2016 Community Health Needs Assessment

JOHN MUIR HEALTH

Acknowledgments

This report was prepared by Applied Survey Research (ASR) on behalf of the hospitals listed in this report.

ASR gratefully acknowledges the contributions of the following individuals:

Diana Camacho, John Muir Health

Molly Bergstrom, Kaiser Permanente – Diablo Area

Jean Nudelman, Kaiser Permanente – East Bay Area

Debra Lambert, Kaiser Permanente – Greater Southern Alameda Area

Michael Cobb, St. Rose Hospital

Sue Fairbanks, San Ramon Regional Medical Center, LLC

Karen Reid, San Ramon Regional Medical Center, LLC

Tim Traver, San Ramon Regional Medical Center, LLC

Denise Bouillerce, Stanford Health Care – ValleyCare

Shelby Salonga, Stanford Health Care – ValleyCare

Adam Davis, UCSF Benioff Children's Hospital Oakland

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Ruth Traylor, Washington Hospital Healthcare System

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Susan Miranda, Kaiser Permanente – Greater Southern Alameda Area

Dana Williamson, Kaiser Permanente – Northern California Region

Applied Survey Research is a social research firm dedicated to helping people build better communities.

Bay Area Office
1871 The Alameda, Suite 180
San Jose, CA 95126
Phone: (408) 247-8319 | Fax: (408) 260-7749

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1. Executive Summary

Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (PPACA), enacted by Congress on March 23, 2010, stipulates that not-for-profit hospital organizations complete a community health needs assessment (CHNA) every three years and make it widely available to the public. This assessment includes feedback from the community and experts in public health, clinical care, and others. This CHNA serves as the basis for implementation strategies that are filed with the Internal Revenue Service (IRS). This CHNA was prepared for John Muir Medical Center - Walnut Creek ("JMMC-WC"), John Muir Medical Center - Concord ("JMMC-Concord"), and the Behavioral Health Center ("BHC") to comply with federal tax law requirements set forth in Internal Revenue Code (IRS) section 501(r) and its implementing regulations.

The IRS requires that the hospital conduct a CHNA by the last day of its taxable year (which is Dec 31st for John Muir Health) and adopt an implementation strategy for each of its facilities. The first John Muir Health CHNA report was conducted in 2013. This CHNA assessment was conducted in 2016, meeting the requirement that the assessment be conducted every three years.

John Muir Health has conducted similar assessments since 1999 in accordance with California SB 697, which requires that not-for-profit hospitals evaluate the health needs of the community and file a written community benefits plan with the California Office of Statewide Health Planning and Development (OSHPD) every three years.

This 2016 assessment builds upon the information and understanding that resulted from the 2013 CHNA and recent OSHPD reports. This report documents how the CHNA was conducted and describes the related findings.

Process & Methods

Twelve local hospitals in Alameda and Contra Costa Counties ("the Hospitals") began the CHNA cycle in 2015. The Hospitals' goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs.

Community input was obtained during the summer and fall of 2015 via key informant interviews with local health experts, focus groups with community leaders and representatives, and focus groups with community residents. Secondary data were obtained from a variety of sources – see Appendix 1 for a complete list. Based on community input and secondary data, the Hospitals generated a regional list of health needs.

In November 2015, health needs in John Muir Health's service area were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then prioritized by John Muir Health and community health experts using a second set of criteria. The results of the prioritization are included on the next page.

Prioritized Needs

Community representatives and representatives of the local, participating hospitals prioritized the needs via a multiple-criteria scoring system. These needs are listed below in the group's priority order, from highest to lowest.

Data found in the needs descriptions below were analyzed on the county and sub-county level. ASR collected data for the John Muir Health service area (JMHSA) where available, which includes cities in the eastern and central regions of Contra Costa County[1]. If JMHSA data were not available, data from the East Contra Costa area (ECC) and/or Tri-Valley/Central Contra Costa (TV/CCC) area were used. (Definitions of these areas are found in Section 3.) All rates in the table below are per 100,000 in the population except where noted.

Health needs identified by CHNA process, in order of priority

Health Need	Why is it Important?	What Does the Data Say?
1. Obesity, Diabetes, Healthy Eating, and Active Living	Healthy diets and achievement and maintenance of a healthy body weight reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and safe, accessible, physical environments allows people to make healthier choices and live healthier lives.	There are higher rates of being overweight and having diabetes among adults and lower percentages of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages in the JMHSA. In addition, in ECC ethnic disparities are evident. Latino and Black youth are much more likely to be obese than White or Asian youth. Also, in the JMHSA a quarter of the population live in a food desert[2], which is well above the state average. In the JMHSA, there is a higher proportion of overweight adults compared to the state, and rate of diabetes prevalence is the same as the state. In addition, over half of TV/CCC residents are overweight or obese, which is similar to the state and Contra Costa County. In Benicia, there are higher rates of diabetes deaths and childhood diabetes hospitalizations than the state. The community says that families are buying cheaper items to make money last, even if the items are not healthy, i.e. fast food.
2. Economic Security	Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve.	JMHSA residents experience food insecurity at rates that miss the HP2020 benchmark. Data indicates that in the ECC area, ethnic disparities exists amongst groups that are living in poverty. In the TV/CCC and ECC areas, data indicates that ethnic disparities exist in the proportion of the population, and specifically the child population, that live in poverty. Regarding education, the proportion of Latino and Black students graduating from high school is lower than both the Healthy People 2020 (HP2020) benchmark and Contra Costa County overall. Also, in the JMHSA the proportion of the population that commutes over 60 minutes to work is double that of the state. The community says that many people must choose between purchasing medicine, paying their rent, or eating.

[1] For data about racial/ethnic subgroups the East Contra Costa and Tri-Valley/Contra Costa areas were used.
[2] A food desert is defined as a low-income census tract where a substantial share of residents have low access to a supermarket or large grocery store.

Health Need	Why is it Important?	What Does the Data Say?
3. Healthcare Access & Delivery, Including Primary & Specialty Care	Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness of healthcare access. Components of delivery of care include: quality, transparency, and cultural competency. Limited access to healthcare and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life.	Wide disparities exist across multiple racial and ethnic groups in the local, uninsured population. The downstream indicator of preventable hospital events show that JMHSA residents are far more likely to be hospitalized for preventable issues than Californians overall. Also, Contra Costa County and the JMHSA fall short of the benchmark in the rate of Federally Qualified Health Centers. The community says that the cost of insurance, co-payments, and deductibles are too high. Regarding specialty care, the community indicates that adequate transportation is especially needed because facilities are far from where residents live. Also, residents indicated that specialty care (e.g., hearing aids, vision care) is not covered by all insurance plans.
4. Oral / Dental Health	Oral health is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services, lack of awareness of the need for care, cost, and fear of dental procedures.	County data indicates that a relatively large proportion of residents live in a dental shortage area, and that Black youth in the county are less likely to have had a recent dental exam. Many residents in the JMHSA report that they had poor dental health. In TV/CCC, many youth had not had a recent dental exam, which is similar to the state. In addition, the community is concerned about oral/ dental health. In JMHSA, two out of four focus groups prioritized oral health as a health need, and it was a top priority of a key informant. The community says that insurance often does not cover dental care, especially for adults, and even when dental care is covered, coverage is often not sufficient.

Health Need	Why is it Important?	What Does the Data Say?
5. Mental Health	Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health.	In the JMHSA, residents expressed a need for mental health care, and suicide rates are higher than the state and HP2020 objective. In addition, the youth intentional injury rate (non-fatal ER visits) in ECC is higher than the state average. In ECC, Latino adults are much more likely to report a need for mental health care as compared to other racial and ethnic groups. The suicide rates in TV/CCC and ECC for Whites were the highest among racial and ethnic groups. However, White adults are much less likely to report a need for mental health care as compared to other racial and ethnic groups. The community says that cultural barriers and stigma keep people from seeking mental health services.
6. Substance Abuse, Including Alcohol, Tobacco, and Other Drugs	Substance abuse has a major impacton individuals, families, and communities. For example, smoking and tobacco use cause many diseases such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide.	The community expressed concern about drug use and the lack of sufficient treatment services available to address illegal drug use (about which data are not available). Data available on alcohol use shows that more JMHSA residents use alcohol excessively and spend more of household expenditures on alcohol compared to the state. In the JMHSA, residents use tobacco in equal proportion to the state, but Benicia residents are more likely to be smokers than Californians overall. The community says that residents use substances to help them sleep and cope with difficulties.

Health Need	Why is it Important?	What Does the Data Say?
7. Unintentional Injuries	Unintentional injuries are defined as those not purposely inflicted, and they are most often the result of accidents. The most common unintentional injuries result from motor vehicle crashes, falls, poisonings, suffocations, and drowning. Although most unintentional injuries are predictable and preventable, they are a major cause of premature death and lifelong disability. More individuals ages 15-44 die as a result of unintentional injuries than from any other cause. Unintentional injury is the fifth leading cause of death for all ages both in the U.S. and California.	Rates of unintentional injuries in the county and service area show that White residents are more likely to be hospitalized due to unintentional injuries, and Black residents are more likely to die from them compared to Californians overall. The community is concerned about the impacts of older adult falls in the area. While in the JMHSA rates of motor vehicle and pedestrian accident deaths are lower than in the state, ECC ethnicity data show higher rates of motor vehicle crash mortality for Blacks. Regarding falls, in Contra Costa County, White, older adults were overrepresented in the proportion of ER visits due to falls and deaths due to falls. The community says that seniors don't go to the doctor very often because of financial barriers, and many seniors are afraid to say they have fallen because they don't want to be removed from their homes. Often seniors can never live alone again after being hospitalized for a fall.
8. Violence and Injury Prevention	Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth.	In the JMHSA, rates of suicide are above the state benchmark and rates of robbery and violent crime are above the HP2020 benchmark. In the ECC area, rates of homicide are above state and HP2020 benchmarks and indicate ethnic disparities. Also, in Contra Costa County non-fatal emergency room (ER) visits for injury due to assault and domestic violence are all much higher than state averages. In addition, the ECC area has rates of school suspensions and school expulsions which are above the state average. The community says that there is a lack of domestic violence shelters in the community.

Next Steps: This written CHNA report was adopted by the governing bodies of John Muir Medical Center- Walnut Creek, Concord, and Behavioral Health Center on November 15, 2016.
We will make this CHNA report publicly available on our website by December 31, 2016. Our hospital will select the health needs we will address and develop implementation strategies to address those selected needs. We will then document the selection process and the strategies in a written Community Health Implementation Plan (CHIP), which will be filed with the Internal Revenue Service by April 15, 2017.

2. Introduction / Background

As a not-for-profit health system, John Muir Health has an obligation to make a charitable contribution to the community, but our commitment to keeping the communities we serve healthy goes far deeper than that. John Muir Health's mission to improve the health of the communities we serve with quality and compassion accurately reflects our community health efforts as a corporate leader and community partner.

Purpose of CHNA Report & Affordable Care Act Requirements

John Muir Health values a systematic approach to identifying community health needs and has completed similar processes in the past. Through collaborative community partnerships, John Muir Health recently completed the CHNA in accordance with the provisions of the Patient Protection and Affordable Care Act (PPACA). As a community-based organization, John Muir Health understands the value of continuously evaluating the health needs of the community we serve. By doing so, we are able to establish a systematic process for identifying community health needs that will guide thoughtful and effective community benefit investment for years to come.

The Patient Protection and Affordable Care Act (PPACA) enacted on March 23, 2010 included new requirements for not-for-profit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all not-for-profit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. Final requirements were published in December 2014. The 2016 CHNA meets both state (SB697) and federal (PPACA) requirements.

Hospitals & Other Partner Organizations

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

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

Identity & Qualifications of Consultants

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

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

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

ASR's expertise in community assessments is well-recognized. ASR won a first place award in 2007 for having the best community assessment project in the country. They accomplish successful assessments by using mixed research methods to help understand the needs in question and by putting the research into action through designing and facilitating strategic planning efforts with stakeholders.

Impact of the Patient Protection and Affordable Care Act (PPACA) on the CHNA

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

Although healthcare access is important in achieving health, a broader view takes into consideration the influence of other factors, including income, education, and where a person lives. According to the Robert Wood Johnson Foundation, health outcomes are largely shaped by social and economic factors (40%), followed by health behaviors (30%), clinical care (20%), and the physical environment (10%)[3]. These factors are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. These underlying social and economic factors cluster and accumulate over one's life and influence health inequities across different populations and places[4]. In order to address the bigger picture of what creates good health, healthcare systems are increasingly extending beyond the walls of medical offices to the places where people live, learn, work, and play.

State and County Coverage and Access Context

The last CHNA report conducted was in 2013, before the full implementation of the PPACA. Healthcare access was a top concern for the community and not-for-profit hospitals and remains so in 2016.

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

coverage for any Californian. In addition, Americans and legal residents with incomes between 139% and 400% of FPL can benefit from subsidized premiums[5].

Between 2013 and 2014, there was a 1.9% drop in the number of uninsured Californians aged 18-64 years old[6], according to data cited by the California Healthcare Foundation. According to the California Health Interview Survey, in 2013, 19% of the population aged 18-64 in Alameda County was uninsured (191,000 people)[7]. Also, according to the California Health Interview Survey, in 2014, 17.7% of the population aged 18-64 in Contra Costa County was uninsured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15.1% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013 when 15.7% of that population was uninsured[8].

Although some Contra Costa County residents may have obtained health insurance for the first time, health insurance costs, the cost of care, and access to timely appointments remains a concern. As discussed later in this report, residents (including those whose insurance plans did not change since PPACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. Indeed, professionals who participated in this assessment also expressed concern about the lack of a sufficient number of doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance. This is supported by evidence that there was an increase in the proportion of the population who said they had forgone care because they could not get an appointment (from 5% in 2013 to 8% in 2014)[9].

Although 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports.

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

3. About John Muir Health

John Muir Health is a tax-exempt organization that owns and operates JMMC-WC, JMMC-Concord, and John Muir Behavior Health ("JMBH") is also a tax-exempt organization that owns and operates the Behavioral Health Center ("BHC"). John Muir health, JMBH, and their affiliates collectively constitute an integrated health delivery system ("JMH").

JMH is a private nationally recognized, community-based, not-for-profit health care organization east of San Francisco and serving patients in Contra Costa, eastern Alameda and southern Solano Counties. It includes a network of more than 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. JMH also has partnerships with San Ramon Regional Medical Center, UCSF Medical Center, and Stanford Children's Health to expand its 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, and is widely recognized as a leader in many specialties – neuroscience, orthopedic, cancer, cardiovascular, trauma, emergency, pediatrics, and high-risk obstetrics care. For more information, visit www.johnmuirhealth.com.

Mission, Vision, Values

JMH is guided by its charitable mission. The JMH mission 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.

JMH's eight core values that guide the Board of Directors, management, and employees in their 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

JMH's mission reflects our community health efforts as a corporate leader and community partner. JMH's 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.

JMH views its 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 our emergency department 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. JMH 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 JMH-sponsored community events and programs, or volunteer in their own communities to make them better places to live and work.

About Community Benefit

The Community Health Improvement department serves as stewards for JMH's charitable purposes by assisting the community in achieving optimal health through education, collaboration, and health and 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 JMH community benefit planning process and to act as the liaison to the community-at-large, which enables JMH to align resources and strategies to better impact its goal of creating healthy communities.

The Community Benefit Oversight Committee provides governance for all community benefit activities. CBOC is comprised of executive leaders from across the health system and key community leaders. Additionally, JMH administration and the JMH Board of Directors oversee community benefit investments through frequent reporting.

The Community Benefit Guiding Principles, approved by the Board of Directors in 2015, include the JMH vision for creating healthy communities and provide a framework for current and future community health priorities and initiatives:

- Provide subsidized care to patients served at JMH facilities according to the Patient Assistance/Charity Care Program Policy.
- Engage in activities that align with JMH Community Benefit focus areas as defined in the triennial Community Health Improvement Plan.
- Focus investments in the JMH 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.

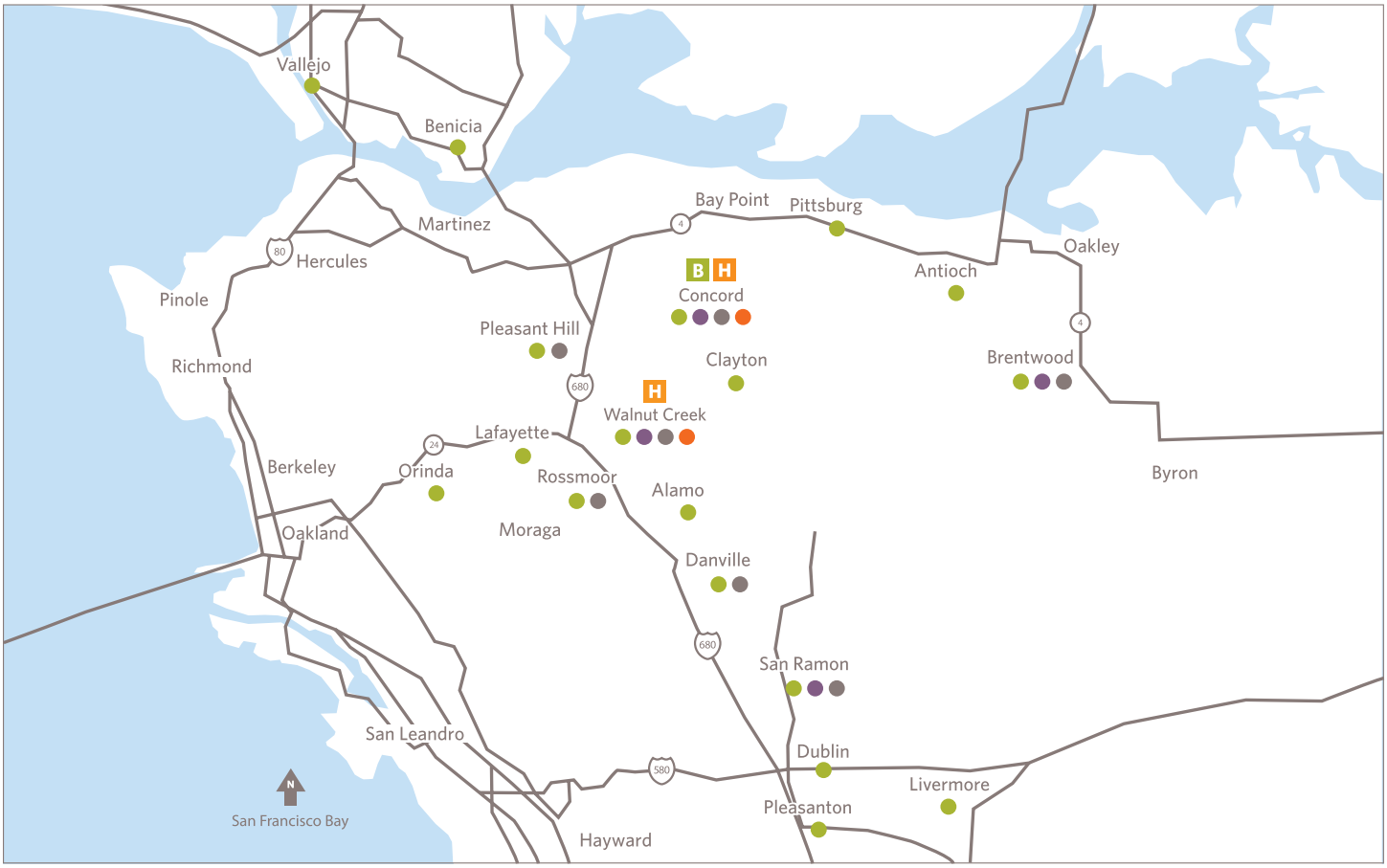
In addition to our direct delivery of care and community benefit programs, JMH provides broad financial and technical support to promote community wellness. JMH contributes $1 million annually to the John Muir/Mt. Diablo Community Fund each year, whose goal is to foster systemic change that improves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

Community Served

JMH's primary and secondary service area extends from southern Solano County into eastern Contra Costa County and south to San Ramon in southern Contra Costa County. JMH's Trauma Center serves all of Contra Costa County, as well as southern Solano County, and is the backup Trauma Center for Alameda County. JMH also serves eastern Alameda County in joint venture with San Ramon Regional Medical Center.

Our Community Benefit programs primarily focus on the needs of the vulnerable populations in central and eastern Contra Costa County, our primary and secondary service area. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care, and the economically disadvantaged. These criteria result in a primary Community Benefit Service Area that includes the communities of the Monument area in Concord and the eastern Contra Costa County cities of Bay Point, Pittsburg, Antioch, Oakley, and Brentwood, and the far east parts of unincorporated Contra Costa County.

John Muir Health Locations



H John Muir Health Hospitals
John Muir Medical Center
Concord
Walnut Creek

B Behavioral Health Center
Concord

Physician Offices

Urgent Care Centers

Other Outpatient Service Locations

Emergency Services

ASR included existing data about the Tri-Valley/Central Contra Costa (TV/CCC) area and the East Contra Costa (ECC). TV/CCC area includes the Central Contra Costa County cities of Concord and Martinez to the north, Walnut Creek, Pleasant Hill, Lafayette, Orinda and Moraga in the center of the area. It also includes the Tri-Valley which is comprised of Alameda County cities of Pleasanton, Livermore and Dublin. ECC comprises the eastern portion of Contra Costa County, which includes the major cities of Antioch, Bay Point, Brentwood, Knightsen, Oakley, and Pittsburg, as well as some unincorporated areas.

The inclusion of these two areas allowed JMH to understand how racial/ethnic populations are impacted by health needs differently; data on a race/ethnicity level were not available for the JMHSA at the time of the CHNA data collection.

Demographic Profile of Community Served

The JMHSA demographics are similar to Contra Costa County overall, as displayed in the table below. The population of the JMHSA is over 850,000. Nearly one quarter (24%) of the population in the service are under the age of 18, while 14% is 65 years or older, leaving approximately 62% who are adults under the age of 65. Less than 67% of the population identifies as White alone. Over 5% of the service area population is of two or more races.

Race / Ethnicity Data

Demographic Data	JMH Service Area	Contra Costa County
Total Population	850,361	1,065,794
White	66.8%	63.1%
Black	6.5%	9.1%
Asian	13.6%	14.7%
Native American/Alaskan Native	<0.05%	0.5%
Pacific Islander/Native Hawaiian	<0.05%	0.5%
Some Other Race	6.3%	6.7%
Multiple Races	5.8%	5.4%
Hispanic/Latino	21.9%	24.5%

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

Less than 5% of JMHSA residents age five or older are linguistically isolated, which is better than Contra Costa County (6.8%)[10]. A larger proportion of this population (13.7%) has limited English proficiency in Contra Costa and (11%) in the JMHSA; that is, they speak a language other than English at home and speak English less than "very well."

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

Socio-Economic Data

Socio-Economic Data	JMH Service Area	Contra Costa County
Living at/Below 200% FPL	21.9%	24.6 %
Children Living at/Below 100% FPL	12.0%	13.8 %
Unemployed	5.3%	6.1 %
Uninsured	9.5%	11.9 %
No High School Diploma	8.7%	14.0 %

Data source: U.S. Census Bureau, American Community Survey, 2009-2013

About one third (32.7%) of the children in JMHSA are eligible for Free & Reduced-Price lunch, while nearly one in eight children (12.0%) lives in a household with income below 100% FPL (U.S. Census Bureau, American Community Survey, 2009-2013). Over one in ten people (9.5%) in the JMHSA are uninsured (U.S. Census Bureau, American Community Survey, 2009-2013).

[10] Definition of linguistic isolation: households where no person 14 years old and over speaks only English, or in which no person 14 years old and over speaks a non-English language and speaks English "very well"

4. 2013 CHNA Summary & Results

In 2013, JMH identified community health needs in a process that met the IRS requirements of the CHNA. During this last CHNA study, the research focused on identifying health conditions, and secondarily the drivers of those conditions (including healthcare access). Our hospital identified the health needs found in the list below. In the 2016 study, the Hospitals, including our hospital, built upon this work by using a combined list of identified needs from 2013 to ask about any additional important community needs, and to delve deeper into questions about healthcare access, drivers of prioritized health needs and barriers to health, and solutions to the prioritized health needs. We also specifically sought to understand how the PPACA implementation impacted residents' access to healthcare, including affordability of care.

2013 CHNA Health Needs List

JMH Health Need / Condition	Selected for Implementation
1. Increased Exercise and Activity	
2. Healthy Eating	
3. Primary Care Services and Information (Health Literacy)	Yes
4. Economic Security	
5. Asthma Prevention and Management	
6. Specialty Care	Yes
7. Affordable, Local Mental Health Services	Yes
8. Peri-Natal Care	
9. Substance Abuse Treatment Services	
10. Parenting Skills and Support	

Written Public Comments to 2013 CHNA

As of the time of this CHNA report development, our hospital had not received written comments about previous CHNA reports. JMH will continue to track any submitted written comments and ensure that relevant submissions are considered and addressed by the appropriate hospital staff.

Community Health Improvement Plan (Implementation Strategies)

The section below describes the health needs our hospital chose to address and the strategies we identified to address them, which was documented in our 2013 Community Health Improvement Plan filed with the IRS. For more information on JMH's plan, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing implementation strategies, please visit: http://www.johnmuirhealth.com/content/dam/jmh/Documents/Community/2013_Community_Health_Improvement_Plan.pdf

5. 2013 Community Health Improvement Plan Evaluation of Impact, by Health Need

The triennial CHNA conducted in 2013 identified the following three priority areas to be addressed from 2013 to 2016.

- **Health Need 1:** Primary care services and information (health literacy), including adequate Spanish capacity
- **Health Need 2:** Specialty Care
- **Health Need 3:** Affordable, local mental health services

For financial information about these implemented strategies, please see: *https://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html.*

Priority 1: Primary care services and information (health literacy), including adequate Spanish capacity

Long Term Goal: Increase access to quality, evidenced based health information, prevention and health care services to vulnerable residents of Central and East Contra Costa County.

Strategies	Selected Outcomes (2014 & 2015)
Strategy 1: Support activities in schools that address the need for health information, services, and referrals for children and their families	**Community Nurse:** Provide Community Nurses in low-income schools in the Monument area of Concord, Pittsburg, and Bay Point to promote health and safety, intervene in health problems, provide care management services, and actively connect students and their families to community resources. • Total referrals to school nurse = 2,067 • Total interventions = 12,385 • Intervention breakdown by type: - Medical Intervention = 1,848 - Family Consultation = 1,985 - First Aid = 3,604 - Notification Letters = 1,951 - Screenings = 2,997 **Mobile Dental Clinic:** The Mobile Dental Clinic provides preventative and restorative dental care for underserved children. • Total children served = 965 • Total preventative treatments = 1,674 • Total restorative treatments = 796

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Strategies	Selected Outcomes (2014 & 2015)
Strategy 2: Provide and/or support medical care services for uninsured adults who are unable to access care quickly and affordably	**Mobile Health Clinic:** Provide primary care via the Mobile Health Clinic for the uninsured in Brentwood and Far East County on Saturdays and in partnership with the Rotocare Concord and the Contra Costa County's Health Care for the Homeless program. • Total patients served during Saturday clinic = 765 • Total patients served by Rotocare = 1,806 • Total patients served by Healthcare for the Homeless = 2,106 • On average, 17% of patients report that they would have received healthcare services in the Emergency Department had they not had access to the MHC.
Strategy 3: Provide care coordination services to connect patients with healthcare and other support services so they can access care quickly and affordably	**Complex Community Care Coordination:** Reduce avoidable ED visits and hospitalizations for frequent users through the Complex Community Care Coordination program. • Total clients served = 155 • 40% of clients improved on clinical, behavioral, and social measures • ED visits decreased by 11% pre-post program with patients from 2011-2015 **Respite Care Center:** Connect homeless patients discharged from hospital to Respite Care Center to provide recuperative care to medically fragile, homeless adults. • Total patients referred to respite = 320 • Total patients placed in respite = 95 • Average number of hospital days saved = 380 **Medication Assistance Program:** The Medication Assistance Program provides low-income seniors with free or low-cost medications. • Total seniors served = 164 • Total medications provided = 788 • Estimate value of medications provided = $908,399 **Monument Community Senior Services Outreach (MCSSO):** Connect seniors in the Monument community with programs and services to address their health, including social barriers to health. • Total referrals to MCSSO = 956 • Total seniors involved in community = 61 • Total seniors attended education presentations = 2,744

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Strategies	Selected Outcomes (2014 & 2015)
Strategy 3: (continued)	**Senior Transportation Program:** The Senior Transportation Program (STP) provides transportation to medical appointments for frail, isolated seniors. • Total seniors served = 309 • Total # of rides provided = 2,328 **Patient Navigator:** The Patient Navigator provides individualized health education, referrals to community resources, and additional support services to seniors who are likely to experience adverse health consequences. • Total seniors served = 2,656 • Total resources provided = 2,656

Strategy 4: Support and/or provide chronic condition management education and support services	**Transforming Chronic Care:** The Transforming Chronic Care program provides chronic care management for low income, frail adults. • Total seniors served in Care Transitions Interventions = 146 • Total seniors served in Tel-Assurance for Congestive Heart Failure & Chronic Obstructive Pulmonary Disease = 75 • Total seniors served in Case Management = 418 • Report on 30-day readmission rates: - Care Transitions Interventions = 7.7% - Tel-Assurance for Congestive Heart Failure = 6.95% - Tel-Assurance for Chronic Obstructive Pulmonary Disease = 13.5% **Geriatric Care Coordination Program:** The Geriatric Care Coordination program enables older adults, families, and caregivers to access all medical, health, and community services that may assist in promoting best quality of life. • Total referrals received = 3,307 • Report on hospitalizations, readmissions, and ED visits avoided: - Hospitalizations avoided = 71 - Readmissions avoided = 20 - ED visits avoided = 211

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Strategies	Selected Outcomes (2014 & 2015)
Strategy 5: Support community based interventions that provide evidenced based health education and support services	**Fall Prevention Program:** The Fall Prevention Program provides safety training, home modifications, and education for seniors. • Total seniors served = 351 • Total education events & number of people in attendance = 48 events with 994 seniors attending • Total home modifications provided = 351 • 99% of seniors who received a home modification reported feeling a positive difference in their daily life. • Total exercise classes provided & number of seniors in attendance breakdown: - Tai Chi = 10 classes with 239 seniors attending - In-Home Exercise Program: = 8 sessions with 103 seniors attending • 88% of seniors who attended the exercise program report that they feel less likely to fall. **Caring Hands Volunteer Caregivers Program:** Promote independence and enhance the quality of life of seniors through the Caring Hands Volunteer Caregivers Program. • Total seniors served = 429 • Total volunteers = 388 • On average, 76% of seniors report quality of life as "good" or "excellent" after receiving services. **Community Health Partnership Program:** Support community wellness, health promotion, and disease prevention. • Total churches in partnership (provided with health education support) = 39 churches • Total community events & number of people in attendance = 12 events with 3,214 people attending • Total churches receiving technical assistance = 25 **Monument Impact:** Support Monument Impact's community health initiatives. • Total people served = 7,466 • Total screenings conducted breakdown: - Number of dental screenings provided = 195 - Number of vision screenings provided = 219 - Number of cholesterol tests provided = 82 - Number of blood pressure (healthy heart) checks provided = 652 • Total health promoters trained = 126

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Strategies	Selected Outcomes (2014 & 2015)
Strategy 5: (continued)	**Healthy and Active Before 5:** Create healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families through the collaborative work of Healthy and Active Before Five. • Total agencies participating in collaborative meetings = 84 • Total number of local policies worked on = 26 policies reaching 11,036 children and 10,025 adults • Total number of community-led park assessments = 75 in 5 cities: Pittsburg, Bay Point, Antioch, Concord, & San Pablo

Priority 2: Specialty Care

Long Term Goal: Increase access to quality specialty care services for vulnerable residents of central and east Contra Costa County.

Strategies	Selected Outcomes (2014 & 2015)
Strategy 1: Support and/or provide specialty care services to uninsured residents through JMH affiliated physicians	**La Clínica Specialty Care Program:** Provide specialty care to low-income, uninsured patients referred by community clinics. • Total patients served = 442 • Total cancer diagnoses = 22 **Operation Access:** Provide low risk outpatient surgery to uninsured patients. • Total patients who received surgeries = 147 • Total volunteer providers providing at least one service = 52
Strategy 2: Support and/or provide screening programs and referral services in order to detect and treat conditions early	**Every Woman Counts:** Every Woman Counts Program will provide free breast screenings for low income women 25 years of age or older for cervical cancer and 40 years of age or older for breast cancer screening. • Total patients served = 775 • Total cancer diagnoses =16 **Lung Cancer Screening Program:** Provide lung cancer CT screening services to people at high risk of developing lung cancer in an effort to decrease barriers to accessing appropriate and timely diagnosis and treatment. • Total screenings conducted = 256 • Total cancer diagnoses = 2

Priority 3: Affordable, local mental health services

Long Term Goal: Improve access to behavioral health support for vulnerable communities.

Strategies	Selected Outcomes (2014 & 2015)
Strategy 1: Provide intervention and referrals to violence related trauma victims in order to prevent recidivism and retaliation	**Beyond Violence:** Reduce recidivism and retaliation by connecting victims of intentional injuries to the Beyond Violence Program. • Total clients = 146 • Total interventions provided = 723 • % remained alive = 100% • % avoided re-injury = 91% • % did not retaliate = 97%
Strategy 2: Support and/or provide behavioral health intervention services to vulnerable populations	**Putnam Clubhouse (PC):** Support the Putnam Clubhouse in Concord to provide peer support and vocational rehabilitation intervention for adults recovering from severe mental health illness. • Total number of PC members = 620 • Total hours spent participating in PC activities = 102,038 • Total members who secured employment = 69 • Total members who returned to school = 28 • % improved mental well-being = 92.5% • % improved emotional well-being = 91.5%

6. Process & Methods

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

Alameda and Contra Costa Counties – Hospitals' CHNA Process

Primary Qualitative Data (Community Input)

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

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulate all health needs that were mentioned, along with health drivers discussed. ASR then made a list of all of the conditions that had been mentioned by a focus group or key informant, counted how many groups or informants listed the conditions, and how many times they had been prioritized by a focus group.

Community Leader Input

Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, and members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input in Contra Costa County, see Appendix 4.

In all, ASR consulted with ten community representatives of various organizations and sectors. These representatives either work in the health field or improve health conditions by serving those from the target populations. See Appendix 4 for the titles and expertise of key stakeholders along with the date and mode of consultation (focus group or key informant interview).

Key Informant Interviews

ASR conducted primary research via key informant interviews with ten Contra Costa County experts from various organizations. Between June and October 2015, experts, including the public health officers,

community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

Experts were interviewed in person or by telephone for approximately one hour. Informants were asked to identify the top needs of their constituencies, including specific groups or areas with greater or special needs; how access to healthcare has changed in the post-Affordable Care Act environment; drivers of the health needs they identified and barriers to health; and suggested solutions for the health needs they identified, including existing or needed resources. See Appendix 6 for key informant interview and focus group protocols.

Focus Groups

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

In order to provide a voice to the community it serves in Contra Costa County, the study team targeted participants who were medically underserved, in poverty, and/or socially or linguistically isolated. Four focus groups were held with community members.

These resident groups were planned in various geographic locations around the county. Residents were recruited by not-for-profit hosts, such as First 5 Contra Costa County and Monument Crisis Center, both of which serve medically underserved and low-income residents.

Focus Groups Details

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Low-Income, Minority (African American)	Pittsburg High School African American Parent Group (PAAACT)	08/27/2015	7
Spanish-Speaking Minority (Latino), Low-Income	First 5 Contra Costa	09/03/15	11
Medically Underserved, Low-Income	Monument Crisis Center	08/24/15	11
Medically Underserved, Low-Income, Minority	Pittsburg Health Center/Community Health Workers	09/08/2015	6

2016 Resident Participant Demographics

Twenty-nine community members participated in the focus group discussions in Contra Costa County[11]. All participants were asked to complete an anonymous demographic survey; the results are reflected below.

- 100% of participants (29) completed a survey.
- 41% (12) of respondents are Latino, 34% are Black, 21% are White, and one is multi-racial.
- 76% (22) are between the ages of 18 and 64 years old; of these, seven are younger than 40, and 15 are aged 40 or older. Three are age 65 or older. Four did not report their age.
- 10% (3) are uninsured, while 66% have benefits through Medi-Cal, Medicare, or another public health insurance program. The rest have private insurance.
- Residents live in various areas of the county: Concord (14), Antioch and Pittsburg (5 each), Contra Costa (3), and Bay Point (2).
- 76% (22) reported having an annual household income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Contra Costa County for two adults with no children ($38,169). More than half (55%) earn under $25,000 per year, which is below FPL for a family of four. This demonstrates a fair level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

Secondary Quantitative Data Collection

ASR analyzed over 150 health indicators to assist the Hospitals with understanding the health needs in Contra Costa County and prioritizing them. Data from existing sources were collected using the Community Commons data platform, the UCLA data platform for the California Health Interview Survey (AskCHIS), and other online sources. In addition, ASR collected data from the Contra Costa County Health Services.

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

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

Information Gaps & Limitations

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

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[11] Does not include participants in the community health workers focus group who were treated as professionals.

7. Identification & Prioritization of Community Health Needs

To identify the community's health needs, ASR and the Hospitals followed these steps:

1. Gathered data on 150+ health indicators using the Community Commons platform[12], public health department reports, Healthy People 2020 objectives, and qualitative data. See Appendix 4 for a list of indicators on which data were gathered.
2. Narrowed the list to "health needs" by applying criteria.
3. Used criteria to prioritize the health needs.

These steps are further defined below.

Identification of Community Health Needs

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

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

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

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.

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

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

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

[12] Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system, found at www.communitycommons.org

In order to be categorized as a prioritized community health need, JMH used the progressive criteria described below. ASR used the Healthy People 2020 (HP2020) objectives as benchmarks, or if no HP2020 benchmark existed, ASR used the state average as a benchmark.

1. The issue must fit the definition of a "health need."
2. At least one indicator performs poorly against a benchmark.
3. The need was prioritized by the community. Needs were considered prioritized by the community if it was mentioned in at least one-third of key informant interviews and focus groups.
4. If the need was not prioritized by the community, at least five related indicators in each region (JMHSA, TV/CCC, and ECCC) performs poorly against a benchmark by 5% or more. (The five indicators may be distinct or may overlap.)

A total of eight health conditions or drivers fit all three criteria and were retained as community health needs: 1) obesity, diabetes, healthy eating and active living; 2) economic security; 3) healthcare access and delivery; 4) oral/dental health; 5) mental health; 6) substance abuse; 7) unintentional injuries; and 8) violence and injury prevention.

Prioritization of Health Needs

Hospital representatives prioritized health needs with local community, public health representatives. By working together, hospital representatives were able to reduce the number of information requests of its community. Before beginning the prioritization process, hospital representatives chose a set of prioritization criteria (listed below). ASR created a survey listing each of the health needs in alphabetical order and offering the first three prioritization criteria for rating. Community public health representatives and representatives of the local, participating hospitals rated each of the health needs on each of the first three prioritization criteria via an online survey in January, 2016. ASR assigned ratings to the fourth criterion based on how many key informants and focus groups prioritized the health need.

Prioritization Criteria:

Severity of need: This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

Magnitude/scale of the need: The magnitude refers to the number of people affected by the health need.

Clear disparities or inequities: This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

Community priority: The community prioritizes the issue over other issues on which it has expressed concern. ASR rated this criterion based on the frequency with which the community expresses concern about each health outcome during the CHNA primary data collection.

Scoring Criteria 1-3: The score levels for the prioritization criteria were:

3: Strongly meets criteria, or is of great concern

2: Meets criteria, or is of some concern

1: Does not meet criteria, or is not of concern

Combining the Scores: For each of the first three criteria, group members' ratings were combined and averaged to obtain a score. Then, the mean was calculated based on the four criteria scores for an overall prioritization score for each health need. The overall need scores ranged between 1.80 and 2.75 on a scale of 1-3 with 1 being the lowest score possible and 3 being the highest score possible. The needs are ranked in order of their

prioritization score in the sections below. The specific scores for each of the four criteria used to generate the overall community health needs prioritization scores may be viewed in Appendix 5.

Summarized Descriptions of Health Needs (2016)

Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve. For that reason, social determinants of health which met the criteria described above are included in the list of significant health needs.

For further details, please consult Appendix 8 - Health Needs Profiles.

Note: Rates cited below are per 100,000 in the population described unless otherwise indicated. For more detail, including data citations, refer to Appendix 3 (Data Indicators) and Appendix 8 (Health Profiles).

Definitions **(see page 12 for city definitions)**

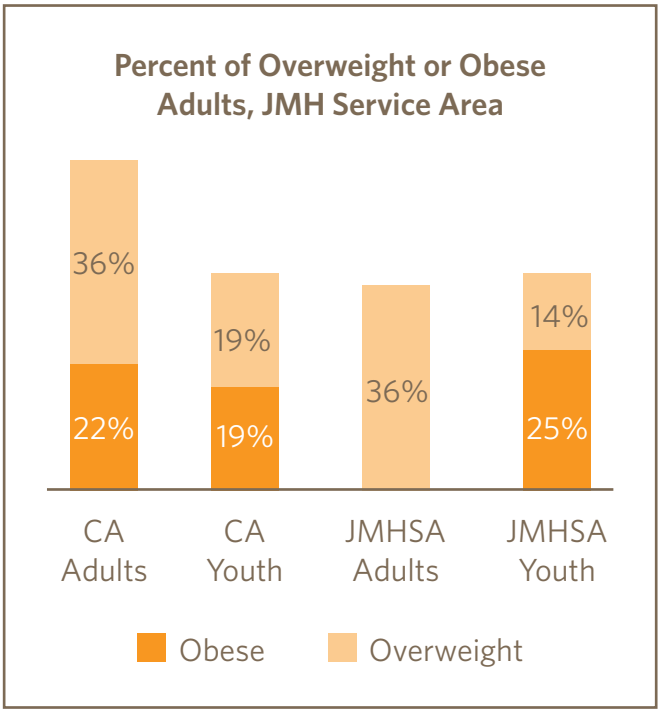
JMHSA – JMH Service Area

ECC – East Contra Costa area

TV/CCC – Tri-valley/Central Contra Costa area

1. Obesity, diabetes, healthy eating and active living (2.75)

are health needs locally as illustrated by higher rates of overweight among adults, ethnic disparities in the rates of obese youth, high rates of diabetes prevalence, and lower percentages of Medicare enrollees with diabetes who have an annual diabetes test compared to the state averages. Community input about these needs was strong, and expressed the connection between obesity, diabetes, and related health behaviors such as poor nutrition and lack of physical activity.



- In the JMHSA, one third of youth are overweight or obese and over a third of adults are overweight (see chart).
- In JMHSA, 8.3% of the population has been diagnosed with diabetes, slightly higher than in the state. Benicia data indicate higher rates of diabetes deaths (2.6 per 10,000) and childhood diabetes hospitalizations (48.8) in the city than in the state.
- 80% of the diabetic Medicare population has an annual blood sugar test, a slightly smaller proportion than in the state (82%).
- 26% of residents in the JMHSA live in areas designated as a food desert, which is well above the state average (14%).

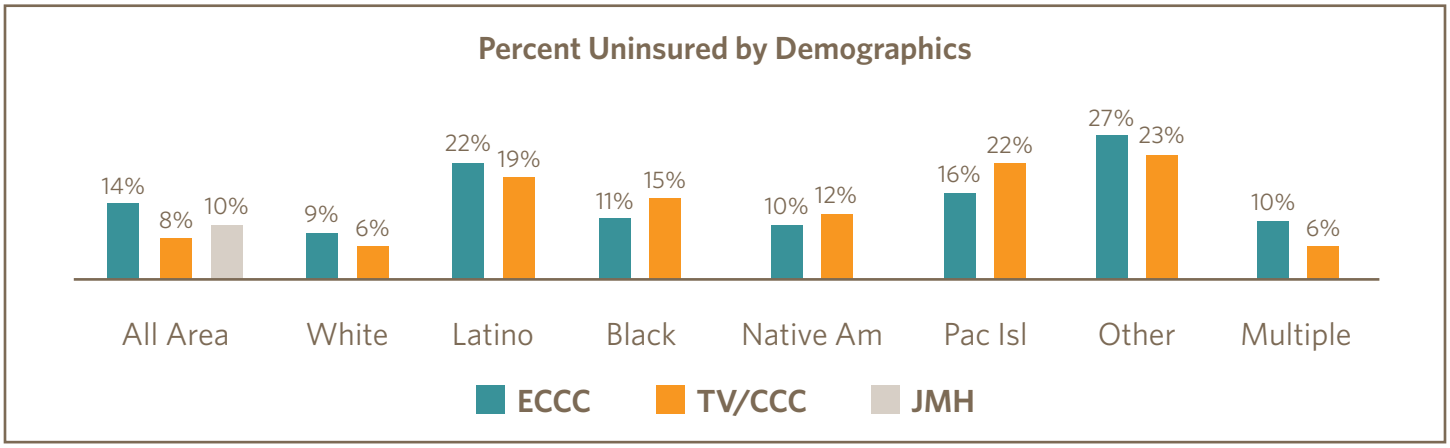
Community input indicated that there is a lack of education around linking mental health and healthy living, and that healthy food is often less affordable than the unhealthy food options. Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to

change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. Creating and supporting healthy food and safe, accessible physical environments allows people to make healthier choices and live healthier lives.

2. Economic security (2.63) is a health need locally as marked by the percentage of residents who experience food insecurity at some point during the year, which is higher than the HP 2020 target. Also, in the JMHSA, 21% of the population commutes over 60 minutes to work, which is 10% higher than the state benchmark. Community input suggests that affordable housing is an issue. Community members felt that many people must choose between buying medicine, paying their rent, and eating.

- In TV/CCC, 12% of Latino residents live in poverty compared to 5% of non-Latino residents.
- While 12% of children in the JMHSA are living in poverty, compared to 14% of county children, ethnicity data from the ECC and TV/CCC areas indicate that 26% of Latino children live in poverty compared to 7% of non-Latino children.
- Other ECC children in poverty by race/ethnicity: 31% of Black children and 25% of "other" races.
- While 86% of Contra Costa County students graduate from high school (meeting the HP2020 target of 82.4%), only 71% of Black students and 79% of Latino students graduate.

3. Healthcare access & delivery, including primary and specialty care (2.40) is a health need locally as demonstrated by stark ethnic disparities in the uninsured population at the regional level (see chart below).



Also, there are high rates of preventable hospital events compared to the state average. Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competency. Limited access to healthcare and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. The community input indicated that insurance premiums and co-payments are too high, and wait times for appointments are too long. Community members also expressed a fear of accessing care because of previous bad experiences and a lack of information about where and how to obtain health insurance. Regarding specialty care, the community said that not all specialty care is covered by insurance (e.g., hearing aids and vision exams). They also reported that adequate transportation is a crucial need because specialty care facilities are not located in close proximity.

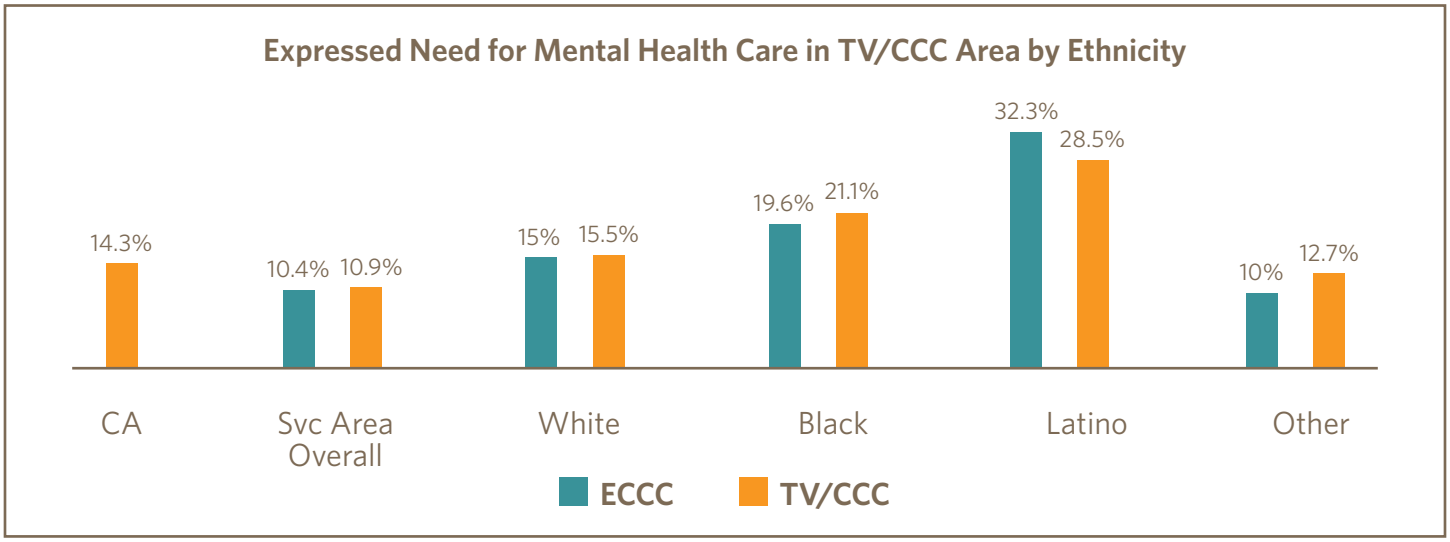
- In JMHSA, the rate of preventable hospital events is 94.9 per 10,000, exceeding the state rate of 83.2. In ECC the rate was 135.3. In the TV/CCC the rate does not exceed the state (72.5).
- In JMHSA, there are 10% uninsured.
- In the JMHSA, there are approximately 0.4 federally qualified health centers for every 100,000 residents, which is worse than in the state (1.97 centers).

4. Oral health (2.38) is essential to overall health. Oral diseases, from cavities to oral cancer, cause pain and disability. Health behaviors that can lead to poor oral health include: tobacco use, excessive alcohol use, poor oral self-care, and poor dietary choices. Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures. Oral/dental health is a health need locally as marked by a slightly higher percentage of children in Contra Costa County who miss school days due to a dental problem compared to the state average (8% compared to 7%). Community input indicated that dental care is not always covered by insurance, benefits are not sufficient, and providers often don't accept the dental insurance residents do have. Community members also expressed a desire for a mobile dental clinic.

- In the JMHSA, 10% report that they have poor dental health.
- In addition, 9% of the county population is living in a Dental Health Professional Shortage Area (HPSA), which is higher than the state (5%).
- In TV/CCC, 17% of youth had not had a recent dental exam, which is similar to the state (19%).
- In Contra Costa County, 12% of Black youth had not had a recent dental exam compared to 4% of White youth.
- 8% of county children miss school days due to a dental problem compared to the state (7%).

5. Mental health (2.25) is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health. Mental health is a health need locally as evidenced by the rate of suicide in the JMHSA, which is higher than the state and national benchmark. The suicide rates for Whites in both in the TV/CCC and ECCC areas were the highest among racial and ethnic groups, while the rates were lowest among Native Hawaiians/Pacific Islanders. However, as shown in the chart, White adults are much less likely to report a need for mental health care as compared to other racial and ethnic groups; Latino and Black adults are much more likely to report a need for mental health care. Community input indicates that cultural barriers make it harder to access mental health care. Community members also felt that primary care physicians are not educating patients about the link between well-being and disease prevention, and that primary care physicians are not making mental health referrals.

- The suicide rate for Whites in ECC was 13.6 and 13.5 in TV/CCC, both exceeding the HP2020 benchmark of 10.2.
- Benicia data indicates that 1 in 5 students (20%) reported suicidal ideation.
- In TV/CCC, 16% of Whites reported a need for mental health care during the past 12 months, as compared to 21% of Black and 28% of Latinos.
- The youth intentional injury rate indicates ER visits by those aged 13-20 due to assaults and self-harm. In the ECC area, the rate is higher than the state average (779.3 as compared to 738.7).



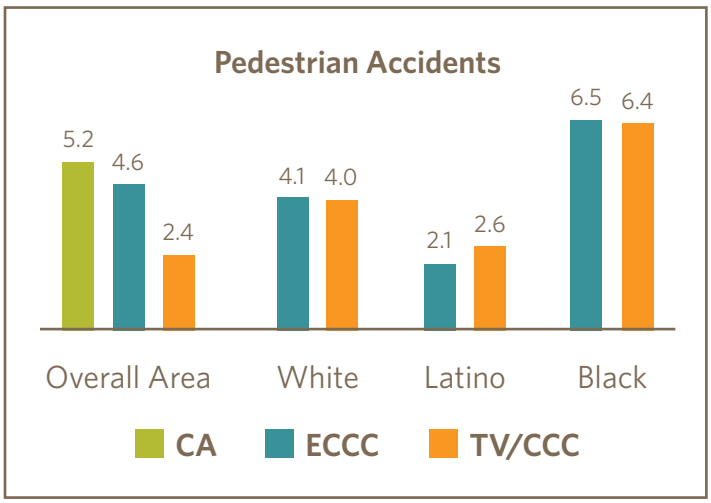
Substance abuse (2.15) has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide. Substance abuse (including tobacco and alcohol) is a health need locally as demonstrated by levels of excessive alcohol consumption among adults. Community feedback indicated that residents are using drugs and alcohol to help them sleep, and homeless residents may be using substances to help cope with being on the street.

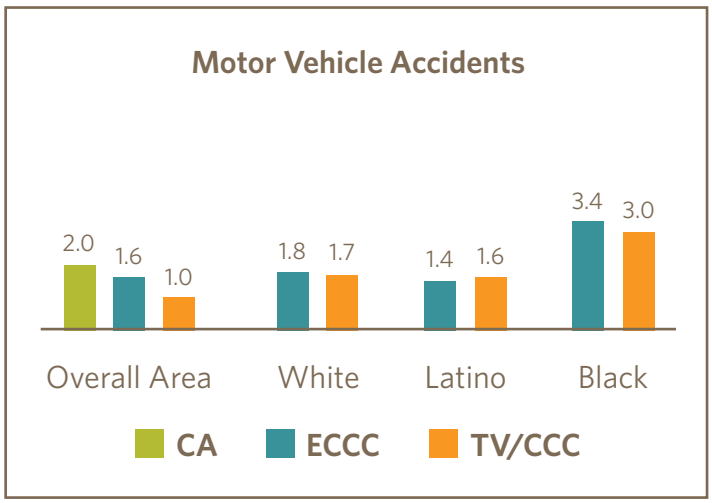
- 19% of JMHSA adults binge drink, higher than the state average (17%).
- 14% of JMHSA residents' total household expenditures are towards alcohol, slightly higher than the state average (13%).
- In the JMHSA, 12% use tobacco, which is similar to the state. Benicia residents are more likely to be smokers (17%) than Californians overall (14%).

Unintentional injuries (1.83) are defined as those not purposely inflicted, and they are most often the result of accidents. The most common unintentional injuries result from motor vehicle crashes, falls, poisonings, suffocations, and drownings. Although most unintentional injuries are predictable and preventable, they are a major cause of premature death and lifelong disability. More individuals ages 15-44 die as a result of unintentional injuries than from any other cause. Unintentional injury is the fifth leading cause of death for all ages both in the U.S. and California. Community input suggests that falls among the older adult population are especially of concern.

- Whites in Contra Costa County are hospitalized due to "all unintentional injuries" at a rate of 723.7 compared to 537.1 in the county and 552.1 in California.
- Blacks in Contra Costa County have higher rates of death due to "all unintentional injuries" (43.2) than county residents (26.7) and California residents (36.4).
- In Contra Costa County, Whites were overrepresented in the population of seniors (aged 65 and over impacted by falls. While Whites are 74% of the senior population, they accounted for 79% of hospitalizations due to falls, and 76% of deaths due to falls.
- Latinos make up 10% of the senior population, but 14% of deaths due to falls[13].

[13] Due to the small number of falls deaths (59 total) caution should be used when interpreting data by race/ethnicity.





Violence and intentional injury (1.80) contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. Violence and injury prevention are health needs locally as marked by rates of homicide, suicide, robbery, violent crime, and domestic violence that are above the state average and/or HP2020 benchmark. In addition, racial and ethnic disparities are stark. Community input indicated that gang violence is a major issue, and that there are a lack of domestic violence shelters in the community.

- Blacks in ECC have a homicide mortality rate 17 times higher than Whites and 18 times higher than Native Americans/Alaskan Natives, who have lowest rates.
- TV/CCC area rates of homicide and domestic violence deaths are worse than the state.
- The age adjusted homicide mortality rate for Blacks is 39.9 in Contra Costa County.
- Overall violent crime rates in TV/CCC (490.0) are higher than the county (396.6) and the state (425.0).
- In ECC, rates of school suspensions (17.7 per 100 students) and school expulsions (0.13 per 100 students) are more than double that of the state and the TV/CCC area. (Students who are suspended or expelled from school are at higher risk for academic failure and incarceration.)[14]

[14] Community Commons, http://www.communitycommons.org

8. Conclusion

JMH worked in collaboration with several not-for-profit hospitals to meet the requirements of the federally required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and doing new primary research as a team, these hospitals were able to collectively understand the community's perception of health needs and prioritize health needs with an understanding of how each compares against benchmarks.

Our hospital identified eight significant health needs in our community: 1: Obesity, diabetes, healthy eating and active living; 2: Economic security; 3: Healthcare access and delivery including primary and specialty care; 4: Oral/dental health; 5: Mental health; 6: Substance abuse; 7: Unintentional injuries; and 8: Violence/ injury prevention.

This CHNA report was adopted by the governing bodies of JMMC-WC, CC, and BHC on 11/15/16.
We will make this CHNA report publicly available on our website by December 31, 2016. Our hospital will go through a selection process by applying a set of criteria to the list of eight significant health needs. Then, our hospital will develop implementation strategies to address selected needs based on the data in this report, including the assets and resources available to address the needs (see Appendix 7). JMH will document the selection process and the strategies it will implement to address the selected health needs in a written Community Health Improvement Plan (CHIP) which will be filed with the IRS as part of our 990 Schedule H, filed by April 15, 2017. The ISR report will also be posted on our public website at *https://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html.*
The public will have an opportunity to provide written comments on both the CHNA and the CHIP reports.

9. List of Appendices

1. Glossary
2. Secondary Data Sources
3. Indicator List
4. List of Community Leaders and Their Credentials
5. Health Needs Prioritization Scores: Breakdown by Area
6. Focus Group and Key Informant Interview Protocols
7. Community Assets and Resources
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Appendix

JOHN MUIR HEALTH

Appendix 1: Glossary

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

Appendix 2: Secondary Data Sources

Alameda County Public Health Department. 2014. Alameda County Health Data Profile 2014.

Alameda County Public Health Department. Various. http://www.healthyalamedacounty.org/. Accessed October and November 2015.

City of Berkeley Public Health Division. 2013. Health Status Report 2013.

Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.

U.S. Department of Health and Human Services. 2015. Healthy People 2020. Office of Disease Prevention and Health Promotion, HealthyPeople.gov, http://www.healthypeople.gov/. Accessed October and November 2015.Alameda County Public Health Department. 2014. Alameda County Health Data Profile 2014.

U.S. Department of Health and Human Services. 2015. Healthy People 2020. Office of Disease Prevention and Health Promotion, HealthyPeople.gov, http://www.healthypeople.gov/. Accessed October and November 2015.

U.S. Department of Health and Human Services. Various. http://www.healthyalamedacounty.org/. Accessed October and November 2015.

UCLA Center for Health Policy Research. 2015. AskCHIS Neighborhood Edition. Accessed October and November 2015.

UCLA Center for Health Policy Research. 2015. AskCHIS. Accessed October and November 2015.

Appendix 3: List of Indicators

Indicator Variable	Data Source
Age 0-4 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 18-24 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 25-34 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 35-44 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 45-54 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 5-17 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 55-64 (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Age 65+ (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11.
Assault Injuries Rate (Per 100,000 Population)	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Assault Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.

Indicator Variable	Data Source
Asthma Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data, additional data analysis by CARES, 2011, and Alameda County Public Health Department. Alameda County Health Data Profile, 2014, and Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Asthma Prevalence (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Average Daily School Breakfast Program Participation Rate	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program. 2013.
Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
BMI > 30.0 Prevalence (Obese) (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
Breast Cancer Deaths (Rate per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Cancer, Age-Adjusted Mortality Rate (Per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Childhood (0-14) Asthma Hospitalization Rate (Per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Children and Teens with Asthma (1-17) (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile, 2014, and Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Children Who Visited Dentist Within Past 12 Months (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Chlamydia Infection Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2012.

Indicator Variable	Data Source
Cigarette Expenditures, Percentage of Total Household Expenditures	Nielsen, Nielsen Site Reports. 2014.
Colorectal Cancer Deaths Rate (Per 100,000 (age-adjusted))	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Coronary Heart Disease Hospitalization Rate (Per 100,000 (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Dentists, Rate (Per 100,000 Pop.)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
Depression (Percentage, Medicare Beneficiaries)	Centers for Medicare, and, Medicaid, Services. 2012.
Diabetes Hospitalizations Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diagnosed Diabetes Prevalence (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012, and Alameda County Public Health Department, Alameda County Health Data Profile, 2014, and Contra Costa Health Services and Hospital Council of Northern and Central California, 2010, Community Health Indicators for Contra Costa County.
Disability (Percentage, Population)	US Census Bureau, American Community Survey. 2009-13.
Domestic Violence Injuries Rate (Per 100,000 Population (Females Age 10+))	California EpiCenter data platform for Overall Injury Surveillance. 2011-13.
Drought Weeks (Any) (Percentage)	US, Drought, Monitor. 2012-14.
Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Fast Food Restaurants, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Federally Qualified Health Centers, Rate (Per 100,000 Population)	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.

Indicator Variable	Data Source
Female Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Food Insecurity (Percentage, Population)	Feeding, America. 2012.
Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen Site Reports. 2014.
Full Immunization at 24 Months (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Gini Index Value (Income Inequality)	US Census Bureau, American Community Survey. 2009-13.
Grade 4 ELA Test Score Not Proficient (Percentage)	California, Department of Education., 2012-13.
Grocery Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2011.
Head Start Programs Rate (Per 10,000 Children Under Age 5)	US Department of Health & Human Services, Administration for Children and Families. 2014.
Heart Disease Prevalence (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Heart Disease, Age-Adjusted Mortality Rate (Per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Heat-related Emergency Department Visits, Rate (per 100,000 Population)	California Department of Public Health, CDPH - Tracking. 2005-12.
Hemoglobin A1c Test, Annual (Percentage, Medicare Enrollees with Diabetes)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
High Blood Pressure and Not Taking Medication (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
High Blood Pressure Prevalence (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
High School Cohort Graduation Rate	California, Department of Education. 2013.

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

Indicator Variable	Data Source
Live within Half Mile of Public Transit (Percentage, Population)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Living in a HPSA-Dental (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.
Living in a HPSA-Primary Care (Percentage, Population)	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015.
Living in Car Dependent (Almost Exclusively) Cities (Percentage)	Walk Score®. 2012.
Low Birth Weight Births (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Low Food Access (Percentage, Population)	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.
Male Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Mammogram in Past 2 Year (Percentage, Female Medicare Enrollees)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012.
Median Age	US Census Bureau, American Community Survey. 2009-13.
Mental Health Care Provider Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2014.
Missed School Days Due to Dental Problem (At Least One Day) (Percentage)	Contra Costa Health Services and Hospital Council of Northern and Central California. 2010. Community Health Indicators for Contra Costa County.
Mothers Breastfeeding (Any) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers Breastfeeding (Exclusively) (Percentage)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Mothers with Late or No Prenatal Care (Percentage)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.

Indicator Variable	Data Source
Never Screened for HIV / AIDS (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
No Air Conditioning (Percentage, Housing Units)	US Census Bureau, American Housing Survey. 2011, 2013.
No High School Diploma (Percentage, Population Age 25+)	US Census Bureau, American Community Survey. 2009-13.
No Leisure Time Physical Activity (Percentage, Population)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
No Motor Vehicle (Percentage, Households)	US Census Bureau, American Community Survey. 2009-13.
Obese Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Obesity (Percentage, Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012, and UCLA Center for Health Policy Research, AskCHIS, 2015.
Occupied Housing Units with One or More Substandard Conditions (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Overweight (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight Youth (Percentage, Students Tested)	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Ozone (03) - Days Exceeding Standards, Pop. Adjusted Average (Percentage)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Particulate Matter 2.5 - Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
People Delayed or had Difficulty Obtaining Care (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.

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

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

Indicator Variable	Data Source
Severe Mental Illness Related Emergency Department Visits (Rate per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Smoking Cigarettes (Age-Adjusted) (Percentage, Population)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Nielsen, Nielsen SiteReports. 2014.
Stroke, Age-Adjusted Mortality Rate (Per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Students Eligible for Free or Reduced Price Lunch (Percentage)	National Center for Education Statistics, NCES - Common Core of Data. 2013-14.
Substance Use Emergency Department Visit Rate (Rate per 100,000 (age-adjusted))	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Suicide, Age-Adjusted Mortality Rate (Per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Teen Birth Rate (Per 1, 000 Female Pop. Under Age 20)	California Department of Public Health, CDPH - Birth Profiles by ZIP Code. 2011.
Teens Who Engage in Regular Physical Activity (Percentage)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Tuberculosis Incidence Rate (Per 100,000)	Alameda County Public Health Department. Alameda County Health Data Profile. 2014.
Unable to Afford Dental Care, Youth (Percentage, Population Age 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2015 - June.
Uninsured Population (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Vacant Housing Units (Percentage)	US Census Bureau, American Community Survey. 2009-13.

Indicator Variable	Data Source
Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Walking or Biking to Work (Percentage, Aged 16+)	US Census Bureau, American Community Survey. 2009-13.
Walking/Skating/Biking to School (Percentage, Aged 5-17)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Weather Observations with High Heat Index Values (Percentage)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Without Adequate Social / Emotional Support (Age-Adjusted) (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Without Dental Insurance (Percentage, Adults)	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Without Recent Dental Exam (Percentage, Adults)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Without Regular Doctor (Percentage, Total Population)	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Workers Commuting by Car, Alone (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Workers Commuting More than 60 Minutes (Percentage)	US Census Bureau, American Community Survey. 2009-13.
Years of Potential Life Lost, Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2008-10.
Youth Without Recent Dental Exam (Percentage)	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.

Appendix 4: Persons Representing the Broad Interests of the Community

The following leaders were consulted for their expertise in the community. They were identified based on their professional expertise and knowledge of target groups* including children, youth, older adults, low-income populations, minorities, and the medically underserved. The coalition included leaders from health systems including the Alameda and Contra Costa Counties' Public Health Departments, local hospital and health care agency leaders and representatives, local government employees, appointed county government leaders, school districts, and nonprofit organizations. For a description of members of the community who participated in focus groups, please see Section 5 "Resident Input."

Sector	Organization	Title	Expertise	Role	Target Group Represented*	Consultation Method	Date Consulted (2015)
County Health	Behavioral Health Services, Contra Costa County	Director	Behavioral Health, Mental Health, Homeless	Leader	1,2,3	Interview	9.22.15
County Health	Contra Costa Health Services	Assistant Director	Health Services, Public Health	Leader	1,2,3	Interview	7.30.15
County Health/ Public Health	Contra Costa County Public Health	Epidemiologist	Public Health	Leader	1,2,3	Interview	6.24.15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15
Local Health	Contra Costa Health Services, Center for Human Development	Lead African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15

Continued on next page

*** Target group represented:**

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

Sector	Organization	Title	Expertise	Role	Target Group Represented*	Consultation Method	Date Consulted (2015)
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15
Local Health	Contra Costa Health Services, Center for Human Development	African American Health Conductor	Community Health, Minority	Representative, Member	1,3	Focus Group	9.8.15
Non-Profit	Meals-on-Wheels Senior Outreach	Executive Director	Low-Income, Underserved, Older Adults	Leader	3	Interview	8.12.15

*** Target group represented:**

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

Appendix 5: 2016 Health Needs Prioritization Scores

Health Need	East Contra Costa Co.	Central Contra Costa Co.	Average	Combined Ranking
Economic Security	2.80	2.45	2.63	2
Healthcare Access & Delivery, Including Primary & Specialty Care	2.45	2.35	2.40	3
Mental Health	2.25	2.25	2.25	5
Obesity, Diabetes, & Healthy Eating/Active Living	2.75	2.75	2.75	1
Oral/Dental Health	2.35	2.4	2.38	4
Substance Abuse (Alcohol, Tobacco, Other Drugs)	1.85	2.45	2.15	6
Unintentional Injuries	2.00	2.00	2.00	7
Violence/Injury Prevention	1.90	1.7	1.80	8

Definitions:

Severity of need: This refers to its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

Magnitude/scale of the need: The magnitude refers to the number of people affected by the health need.

Clear disparities or inequities: This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

Community priority: The community prioritizes the issue over other issues on which it has expressed concern. ASR rated this criterion based on the frequency with which the community expresses concern about each health outcome during the CHNA primary data collection.

Appendix 6: CHNA Qualitative Data Collection Protocols

Professionals (Providers) Focus Group Protocol

Introductory remarks

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

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

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

Focus Group Questions

1. Community Health Needs & Prioritization

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

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

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

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

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

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

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

2. Access to Care

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

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

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

c. What barriers to access still exist? (Focus on comparison pre- and post-ACA)

   i. Is the same proportion still medically uninsured/under-insured; or is it a smaller proportion, or a larger proportion than before ACA?

   ii. Do more people, the same, or fewer people have a primary care physician than before ACA?

   iii. Are people using the ER as primary care to the same degree, less, or more than before ACA?

   iv. Is the same proportion of the community facing difficulties affording health care, or is it a smaller proportion, or a greater proportion than before ACA?

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

3. Drivers / Barriers

What other drivers or barriers are contributing to the health needs that you prioritized? We will talk about solutions in just a minute.

Prompts if they are having trouble thinking of anything:

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

4. Suggestions / Improvements / Solutions

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

a. Are there any policy changes you would recommend that could address these issues?

b. Are there existing assets or resources available to address these needs that people are not using? Why?

c. What other assets or resources are needed?

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

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

Concluding Remarks

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

Residents (Non-Professionals) Focus Group Protocol

Introductory remarks

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

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

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

Focus Group Questions

1. Community Health Needs & Prioritization

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

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

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

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

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

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

2. Access to Care

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

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

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

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

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

3. Drivers / Barriers

What else is influencing the health needs that you prioritized? We will talk about solutions in just a minute.
Prompts if they seem to be having trouble coming up with anything:

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

4. Suggestions / Improvements / Solutions

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

a. Are there existing assets or resources available to address these needs that people are not using? Why?

b. What other assets or resources are needed?

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

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

Concluding Remarks

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

Collect surveys
Pass out incentives and get signed receipts

Key Informant Interview Protocol

Introduction

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

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

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

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

Preamble

Our questions mainly relate to:

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

Interview questions

1. Background

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

2. Health Needs

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

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

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

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

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

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

3. Challenges: Access to healthcare – post-ACA

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

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

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

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

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

4. Other Challenges

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

Prompts if they seem to be having trouble coming up with anything:

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

5. Suggestions / Improvements / Solutions

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

a. Are there any policy changes you would recommend that could address these issues? Consider those that are readily achievable and politically feasible.

b. Are there existing resources available to address these needs? If so, why aren't people using them?

c. What other resources are needed?

d. Of the resources/solutions to improve health, which do you feel is the most significant improvement needed, second, and third?

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

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

Concluding Remarks

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

Appendix 7: Community Assets and Resources

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

Overall:

Existing Health Care Facilities

- Contra Costa Regional Medical Center
- John Muir Medical Center
  - Concord
  - Walnut Creek
- John Muir Behavioral Health Center
- Kaiser Permanente – Diablo (Antioch and Walnut Creek)
- Kaiser Permanente – East Bay (Richmond)
- San Ramon Regional Medical Center
- Sutter Alta Bates Summit Medical Center
- Sutter Delta Medical Center
- Veterans Affairs Medical Center/Concord Vet Center

Existing Federally Qualified Health Centers

- Axis Community Health
- La Clinica de la Raza
  - Monument (Concord)
  - Pittsburg-Medical
  - Oakley
- Lifelong Brookside Community Health Center
  - Richmond
  - San Pablo
- Lifelong Dr. William M. Jenkins Pediatric Center
- Lifelong Medical Care
  - Richmond
- Native American Health Center

Other Existing Community Resources and Programs for Each Health Need (in Priority Order)

1: Obesity, Diabetes, and Healthy Eating/Active Living

- Ambrose Recreation and Park District
- Bay Point All Stars
- Bay Point Community Foundation
- Building Blocks for Kids Collaborative
- Center for Human Development
- Centro de Servicios
- Children's Emergency Food Bank
  - Concord
- City of Antioch
- Commodity and Food Programs
- Contra Costa Health Services
- East Bay Regional Parks
- East County Midnight Basketball
- Emergency Shelter Program, Inc. (SHELTER, Inc.)
- First 5 Contra Costa
- Food Bank of Contra Costa
- Get Fit Antioch
- Greater Richmond Interfaith Programs
- Healthy and Active Before 5
- Healthy and Livable Pittsburg
- Meals on Wheels and Senior Outreach Services
- Senior Exercise Program
- Senior Outreach Services
- Monument Crisis Center
- Monument Impact
- New Start Tattoo Removal
- Open Heart Kitchen
- Pogo Park
- Second Chance – Emergency Shelter
- Service Opportunities for Seniors – Meals on Wheels and Senior Outreach Services
- Urban Tilth
- Village Community Resource Center
- White Pony Express
- YMCA Antioch

2: Economic Security

- Antioch/East Contra Costa Health and Wealth Initiative
- Brighter Beginnings
- Building Blocks for Kids Collaborative
- Catholic Charities of the East Bay
- Center for Independent Living Employment Academy
- Centro de Servicios
- Community Resources for Independent Living (CRIL)
- Computer Technologies Program
- Contra Costa County Employment & Human Services
- Contra Costa County Early Head Start and Head Start
- EBALDC – East Bay Asian Local Development Corporation
- Economic Opportunity Council
- East Richmond Youth Development Center
- Ensuring Opportunity Contra Costa
- Jewish Vocational Services
- Monument Community Partnership & Michael Chavez Center for Economic Opportunity
- Monument Impact
- Opportunity Junction
- Richmond Health Equity Partnership
- Richmond Works
- Shelter Inc.
- SparkPoint Bay Point
- The Stride Center

3: Health Care Access & Delivery, Including Primary and Specialty Care

- American Heart Association
- Brighter Beginnings
- Brookside Community Health Center
- Centro de Servicios
- CPUC – Community Education
- Coalition
- Concord RotaCare Clinic
- Contra Costa County Health Services Health Centers
- Deaf Counseling Advocacy and Referral Agency
- New Start Tattoo Removal
- Emergency Shelter Program, Inc.
- Every Woman Counts
- Gray Panthers
- Healthy Richmond
- Jewish Family & Children's Services of the East Bay
- JMH Mobile Health Clinic
- La Clinica de La Raza
- La Familia – FRC - Fuller
- LifeLong Medical Care
- Lighthouse Community Center
- Native American Health Center
- Operation Access
- Planned Parenthood
- Pittsburg RotaCare Clinic
- Ronald McDonald Care Mobile Dental Clinic
- Silva Pediatric Medical Clinic
  - Silva Pediatric Medical Clinic
  - Women's Center
  - Women's Imaging Center
- St. Vincent de Paul RotaCare Clinic
- Sutter Delta Community Clinic
- The Latina Center
- Philip Dorn Respite Care Shelter

4: Oral/Dental Health

- Contra Costa County Dental Services
- La Clinica de la Raza
- Ronald McDonald Dental Care Mobile

5: Mental Health

- Bay Area Community Services, Inc., including Adult Day Care Services
- Centro de Servicios
- Christian Counseling Centers, Inc.:
- Concord Family Services Center
- Contra Costa Crisis Center
- Contra Costa Health Services
- Crockett Counseling Center
- Early Childhood Mental Health Program
- Familias Unidas
- Family Education and Resource Center (FERC)
- EHSD: Youth and Family Services
- Jewish Family & Community Services East Bay
- JFK University – Community Counseling Center
- John Muir Health Adolescent, Adult & Children's Psychiatric Programs
- Kidango, Inc.:
  - Early Head Start/Head Start Programs
  - Mental Health
  - Special Needs/Early Intervention Services
- La Cheim School, Inc
- Monument Impact – Mentes Positivas
- NAMI (National Alliance on Mental Illness):
  - Contra Costa (National Alliance on Mental Illness)
- Power Program
- Putnam Clubhouse
- The Latina Center

6: Substance Abuse (including tobacco and alcohol)

- 12-Step programs (Al-Anon, Alcoholics Anonymous, Narcotics Anonymous)
- A Chance for Freedom
- Adult Behavioral Health Services
- Center for Human Development
- Christian Counseling Centers, Inc. Fremont Christian Counseling Center
- Contra Costa Health Services
- Health Care Transitional Housing
- John Muir Behavioral Health Center
- Narcotics Anonymous
- Neighborhood House
- Ujima:
  - East
  - West

7: Unintentional Injuries

- Contra Costa Health Services
- Fall Prevention Program of Contra Costa County

8: Violence and Injury Prevention

- Beyond Violence
- Building Blocks for Kids Collaborative
- Center for Human Development
- City of Richmond Office of Neighborhood Safety
- Community Violence Solutions
- Family Justice Centers
- Healing Circles of Hope
- Healthy Richmond (sponsored by The California Endowment)
- One Day at a Time
- Pogo Park
- Richmond Police Department
- RYSE Youth Center
- Victim Witness Assistance
- Youth Intervention Network
- Safe Alternatives to Violent Environments (SAVE)
- STAND! for Families Free of Domestic Violence
- Victim Witness Assistance
- Zero Tolerance for Domestic Violence Initiative

Appendix 8: 2016 CHNA Health Needs Profiles

1. Economic security
2. Healthcare access & delivery, including primary & specialty care
3. Mental health
4. Obesity, diabetes, & healthy eating/active living
5. Oral/dental health
6. Substance abuse, including alcohol, tobacco, and other drugs
7. Unintentional injuries
8. Violence/injury prevention