2022
Community Health Needs Assessment

Sutter Health
Alta Bates Summit
Medical Center

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Executive Summary

Background

Every three years, Alta Bates Summit Medical Center conducts a community health needs assessment (CHNA). The CHNA process is driven by a commitment to improve health equity and is intended to be transparent, rigorous, and collaborative. This CHNA identifies and prioritizes needs unique to our service area, based on community-level data and input from key informants and community residents representing the broad interests of the community.

The 2022 CHNA presents a comprehensive picture of community health that encompasses the conditions that impact health in the county. The overall goal of the CHNA is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being for all Alta Bates Summit Medical Center service area residents. From data collection and analysis to the identification of prioritized needs, the development of the 2022 CHNA report has been a comprehensive process with input from diverse community stakeholders and residents.

Conducting a CHNA every three years has been a California requirement for nonprofit hospitals for over 25 years (Senate Bill 697). The federal Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals that wish to maintain their tax-exempt status to conduct a CHNA every three years and hospitals must make the CHNA report widely available to the public. The CHNA must include input from public health departments and the community, including minority, low-income, medically underserved populations or representatives of community-based organizations serving these populations. [1]

Process

The 2022 CHNA was a collaborative effort of nonprofit hospitals serving Alameda and Contra Costa Counties. In addition, the Alameda County Public Health Department was an essential partner in collecting primary and secondary data and prioritizing health needs. The CHNA process applied a social determinants of health framework and examined social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the priority health needs for Alta Bates Summit Medical Center's service area. This CHNA report placed particular emphasis on the health issues and contributing factors that impact underserved populations that disproportionately have adverse health outcomes across multiple health needs. These analyses will inform intervention strategies to promote health equity.

Primary data (community input) were obtained during the summer and fall of 2021 through:

- Key informant interviews with local health experts, community leaders and community organizations
- Focus groups with community residents

[1] Internal Revenue Service (IRS). (2021). Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3). https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3 Accessed May 2022.

Secondary data were obtained from a variety of sources. (Appendix D: CHNA Secondary Data Indicator Definitions, Sources, and Dates.) Data were collected for Alameda County as a whole, as well as for Alta Bates Summit Medical Center's Service Area – Northern Alameda County.

Through a comprehensive process combining findings from primary and secondary data, health needs were scored to identify a list of the top eight health needs for the service area. In December 2021, Alta Bates Summit Medical Center participated in a meeting with key leaders in Alameda County where participants individually ranked the health needs according to a set of criteria. Rankings were then averaged across all participants to obtain a final rank order for the health needs. The results of the prioritization appear in Figure 1 and brief descriptions of the top eight priority health needs are provided below.

Figure 1. CHNA Health Needs in Priority Order

- Behavioral health (first place)
- Housing and homelessness (second place)
- Healthcare access and delivery (tied for third place)
- Economic security (tied for third place)
- Community and family safety (tied for third place)
- Dismantling structural racism (fourth place)
- Food security (fifth place)
- Transportation (sixth place)

Top Priority Health Need Descriptions

Behavioral Health: Behavioral health, which refers to both mental health and substance use, affects many Americans. Anxiety, depression, and suicidal ideation are on the rise, and heightened further due to the COVID-19 pandemic, particularly among Black/African American and Latinx community members. Key informants serving Alameda County described behavioral health concerns as a number one issue for the communities they serve, reporting intense distress about the level of behavioral health needs going untreated. Focus group participants reported inadequate mental health services for non-English speakers, immigrants, children/teens, and residents who identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, allies and others). In Northern Alameda County, key informants noted high levels of intergenerational trauma in their community, yet significant stigma around accessing behavioral healthcare. Northern Alameda County focus group participants also cited insufficient availability of behavioral health services, specifically for low-income families. They discussed that teens are experiencing increased rates of anxiety, depression, and fear, and are suffering due to the social isolation caused by the pandemic.

Housing and Homelessness: The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with health, well-being, educational achievement, and economic success. Almost all Alameda County key informants and nearly half of focus groups identified housing and homelessness as a top priority health need for Alameda County; they described a variety of housing challenges including a concern that specific populations are at highest risk of becoming unhoused, such as Black/African American, Latinx, and LGBTQIA+ community members, immigrants, seniors, women fleeing domestic violence, people

with disabilities, and those experiencing mental illness or addiction. According to key informants, seniors are increasingly likely to face housing instability or become unhoused and need targeted assistance to preserve existing housing or find an appropriate senior living setting. Focus group participants echoed this concern and specifically noted a surge in unhoused LGBTQIA+ seniors. Focus group participants from Northern Alameda County noted that housing discrimination is prevalent, particularly towards Black/African American and transgender residents.

Healthcare Access and Delivery: Access to comprehensive, quality healthcare has a profound impact on health and quality of life. Components of access to and delivery of care include insurance coverage, adequate numbers of primary and specialty care providers, health care timeliness, quality and transparency, and cultural competence/cultural humility. The majority of key informants and nearly half of focus groups identified healthcare access and delivery as a top priority health need for Alameda County, describing that too few healthcare providers with specialized training for working with specific populations serves as a barrier to care, particularly for LGBTQIA+ residents, people with certain disabilities, non-English speakers, and undocumented residents. Additionally, while the shift to telehealth during the pandemic was helpful for many, it presented barriers to low-income families and seniors, who struggle to use technology or have little or no internet access. Increasing Medicaid/public insurance enrollment is a big need in Alameda County with enrollment eight percentage points below the state. Key informants stated that many residents in this region forego any health insurance because of high costs. Both key informants and focus group participants in Northern Alameda County discussed inequities in care, noting that people of color are more likely to be on Medi-Cal and have access to fewer high quality services. Infant mortality is substantially higher for Northern Alameda County multiracial residents and Black/African Americans than the county overall. Additionally, Black/African American and multiracial residents had substantially higher rates of death from COVID-19 than Northern Alameda County overall and multiracial residents have much lower COVID-19 vaccination rates than Northern Alameda County overall (34 versus 74%).

Economic Security: People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The majority of key informants and focus groups listed economic security as a top priority health need. Key informants reported that Alameda County residents struggle to find living wage jobs given the county's extremely high cost of living. They also reported extensive job loss because of the COVID-19 pandemic, reporting that despite a strong job market, many residents are still not working. Key informants in Northern Alameda County noted that the Latinx population was one of the hardest hit due to COVID-19, with many having to choose between continuing to go into work with an increased risk of exposure or losing their jobs. Latinx and Black/African American residents in Oakland and Berkeley face significant income and employment disparities; many measures are worse than the state in ZIP codes with larger proportions of residents of color, including median household income, unemployment rate, young people not in school and not working, children living in poverty, and poverty rate, and high-speed internet access.

Community and Family Safety: Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries.

Crime, violence, and intentional injury are related to poorer physical and mental health outcomes. Children and adolescents exposed to violence are at risk for poorer long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color — particularly males — is disproportionately affected by juvenile arrests and incarceration related to policing practices. A quarter of key informants and nearly half of focus groups identified community and family safety as a top priority health need for Alameda County. This health need is linked closely with transportation, as key informants believed this was an area where community and family safety could be improved. Two key measures of community and family safety, violent crime, and injury deaths, were substantially higher in Alameda County than the state overall. Key informants in Northern Alameda County described violence in their community as a symptom and a cause of behavioral health issues and stated that violence disproportionately affects young men of color (teens-30s). The number of violent crimes is 50% higher in Northern Alameda County than the state overall and rates of death by all injuries are highest among Black/African Americans compared to Northern Alameda County overall.

Dismantling Structural Racism: Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms. Centuries of racism in this country have had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. Data show that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions. The COVID-19 pandemic, which has disproportionately impacted racial and ethnic minority populations, is another example of these enduring health disparities. Many key informants named structural racism as a significant concern affecting health in their communities, namely as a contributor to the other health needs. Key informants described race-based inequalities in access to and provision of healthcare, resulting in many children and adults of color not receiving necessary physical or behavioral healthcare that is often not culturally or linguistically competent. Key informants noted that housing discrimination is prevalent, particularly towards Black/African American residents. Black/African American and multiracial residents had substantially higher rates of COVID-19 deaths than Northern Alameda County overall and in 2020, infant mortality was more than twice as high for Black/African American residents than for the rest of Northern Alameda County.

Food Security: Food insecurity is the lack of consistent access to enough food for an active, healthy life. Food insecurity encompasses household food shortages; reduced quality, variety, or desirability of food; diminished nutrient intake; disrupted eating patterns; and anxiety about food insufficiency. Black/African American and Latinx households have higher rates of food insecurity than other racial/ethnic groups. The COVID-19 pandemic substantially increased food insecurity due to job losses, closure/changes to feeding programs, and increased demand on food banks. According to key informants, many Alameda County families experienced such an increase in food insecurity during the pandemic. Despite robust food distribution programs in several sectors (schools, food banks, healthcare, mobile clinics, community organizations), key informants reported that not all populations in need are reached, particularly unhoused county residents and populations that may be reluctant to seek out food assistance due to the stigma of being "needy." In Northern Alameda

County, 9% of residents are food insecure. Key informants stated that CalFresh, California's Supplemental Nutrition Assistance Program (SNAP), is an underutilized resource in Northern Alameda County.

Transportation: Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing healthcare, and securing food. For households without access to a car, including many low-income individuals and people of color, walking, biking, and using public transportation provide critical links to jobs and essential services. Key informants and focus group participants noted that many low-income families are dependent on public transportation and, therefore, experience this as a barrier to accessing healthcare; many people have to travel outside of their immediate community for appointments and to access specialty care and resources. Safety when using public transportation was an additional concern voiced by focus group participants; this concern was further exacerbated by the COVID-19 pandemic, as county residents were fearful that using public transportation would increase their risk of virus exposure. Key informants from Northern Alameda County stated that the lack of reliable, accessible, and affordable transportation is a barrier to accessing healthcare, and noted that public transit in West Oakland is particularly inadequate.

For additional details, including statistical data and sources, see Section VI C: Prioritized Description of Health Needs and Appendices D and E: CHNA Secondary Data Indicator Definitions, Data Sources and Dates and CHNA Secondary Data Table.

Next Steps

This CHNA report will be publicly available by December 31, 2022 (https://www.sutterhealth.org/for-patients/community-health-needs-assessment). Alta Bates Summit Medical Center will also develop an Implementation Strategy Plan based on the CHNA results, which will be filed with the IRS by May 15, 2023. Feedback and comments about the 2022 CHNA and 2022-2024 Implementation Strategy Plan can be submitted to SHCB@sutterhealth.org and will be considered as part of the community input component in the development of ABSMC's 2025–2027 CHNA.

I. Introduction/Background

The Alameda County 2022 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health. The overall goal is to inform and engage local decision-makers, key stakeholders, and the community-at-large around the conditions that impact health and health disparities in the county in efforts to improve the health and well-being of all county residents.

In 2021/2022, seven local hospitals in Alameda and Contra Costa Counties, members of the Alameda and Contra Costa Counties Hospital CHNA Group, collaborated for the purpose of identifying critical health needs for their service areas. Alta Bates Summit Medical Center worked with its partners to conduct an extensive CHNA. This 2022 CHNA builds upon earlier assessments conducted by the hospitals. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone residing in the communities served. The CHNA results will drive plans for strategic investments that address health needs. The 2022 CHNA report will be available at: https://www.sutterhealth.org/for-patients/community-health-needs-assessment.

The hospitals involved in the CHNA will each develop an implementation plan that outlines how they will address priority health needs. These strategies will build on a hospital's own assets and resources, as well as on evidence-based strategies and best practices, wherever possible. Their Implementation Strategy (IS) Plans will be filed with the Internal Revenue Service. Both the CHNA and the IS Plan will be posted publicly on each of the hospitals' websites.

A. About Alta Bates Summit Medical Center

Alta Bates Summit Medical Center, part of the Sutter Health Network, offers comprehensive services designed to meet the healthcare needs of the diverse communities of the greater East Bay Area. The medical center is the East Bay's largest private, nonprofit hospital, with three campuses in Berkeley and Oakland.

Alta Bates Summit's 100-year tradition of commitment and service continues today, with recognition as one of the nation's top hospitals for clinical excellence and patient safety.

B. About Alta Bates Summit Medical Center Community Health

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

Community benefit:

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

C. Purpose of the Community Health Needs Assessment Report

Conducting a triennial CHNA has been a California requirement for nonprofit hospitals for more than 25 years (SB 697). The Patient Protection and Affordable Care Act (ACA) adopted a federal model similar to regulations already in place in California, making the CHNA a national mandate for hospitals 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 regulations is a requirement that all nonprofit hospitals conduct a CHNA and develop an IS Plan every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

The development of the 2022 CHNA report has been a comprehensive process, from data collection and analysis to the identification of the prioritized needs, and was guided by representatives from the Alameda and Contra Costa Counties Hospital CHNA Group. Voices from communities throughout the county were captured through key informant interviews and focus groups; opinions were sought from key informants serving communities experiencing health inequities and disparities.

D. Description of the CHNA Process

The CHNA was a collaborative examination of health in Alameda County, updating and building on work done in prior years, including many of the themes identified in previous CHNA cycles. The 2022 CHNA process applied a social determinants of health framework and examined Alameda County's social, environmental, and economic conditions that impact health in addition to other factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the county.

The 2022 CHNA assessed the health issues and contributing factors with greatest impact among vulnerable populations[2] whose health is disproportionately affected across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas referred to in this report as "Priority Communities", as well as disparities among the county's diverse ethnic populations. These analyses will inform intervention strategies to promote health equity.

This CHNA utilized a mixed-methods approach. The Alameda and Contra Costa Counties Hospital CHNA Group, community partners, and consultants reviewed secondary data available through Kaiser Permanente's Community Health Data Platform and compiled additional data from national, statewide, and local sources to provide a descriptive picture of health in Alameda County. These data were compared to benchmark data and analyzed to identify potential areas of need. In addition, primary data were collected via key informant interviews conducted by Applied Survey Research (ASR), and focus groups conducted by Alameda County Public Health Department. Primary data offered a wide range of perspectives on the issues with the greatest impact on the health of county communities. The data also provided examples of existing resources that work to address those needs, and suggestions for continued progress in improving these issues. The analyzed quantitative and qualitative data were triangulated, an approach using multiple sources of data to enhance the credibility of the outcomes. This enabled the identification of the top health needs in the county and supported development of a health need profile summarizing key data points and findings for each health need.

[2] California Department of Health Care Access and Information (2022). HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations. Accessed July 6, 2022 from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf.

A multi-step process was conducted to rank the health needs. The key findings from the CHNA primary and secondary data analysis were shared with 14 representatives from organizations serving diverse low-income populations experiencing health inequities. A series of meetings was held to review data and prioritize the health needs. Final prioritization was reached through a voting process conducted with meeting attendees. The methods used to conduct the CHNA, the data collected, and the resulting prioritized community health needs are presented in this report and appendices.

II. Community Served

A. Definition of Community Served

Each hospital participating in the Alameda and Contra Costa Counties Hospital CHNA Group defines its service area to include all individuals residing within a defined geographic area surrounding the hospital. For this collaborative CHNA, Alameda County was the overall service area, with each hospital adding additional focus on their specific service area.

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

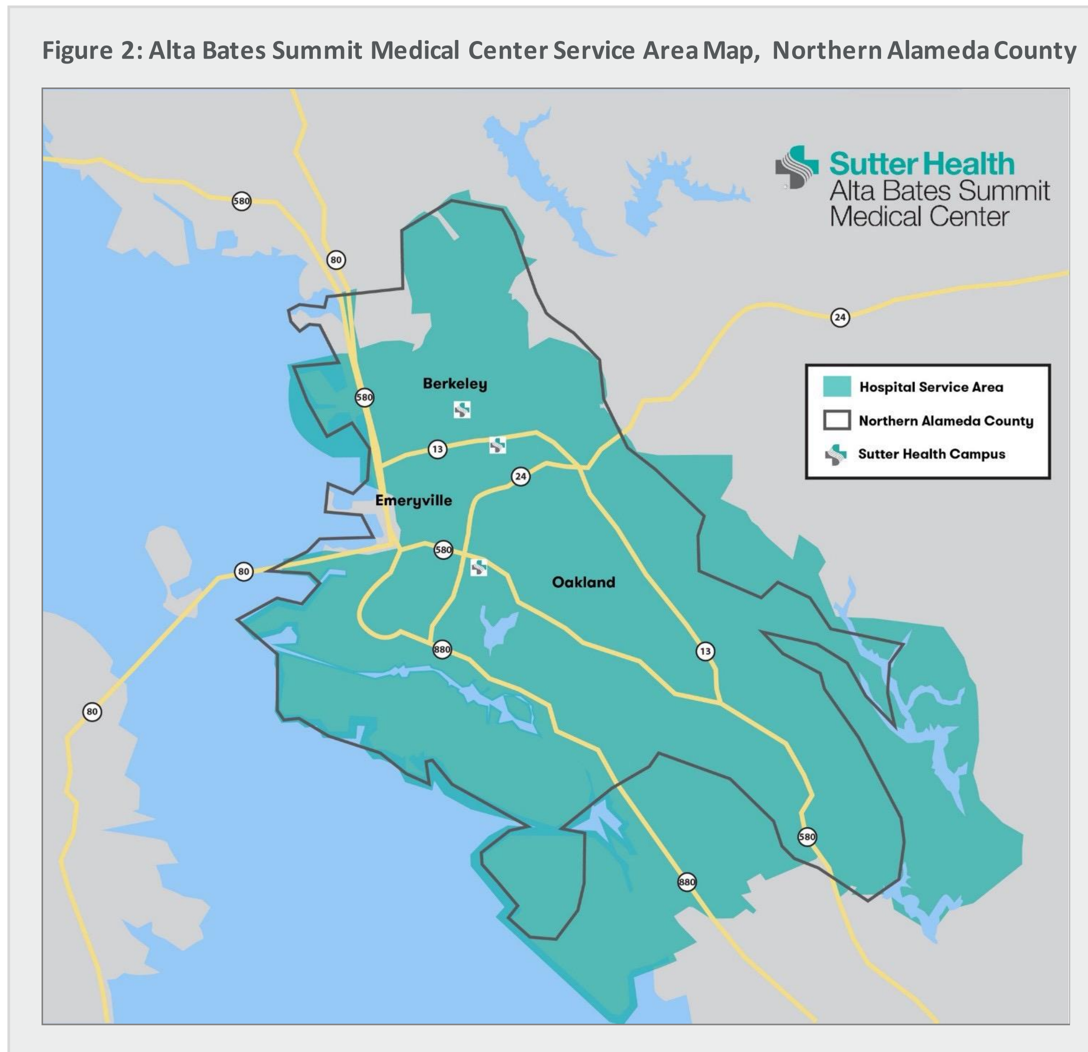
Alta Bates Summit Medical Center's campuses are located in the cities of Berkeley and Oakland in the Northern Alameda County region of Alameda County. Alta Bates Summit Medical Center's hospital service area includes 25 ZIP codes surrounding the hospital and its neighboring communities.[3] As previously noted, the medical center collaborated on the 2022 CHNA with other healthcare facilities serving Alameda County. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, which include the cities of Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont.

The map on the next page (Figure 2) shows the alignment of the Northern Alameda County region with Alta Bates Summit Medical Center's service area.

[3] The hospital's service area covers ZIP codes 94501, 94601, 94602, 94603, 94605, 94606, 94607, 94608, 94609, 94610, 94611, 94612, 94613, 94618, 94619, 94621, 94702, 94703, 94704, 94705, 94707, 94708, 94709, 94710, and 94720.

B. Map and Description of Community Served

Figure 2: Alta Bates Summit Medical Center Service Area Map, Northern Alameda County



i. Demographic Profile and Other Characteristics of Community Served

The 2022 CHNA for Alta Bates Summit Medical Center placed particular emphasis on the health issues and contributing factors that impact populations with disproportionately poorer health outcomes. Priority Community Profiles were developed to present local data as a complement to the county-wide data reported elsewhere in the CHNA. The profiles include demographics, data on root causes of health, and additional statistics. Appendix F provides more information on the Healthy Places Index scores.

Alta Bates Summit Medical Center has identified Berkeley and Oakland as Priority Communities in the Northern Alameda County service area. The profiles include a map, demographics, data on root causes of health, and additional statistics on homelessness. The profiles highlight disparities experienced by populations residing in these geographies and aim to guide development of intervention strategies to address identified health needs and promote health equity.

The tables in the Priority Community Profiles compare data for the priority community to data for the overall county to illustrate how the population in the priority community differs from the county.

Northern Alameda County Priority Communities: Berkeley/Oakland

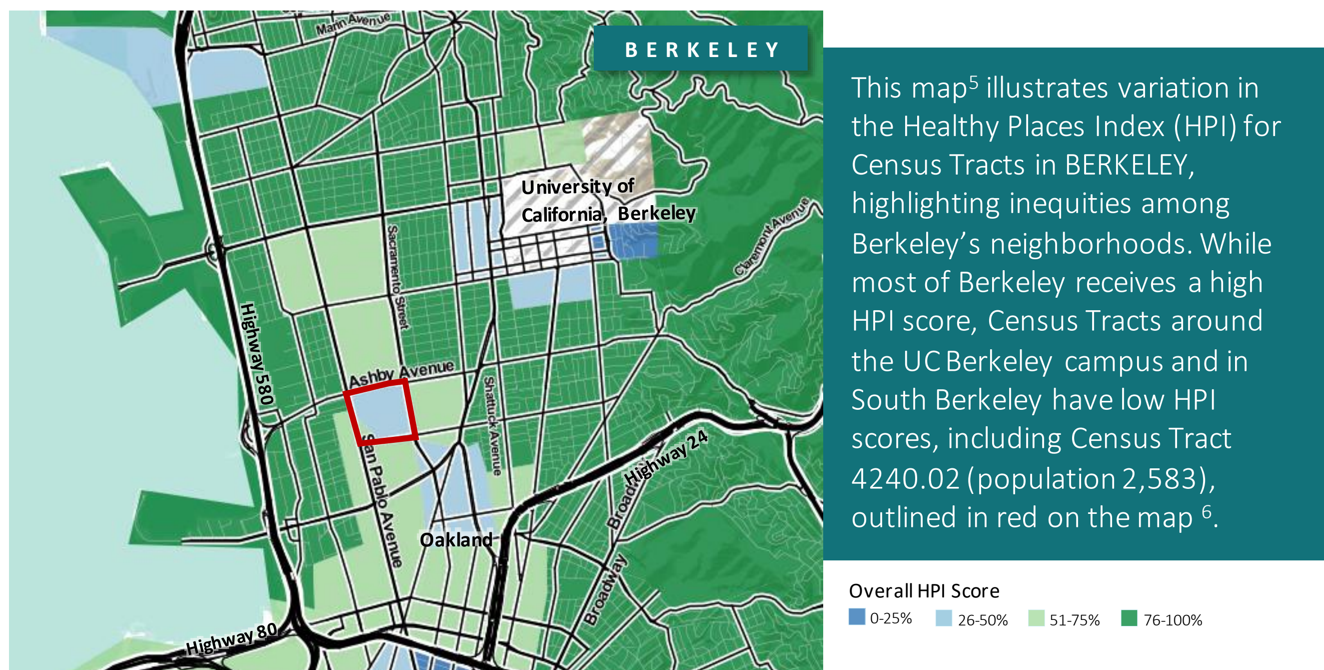
Berkeley and Oakland are the largest cities in Northern Alameda County. These cities reflect the diverse population and geographic disparities existing in Alameda County. This profile presents demographic and root causes of health data for each city, a Census Tract in each city, and Alameda County overall, including scores from the Healthy Places Index 2.0 (HPI)[4]. The HPI 2.0 includes 25 indicators related to root causes of health and compares all California communities to create scores for individual geographies. The higher the HPI score, the healthier the geography. The map of each city illustrates health disparities and inequities between neighborhoods within each city, where areas shaded in light and dark blue have fewer community resources needed for health and wellbeing.

The Priority Community Profiles were developed in 2021 and used the Healthy Places Index (HPI) 2.0 data/website, prior to the release of HPI 3.0 in 2022. Identification and prioritization of health needs were based on multiple primary and secondary data sources, including the Kaiser Permanente Community Health Data Platform.

Demographics & Socioeconomics

Berkeley is home to 121,353 people as well as University of California, Berkeley with a large student population. This population makes Berkeley's data different from other cities; due to the university, Berkeley is a city with a highly educated population.

Figure 3. Healthy Places Index for Census Tracts in Berkeley



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[4] Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

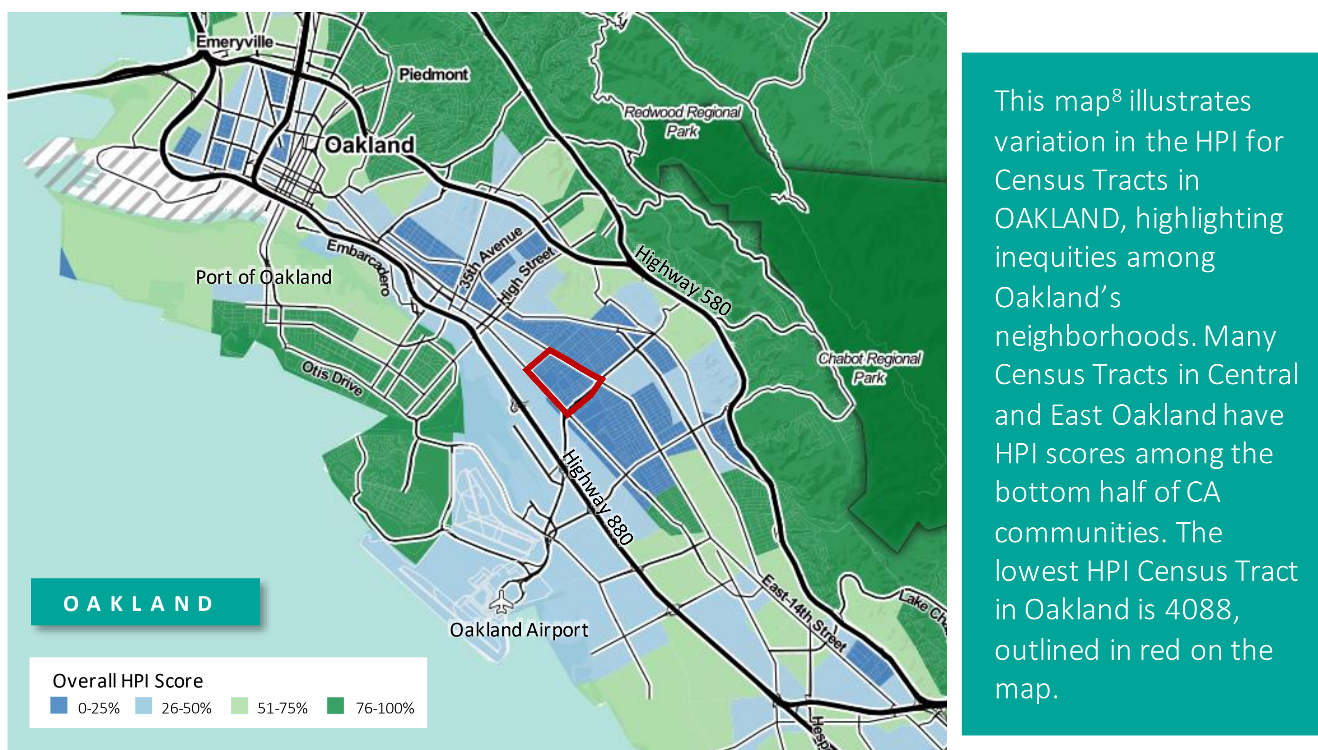
[5] Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

[6] United States Census Bureau (2019). American Community Survey. Demographic Information for Census Tract 4240.02. https://data.census.gov/cedsci/table?q=acs&g=1400000US06001424002&tid=ACSDP5Y2019.DP05

Berkeley's overall racial and ethnic composition is majority White (60%) and Non-Hispanic (88%), with less than a quarter of residents identifying as Asian and smaller population segments identifying as Hispanic (Latinx) (12%), Multiracial (8%) and Black/African American (6%). In comparison, Berkeley's lowest HPI Census Tract has a larger proportion of Black/African American (34%) and Other (16%) residents and a lower percentage of Asian (11%) residents (Table 1). Table 2 shows that Berkeley has a higher percentage of residents living in poverty than Alameda County (19% versus 9%) while Berkeley's lowest HPI Census Tract has a smaller percentage of residents living in poverty (8%) than the county. When compared to Alameda County overall, Berkeley has a smaller percentage of children (0-18) in poverty (6% versus 10%) and a higher education level with only 4% of adults without a high school diploma. Berkeley's lowest HPI Census Tract has a similar poverty rate for children (0-18) (7%) and a lower poverty rate for seniors (4%). Less than 10% of residents from Berkeley's lowest HPI Census Tract are without a high school diploma.

Oakland is home to 425,097 people. Oakland's 2018 Equity Report describes many health disparities and inequities among Oakland's racial/ethnic groups.[7]

Figure 4. Healthy Places Index for Census Tracts in Oakland



Oakland has significant representation from several racial groups; White is the largest racial group at 35%; Black/African American (25%) and Hispanic (Latinx) (27%) populations each account for approximately a quarter of Oakland residents and Asian residents represent 14% of the Oakland

[7] Department of Race and Equity (2018). City of Oakland Equity Indicators. *Oakland City Department of Race and Equity*. https://cao-94612.s3.amazonaws.com/documents/2018-Equity-Indicators-Full-Report.pdf

[8] Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

population (Table 1). Oakland's lowest HPI Census Tract (population 7,149[9]) demographics differ from the city overall with 47% Hispanic (Latinx) and 38% Black/African American residents and smaller White (10%) and Asian (4%) populations. Table 2 shows that Oakland residents fare worse than the county on almost all socioeconomic indicators, including 25% of Oakland children living in poverty compared to 10% of children living in poverty county-wide. Seniors in Oakland fare worse than the county overall, with 16% living in poverty compared to 10% living in poverty county-wide. Oakland's lowest HPI Census Tract has 35% of the population living in poverty, nearly half of children (0-18) (49%) and approximately one in five seniors (19%) living in poverty. The proportion of adults without a high school diploma (43%) in the lowest HPI Census Tract is close to three times the Oakland percentage (15%) and 3.5 times the Alameda County percentage (12%).

Table 1: Berkeley and Oakland Demographic Characteristics[10,11,12,13,14]

Category	Group	Berkeley	Lowest HPI Census Tract (4240.02)	Oakland	Lowest HPI Census Tract (4088)	Alameda County
Race	White	60%	31%	35%	10%	39%
	Black	6%	34%	25%	38%	11%
	Asian	22%	11%	14%	4%	31%
	Other	3%	16%	19%	40%	11%
	Multiracial	8%	8%	6%	2%	6%
	American Indian/ Alaska Native	<1%	<1%	<1%	<1%	<1%
	Native Hawaiian/ Pacific Islander	<1%	<1%	<1%	5%	<1%
Ethnicity	Hispanic	12%	23%	27%	47%	22%
	Non-Hispanic	88%	77%	73%	53%	78%
Gender	Female	51%	51%	58%	54%	51%
	Male	49%	49%	42%	46%	49%
Age	Under 5	4%	7%	6%	10%	6%
	5-9	2%	6%	5%	10%	5%
	10-19	15%	9%	10%	15%	12%
	20-44	45%	44%	42%	40%	38%
	45-64	19%	23%	23%	16%	25%
	>65	15%	11%	14%	9%	14%

[9] United States Census Bureau (2019). American Community Survey. Demographic Information for Census Tract 4088. https://data.census.gov/cedsci/table?q=acs&g=1400000US06001408800&tid=ACSDP5Y2019.DP05

[10] United States Census Bureau (2019). American Community Survey. Demographic Information for Berkeley. https://data.census.gov/cedsci/table?q=berkeley%20city%20ca%20acs&tid=ACSDP1Y2019.DP05

[11] United States Census Bureau (2019). American Community Survey. Demographic Information for Census Tract 4240.02. https://data.census.gov/cedsci/table?q=acs&g=1400000US06001424002

[12] United States Census Bureau (2019). American Community Survey. Demographic Information for Oakland. https://data.census.gov/cedsci/table?q=oakland%20city%20ca&tid=ACSDP1Y2019.DP05

[13] United States Census Bureau (2019). American Community Survey. Demographic Information for Census Tract 4088. https://data.census.gov/cedsci/table?q=acs&g=1400000US06001408800

[14] United States Census Bureau (2019). American Community Survey. Demographic Information for Alameda County. https://data.census.gov/cedsci/table?q=Alameda%20county%20acs

Table 2: Berkeley and Oakland Socioeconomic Status[15,16,17,18,19]

Indicator	Berkeley	Low HPI Census Tract (4240.02)	Oakland	Low HPI Census Tract (4088)	Alameda County
Living in poverty (<100% Federal Poverty Level)	19%	8%	17%	35%	9%
Children (0-18) in poverty	6%	7%	25%	49%	10%
Seniors (>65) in poverty	9%	4%	16%	19%	10%
Unemployment	3%	4%	4%	9%	4%
Uninsured population	3%	9%	7%	10%	5%
Adults with no high school diploma	4%	9%	15%	43%	12%

Root Causes of Health

Berkeley's overall Healthy Places Index rating is similar to Alameda County's healthiest communities which rank above 89% of CA communities (Table 3). Berkeley scored lower than the county's healthiest communities on economic indicators. Berkeley performs higher on education measures, transportation, clean environment, and neighborhood indicators. Berkeley's lowest HPI Census Tract (population 2,583) receives lower scores than the city with the exception of clean environment. This Census Tract's overall HPI score is comparable to most California communities (50%) and the tract has economic, housing, and healthcare access indicators in the bottom half of scores for the state – substantially lower than the healthiest Alameda County communities.

Oakland's overall Healthy Places Index rating is better than 57% of CA communities, but lower compared to Alameda County's healthiest communities (89%) (Table 3). Oakland ranks substantially lower than the healthiest Alameda County communities on economics, education, healthcare access, and housing indicators. Oakland's lowest HPI Census Tract (population 7,149) has an overall Healthy Places Index score of 6%--in the bottom 10% of all California communities. Oakland's lowest HPI Census Tract scores below most California communities in most categories and in the bottom 10% of CA communities for transportation (2%), economic (5%) and social (6%) indicators. This Census Tract also scores worse than Oakland in most categories, except for housing and clean environment.

[15] United States Census Bureau. https://data.census.gov/cedsci/table?q=berkeley%20city%20ca%20acs&tid=ACSDP1Y2019.DP05
[16] United States Census Bureau. https://data.census.gov/cedsci/table?q=acs&g=1400000US060014224002
[17] United States Census Bureau. https://data.census.gov/cedsci/table?q=oakland%20city%20ca&tid=ACSDP1Y2019.DP05
[18] United States Census Bureau. https://data.census.gov/cedsci/table?q=acs&g=1400000US06001408800
[19] United States Census Bureau. https://data.census.gov/cedsci/table?q=Alameda%20county%20acs

Table 3: Healthy Places Index (HPI) Rankings of Root Causes of Health[20]

Category	Berkeley	Lowest HPI Census Tract (4240.02)	Oakland	Lowest HPI Census Tract (4088)	Healthiest Alameda County Communities	Indicators
Overall HPI Score	**88**	**50**	**57**	**6**	**89**	
Economic	**65**	**29**	**54**	**5**	89	• Employment • Median Income
Housing	44	40	**14**	**16**	50	• Low Income Renter & Homeowner Cost Burden • Housing Habitability • Uncrowded Housing • Homeownership
Education	97	83	**69**	**31**	91	• Preschool Enrollment • High School Enrollment • Bachelor's Education or Higher
Social	45	25	28	**6**	43	• Two Parent Households • Voting in 2012
Healthcare Access	88	**42**	**48**	**22**	86	• Insured
Transportation	99	93	88	**2**	95	• Automobile Access • Active Commuting
Neighborhood	**80**	39	60	**29**	55	• Retail Density • Park Access • Tree Canopy • Supermarket Access • Alcohol Outlets
Clean Environment	82	89	76	88	70	• Ozone • Particulate Matter 2.5 • Diesel Particulate Matter • Water Contaminants

Legend:
(red) = Scores worse than healthiest communities by 20+ points
(green) = Scores better than healthiest communities by 20+ points

Homeless Point in Time (PIT) Counts

Berkeley has a large homeless population that accounts for nearly 14% of Alameda County's unhoused residents despite Berkeley representing approximately 8% of the county's overall population (Table 4). The Black/African American unhoused population (57%) is strikingly overrepresented given that Black/African American residents are 6% of the city's total population. In addition, there are significant White (29%), Latinx/Hispanic (12%) and Other/Multiracial racial (10%) homeless populations, similar to Alameda County's racial breakdown for the unhoused population.

[20] Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

Oakland accounts for more than half (59%) of Alameda County's homeless population while only making up 25% of the county's total population (Table 4). Seventy percent of the homeless population in Oakland is Black/African American, illustrating major housing inequities given that one quarter of Oakland residents are Black/African American. Latinx/Hispanic (13%) and Other/Multiracial (13%) populations account for smaller but significant proportions of unhoused Oakland residents.

Table 4: Point in Time Counts by Race and Ethnicity

Category		Race/Ethic Group	Berkeley	Oakland	Alameda County
Homeless PIT Count in 2019[21,22]			1,108	4,701	8,022
PIT Count by Race and Ethnicity	**Race**	White	29%	11%	31%
		Black	57%	70%	47%
		Asian	1%	1%	2%
		Other/Multiracial	10%	13%	14%
		American Indian/Alaska Native	3%	4%	2%
		Native Hawaiian/Pacific Islander	<1%	<1%	2%
	Ethnicity	Latinx/Hispanic	12%	13%	17%

Suicide Rate

Berkeley has a suicide rate of just over 9 per 100,000 population (Figure 5), with White residents having a higher rate than the city overall. Berkeley's suicide rate is higher than that of Alameda County overall (7.7 per 100,000). Data are unavailable for the other races/ethnicities in Berkeley.

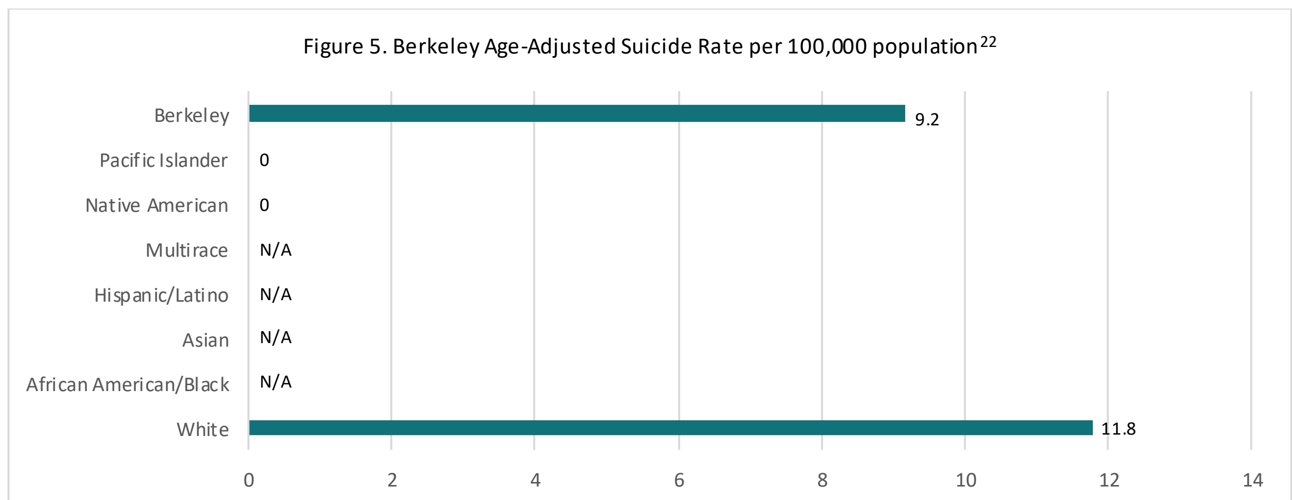


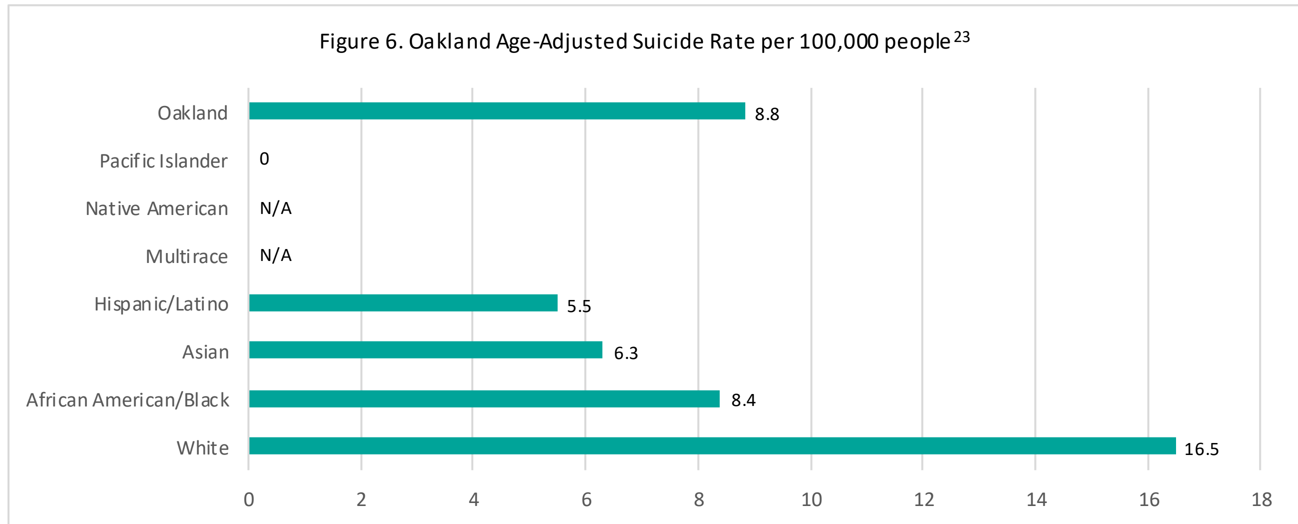
Figure 5. Berkeley Age-Adjusted Suicide Rate per 100,000 population[22]

[21] Everyone Home (2019). Point in Time Count Report for Alameda County. https://everyonehome.org/wp-content/uploads/2019/07/2019_HIRDReport_Alameda_FinalDraft_8.15.19.pdf

[22] Everyone Home (2019). Point in Time Count Report for Berkeley. https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf

Oakland's suicide rate is nearly 9 per 100,000 population (Figure 6). The suicide rate is higher for the White population than any other racial or ethnic group. The suicide rate for Black/African American residents is similar to the rate for Oakland overall and the rate is lower for Asian and Hispanic/Latino residents. Oakland's suicide rate is higher than Alameda County overall (7.7 per 100,000).

Figure 6. Oakland Age-Adjusted Suicide Rate per 100,000 people[23]



[23] Alameda County Health Department Community Assessment Planning and Evaluation, with data from CCDF 2016-2021.

III. Who Was Involved in the Assessment?

A. Identity of hospitals and other partner organizations collaborating on the assessment

Alta Bates Summit Medical Center was part of the Alameda and Contra Costa Counties Hospital CHNA Group that worked with the following partners:

Figure 7. CHNA Partners

Alameda and Contra Costa Counties Hospital CHNA Group
John Muir Health
Sutter Health
St. Rose Hospital
Stanford Health Care ValleyCare
UCSF Benioff Children's Hospitals

Partners
Kaiser Permanente
Alameda County Public Health Department
Contra Costa Health Services

B. Identity and qualifications of consultants used to conduct the assessment

Alta Bates Summit Medical Center contracted with Ad Lucem Consulting (www.adlucemconsulting.com), a public health consulting firm, to conduct the CHNA. Ad Lucem Consulting specializes in initiative design, strategic planning, grants management, and program evaluation, tailoring methods and strategies to each project and adapting to client needs and priorities, positioning clients for success. Ad Lucem Consulting works in close collaboration with clients, synthesizing complex information into easy-to-understand, usable formats, bringing a hands-on, down to earth approach to each project. Ad Lucem Consulting has developed numerous CHNA reports and IS Plans for hospitals including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies.

ASR (www.appliedsurveyresearch.org) is the consultant hired by Kaiser Permanente Alameda and Contra Costa service areas to prepare their 2022 CHNA, including conducting key informant interviews. Secondary data charts/tables and interview data were generously shared with members of the Alameda and Contra Costa Counties Hospital CHNA Group and are included in this CHNA report. ASR also convened community stakeholders and hospital representatives to review service area data and participate in a health need ranking process. ASR is a social research organization dedicated to helping people build better communities through measuring and improving organizational impact and services and quality of life. ASR has a strong history of working with vulnerable populations and extensive experience working with public and private agencies, federal and local government, health and human service organizations, cities and county offices, school districts, institutions of higher learning and charitable foundations.

IV. Process and Methods Used to Conduct the CHNA

A. Community Input

i. Description of Who Was Consulted

Community input was provided by a broad range of community members via 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 public health and other public agencies, community organizations, and members of medically underserved, low-income, and underrepresented populations (See Appendix A for a complete list of individuals who provided input).

ii. Methodology for Collection and Interpretation

Key Informant Interview Methodology

ASR conducted 43 key informant interviews with individuals from organizations serving Alameda County, representing diverse sectors (Figure 8). The key informants were identified collaboratively by Kaiser Permanente, the public health agencies and members of the Alameda and Contra Costa Counties Hospital CHNA Group.

All interviews were conducted in English and followed a standard set of interview questions. Confidentiality was assured at the beginning of each interview and interviewers took detailed notes during the call.

Figure 8. Sectors Represented by Key Informants

- Children/youth/families
- Communities of color
- Formerly incarcerated
- Immigrants/undocumented
- LGBTQIA+
- Older adults
- People with disabilities
- Unhoused
- Violence survivors

Interview topics: Interview questions were developed by ASR. Appendix B provides a complete list of interview questions. Questions addressed the following topics:

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

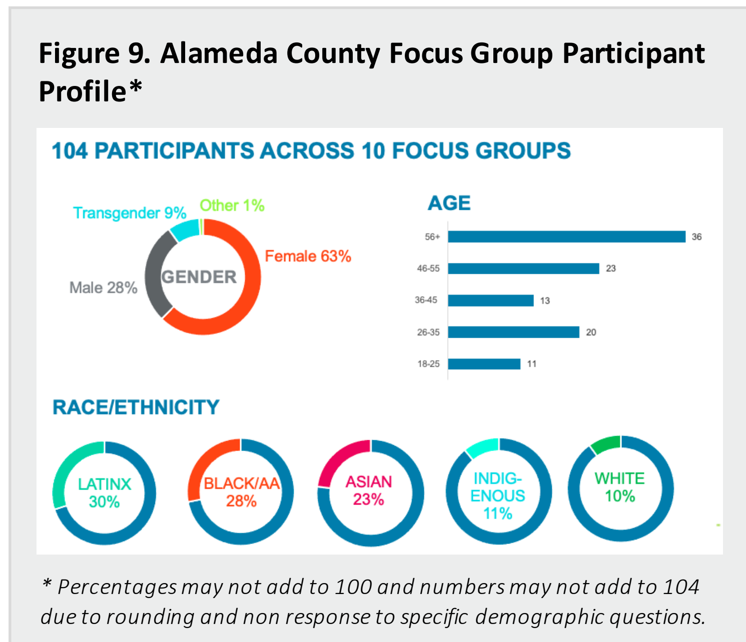
Data Analysis: ASR delivered a spreadsheet containing individual interviewee responses and key themes to Ad Lucem Consulting. The themes were further organized by Ad Lucem Consulting into the health needs defined by the Kaiser Permanente Community Health Data Platform. The number of mentions for all themes related to a particular health need were tallied to develop an interview data score. Health needs were assigned points based on the frequency of mentions of the health

need by key informants. Points for each health need were tallied across interviewees to develop interview scores for health need priority, racial/ethnic disparities, geographic or other disparities and impact of the COVID-19 pandemic on the health need.

Focus Group Methodology

Ten community resident focus groups were conducted in geographic areas within Northern and Central Alameda County and the Tri Valley area. Three groups were conducted in English, four were conducted in Spanish, one in Vietnamese, one in Cantonese, and one in a combination of English and Spanish. Participants were from underserved, low-income, senior, unhoused, LGBTQIA+, and diverse racial/ethnic communities (Vietnamese, Cantonese, Black/African American, Indigenous, and Latinx).

Figure 9. Alameda County Focus Group Participant Profile*



** Percentages may not add to 100 and numbers may not add to 104 due to rounding and non response to specific demographic questions.*

The Alameda County Public Health Department conducted the focus groups. Public Health staff recruited participants in partnership with community organizations, organized logistics, and facilitated the focus groups. Each focus group session averaged 60 minutes and was audio recorded.

Public Health staff collected focus group participant demographics (see Figure 9) through a screener survey. Focus group recordings were transcribed and translated into English as needed. Focus group transcripts were delivered to Ad Lucem Consulting for analysis. Participants received a $25 gift card as a thank you for their time and engagement.

<u>Focus group question guide:</u> The focus group questions were developed by the Alameda and Contra Costa Counties Hospital CHNA Group based on focus group questions from the Hospitals' 2019 CHNA. The focus group guide was designed by Ad Lucem Consulting based on previous work. Questions were open-ended and additional probing questions were used as needed to elicit more in-depth responses and richer details. The questions were translated into Spanish. Focus group facilitators adjusted the questions as needed to ensure participant comprehension and maximize interaction.

The scripted focus group guide was used to ensure consistency across groups. At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses. An overview of the discussion was provided as well as a review of discussion ground rules. For the complete list of focus group questions, see Appendix C. Questions addressed the following topics:

- Facilitators and barriers to health in the community
- Priority health needs facing the community and why they are important
- Priority given to behavioral health, economic security, and access to care

- Impact of COVID-19 on health needs
- Strategies that are working to address health issues and new strategies needed
- Health inequities and disparities and strategies to reduce inequities and disparities

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

B. Secondary Data

i. Sources and Dates of Secondary Data Used in the Assessment

The Hospital CHNA Group used the Kaiser Permanente Community Health Data Platform (https://public.tableau.com/app/profile/kp.chna.data.platform/viz/CommunityHealthNeedsDashboard-AllCountiesinKPStates/Starthere) to review a core set of approximately 100 publicly available indicators using the County Health Rankings population health framework, which emphasizes social and environmental determinants of health. This platform allows users to view, map, and analyze indicators, understand racial/ethnic disparities, and compare local indicators with state and national benchmarks.

Additional data sources were used to inform the health need prioritization and health need profiles, including the Healthy Places Index (https://healthyplacesindex.org/), data from the Alameda County Public Health Department, California Health Interview Survey, California Healthy Kids Survey, the Bay Area Equity Atlas, KidsData.org and Point In Time Count reports on homelessness.

Specific sources and dates for secondary data are listed in Appendix D. Appendix E presents data for Northern Alameda County and Alameda County from the Kaiser Permanente Community Health Data Platform.

C. Written Comments

Alta Bates Summit Medical Center provided the public an opportunity to submit written comments on the facility's previous CHNA Report. As of the time of this CHNA report development, Alta Bates Summit Medical Center had not received written comments about the previous CHNA report.

This CHNA report will be publicly available by December 31, 2022 (https://www.sutterhealth.org/for-patients/community-health-needs-assessment). Alta Bates Summit Medical Center will also develop an Implementation Strategy Plan based on the CHNA results, which will be filed with the IRS by May 15, 2023. Feedback and comments about the 2022 CHNA and 2022-2024 Implementation Strategy Plan can be submitted to SHCB@sutterhealth.org and will be considered as part of the community input component in the development of ABSMC's 2025–2027 CHNA.

D. Data Limitations and Information Gaps

The Kaiser Permanente Community Health Data Platform includes approximately 100 secondary indicators that provide comprehensive data to identify the broad health needs faced by a community. The supplemental indicators included in this CHNA to describe the Priority Communities provide additional measures of factors influencing health. However, there are limitations with regard to these measures, as is true with any secondary data:

- Some data were only available at a county level and did not contribute to the understanding of neighborhood level needs.
- Data illustrating racial/ethnic disparities in the Kaiser Permanente Community Health Data Platform were only available based on population composition for a given geography.
- A number of indicators reported rely on the Census/American Communities Survey which may be based on small sample sizes and are estimates rather than actual measures.
- Data are not always collected on a yearly basis, and some data are several years old.
- The COVID-19 pandemic had an impact on both socioeconomics and health and exacerbated existing racial/ethnic disparities[24]; the impact of the pandemic is not necessarily captured by the secondary data presented in the CHNA as most of this data was collected pre-pandemic.

Primary data collection and the health need ranking processes are also subject to the following limitations and information gaps:

- Themes identified during interviews and focus groups were dependent upon the experience of individuals selected to provide input; input from a carefully selected, diverse group of key informants and focus group participants sought to minimize this bias (Appendix A).
- The final list of ranked health needs is subject to the affiliation and experience of the individuals who attended the ranking meeting.

[24] Center for Disease Control and Prevention (January 2022). Health Equity Considerations and Racial and Ethnic Groups. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

V. Identification and Prioritization of the Community's Health Needs

A. Identifying Community Health Needs

i. Definition of "Health Need"

For the purposes of the CHNA, health needs are defined as including the elements essential to improving or maintaining health status in the community at large and in particular parts of the community, such as particular geographies or populations experiencing health inequities. Essential elements may include addressing financial and other barriers to care as well as preventing illness, ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive collection, analysis, and interpretation of primary and secondary data (Figure 10).

Figure 10. Health Need Identification and Prioritization Process

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

Measures in the Kaiser Permanente Community Health Data Platform were clustered into 16 potential health needs, which formed the backbone of a prioritization tool to identify significant health needs in Alameda County.

For secondary data, a score was assigned to each need (4: very high, 3: high, 2: medium, 1: lower, 0: no need) based on how many measures were 20% or more worse than the California overall.

Themes from key informant interviews and other primary data sources were identified, clustered, and assigned scores on a 0-4-point scale, based on the number of times the theme was mentioned. Both the Data Platform and primary data informed scores for geographic, racial/ethnic, and other disparities.

Each data collection method was assigned a weight, based on rigor of the data collection method, timeliness, and ability to describe inequities/disparities. Primary data (key informant interviews and focus groups) were weighted significantly more than the secondary data to prioritize timely input from diverse, underserved communities. Weighted values for each potential need were summed, converted to a percentile score for easy comparison, and then ranked highest to lowest.

The eight highest scoring health needs were presented at meetings attended by the Alameda and Contra Costa Counties Hospital CHNA Group, Kaiser Permanente, and community partners.

Data were explored for a number of health needs (cancer, chronic disease and disability, climate and environment, education, healthy eating/active living (HEAL) opportunities, substance use, and sexual health) that were scored, but not discussed at the health needs ranking meeting due to their low scores.

B. Criteria and Process Used for Prioritization of Health Needs

i. Prioritization Criteria

The following criteria were employed to prioritize the list of health needs for Alameda County:

- **Severity:** How severe the health need is (potential to cause death or disability)
- **Magnitude or scale:** The number of people affected by the health need
- **Clear disparities or inequities:** Differences in health outcomes by subgroups (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
- **Multiplier effect:** A successful solution to the health need has the potential to solve multiple problems

ii. Prioritization Process

A process was conducted to rank the health needs and identify the top priority health needs during a virtual meeting. In partnership with Kaiser Permanente Community Health Managers, ASR contacted community leaders including county health, partner hospitals, and community organization leaders to attend a county-level group meeting to rank top health needs for service areas falling within Alameda County. The meeting was attended by 14 participants serving diverse low-income populations experiencing health inequities, including: hospital representatives, Alameda County Public Health Department, Community Health Center Network, Alameda County Office of Education and The California Endowment (a health funder). ASR presented qualitative and quantitative findings for the top eight health needs identified using matrix results calculated from sources such as key informant interviews, focus groups, and data from the Kaiser Permanente Community Health Data Platform. Representatives affiliated with each service area ranked the health needs on a scale of 0-4, with 0 being "not a priority" to 4 being a "very high priority." Each organization voted once for their respective service areas and vote values were averaged.

C. Prioritized Description of Health Needs

The process resulted in the following prioritized health needs, presented from highest to lowest ranking per the prioritization process described in section B.ii above. Detailed profiles for each health need highlighting findings from key informant interviews, focus groups, and secondary data are presented below.

Behavioral Health

What is the Health Need?

Behavioral health includes mental health, emotional and psychological well-being, along with the ability to cope with normal, daily life and affects a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities.[25] Behavioral health also includes substance use, which impacts many aspects of health and often co-occurs with mental health disorders. Behavioral health and the maintenance of good physical health are closely related; common mental health disorders such as depression and anxiety can affect one's ability for self-care while chronic diseases can lead to negative impacts on mental health.[26] Behavioral health issues affect many Americans; anxiety, depression, and suicidal ideation are on the rise due to the COVID-19 pandemic, particularly among Black/African American and Latinx community members.[27]

What Community Stakeholders Say About Behavioral Health

Based on key informant interviews and focus groups

Overall

- Almost all key informants (93%; 40 of 43) and 2 of 9 focus groups identified behavioral health as a top priority health need in Alameda County.
- Many key informants stated that behavioral health concerns are the number one health issue for the communities they serve in Alameda County. They described intense distress about the level of need among their clients, especially as much of the current need is going untreated.
- Focus group participants and key informants reported a high need for behavioral health services for Alameda County children and that there are long wait times for services. According to key informants, school-based behavioral health services, described as the most convenient and cost-effective way to reach children, were largely unavailable during the pandemic and have yet to return fully to many schools.
- North Alameda County key informants noted high levels of intergenerational trauma in their community; yet significant stigma around accessing behavioral healthcare creates a barrier to healing.

Key informant thoughts on BEHAVIORAL HEALTH inequities:

"In the Black community, people of color, especially women, have real, emotional, traumatizing events that occur on a daily basis (the micro-aggressions) and there is no outlet for them to express how they feel."

Focus group participant thoughts on BEHAVIORAL HEALTH inequities:

"It is very frustrating for children, adults, people of all ages who are always on waiting lists because there are not enough Spanish-speaking therapists."

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

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

[27] Czeisler MÉ , Lane RI, Petrosky E, et al. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

Inequities

- Many focus group participants of color or from immigrant communities have experienced or continue to experience trauma due to racially or culturally motivated violence.
- Key informants described a lack of bilingual and bicultural behavioral health providers in Alameda County, stating that patients prefer and feel more comfortable with a racially or culturally congruent provider. Focus group participants expressed frustration with long waitlists for behavioral health services for those who do not speak English or need a provider with specialist training.
- Key informants pointed to a shortage of trained providers for LGBTQIA+ residents; LGBTQIA+ focus group participants spoke of the intense trauma that many within their community have experienced and continue to live with, and the significant barriers to receiving the behavioral health services needed to recover and heal.
- North Alameda County focus groups specifically cited insufficient availability of behavioral health services for low-income families.

Impact of COVID-19

- The COVID-19 pandemic exacerbated existing behavioral health issues among Alameda County residents, according to many key informants and focus group participants, and caused feelings of depression, anxiety, fear, boredom, isolation, and despair.
- Many key informants noted mixed results from the switch to phone/online behavioral health services during the pandemic, describing that some patients preferred remote care, which reduced COVID-19 exposure and removed transportation barriers. Key informants reported that other Alameda County residents who lacked privacy, a computer/phone with a reliable internet connection, or the technological know-how to navigate e-visits, were effectively cut off from receiving behavioral health services.
- North Alameda County focus groups discussed that teens are suffering due to social isolation caused by COVID-19 and are experiencing increased rates of anxiety, depression, and fear.

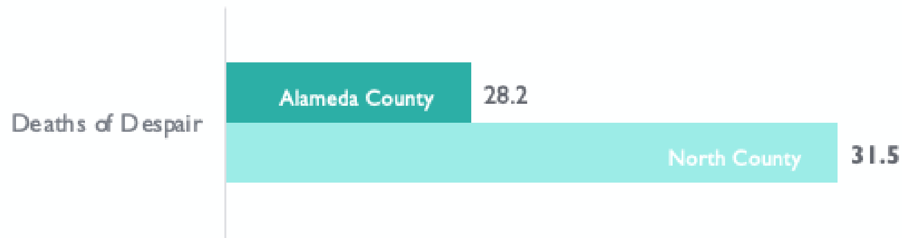
Behavioral Health Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- North Alameda County is experiencing substantially higher rates of deaths of despair compared to the county overall (32 versus 28 per 100,000). (Figure 11)
- American Indians in North Alameda County are facing disproportionately high rates of deaths of despair (151 per 100,000). (Figure 12)
- White and Hispanic/Latino populations in North Alameda County are experiencing rates of suicide higher than the service area overall. (Figure 12)

Figure 11.

Deaths of Despair in North Alameda County

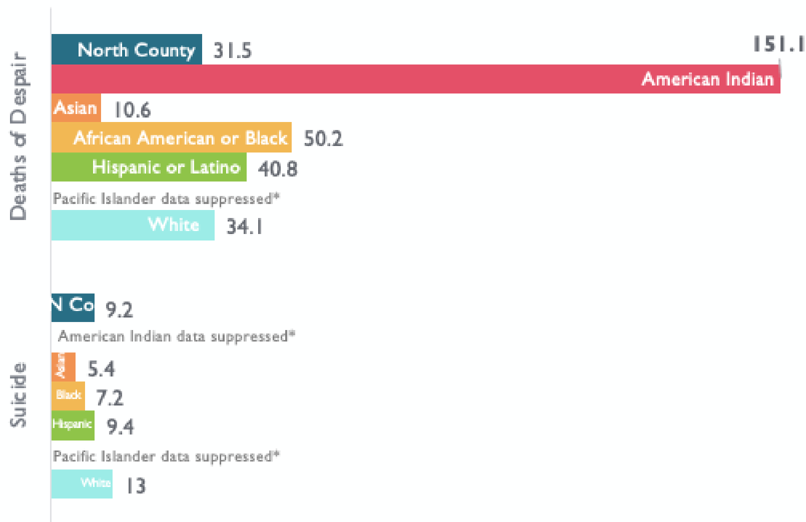


Deaths of Despair- Age-adjusted rate of death due to suicide, alcohol-related disease, and drug overdoses per 100,000 population. Data source: ACPHD CAPE, with data from Alameda County mortality files and California Comprehensive Death File (2016-2020)

Data visuals created by ASR, 12/2021

Figure 12.

Deaths of Despair, Suicide in North Alameda County by Race/Ethnicity



**Data suppressed when fewer than 10 cases; Deaths of Despair- Age-adjusted rate of death due to suicide, alcohol-related disease, and drug overdoses per 100,000 population. Data source: ACPHD CAPE, with data from Alameda County mortality files and California Comprehensive Death File (2016-2020)*

Data visuals created by ASR, 12/2021

Housing and Homelessness

What is the Health Need?

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care.[28] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.[29] Homelessness is correlated with poor health; poor health can lead to homelessness and homelessness is associated with greater rates of preventable diseases, longer hospital stays, and greater risk of premature death.[30]

What Community Stakeholders Say About Housing and Homelessness

Based on key informant interviews and focus groups

Overall

- Almost all key informants (91%; 39 of 43) and nearly half of focus groups (4 of 9) identified housing and homelessness as a top priority health need in Alameda County.
- Alameda County key informants and focus group participants concurred that housing challenges negatively impact residents' ability to obtain other basic needs (food, employment, healthcare, and childcare) and result in poor mental and physical health.
- County residents needing assistance with housing often need assistance in other areas, which makes for complex case management, according to key informants. Agencies assisting residents with these needs are overwhelmed and unable to meet demand for services.
- Key informants stated that housing costs are prohibitively high for many residents of Alameda County and that there are insufficient affordable housing units; this results in limited neighborhood choice and forces some residents to tolerate unhealthy, overcrowded, or unsafe living conditions.
- Key informants stated that a high rate of housing instability, particularly in Oakland, is impacting residents' overall health, access to care, behavioral health, and substance use.
- Key informants noted a shortage of affordable homes, specifically in West Oakland, and stated that even upper-middle class residents struggle to find affordable housing.

Focus group participant thoughts on HOUSING AND HOMELESSNESS inequities:

"When trans people show up for housing it doesn't matter if we have all the papers and meet all the requirements. People see that, they're not going to rent it to you… There's housing discrimination that happens toward trans people, especially Black trans people."

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

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

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

Inequities

- Specific Alameda County populations are more likely to become unhoused, and key informants expressed concern that not enough housing support is available for these vulnerable groups: Black/African American, Latinx, immigrants, LGBTQIA+, seniors, people fleeing domestic violence, people with disabilities, and those experiencing mental illness or addiction.
- According to key informants, Alameda County seniors are increasingly likely to face housing instability or become unhoused and need targeted assistance to preserve existing housing or find an appropriate senior living setting. Focus group participants echoed this concern and specifically noted a surge in unhoused LGBTQIA+ seniors.
- Focus group participants from North Alameda County noted that housing discrimination is prevalent, particularly towards Black/African American and transgender people.

Impact of COVID-19

- Key informants reported that the pandemic has caused data collection on the unhoused population to all but cease, making it difficult to thoroughly understand current needs.
- According to focus group participants, many Alameda County residents living on the edge of homelessness have been pushed into overcrowded living conditions. They believe this led to increased transmission of the COVID-19 virus.
- The end of the COVID-19 eviction moratorium, which protected many Alameda County residents from losing their housing, was a pressing issue for key informants who expressed fear about the potentially devastating impact for residents living on the edge of homelessness.
- Key informants serving North Alameda County described that housing and COVID-19 stressors resulted in behavioral health crises when unhoused residents simultaneously felt unprotected from the virus and had no viable shelter.

> **Key informant thoughts on HOUSING AND HOMELESSNESS and COVID-19:**
>
> "Clients are in crisis mode in that they are very concerned and frantic. It went from 'Hey I'm a little behind in rent" to "If I don't get help for this, I'm going to kill myself.'"

Communities Disproportionately Impacted

Based on Priority Community Profiles

- Oakland's housing quality/affordability ranks in the bottom fifth of all CA communities at 14%, while Alameda County's Healthiest communities rank substantially higher (50%).
- The percentage of uninsured residents in Berkeley (9%) and Oakland's (10%) least healthy Census Tract (according to the Healthy Places index) is greater than Alameda County overall (6%).

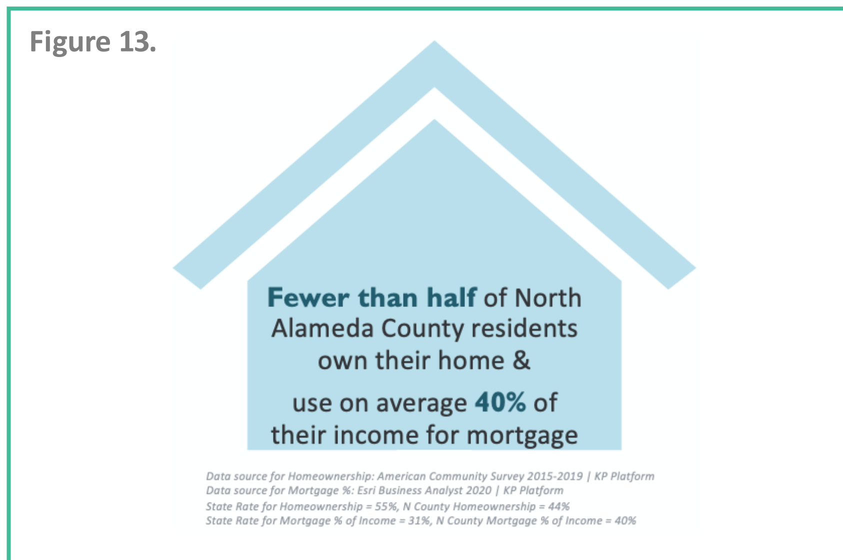
North Alameda County Housing and Homelessness Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- In Alameda County, the median rental cost is 17% higher than the state overall ($1972 versus $1689). (Appendix E)

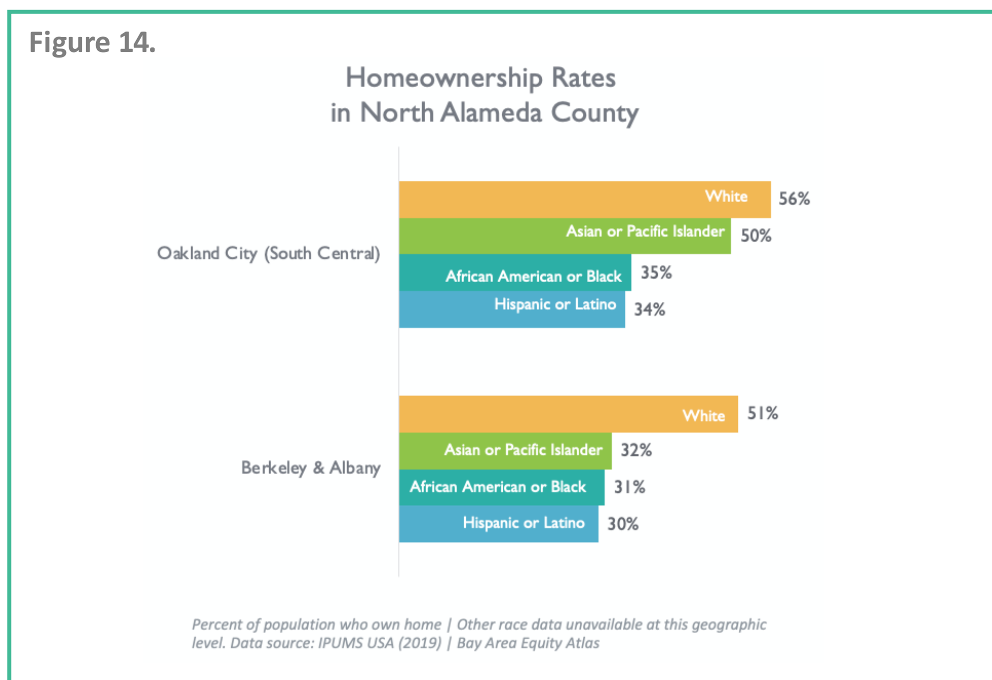
- Alameda County rates worse on the housing affordability index than the state overall, 77 versus 88 (Appendix E). The HAI index has a value of 100 when a median-income family has sufficient income to purchase a median-priced existing home.
- Homeownership rates in North Alameda County are lowest among Hispanic/Latino and Black/African American populations. (Figure 13 & 14)
- In a number of ZIP codes with a larger Black/African American population (West Berkeley, Oakland) than the county overall, the homeownership rate, housing cost burden, housing affordability index, percent of income spent on mortgage, and overcrowded housing are all worse than the state overall. (Figure 15)
- In some ZIP codes with larger Latinx/Hispanic populations than the county average (West Oakland, West Berkeley), housing cost burden, overcrowded housing, and homeownership rate are all worse than the state overall. (Figure 16)

Figure 13.



Data visuals created by ASR, 12/2021

Figure 14.

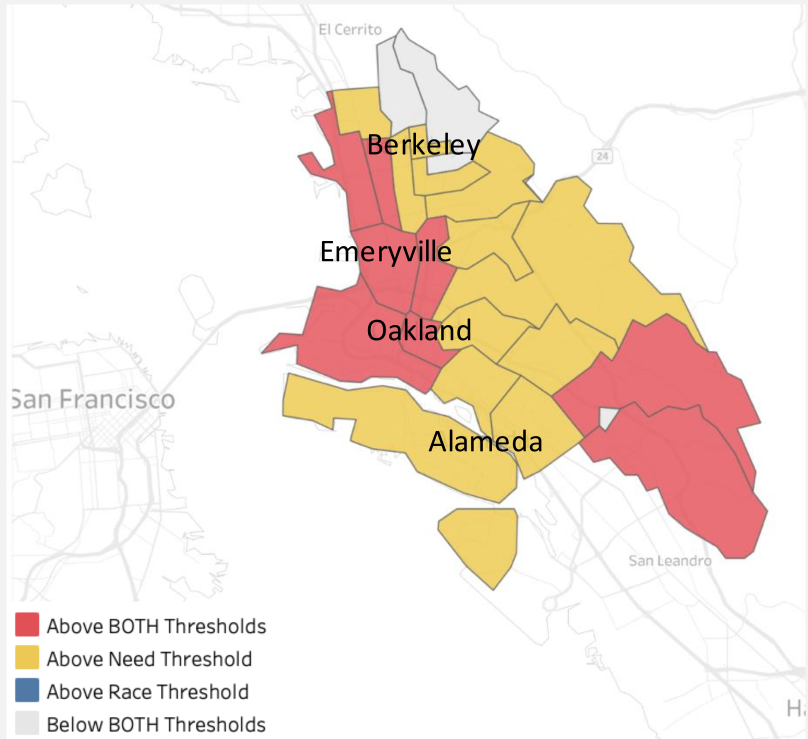


Data visuals created by ASR, 12/2021

Figure 15.

HOUSING AFFORDABILITY INDEX, NORTH ALAMEDA COUNTY, 2020

Areas shaded in red are ZIP codes with a Black/African American population greater than 15% (the service area average) and a lower housing affordability index than the state overall.

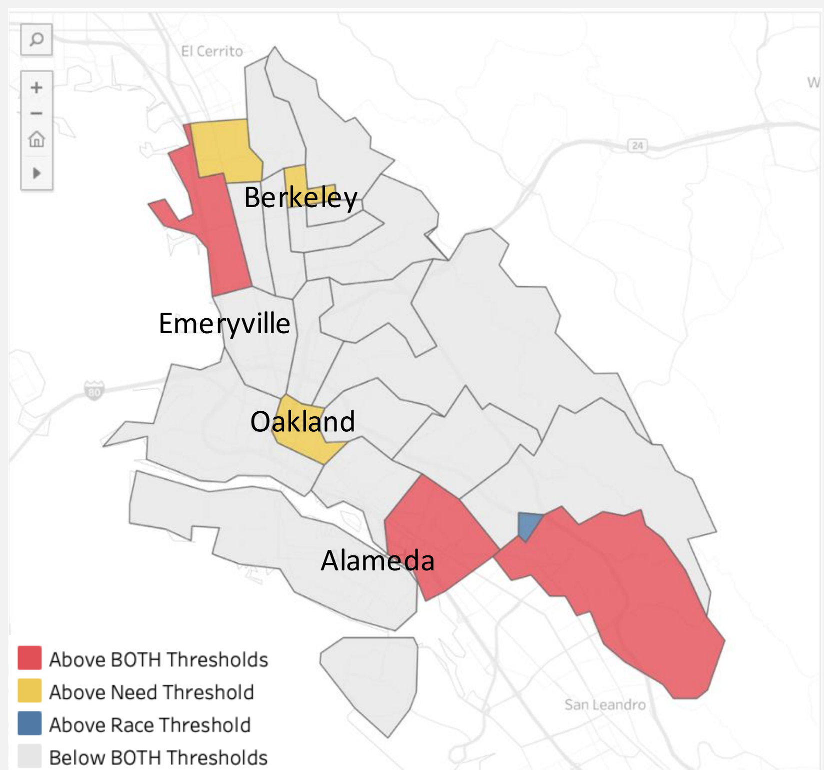


Source: Kaiser Permanente Community Health Data Platform

Figure 16.

MODERATE HOUSING COST BURDEN, NORTH ALAMEDA COUNTY, 2015-2019

Areas shaded in red are ZIP codes with a Latinx population greater than 22% (the service area average) and a higher moderate housing cost burden than the state overall.



Source: Kaiser Permanente Community Health Data Platform

Healthcare Access and Delivery

What is the Health Need?

Access to comprehensive, quality healthcare has a profound impact on health and quality of life. Components of access to and delivery of care include insurance coverage; adequate numbers of primary and specialty care providers; health care timeliness, quality and transparency; and cultural competence/cultural humility.[31] Limited access to healthcare and compromised healthcare delivery negatively affects health outcomes and quality of life. The COVID-19 pandemic exacerbated existing racial and health inequities, with people of color accounting for a disproportionate share of COVID-19 cases, hospitalizations, and deaths.[32]

Key informant thoughts on HEALTHCARE ACCESS AND DELIVERY inequities:

"People don't go to the doctor unless they really have to, and if they have to, they don't want to go because people don't have [health insurance]. If you are under Medi-Cal, you might have a really sh** provider. People don't have coverage for dental care and get bare minimum services. "

What Community Stakeholders Say About Healthcare Access and Delivery

Based on key informant interviews and focus groups

Overall

- 79% of the key informants (34 of 43) and 4 of 9 focus groups identified healthcare access and delivery as a top priority health need for Alameda County.
- Key informants described inadequate partnership between healthcare and community organizations that had limited information and data sharing, failed to capitalize on existing trust-based community relationships, and hindered innovation around care provision models that reach underserved communities such as mobile, or pop-up clinics.
- Several key informants mentioned that the cost of care and insurance is a barrier to accessing quality healthcare in the county.
- Key informants discussed the lack of hospitals in East Oakland as problematic. Though clinics exist in the area, the community lacks pharmacies, dentists, and specialty care.

Key Informant thoughts on HEALTHCARE ACCESS AND DELIVERY inequities:

"The issue is more about access to healthcare people would choose for themselves. For example, community clinics, although there is cultural congruency in these community clinics, folks do not have the capacity to access specialty care."

Inequities

- Key informants reported an urgent need for more access to dental care in county areas with underserved populations.

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

[32] Center for Disease Control and Prevention (2020). Introduction to COVID-19 Racial and Ethnic Health Disparities. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html

- Focus group participants and key informants perceived Alameda County healthcare providers' increasing reliance on online communications/appointments as helpful for many, increasing the likelihood that needed care was received and eliminating transportation challenges. At the same time, there were concerns that the pivot to online services impeded healthcare access and delivery for populations that lack reliable internet or an understanding of how to use technology, especially for seniors, those with certain disabilities, non-English speakers, and undocumented residents.
- Focus group participants and key informants stated that language and cultural barriers persist within healthcare settings in Alameda County, specifically citing a lack of interpreters for diverse languages, which disincentivizes many residents from seeking needed care.
- Focus group participants discussed how a lack of Alameda County healthcare providers with specialized training for working with specific populations serves as a barrier to care. LGBTQIA+ focus group participants described interactions with providers who misgendered them, identified them by former names, and seemed unaware of appropriate LGBTQIA+ terminology, leaving patients feeling judged, discriminated against, and less likely to continue care.
- Key informants said that partnerships between health care and community-based organizations can be particularly useful when serving populations requiring specific skills or expertise, such as migrants or refugees, people who identify as LGBTQIA+, those who are unhoused, and adolescents and teens. Individuals in these groups may be more likely to seek out necessary healthcare when an entity representing their perspective is involved.
- Key informants and focus group participants in North Alameda County discussed inequities in healthcare access citing that people of color are more likely to be on Medi-Cal and have access to fewer high quality services that those with other types of insurance.

Impact of COVID-19

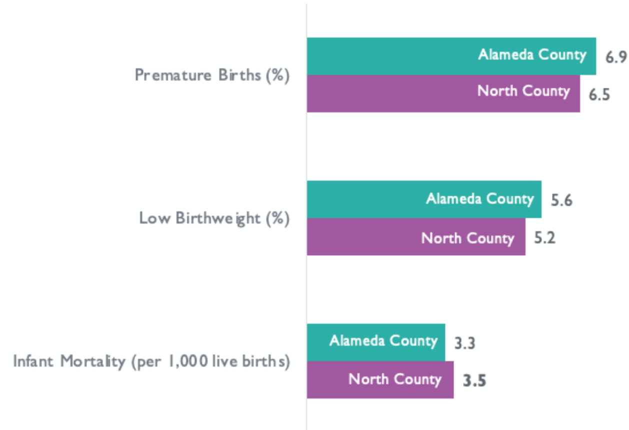
- A number of key informants described county residents' continuing reluctance to get COVID-19 vaccines, due in part to mistrust of medical professionals, suggesting that work is necessary to build trust and overcome vaccine hesitancy.

Healthcare Access and Delivery Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- Infant mortality is worse in North Alameda County than in the county overall (Figure 17) and is substantially higher for North Alameda County multiracial residents (10.5 per 1,000 live births) and Black/African Americans (9.2 per 1,000 live births) than the North County rate (3.5 per 1,000 live births). (Figure 18)
- Black/African American and multiracial residents had a substantially higher rate of death from COVID-19 than North Alameda County overall (161 and 140 deaths per 100,000 respectively versus 84). Multiracial residents have much lower vaccination rates than the North Alameda County overall (34 versus 74%). (Figure 19)
- A number of ZIP Codes in Alameda County with large Black/African American populations have low Medicaid enrollment compared to the state overall. (Figure 20)

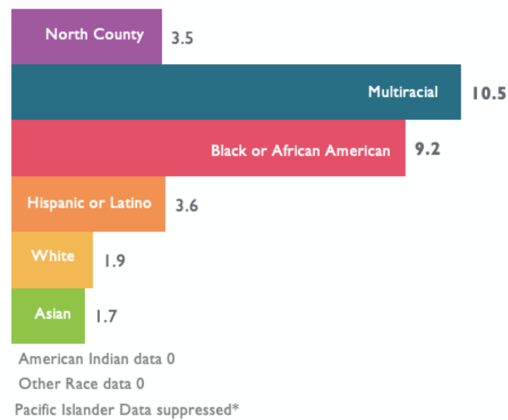
Figure 17.



Terms Defined: low birthweight (<2,500 grams) / preterm birth defined as < 37 weeks
Data source: ACPHD CAPE (Community Assessment, Planning, and Evaluation), with data from CCBF 2016-2020

Data visuals created by ASR, 12/2021

Figure 18.

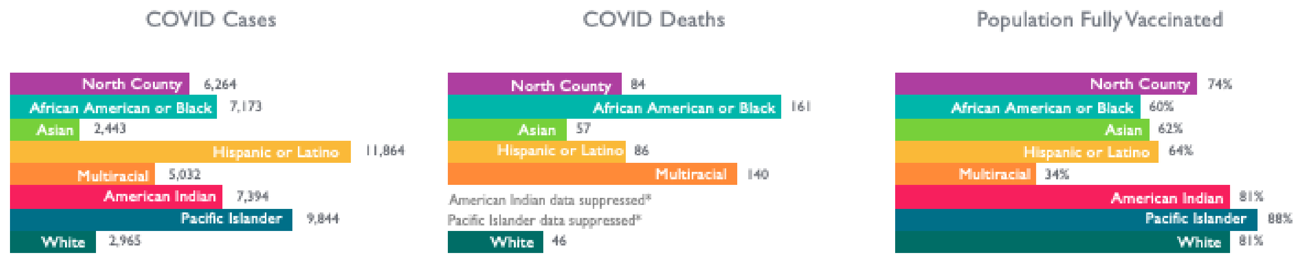


**Data suppressed when fewer than 10 cases | Per 1,000 live births*
Data source for infant mortality: ACPHD CAPE (Community Assessment, Planning, and Evaluation), with data from CCBF 2016-2020
Data source for delayed care: CA Health Interview Survey, 2020 (34%)

Data visuals created by ASR, 12/2021

Figure 19.

North Alameda County COVID-19 Impact

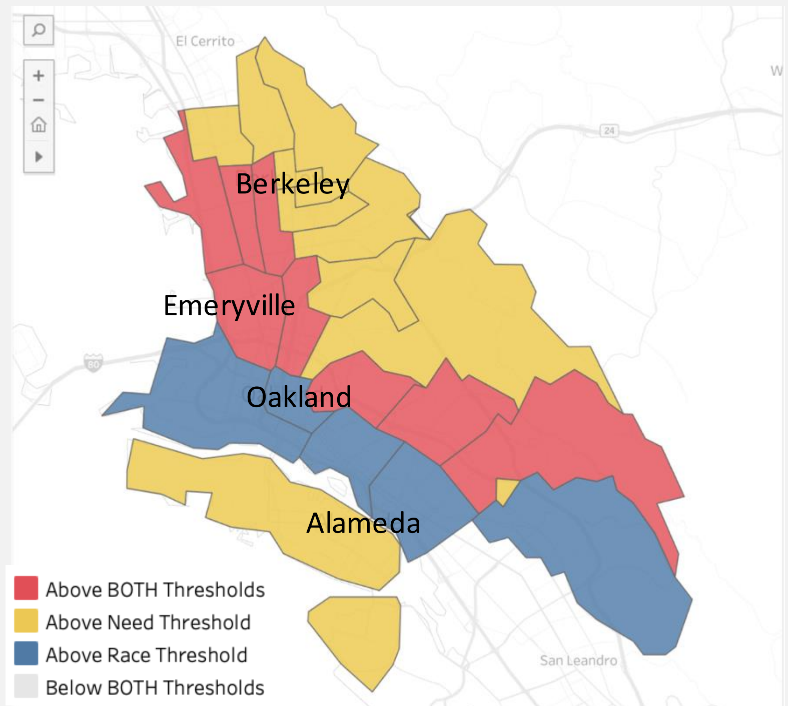


Data visuals created by ASR, 12/2021

Figure 20.

MEDICAID/PUBLIC INSURANCE ENROLLMENT, NORTH ALAMEDA COUNTY, 2015-2019

Areas shaded in red are ZIP codes with a Black/African American population greater than 15% (the service area average) and a lower Medicaid/public insurance enrollment than the state overall.



Source: *Kaiser Permanente Community Health Data Platform*

Economic Security

What is the Health Need?

People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs.[33] Childhood poverty has long-term effects. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes.[34] The establishment of policies that positively influence economic conditions can improve health for a large number of people in a sustainable fashion over time.[35]

Key Informant thoughts on ECONOMIC SECURITY overall:

"Trauma is often related to basic needs like jobs, housing, food insecurity, and the shame associated for not being able to access those basic needs."

What Community Stakeholders Say About Economic Security

Based on key informant interviews and focus groups

Overall

- Most key informants (74%; 32 of 43) and 6 of 9 focus groups identified economic security as a top priority health need in Alameda County.
- Key informants reported that Alameda County residents struggle to find living wage jobs given the county's extremely high cost of living.
- Several focus group participants described the challenge of having income too high to qualify for assistance (e.g., Medi-Cal) but not making enough money to cover basic needs.
- A number of key informants highlighted the interconnected nature of employment and behavioral and physical health. For many people, health insurance is tied to employment – job loss threatens access to healthcare for a whole family. Alameda County residents working at jobs without healthcare benefits or with limited sick time are particularly vulnerable to stress, anxiety, and poor health outcomes.
- Focus group participants identified two major Alameda County employment challenges: 1) low-wage jobs that require lengthy commutes and 2) the need to work multiple jobs simultaneously to afford basic needs.
- Key informants in North Alameda County discussed that many residents are experiencing trauma as a result of not being able to afford and access basic needs like housing and food.

[33] Prevention Institute. (2015). Making the Case with THRIVE: Background Research on Community Determinants of Health.
[34] National Research Council & Institute of Medicine. (2013). Physical and Social Environmental Factors. U.S. Health in International Perspective: Shorter Lives, Poorer Health. Woolf, S.H., & Aron, L., editors. Washington, D.C.: National Academies Press.
[35] Office of Disease Prevention and Health Promotion. (2018). Social Determinants of Health.

Inequities

- People of color, undocumented residents, youth, seniors, formerly incarcerated individuals, "lower-skilled" workers, parents without childcare and LGBTQIA+ individuals, were mentioned by focus group participants as most likely to face employment roadblocks in Alameda County.
- Key informants promoted the idea of universal basic income for Alameda County residents as a strategy (with evidence of success) for ending the cycle of poverty and the potential to address wrongs perpetuated by structural racism.
- Key informants in North Alameda County noted that people with disabilities are discriminated against in the workplace and paid less than people without disabilities people in the same position.

> **Key Informant thoughts on ECONOMIC SECURITY inequities:**
> "Trans women of color are having sex for money, so they need a job but what to tell them? [They face] discrimination when finding jobs."

Impact of COVID-19

- Key informants and focus group participants reported extensive job loss due to the pandemic, reporting that despite a strong job market, many Alameda County residents are not working.
- Key informants in North Alameda County noted that the Latinx population was one of the hardest hit populations due to COVID-19 with many having to choose between continuing to go into work with an increased risk of exposure or losing their jobs and therefore their source of income.

Communities Disproportionately Impacted

Based on Priority Community Profiles

- Oakland's least healthy Census Tract (according to the Healthy Places Index) performs worse than 95% of CA communities on measures of economic security; the percentage of children living in poverty in this Census Tract is nearly five times that of the county overall (49% versus 10%).

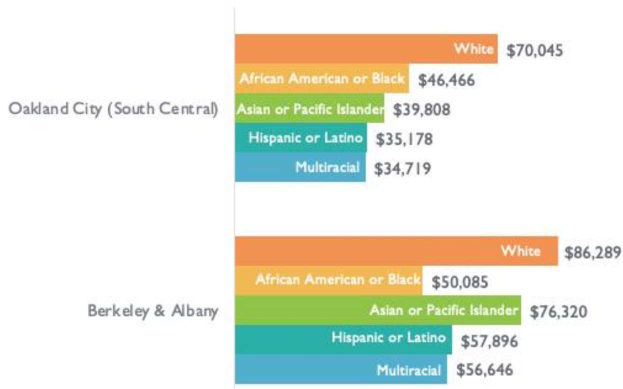
Economic Security Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- Black/African American, Hispanic/Latino, Asians, and Multiracial residents in North Alameda County all have lower median incomes than their White counterparts. (Figure 21)
- 10% of North Alameda County residents either had difficulty paying their mortgage or lost a job due to COVID-19. (Figure 22)
- Latinx/Hispanic and Black/African American populations in Oakland and Berkeley face significant income and employment disparities; many measures are worse than the state overall in ZIP codes with higher populations of color, including free and reduced-price lunch eligibility, high speed internet access, median household income, unemployment rate, young people not in school and not working, children living in poverty, and poverty rate. (Appendix E, Figures 23 and 24)

Figure 21.

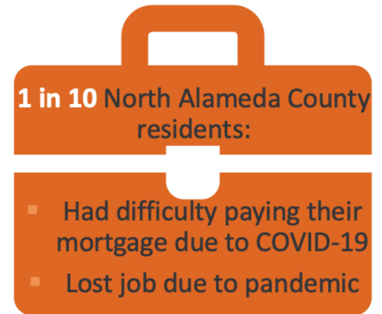
Median Income by Race/Ethnicity in North Alameda County



Data source: American Community Survey; GeoLytics, Inc. (2019) | Bay Area Equity Atlas

Data visuals created by ASR, 12/2021

Figure 22.



Data source: California Health Interview Survey (2020)

Data visuals created by ASR, 12/2021

Figure 23.

POVERTY RATE, NORTH ALAMEDA COUNTY, 2015-2019

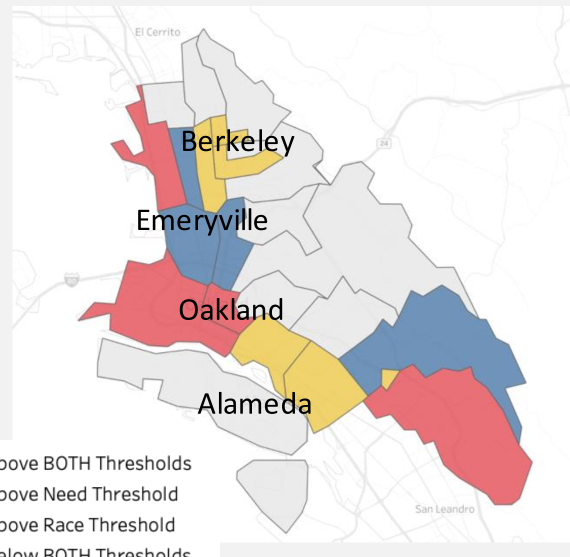
Areas shaded in red are ZIP codes with a Latinx population greater than 17% (the service area average) and a higher poverty rate than the state overall.

Source: *Kaiser Permanente Community Health Data Platform*

Figure 24.

POVERTY RATE, NORTH ALAMEDA COUNTY, 2015-2019

Areas shaded in red are ZIP codes with a Black/African American population greater than 15% (the service area average) and a higher poverty rate than the state overall.



Source: *Kaiser Permanente Community Health Data Platform*

Community and Family Safety

What is the Health Need?

Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to poorer physical and mental health outcomes.[36] Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes.[37] In addition, the physical and mental health of youth of color — particularly males — is disproportionately affected by juvenile arrests and incarceration related to policing practices.[38] Motor vehicle crashes, pedestrian accidents and falls are common causes of unintended injuries, lifelong disability, and death.[39]

What Community Stakeholders Say About Community and Family Safety

Based on key informant interviews and focus groups

Overall

- 26% of key informants (11 of 43) and 4 of 9 focus groups listed community and family safety as a top priority health need in Alameda County.
- Focus group participants linked mental illness, domestic violence, and neighborhood waste dumping to community crime and violence in Alameda County.
- Key informants noted a recent dramatic rise in gun violence in East and West Oakland, causing physical and mental trauma, causing fear of gun-related crime that prevents residents from accessing medical care.
- Key informants in North Alameda County described violence in their community as a symptom and a cause of behavioral health issues.

Inequities

- Many Alameda County key informants perceived community and family violence as a symptom of trauma due to racism and stated that eliminating racism across all sectors will promote healing and safety, preventing trauma before it happens.
- Key informants pointed to a rise in violent crime directed at Alameda County's Asian communities.
- Focus group participants and key informants reported that Alameda County's Black/African American

Key informant thoughts on COMMUNITY AND FAMILY SAFETY inequities:

"Violence disproportionately affects young men (upper teens, 20s, 30s), African American men the most, though; also Black/Brown."

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

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

[38] Liberman, A.M. & Fontaine, J. (2015). Reducing Harms to Boys and Young Men of Color from Criminal Justice System Involvement. Urban Institute. https://www.issuelab.org/resources/22861/22861.pdf

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

communities suffered more threatening behavior and targeted attacks than other racial/ethnic groups, likely a result of the social and political upheaval in 2020 and 2021.

- Key informants in North Alameda County stated that violence disproportionately affects young men of color (teens-30s).

Impact of COVID-19

- Many focus group participants felt that Alameda County communities had become less safe during the COVID-19 pandemic. LGBTQIA+ residents, seniors, and Black/African American focus group participants expressed fear of violence while out in public, and perceived law enforcement as not adequately present or effective in managing crime.
- Key informants in North Alameda County perceived that domestic violence was underreported during the pandemic as some residents felt forced to stay with abusers due to shelter in place requirements.

Key informant thoughts on COMMUNITY AND FAMILY SAFETY and COVID-19:

"Because the [Trump] administration was painting COVID with terms like "kung flu" our community [Asian] became scared to come out. So many attacks, assaults, and shootings, that people don't want to come in for services."

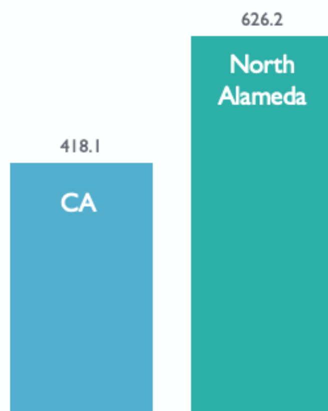
Community and Family Safety Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- The number of violent crimes is 50% higher in North Alameda County than the state overall. (Figure 25)
- Rates of death by all injuries are highest among Black/African Americans compared to North Alameda County overall (96 versus 46 per 100,000 population). (Figure 26)

Figure 25.

North Alameda County Violent Crime



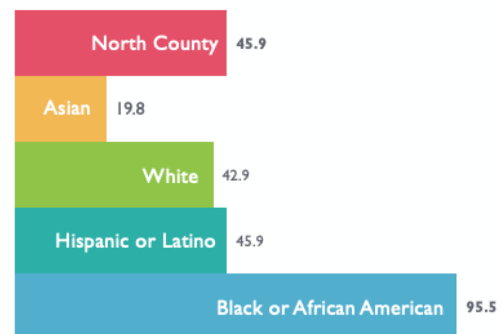
Violent Crime = Number of violent crime offenses (including homicide, rape, robbery and aggravated assault) reported by law enforcement per 100,000 population

Data source: FBI Uniform Crime Statistics (2014-18) | KP Platform

Data visuals created by ASR, 12/2021

Figure 26.

North Alameda County Deaths by All Injury by Race/Ethnicity



Pacific Islander data suppressed*
American Indian data suppressed*

**Data suppressed when fewer than 10 cases*
Age-adjusted rate per 100,000
*All Injury Deaths (ICD-10 Codes: *U01-*U03, V01-Y36, Y85-Y87, Y89)*
Data source: ACPHD CAPE, with data from Alameda County mortality files and California Comprehensive Death File (2016-2020)

Data visuals created by ASR, 12/2021

Dismantling Structural Racism

What is the Health Need?

Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms.[40] Centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment.[41] Data show that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions. The COVID-19 pandemic, which has disproportionately impacted racial and ethnic minority populations, is another example of these enduring health disparities.[42]

What Community Stakeholders Say About Structural Racism

Based on key informant interviews and focus groups

Overall

- 28% of key informants (12 of 43) listed structural racism as a top priority health need for Alameda County and reported that structural racism is a contributor to other health needs.
- Structural racism has a profound effect on health, according to key informants. Race-based inequities in access to and provision of healthcare keep many children and adults of color from receiving necessary physical or behavioral health treatment, and the care they do receive is often not culturally or linguistically competent.
- Key informants in North Alameda County reported that systemic policies have created intentional barriers for marginalized groups to access health care, basic needs, and economic opportunity.

Key informant thoughts on STRUCTURAL RACISM overall:

"Addressing root causes and equity go hand in hand. … How can [hospitals] invest in social enterprises where that dollar can stay in the local economy and benefit those creating the products?"

Inequities

- Key informants described how racial, social, and economic inequities have led to housing insecurity in Alameda County. When people of color become unhoused, they face barriers to accessing and receiving services and housing support. A few key informants pointed out that trans people of color, especially trans women of color, are particularly vulnerable to becoming unhoused.

Key informant thoughts on STRUCTURAL RACISM inequities:

"Racism contributed to the system, and the system is contributing to poverty. People are in this 'hamster wheel' and it's hard to get off this wheel because of the system."

[40] Gee, G. C., & Ford, C. L. (2011). Structural Racism and Health Inequities: Old Issues, New Directions. *Du Bois review: social science research on race*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130

[41] Center for Disease Control and Prevention (2021). Racism and Health: Racism is a Serious Threat to the Public's Health. https://www.cdc.gov/healthequity/racism-disparities/index.html

[42] Center for Disease Control and Prevention (2020). Introduction to COVID-19 Racial and Ethnic Health Disparities. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html. Accessed May 2, 2022.

- Several key informants expressed concern about inequitable practices within the educational system ("anti-blackness" in curricula and traumatizing disciplinary practices were specifically mentioned) in Alameda County that create a disconnect between schools and communities of color, particularly for Black/African American communities.
- Key informants perceived that people of color in Alameda County are more likely to experience violence through gun violence, interpersonal aggression, and/or police brutality, reporting that violence disproportionately affects young men of color (teens-30s).
- Key informants in North Alameda County noted that housing discrimination is prevalent in the community, particularly towards Black/African American residents.

Impact of COVID-19

- Key informants in North Alameda County noted that the Latinx population was hardest hit by COVID-19, with many choosing between continuing to work and risking virus exposure or losing their jobs and their source of income.

Communities Disproportionately Impacted

Based on Priority Community Profiles

- In Oakland's least healthy Census Tract (according to the Healthy Places Index), where the majority of residents identify as Hispanic (Latinx) (47%), Other race (40%), and Black/African American (38%), has nearly double the poverty rate (35%) of Oakland overall (17%) and four times the Alameda County rate (9%).
- Black/African American residents are overrepresented among Oakland's unhoused population, representing 70% of homeless residents but accounting for 25% of the total Oakland population.
- Black/African American residents are overrepresented among Berkeley's unhoused population, representing 57% of homeless residents but accounting for 6% of the total Berkeley population.

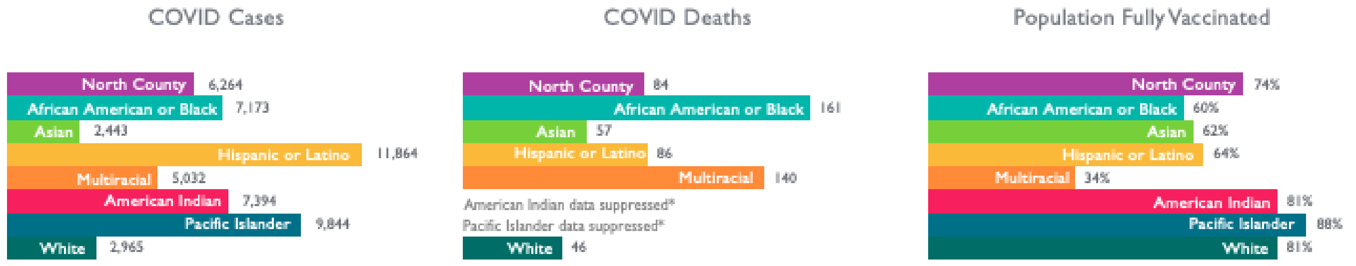
Structural Racism Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- As of November 2021, multiracial COVID-19 vaccination rates were half the rate of the general population of North Alameda County (34 versus 74%). (Figure 27)
- Black/African American and multiracial residents had substantially higher rates of COVID-19 deaths than North Alameda County overall (161 and 140 deaths per 100,000 respectively versus 84). (Figure 27)
- Black/African American, Hispanic/Latino, Asians, and multiracial residents in North Alameda County all have lower median incomes than their white counterparts. (Figure 28)
- Homeownership rates in North Alameda County are lowest among Hispanic/Latino and Black/African Americans (30-35% versus 51-56% for Whites). (Figure 29)
- Infant mortality is substantially higher for North Alameda County multiracial residents (10.5 per 1,000 live births) and Black/African Americans (9.2 per 1,000 live births) than the North County rate (3.5 per 1,000 live births). (Appendix E)

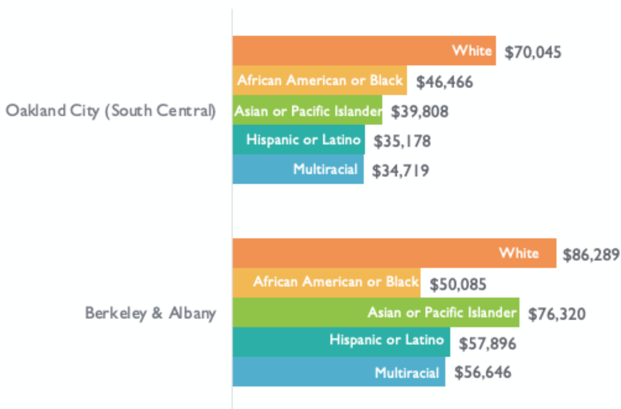
- Rates of death by all injury are highest among Black/African Americans compared to North Alameda County overall (96 versus 46 per 100,000 population). (Appendix E)

Figure 27.



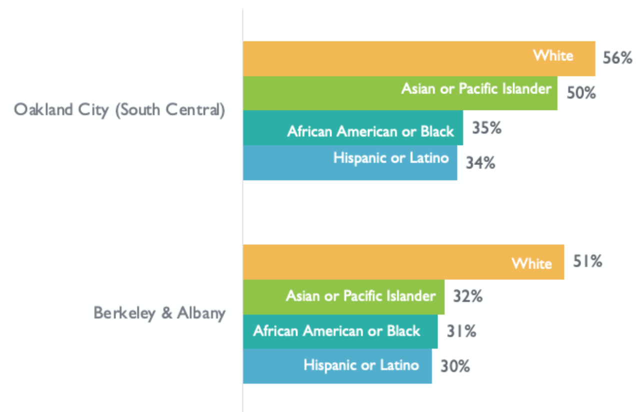
Data visuals created by ASR, 12/2021

Figure 28.



Data visuals created by ASR, 12/2021

Figure 29.



Data visuals created by ASR, 12/2021

Food Security

What is the Health Need?

Food insecurity is the lack of consistent access to enough food for an active, healthy life.[43] Food insecurity encompasses household food shortages; reduced quality, variety, or desirability of food; diminished nutrient intake; disrupted eating patterns; and anxiety about food insufficiency.[44] Black/African American and Latinx households have higher rates of food insecurity than other racial/ethnic groups.[45] Diabetes, hypertension, heart disease, and obesity have been linked to food insecurity and food insecure children are at risk for developmental complications and behavioral health challenges.[46] The COVID-19 pandemic substantially increased food insecurity due to job losses, closure/changes to feeding programs, and increased demand on food banks.[47]

What Community Stakeholders Say About Food Security

Based on key informant interviews and focus groups

Overall

- 40% of key informants (17 of 43) identified food security as a top priority health need in Alameda County. Food security was discussed in 6 of the 9 focus groups, though none identified it as a top need.
- Many key informants spoke of a burgeoning "food as medicine" movement in Alameda County. This cross-sector approach links food distribution, healthcare, nutrition programming, agriculture, and employment to address multiple needs concurrently.
- Food banks provided food to many of the focus group participants, but participants noted that much of the available food is canned or non-perishable rather than preferred fresh produce and meat, and few food banks offered culturally specific items such as tortillas or corn flour.
- Key informants in North Alameda County believe that CalFresh is an underutilized resource.

Focus group participant thoughts on FOOD SECURITY overall:

"I've been seeing folks having to make a conscious decision of staying housed, buying groceries, or paying their copay."

Inequities

- Key informants expressed particular concern for Alameda County populations at highest risk for food insecurity, including unhoused residents and populations who may be reluctant to seek out food assistance due to the stigma of being "needy" (especially moderate-income families).

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[43] U.S. Department of Agriculture, Economic Research Service. (2018). Food Security in the U.S.

[44] U.S. Department of Agriculture, Economic Research Service. (2018). Definitions of Food Security.

[45] Odoms-Young, A., & Bruce, M. A. (2018). Examining the Impact of Structural Racism on Food Insecurity: Implications for Addressing Racial/Ethnic Disparities. *Family & community health*, *41 Suppl 2 Suppl, Food Insecurity and Obesity* (Suppl 2 FOOD INSECURITY AND OBESITY), S3–S6. https://doi.org/10.1097/FCH.0000000000000183

[46] Healthy People 2020 (2018). Food Insecurity.

[47] Morales, D. X., Morales, S. A., & Beltran, T. F. (2021). Racial/Ethnic Disparities in Household Food Insecurity During the COVID-19 Pandemic: a Nationally Representative Study. Journal of racial and ethnic health disparities, 8(5), 1300–1314. https://doi.org/10.1007/s40615-020-00892-7

- Focus group participants in North Alameda County noted that undocumented residents experience disproportionately high rates of food insecurity, as they are often unable to utilize government resources.

Impact of COVID-19

> **Focus group participant thoughts on FOOD SECURITY and COVID-19:**
>
> "During the epidemic, many food shops have closed. Now the price is so high that we can't afford it."

- According to key informants, many Alameda County families experienced an increase in food insecurity due to the COVID-19 pandemic. Despite robust food distribution programs in several sectors (schools, food banks, healthcare, mobile clinics, community organizations), key informants reported that not all populations in need are reached.
- Key informants described the difficulty many Alameda County residents experienced trying to access food distribution services during the pandemic due to the switch from in-person to online registration and communication, which was difficult for residents already more likely to experience food insecurity (seniors, non-English speakers, visually impaired).
- Focus group participants reported that many small grocery/convenience stores closed because of the pandemic, and remaining stores raised food prices, especially for fresh produce.
- Key informants in North Alameda County noted that many residents, including those with moderate incomes, experienced food insecurity during the pandemic because of job loss or reduced work hours.

Communities Disproportionately Impacted

Based on Priority Community Profiles

- Supermarket access in Oakland's least healthy Census Tract (according to the Healthy Places index) is nearly in the bottom third of CA communities (35%), substantially worse than the city overall which ranks better than 87% of CA communities.

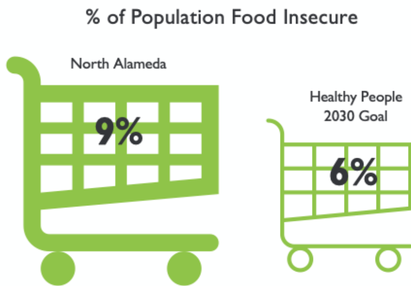
Food Security Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- In North Alameda County, 9% of residents are food insecure. (Figure 30)
- Alameda County has just under 140,000 adults and children receiving CalFresh food assistance. (Appendix E)
- A number of Oakland neighborhoods are food deserts with low access to grocery stores. (Figure 31)
- A number of ZIP Codes with Black/African American and Latinx/Hispanic populations larger than the county average have SNAP enrollment higher than the state overall. While this indicates that residents are disproportionately impacted by food insecurity, utilization of food assistance resources is key to addressing food insecurity. (Figures 32 and 33)

Figure 30.

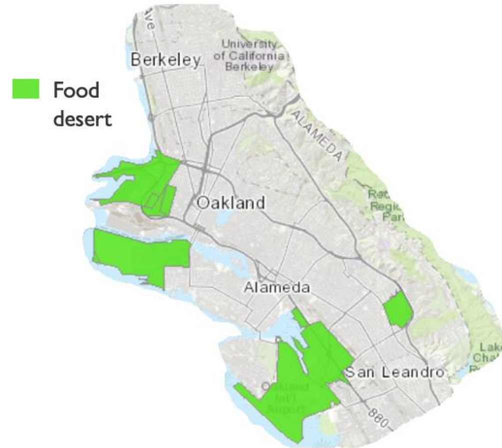
Food insecurity rate does *not* meet the Healthy People 2030 goal.



Food insecure: (low food security) reduced quality, variety, or desirability of diet or multiple indications of disrupted eating patterns + (very low food security) reduced food intake (USDA.gov)
Data source: USDA Food Environment Atlas 2015 | KP Platform; Healthy People 2030: US Dept of Health and Human Services 10-year goals for public health

Data visuals created by ASR, 12/2021

Figure 31.



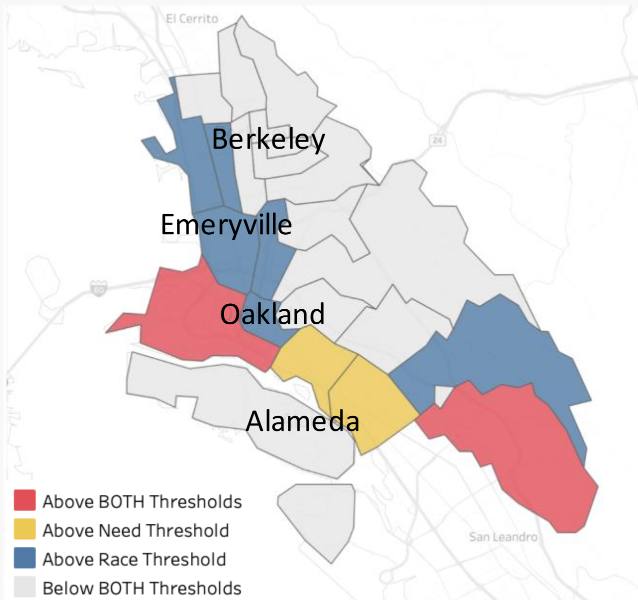
Food desert: Census tracts with both low income and low access to food. Low income: tract with poverty rate greater than 20% or median family income less than 80% median family income for state or metro area, Low access: more than 1 mile away from a grocery store in urban areas and more than 10 miles from grocery store in rural areas | Data source: USDA Food Environment Atlas 2015

Data visuals created by ASR, 12/2021

Figure 32.

SNAP ENROLLMENT, NORTH ALAMEDA COUNTY 2015-2019

Areas shaded in red are ZIP codes with a Black/African American population greater than 15% (the service area average) and a higher SNAP enrollment than the state overall.

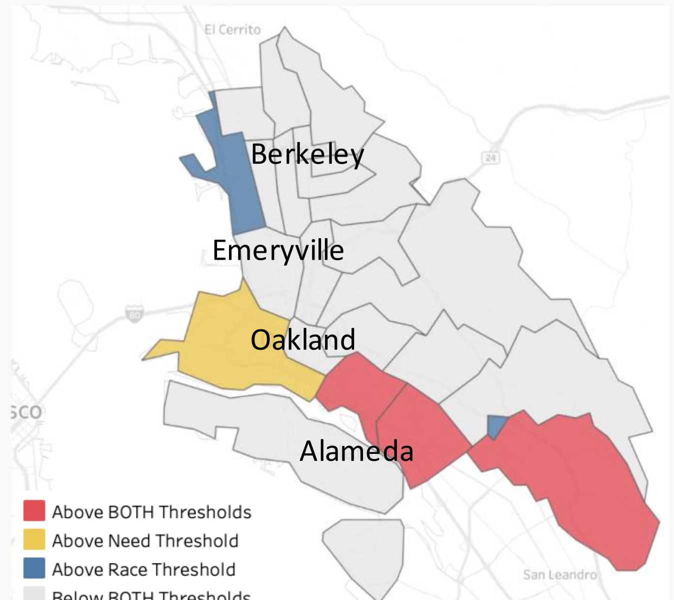


Source: *Kaiser Permanente Community Health Data Platform*

Figure 33.

SNAP ENROLLMENT, NORTH ALAMEDA COUNTY 2015-2019

Areas shaded in red are ZIP codes with a Latinx population greater than 17% (the service area average) and a higher SNAP enrollment than the state overall.



Source: *Kaiser Permanente Community Health Data Platform*

Transportation

What is the Health Need?

Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing health care, and securing food. Transportation infrastructure favors individual car use, which is associated with a number of adverse consequences, including motor vehicle injuries and deaths, the expenses of owning a vehicle, and greenhouse gas emissions which are a risk factor for heart disease, stroke, asthma, and cancer.[48] For households without access to a car, including many low-income individuals and people of color, walking, biking, and using public transportation provide critical links to jobs and essential services.[49]

What Community Stakeholders Say About Transportation

Based on key informant interviews and focus groups

Overall

- 14% of key informants (6 of 43) and 2 of 9 focus groups identified transportation as a top priority health need for Alameda County.
- According to key informants, public transit in Alameda County needs improvement and expansion, especially to underserved neighborhoods where residents are less likely to own/have access to reliable vehicles.
- Focus group participants described transportation as prohibitively expensive in Alameda County.
- Many focus group participants reported using public transit, especially buses, but noted safety concerns.
- Key informants from North Alameda County noted that lack of reliable, accessible, and affordable transportation is a barrier to accessing healthcare.

Key informant thoughts on TRANSPORTATION inequities:

"Transit operations were significantly impacted when COVID-19 cut off services; transit agencies are relying on COVID-relief federal funding."

Inequities

- Key informants frequently mentioned that Alameda County agencies/clinics should consider mobile or door-to-door services for those who are homebound or have difficulty traveling to appointments.
- Key informants linked transportation to increased air pollution particularly in underserved areas of the county, describing that pollution exacerbates acute and chronic conditions

Key informant thoughts on TRANSPORTATION inequities:

"East Oakland is typically a resource desert, not a lot of jobs, transportation is hard in terms of it being more expensive and taking longer to take folks from East Oakland to other parts of town."

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

[49] United States Census Bureau. (2019). American Community Survey. Walking and Biking to Work the Most. www.census.gov/acs/www

(specifically asthma) that are disproportionately experienced by these communities.

- Key informants from North Alameda County noted that public transit in East Oakland in particular is inadequate.
- Key informants in North Alameda County noted that seniors often have difficulty accessing healthcare because they may not have reliable or accessible transportation.

Impact of COVID-19

- A number of key informants noted that the pandemic necessitated a switch to drive-through services (e.g., food banks, medical clinics, COVID-19 vaccinations), but this presented an access barrier for Alameda County residents without a car.
- Many focus group participants reported that their reliance on public transit enhanced concerns about COVID-19 exposure.
- Key informants in North Alameda County noted that due to the pandemic, public transit services were cut and relied on federal relief funding to stay operational.

Communities Disproportionately Impacted

Based on Priority Community Profiles

- Oakland's least healthy Census Tract (according to the Healthy Places index) ranks in the bottom 2% of CA communities on transportation measures (active commuting, automobile access).

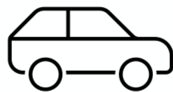
Transportation Data

See Appendix D for data sources and Appendix E for indicators from the Kaiser Permanente Community Health Data Platform

- In Alameda County, the percentage of workers driving alone with long commutes is higher than the state overall (11 versus 13%). (Appendix E)
- In Oakland, extreme commuting (90 minutes or more, one way) was slightly higher for women than men (5.2 versus 4.6%) and highest among Whites versus other races. (Figure 34 and 35)

Figure 34.

Oakland extreme commuting
(>90 min, one-way, alone) **slightly higher for women than men**



Women extreme commuting
(5.2%)

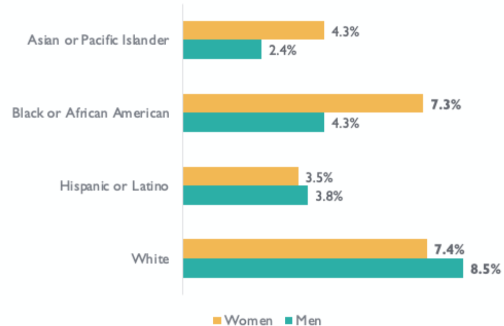
Men extreme commuting
(4.6%)

Extreme Commuting: The share of workers aged 16 or older who work outside of home that commute 90 minutes or more to work, one-way.
Data source: IPUMS USA (2019) | Bay Area Equity Atlas

Data visuals created by ASR, 12/2021

Figure 35.

Oakland Extreme Commuting by Race/Ethnicity and Gender



Extreme Commuting: The share of workers aged 16 or older who work outside of home that commute 90 minutes or more to work, one-way. Data source: IPUMS USA (2019) | Bay Area Equity Atlas

Data visuals created by ASR, 12/2021

D. Community Resources Potentially Available to Respond to the Identified Health Needs

Alameda County contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community organizations engaged in addressing many of the health needs prioritized by this assessment. Key resources available to respond to the identified health needs of the community are listed in Appendix G Community Assets and Resources.

VI. Alta Bates Summit Medical Center 2019 Implementation Strategy Evaluation of Impact

A. Impact of Implemented Strategies 2019–2021

This section is based on the 2019–2021 Implementation Strategy that described how Alta Bates Summit Medical Center planned to address significant health needs identified in its 2019 Community Health Needs Assessment (CHNA). The 2019 CHNA identified nine community health needs. Working within its mission and capabilities, Alta Bates Summit Medical Center selected the following needs to address in its Implementation Strategy:

1. Behavioral Health
2. Housing and Homelessness
3. Economic Security
4. Community and Family Safety
5. Healthcare Access and Delivery

The Implementation Strategy provided details of actions the hospital intended to take, including programs and resources it planned to commit. The tables below highlight the 2019, 2020, and 2021 impacts achieved by the programs that Alta Bates Summit Medical Center featured in its 2019–2021 Implementation Strategy.

i. Behavioral Health Impact

Name of Program, Activity, or Initiative	Investments in Behavioral Health
Description	Investments made through grants and sponsorships are decided annually and based on community health need. Alta Bates Summit Medical Center (ABSMC) seeks to promote behavioral health, in part, by supporting the provision of behavioral health programs, including those focused on the effective delivery of preventive interventions. Childhood and youth are opportune ages for promotion and preventive behavioral health interventions; schools are promising settings from which to prioritize these age groups.[50] Supporting organizations and programs that provide culturally responsive services, which can improve patient/client retention and treatment outcomes,[51] is also a priority for ABSMC. Further, ABSMC supports workforce development strategies, which are critical

[50]U.S. Office of Disease Prevention and Health Promotion, Healthy People 2020. Mental health and mental disorders. Retrieved August 8, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

[51]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A treatment improvement protocol: Improving cultural competence. Retrieved August 15, 2019 from https://store.samhsa.gov/system/files/sma14-4849.pdf

	to ensuring that present and future behavioral health needs of the community can be met. Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting and improving access to wraparound resources that support health and well- being are approaches to behavioral healthcare services that ABSMC supports. ABSMC invests in organizations, programs, and initiatives that work to address behavioral health.
Goals	Youth and adult residents are aware of and easily able to access evidenced-based, culturally responsive behavioral health resources and services through sustainable, prevention-focused interventions
Anticipated Outcomes	Residents experience improved access to evidenced-based, culturally responsive behavioral health resources and services, including promotion and preventive approaches Mental health professionals and trainees increase their knowledge of and skills in evidenced-based, culturally responsive, and/or trauma- informed behavioral health resources and services, including promotion and preventive approaches Residents demonstrate or report increased mental health and wellness knowledge, life skills, and/or improved mental health and wellbeing
2019–2021 Impact	6,112 persons served 8,333 encounters 2,577 received and/or were connected to mental health services 814 class/workshop sessions provided 161 referred out to social services (2021) 37 received substance use services (2021) 588 received case management services (2021) Note: Data were reported 2019-2021 unless otherwise specified

Name of Program, Activity, or Initiative	MPI Treatment Services
Description	MPI Treatment Services is the oldest hospital-based treatment program in the San Francisco Bay Area. Founded in 1979, MPI has treated over 15,000 patients and provided community-wide chemical dependency services to physicians, industry, and the community. In order to increase access to chemical dependency education, treatment, and support, MPI Treatment Services offers the following services free of charge for the community and/or former patients and their families: Saturday Community Lectures are offered to the public to provide education about chemical dependency, the disease concept of addiction, abstinence-based treatment, and medically assisted recovery options. Confidential assessments are conducted by a trained and licensed MPI assessment counselor to determine appropriateness of potential patients for the various programs offered. For those that do not enroll, MPI supports first steps toward recovery by discussing the personal, interpersonal, and professional impacts of addiction and connecting these impacts to participants’ life experiences.

	Continuing Care Groups support former patients newly in recovery and their families in their transition from life in addiction to life in recovery. Language interpretation is offered to remove barriers to treatment so clients can be better served, and services can be extended to a greater portion of the local population.
Goals	To provide participants with the caring, ongoing support and medical attention they need to understand the disease of chemical dependency and make the transition to recovery
Anticipated Outcomes	Community members will build their knowledge of the symptoms of and treatment for chemical dependency Assessment participants will feel supported in their first steps toward treatment and recovery Former clients and their families will receive the support needed to prevent relapse and thrive in recovery Clients with limited English proficiency will be able to access treatment through the provision of language interpretation services
2019–2021 Impact	3,622 people served 60 workshops (Saturday Community Lectures) provided 652 support group (Continuing Care Groups) meetings provided 1,137 free assessments conducted 14 eople served through language interpretation services

ii. Housing and Homelessness Impact

Name of Program, Activity, or Initiative	Investments in Housing and Homelessness
Description	Investments made through grants and sponsorships are decided annually and based on community health need. Alta Bates Summit Medical Center (ABSMC) works to address housing and homelessness, in part, by partnering with organizations that provide case management, navigation, and support services to individuals at risk of, currently experiencing, or exiting homelessness and/or housing instability. Programs that prevent homelessness and housing instability through strategies such as developing and facilitating access to affordable housing, housing assistance, and employment supports for low-income residents, are also important preventive approaches.[52] Housing and homelessness is multi-sectoral issue; ABSMC partners with organizations that convene and participate in collaborative efforts between governmental and nonprofit organizations in service outreach and delivery and/or in developing long-term solutions. ABSMC invests in organizations, programs, and initiatives that work to address housing and homelessness.
Goals	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well-being
Anticipated Outcomes	Increased access to services and resources that: Prevent entry into homelessness and alleviate housing instability Shelter and support individuals experiencing homelessness Improve exits from homelessness to stable housing
2019–2021 Impact	2,500 persons served (2019 and 2020) 16 connected to permanent or temporary housing (2019) 42 persons housed in homeless shelters (2019) 659 placed in interim housing (2021) 362 placed in permanent housing (2021)

[52] United States Interagency Council on Homelessness. Home, together: Federal strategic plan to prevent and end homelessness. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf

iii. Economic Security Impact

Name of Program, Activity, or Initiative	Investments in Economic Security
Description	Investments made through grants and sponsorships are decided annually and based on community health need. Financial health is associated with physical and mental health. Alta Bates Summit Medical Center (ABSMC) works to promote economic security, in part, by supporting the provision of job training and workforce development, financial education and coaching, as well as the connection to income supports including food security programs for low-income families. Establishing long-term financial security requires a multi-faceted approach; ABSMC partners with programs that connect their clients to bundled services such as job training, financial coaching, and access to wraparound resources that support health and well-being in collaboration with multi-sector partners. Supporting access to quality educational opportunities, from early childhood through higher education, is also critical to promoting financial security. ABSMC invests in organizations, programs, and initiatives that work to address economic security.
Goals	Residents achieve financial security through increased income or other resources and/or improved financial management practices
Anticipated Outcomes	Increased coordination and systems among placed-based, multi-sector partners including residents, organizations, and institutions Residents experience: Improved knowledge, skills, and experience to support financial security and/or employability Increased feeling of financial security Increased access to financial education and coaching services and/or stable employment opportunities Attainment and retention of new employment opportunities or increased stability and/or wages of existing employment
2019–2021 Impact	12,667 persons served 262 class/workshop sessions provided (2019-2020) 528 placed in/secured employment (2020-2021) Note: Data were reported 2019-2021 unless otherwise specified

iv. Community and Family Safety Impact

Name of Program, Activity, or Initiative	Investments in Community and Family Safety
Description	Investments made through grants and sponsorships are decided annually and based on community health need. Health is influenced by the settings in which we live, learn, work, shop, and play; feeling safe in one's home and community is fundamental to overall health. Alta Bates Summit Medical Center (ABSMC) seeks to promote community and family safety, in part, by supporting the provision of programs that focus on interpersonal and community violence prevention and neighborhood safety. Engaging and empowering children, youth, adults and seniors through school and neighborhood-based initiatives that build community and foster interpersonal safety is a priority. ABSMC invests in organizations, programs, and initiatives that work to address this health need
Goals	Residents gain knowledge, skills, empowerment, and opportunities to connect with their neighborhood that make them safer
Anticipated Outcomes	Increased knowledge of ways to avoid violence and how to stay safe Increased belief in ability to be positive role models Increased experience in peacefully resolving conflicts Increased feeling of neighborhood safety
2019–2021 Impact	6,032 persons served (2020-2021) 104 class/workshop sessions provided (2020-2021)

v. Healthcare Access and Delivery Impact

Name of Program, Activity, or Initiative	Investments in Healthcare Access and Delivery
Description	Investments made through grants and sponsorships are decided annually and based on community health need. Alta Bates Summit Medical Center (ABSMC) addresses healthcare access and delivery, in part, by partnering with community-based organizations that develop, expand, and promote affordable, culturally, and linguistically appropriate health services for uninsured and underinsured patients. This includes support for initiatives that improve access to primary care, which can offer a usual source of care, preventive care, early detection and treatment of disease, and chronic disease management.[53] Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting is an approach to care delivery that ABSMC supports. Primary care has also been identified as an important setting in which to address the social determinants of health,[54] and ABSMC partners with organizations that connect patients to additional wraparound resources that promote health and well-being, such as food and housing assistance and employment supports. ABSMC invests in organizations, programs, and initiatives that work to address healthcare access and delivery
Goals	To improve community health by expanding access to healthcare for uninsured and underinsured populations
Anticipated Outcomes	Improve access to primary healthcare services for low-income patients Increase the percentage of primary care physician appointments that are scheduled and kept
2019–2021 Impact	39,192 persons served 12,129 patients received services from a primary care physician (2019 and 2021) 10,016 referred to a primary care physician 5,125 health screenings provided (2019 and 2020) 34 trained to be community health workers/peer educators (2019 and 2020) Note: Data were reported 2019-2021 unless otherwise specified

[53] Healthy People 2020. Access to primary care. Retrieved August 7, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary

[54] World Health Organization. Primary health care. Retrieved August 7, 2019, from https://www.who.int/news-room/fact- sheets/detail/primary-health-care

Name of Program, Activity, or Initiative	Advanced Illness Management (AIM) Program
Description	Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to improve care transitions and reduce future hospitalization. The program helps patients manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want. Alta Bates Summit Medical Center supports the program, providing funding towards the care of the people who enroll in the East Bay service area. Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness
2019–2021 Impact	1,480 persons enrolled in the program's East Bay service area 242 persons transitioned to home/self-care from hospital in the program's East Bay service area 1,164 persons transitioned to home healthcare service in the program's East Bay service area

Name of Program, Activity, or Initiative	Asthma Resource Center
Description	Alta Bates Summit Medical Center's Asthma Resource Center is a program designed to help individuals control their asthma and improve their quality of life by providing education and tools for asthma management with a focus on the uninsured or underinsured. Individuals learn about basic asthma facts, medications and techniques, environmental controls, and asthma action plans. Efforts are made to also assist individuals who have no follow-up medical care with locating ongoing care in the community.
Goals	Assist those who are uninsured or underinsured in better managing their asthma
Anticipated Outcomes	Increased asthma management and control Increased proper medication use
2019–2021 Impact	310 persons served 293 (98%) persons properly taking asthma medication (2019-2020) 233 referrals for additional Asthma Education (2019) Note: Data were reported 2019-2021 unless otherwise specified

Name of Program, Activity, or Initiative	Cancer Supportive Care Services
Description	Alta Bates Summit Medical Center's Cancer Supportive Care Services offers the following educational, screening, and support group opportunities free to the community.[55] *Community screening and prevention programs* are conducted in the community to provide cancer prevention and early detection education, resources and screening clinics for cancers including breast, colorectal, and prostate cancers. *Breast cancer navigation* provides one-on-one guidance, education, case-management, resources, and patient advocacy to patients diagnosed with breast cancer. *Disease specific patient and family support groups,* such as Metastatic Cancer Support Group, Breast Cancer Support Group, and Caring for the Caregiver Support Group. *Fitness, nutrition, and lifestyle classes and series* including Healing Yoga, Qi Gong, Stress Relief, and writing classes. *Cancer treatment and planning classes, workshops, and symposiums*, such as Advance Health Care Directives Workshops, and annual highlights from the San Antonio Breast Cancer Symposium.
Goals	Dedicated to decreasing the incidence of cancer through early detection and outreach and the improvement of quality of life for those with cancer
Anticipated Outcomes	Increased knowledge of cancer risk factors, cancer prevention and early detection strategies Increased access to cancer screening services Increased awareness of and access to community resources that promote health and wellness Increased knowledge of strategies to maximize quality of life Increased sense of social support
2019–2021 Impact	4,149 persons served 630 health screenings 867 class, workshop or support group sessions provided: 518 Cancer Classes 337 Cancer Support Groups 12 Cancer Workshops and Symposiums

[55] More information about Cancer Supportive Care Services can be found at https://www.sutterhealth.org/absmc/services/cancer/special-support

Name of Program, Activity, or Initiative	Diabetes Center
Description	Alta Bates Summit Medical Center's Diabetes Center supports uninsured and underinsured individuals with diabetes, who have recently been served by the Inpatient or Emergency Departments, in maximizing their health through Diabetes Self-Management Education (DSME) and case management. Individuals learn about the diabetes disease process and treatment options, nutrition and physical activity recommendations, safe medication use, blood glucose monitoring, recognizing, and avoiding complications of diabetes, and strategies to promote health and behavior change. Individuals without a primary care physician are assisted with locating a medical home for ongoing care and with obtaining needed diabetes medications.
Goals	Uninsured and underinsured individuals with diabetes have the skills, resources and support to successfully manage their diabetes
Anticipated Outcomes	Improved diabetes self-management, as demonstrated by success in meeting personal action plans Improved glucose control, as demonstrated by decreased A1C level
2019–2021 Impact	264 persons served 762 encounters 60 class/workshop sessions provided 217 persons who self-report success in meeting personal action plan more than 75% of the time 151 persons with decreased A1C level three months after completing DSME program

Name of Program, Activity, or Initiative	Regional Rehabilitation Support Services
Description	The Regional Rehabilitation Support Services offers educational and support group opportunities free to the community, including the Brain Injury Life Skills Program, Stroke Support Group, and the Arthritis Support and Education Group.[56] The *Brain Injury Life Skills Program* provides the following groups for brain injury survivors and their family and caregivers. • The Brain Injury Life Skills Group, facilitated by a neuropsychologist, provides a supportive environment and education for individuals with brain injuries; the group focuses on strategies for dealing with memory loss, decreased attention and concentration, anger and depression, communication and social skills, emotional stress, and isolation. • The Advanced Life Skills Group, facilitated by a speech therapist, is designed to give participants who have completed the Brain Injury Life Skills Group additional cognitive strategies to improve their abilities to function better at home and in the community, and identify a pathway for returning to school, work, or volunteering. • The Family/Caregiver Education and Support Group, facilitated by a neuropsychologist, provides caregivers and family an understanding of the cognitive and emotional changes that have resulted from the brain injury.

[56] More information about Regional Rehabilitation Support Services' educational and support group opportunities can be found at https://www.sutterhealth.org/absmc/classes-events

	The *Stroke Support Group* is offered for stroke survivors, their families, and caregivers. Participants learn about rehabilitation, coping techniques, stroke prevention and other resources. The *Arthritis Support and Education Group* provides educational presentations by physicians and other health care professionals on treatment options and self-help strategies to maximize quality of life with arthritis.
Goals	Provide education, support, and opportunities to share personal experiences in a positive and caring environment
Anticipated Outcomes	Increased sense of social support Increased awareness of community resources that support health and wellness *Brain Injury Life Skills Program* Brain Injury survivors and their caregivers experience an increased understanding of the cognitive and emotional changes caused by brain injuries as well as strategies for managing and adapting to these changes *Stroke Support Group* Stroke survivors and their caregivers experience increased awareness of stroke prevention strategies and positive coping techniques *Arthritis Support and Education Group* Participants gain knowledge of arthritis treatment and self-management strategies
2019–2021 Impact	289 persons served 242 class/support group sessions provided for the programs below: 212 Brain Injury Life Skills Program 17 Stroke Support Group (2020-2021) 13 Arthritis Support and Education Group (2019-2020) Note: Data were reported 2019-2021 unless otherwise specified

Name of Program, Activity, or Initiative	Women and Infant Services
Description	Alta Bates Summit Medical Center's Women and Infant Services provides educational opportunities and support groups for parents and their children, which are open and free to the community, including the following.[57] The *Breastfeeding Support Group*, facilitated by an Alta Bates Summit board-certified Lactation Consultant, provides parents with a caring and supportive environment to ask questions about and receive help with breastfeeding, as well as make social connections in the community. The *Support After Neonatal Death (SAND) Group*, facilitated by a Certified Perinatal Educator, provides parents who have lost a baby a space to share information, experiences, and support with other parents. *Parent Education Lectures*, facilitated by a Certified Perinatal Educator, are focused on topics of interest to new and/or expecting parents.

[57] More information about Women and Infant Services' educational and support group opportunities can be found at https://www.sutterhealth.org/absmc/classes-events

Goals	New and/or expecting parents have the information and support they need to partner in their health and that of their babies Parents experiencing the loss of a baby have the information and support they need to process their grief
Anticipated Outcomes	Increased knowledge of strategies related to parenting and/or coping with grief Increased sense of social support Increased belief in ability to address challenges experienced in parenting
2019–2021 Impact	1,229 persons served 357 class/support group sessions provided for each program below: 316 Breastfeeding Support Groups 32 SAND Groups 9 Parent Education Lectures

Name of Program, Activity, or Initiative	Operation Access
Description	Alta Bates Summit Medical Center (ABSMC) partners with Operation Access to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. ABSMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms.
Goals	Increase healthcare equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by providing the resources and promoting the medical volunteerism needed for the donation of these services
Anticipated Outcomes	Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients
2019–2021 Impact	355 persons served 438 surgical and diagnostic procedures provided

VII. Conclusion

Alta Bates Summit Medical Center collaborated with partners to meet the requirements of the federally mandated CHNA by pooling expertise, guidance, and resources to produce this 2022 CHNA report. By gathering secondary data and conducting primary research with other healthcare facilities and the local public health department, the hospitals gained a shared understanding of how health indicator data for Northern Alameda County compared to state benchmarks as well as the community's perception of health needs. This rich base of information informed the hospital's prioritization of health needs.

Next Steps for Alta Bates Summit Medical Center:

- Ensure the 2022 CHNA is adopted by the hospital board and made publicly available at https://www.sutterhealth.org/for-patients/community-health-needs-assessment.
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address.
- Develop an Implementation Strategy (IS) Plan to address priority health needs.
- Ensure the IS Plan is adopted by the hospital board and filed with the IRS.

Appendices

A. Alameda County Community Input List
B. Key Informant Interview Guide
C. Focus Group Screener and Guide
D. CHNA Secondary Data Indicator Definitions, Data Sources and Dates
    i. Kaiser Permanente Community Health Data Platform
    ii. Other Secondary Data
E. Alameda County CHNA Secondary Data Table
F. Priority Community Healthy Places Index Scores
G. Alameda County Community Assets and Resources

Appendix A: Alameda County Community Input List

	Data collection method	Organization	# Participants	Group(s) Represented	Role in group	Date Input Gathered
1	Key Informant Interview	Association of Bay Area Governments	1	Alameda County residents and local governments	Leader	8/4/21
2	Key Informant Interview	Adobe Services	1	Unhoused	Leader	8/20/21
3	Key Informant Interview	Alameda County Public Health Department	1	Pregnant people and people with young families	Program Manager	8/9/21
4	Key Informant Interview	Afghan Coalition	1	Afghan community and refugees	Leader	8/17/21
5	Key Informant Interview	Alameda County Community Food Bank	1	Food insecure	Leader	7/27/21
6	Key Informant Interview	Alameda County Sheriff's Department	1	Professionals in community safety	Leader	8/19/21
7	Key Informant Interview	Alameda County Transportation Commission	1	Public transportation providers/users	Leader	7/14/21
8	Key Informant Interview	ALL IN Alameda County	1	Residents experiencing poverty	Leader	8/26/21
9	Key Informant Interview	Asian Pacific Environmental Network (APEN) and Greenlining	1	Underserved communities experiencing inequities	Leader	8/12/21
10	Key Informant Interview	Asian Health Services	1	Asian	Leader	8/20/21
11	Key Informant Interview	Bay Area Community Health Center/Tiburcio Vasquez Health Center	4	Medically underserved	Program Managers	8/26/21
12	Key Informant Interview	Building Opportunities for Self-Sufficiency (BOSS)	1	Unhoused, (formerly) incarcerated	Leader	8/10/21
13	Key Informant Interview	Castro Valley/Hayward/San Leandro/Fremont Unified School Districts	2	K-12 students/families	Program Managers	7/19/21
14	Key Informant Interview	Community Clinic Consortium/Alameda Health Consortium/Federally Qualified Health Centers (La Clínica de la Raza, Lifelong, Axis Community Health Center)	2	Medically underserved	Leader and Program Manager	8/18/21
15	Key Informant Interview	Daily Bowl	1	Food insecure	Leader	8/12/21
16	Key Informant Interview	Day Break Adult Day Center and Alameda County Age-friendly Coalition	2	Seniors and care givers	Leaders	8/3/21
17	Key Informant Interview	East Bay Asian Local Development Corporation (EBALDC)/Berkeley Food and Housing Project (BFHP)/Bay Area Community Services (BACS)	3	Asians, unhoused	Leaders	8/24/21
18	Key Informant Interview	East Oakland Collective	1	East Oakland residents	Leader	8/20/21

	Data collection method	Organization	# Participants	Group(s) Represented	Role in group	Date Input Gathered
19	Key Informant Interview	Eden Housing Resident Services, Inc.	1	Low-income seniors, families, and persons with disabilities	Program Manager	8/17/21
20	Key Informant Interview	Family Support Services	1	Care givers of children	Leader	8/12/21
21	Key Informant Interview	Fred Finch Youth Center and Lincoln	5	Youth	Leaders and Program Managers	7/29/202
22	Key Informant Interview	Health Care Services Agency (HCSA) Office of Homeless Care and Coordination and Everyone Home	2	Unhoused	Leader and Program Manager	8/19/21
23	Key Informant Interview	HOPE Collaborative	1	Schools, youth, food vendors	Leader	7/26/21
24	Key Informant Interview	Horizon Services, Project Eden	1	Youth	Leader	8/13/2021
25	Key Informant Interview	Latina Center	1	Latina/domestic violence survivors	Leader	8/16/21
26	Key Informant Interview	Livermore Valley Unified School District	2	K-12 students/families	Leader and Nurse	8/27/21
27	Key Informant Interview	National Alliance on Mental Illness (NAMI)	2	Caregivers and people with mental illness	Leaders	7/30/21
28	Key Informant Interview	Oakland Unified School District	1	K-12 students/families	Leader	8/19/21
29	Key Informant Interview	Ombudsman/Empowered Aging	1	Older adults	Leader	8/23/21
30	Key Informant Interview	Open Heart Kitchen	1	Food insecure (seniors, students, families)	Leader	7/22/21
31	Key Informant Interview	Pacific Center for Human Growth	1	Trans, LGBTQ, HIV+	Program Manager	9/29/21
32	Key Informant Interview	Partnership for Trauma Recovery	1	Refugees, asylum seekers	Leader	8/18/21
33	Key Informant Interview	Planting Justice	1	Incarcerated and those experiencing intergenerational poverty	Leader	7/22/21
34	Key Informant Interview	Rubicon	1	Adults seeking employment	Leader	7/26/21
35	Key Informant Interview	Roots Health Center	1	African American	Leader	7/23/21
36	Key Informant Interview	Side by Side (TAY)	1	Transition age youth	Program Manager	8/31/21
37	Key Informant Interview	Sparkpoint	3	Low-income	Program Managers	8/6/21
38	Key Informant Interview	St. Vincent de Paul RotaCare Clinic, Pittsburg	3	Residents with chronic health conditions	Leaders and Program Managers	8/10/21
39	Key Informant Interview	Tri-Valley Haven	2	Unhoused, food insecure, DV and sexual assault survivors	Leader and Director	8/4/21

	Data collection method	Organization	# Participants	Group(s) Represented	Role in group	Date Input Gathered
40	Key Informant Interview	Union City Family Center and Fremont Family Resource Center	3	Families	Leaders	8/6/21
41	Key Informant Interview	Unity Council	1	Unhoused, food insecure, low-income, seniors	Leader	9/1/21
42	Key Informant Interview	Urban Peace Movement	1	Communities of color	Program Manager	9/1/21
43	Key Informant Interview	Youth Alive!	1	Youth	Leader	8/16/21
44	Focus group	Mujeres Unidas y Activas (MUA)	8	Latinx women with children	Member	9/8/2021
45	Focus group	La Familia	9	Seniors	Member	9/24/2021
46	Focus group	Allen Temple	12	Seniors	Member	9/24/2021
47	Focus group	La Familia	13	Young adults/Adults	Member	9/30/2021
48	Focus group	Street Level Health	11	Indigenous families with young children	Member	9/30/2021
49	Focus group	Oakland LGBTQ Center	9	LGBTQ	Member	10/1/2021
50	Focus group	Goodness Village	9	Formerly unhoused	Member	10/6/2021
51	Focus group	Asian Health Services	13	Cantonese adults	Member	10/6/2021
52	Focus group	Asian Health Services	8	Vietnamese adults	Member	10/7/2021
53	Focus Group	Oakland LGBTQ Center	10	Trans Women	Member	10/28/21
54	Prioritization Meeting	Hospital representatives, Alameda County Public Health Department, the Community Health Center Network, the Alameda County Office of Education and The California Endowment	14	Health care and public health organizations/ agencies serving low-income and communities of color; underserved and disinvested communities	Leader	12/8/21

Appendix B: Key Informant Interview Guide

CHNA 2021 Interview Questions

INTRODUCTION

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

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

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

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

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

Do you have any questions before we get started?

KEY INFORMANT BACKGROUND INFORMATION

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

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

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

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

HEALTH NEEDS

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

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

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

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

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

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

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

EQUITY

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

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

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

COMMUNITY RESOURCES

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

CLOSING

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

Thank you **<KEY INFORMANT NAME>.** That is all that I have for you today. Kaiser Permanente will be developing their implementation strategy for investing resources to address critical health needs in your community over the next year. A final report of the community health needs assessment will be made available in 2022.

Appendix C: Focus Group Screener and Guide

Alameda County Public Health

Focus Group Participant Information 2021

1) In what city do you live? ______________________

2) What is your age group?

( ) Less than 18 years
( ) 18-25
( ) 26-35
( ) 36-45
( ) 46-55
( ) 56 and older

3) What is your gender?

[ ] Female
[ ] Male
[ ] Transgender
[ ] Other ____________________

4) What is your race/ethnicity?

[ ] White
[ ] Black
[ ] Asian
[ ] Pacific Islander
[ ] Latino/a/x
[ ] Middle Eastern
[ ] South East Asian
[ ] Indigenous
[ ] Other - Write In (Required): ____

Thank You!

Community Health Needs Assessment 2021
Focus Group Questions

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

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

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

- Hello everyone, thank you for joining our focus group today.
- My name is (Leader).
    a. **Leader Note:** Let the group know your name and why you wanted to do this focus group. Share your interest in the focus group discussion.
- As the focus group leader, I'll be asking you questions, asking follow up questions and keeping track of time and keeping the discussion moving so we can get through all of the questions.
- This is (Notetaker) who will be taking notes during our conversation.
- Our discussion today will take about 1 ½ hours.
- We want you to know that your participation is voluntary and you can leave the group at any time.
- We are recording the session today so we do not miss any of your thoughts. During the focus group, feel free to ask that we turn off the recording if you do not want to be recorded for a specific comment. Is anyone NOT OK to start recording?
    a. Leader Note: START RECORDING

  IN PERSON – start recording on iPad using the VoiceMemo app.

  VIRTUAL – press the Zoom record button.
- Now I'd like to have each of you introduce yourself. IN PERSON: Please introduce yourself by telling us your first name. VIRTUAL: I'll call on you by your first name and please wave and say hi so the group knows who you are.

Notetaker Note: Write down the name of each participant.

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

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

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

Public Health, nonprofit hospitals, and others will use the information gathered during the focus group to identify important health issues in our community and come up with a plan to address the major health issues affecting people in the county. We are interested in hearing your thoughts about what makes it easy or difficult to be healthy in your community and what services and resources are available and needed in the community to promote health.

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

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

Consent and Incentive

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

Discussion Questions
Facilitators and barriers to health in the community
We would like to discuss what is healthy and not so healthy about your community. Things that make a community healthy can include the <u>environment</u> -- examples are sidewalks, clean streets,

parks; social/emotional factors -- examples include feeling safe, access to behavioral or mental health services; opportunities for healthy behaviors -- for example, places to buy healthy food, places to exercise; community services and events such as low cost or free activities for families; and access to health care services.

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

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

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

Three most important health issues facing the community and why important (asking about behavioral health, economic security, and access to care, if not addressed)
Part of our task today is to find out which health issues you think are most important. We have a list of the health issues, many of which the community came up with when the hospitals did the Community Health Needs Assessment in this area in 2019.
Leader Note: Read all of the issues aloud and define where needed (e.g., "Healthcare Access and Delivery" means insurance, having a primary care physician, preventive care instead of emergency room, being treated with dignity and respect, wait times, etc.).

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

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

IN PERSON – What we would like you to do is vote for **three health issues** that you think are the most important to address in the next few years. Make a check mark next to each of the three health needs you think are most important. We really want your personal perspective and opinion; it's totally OK if it's different from others' here in the room. Then we will discuss the results of your votes.

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

If there is a tie:
IN PERSON and VIRTUAL – If there is a tie for the third health need, ask participants to think about which of the tied health needs is most important. Read off the first health need and ask participants to raise their hand if that is the health need they select. Read off the second health need and count the number of raised hands.

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

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

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

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

[Only If *Not* Voted a Top Need: (top 2019 health need 1]
    a. What about (top 2019 health need 1)? This was one of the top health issues last time.
    b. In your opinion, what are the specific (top 2019 health need 1) needs in our community? *Prompt, if needed.*

[Only If *Not* Voted a Top Need: top 2019 health need 2]
    a. What about (top 2019 health need 2? This was another top health issue last time.
    b. In your opinion, what are the specific (top 2019 health need 2) needs in our community? *Prompt, if needed.*

[Only If *Not* Voted a Top Need: top 2019 health need 3]
    a. What about healthcare access and delivery? This was also a top health issue last time.
    b. In your opinion, what are the specific (top 2019 health need 3) issues in our community? *Prompt, if needed.*

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

    c. In what ways, if any, did COVID-19 change [Health issue 3]?

Strategies that are working well and new strategies that are needed

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

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

Health inequities/disparities and strategies to reduce inequities/disparities

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

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

10. What resources, services, or strategies would help address these important health issues for the groups just mentioned?
    a. Let's start with [Health issue 1].
    b. What would help address [Health issue 2] for [the group(s) discussed]?
    c. What would help address [Health issue 3] for [the group(s) discussed]?
    d. Anything else important to know about health in the community

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

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

<u>Wrap Up and Gift Cards</u>

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

<u>IN PERSON</u>: Now we will hand out gift cards as our thank you for taking the time to join the focus group. Please stick around for a few more minutes to get your gift card.
Leader Note: Hand one gift card to each participant.

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

Appendix D: CHNA Secondary Data Indicator Definitions, Data Sources and Dates

Data sources described below informed the health need prioritization process and health need profiles.

i. Kaiser Permanente Community Health Data Platform

Health Topic	Measure	Definition	Year	Source
Access to care	Dentists per 100,000 population	Licensed dentists (including DDSs and DMDs) per 100,000 population.	2019	HRSA Area Resource File
	Infant deaths	Deaths of infants less than 1 year of age per 1,000 births	2020	HRSA Area Resource File
	Low birth weight births	Percent of total births are under 2500 grams	2016-2018	HRSA Area Resource File
	Medicaid/public insurance enrollment	Percent of population enrolled in Medicaid or another public health insurance program	2015-2019	American Community Survey
	Percent uninsured	Percent of total population without health insurance coverage	2015-2019	American Community Survey
	Pre-term births	Percent of total births that occur before 37 weeks of pregnancy	2016-2018	HRSA Area Resource File
	Primary care physicians per 100,000 population	Number of primary care physicians practicing general family medicine, general practice, general internal medicine, and general pediatrics per 100,000 population	2018	HRSA Area Resource File
	Uninsured children	Percent of children under age 18 without health insurance coverage	2015-2019	American Community Survey
Cancer	Breast cancer incidence	Average age-adjusted incidence of female breast cancer per 100,000 female population	2013-2017	NCI State Cancer Profiles
	Cancer deaths	Average age-adjusted deaths due to malignant neoplasm (cancer) per 100,000 population	2013-2017	NCI United States Cancer Statistics
	Colorectal cancer incidence	Age-adjusted incidence of colon and rectum cancer cases per 100,000 population	2013-2017	NCI State Cancer Profiles
	Lung cancer incidence	Average age-adjusted incidence of lung cancer per 100,000 population	2013-2017	NCI State Cancer Profiles
	Prostate cancer incidence	Average age-adjusted incidence of prostate cancer per 100,000 male population	2013-2017	NCI State Cancer Profiles
Chronic disease and disability	Adults reporting poor or fair health	Percent of adults that report having poor or fair health	2020	Behavioral Risk Factor Surveillance System
	Asthma prevalence	Percent of the Medicare fee-for-service population with a diagnosis of asthma	2018	Center for Medicare and Medicaid Services
	Diabetes prevalence	Percent of adults age 20 years and older that have ever been told by a doctor that they have diabetes	2017	Center for Medicare and Medicaid Services
	Heart disease deaths	Annual average age-adjusted deaths due to coronary heart disease per 100,000 population	2016-2018	CDC, Interactive Atlas of Heart Disease and Stroke

Health Topic	Measure	Definition	Year	Source
	Heart disease prevalence	Percent of adults age18 and older that have ever been told by a doctor that they have coronary heart disease or angina	2018	Center for Medicare and Medicaid Services
	Poor physical health (days per month)	Age-adjusted average number of self-reported physically unhealthy days per month among adults	2020	Behavioral Risk Factor Surveillance System
	Population with any disability	Percent of population with any disability	2015-2019	American Community Survey
	Stroke deaths	Annual average age-adjusted deaths due to cerebrovascular disease (stroke) per 100,000 population	2016-2018	CDC, Interactive Atlas of Heart Disease and Stroke
	Stroke prevalence	Percent of the Medicare fee-for-service population diagnosed with stroke	2017	Center for Medicare and Medicaid Services
Climate and environment	Air pollution: PM2.5 concentration	The average modeled particulate matter 2.5 concentration in PM2.5 in µg/m³	2018	Harvard University Project (UCDA)
	Coastal flooding risk	Risk of water inundating or covering normally dry coastal land as a result of high or rising tides or storm surges	2020	FEMA National Risk Index
	Drought risk	Risk of deficiency of precipitation over an extended period of time resulting in a water shortage	2020	FEMA National Risk Index
	Heat wave risk	Risk of abnormally and uncomfortably hot and unusually humid weather typically lasting two or more days with temperatures outside the historical average	2020	FEMA National Risk Index
	Respiratory Hazard Index	Index estimating the non-cancer respiratory risk for adverse health effects over a lifetime	2014	EPA National Air Toxics Assessment
	River flooding risk	Risk of streams and rivers exceeding the capacity of their natural or constructed channels and overflowing banks, spilling into adjacent low-lying, dry land	2020	FEMA National Risk Index
	Road network density	Road miles per square mile of area	2013	EPA Smart Location Mapping
	Tree canopy cover	Percent of land within the report area that is covered by tree canopy	2016	US Geological Survey; National Land Cover Database
Community safety	Injury deaths	Number of deaths from intentional and unintentional injuries per 100,000 population	2020	NCHS National Vital Statistics System
	Motor vehicle crash deaths	Age-adjusted number of deaths due to motor vehicle crashes per 100,000 population	2015-2019	NCHS National Vital Statistics System
	Pedestrian accident deaths	Number of deaths due to pedestrian accidents per 100,000 population	2015-2019	NCHS National Vital Statistics System
	Violent crimes	Number of violent crime offenses (including homicide, rape, robbery and aggravated assault) reported by law enforcement per 100,000 population	2014-2018	FBI Uniform Crime Reports
Demographics	% American Indian/Alaska native population	Percent of the total population that identify as American Indian/Alaska native, non-Hispanic	2020	Esri Demographics

Health Topic	Measure	Definition	Year	Source
	% Asian population	Percent of the total population that identify as Asian, non-Hispanic	2020	Esri Demographics
	% Black population	Percent of the total population who identify as Black or African American, non-Hispanic	2020	Esri Demographics
	% Hispanic population	Percent of the total population that identify as ethnically Hispanic	2020	Esri Demographics
	% Multiracial population	Percent of the total population that identify as multiple races, non-Hispanic	2020	Esri Demographics
	% Native Hawaiian/other Pacific Islander population	Percent of the total population that identify as Native Hawaiian/other Pacific Islander, non-Hispanic	2020	Esri Demographics
	% Some other race population	Percent of the total population that identify as some other race, non-Hispanic	2020	Esri Demographics
	% White population	Percent of the total population that identify as White, non-Hispanic	2020	Esri Demographics
	Life expectancy	The average number of years a person can expect to live at birth	2010-2015	NCHS US Small-area Life Expectancy Estimates Project
	Median age	Population median age	2015-2019	American Community Survey
	Population age 65+	Percent of total population age 65 and older	2015-2019	American Community Survey
	Population density	Population per square mile	2020	Esri Demographics
	Population under age 18	Percent of the population aged 5 to 17 years	2015-2019	American Community Survey
	Total population	Total population	2020	Esri Demographics
Disparity measure	Neighborhood Deprivation Index	Standardized Neighborhood Deprivation Index (NDI)	2019	UCDA calculation with ACS data
Education	Adults with no high school diploma	Percent of the population over age 25 with less than a high school degree	2015-2019	American Community Survey
	Adults with some college education	Population of the population over age 25 with some college education	2015-2019	American Community Survey
	Elementary school proficiency index	Performance of 4th grade students on state exams	2020	HUD Policy Development and Research
	On-time high school graduation	Percentage of 9th grade cohort receiving their high school diploma within four years	Varies	Dept of Education ED Facts and state data sources
	Preschool enrollment	Percent of the population age 3 to 4 years that is enrolled in preschool	2015-2019	American Community Survey
Family and social support	Children in single-parent households	Percent of children that live in households with only one parent present	2015-2019	American Community Survey

Health Topic	Measure	Definition	Year	Source
	Limited English Proficiency	Percent of the population age 5 years and older that speak a language other than English at home and speak English less than "very well"	2015-2019	American Community Survey
	Percent over age 75 with a disability	Percent of the population age 75 years and older with a disability	2015-2019	American Community Survey
	Population 65 and older living alone	Percent of total households with someone 65 and older living alone	2015-2019	American Community Survey
Food security	Convenience stores per 1,000 pop	Number of convenience stores per 1,000 population	2016	USDA Food Environment Atlas
	Food insecure	Estimated percentage of the total population in food-insecure households	2018	Feeding America
	Grocery stores per 1,000 pop	Number of grocery stores per 1,000 population	2020	USDA Food Environment Atlas
	Low access to grocery store	Percent of population with low access to a grocery store	2015	USDA Food Environment Atlas
	SNAP enrollment	Estimated percent of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits	2015-2019	American Community Survey
	Supercenters and club stores per 1,000 pop	Number of supercenters and club stores per 1,000 population	2016	USDA Food Environment Atlas
HEAL opportunities	Exercise opportunities	Percent of the population that live in close proximity to a park or recreational facility	2020	Esri, Business Analyst
	Food Environment Index	An index of affordable, close, and nutritious food retailers in a community	2020	USDA Food Environment Atlas
	Obesity (Adult)	Percentage of adults 20 years and older that self-report having a Body Mass Index (BMI) greater than 30.0	2018	National Center for Chronic Disease Prevention and Health Promotion
	Physical inactivity (Adult)	Percent of adults aged 20 years and older that self-report not participating in physical activities or exercise	2018	National Center for Chronic Disease Prevention and Health Promotion
	Walkability index	Index scores walkability depending upon characteristics of the built environment that influence the likelihood of walking being used as a mode of travel	2012	EPA Smart Location Mapping
Housing	Home ownership rate	Percent of population that owns a home	2015-2019	American Community Survey
	Housing affordability index	Index of the ability of a typical resident to purchase an existing home in the area	2020	Esri Business Analyst
	Median rental cost	Median gross rent plus estimated cost of utilities and fuels	2015-2019	American Community Survey
	Moderate housing cost burden	Percent of households with housing costs greater than 30% but less than 50% of monthly income	2015-2019	American Community Survey
	Overcrowded housing	Percentage of housing units with more than 1 occupant per room	2015-2019	American Community Survey

Health Topic	Measure	Definition	Year	Source
	Percent of income for mortgage	Percent of income spent on home mortgage	2020	Esri Business Analyst
	Severe housing cost burden	Percentage of households with housing costs are greater than 50% of income	2015-2019	American Community Survey
Income and employment	Children living in poverty	Percent of children aged 0 to 17 years that live in households with incomes below the Federal Poverty Level (FPL)	2015-2019	American Community Survey
	Free and reduced price lunch	Percent of public school students eligible for free or reduced price school meals	2017-2018	National Center for Education Statistics
	High speed internet	Percent of population with access to high-speed internet	2015-2019	American Community Survey
	Income inequality - Gini index	Measure of statistical dispersion representing the degree of income inequality or wealth inequality in an area	2015-2019	American Community Survey
	Jobs Proximity Index	Index of geographic access to job opportunities	2014	HUD Policy Development and Research
	Median household income	Median inflation-adjusted household income	2015-2019	American Community Survey
	Poverty rate	Percent of households with income in the past 12 months below the Federal Poverty Level	2015-2019	American Community Survey
	Unemployment rate	Percent of population age 16 years and older that is unemployed and seeking work	2020	Esri Demographics
	Young people not in school and not working	Percent of youth age 16 to 19 years who are not currently enrolled in school or employed	2015-2019	American Community Survey
Mental/ behavioral health	Deaths of despair	Age-adjusted rate of death due to suicide, alcohol-related disease, and drug overdoses per 100,000 population	2018	National Center for Health Statistics
	Mental health providers per 100,000 pop	Number of mental healthcare providers per 100,000 population	2019	CMS National Provider Identification
	Poor mental health (days per month)	Age-adjusted average number of self-reported mentally unhealthy days per month among adults	2020	Behavioral Risk Factor Surveillance System
	Suicide deaths	Age-adjusted rate of death due to intentional self-harm per 100,000 population	2020	NCHS National Vital Statistics System
Sexual health	Chlamydia incidence	Incidence rate of chlamydia cases per 100,000 population per year	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
	HIV/AIDS deaths	Rate of death due to HIV and AIDS per 100,000 population	2016-2018	HRSA Area Resource File
	HIV/AIDS prevalence	Prevalence of HIV infection per 100,000 population	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
	Teen births	Estimated teen birth rates per 1,000 females aged 15–19 years	2018	National Center for Health Statistics
Substance use	Current smokers	Percent of adults aged 18 years and older that self-report smoking cigarettes some days, most days or every day	2020	Behavioral Risk Factor Surveillance System

Health Topic	Measure	Definition	Year	Source
	Excessive drinking	Percent of adults aged 18 years and older that self-report heavy alcohol consumption	2020	Behavioral Risk Factor Surveillance System
	Impaired driving deaths	Percent of motor vehicle crash deaths in which alcohol played a role	2014-2018	NHTSA Fatality Analysis Reporting System
	Opioid overdose deaths	Age-adjusted opiate Death Rate per 100,000 population	2015-2019	NCHS National Vital Statistics System
Transportation	Workers commuting by transit, biking or walking	Percent of population age 16 years and older who use public transit, bike or walk to work	2015-2019	American Community Survey
	Workers driving alone to work	Percent of population age 16 years and older who drive alone to work via car, truck, or van	2015-2019	American Community Survey
	Workers driving alone with long commutes	Percent of population age 16 years and older who drive alone to work with a commute time longer than 60 minutes	2015-2019	American Community Survey

ii. Other secondary data sources

Data Source	Date	Link
Alameda County Public Health	2021	Data emailed from source
Bay Area Equity Atlas	2019	https://bayareaequityatlas.org/
California Health Interview Survey (CHIS)	2020	https://healthpolicy.ucla.edu/chis/about/Pages/about.aspx
California Healthy Kids Survey (CHKS)	2017-2019	https://calschls.org/
City of Oakland	2021	https://cityofoakland2.app.box.com/s/xqloqg6rpaljxz6h0cajle6s kmoea5ct/file/856855404757
City of Oakland: Department of Race and Equity	2018	https://cao-94612.s3.amazonaws.com/documents/2018-Equity-Indicators-Full-Report.pdf
City of San Leandro	2021	https://civicaadmin.sanleandro.org/civicax/filebank/blobdload. aspx?BlobID=3216
Everyone Home	2019	https://everyonehome.org/wp-content/uploads/2019/07/2019_HIRDReport_Alameda_FinalDraft_8.15.19.pdf https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf
Public Health Alliance of Southern California	2021	https://map.healthyplacesindex.org/
UCLA LPPI Census Analysis Shows California has 11 Majority-Latino Counties	2020	https://latino.ucla.edu/
United States Census Bureau, American Community Survey	2019	https://data.census.gov/cedsci/table?q=acs
www.kidsdata.org, a program of Population Reference Bureau.	2021	https://www.kidsdata.org/topic/764/food-insecurity/table#fmt=2955&loc=2,127,171&tf=124&sortType=asc https://www.kidsdata.org/topic/742/calfresh/table#fmt=2261&loc=127,2,171&tf=110&sortType=asc

Appendix E: CHNA Secondary Data Table

Prevalence/incidence rates for indicators of health status, behavior, and risk factors are shown below for Northern Alameda County and Alameda County in comparison to statistics for the state of California. Indicators (percentage of county population or a rate per designated number of residents) are presented for 15 health need categories as organized in the Kaiser Permanente Community Health Data Platform.

Health Need	Indicator	Northern Alameda County (# or %)	Alameda County (# or %)	California (# or %)
Access to care	Low birth weight births	7%	7%	7%
	Pre-term births	9%	9%	9%
	Dentists per 100,000 population	96	96	87
	Infant deaths	4	4	4
	Primary care physicians per 100,000 population	110	110	80
	Uninsured children	3%	2%	3%
	Percent uninsured	5%	4%	8%
	Medicaid/public insurance enrollment	32%	30%	38%
Cancer	Breast cancer incidence	122	122	121
	Colorectal cancer incidence	34	34	35
	Cancer deaths	135	135	143
	Lung cancer incidence	41	41	41
	Prostate cancer incidence	92	92	93
Chronic disease and disability	Asthma prevalence	6%	6%	5%
	Diabetes prevalence	28%	27%	28%
	Heart disease deaths	112	112	144
	Stroke deaths	40	40	37
	Heart disease prevalence	13%	13%	15%
	Poor physical health (days per month)	3	3	4
	Adults reporting poor or fair health	12%	12%	16%
	Population with any disability	11%	9%	11%
	Stroke prevalence	4%	4%	4%
Climate and environment	Tree canopy cover	3	3	4
	Coastal flooding risk	0.6	5	0.2
	Drought risk	0.1	27	3
	Heat wave risk	7	9	8
	Air pollution: PM2.5 concentration	13	9	12
	River flooding risk	3	16	6

Health Need	Indicator	Northern Alameda County (# or %)	Alameda County (# or %)	California (# or %)
	Respiratory Hazard Need Rating	0.4	0.4	1
	Road network density	26	23	18
Community safety	Violent crimes	626	629	418
	Injury deaths	42	42	50
	Motor vehicle crash deaths	6	6	10
	Pedestrian accident deaths	2	2	3
Education	Education - Preschool enrollment	63%	58%	51%
	Education - On-time high school graduation	87%	87%	84%
	Education - Elementary school proficiency index	48	53	49
	Education - Adults with some college education	15%	17%	21%
	Education - Adults with no high school diploma	11%	12%	18%
Family and social support	Children in single-parent households	30%	26%	32%
	Limited English Proficiency	8%	9%	10%
	Percent over age 75 with a disability	51%	49%	51%
	Population 65 & older living alone	2%	2%	2%
Food security	SNAP enrollment	8%	7%	10%
	Convenience stores per 1,000 population	<1	<1	<1
	Food Environment Need Rating	8	8	8
	Grocery stores per 1,000 population	0.2	0.2	0.2
	Low access to grocery store	7%	7%	12%
	Supercenters & club stores per 1,000 population	<1	<1	1
	Food insecure	9%	9%	11%
HEAL opportunities	Obesity (Adult)	23%	23%	25%
	Exercise opportunities	100%	100%	93%
	Physical inactivity (Adult)	15%	15%	18%
	Walkability index	15	14	11
Housing	Overcrowded housing	6%	8%	8%
	Moderate housing cost burden	20%	20%	21%
	Severe housing cost burden	20%	17%	19%
	Median rental cost	$1748	$1,972	$1,689
	Home ownership rate	44%	54%	55%
	Housing affordability index	63	77	88
	Percent of income for mortgage	40%	33%	31%
	High speed internet	87%	89%	86%

Health Need	Indicator	Northern Alameda County (# or %)	Alameda County (# or %)	California (# or %)
Income and employment	Children living in poverty	15%	11%	17%
	Poverty rate	14%	10%	13%
	Unemployment rate	15%	14%	16%
	Income inequality - Gini index	0.5	0.4	0.4
	Young people not in school and not working	3%	2%	2%
	Jobs Proximity Index	60	46	48
	Median household income	$93,206	$107,216	$82,053
	Free and reduced price lunch	34%	33%	44%
Mental/ behavioral health	Deaths of despair	27	27	34
	Suicide deaths	9	9	11
	Poor mental health (days per month)	3	3	4
	Mental health providers per 100,000 population	612	614	352
Sexual health	Teen births	7	7	13
	Chlamydia incidence	583	583	585
	HIV/AIDS deaths	23	23	74
	HIV/AIDS prevalence	426	427	390
Substance use	Current smokers	10%	10%	11%
	Impaired driving deaths	26%	26%	29%
	Opioid overdose deaths	4	4	6
	Excessive drinking	20%	20%	20%
Transportation	Workers driving alone to work	47%	62%	74%
	Workers driving alone with long commutes	12%	13%	11%
	Workers commuting by transit, biking or walking	34%	20%	8%

Appendix F: Priority Community Healthy Places Index Scores

The Priority Community Profile examines root causes of health through the Healthy Places Index (HPI)*, which scores the overall health of California cities and counties using 25 indicators. HPI indicators reflect the social determinants of health, or the community conditions that affect health and well-being. The HPI compares all California communities to create scores for individual geographies. The subsequent tables compare the priority communities to the healthiest communities in Alameda County to identify disparities. The higher the HPI score, the healthier the geography is for that indicator. Definitions for the HPI indicators are provided below.

HPI Indicator	Definition
Economic	
Employed	Percentage of people aged 25-64 who are employed
Income	Median annual household income
Housing	
Homeownership	Percentage of homeowners
Housing Habitability	Percent of households with basic kitchen facilities and plumbing
Low-Income Homeowner Severe Housing Cost Burden	Percentage of low-income homeowners who pay more than 50% of their income on housing costs
Low-income Renter Severe Housing Cost Burden	Percentage of low-income renters who pay more than 50% of their income on housing costs
Uncrowded Housing	Percentage of households with 1 or less occupant per room
Education	
Bachelor's Education or Higher	Percentage of people over age 25 with a bachelor's education or higher
High School Enrollment	Percentage of 15-17 year olds in school
Preschool Enrollment	Percentage of 3 and 4 year olds in school
Social	
Two Parent Household	Percentage of children with two married or partnered parents/caregivers
Voting	Percentage of registered voters who voted in the 2012 general election
Healthcare Access	
Insured Adults	Percentage of adults aged 18 to 64 years with health insurance
Transportation	
Automobile Access	Percentage of households with access to an automobile
Active Commuting	Percentage of workers (16 years and older) who commute to work by transit, walking, or cycling
Neighborhood	
Alcohol Access	Percentage of people who live more than ¼ mile of a store that sells alcohol
Park Access	Percentage of the population living within walkable distance (half-mile) of a park, beach, or open space greater than 1 acre

Retail Density	Number of retail, entertainment and education jobs per acre. Communities with mixed land use, and easy access to jobs, schools, shops, and essential services.
Supermarket Access	Percentage of people in urban areas who live less than a half mile from a supermarket/large grocery store, or less than 1 mile in rural areas
Tree Canopy	Percentage of land with tree canopy (weighted by number of people per acre)
Clean Environment	
Diesel Particulate Matter	Average daily amount of particulate pollution (very small particles) from diesel sources (during July)
Water Contaminants	Index score combining information about 13 contaminants and 2 types of water quality violations
Ozone	Average amount of ozone in the air during the most polluted 8 hours of summer days
Particulate Matter 2.5	Yearly average of fine particulate matter concentration from various sources

* Source: Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

Berkeley Healthy Places Index (HPI) Rankings of Root Causes of Health Compared to Healthiest Alameda County Communities*

Category	Indicator	Berkeley	Lowest HPI Census Tract (4240.02)	Healthiest Alameda County Communities
Overall	**HPI Total Score**	**88**	**50**	**89**
Economic	**Total Score**	65	45	**89**
	Employed	64	18	86
	Income	70	24	91
Housing	**Total Score**	**44**	**40**	**50**
	LI Renter Cost Burden	31	49	61
	LI Homeowner Cost Burden	82	77	73
	Housing Habitability	69	13	58
	Uncrowded Housing	70	47	39
	Homeownership	10	29	16
Education	**Total Score**	**97**	**83**	**91**
	Preschool Enrollment	90	87	89
	High School Enrollment	83	100	60
	Bachelor's Education or Higher	97	68	93
Social	**Total Score**	**45**	**25**	**43**
	Two Parent Households	37	10	55
	Voting in 2012	47	52	41
Healthcare Access	**Total Score/Insured**	**88**	**42**	**86**
Transportation	**Total Score**	**99**	**93**	**95**
	Automobile Access	1	8	4
	Active Commuting	100	96	96
Neighborhood	**Total Score**	**80**	**39**	**55**
	Retail Density	99	54	96
	Park Access	92	81	93
	Tree Canopy	69	44	38
	Supermarket Access	94	77	93
	Alcohol Outlets	5	4	5
Clean Environment	**Total Score**	**82**	**90**	**70**
	Ozone	99	96	91
	Particulate Matter 2.5	51	75	36
	Diesel Particulate Matter	2	11	2
	Water Contaminants	99	97	100

Legend:
- Scores worse by 20+ points than healthiest communities (pink)
- Scores better by 20+ points than healthiest communities (green)

* Source: Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

Oakland Healthy Places Index (HPI) Rankings of Root Causes of Health Compared to Healthiest Alameda County Communities*

Category	Indicator	Oakland	Lowest HPI Census Tract (4088)	Healthiest Alameda County Communities
Overall	**HPI Total Score**	**57**	**6**	**89**
Economic	**Total Score**	**54**	**5**	**89**
	Employed	65	5	86
	Income	55	5	91
Housing	**Total Score**	**14**	**16**	**50**
	LI Renter Cost Burden	29	23	61
	LI Homeowner Cost Burden	25	27	73
	Housing Habitability	26	33	58
	Uncrowded Housing	28	87	39
	Homeownership	9	7	16
Education	**Total Score**	**69**	**31**	**91**
	Preschool Enrollment	72	47	89
	High School Enrollment	35	100	60
	Bachelor's Education or Higher	77	2	93
Social	**Total Score**	**28**	**6**	**43**
	Two Parent Households	13	3	55
	Voting in 2012	45	27	41
Healthcare Access	**Total Score/Insured**	**48**	**22**	**86**
Transportation	**Total Score**	**88**	**2**	**95**
	Automobile Access	2	3	4
	Active Commuting	98	85	96
Neighborhood	**Total Score**	**60**	**29**	**55**
	Retail Density	97	82	96
	Park Access	87	81	93
	Tree Canopy	60	27	38
	Supermarket Access	87	35	93
	Alcohol Outlets	3	30	5
Clean Environment	**Total Score**	**76**	**88**	**70**
	Ozone	98	96	91
	Particulate Matter 2.5	51	75	36
	Diesel Particulate Matter	1	75	2
	Water Contaminants	97	97	100

Legend:
- Scores worse by 20+ points than healthiest communities (pink)
- Scores better by 20+ points than healthiest communities (green)

* Source: Public Health Alliance of Southern California. (2021). California Healthy Places Index 2.0. https://map.healthyplacesindex.org/. Accessed Fall 2021.

Appendix G: Alameda County Community Assets and Resources

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

Healthcare Facilities and Agencies

The following healthcare facilities are available in Northern and Southern Alameda County.

HOSPITALS

- Alameda County Medical Center
- Alameda Health System Alameda Hospital
- Alameda Health System Highland Hospital
- Alameda Health System San Leandro Hospital
- John Muir Health
- Kaiser Foundation Hospital–Oakland
- Kaiser Foundation Hospital–San Leandro
- St. Rose Hospital
- Sutter Health Alta Bates Summit Medical Center
- Sutter Health Eden Medical Center
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

FEDERALLY QUALIFIED HEALTH CENTERS

- Asian Health Services
- Davis Street
- La Clínica
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vásquez Health Center
- Tri-City Health Centers (and Mobile Clinic)
- West Oakland Health

OTHER HEALTH CLINICS

- Ashland Free Medical Clinic
- Center for Elder Independence
- Order of Malta Clinic
- Roots Community Health Center
- RotaCare Clinic

Assets and Resources by Identified Health Need

BEHAVIORAL HEALTH

Resource Name	Summary Description	Website
Alameda County Behavioral Health Care Services	Provides services to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns	http://www.acbhcs.org/
Alameda County Housing and Community Development	Develops housing and programs to serve the County's low- and moderate-income, homeless, and disabled populations	https://www.acgov.org/cda/hcd/
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh ("food stamps"), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance	https://www.alamedasocialservices.org/public/index.cfm
Alameda Health System	Aims to extend care, wellness, and prevention to all members of the community	http://www.alamedahealthsystem.org/
Al-Anon	12-step program for adult relatives and friends of alcoholics or someone coping with alcoholism	https://al-anon.org/
Alateen	12-step program for teen relatives and friends of alcoholics or someone coping with alcoholism	https://al-anon.org/for-members/group-resources/alateen/
Alcoholics Anonymous	12-step program for individuals who need help with alcohol addiction or excessive drinking	https://www.aa.org/
Beats, Rhymes and Life	Engages youth in Oakland to use hip-hop and self-expression as a form of therapy to facilitate healing	http://brl-inc.org/
Boldly Me	Helps people with differences due to birth conditions, medical treatments, injury, disease, and self-perception heal from emotional trauma	http://www.boldlyme.org/
Center for Healthy Schools and Communities, REACH Ashland Youth Center	Provides youth programs in the areas of arts, recreation, education, career development, and health and wellness	https://reachashland.org/
Center for Human Development	Facilitates the growth and strengthening of communities by providing services for at-risk youth, individuals, and families	http://chd-prevention.org/

Resource Name	Summary Description	Website
City of Berkeley Department of Health Services	Provides services to monitor the health of the community, prevent epidemics and the spread of disease, protect against environmental hazards, respond to disasters, and promote and encourage healthy behaviors	https://www.cityofberkeley.info/publichealth/
Crisis Support Services of Alameda, County 24-Hour Crisis Line	Gives round-the-clock telephone support to people coping with difficult circumstances or emotions, or suicidal thoughts or feelings	https://www.crisissupport.org/pro grams/crisis-line/
CURA, Inc.	Helps individuals experiencing difficulties with substance abuse achieve sobriety, health, and wellness	https://www.curainc.com/Home.html
East Bay Agency for Children	Offers comprehensive services designed to reduce the incidence/impact of adverse childhood experiences and other traumas	http://www.ebac.org/
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/
Family Education and Resource Center	Offers educational information on health, family relationships and well-being	http://askferc.org/
Family Paths 24-Hour Parent Support Hotline	Provides free, confidential counseling and information to anyone in need of parenting support as well as referrals to nearly 900 community resources	https://familypaths.org
Flourish Agenda	Strives to help youth of color flourish	https://flourishagenda.com/
Gamblers Anonymous	12-step program for people coping with a gambling addiction	http://www.gamblersanonymous.org/ga/
George Mark Children's Home	Offers round-the-clock skilled pediatric nursing, fun activities for children with complex medical conditions, transitional care, end-of-life care, respite care, and bereavement care	https://georgemark.org/
Girls, Inc.	Runs programs designed to empower and inspire girls and young women	https://girlsinc.org/
Horizon Services, Inc.	Provides preventive, educational, and therapeutic services and environments for individuals, families, and the community	https://www.horizonservices.org/
Jewish Family & Community Services East Bay	Promotes the well-being of individuals and families of all ages, races, and religions with essential mental health and social services at every stage of life	https://jfcs-eastbay.org/
Wellness Together	Partners with K-12 school districts and colleges to provide mental health services for students, families, and educators	https://www.wellnesstogether.org/
Kidango, Inc.	Runs free and reduced-cost pre-school/ child care centers	https://www.kidango.org/

Resource Name	Summary Description	Website
La Familia Counseling Services	Supplies mental health and community support services to underserved multicultural communities	https://www.lafamiliacounseling.org/
Lincoln	Provides children with support and services, from an early age through high-school graduation	http://lincolnfamilies.org/
Mindful Life Project	Empowers underserved children to gain self-awareness, confidence, self- regulation and resilience through mindfulness and other transformative skills	http://www.mindfullifeproject.org/
Narcotics Anonymous	12-step program for individuals coping with substance abuse or drug addiction	https://www.na.org/
National Alliance on Mental Illness	Offers education, support, and advocacy for people affected by mental illness	http://www.namiacs.org/
Niroga	Offers programs in schools to strengthen resilience and empathy, using trauma-informed Dynamic Mindfulness	https://www.niroga.org/
Overeaters Anonymous	12-step program for people coping with compulsive overeating, undereating, food addiction, anorexia, bulimia, binge eating and/or excessive exercising	https://oa.org/
Pacific Center for Human Growth	Delivers LGBTQ-proficient mental health and wellness services to enhance the well- being of community members	http://pacificcenter.org/
Partnership for Trauma Recovery	Addresses the psychosocial impacts of trauma among international survivors of human rights abuses through culturally aware, trauma-informed, and linguistically accessible mental-health care, clinical training, and policy advocacy	https://traumapartners.org/
Second Chance, Inc.	Offers individual and group substance abuse treatment	https://secondchanceinc.com/
Seneca Center	Provides a comprehensive continuum of school, community-based and family- focused treatment services for children and families experiencing high levels of trauma who are at risk for family disruption or institutional care for the children	https://www.senecafoa.org/
Side by Side	Helps youth overcome traumas caused by adversity and embrace resilience	https://www.sidebysideyouth.org/
Women and Men on the Way	Provides an alcohol and drug free environment and recovery services in a home like setting for a period of 6-12 months with an ongoing aftercare plan.	https://womenandmenontheway.org/
YMCA of the East Bay	Offers a variety of programs through its five health and wellness centers, 20-plus childcare sites, a teen center, and three camps	https://ymcaeastbay.org/

COMMUNITY AND FAMILY SAFETY

Resource Name	Summary Description	Website
A Safe Place	Provides domestic violence shelter and services	https://www.asafeplace.org/
Afghan Coalition	Supports and empowers Afghani refugee families, women, and youth to achieve health and wellness	https://www.afghancoalition.org/
Alameda County Deputy Sheriffs' Activities League	Collaborates with residents on initiatives that reduce crime and improve community health	https://www.acdsal.org/
Alameda County Family Justice Center	Ensures the safety, healing, and self-empowerment of victims of interpersonal violence through supportive services related to counseling, trauma recovery, and resource referral	http://www.acfjc.org/
Alameda Family Services	Offers programs to improve the emotional, psychological, and physical health of children, youth and families	https://www.alamedafs.org/
Alternatives in Action	Offers school and community programs for youth	https://www.alternativesinaction.org/
Bananas	Supports families and individuals with children by providing referrals to child care, education around imbursement for child care, and workshops for parents	https://bananasbunch.org/
Bay Area Women Against Rape	Addresses the issue of sexual assault by providing support services to survivors and leading education efforts in the community around the topic	https://bawar.org/
Berkeley Youth Alternatives	Helps at-risk youth through programs that emphasize education, health and well-being, and economic self-sufficiency	https://www.byaonline.org/
Building Futures	Provides a continuum of care through residential programs, crisis lines, and case management to help county residents build a future free of violence and homelessness	http://www.bfwc.org/
Calico Center	Works with law enforcement officers, child welfare workers, prosecutors, and other professionals to achieve justice for abused children by investigating abuse allegations and eliciting testimony from children	https://www.calicocenter.org/

Resource Name	Summary Description	Website
Center for Healthy Schools and Communities, REACH Ashland Youth Center	Empowers youth living in poverty to be healthy, resilient, and successful by offering programs around recreation, education, childhood development, literacy, art, career and employment, and health and wellness	http://achealthyschools.org/reach-ashland-youth-center.html
Center for Human Development	Facilitates the growth and strengthening of communities by providing services for at-risk youth, individuals, and families	http://chd-prevention.org/
City of Berkeley Department of Health Services	Provides a wide array of services to monitor the health of the community, to prevent epidemics and the spread of disease, to protect against environmental hazards, to respond to disasters, and to encourage healthy behaviors	https://www.cityofberkeley.info/publichealth/
Community and Youth Outreach	Provides outreach, mentoring, case management, and support to high-risk youth and young adults	http://www.cyoinc.org/
Community Violence Solutions	Works to end sexual assault and family violence by providing services to survivors of sexual assault or abuse and their families	https://cvsolutions.org/
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/
Eden Youth and Family Center	Provides services to promote the health and socioeconomic well-being of children, youth, and families	http://www.eyfconline.org/
Exonerated Nation	Helps exonerated formerly incarcerated individuals transition to life outside prison	https://exoneratednation.org/
Family Support Services	Assists families who face serious challenges in successfully caring for their children	https://fssba.org/
First 5 Alameda County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children ages 0–5 and their families	http://www.first5alameda.org/
Fresh Lifelines for Youth	Prevents juvenile crime and incarceration through legal education, leadership training, and one-on-one mentoring	https://flyprogram.org/
Girls, Inc.	Runs programs designed to empower and inspire girls and young women	https://girlsinc.org/

Resource Name	Summary Description	Website
Immigration Institute of the Bay Area	Helps immigrants, refugees, and their families settle in the community by providing legal-aid services as well as education and community engagement opportunities	https://iibayarea.org/
Koreatown Northgate (KONO)	Ensures the district (Telegraph Avenue from 20th to 35th Streets in Oakland) is safe, clean, and promoted	https://www.koreatownnorthgate.org/
The Latina Center	Focuses on uplifting the health and growth of the Latinx community by providing leadership and personal development opportunities	https://thelatinacenter.org/
Narika	Helps domestic violence survivors with advocacy, support, and education	https://www.narika.org/
Oakland Unite!	Targets the highest-risk community members and neighborhoods, with programs focused on interrupting violence as it is occurs and preventing future violence	http://oaklandunite.org/
Project Avary	Runs a program that meets the unique emotional needs of children with a parent in prison, starting at ages 8–11 and continuing for 10 years	http://www.projectavary.org/
Reentry Success Center	Supports formerly incarcerated individuals in transitioning back into the community	http://reentrysuccess.org/
Ruby's Place	Offers women, men, transgender people, and accompanied minors who have been affected by domestic violence or human trafficking with shelter, case management, therapy, and housing services	http://www.rubysplace.org/wp/
Safe Alternatives to Violent Environments	Supports victims of domestic violence through providing shelter, support and educational opportunities	https://save-dv.org/
STAND! for Families Free of Domestic Violence	Strives to break the cycle of violence in families impacted by domestic violence and child abuse by providing services around therapy, crisis lines and educational opportunities	http://www.standffov.org/
Youth Alive!	Works to prevent violence, and helps violently wounded people heal themselves and their community	http://www.youthalive.org/
Youth Uprising	Engages youth in East Oakland in leadership opportunities to drive the health and economic growth of the community	https://www.youthuprising.org/

ECONOMIC SECURITY

Resource Name	Summary Description	Website
Alameda County Community Food Bank	Partners with and provides food to local charities, pantries, and nonprofits, which pass out groceries and food items (*Website has a search function to find multiple food resources in any city in Alameda County; use that for the most up-to-date resources*)	http://foodnow.net/food-today/
Alameda County Food Resources	Lists community groups providing food assistance	https://www.needhelppayingbills.com/html/alameda_county_food_banks.html
Alameda County Nutrition Services – Women, Infants, and Children (WIC)	Promotes healthy eating via nutrition advice, help with breastfeeding, referrals to services, and special checks to buy healthy food items	http://www.acphd.org/wic.aspx
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh ("food stamps"), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance	https://www.alamedacountysocialservices.org/our-services/Health-and-Food/index
Bay Area Legal Aid	Increases access to the civil justice system through legal assistance for low-income individuals	https://baylegal.org/
Building Opportunities for Self-Sufficiency	Operates programs and services designed to empower homeless, poor, and disabled individuals to become self-sufficient	https://self-sufficiency.org/
Catholic Charities of the East Bay	Offers services to aid youth, children, and families facing difficulties with immigration, eviction, literacy, or surviving traumatic violence	http://www.cceb.org/
Clausen House	Provides housing, wellness programs, and advocacy for developmentally disabled adults in Oakland and the surrounding East Bay area.	https://clausenhouse.org/
City of Berkeley Health, Housing, and Community Services Department	Works to improve the quality of life for individuals and families in Berkeley through innovative policies, effective services, and strong community partnerships	https://www.cityofberkeley.info/dhs/

Resource Name	Summary Description	Website
City of Oakland Department of Human Services	Collaborates with a diverse group of local organizations to provide a services in the community	https://www.oaklandca.gov/departments/department-of-human-services
Community Resources for Independent Living	Focuses on providing disabled individuals with peer-based resources and advocacy to improve their lives and their ability to navigate their environment	http://www.crilhayward.org/
East Bay Asian Local Development Corporation	Works with and for the diverse populations of the East Bay to build healthy, vibrant, and safe neighborhoods through community development	https://ebaldc.org/
East Bay Community Law Center	Addresses the underlying causes of poverty and economic and racial inequality to improve opportunities in economic security, education, health and welfare, housing, and immigration	https://ebclc.org/
East Bay Works	Partners with job centers, economic developers, support service providers, and educational entities to provide benefits and services to employers, job seekers and youth ages 16–24 at no cost	http://www.eastbayworks.com/
East Oakland Youth Development Center	Develops the social and leadership capacities of youth and young adults ages 6–24 so that they are prepared for employment, higher education, and leadership roles	http://eoydc.org/
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/
First Place for Youth	Supports youth, particularly those in foster care, in developing self-sufficiency and a sense of purpose by offering housing and case-management services	https://www.firstplaceforyouth.org
Hayward Day Labor Center	Enables low-income, mostly migrant workers in the East Bay achieve self-sufficiency	http://daylaborcenter.org/
LIFE Eldercare, Inc.	Offers Meals on Wheels, transportation, friendly visitors, and fall prevention for the elderly	https://lifeeldercare.org
OneChild	Helps youth take action against sex trafficking through education, advocacy, mobilization, and survivor care and empowerment	https://www.onechild.ca/

Resource Name	Summary Description	Website
Rising Sun Center for Opportunity	Provides green training, employment, and residential energy-efficiency services	https://risingsunopp.org
Rubicon Programs	Equips East Bay residents with resources to break the cycle of poverty	http://rubiconprograms.org/
Unity Council	Helps families and individuals build wealth and assets through sustainable economic, social, and neighborhood development programs	https://unitycouncil.org/
Youth Spirit Artworks	Engages homeless and low-income individuals in artistic jobs and training to help them develop skills, experience, and self-confidence	http://youthspiritartworks.org/

EDUCATION

Resource Name	Summary Description	Website
Alameda County Early Head Start and Head Start	Provides child development and family support services to facilitate children's health and education	https://www.alamedafs.org/hs-ehs.html
Boys and Girls Clubs of Oakland	Provides safe places to learn and grow, ongoing relationships with caring adult professionals, life-enhancing programs, and character development experiences for youth ages 6 to 17	http://www.bgcoakland.org/
California State University, East Bay, Hayward Promise Neighborhood	Through collaborative partnership, offers over 35 programs that serve residents, families, children, and students in the Hayward area to ensure educational success and a safe, healthy, thriving community	http://www.haywardpromise.org/
Community Child Care Council (4C's) of Alameda County	Strengthens children and families by helping parents find and pay for affordable childcare	https://www.4c-alameda.org
Eden Youth and Family Center	Provides services to promote the health and socioeconomic well-being of children, youth, and families	http://www.eyfconline.org/
Hidden Genius Project	Focuses on increasing diversity in the workforce and transforming communities by mentoring black male youth in technology creation, entrepreneurship, and leadership skills	http://www.hiddengeniusproject.org/

SCHOOL DISTRICTS IN ALAMEDA COUNTY

School District	Location	Website
Alameda USD	Alameda	https://alamedausd-ca.schoolloop.com/
Albany USD	Albany	https://www.ausdk12.org/
Berkeley USD	Berkeley	https://www.berkeleyschools.net/
Castro Valley USD	Castro Valley	https://www.cv.k12.ca.us/
Emeryville USD	Emeryville	https://emeryusd.k12.ca.us/
Hayward USD	Hayward	https://www.husd.us/
San Leandro USD	San Leandro	https://www.sanleandro.k12.ca.us/
San Lorenzo USD	San Lorenzo	https://www.slzusd.org/
Oakland USD	Oakland	https://www.ousd.org/
Piedmont USD	Piedmont	http://www.piedmont.k12.ca.us/

FOOD SECURITY

Also see Economic Security for resources related to food insecurity.

Resource Name	Summary Description	Website
Acta Non Verba	Provides urban farming opportunities for children, youth, and families in East Oakland to deepen their understanding of nutrition, food production, and healthy living, and strengthen their ties to the community	https://anvfarm.org/
Alameda County Community Food Bank	Pursues a hunger-free community by conducting food distribution services, CalFresh outreach, youth and student nutrition programs, and mobile produce stands at health-delivery centers	https://www.accfb.org/
Alameda County Deputy Sheriffs' Activities League	Collaborates with Alameda County adults and youth on initiatives to reduce crime and improve community health	https://www.acdsal.org/
Alameda County Nutrition Services–Women, Infants, and Children (WIC)	Promotes healthy eating at public events, conducts cooking demonstrations, teaches nutrition and cooking classes, provides nutrition education, plants gardens, and develops and implements healthy food and beverage standards	http://www.acphd.org/nutrition-services
Alameda County Public Health Department	Offers community-based activities that engage residents and local partners in the planning, evaluation, and implementation of health activities	http://www.acphd.org/
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh ("food stamps"), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance	https://www.alamedasocialservices.org/public/index.cfm
City Slicker Farms	Reinforces self-sustaining access to food through urban farming, education, and recreation	http://www.cityslickerfarms.org/
Fresh Approach	Improves healthy food access in the community through farmers markets, community gardens, and cooking and nutrition classes	https://www.freshapproach.org/
Mandela MarketPlace	Builds health, wealth, and assets in low-income communities by creating local food enterprises	https://www.mandelapartners.org/
Meals on Wheels of Alameda County	Delivers nutritious meals to, and performs wellness checks on, frail and/or homebound seniors	https://www.feedingseniors.org/

HEALTHCARE ACCESS AND DELIVERY

Resource Name	Summary Description	Website
Alameda County Healthcare for the Homeless	Increases access to quality healthcare for homeless individuals through free health centers and mobile clinics that provide primary care, substance abuse treatment, and other services	https://www.achch.org/
Alameda County Housing & Community Development	Supports the preservation and development of affordable housing for low- and moderate-income residents	https://www.acgov.org/cda/hcd/
American Diabetes Association	Educates people about ways to live healthier lives and support friends and loved ones living with diabetes	http://www.diabetes.org/in-my-community/local-offices/san-francisco-california/
American Heart Association	Strives to prevent and cure heart disease	https://www.heart.org/en/affiliates/california/greater-bay-area
Bay Area Legal Aid	Improves access to the civil justice system through legal assistance for low-income individuals	https://baylegal.org/
California Department of Health Care Services	Helps low-income and disabled people get access to affordable, integrated, high-quality healthcare, including medical, dental, mental health, and substance use treatment services, as well as long-term care	https://www.dhcs.ca.gov/Pages/default.aspx
Center for Healthy Schools and Communities	Provides integrated health and wellness services (medical, dental, behavioral health, health education, and youth development) in 29 school health centers throughout Alameda County	https://achealthyschools.org/projects
Eden I&R, Inc.	Connects individuals in need with human services agencies	http://edenir.org/
George Mark Children's Home	Provides pediatric nursing and other support services to children with complex medical conditions	https://georgemark.org/
Operation Access	Enables Bay Area healthcare providers to donate surgical and specialty care to people in need	https://www.operationaccess.org/
Planned Parenthood Northern California	Delivers comprehensive sexual and reproductive health services	https://www.plannedparenthood.org/planned-parenthood-northern-california
Ronald McDonald Care Mobile Dental Clinic	Provides pediatric health services for underserved populations through health education and treatment and referral services	https://rmhcbayarea.org/what-we-do/ronald-mcdonald-care-mobile/

Resource Name	Summary Description	Website
Women's Cancer Resource Center	Helps women with cancer improve their quality of life through education, practical assistance, and support services	https://www.wcrc.org/
United Seniors of Oakland and Alameda County	Offers programs for older adults	https://www.usoac.org/

HOUSING AND HOMELESSNESS

Resource Name	Summary Description	Website
Abode Services	Works with government, supporters, landlords, and clients to provide housing for people experiencing homelessness	https://www.abodeservices.org/
Alameda County Healthcare for the Homeless	Increases access to quality healthcare for homeless individuals through free health centers and mobile clinics that provide primary care, substance abuse treatment, and other services	https://www.achch.org/
Alameda County Housing & Community Development	Leads the development of housing and programs to serve low- and moderate-income households, people experiencing homelessness, and disabled individuals	http://www.acgov.org/cda/hcd/
Alameda Point Collaborative	Permanent supportive housing community for individuals experiencing homelessness, which aims to break the cycle of poverty by providing supportive services around education, employment, nutrition, and entrepreneurship	https://apcollaborative.org/
Bay Area Community Services	Provides behavioral health and housing services for teens, adults, older adults, and their families across the Bay Area.	https://www.bayareacs.org/
Bay Area Legal Aid	Increases access to the civil justice system through legal assistance for low-income people	https://baylegal.org/
Building Opportunities for Self-Sufficiency	Operates a variety of programs and services targeted towards empowering homeless, poor and disabled individuals to be self-sufficient	https://self-sufficiency.org/
Catholic Charities of the East Bay	A wide variety of services to aid youth, children and families facing eviction including rent assistance and funds for housing deposits	http://www.cceb.org/housing-services-in-the-county-of-alameda/
Downtown Streets Team	Provides case management and volunteer programs to homeless individuals (or those at risk of becoming homeless), to develop job skills and find employment and housing	https://www.streetsteam.org/index
East Bay Community Law Center Housing Program	Defends low-income tenants in eviction lawsuits brought against them	https://ebclc.org/need-services/housing-services
East Bay Housing Organizations	Works through organized campaigns focused on policy or a geographic community through ongoing committees	http://ebho.org/resources/looking-for-housing/

Eden Housing	Creates and sustains affordable housing for very low, low and moderate-income families, seniors, veterans, people living with physical, mental, or developmental disabilities, and the formerly homeless	https://edenhousing.org/
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/
Everyone Home	Supports collaborative projects to end homelessness	http://everyonehome.org/
FESCO	Provides low/extremely low-income homeless families with food, emergency, transitional, permanent housing, and supportive services	https://www.fescofamilyshelter.org/
First Place for Youth	Supports youth, particularly those in foster care, in building self-sufficiency and a sense of purpose by offering housing and case management services	https://www.firstplaceforyouth.org
Homeless Action Center	Makes it possible for people who are experiencing severe homelessness, poverty, or disability to access social safety net programs through free, culturally sensitive legal representation	http://homelessactioncenter.org/
Lava Mae	Brings critical self-care services to people experiencing homelessness via mobile hygiene and pop-up care village programs	https://lavamae.org/
MidPen Housing	Nonprofit developer that owns and manages high-quality affordable housing for low-income families, seniors and people with special needs	https://www.midpen-housing.org/
Rebuilding Together East Bay North	Provides free rehabilitation and critical repairs to the homes of income qualified seniors, veterans, and people with disabilities	https://rtebn.org/
Rubicon Programs	Equips East Bay residents with resources to break the cycle of poverty	http://rubiconprograms.org/

TRANSPORTATION

Resource Name	Summary Description	Website
Alameda–Contra Costa Transit District (AC Transit)	Provides regional bus service	http://www.actransit.org/
Bay Area Rapid Transit (BART)	Provides elevated and subway rail travel across Bay Area counties	https://www.bart.gov/
Bay Wheels	Offers an affordable, accessible mode of transportation via a bicycle-sharing service (operated by Lyft), with discounted memberships for low-income individuals	https://www.lyft.com/bikes/bay-wheels
Bike East Bay	Promotes a healthy, sustainable community by making cycling safe, fun and accessible	https://bikeeastbay.org/
Drivers for Survivors	Offers free transportation services and supportive companionship for ambulatory cancer patients	http://driversforsurvivors.org/
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/
LIFE Eldercare, Inc.	Meals on Wheels, transportation, friendly visitors and fall prevention for the elderly	https://lifeeldercare.org
Paratransit	Public transit service for people who are unable to use regular buses or trains because of a disability or a disabling health condition	https://www.eastbayparatransit.org/