospitalizations, Medicare Beneficiaries (per 10,000)	rate	3.0	2.4	-1.0	25.0%
Adults Delayed/Didn't Get "Other Medical" Care (AC) (AskCHIS)	percent	7.0	9.8	N/A	28.6%
Avoidable ER Visits (AC) (HAC.org)	rate	3,740.6	3,950.2	N/A	5.3%
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	percent	61.3	59.7	0.3	2.7%
Chronic Preventable Hospitalizations (AC) (HAC.org)	rate	787.5	787.0	N/A	0.1%
Colon Cancer Screening, Adults Age 50+ (AC) (HAC.org)	percent	71.3	68.1	N/A	4.7%
Dentists	rate	89.4	80.3	0.5	11.3%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	80.9	81.8	-0.4	1.1%
Federally Qualified Health Centers	rate	4.7	2.5	1.2	88.0%
*Have Usual Source of Health Care (AC) (HAC.org)	percent	87.5	95.0 (HP)	N/A	7.9%
Lack of Dental Insurance Coverage, CA	percent	29.0	38.5	1.4	24.7%
Medicaid/Public Insurance Enrollment	percent	18.9	21.8	0.5	13.3%
Medicare Health Care Costs, Dollars per Capita (AC) (HAC.org)	dollars	8,707	9,100	N/A	4.3%
Mental Health Providers	rate	513.4	288.7	1.8	77.8%
*Non-Physician PCPs (AC) (HAC.org)	rate	47	52	N/A	9.6%
*People Delayed/Did Not Receive "Other Medical" Care (AC) (HAC.org)	percent	8.3	4.2 (HP)	N/A	97.6%
Poor or Fair Health, Adults	percent	11.1	17.2	1.6	35.5%
Poor Physical Health Days, Adults	number	3.0	3.7	1.6	18.9%
*Premature Death, Racial/Ethnic Disparity Index	number	50.1	36.8	-1.6	36.1%
Preventable Hospital Events	rate	33.1	35.9	0.4	7.8%
Primary Care Physicians	rate	106.8	78.1	1.3	36.7%
Recent Dental Exam (Youth), CA	percent	88.9	86.7	1.2	2.5%
Recent Dental Visit (Adults) (AC) (AskCHIS)	percent	78.4	70.3	N/A	11.5%
Recent ER Visit, Adults (AC) (AskCHIS)	percent	15.6	21.4	N/A	27.1%
Recent Primary Care Visit, CA	percent	74.1	72.4	0.4	2.3%
*Students per School Nurse (AC) (Kidsdata.org)	number	5,442	2,784	N/A	95.5%
Students per School Psychologist (AC) (Kidsdata.org)	number	1,233	1,265	N/A	2.5%
*Students per School Speech/Language/Hearing Specialist (AC) (Kidsdata.org)	number	1,466	1,263	N/A	16.1%
Uninsured Children	percent	3.5	10.4	3.0	66.3%
Uninsured Population	percent	9.0	12.6	1.2	28.6%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- Access to a Car (COEI): Access to a car is correlated with increased access to work, school, appointment, social events, and other critical resources. Overall, 10.2% of

individuals living in housing units in Oakland do not have a car. By ethnicity, the following are percentages of individuals who do not have access to a car:

- African American: 18.7%
- Other: 14.2%
- Asian: 10.0%
- Latino: 7.6%
- White: 6.1%

Trends

Trend data are available on certain indicators.

- Avoidable ER Visits: Trending up since 2010.
- Children with Health Insurance: Trending up since 2013.
- Colon Cancer Screening: Trending up since 2003.
- Have Usual Source of Health Care: Generally trending down since 2005.
- Medicare Health Care Costs, Dollars per Capita: Trend is mixed.
- Non-Physician PCPs: Trending up since 2013.
- Students per School Nurse: Generally trending down since 2012.
- Students per School Psychologist: Trending down since 2012.
- Students per School Speech/Language/Hearing Specialist: Trending down since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Acute Preventable Hospitalizations (HAC.org)	500.6	489.4	681.5	274.3*		299.0			370.8
Breast Cancer Screening (Mammogram), Female Medicare Beneficiaries	59.7%	62.1%	55.6%						
Chronic Preventable Hospitalizations (HAC.org)	787.0	673.8	2,055.1	425.2*		684.6			632.2
Colon Cancer Screening, Adults Age 50+ (AC) (HAC.org)	68.1%	72.2%	76.0%	62.3%*		65.7%		50.4%	81.2%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	83.4%	68.6%						
Uninsured Children	10.4%	1.1%	4.4%	3.5%	4.8%	4.6%	7.3%	2.9%	6.4%
Uninsured Population	12.6%	4.9%	10.5%	8.3%	10.5%	18.9%	21.3%	8.1%	18.3%

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

HEALTHY EATING/ACTIVE LIVING

Indicator	Indicator type	Value	State avg	SDs	% different
Adequate Fruit and Vegetable Consumption, Children Age 2-11 (AC) (Kidsdata.org)	percent	34.9	32.0	N/A	9.1%
Adequate Fruit and Vegetable Consumption, Children Age 12-17 (AC) (Kidsdata.org)	percent	30.5	22.4	N/A	36.2%
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
Children Walking or Biking to School, CA	percent	50.1	39.3	1.1	27.5%
Current/Former Smokers, Adults, CA	percent	11.8	13.7	0.5	13.9%
Diabetes Deaths (AC) (HAC.org)	rate	19.9	20.7	N/A	3.9%
Diabetes Hospitalizations (AC) (HAC.org)	rate	879.6	1,017.7	N/A	13.6%
*Diabetes Hospitalizations, Children Age 0-17 (AC) (Kidsdata.org)	percent	1.6	1.4	N/A	14.3%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	80.9	81.8	-0.4	1.1%
Diabetes Prevalence, CA	percent	5.3	8.4	1.4	36.9%
Did Not Eat Breakfast, 7 th Graders (AC) (CHKS)	percent	30.5	34.0	N/A	10.3%
Did Not Eat Breakfast, 9 th Graders (AC) (CHKS)	percent	35.7	38.3	N/A	6.8%
Did Not Eat Breakfast, 11 th Graders (AC) (CHKS)	percent	37.5	39.4	N/A	4.8%
Driving Alone to Work	percent	47.8	73.5	3.0	35.0%
Driving Alone to Work, Long Distances	percent	38.8	39.3	0.1	1.3%
Exercise Opportunities	percent	99.7	93.6	0.8	6.5%
Fast Food Consumption (AC) (HAC.org)	percent	58.3	65.6	N/A	11.1%
Food Environment Index	number	7.7	7.8	-0.3	1.3%
*Food Insecure Children Ineligible for Assistance (AC) (HAC.org)	percent	41	33	N/A	24.2%
*Food Insecurity	percent	14.9	13.4	-0.8	11.2%
Food Insecurity, Child (AC) (HAC.org)	percent	15.9	19.0	N/A	16.3%
Free and Reduced Price Lunch	percent	52.4	58.9	0.5	11.0%
Grocery Stores and Produce Vendors	rate	3.5	2.4	1.8	45.8%
Heart Disease Deaths	rate	71.8	99.5	1.4	27.8%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	10.3	10.5	0.1	1.9%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.6	7.0	0.9	20.0%
Lack of Healthy Food Stores	percent	4.8	13.4	1.2	64.2%
Obesity (Adult), CA	percent	20.7	26.5	0.8	21.9%
Obesity (Youth), CA	percent	16.4	20.1	1.0	18.4%
Obesity Hospitalizations (AC) (HAC.org)	rate	367.3	396.8	N/A	7.4%
Physical Inactivity (Adult)	percent	15.8	17.3	0.7	8.7%
Physical Inactivity (Youth), CA	percent	38.0	37.8	0.0	0.5%
Public Transit Stops Within 0.5 Miles	percent	18.4	16.8	0.2	9.5%
SNAP Benefits	percent	7.6	9.4	0.4	19.1%
SNAP Benefits – Households with Children (AC) (HAC.org)	percent	64.4	69.8	N/A	7.7%
Soft Drink Consumption, CA	percent	12.7	18.1	1.0	29.8%
Stroke Deaths	rate	36.4	35.4	-0.2	2.8%

Indicator	Indicator type	Value	State avg	SDs	% different
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9	7.4	-0.6	6.8%
Stroke Prevalence, Medicare Beneficiaries	percent	3.8	3.7	-0.3	2.7%
Students Meeting Fitness Standards, 5 th Graders (AC) (Kidsdata.org)	percent	28.4	24.9	N/A	14.1%
Students Meeting Fitness Standards, 7 th Graders (AC) (Kidsdata.org)	percent	34.1	31.4	N/A	8.6%
Students Meeting Fitness Standards, 9 th Graders (AC) (Kidsdata.org)	percent	33.2	34.8	N/A	4.6%
Walkable Destinations	percent	56.4	29.0	1.6	94.5%
Youth Fruit Consumption (AC) (HAC.org)	percent	70.4	64.3	N/A	9.5%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Environmental Health-Park Quality (COEI):** Park quality impacts park use and community benefit. The average park quality score for the City of Oakland was 2.5 out of 4 on an annual community survey by City Council District.

Trends

Trend data are available on certain indicators.

- **Diabetes Deaths:** Trending down since 2012.
- **Diabetes Hospitalizations:** Trending down since 2010.
- **Diabetes Hospitalizations, Children Age 0-17:** Long-term trend mixed, trending up since 2011.
- **Fast Food Consumption:** Long-term trend mixed, trending up since 2014.
- **Food Insecure Children Ineligible for Assistance:** Generally trending down since 2012.
- **Food Insecurity, Child:** Trending down since 2013.
- **Obesity-Related Hospitalizations:** Trending up since 2009.
- **Students Meeting Fitness Standards, 5th Graders:** Trend is mixed.
- **Students Meeting Fitness Standards, 7th Graders:** Generally trending upward since 2011.
- **Students Meeting Fitness Standards, 9th Graders:** Trend is mixed.
- **Youth Fruit Consumption:** Generally trending up since 2012.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	83.4%	68.6%						
Did Not Eat Breakfast (CHKS)	#	26.0%	41.6%	25.2%	40.5%	34.9%	29.4%	36.8%	40.8%
Heart Disease Deaths	99.5	80.8	97.6	48.2		50.3			56.1
Obesity (Adult), CA	26.5%	18.2%	34.2%	8.9%					27.9%
Obesity (Youth), CA	20.1%	5.9%	22.6%	8.5%	42.5%	0.0%	13.4%†	11.5%	24.1%
Physical Inactivity (Youth), CA	37.8%	18.5%	52.0%	22.5%	54.1%	0.0%	33.1%†	41.4%	48.1%
SNAP Benefits	9.4%	2.6%	15.6%	7.5%	12.7%	18.3%	16.3%	9.1%	15.0%
Students Meeting Fitness Standards, 5th Graders (Kidsdata.org)	24.9%	38.2%	21.0%	36.9%	20.9%		30.2%†	35.8%	18.2%
Students Meeting Fitness Standards, 7th Graders (Kidsdata.org)	31.4%	42.7%	23.3%	45.7%	17.2%	34.2%	38.7%†	39.5%	22.4%
Students Meeting Fitness Standards, 9th Graders (Kidsdata.org)	34.8%	45.8%	22.6%	45.5%	16.3%	34.9%	38.7%†	33.7%	20.3%

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

HEART/STROKE

Indicator	Indicator type	Value	State avg	SDs	% different
Atrial Fibrillation Among Medicare Beneficiaries (AC) (HAC.org)	percent	6.2	7.3	N/A	15.1%
*Congestive Heart Failure Hospitalizations (AC) (HAC.org)	rate	195.9	174.1	N/A	12.5%
Current/Former Smokers, Adults, CA	percent	11.8	13.7	0.5	13.9%
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	percent	80.9	81.8	-0.4	1.1%
Exercise Opportunities	percent	99.7	93.6	0.8	6.5%
Heart Disease Deaths	rate	71.8	99.5	1.4	27.8%
Heart Disease Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	10.3	10.5	0.1	1.9%
Heart Disease Prevalence, Medicare Beneficiaries, CA	percent	5.6	7.0	0.9	20.0%
High Blood Pressure Prevalence (AC) (HAC.org)	percent	25.5	26.9 (HP)	N/A	5.2%
Hyperlipidemia Among Medicare Beneficiaries (AC) (HAC.org)	percent	38.6	41.5	N/A	7.0%
Hypertension Among Medicare Beneficiaries (AC) (HAC.org)	percent	50.0	49.6	N/A	0.8%
Hypertension Hospitalizations (AC) (HAC.org)	rate	986.4	1,234.8	N/A	20.1%
Obesity (Adult), CA	percent	20.7	26.5	0.8	21.9%
Obesity (Youth), CA	percent	16.4	20.1	1.0	18.4%
Obesity Hospitalizations (AC) (HAC.org)	rate	367.3	396.8	N/A	7.4%
Physical Inactivity (Adult)	percent	15.8	17.3	0.7	8.7%
Physical Inactivity (Youth), CA	percent	38.0	37.8	0.0	0.5%
Stroke Deaths	rate	36.4	35.4	-0.2	2.8%
*Stroke Hospitalizations, Medicare Beneficiaries (per 1,000)	rate	7.9	7.4	-0.6	6.8%
Stroke Prevalence, Medicare Beneficiaries	percent	3.8	3.7	-0.3	2.7%
Walkable Destinations	percent	56.4	29.0	1.6	94.5%

Trends

Trend data are available on certain indicators.

- Atrial Fibrillation Among Medicare Beneficiaries: Trending down since 2013.
- Congestive Heart Failure Hospitalizations: Generally trending down since 2009.
- High Blood Pressure Prevalence: Generally trending down since 2012.
- Hyperlipidemia Among Medicare Beneficiaries: Long-term trend is mixed, trending down since 2013.
- Hypertension Among Medicare Beneficiaries: Generally trending down since 2011.
- Hypertension Hospitalizations: Trending down since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Diabetes Management (Hemoglobin A1c Test), Medicare Beneficiaries	81.8%	83.4%	68.6%						
Heart Disease Deaths	99.5	80.8	97.6	48.2		50.3			56.1
Obesity (Adult), CA	26.5%	18.2%	34.2%	8.9%					27.9%
Obesity (Youth), CA	20.1%	5.9%	22.6%	8.5%	42.5%	0.0%	13.4%†	11.5%	24.1%
Physical Inactivity (Youth), CA	37.8%	18.5%	52.0%	22.5%	54.1%	0.0%	33.1%†	41.4%	48.1%
Stroke Deaths	35.4	35.2	52.5	31.3					33.0

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

HOUSING AND HOMELESSNESS

Indicator	Indicator type	Value	State avg	SDs	% different
*Asthma Diagnoses, Children Age 1-17 (AC) (Kidsdata.org)	percent	20.1	15.2	N/A	32.2%
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC) (Kidsdata.org)	rate	36.9	19.6	N/A	88.3%
*Asthma Hospitalizations, Children/Youth Age 5-17 (per 10,000) (AC) (Kidsdata.org)	rate	12.7	7.7	N/A	64.9%
Banking Institutions (per 10,000)	rate	2.9	2.7	0.3	7.4%
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
Children Living in Crowded Households (AC) (Kidsdata.org)	percent	23.5	28.2	N/A	16.7%
Cost Burdened Households	percent	41.7	42.8	0.3	2.6%
*Elevated Blood Lead Levels in Children Age 0-5 (AC) (Kidsdata.org)	percent	0.3	0.2	N/A	50.0%
*Elevated Blood Lead Levels in Children/Youth Age 6-20 (AC) (Kidsdata.org)	percent	0.5	0.3	N/A	66.7%
Home Ownership (AC) (AskCHIS)	percent	56.6	55.2	N/A	2.5%
Homeless Children Age 0-17 Who Are Unsheltered (AC) (Kidsdata.org)	percent	86.1	88.0	N/A	2.2%
Homeless Individuals Who Are Unsheltered (AC, CA) (PIT; HUD)	percent	69	78	N/A	11.5%
Homeless Public School Students (AC) (Kidsdata.org)	percent	1.8	4.4	N/A	59.1%
Homeless Young Adults Age 18-24 Who Are Unsheltered (AC) (Kidsdata.org)	percent	73.6	81.8	N/A	10.0%
Housing Burden – Rents (AC) (HAC.org)	percent	49.6	56.5	N/A	12.2%
Housing Problems	percent	43.2	45.6	0.5	5.3%
*Median Rent, 2 Bedrooms (AC) (Zilpy)	dollars	2,595	2,150	N/A	20.7%
Segregation Index	number	0.43	0.43	0.0	0.0%
Severe Housing Problems	percent	25.1	27.3	0.5	8.1%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- Built Environment-Long-Term Residential Vacancy (COEI):** Long-term residential vacancies are correlated with decreased safety and neighborhood quality. Overall, the percent of residential addresses in Oakland that have been vacant for 2 or more years was 0.47%. By majority ethnicity census tracts, the percent of residential vacancies for 2 or more years are as follows:
 - African American: 0.88%
 - Asian: 0.66%
 - Non-White/Mixed: 0.52%
 - White: 0.39%
 - Latino: 0.27%
- Childhood Asthma ED Visits (COEI):** Childhood asthma and related ED visits are associated with poor housing conditions, as well as child absences from school and

parents' absences from work. The rate of asthma-related emergency visits among all children in Oakland was 1,658.0 per 100,000 population. By ethnicity, the following are rates of asthma-related emergency visits among children:

- African American: 4,093.3
- Asian: 408.0
- Latino: 1,134.0
- White: 407.4
- Homelessness (PIT): A total of 5,629 individuals experienced homelessness in Alameda County in 2017.

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Homeless Population (PIT)	#	30%	49%			3%		15%	17%

Blank cells indicate that data were unavailable. # Benchmarks not available; comparison category is White.

MATERNAL/INFANT HEALTH

Indicator	Indicator type	Value	State avg	SDs	% different
*Asthma Hospitalizations, Children Age 0-4 (per 10,000) (AC) (Kidsdata.org)	rate	36.9	19.6	N/A	88.3%
Breastfeeding (AC) (HAC.org)	percent	97.4	93.8	N/A	3.8%
Child Mortality (AC) (CHR)	rate	30	40	N/A	25.0%
Children Below 100% FPL	percent	18.8	21.9	0.5	14.2%
Early Prenatal Care (AC) (HAC.org)	percent	89.9	83.3	N/A	7.9%
*Elevated Blood Lead Levels in Children Age 0-5 (AC) (Kidsdata.org)	percent	0.3	0.2	N/A	50.0%
Female Received Birth Control Information from Doctor (AC) (AskCHIS)‡	percent	37.1	32.1	N/A	15.6%
Infant Deaths	rate	4.4	5.0	0.8	12.0%
Life Expectancy at Birth	number	81.5	80.8	0.4	0.9%
*Low Birth Weight	percent	7.2	6.8	-1.0	5.9%
Preschool Enrollment	percent	65.4	48.6	2.0	34.6%
Pre-Term Births	percent	8.9	9.0	0.1	1.1%
Teen Births (per 1,000 females age 15-19)	rate	19.6	29.3	1.0	33.1%
Very Low Birth Weight (AC) (Kidsdata.org)	percent	1.2	1.2	N/A	0.0%

‡ Male comparison not provided because data are statistically unstable.

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Infant Mortality (COEI):** Infant mortality rates are used as measures of population health and healthcare quality. Overall, 5.1 infants died per 1,000 live births in Oakland. By ethnicity, the infant mortality rates are as follows:
 - African American: 11.7
 - Other: 11.2
 - Latino: 4.7
 - Asian: 3.1
 - White: 1.9

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Child Mortality (CHR)	40	30	70						30
Children Below 100% FPL	21.9%	5.0%	34.0%	18.1%	13.9%	44.9%	32.9%	13.2%	28.4%
Teen Births (per 1,000) (Kidsdata.org)	23.2	4.7	28.3	2.2*				11.4	25.3

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

ORAL HEALTH

Indicator	Indicator type	Value	State avg	SDs	% different
*Annual Dental Visit Among Denti-Cal Beneficiaries, Age 0-20 (AC) (HAC.org)	percent	48.2	51.0	N/A	5.5%
Condition of Teeth (Adults): Less than Good (AC) (AskCHIS)	percent	22.4	29.3	N/A	23.5%
Current/Former Smokers, Adults, CA	percent	11.8	13.7	0.5	13.9%
Dentists	rate	89.4	80.3	0.5	11.3%
Health Professional Shortage Area - Dental	percent	0.0	13.2	0.5	100.0%
Lack of Dental Insurance Coverage, CA	percent	29.0	38.5	1.4	24.7%
Oral Cancer Incidence (AC) (HAC.org)	rate	9.6	10.3	N/A	6.8%
Recent Dental Exam (Youth), CA	percent	88.9	86.7	1.2	2.5%
Recent Dental Visit (Adults) (AC) (AskCHIS)	percent	78.4	70.3	N/A	11.5%
Soft Drink Consumption, CA	percent	12.7	18.1	1.0	29.8%

Trends

Trend data are available on certain indicators.

- Annual Dental Visit Among Denti-Cal Beneficiaries: Trending down (i.e., getting worse) since 2013.
- Oral Cancer Incidence: Generally trending down since 2004.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Oral Cancer Incidence (AC) (HAC.org)	10.3	10.4	7.9	8.5*					5.8

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

SEXUALLY TRANSMITTED INFECTIONS

Indicator	Indicator type	Value	State avg	SDs	% different
Chlamydia Incidence	rate	456.2	459.9	0.0	0.8%
*Chlamydia Incidence Among Youth Age 10-19 (AC) (Kidsdata.org)	rate	810.4	709.2	N/A	14.3%
*Gonorrhea Incidence (AC) (HAC.org)	rate	186.7	164.3	N/A	13.6%
*Gonorrhea Incidence Among Youth Age 10-19 (AC) (Kidsdata.org)	rate	203.5	121.2	N/A	67.9%
HIV/AIDS Deaths	rate	70.3	323.9	3.0	78.3%
*HIV Incidence (AC) (HAC.org)	rate	16.3	12.7	N/A	28.3%
*HIV/AIDS Prevalence	rate	405.0	374.6	-0.1	8.1%
Syphilis Incidence (AC) (HAC.org)	rate	11.2	15.0	N/A	25.3%

Trends

Trend data are available on certain indicators.

- Chlamydia Incidence Among Youth Age 10-19: Trending down since 2010.
- Gonorrhea Incidence: Generally trending up since 2009.
- Gonorrhea Incidence Among Youth Age 10-19: Long-term trend mixed; flat since 2013.
- HIV Incidence: Trend is mixed.
- Syphilis Incidence: Trending up since 2009.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Chlamydia Incidence Among Youth Age 10-19 (Kidsdata.org)	709.2	443.2	3,727.6	206.8*					548.3
Gonorrhea Incidence Among Youth Age 10-19 (Kidsdata.org)	121.2	40.9	1,257.1	28.1*					84.0

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

TRANSPORTATION AND TRAFFIC

Indicator	Indicator type	Value	State avg	SDs	% different
*Beer, Wine, and Liquor Stores (per 10,000)	rate	1.7	1.1	-1.9	54.5%
*Bicycle-Involved Collisions (AC) (HAC.org)	rate	43.4	35.1	N/A	23.6%
Driving Alone to Work	percent	47.8	73.5	3.0	35.0%
Driving Alone to Work, Long Distances	percent	38.8	39.3	0.1	1.3%
Impaired Driving Deaths	percent	29.6	29.0	-0.1	2.1%
Motor Vehicle Crash Deaths	rate	5.5	8.6	1.0	36.0%
*Motor Vehicle Crash ER Visits (AC) (HAC.org)	rate	809.3	747.3	N/A	8.3%
Pedestrian Accident Deaths	rate	2.0	2.3	0.6	13.0%
Public Transit Stops Within 0.5 Miles	percent	18.4	16.8	0.2	9.5%
*Road Network Density	rate	21.6	2.0	-3.0	980.0%
Walkable Destinations	percent	56.4	29.0	1.6	94.5%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Access to a Car (COEI):** Access to a car is correlated with increased access to work, school, appointment, social events, and other critical resources. Overall, 10.2% of individuals living in housing units in Oakland do not have a car. By ethnicity, the following are percentages of individuals who do not have access to a car:
 - African American: 18.7%
 - Other: 14.2%
 - Asian: 10.0%
 - Latino: 7.6%
 - White: 6.1%

Trends

Trend data are available on certain indicators.

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

Race and Ethnicity

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

Indicators	Benchmark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Motor Vehicle Crash Deaths	8.6	5.3	7.3	3.9					6.9

Blank cells indicate that data were unavailable.

OVERALL HEALTH

Indicator	Indicator type	Value	State avg	SDs	% different
Alzheimer's Disease Deaths (AC) (CDPH)	rate	32.0	34.2	N/A	6.4%
*Alzheimer's Disease or Dementia Among Medicare Beneficiaries (AC) (HAC.org)	percent	10.0	9.3	N/A	7.5%
Arthritis Among Medicare Beneficiaries (AC) (HAC.org)	percent	23.1	27.6	N/A	16.3%
Chronic Kidney Disease Among Medicare Beneficiaries (AC) (HAC.org)	percent	18.6	17.9	N/A	3.9%
Frequent Physical Distress (AC) (HAC.org)	percent	9.1	10.9	N/A	16.5%
General Health (Self-Report): Good or Better (AC) (HAC.org)	percent	86.4	82.0	N/A	5.4%
Life Expectancy at Birth	number	81.5	80.8	0.4	0.9%
Osteoporosis Among Medicare Beneficiaries (AC) (HAC.org)	percent	5.9	6.7	N/A	11.9%
Poor or Fair Health, Adults	percent	11.1	17.2	1.6	35.5%
Poor Physical Health Days, Adults	number	3.0	3.7	1.6	18.9%
Population with Any Disability	percent	11.0	10.6	-0.2	3.8%
Premature Death	rate	4,767	5,251	0.5	9.2%
*Students per Social Worker (AC) (Kidsdata.org)	number	37,494	12,870	N/A	191.3%

Data without Benchmarks

Certain indicators have no state or national comparison available.

- **Civic Engagement-Voter Turnout (COEI):** Voter turnout is directly correlated with political engagement. In Oakland, 26.2% of registered voters did not vote in the 2016 general election.

Trends

Trend data are available on certain indicators.

- **Alzheimer's Disease or Dementia Among Medicare Beneficiaries:** Trending down since 2010.
- **Arthritis Among Medicare Beneficiaries:** Trending up since 2012.
- **Chronic Kidney Disease Among Medicare Beneficiaries:** Trending up since 2010.
- **General Health (Self-Report): Good or Better:** Generally trending down since 2011.
- **Osteoporosis Among Medicare Beneficiaries:** Generally trending down since 2011.
- **Students per Social Worker:** Generally trending down since 2011.

Race and Ethnicity

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

Indicators	Bench- mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Population with Any Disability	10.6%	9.2%	19.4%	9.8%	12.2%	19.8%	8.3%	9.4%	8.6%

Blank cells indicate that data were unavailable.

Attachment 5. Community Assets and Resources

Health Care Facilities

The following health care facilities are available in Contra Costa and northern Alameda counties. Many hospitals provide charity care and cover Medi-Cal shortfalls.

Hospitals

- Alameda County Behavioral Health Center
- Alameda Health System (Alameda and Highland Hospitals)
- Contra Costa Regional Medical Center
- John Muir Behavioral Health Center
- John Muir Medical Center Concord
- John Muir Medical Center Walnut Creek
- Kaiser Permanente–Diablo (Antioch and Walnut Creek)
- Kaiser Permanente–East Bay (Oakland and Richmond)
- San Ramon Regional Medical Center
- Stanford Health Care - ValleyCare
- Sutter Health Alta Bates Summit Medical Center
- Sutter Delta Medical Center
- UCSF Benioff Children’s Hospital
- Veterans Affairs Medical Center/Concord Vet Center

Federally Qualified Health Centers

- Asian Health Services
- Axis Community Health
- Brighter Beginnings
- Community Clinics
- La Clínica (multiple locations)
- LifeLong Medical Care (multiple locations)
- Native American Health Center
- Planned Parenthood (multiple locations)
- RotaCare (multiple locations)
- West Oakland Health

Additional Assets and Resources by Identified Health Need

The following assets and resources—organized alphabetically by identified community health need—include alliances, campaigns, initiatives, and general resources (such as public/government services, school-based services, community-based organizations, and clinics). Please note that this list is not comprehensive. Additional organizations working to promote the health and well-being of the community may not be reflected here.

Behavioral Health

- 12-Step programs: Al-Anon/Alateen, Alcoholics Anonymous, Narcotics Anonymous
- Adobe Services, HOPE Project Mobile Health Clinic
- Alameda County Health Care Services
- Alameda County Housing and Community Development
- Alameda County Medical Center, Substance Abuse Program
- Alameda County Social Services Agency
- Ashland Youth Center
- Axis Community Health Adult Behavioral Health Services
- Center for Human Development
- Cherry Hill Detox
- Child Abuse Prevention Council of Contra Costa County
- City of Berkeley Health Department of Health Services
- Contra Costa Crisis Center
- Contra Costa Health Services
- Crisis Support Services of Alameda County 24-Hour Crisis Line
- Eden I&R, Inc.
- Family Paths
- Family Paths 24-Hour Parent Support Hotline
- George Mark Children's Home
- Girls, Inc.
- #hersmile Nonprofit
- HIV/AIDS Care and Treatment Program
- HOPE Project Mobile Health Clinic
- Jewish Family and Community Services East Bay
- John George Psychiatric Hospital
- John Muir Behavioral Health Center
- John Muir Health Adolescent, Adult, and Children's Psychiatric Programs
- La Clínica de la Raza, San Leandro
- Lincoln
- Mindful Life Project
- National Alliance on Mental Illness (NAMI)
- Niroga

- Partnership for Trauma Recovery
- Project Independence
- Project Moorehouse
- Putnam Clubhouse
- Seneca Center
- Ujima: East
- West Oakland Health Council
- Willow Rock Center 23-hour Crisis Stabilization and Outpatient Services
- YMCA of the East Bay

Climate and Natural Environment

- Agricultural Natural Resources Trust
- Alameda County Citizens' Climate Lobby
- Alameda County Department of Environmental Health
- Bay Area Air Quality Management District Climate Protection Planning Program
- Carquinez Regional Environmental Education Center
- City of Livermore Environmental Services Division
- City of Pleasanton Environmental Services Division
- Contra Costa County Citizens' Climate Lobby
- Contra Costa County Climate Leaders (4CL)
- Contra Costa Watershed Forum
- Dublin San Ramon Services District Environmental Health and Safety Program
- Earth Team
- EcoVillage Farm Learning Center
- Friends of the Creeks
- Friends of Pinole Creek Watershed
- Generation Green
- Global Community Monitor
- Marine Applied Research and Exploration
- San Pablo Watershed Neighbors Education and Restoration Society
- Sierra Club Tri-Valley Group
- Sustainable Contra Costa
- The Watershed Project
- West Contra Costa Integrated Waste Management Authority
- Urban Tilth Basins of Relations program

Community and Family Safety

- A Safe Place
- Afghan Coalition
- Alameda County Family Justice Center
- Alameda Family Services

- Allen Temple Baptist Church Health and Social Services Ministries
- Alternatives in Action
- Berkeley Youth Alternatives
- Beyond Violence
- Building Blocks for Kids Collaborative
- Center for Human Development
- Child Abuse Prevention Council of Contra Costa County
- Child Passenger Safety Program
- City of Berkeley Department of Health Services
- City of Richmond Office of Neighborhood Safety
- Community and Youth Outreach
- Community Violence Solutions
- Contra Costa Family Justice Center
- Exonerated Nation
- First 5 Alameda County
- First 5 Contra Costa County
- Fresh Lifelines for Youth
- Girls Inc.
- Healthy Richmond (sponsored by The California Endowment)
- The Latina Center
- Narika
- Oakland Unite!
- Office of Neighborhood Safety
- One Day at a Time
- Project Avary
- Reentry Success Center
- Richmond Police Department
- Ruby's Place
- RYSE Youth Center
- San Leandro Boys and Girls Club
- San Leandro Education Foundation
- STAND! for Families Free of Domestic Violence
- Youth Alive!
- Youth Intervention Network

Economic Security

- Alameda County Community Food Bank (multiple sites)
- Alameda County Homeless Project (including special needs housing)
- Alameda County Nutrition Services: Women, Infants, and Children (WIC)
- America Works (formerly incarcerated)
- Axis Community Health: WIC Program

- Berkeley City College: CalWORKS Program
- Brighter Beginnings
- Building Blocks for Kids Collaborative
- Calle House
- Catholic Charities of the East Bay
- City of Berkeley Health, Housing and Community Services Department
- City of Oakland Department of Human Services
- Contra Costa County Early Head Start and Head Start
- Contra Costa County Employment and Human Services
- Contra Costa County Food Resource
- East Bay Community Foundation
- East Bay Community Law Center
- East Bay Green Jobs Corps
- East Oakland Youth Development Center
- East Bay Asian Local Development Corp.
- Eden I&R, Inc.
- Ensuring Opportunity Contra Costa
- Food Bank of Contra Costa and Solano County
- Loaves and Fishes of Contra Costa
- Meals on Wheels of Alameda County
- Meals on Wheels Diablo Region
- Open Heart Kitchen
- Opportunity Junction
- San Pablo Economic Development Corp.
- SparkPoint Bay Point, United Way Bay Area
- Tri-Valley Haven for Women: food pantry
- The Unity Council
- White Pony Express

Education and Literacy

- Alameda County Office of Education
- Alameda Union School District
- Albany Union School District
- Antioch Unified School District
- Berkeley Public Schools
- Brentwood Union School District
- Byron Union School District
- Castro Valley Union School District
- CocoKids
- Contra Costa County Office of Education
- Contra Costa Early Head Start and Head Start

- Dublin Union School District
- Emeryville Union School District
- First 5 Alameda
- First 5 Contra Costa
- John Swett Union School District
- Knightsen Elementary School District
- Liberty Union High School District
- Livermore Valley Joint Union School District
- Oakland Union School District
- Oakley Union Elementary School District
- Piedmont Union School District
- Pittsburg Unified School District
- Pleasanton Union School District
- Richmond Promise
- San Ramon Union School District
- West Contra Costa Union School District

Health Care Access and Delivery

- Abode Services
- Adobe Services HOPE Project Mobile Health Clinic
- Alameda County Health Care Services, School Health Services
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- Antioch Health Center
- Axis Community Health
- Bay Area Cancer Connections
- Bay Area Communities for Health Education
- Bay Point Family Health Center
- Brentwood Health Center
- Brighter Beginnings
- California Department of Health Care Services
- CancerCare
- Community Oral Health Program
- Contra Costa Dental Clinics
- Contra Costa Dental Society
- Contra Costa Health Services
- Contra Costa School–Based Health Services
- DVC Community Dental Clinic
- Eden I&R, Inc.

- Every Woman Counts
- George Mark Children's Home
- Healthy Richmond
- HIV/AIDS Consortium
- Jewish Family and Community Services East Bay
- The Leukemia and Lymphoma Society
- Northern California Cancer Center
- Operation Access
- Pittsburg Health Center
- Planned Parenthood Northern California
- Regional Asthma Management Program
- Ronald McDonald Care Mobile Dental Clinic
- RotaCare Pittsburg Free Medical Clinic
- Rubicon Programs
- Sandra J. Wing Foundation
- SaferSTDtesting.com
- Women's Cancer Resource Center
- United Seniors of Oakland and Alameda County

Healthy Eating/Active Living

See Economic Security for resources related to food insecurity.

- 18 Reasons
- Acta Non Verba: Youth Urban Farm Project
- Alameda County Deputy Sheriffs' Activities League
- Alameda County Nutrition Services
- Alameda County Public Health Department
- Ambrose Recreation and Park District
- Bike East Bay
- Building Blocks Collaborative
- Center for Human Development
- City of Antioch Recreation Department
- City of Dublin Parks and Community Services
- City of Livermore Recreation and Park District
- City of San Ramon Parks and Community Services
- City Slicker Farms
- CocoKids
- Contra Costa Boys and Girls Club
- Contra Costa Health Services
- East Bay Agency for Children
- East Bay Regional Parks District
- East County Midnight Basketball

- First 5 Alameda County
- First 5 Contra Costa County
- Fresh Approach
- Healthy and Active Before 5
- Healthy Hearts Institute
- Public Health Institute
- REACH Ashland Youth Center
- Rollingwood-Wilart Park Recreation and Park District
- Senior Support Program of the Tri-Valley
- Spectrum Community Services: Meals on Wheels, Senior Nutrition and Activities Program
- Village Community Resource Center

Housing and Homelessness

- Abode Services
- Alameda County Housing and Community Development
- Alameda-Contra Costa Transit District (AC Transit)
- Bay Area Rapid Transit (BART)
- CityServe of the Tri-Valley
- Collaborative working to end homelessness
- Contra Costa Council on Homelessness
- Contra Costa Health Services: Health, Housing and Homelessness
- Contra Costa Interfaith Housing
- Downtown Street Team
- Drivers for Survivors
- East Bay Community Law Center Housing Program
- East Bay Housing Organizations
- Everyone Home
- Love-A-Child Missions Homeless Recovery Shelter
- Mobility Matters
- Neighborhood Housing Services
- Paratransit
- Satellite Affordable Housing Associates (SAHA)
- SHELTER, Inc.
- Shepherd's Gate
- Tri-Valley Haven

Transportation and Traffic

- Alameda-Contra Costa Transit District (AC Transit)
- Bay Area Rapid Transit (BART)
- Bay Wheels

- Bike East Bay
- CountyConnection.com
- Drivers for Survivors
- Mobility Matters
- Paratransit
- Tri Delta Transit

Attachment 6. Qualitative Research Protocols

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

2016 Community Health Needs List

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

Key Informant Protocol – Professionals

Introduction – 5 min.

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

Health Needs Prioritization – 6-10 min.

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

Thinking specifically about [geographic sub-area] ...

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

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

Health Needs Discussion, Including Expertise Area – 20 min.

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

3. When you think about [health need 1]...

- What barriers exist to seeing better health in this area?

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

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

4. Which groups, if any, are more affected by this health need than others?

Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

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

[Repeat 3-5 for each health need they prioritized.]

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

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

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

7. Would you say that healthcare access [related to your specific expertise and/or population you serve] is sufficient or not? If not, what issues do you see?**8. What differences do you see, if any, among various groups in your work?**

Prompts if needed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

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

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

9. Do you agree? In your opinion, what are the specific behavioral health needs in our community?

Prompts if needed: Stress, depression, addiction; suicide; stigma; behavioral health care access

10. In what ways might people who are struggling with behavioral health issues be doing worse than others when it comes to health?

Prompt if needed: Behavioral health issues driving other health needs?

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about...

11. What are some existing assets, services, or strategies that are working well in the community to address these needs?

Prompts if needed: Particular community-based organizations, their programs/ services, hospitals & health care – specific offerings, specific social services

12. What types of assets, services, or strategies does the community need more of to address these needs?

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

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

[Time permitting] Additional comments

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

Closing

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

Focus Group Protocols

During focus groups, facilitators presented the 2016 CHNA List (see the table on the first page of this attachment; note that, at the recommendation of the Contra Costa County public health officer, in focus groups with residents “behavioral health” was called “mental health”). Questions found in these protocols refer to that list.

Focus Groups with Professional or Community Representatives

Introduction – 6 min.

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

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

Health Needs Prioritization – 10 min.

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

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

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

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

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

[When participants have voted, start audio recorder.]

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

Health Needs Discussion, Including Expertise Area – 20 min.

- 4. When you think about [health need1]...**
 - What barriers exist to seeing better health in this area?
Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/ bullying/crime
 - What impact do these barriers have on people's health?
- 5. Which groups, if any, are more affected by this health need than others?**

Prompts if not already discussed: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

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

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

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

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

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

8. Would you say that healthcare access related to [the specific population you serve] is sufficient? Why or why not?

9. What differences do you see, if any, among various groups in your work?

Prompts: Differences by age, ethnicity, education level, sexual orientation, disability status, income (affecting housing and transportation), language, immigration status, etc.

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

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

10. Do you agree? In your opinion, what are the specific behavioral health needs in our community?

Prompts if needed: Stress, depression, addiction; suicide; stigma; behavioral health care access

11. In what ways might people who are struggling with behavioral health issues be doing worse than others when it comes to health?

Prompt if needed: Behavioral health issues driving other health needs?

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about...

12. What are some existing assets, services, or strategies that are working well in the community to address these needs?

Prompts if needed: Particular community-based organizations, their programs/ services, hospitals & health care – specific offerings, specific social services

13. What types of assets, services, or strategies does the community need more of to address these needs?

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

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

Closing – 5 min.

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

Focus Groups with Local Residents (90 min.)

Introduction – 6 min.

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

- Cell phones: On vibrate; please take calls outside.
- Bathroom location
- Incentives – please sign the sheet
- Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.

Imagining a Healthy Community – 5 min.

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

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

Prompt if needed: What makes a community healthy?

Health Needs Prioritization – 10 min.

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

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

2. Are there any that should be added to the list?

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

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

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

Understanding the Needs – 15 min.

5. When you think about [health need1]...

- What barriers exist to people getting healthy or staying healthy?
Prompts for barriers if they are having trouble thinking of anything: Income, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, transportation, housing, addiction, stress, being victims of abuse/bullying/crime
- What impact do these barriers have on people's health?

- When you think about this need, are any groups of people worse off than others?
If so, which groups?

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

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

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

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

7. What about healthcare access?

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

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

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

- In your opinion, what are the specific mental health needs in our community?**
Prompt if needed: Conditions like stress, depression, addiction; outcomes like suicide; concerns about stigma; access to mental health care
- Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how? [Elicit drivers.]**

Equity & Cultural Humility – 15 min.

9. Do you think that everyone in our community is getting the same health care, and has the same access to care? If not, what are the barriers for them?

Prompt: Think about all of the people in our community... children, youth, adults, seniors... some have different ethnicities, languages, sexual orientations, and religions. They may be disabled or be low-income or be experiencing homelessness. It could also be people from different geographic parts of the community have different experiences.

Suggestions/Improvements/Solutions – 5-10 min.

In addition to what we have already talked about...

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

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

11. What types of resources, services, or strategies, if any, does the community need more of to address these needs?

Prompt if needed: Preventive care? Deep-end services? Workforce changes?

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

Closing – 5 min.

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

Attachment 8. IRS Checklist

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

Federal Requirements Checklist		Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)			
	Describes the written 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 8
B. Process and Methods			
Background Information			
	Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section 4
	Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section 4
	Defines the community it serves, which: <ul style="list-style-type: none"> • 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 <i>not</i> 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.	(b)(6)(i)(A)	Section 3
Health Needs Data Collection			
	Describes data and other information used in the assessment:		
	a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 2, 3, and 4
	b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Section 5

Federal Requirements Checklist		Regulation Section Number	Report Reference
	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 and Attachment 1
	b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations — names or other identifiers not required.)	(b)(5)(i)(B)	Section 5 and Attachment 1
	I. Medically underserved populations	(b)(5)(i)(B)	Section 5 and Attachment 1
	II. Low-income populations	(b)(5)(i)(B)	Section 5 and Attachment 1
	III. Minority populations	(b)(5)(i)(B)	Section 5 and Attachment 1
	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 and Attachment 1
	Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section 5 and Attachment 1
	Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section 5 and Attachment 1
	Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section 5
C. CHNA Needs Description and Prioritization			
	Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Section 6

Federal Requirements Checklist		Regulation Section Number	Report Reference
	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 6
	Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility).	(b)(4) (b)(6)(E)	Section 7 and Attachment 5
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 website” is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	Date(s) on which a-f below were done:
	a. May not be a copy marked “Draft.”	(b)(7)(ii)	12/31/19
	b. Posted conspicuously on website (either the hospital facility’s website or a conspicuously located link to a web site established by another entity).	(b)(7)(i)(A)	12/31/19
	c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	12/31/19
	d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	12/31/19
	e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	12/31/19
	f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	12/31/19

Further IRS requirements available:

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