Community Health Needs Assessment

John Muir Health

2013

JOHN MUIR HEALTH

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I. Executive Summary

John Muir Health (JMH) submits this Community Health Needs Assessment (CHNA) in response to the federal requirements described in section 501(r)(3) of the Internal Revenue Code and related excise tax and reporting obligations, applicable to hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) of the Code.

John Muir Health has long valued a systematic approach for identifying community health needs in order to guide thoughtful and effective community benefit investment for years to come. JMH has conducted community health needs assessments on a three-year cycle under the requirements of California Senate Bill 697, enacted in 1994. This 2013 CHNA continues the JMH's long-standing commitment to the communities we serve by understanding their needs and assets in order to define where and how JMH community investments can have the greatest impact.

All John Muir Health entities collaborated with Kaiser Foundation Hospital Walnut Creek and Kaiser Foundation Hospital Antioch in the 2013 CHNA process. The process included comprehensive review of secondary data on health outcomes, drivers, conditions and behaviors in addition to the collection and analysis of primary data through community conversations with members of vulnerable populations in our service area. We gathered input on the identified community health needs, and the relative priority among them, through a convening of public and community health leaders, advocates and experts. The resulting prioritized list represents a community understanding informed by both data and experience with particular relevance for vulnerable populations in the JMH service area (listed in priority order).

1. Increased exercise and activity
2. Healthy eating
3. Primary care services and information (health literacy) including adequate Spanish capacity
4. Economic security
5. Asthma prevention and management
6. Specialty care
7. Affordable, local mental health services
8. Peri-natal care
9. Affordable, local substance abuse treatment services
10. Parenting skills and support

II. Background and Introduction

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

The Patient Protection and Affordable Care Act (PPACA), enacted March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the health needs identified through the assessments. The CHNA requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which were added to the Code by section 9007(a) of the Patient Protection and Affordable Care Act, enacted March 23, 2010.

The CHNA report was developed jointly in collaboration with all John Muir Health entities, including two acute care hospitals and a behavioral health center, Kaiser Foundation Hospital Walnut Creek and Kaiser Foundation Hospital Antioch.

John Muir Health values a systematic approach to identifying community health needs and has completed a similar process in the past. Through collaborative community partnerships, John Muir Health recently completed the Community Health Needs Assessment in accordance with the provisions of the PPACA . As a community-based organization, John Muir Health understands the value of continuously evaluating the health needs of the community it serves. By doing so, we are able to establish a systematic process for identifying community health needs that will guide thoughtful and effective community benefit investment for years to come.

About John Muir Health

Mission, Vision, Values

John Muir Health, a private, not-for-profit health care organization, is guided by its charitable mission. The John Muir Health mission serves as the foundation for directing the organization's community benefit activities. The mission states:

"We are dedicated to improving the health of the communities we serve with quality and compassion."

John Muir Health also adopted eight core values that guide the Board of Directors, management, physicians, employees and volunteers in their efforts: *Excellence, Honesty and Integrity, Mutual Respect and Teamwork, Caring and Compassion, Commitment to Patient Safety, Continuous Improvement, Stewardship of Resources, and Access to Care.* The mission and core values guide the activities within and outside the organization's locations.

The "Community Health Guiding Principles," approved by the John Muir Health Board of Directors in 2000, and updated in 2008, include the John Muir Health vision for all the communities of Contra Costa County and provide the framework for current and future community health priorities and initiatives.

The John Muir Health Vision for a Healthy Community is:

- *All residents achieve and maintain optimal physical and mental health.*
- *Children succeed in school and reach their full potential.*
- *Residents are economically independent and have access to adequate, affordable housing.*
- *Neighborhoods are safe.*
- *Violence, discrimination and injustice are eliminated.*
- *The air, water and food are clean, safe and sufficient.*
- *Residents are civically engaged and connected to their community.*

Most important, the "…purpose of the John Muir Health community health initiative is to increase the capacity of the communities it serves to build partnerships and the ability of individuals to make healthy decisions, which can achieve the vision of a healthy community."[1]

John Muir Health also recognizes the broad diversity of the communities it serves and works hard to bring culturally and linguistically appropriate services to the community.

Structure

John Muir Health consists of two acute care hospitals, a behavioral health center, four urgent care centers, two outpatient facilities and a physician network of primary care and specialty physicians in Contra Costa County. The Community Health Alliance and the Community Health Fund deliver John Muir Health's community benefit programs.

John Muir Community Health Alliance

1341 Galaxy Way, Suite D, Concord, CA

John Muir Health created the Community Health Alliance to assist the community in achieving optimal health through education, collaboration and health and wellness services. The John Muir Health Community Health Alliance brings to the community an array of resources, including health care professionals, mobile health services, information and education services. The John Muir Health Community Health Alliance also works in partnership with local communities, other nonprofit health systems, public health providers, nonprofit organizations and school districts to identify and address unmet health needs among uninsured and vulnerable populations. Serving as a steward for John Muir Health's charitable purposes, the Community Health Alliance's main roles are to coordinate the John Muir Health community benefit planning process and act as the liaison to the community-at-large. By aligning resources through interdepartmental planning and collaboration, John Muir Health is better able to impact its goal of creating healthy communities.

Programs managed directly by the John Muir Health Community Health Alliance include the Mobile Health Clinic, the Mobile Dental Clinic, Faith and Health Partnership and Community Nursing.

In addition to funding from John Muir Health, the Community Health Alliance received grant funds for the Dental Collaborative of Contra Costa, which operates the Ronald McDonald Care Mobile® from Wells Fargo, Los Medanos Community Hospital District, Safeway

[1] John Muir Health Community Health Guiding Principles, Purpose Statement. Fall 2000. p. 3.

Foundation and Ronald McDonald House Charities. We are grateful for their support and recognition of the critical needs of our community. We are also grateful for funding for outreach programs to address disparities in health outcomes in Pittsburg and Bay Point, California from the Los Medanos Community Health care District, Heffernan Insurance Brokers, Vesper Society and the Department of Health and Human Services Office of Women's Health.

John Muir/Mt. Diablo Community Health Fund
1399 Ygnacio Valley Road, Suite 36, Walnut Creek, CA

The John Muir/Mt. Diablo Community Health Fund distributes grants to community-based, nonprofit organizations whose health care capabilities and trusted relationships with uninsured and under-served populations expand and enhance health care services for those who need them most in Central and East Contra Costa County. The Community Health Fund distributes grants through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systematic change.

Many programs that receive their start from the Community Health Fund continue past the grant periods to deliver critical health care services. Consequently, thousands of Contra Costa County residents who may have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for a wide range of conditions. Our mission is to deliver the same kinds of results to the many more in central and east Contra Costa County who still struggle to find adequate care. More detailed information about the Fund, its governance, grant program and community benefit reports can found on its website: www.jmmdcommunityhealthfund.com.

John Muir Medical Center, Walnut Creek
1601 Ygnacio Valley Road, Walnut Creek, CA

John Muir Medical Center, Walnut Creek is a 572-bed acute care facility designated as the only trauma center for Contra Costa County and portions of Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report*, areas of specialty include high and low-risk obstetrics, orthopedics, rehabilitation, neurosciences, cardiac care, emergency care and cancer care. John Muir Medical Center, Walnut Creek is accredited by The Joint Commission, a national surveyor of quality patient care.

John Muir Medical Center, Concord
2540 East Street, Concord, CA

John Muir Medical Center, Concord is a 313-bed acute care facility that serves Contra Costa County and southern Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report,* the medical center has long been known as a preeminent center for cancer care and cardiac care, including open heart surgery and interventional cardiology. Other areas of specialty include general surgery, orthopedic and neurology programs. John Muir Medical Center, Concord is accredited by The Joint Commission.

John Muir Health Behavioral Health Center
2740 Grant Street, Concord, CA

John Muir Health offers complete inpatient and outpatient behavioral health programs and services through the John Muir Health Behavioral Health Center, our fully accredited, 73-bed psychiatric hospital located in Concord. The John Muir Health Behavioral Health Center offers psychiatric treatment for adults, children and adolescents experiencing emotional or behavioral problems. For those who are dependent on alcohol or drugs, we offer a full array of chemical dependency treatment programs. John Muir Health Behavioral Health Center is accredited by the Joint Commission.

John Muir Health Outpatient Center, Brentwood
2400 Balfour Road, Brentwood, CA

This state-of-the-art facility offers a variety of outpatient services to residents of Brentwood, Antioch, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island and surrounding areas. Services offered include family practice physicians and pediatricians; urgent care; outpatient surgery; digital medical imaging, including mammography, CT, and MRI; laboratory services; rehabilitation services, including PT and OT; cardiac conditioning (rehabilitation and education) and pulmonary rehabilitation. Independent physician offices are also in the building as well as more than two dozen medical specialists who either have permanent offices or see patients in our "Timeshare" Suites. Senior Services offers information and referral and geriatric care coordination services. Other programs available include the Behavioral Health Partial Hospitalization Program, and the Women's Health Program, offering classes on child birth and parenting.

John Muir Health Outpatient Center, Tice Valley/Rossmoor
1220 Rossmoor Parkway, Walnut Creek, CA

John Muir Health Outpatient Center, Tice Valley/Rossmoor is a comprehensive outpatient medical facility offering a wide range of physician and clinical services. This 30,000 square foot outpatient facility is located outside the entrance to the Rossmoor residential area in Walnut Creek and is open to the public. John Muir Medical Group internists are the exclusive providers of primary care services at this location. More than 25 physician specialists in 15 specialties see patients at the facility on a regularly scheduled basis each week. Outpatient services offered include laboratory, medical imaging and physical and occupational therapy. Senior Services offers information and referral and geriatric care coordination services. A patient's ordering physician does not have to be at this facility to use these services. Full time dental, optical and hearing aid services are also available as well as community education classes.

John Muir Physician Network
1350 Treat Boulevard, Suite 450, Walnut Creek, CA

The John Muir Physician Network is a not-for-profit public benefit corporation, whose sole corporate member is John Muir Health. Since its inception in 1996, it has become one of the largest medical groups in Northern California, with more than 926 primary care and specialty physicians who deliver coordinated patient care. Physicians associated with the Physician Network belong to either John Muir Medical Group (JMMG) or Muir Medical Group IPA, Inc. The Physician Network owns and operates primary care practices staffed by JMMG

physicians in 23 locations from Brentwood to Pleasanton. The Group also provides hospitalists (in-patient medical services) at John Muir Health's two hospitals. The Physician Network is active in community service, health education and clinical research. The Physician Network currently holds contracts with six major health plans for more than 63,000 commercial and senior HMO members. Additionally, the Physician Network provides a physician panel, medical management and claims services for more than 6,000 John Muir Health employees and dependents participating in the Exclusive Provider Organization health plan. The Physician Network manages health plan contracting for John Muir Health and its hospitals and engages in physician recruitment to meet community needs.

Other important components within the John Muir Health organization include four urgent care centers and three other entities that serve the two medical centers in Concord and Walnut Creek: John Muir Medical Center, Walnut Creek Auxiliary, John Muir Medical Center, Concord Volunteers and John Muir Health Foundation.

2013 Community Health Needs Assessment Introduction

The Affordable Care Act, enacted March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the health needs identified through the assessments.

John Muir Health values a systematic approach to identifying community health needs and has completed a similar process in the past. As part of the SB697 triennial cycle, a comprehensive community assessment was completed in 2010. The 2010 community assessment was conducted through collaboration with other health care providers in Contra Costa County. The assessment included both a quantitative analysis of existing health data and a qualitative analysis of a widely distributed community survey. Results of the assessment are made available to the public and are used to inform John Muir Health's community benefit plan goals, priorities and strategies.

III. Community Served

John Muir Health defines the community served by the hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. All John Muir Health entities, including the medical centers and the Behavioral Health Center share the same service area.

John Muir Health's primary and secondary service area extends from southern Solano County into eastern Contra Costa County and south to San Ramon in southern Contra Costa County. The communities that comprise the primary service area include Concord, Walnut Creek, Pleasant Hill, Martinez, Lafayette, Danville, Alamo, Orinda, Moraga and Clayton. The communities that comprise the secondary service area include Brentwood, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island, Benicia, Pittsburg, Bay Point, Antioch and San Ramon. John Muir Health's Trauma Center serves all of Contra Costa County, as well as southern Solano County and is the backup Trauma Center for Alameda County.

Map of John Muir Health Service Area

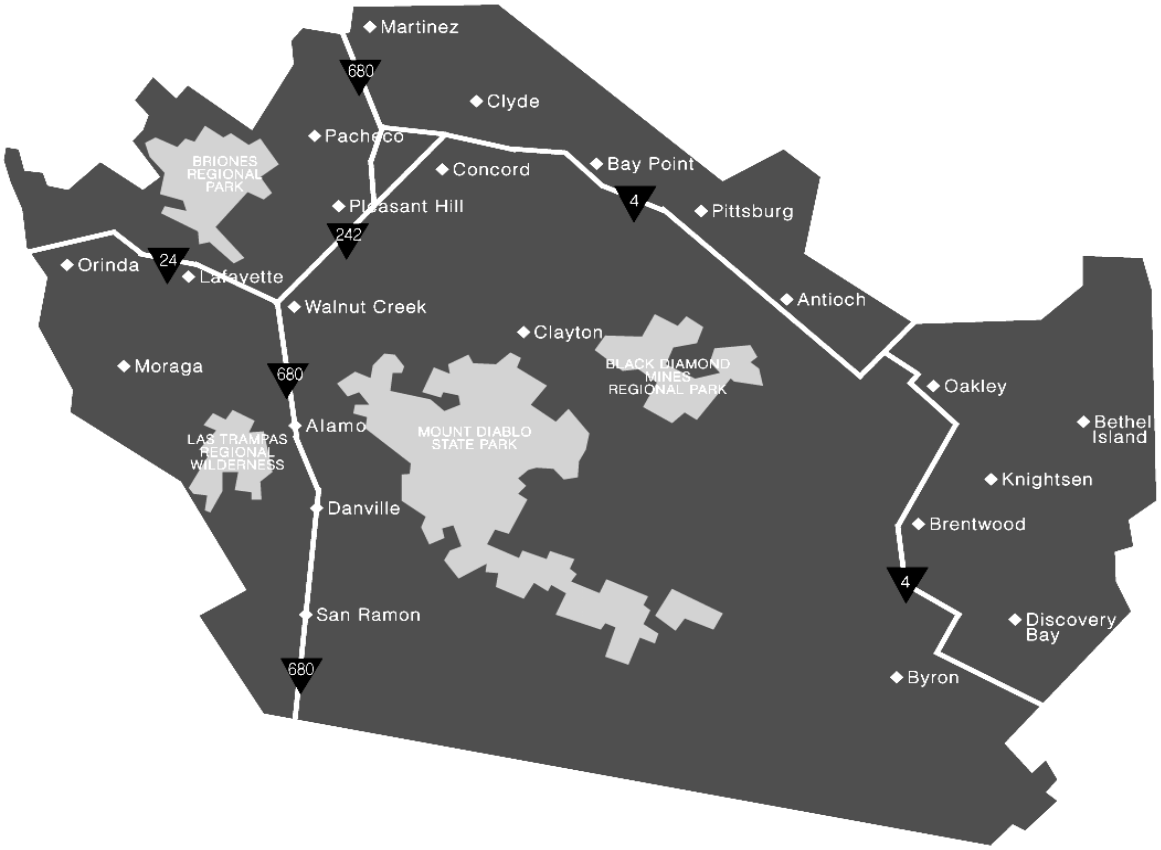

TABLE 1: DEMOGRAPHIC PROFILE OF JOHN MUIR HEALTH SERVICE AREA

Central Contra Costa	
Under 5 years old	6.09%
Ages 5-17	17.75%
Ages 18 – 34	18.86%
Ages 35-64	44.69%
Ages 65+	12.62%
White	72.77%
Black	2.54%
Asian	15.05%
Hispanic	14.02%
Linguistically Isolated	9.33%

East Contra Costa	
Under 5 years old	7.61%%
Ages 5-17	22.13%
Ages 18 – 34	22.47%
Ages 35-64	39.87%
Ages 65+	8.98%
White	56.15%
Black	12.44%
Asian	9.35%
Hispanic	34.16%
Linguistically Isolated	14.89%

The primary focus of our community benefit programs is on the needs of vulnerable populations. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care and the economically disadvantaged. These criteria result in a primary Community Benefit Service Area that includes the communities of

the Monument area in Concord and the Eastern Contra Costa County cities of Bay Point, Pittsburg, Antioch, Oakley, Brentwood and the far east parts of unincorporated Contra Costa County. The populations at the highest risk (highest poverty rates, lowest levels of health insurance and lowest rates of high school degree completion) in these areas are Blacks and Latinos.

TABLE 2: KEY DRIVERS OF HEALTH IN THE JOHN MUIR HEALTH SERVICE AREA

CENTRAL CONTRA COSTA COUNTY	Poverty	Uninsured	No HS Diploma	EASTERN CONTRA COSTA COUNTY	Poverty	Uninsured	No HS Diploma
Service Area	5.27%	7.85%	6.36%	Service Area	11.77%	14.68%	16.92%
Males	4.92%	9.01%	6.53%	Males	11.01%	16.49%	17.45%
Females	5.59%	6.68%	6.21%	Females	12.5%	12.81%	16.42%
Whites	4.5%	7.01%	4.8%	Whites	10.23%	13.14%	14.98%
Blacks	11.04%	12.57%	11.53%	Blacks	18.93%	11.61%	9.60%
Asians	4.5%	7.73%	6.01%	Asians	7.19%	10.87%	11.42%
Multiple Race	6.0%	7.19%	5.6%	Multiple Race	8.81%	12.69%	14.23%
Hispanics	10.43%	19.41%	24.68%	Hispanics	15.11%	22.32%	35.98%

IV. Collaboration for the 2013 Community Health Needs Assessment

This Community Health Needs Assessment was conducted through collaboration among John Muir Health, Kaiser Permanente Walnut Creek, and Kaiser Permanente Antioch. These three hospitals serve the populations in Central and Eastern Contra Costa County.

John Muir Health, along with Kaiser Permanente Walnut Creek, and Kaiser Permanente Antioch contracted with Caroline McCall dba Arete Consulting to complete the data analysis required for the Community Health Needs Assessment. Ms. McCall also designed and facilitated primary data collection as well as a prioritization session that engaged public and community health experts from across Central and Eastern Contra Costa County. Ms. McCall subcontracted with Nancy Shemick to conduct primary data collection in Spanish.

Ms. McCall holds Masters Degrees in Public Health and Public Policy and has worked with community and public health data for over 15 years. She completed the required California SB 697 Community Needs Assessments for Kaiser Permanente hospitals in Contra Costa County in 2004, 2007, and 2010. Ms. McCall has also worked as a consultant to the Contra Costa County Public Health Department as well as several community agencies in Central and Eastern Contra Costa County. She is a skilled data analyst, process and project manager, and group facilitator.

V. Process and Methods Used to Conduct the CHNA

Secondary data

The secondary data used in this CHNA are available through the Kaiser Permanente Community Health Needs Assessment data platform, powered by the Center for Applied Research and Environmental Systems (CARES), and the Institute for People, Places, and Possibility (iP3). These data are organized into six distinct categories: demographics, social and emotional factors, physical environment, clinical care, health behaviors, and health outcomes. A full list of data sources for each of these categories is provided in Appendix II.

The statisticians at the CARES used data from the sources listed in Appendix II to create the Kaiser Permanente Community Health Needs Assessment data platform. The platform analysis of data by geographic areas is limited by the geography for which the data were originally collected.

Health outcomes data from the platform were downloaded for the John Muir Health service area (East Contra Costa County and Central Contra Costa County) and compared to benchmarks defined either by Healthy People 2020, relevant County-level rates or State-level rates. After identifying those outcomes indicators for which the population in the John Muir Health service area that compared poorly to benchmarks, associated indicators of health (health behaviors, clinical care, physical environment and social and economic factors) were reviewed and analyzed to see where these indicators also showed poor performance relative to benchmarks.

Based on the combined analysis described above, a set of community health concerns were identified and served as the basis for a series of facilitated community conversations as described below.

Community Input

John Muir Health, in collaboration with Kaiser Foundation Hospital Antioch and Kaiser Foundation Hospital Walnut Creek, collected community input in two forms. First, the findings regarding community health concerns was gathered from the secondary data (as described above) discussed with groups of people from underserved, minority and low-income populations. The results of these community conversations were considered along with the secondary data, and a set of “community health needs” was identified using the following guidelines:

- The community health need arises from comprehensive review and interpretation of a robust set of data
- More than one indicator and/or data source (i.e., the health need is suggested by more than one source of secondary and/or primary data) confirms the community health need
- Indicator(s) related to the health need perform(s) poorly against a defined benchmark (e.g., state average or HP 2020)
- A group of community members collectively agreed on the level of significance (and inclusion)

The defined list of Community Health Needs was shared and discussed with a large meeting of public health and social service agency leaders who were asked to determine relative priority among the needs using established criteria (described below).

Community Conversations

Community agencies serving vulnerable populations recruited seven groups of community members were. The groups ranged from 12 - 26 participants and were held in communities with high rates of poverty, low rates of high school graduation and relatively low rates of insurance coverage. Four of the seven groups were held in Spanish, two were with primarily African American individuals, and one was with homeless and very low-income residents. The community agencies whom John Muir Health and Kaiser Permanente partnered with for these community conversations recruited participants and provided space. John Muir Health and Kaiser Permanente shared the cost of food and thank-you gifts for the participants. Each hosting agency received an organizational grant as a thank you for their support of the CHNA process. The table below shows the specific partner agencies, the conversation language, the number of individuals present and the target populations from which they were drawn (minority, low-income, chronic conditions, etc...) All of the community conversations took place between October 1, 2012 and October 15, 2012.

TABLE 3: COMMUNITY CONVERSATIONS IN EAST AND CENTRAL CONTRA COSTA COUNTY
(October 1 – 15, 2012)

Partner Agency	Language	Number of Participants	Age Range	Populations Represented
Village Resource Center, Brentwood (October 1, 2012)	Spanish	14	23–65	Latino Low Income Chronic Conditions
Loaves and Fishes, Martinez (October 3, 2012)	English	23	29–65	Homeless Low-income Chronic Conditions
Cambridge School, Concord (October 5, 2012)	Spanish	12	30-49	Latino Low-income
Monument Crisis Center, Concord (October 5, 2012)	Spanish and English	14	65+	Low-income Chronic Conditions
Mind, Body and Soul, Pittsburg (October 8, 2012)	English	26	18-60	Low-income African American
Promotores, Location Varies (October 9, 2012)	Spanish	14	23-79	Latino Chronic Conditions
Solomon Temple, Pittsburg (October 10, 2012)	English	18	30 - 72	African American Chronic Conditions

Expert Stakeholders

The second means of gathering community input included convening a group of public health and social services professionals to discuss and prioritize among the community health needs that emerged from the synthesis of secondary data and community conversations. The stakeholder meeting was held on October 17, 2012. The meeting format included an opening

presentation followed by small group and large group discussions. Participants were provided with demographic data for East and Central Contra Costa County as well as health outcomes data and other related health indicators for all of the health concerns that emerged from analysis of the primary and secondary data. Stakeholders offered recommendations regarding the relative priority of each defined community health need as a result of the small and large group conversations.

Participants, the agency for which they work, and their specific area of expertise are provided in the table below.

TABLE 4: PUBLIC AND COMMUNITY HEALTH EXPERTS CONVENED ON OCTOBER 17, 2012

Name	Agency Represented	Title	Area of Expertise
Alexis Adorador	Familias Unidas	Executive Director	Mental Health Latino Population
Alvaro Fuentes	Community Clinic Consortium	Executive Director	Primary and Specialty care for low-income populations
Audrey Tormey	Youth Homes	Human Resource Director	At-risk Youth
Barbara Hunt	St Vincent de Paul of Contra Costa County	Development Director	Low-income populations
Benjamin Aune	Operation Access	Chief Executive Office	Specialty care for homeless and low-income populations
Christy Kaplan	John Muir Health	Director, Community Health Improvement	Community Health Improvement
Cynthia Belon	Contra Costa Health Services – Behavioral Health Services Administration	Behavioral Services Director	Public Health Behavioral Health Local Health Department
Gennifer Mountain	Meals on Wheels and Senior Outreach Service	Development Director	Senior Services Low Income
Helene Glasser	RotaCare Pittsburg Free Medical Clinic at St Vincent de Paul	Volunteer Nurse	Dental care
Joanne Genet	Public and Environmental Health Advisory Board	Public Health Program Specialist	Public Health Local Health Department
Kate Goheen, MD	Contra Costa Health Services – Concord Health Center	Medical Staff Physician	Public Health Local Health Department
Luz Gomez	Office of Supervisor John Gioia	Deputy Chief of Staff	Public policy Community Health

Name	Agency Represented	Title	Area of Expertise
Mariana Moore	Human Services Alliance of Contra Costa	Executive Director	Low income populations
Nicole Ramos	John Muir Health	Program Manager	Community Education
Rebecca Rozen	Hospital Council of Northern and Central CA	Regional Vice President, East Bay	Community Health
Robin Poppino-Kuntz	Planned Parenthood Shasta Pacific	Regional Director	Women's health Low income primary care
Rosa Maria Stemberg	Public and Environmental Health Advisory Board	Board Member	Public Health
Sandra Washington	John Muir Health	Manager, Women's Health	Community Education and Women's Health
Vic Montoya	Contra Costa Health Services – Mental Health/Older Adult Program	Mental Health Program Chief	Mental Health Seniors Local Health Department
Viola Lujan	La Clinica de La Raza	Director, Contra Costa and Solana Counties	Latino population Low income primary care
William Walker, MD	Contra Costa Health Services	Director and Health Officer	Public Health Local Health Department

The biggest challenge to the clear analysis and interpretation of data was the variation in geographic and racial/ethnic sub-group detail across the relevant indicators of health status and health outcomes. In many cases data are only available at the county level, which makes careful analysis for specific target communities very difficult. Based on the experience of the expert stakeholders as well as the direct information we received from members of under-served or at-risk populations, we are confident that the community health needs we identified have a significant impact on vulnerable populations.

VI. Identification and Prioritization of Community Health Needs

John Muir Health, along with Kaiser Foundation Hospital Antioch and Kaiser Foundation Hospital Walnut Creek identified a list of nine community health needs. The working definition of a community health need is:

- The community health need arises from comprehensive review and interpretation of a robust set of data
- More than one indicator and/or data source (i.e., the health need is suggested by more than one source of secondary and/or primary data) confirms the community health need
- Indicator(s) related to the health need perform(s) poorly against a defined benchmark (e.g., state average or HP 2020)

- A group of community members collectively agreed on the level of significance (and inclusion)

Community Health Needs for the John Muir Health service area were defined and prioritized through the following sequential steps:

1. Analysis of secondary data on health outcomes, identifying all of the health outcomes for which the data showed poor performance relative to benchmark. (see Table 5 below)
2. For each of the health outcomes showing poor performance, related health drivers, behaviors and conditions were also analyzed to determine which are of concern in East and Central Contra Costa County and thus are likely to be factors contributing to the health outcome (See Table 6 below).
3. Community conversations to test the data findings, assess community knowledge about the issue and understand available community resources.
4. A synthesis of all of the data and conversations to define a set of community health needs
5. Discussion and prioritization of the community health needs with expert stakeholders from the Contra Costa County Public Health Department and other agencies serving the target populations (See list of criteria and prioritized community health needs below).

TABLE 5: CENTRAL AND EAST CONTRA COSTA COUNTY POOR HEALTH OUTCOMES AND BENCHMARKS

Health Outcome	Central County	East County	Benchmark
Adult asthma prevalence	15.73%	15.69%	State 13.12%
Age-adjusted asthma discharges per 10,000	n/a	14.98	State 8.9
Asthma discharges as % of total discharges	Blacks 3.26%	1.37% Whites 1.17% Blacks 2.46% Asian 1.52%	State 0.88%
Adult obesity prevalence	n/a	24.2%	State 23.25%
Youth overweight prevalence	Hispanics 15.10%	Blacks 15.53%	
Youth obesity prevalence	Hispanics 36.74%	32.39% Blacks 33.41% Hispanic 38.09%	State 29.81%
Age-adjusted diabetes discharges per 10,000	n/a	10.65	State 10.4
Diabetes discharges as % of total discharges	Blacks 3.26%	0.98% Blacks 1.63%	State 0.86%
Heart disease mortality per 100,000	n/a	104.4	HP2020 <=100.8

Health Outcome	Central County	East County	Benchmark
Stroke mortality per 100,000	n/a	46.6	State 39.5
Breast cancer incidence per 100,000	134.4 Whites 142.5 Blacks 129	136.6 Whites 143.2 Blacks 129.1	State 123.2
Colorectal cancer incidence per 100,000	45.8 Blacks 54.4 Whites 46.5 Hispanic 39.2	46 Blacks 53.1 Whites 47	HP2020 <=38.6
Prostate cancer incidence per 100,000	155.8 Whites 154.9 Blacks 230.8	157.9 Blacks 235.4 Hispanics 143.8	State 143
Lung cancer incidence per 100,000	52.6 Blacks 68.8 Whites 53.9	52.6 Blacks 64.5 Whites 54.8	State 52.4
Suicide death rate per 100,000	10.8	n/a	HP2020 <=10.2
Poor mental health (self-report)	14.80%	14.81%	State 14.26%
Homicide rate per 100,000		9.4	HP2020 <=5.5
HIV discharges as % of total discharges	Blacks 0.61% Hispanic 0.18%	Blacks 0.46% Hispanic 0.17%	State 0.14%
Infant Mortality per 1,000	Blacks 10.01	Blacks 9.99	HP2020 <=6
Age-adjusted preventable hospitalizations rate per 10,000	n/a	135.47	State 83.17
Preventable hospitalization discharges as % of total discharges	White 10.71% Blacks 11.97%	11.35% White 12.19% Blacks 13.6% Asian 9.7%	State 9.88%

CRITERIA USED TO PRIORITIZE AMONG COMMUNITY HEALTH NEEDS

A. Severity of issue and impact of related health outcomes
B. Size of the population affected
C. Effective and feasible interventions exist
D. Existing resources/attention dedicated to the issue
E. Successful solution or intervention has the potential to solve multiple problems
F. Addressing this CHN will have a positive impact on other identified CHNs
G. Opportunity to intervene at the prevention level
H. Community prioritizes issue over others

PRIORITIZED LIST OF COMMUNITY HEALTH NEEDS

1. Increased exercise and activity
2. Healthy eating
3. Primary care services and information (health literacy) including adequate Spanish capacity
4. Economic security
5. Asthma prevention and management
6. Specialty care
7. Affordable, local mental health services
8. Peri-natal care
9. Affordable, local substance abuse treatment services
10. Parenting skills and support

VII. Community assets and resources available to respond to the identified health needs of the community

TABLE 6: SIGNIFICANT COMMUNITY ASSETS AND RESOURCES RELATED TO CHNs

Community Health Needs	Existing Community Assets and Resources (Those in **BOLD** are current JMH Community Partners)
Increased exercise and active living	**JMH Faith & Health Partnership** (seven churches offer exercise and active living programs and services) **Healthy and Active Before 5**
Healthy eating	Food Bank of Contra Costa and Solano County Loaves and Fishes **Village Resource Center**[2] **Meals on Wheels and Senior Outreach Services** **JMH Faith & Health Partnership** (six churches offer healthy food programs and services) **Healthy and Active Before 5**
Primary care services and information (health literacy) including adequate Spanish capacity	**La Clinica de La Raza** **Contra Costa County Health Services Health Centers** Planned Parenthood **RotaCare Clinic** **Sutter Delta Community Clinic** **Ronald McDonald Care Mobile Dental Clinic** **St. Vincent de Paul** **JMH Mobile Health Clinic** **Operation Access** **JMH Faith & Health Partnership** **American Heart Association** **American Diabetes Association** Center for Human Development
Economic Security	SparkPoint Bay Point Opportunity Junction

[2] JMH Community Partner for health need other than one listed

Community Health Needs	Existing Community Assets and Resources (Those in **BOLD** are current JMH Community Partners)
	One Stop Center **Monument Community Partnership & Michael Chavez Center for Economic Opportunity**
Asthma prevention and management	Contra Costa County Public and Environmental Health Advisory Board
Specialty care	**Contra Costa County Health Services Health Centers** **Operation Access**
Affordable, local mental health services	Concord Family Services Center Crockett Counseling Center Families Forward Power Program **NAMI Contra Costa (National Alliance on Mental Illness)** **Putnam Clubhouse**
Peri-natal care	Healthy Start Planned Parenthood Brighter Beginnings First 5 Contra Costa WIC Gold Start
Affordable, local substance abuse treatment services	REACH project Ujima East 12-Step programs (Al-Anon, Alcoholics Anonymous, Narcotics Anonymous) A Chance for Freedom Crossroads Recovery Center
Parenting skills and support	First 5 Contra Costa County Newborn Connections (child abuse prevention council) Brighter Beginnings (teen family support) WIC Center for Human Development

Appendix I: Community Health Need Profiles

1. Increased exercise and activity are needed to improve multiple health outcomes, including obesity, diabetes, cardiovascular disease, and mental health. Rationale: A lack of exercise and physical activity contributes to multiple poor health outcomes. Parents indicated that they are concerned about both safety and cost related to having their children in parks and youth sports		
Indicators of the Need for Increased Exercise and Activity		
Central County	**East County**	**Benchmarks**
Physical Inactivity 18.72% Adults Physically Inactive 22.5% Youth Physically Inactive	Physical Inactivity 19.10% Adults Physically Inactive 39.04% Youth Physically Inactive	Physical Inactivity 22.7% Adults Physically Inactive 37.45% Youth physically Inactive
Park access 65.29% residents within a half mile of a park	Park access 52.09% residents within a half mile of a park	Park access 58.6% residents within a half mile of a park
Direct Negative Health Outcomes from Inadequate Exercise and Activity		
Central County	**East County**	**Benchmarks**
Weight Adult obesity = 23.01% Youth Obesity = 19.43% Hispanic youth overweight = 15.1% Hispanic youth obesity = 36.74% Black youth overweight = 14% Black youth obesity = 21.2%	Weight Adult obesity = 24.2% Youth obesity = 32.39% Hispanic youth overweight = 13.01% Hispanic youth obesity = 38.09% Black youth overweight = 15.53% Black youth obesity = 33.41%	Adult obesity = 23.25% Youth overweight = 14.3% Youth obesity = 29.82%
Diabetes Diabetes discharge rate per 10,000 (age-adjusted) = 4.83 Diabetes discharges as a % of total discharges = 0.59% Diabetes discharges among Blacks as a % of total discharges = 3.26%	Diabetes Diabetes discharge rate per 10,000 (age-adjusted) = 10.65 Diabetes discharges as a % of total discharges = 0.98% Diabetes discharges among Blacks as a % of total discharges = 1.63%	Age-adjusted diabetes discharge rate = 10.4/10,000 Diabetes discharges as a % of total discharges = 0.86%

Cardiovascular Disease Mortality: Heart disease mortality = 88.9/100,000 Stroke mortality = 38.8/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 104.4/100,000 Stroke mortality = 46.6/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 100.8/100,000 Stroke mortality = 39.46/100,000
Indirect Negative Health Outcomes from Inadequate Exercise and Activity		
Central County	**East County**	**Benchmarks**
Mental Health: Poor mental health = 14.80% Poor mental health among Whites = 18.08% Suicide = 10.8/100,000	Mental Health: Poor mental health = 14.81% Whites poor mental health = 16.55% Suicide = 9.9/100,000	Mental Health: Poor mental health = 14.21% Suicide <=10.2/100,000
Primary Data Highlights		
Community sports and other activities for youth have been cut back and/or are too expensive for many families. Parents are concerned about the safety of their children after school and before they get home from work so they do not let them go outside to play		

2. Healthy eating is a significant need in order to address several of the poor health outcomes, including obesity and overweight, diabetes, and cancers. Rationale: Several of the poor health outcomes are related to poor eating habits. Many related economic and social factors show that healthy food is less available to vulnerable populations		
Indicators of the Need for Increased Healthy Eating		
Central County	**East County**	**Benchmarks**
Fruit and Vegetable Consumption 72.07% of adults report inadequate fruit and vegetable consumption 47.45% of youth report adequate fruit and vegetable consumption 1.39% of household expenditures on fruit and veg	Fruit and Vegetable Consumption 72.1% of adults report inadequate fruit and vegetable consumption 49.6% of youth report adequate fruit and vegetable consumption 1.59% of household expenditures on fruit and veg	Fruit and Vegetable Consumption 71.9% of adults report inadequate fruit and vegetable consumption 48.37% of youth report adequate fruit and vegetable consumption 1.64% of household expenditures on fruit and veg
Availability of Healthy Food 21.6 Grocery stores per 100,000 population 12.5 WIC authorized food stores per 100,000 4.85% Population living in food desert 81.1 Fast Food establishments per 100,000	Availability of Healthy Food 20.20 Grocery stores per 100,000 population 12.6 WIC authorized food stores per 100,000 6.51% Population living in food desert 61.2 Fast Food establishments per 100,000	Availability of Healthy Food 22.16 Grocery stores per 100,000 population 15.8 WIC authorized food stores per 100,000 5.71% Population living in food desert 69.37 Fast Food establishments per 100,000
Direct Negative Health Outcomes from Unhealthy Eating		
Central County	**East County**	**Benchmarks**
Weight Adult obesity = 23.01% Youth Obesity = 19.43% Hispanic youth overweight = 15.1% Hispanic youth obesity = 36.74% Black youth overweight = 14% Black youth obesity = 21.2%	Weight Adult obesity = 24.2% Youth obesity = 32.39% Hispanic youth overweight = 13.01% Hispanic youth obesity = 38.09% Black youth overweight = 15.53% Black youth obesity = 33.41%	Adult obesity = 23.25% Youth overweight = 14.3% Youth obesity = 29.82%

Diabetes Diabetes discharge rate per 10,000 (age-adjusted) = 4.83 Diabetes discharges as a % of total discharges = 0.59% Diabetes discharges among Blacks as a % of total discharges = 3.26%	Diabetes Diabetes discharge rate per 10,000 (age-adjusted) = 10.65 Diabetes discharges as a % of total discharges = 0.98% Diabetes discharges among Blacks as a % of total discharges = 1.63%	Age-adjusted diabetes discharge rate = 10.4/10,000 Diabetes discharges as a % of total discharges = 0.86%
Indirect Negative Health Outcomes from Unhealthy Eating		
Cancers: Colorectal Cancer incidence = 45.8/100,000 (White = 46.5; Black = 54.4; Hispanic = 39.2) Prostate cancer incidence = 155.8/100,000 (White = 154.9; Black = 230.8)	Cancers: Colorectal cancer incidence = 46/100,000 (White = 47; Black = 53.1) Prostate cancer incidence = 157.9/100,000 (White = 156.7; Black = 235.4)	Cancers: Colorectal cancer incidence = 38.6/100,000 Prostate cancer incidence = 143/100,000
Primary Data Highlights		
Healthy food is more expensive and less convenient than fast food Healthy food (fresh food) takes more work to prepare. Community members know what they should eat, but they do not limit their diets consistently either because of cost, convenience or knowledge of how to prepare healthier food.		

3. Primary care services and information (health literacy), including adequate Spanish capacity are needed to improve primary care outcomes, including chronic conditions prevention and management. Secondary data indicators show the need to be most significant among Blacks. Rationale: Many health outcomes indicate a need for accessible primary care information and intervention in vulnerable populations. Community members indicated that both access to care and availability of health information limited their ability to receive consistent primary care		
Indicators of the Need for Increased Primary Care Services		
Central County	**East County**	**Benchmarks**
Perinatal Outcomes Percent with late or no prenatal care 13.41% Black Infant Mortality = 10.01/1,000 live births	Perinatal Outcomes Percent with late or no prenatal care 19.04% Black Infant Mortality = 9.99/1,000 live births	Perinatal Outcomes Late or no prenatal care 3.14% Infant Mortality = 6/1,000 live births
Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 72.57/10,000 Preventable hospital discharges as % of total discharges= 9.72% Preventable hospital discharges among Whites as % of total discharges= 10.71% Preventable hospital discharges among Blacks as % of total discharges= 11.97%	Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 135.47/10,000 Preventable hospital discharges as % of total discharges= 11.35% Preventable hospital discharges among Whites as % of total discharges= 12.19% Preventable hospital discharges among Blacks as % of total discharges= 13.6%	Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 83.17/10,000 Preventable hospital discharges as % of total discharges= 9.88%
Direct Negative Health Outcomes from Inadequate Primary Care		
Central County	**East County**	**Benchmarks**
Asthma Hospitalizations Asthma discharge rate (age-adjusted) = 5.93/10,000 Asthma discharges as % of total discharges = 0.75% Asthma discharges among Whites as % of total discharges = 0.66% Asthma discharges among Blacks as % of total discharges = 1.14% Asthma discharges among Asians as % of total discharges = 0.54%	Asthma Hospitalizations Asthma discharge rate (age-adjusted) = 14.98/10,000 Asthma discharges as % of total discharges = 1.37% Asthma discharges among Whites as % of total discharges = 1.17% Asthma discharges among Blacks as % of total discharges = 2.46% Asthma discharges among Asians as % of total discharges = 1.52%	Asthma Hospitalizations Asthma discharge rate (age-adjusted) = 8.9/10,000 Asthma discharges as % of total discharges = 0.88%

Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 4.83 Diabetes discharges as a % of total discharges = 0.59% Diabetes discharges among Blacks as a % of total discharges = 3.26%	Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 10.65 Diabetes discharges as a % of total discharges = 0.98% Diabetes discharges among Blacks as a % of total discharges = 1.63%	Diabetes Hospitalizations Age-adjusted diabetes discharge rate = 10.4/10,000 Diabetes discharges as a % of total discharges = 0.86%
Cardiovascular Disease Mortality: Heart disease mortality = 88.9/100,000 Stroke mortality = 38.8/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 104.4/100,000 Stroke mortality = 46.6/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 100.8/100,000 Stroke mortality = 39.46/100,000
Primary Data Highlights		
Families do not pass along information about chronic disease or other health issues. People need both information and primary care to identify potential concerns and prevent them. Need for affordable primary care relationships that are stable and comprehensive. More and more accurate information about health care and health concerns would help community members know how to identify health issues early and how to prevent them. Spanish speakers indicate that they wait longer for services if they ask for Spanish speaking clinicians or call the Spanish phone lines		

4. Economic security Research has shown that in the United States poverty is one of the key drivers of health status. In the JMH Service Area there is a particular need to address economic security to improve health outcomes in neighborhoods where both poverty and negative health outcomes are seen at disproportionate levels. These areas include the Monument Blvd area of Concord and many neighborhoods in East County. As a result of economic insecurity, individuals and families experience multiple physical, emotional and social stressors, which in turn contribute to negative health outcomes. The stress related to economic insecurity plays a role in mental health and violence, cardiovascular disease, and in poor eating and exercise habits (lack of money and time). Rationale: All community groups and the public health experts felt improved economic security would have a meaningful impact across ALL health outcomes.

Indicators of the Need for Increased Economic Security		
Central County	**East County**	**Benchmarks**
Poverty 13.53% population under 100% FPL Monument Area in Concord 58.63% of population under 200% FPL in the Monument Area in Concord 15.66% Black children living in poverty	Poverty 11.77% population under 100% FPL 45%-55% of population under 200% FPL in the Antioch, Pittsburg and Bay Point 15.52% children living in poverty 42.19% children living in poverty in some areas of Antioch	Poverty 13.71% population under 100% FPL 32.83% population under 200% poverty 19.06% children living in poverty
Education <80% High School Graduation rate in Concord 4th grade reading proficiency = 17.94% not proficient	Education High School Grad rate = 74.18% 4th grade reading proficiency = 38.83% not proficient	Education High School Graduation rate = 82.4% 4th grade reading proficiency = <36.3% not proficient
Direct Negative Health Outcomes from Economic Insecurity		
Central County	**East County**	**Benchmarks**
Mental Health Poor mental health = 14.8% Suicide death rate = 10.8/100,000	Mental Health Poor Mental Health = 14.8% Suicide death rate = 9.9/100,000	Mental Health Poor Mental Health = 14.21% Suicide death rate = <=10.2/100,000
Indirect Negative Health Outcomes from Economic Insecurity		
Central County	**East County**	**Benchmarks**
Cardiovascular Disease Mortality: Heart disease mortality = 88.9/100,000 Stroke mortality = 38.8/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 104.4/100,000 Stroke mortality = 46.6/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 100.8/100,000 Stroke mortality = 39.46/100,000

Weight Adult obesity = 23.01% Youth Obesity = 19.43% Hispanic youth overweight = 15.1% Hispanic youth obesity = 36.74% Black youth overweight = 14% Black youth obesity = 21.2%	Weight Adult obesity = 24.2% Youth obesity = 32.39% Hispanic youth overweight = 13.01% Hispanic youth obesity = 38.09% Black youth overweight = 15.53% Black youth obesity = 33.41%	Adult obesity = 23.25% Youth overweight = 14.3% Youth obesity = 29.82%
Primary Data Highlights		
Economic stress leads to anger, anxiety, depression and violence Parents who are trying to make ends meet will purchase cheap and unhealthy food. Community activities, particularly youth sports, are too expensive – they are working long hours and cannot afford to pay for anything extra.		

5. Asthma prevention and management Asthma is a serious health issue for both children and adults. Asthma can affect the development of young children in multiple ways, both physically and cognitively. Asthma is one of the top health conditions keeping children out of the classroom. For adults, asthma has a negative impact on their ability to perform certain jobs, attendance at work, and productivity. Asthma cannot be cured, so improved prevention and management are needed. Rationale: Chronic asthma contributes to a decreased sense of well-being, and can result in decreased time at school, decreased exercise and activity, and decreased productivity. Community groups all indicated that asthma is a community health issue and that poor air quality is one of the contributing factors

Direct Negative Health Outcomes from Inadequate Asthma Prevention and Management

Central County	East County	Benchmarks
Asthma Asthma prevalence = 15.73% Asthma discharge rate (age-adjusted) = 5.93/10,000 Asthma discharges as % of total discharges = 0.75% Asthma discharges among Whites as % of total discharges = 0.66% Asthma discharges among Blacks as % of total discharges = 1.14% Asthma discharges among Asians as % of total discharges = 0.54%	Asthma Asthma prevalence = 15.69% Asthma discharge rate (age-adjusted) = 14.98/10,000 Asthma discharges as % of total discharges = 1.37% Asthma discharges among Whites as % of total discharges = 1.17% Asthma discharges among Blacks as % of total discharges = 2.46% Asthma discharges among Asians as % of total discharges = 1.52%	Asthma Asthma prevalence = 13.12% Asthma discharge rate (age-adjusted) = 8.9/10,000 Asthma discharges as % of total discharges = 0.88%

Factors Contributing to High Asthma Prevalence and Poor Asthma Management

Central County	East County	Benchmarks
Percent adults who are Smokers = 12.68%	Percent adults who are Smokers =13.00%%	Percent adults who are Smokers = 12.68%
Percent of days exceeding emissions standard = 6.54%	Percent of days exceeding emissions standard = 8.04%	Percent of days exceeding emissions standard = 4.15%

Primary Data Highlights

Living near refineries exposes residents to air pollution

Homes have mold and tobacco smoke reducing air quality

Asthma and other respiratory issues are believed to be a problem for most of the population

In Martinez, the refineries contribute to poor air quality and asthma.

6. Specialty Care is a health need for low-income residents in Eastern Contra Costa. Improved specialty care access could have a positive effect on several of the poor health outcomes, particularly diabetes and HIV hospitalizations, heart disease and stroke mortality, and preventable hospital admissions. Rationale: Antioch health care providers indicate that specialty care access is limited for low-income residents of East Contra Costa County. Low-income residents without insurance receive specialty care from Contra Costa County Regional Medical Center, which is in Martinez and requires long travel times from Eastern areas of the county.		
Negative Health Outcomes Associated with a Need for Specialty Care		
Central County	**East County**	**Benchmarks**
Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 4.83 Diabetes discharges as a % of total discharges = 0.59% Diabetes discharges among Blacks as a % of total discharges = 3.26%	Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 10.65 Diabetes discharges as a % of total discharges = 0.98% Diabetes discharges among Blacks as a % of total discharges = 1.63%	Diabetes Hospitalizations Age-adjusted diabetes discharge rate = 10.4/10,000 Diabetes discharges as a % of total discharges = 0.86%
HIV Hospitalizations (non-Whites; Concord): HIV discharges among Blacks as % of total discharges = 0.61% HIV discharges among Hispanics as % of total discharges = 0.18%	HIV Hospitalizations HIV discharges among Blacks as % of total discharges = 0.46% HIV discharges among Hispanics as % of total discharges = 0.17%	HIV Hospitalizations HIV Discharges as a % of total discharges = 0.14%
Cardiovascular Disease Mortality: Heart disease mortality = 88.9/100,000 Stroke mortality = 38.8/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 104.4/100,000 Stroke mortality = 46.6/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 100.8/100,000 Stroke mortality = 39.46/100,000
Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 72.57/10,000 Preventable hospital discharges as % of total discharges= 9.72% Preventable hospital discharges among Whites as % of total discharges= 10.71% Preventable hospital discharges among Blacks as % of total discharges= 11.97%	Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 135.47/10,000 Preventable hospital discharges as % of total discharges= 11.35% Preventable hospital discharges among Whites as % of total discharges= 12.19% Preventable hospital discharges among Blacks as % of total discharges= 13.6%	Preventable Hospitalizations Preventable discharge rate (age-adjusted) = 83.17/10,000 Preventable hospital discharges as % of total discharges= 9.88%
Primary Data Highlights		

Unnecessary hospitalizations and emergency room visits are the result of a lack of specialty care in the Antioch area and further east in the county. Specialty care services for most low-income individuals require travel to Martinez, which poses significant transportation challenges to individuals living in East County.

7. Affordable, local mental health services Mental health needs and services are a significant concern for residents in the JMH service area. Almost 15% of adults indicate that they have poor mental health. Exacerbating the situation, there are social and cultural barriers to accessing mental health services, which contribute to crises that are seen in emergency departments rather than in community settings. Community members and providers indicate that mental health services are most likely to be used when they are in the local community, financially accessible and culturally relevant. Poor mental health can both result from, and contribute to, other poor health and social conditions. Rationale: Mental health status has an impact through intentional violence (suicide, homicide) as well as general quality of life and ability to be productive.

Indicator of the Need for Mental Health Services		
Central County	**East County**	**Benchmarks**
Poor Mental Health = 14.8% Poor mental health for Whites = 18.08%%	Poor mental health = 14.81% Poor mental health for Whites = 16.55%	Poor mental health = 14.21%
Negative Health Outcomes of Inadequate Mental Health Services		
Central County	**East County**	**Benchmarks**
Suicide Death rate = 10.8/100,000	Suicide Death rate = 9.9/100,000	Suicide death rate <=10.2/100,000
Homicide death rate = 2.8/100,000	Homicide death rate = 9.4/100,000	Homicide death rate = <5.5/100,000

Primary Data Highlights

Families are under too much financial stress and need access to MH services.

Youth in particular need to learn to cope with anger and stress

There are not enough providers of low-cost or free mental health services.

Parents need mental health support to keep an even keel and support children without resorting to alcohol or violence.

8. Peri-Natal Care is a significant need for Black residents in JMH service area. Increased access to and use of pre-natal and peri-natal care could decrease infant mortality among Blacks. In the Antioch area, over 19% of mothers have late or no pre-natal care and in the Monument Area of Concord 38.9% of mothers have late or no prenatal care. This is linked to the need for primary care. Rationale: Black infant mortality continues to be disproportionately high.		
Indicators of the Need for Peri-Natal Care		
Central County	**East County**	**Benchmarks**
13.41% of mothers received late or no prenatal care In the Monument Area of Concord, 38.9% of mothers received late or no prenatal care	19% of mothers received late or no prenatal care in Antioch	3.14% of mother received late or no prenatal care
Negative Health Outcomes Related to Inadequate Peri-natal Care		
Central County	**East County**	**Benchmarks**
Black infant mortality = 10.01/1,000 live births	Black infant mortality = 9.99/1,000 live births	Infant mortality = <6/1,000 live births
Primary Data Highlights		
"Black teens are having babies before they should." "Sometimes they do not tell anyone until it is almost time to deliver"		

9. Affordable, local substance abuse treatment services are needed to address alcohol use as well as the use of other drugs. Rationale: Heavy alcohol consumption is associated with several of the poor health outcomes. Community members indicate that illegal drug use is also common and related to poor mental health and violence.		
Indicators of a Need for Substance Abuse Services		
Central County	**East County**	**Benchmarks**
18.94% of adults are considered to be heavy drinkers	19% of adults are considered to be heavy drinkers	16.8% of adults are considered to be heavy drinkers
Negative Health Outcomes Associated with Substance Abuse (Alcohol Abuse)		
Central County	**East County**	**Benchmarks**
Poor mental health = 14.8%	Poor mental health = 14.81%	Poor mental health = 14.21%
Homicide death rate = 2.8/100,000	Homicide death rate = 9.4/100,000	Homicide death rate = <5.5/100,000
Cardiovascular Disease Mortality: Heart disease mortality = 88.9/100,000 Stroke mortality = 38.8/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 104.4/100,000 Stroke mortality = 46.6/100,000	Cardiovascular Disease Mortality: Heart disease mortality = 100.8/100,000 Stroke mortality = 39.46/100,000
Cancers: Breast Cancer incidence = 134.4/100,000 Lung Cancer incidence = 52.6/100,000 Colorectal Cancer incidence = 45.8/100,000	Cancers: Breast cancer incidence = 136.6/100,000 Lung cancer incidence = 52.6/100,000 Colorectal cancer incidence = 46/100,000	Cancers: Breast cancer incidence = 123.2/100,000 Lung cancer incidence = 52.4/100,000 Colorectal cancer incidence = 38.6/100,000
Primary Data Highlights		
Many people drink to relax or keep themselves from thinking of the economic issues in their lives Drinking alcohol is common Teens and adults all drink – it is acceptable. There are drugs available and used in the schools		

10. Parenting skills and support were identified as a need by all of the community groups. The need relates to understanding how to raise children in a healthy way, using effective discipline as well as good cooking and eating habits. Parents also wanted skills and support for caring for children with diabetes and asthma, and addressing mental health and substance use/abuse issues with their children. Rationale: Parents felt that improved skills and support is a critical need in families that are isolated (immigrants in particular) or where parents are struggling to manage jobs, commutes and children

Negative Health Outcomes that May Result from Inadequate Parenting Skills and Support		
Central County	**East County**	**Benchmarks**
Poor mental health = 14.8%	Poor mental health = 14.8%	Poor mental health = 14.21%
Homicide death rate = 2.8/100,000	Homicide death rate = 9.4/100,000	Homicide death rate = <5.5/100,000
Suicide Death rate = 10.8/100,000	Suicide Death rate = 9.9/100,000	Suicide death rate <=10.2/100,000
Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 4.83 Diabetes discharges as a % of total discharges = 0.59% Diabetes discharges among Blacks as a % of total discharges = 3.26%	Diabetes Hospitalizations Diabetes discharge rate per 10,000 (age-adjusted) = 10.65 Diabetes discharges as a % of total discharges = 0.98% Diabetes discharges among Blacks as a % of total discharges = 1.63%	Diabetes Hospitalizations Age-adjusted diabetes discharge rate = 10.4/10,000 Diabetes discharges as a % of total discharges = 0.86%
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Primary Data Highlights

Parents are struggling to keep above water economically and do not have enough support to also be good parents. It is easier to give-in to their children when they are tired and under stress. If they do not give in, they get angry.

Parents are worried about the stress that their lack of money and availability places on their children.
Parents are concerned that they do not have the resources or knowledge to keep their children safe and healthy.
Parents want more help, particularly those who do not have family members nearby and/or who feel isolated in their communities and neighborhoods.

Appendix II: Data Sources

(1) **Demographics**. The source for demographic data is the US Census Bureau, 2006-2010 American Community Survey 5 year estimates.

(2) **Social and Economic Factors.** These data were from the following sources:
- (a) US Census Bureau, American Community Survey 2006-2010 5-year estimates and 2008-2010 3-year estimates
- (b) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
- (c) US Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2009-2010 and Local Education Agency (School District) Universe Survey Drop-out and Completion Data, 2008-2009
- (d) States' Department of Education, Student testing Reports, 2011
- (e) US Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009
- (f) US Bureau of Labor Statistics, July 2012 Local Area Unemployment Statistics
- (g) US Federal Bureau of Investigation, Uniform Crime Reports, 2010

(3) **Physical Environment**, including data from the following sources:
- (a) US Census Bureau, ZIP Code Business Patterns, 2009 and County Business Patterns, 2010
- (b) California Department of Alcoholic Beverage Control, Active License File, April 2012
- (c) US Census Bureau, 2010 Census of Populations and Housing, Summary File 1;Esru's USA Parks layer (compilation of Esri, National Park Services and TomTom source data) 2012
- (d) Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008
- (e) US Department of Agriculture, Food Desert Locator, 2009
- (f) Walkscore.com 2012
- (g) US Department of Agriculture, Food Environment Atlas, 2012

(4) **Clinical Care** data from the following sources:
- (a) California Health Interview Survey (CHIS) 2005, 2007, and 2009

(b) US Health Resources and Services Administration Area Resource File 2009 (as reported in the 2012 County Health Rankings) and Health Professional Shortage Area File 2012
(c) Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality 2003-2007,
(d) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
(e) US Health Resources and Services Administration Centers for Medicare and Medicaid Services, Provider of Service File, 2011
(f) California Department of Public Health Birth Profiles by ZIP code, 2010
(g) California Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2010

(5) **Health Behaviors** data from the following sources:
(a) California Health Interview Survey (CHIS) 2009
(b) Nielsen Claritas SiteReports Consumer Buying Power, 2011
(c) California Department of Public Health, In-Hospital Breastfeeding Initiations Data, 2011
(d) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
(e) California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011

(6) **Health Outcomes** data, based on incidence and mortality.
(a) California Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2010
(b) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
(c) Centers for Disease Control and Prevention and the National Cancer Institute: State Cancer Profiles, 2005-2009
(d) California Department of Public Health, Death Statistical Master File, 2008-2010
(e) Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009
(f) Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
(g) California Health Interview Survey (CHIS) 2009
(h) California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011
(i) Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As reported in the 2012 County Health Rankings)