2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Vallejo

License number: 110000026

Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit CHNA Report for KFH-Vallejo

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Health

For more than 70 years, Kaiser Permanente has been dedicated to providing high quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at www.kp.org/chna.

D. Kaiser Permanente's approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 130 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-Vallejo will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

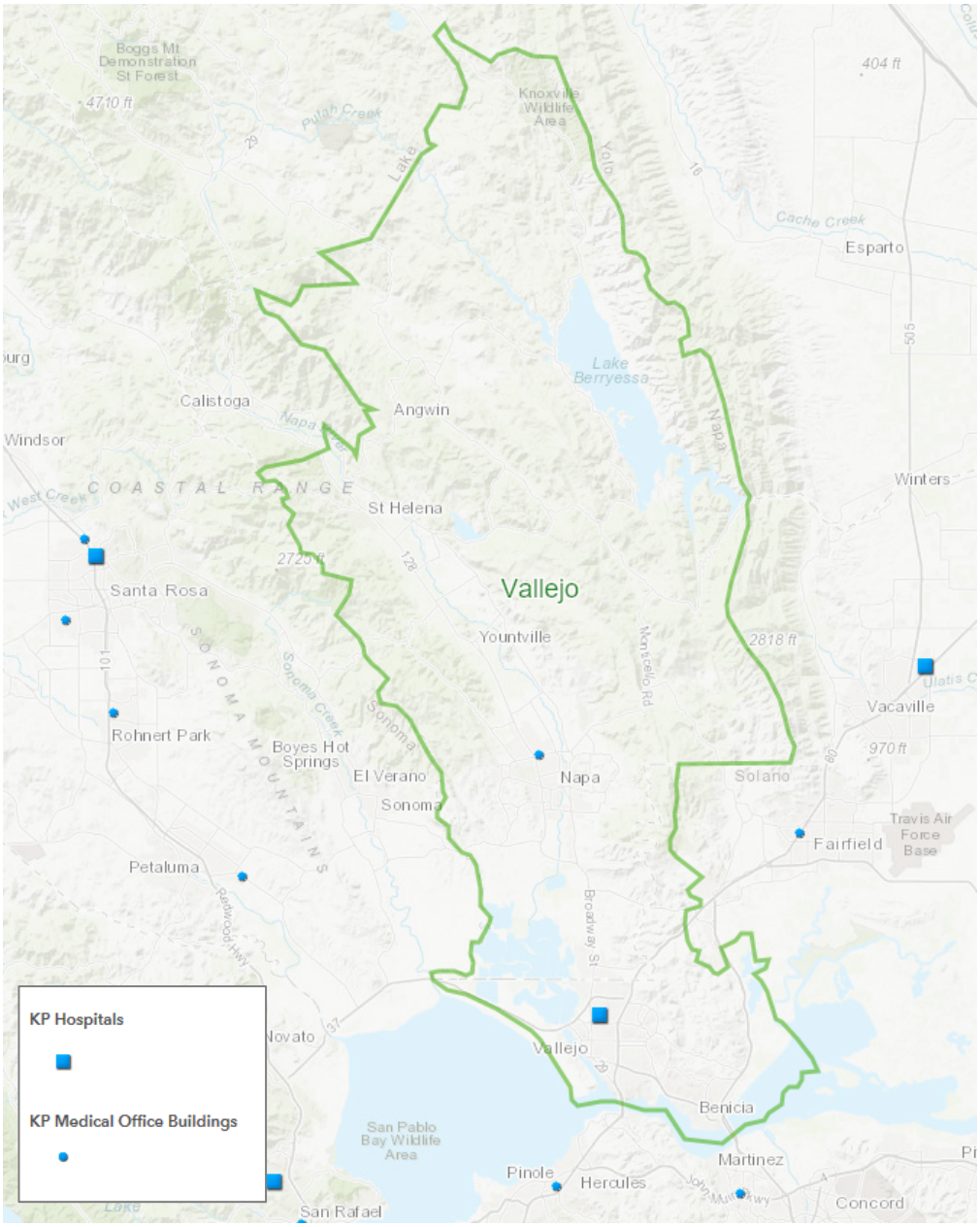
II. Community served

A. Kaiser Permanente's definition of community served

Kaiser Permanente defines the community served by a 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.

B. Map and description of community served

i. Map



KFH-Vallejo Service Area

ii. Geographic description of the community served

The KFH-Vallejo service area includes communities in Napa and Solano counties. The major communities are Benicia and Vallejo in Solano County and American Canyon, Calistoga, Napa, Oakville, Rutherford, St. Helena, and Yountville in Napa County. The service area is further

defined by Highway 29 leading from Vallejo to Napa and Interstate 80 in Solano County.

iii. Demographic profile of the community served

Demographic profile: KFH-Vallejo

Race/ethnicity		**Socioeconomic Data**	
Total Population	284,616	Living in poverty (<100% federal poverty level)	12.2%
Asian	15.0%	Children in poverty	15.6%
Black	10.8%	Unemployment	3.6%
Native American/Alaska Native	0.6%	Uninsured population	9.9%
Pacific Islander/Native Hawaiian	0.5%	Adults with no high school diploma	13.4%
Some other race	8.4%		
Multiple races	5.6%		
White	59.0%		
Hispanic/Latino	27.8%		

III. Who was involved in the assessment?

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

KFH-Vallejo worked with both hospital and other partner organizations with similar service areas in Napa and Solano counties to develop a coordinated approach to primary data collection, and then collaborated within the same group to determine the list of significant health needs based on both primary and secondary data.

Collaborative hospital partners:

1. Kaiser Foundation Hospital–Vallejo
2. Sutter Health[1]

Additional partners:

1. Napa County Health and Human Services
2. Solano County Health and Social Services

[1] *Sutter Health and their consultant Community Health Insights (CHI) collaborated on the data collection and identification of health needs phases of the assessment, but had a separate process for health need prioritization and reporting.

3. Community Health Insights (CHI)*

KFH-Vallejo also engaged representatives of Live Healthy Napa County (LHNC) as key informants through a group interview. LHNC is a public-private partnership bringing together representatives from public health, business, government, education, nonprofits, and the broader community.

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

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts—including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other Kaiser Foundation Hospital service areas in Roseville, Sacramento, San Bernardino, San Rafael, Santa Rosa, South Sacramento, and Vacaville.

IV. Process and methods used to conduct the CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KFH-Vallejo used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources.

KFH-Vallejo also used additional data sources beyond those included in the CHNA Data Platform. Napa and Solano county health department partners shared additional data from their internal platforms and studies, and other online sources were referenced (e.g., kidsdata.org, California Healthy Places Index).

For details on specific sources and dates of the data used, please see Appendix A. Secondary data sources and dates.

ii. Methodology for collection, interpretation, and analysis of secondary data

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KFH-Vallejo also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners (e.g., county health departments, service providers, and other stakeholders) provided additional data (e.g., frequency tables, reports, etc.) to inform both the identification and prioritization of health needs across the service area (see Appendix A. Secondary data sources and dates for a list of additional data sources). This data provided additional context and, in some cases, more up-to-date statistics to the indicators included in the CHNA Data Platform. The Harder+Company team did not conduct additional analysis on secondary data shared by CHNA partners as the data was already disaggregated across several variables including region, race/ethnicity, and age. Each health need profile includes a reference section with a detailed list of all secondary data sources used in that profile to inform the prioritization of health needs (see Appendix C. Health Need Profiles).

B. Community input

i. Description of who was consulted

A broad range of community members provided input through key informant interviews, group interviews, and focus groups. The research team consulted individuals with knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, the team gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., race/ethnic minorities and individuals experiencing homelessness). For a complete list of communities and organizations that provided input, see Appendix B. Community input tracking form.

ii. Methodology for collection and interpretation

In an effort to include a wide range of community voices from individuals with diverse perspectives and experiences and those who work with or represent underserved populations and geographic communities within the KFH-Vallejo service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need

communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries. (For a complete list of participating organizations, see Appendix B. Community input tracking form).

The consulting team developed interview and focus group protocols, which the CHNA Collaborative reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. The research team also asked participants to describe any new or emerging health issues and to prioritize the top health concerns in their community.

We conducted key informant interviews over the phone by a single interviewer, while provider group interviews and community focus groups were in person and completed by both a facilitator and notetaker. When respondents granted permission, the team recorded and transcribed all interviews.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended health care solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the team finalized the codebook to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

In comparison to secondary (i.e., quantitative) data sources, primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

Harder+Company also coordinated with Sutter Health's CHNA consultant, Community Health Insights (CHI) for data collection in regions where service areas overlapped. CHI and Harder+Company conducted those activities independently and then shared transcripts (respondents were informed of this information sharing in the protocol). CHI recorded all data collection activities, which the Harder+Co team then had transcribed through an independent transcription service. In cases where participants did not give permission to record, CHI shared

their notes from the interview with the Harder+Company team who then coded the notes through the Atlas.ti platform. For the data collection activities that CHI conducted in Spanish, notes were documented in English by the interviewer and therefore no quotations were available.

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH-Vallejo had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

The KP CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that perform poorly compared to the state flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-

based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, the team made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, the team conducted focus groups in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.

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, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

Extensive secondary quantitative data (from the Kaiser CHNA Data Platform and other publically available data), as well as primary qualitative data collected from key informant interviews, provider group interviews, and focus groups, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews, see Section IV B ii for details). Part of the analysis included grouping individual qualitative themes (e.g., green spaces, safe spaces, food security, obesity, diabetes) into health need categories (e.g., healthy eating and active living) similar to those identified in the Kaiser CHNA Data Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as **high need based on secondary data** from the Kaiser CHNA Data Platform if it met *any* of the following conditions:
    - *Overall severity:* at least one indicator Z-score within the health need was much worse or worse than benchmark.
    - *Disparities:* at least one indicator Z-score within the health need was much worse or worse than benchmark for any defined racial/ethnic group.
    - *External benchmark:* indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020).
2. A health need category was identified as **high need based on primary data** if it was identified as a theme in a majority of key informant interviews, group interview, *and* focus groups.
3. Classification of primary and secondary data was combined into the final health need category using the following criteria:
    - **Yes**: high need indicated in *both* secondary and across *all types* of primary data. Kaiser Permanente and CHNA partners then confirmed these health needs.
    - **Maybe**: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with Kaiser Permanente and CHNA partners to determine final status.
        - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
        - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
    - **No**: high need indicated in only one or fewer sources.

B. Process and criteria used for prioritization of health needs

For each identified community health need, Harder+Company developed a three- to four-page written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers, residents, and others) to prioritize the health needs. (The meeting began with a brief presentation of each health need profile,

highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity:** Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.
- **Clear Disparities or Inequities:** Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
- **Impact:** The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

During the small-group discussions, meeting participants referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-8 (*1=lowest priority*; *8=highest priority*). Ranking required that no two health needs were scored the same within each criterion. Harder+Company tallied the votes after the prioritization meeting and shared the final ranked list of health needs with participants via email.

C. Prioritized description of all the community needs identified through the CHNA

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see B. Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to Appendix C. Health Need Profiles.

1. **Violence and Injury Prevention:** Direct and indirect exposure to violence and injury, such as domestic and community violence have significant effects on well-being and health. The Vallejo service area overall has a slightly higher rate of violent crime than the state average, and is more concentrated in the Solano County region of the service area. Focus group and interview respondents discussed a deeply embedded environment of trauma and violence in the community, including among youth, and disparities across regions and demographics. Service providers identified North Vallejo as a particularly unsafe region, and explained that there is a long history of gang-related violence in urban pockets such as the “Crest” neighborhood. Solano County service providers also discussed the incidence of human trafficking and prostitution rings, and emphasized that it impacts youth from families across all economic classes.

Domestic violence is particularly prevalent in the Solano County portion of the service area as indicated by hospitalizations due to domestic violence that occur at a rate of 12 per 100,000 in Solano County compared to a rate of 5 for the state and 3 in Napa County specifically (Vallejo service area rate is 8).[2] Service providers in Napa County also commented on the depth of impact that domestic violence can have on one's health and daily routine, including as it relates to one's comfort to use public transportation with the fear they may encounter a perpetrator or their relative. Economic insecurity can also increase cases of both violence and injury. Deaths due to injury, impaired driving, motor vehicle crashes, and suicide are also all higher in the Vallejo service area compared to the state average. Motor vehicle crash deaths are highest among the Non-Hispanic Black population at a rate of 12 per 100,000 population compared to a rate of five for Non-Hispanic Asians.[3] Non-Hispanic Whites and Blacks have the highest rates of suicide mortality in the Vallejo service area at 17 per 100,000 population and 12 per 100,000 population respectively.[4] Community members, including service providers, shared concern of recent shootings in the community, unsafe public parks, and childhood trauma stemming from abusive family environments.

2. **Education:** Education not only includes one's means to academic achievement but also the support and resources to enhance one's educational development, which is connected to longer-term health outcomes. It is a key driver in achieving both health and economic equity. The Vallejo service area fares worse than the state across educational indicators such as reading proficiency, expulsions, and suspensions. For example, reading proficiency in the service area is at 34 percent and is lower than both the average for California (40 percent), and also compared to Napa County (44 percent)—indicating that low reading proficiency is more pronounced in the Solano County region of the service area.[5] Evident racial disparities exist, including that Hispanic, Black, and Asian adults were more likely not to have completed a high school diploma compared to Non-Hispanic Whites. Math proficiency scores for third graders in the Vacaville City Unified School District also reflect disparities across race, with only 20 percent of Black/African American students meeting or exceeding mathematic standards compared to over half of Asian students (57 percent).[6] The highest percentage of adults without a high school diploma in the region is among Hispanic/Latinos at 37 percent, more than twice that of the Vallejo service area average (13 percent) and state average (18 percent).[7] Community members provided context about these educational gaps, and purposefully mentioned barriers in translation services and the need for children/youth support programs outside of school.

[2] California EpiCenter. (2013-2014).
[3] National Vital Statistics System. (2011-2015).
[4] Same as above.
[5] EDFacts. (2015-2016). *National Center for Education Statistics.*
[6] CAASPP Smarter Balanced Test. (2017-2018). *California Department of Education.*
[7] American Community Survey. (2012-2016).

3. **Economic Security:** Economic security is one of the most widely recognized social determinants of health that affects countless health needs for the Vallejo service area community. Even though the Vallejo service area has a lower degree of economic inequality than California as a whole, many community members noted the sizable low-income population that feels largely "unseen" within the wealthy counties, particularly Napa. Further, financial distress is concentrated among communities of color. The prevalence of Black children below the federal poverty line (36 percent) is higher than the California average (33 percent), and at least twice that of other race/ethnic populations in the service area.[8] Similarly, Black and Hispanic adults make up a disproportionate number of supplemental nutrition assistance program (SNAP) recipients at 20 percent and 12 percent respectively.[9] Focus group and interview respondents also mentioned the unequal geography of economic troubles. Urban areas face the pressures of gentrification, while rural areas lack adequate public transportation to access employment opportunities. Service providers noted that Napa County has become more and more unaffordable, displacing much of the lower income population. Vallejo service area providers also identified Benicia as having an "unseen" but large population of low-income community members.

4. **Healthy Eating and Active Living (HEAL):** Healthy Eating and Active Living (HEAL) relates to Vallejo service area residents' ability to shape health outcomes through a focus on nutrition and exercise. Regular physical activity can help control weight, reduce depression and anxiety, and reduce risks for chronic diseases. Similarly, healthy eating behaviors are associated with health benefits including lower risk for obesity and related chronic diseases. The Vallejo service area scores more poorly than the state of California on many HEAL indicators such as diabetes management, the rate of physical inactivity, and proximity to walkable destinations. For example, physical inactivity among youth is 46 percent in the service area compared to 38 percent for the state average, and is highest among Black youth at 61 percent, followed by Hispanic (49 percent) and Filipino youth (46 percent).[10] Blacks residents have the highest rate of heart disease mortality (97 per 100,000 population) followed by Whites (84 per 100,000), Asians (55 per 100,000), and then Hispanic/Latino (49 per 100,000) populations.[11] Similar racial disparities are seen among the rates of stroke mortality. Service providers also noted that diabetes, chronic obstructive pulmonary diseases (COPD) and cardiovascular diseases (CVD) are common among older adults. During interviews, service providers also highlighted the relationship between economic deprivation and obesity, which is correlated with CVD, stroke, and diabetes. Napa County service providers mentioned that middle and high school students from economically disadvantaged families have higher percentages of obesity compared to students in the same grades from higher income families. Both focus group and interview respondents pointed to equitable solutions like improving built environments,

[8] American Community Survey. (2012-2016).
[9] Same as above
[10] FITNESSGRAM® Physical Fitness Testing. (2016-2017).
[11] National Vital Statistics System. (2011-2015).

increasing access and affordability of healthy food, and increasing education on nutrition.

5. **Housing:** Access to safe, secure, and affordable housing is an important social determinant of health. Families with fewer financial resources are more likely to experience substandard housing conditions and the associated risks. The Vallejo service area has a lower proportion of cost-burdened households and a less severe housing problem when compared to the state of California. However, the region reflects clear disparities across race and ethnicity, and at the census tract level. Across the region, many families with young children are paying more than 30 percent of their income on housing; this is most pronounced for the Hispanic/Latino population in Napa County (74 percent) and African American/Black population in Solano County (75 percent).[12] Communities with severe housing problems—wherein housing or quality of life is considered substandard (e.g., low quality kitchen/plumbing, overcrowded, and/or severely cost-burdened at more than 50% of monthly income)—are concentrated in census tracts within and around Vallejo (Solano County) near River Park and in Napa on both sides of CA 29.[13] Focus group and interview respondents provided additional insights; they identified social tensions and stigma on the issue of homelessness, cost-prohibitive rental fees on top of rising housing costs, as well as an influx of residents from other regions that seems to be connected to less available low-income housing options (e.g., Section 8). Service providers and community members also noted that housing barriers are a concern for the increasing older adult population, and suggested home-sharing programs as one option to consider.

6. **Access to Care:** Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. It is also one of the main drivers in achieving health equity. The service area does perform better than the state average in terms of number of physicians proportional to the population. However, the Vallejo service area fares worse than the state across important indicators such as lung cancer incidence and the percentage of Medicare beneficiaries recently having a primary care visit. Focus group and interview respondents also identified a shortage of dental health services specifically for low-income community members.

   Access to care, such as preventative screenings and cancer treatment can help patients live longer and with higher quality of life—though it may not be accessible to all community members alike based on income or other factors. Lung cancer incidence is highest among the non-Hispanic Black population at 187 per 100,000 population, compared to 165 per 100,000 for the Vallejo service area on average, and 147 per

[12] Housing Stability and Family Health: An Issue Brief; Bay Area Regional Health Inequities Initiative (BARHII), Federal Reserve Bank of San Francisco; extra analysis by BARHII and Alameda County Public Health of the American Community Survey PUMS data. (2016).
[13] Consolidated Planning/CHAS Data. (2011-2015).

100,000 population for the state.[14] Additionally, existing racial disparities in accessing care are evident in the Vallejo service area. For example, White Medicare patients with diabetes were more likely to receive a blood sugar test compared to their Black peers, and children of color are more likely to be uninsured compared to White children. The highest percentage of uninsured children is among Hispanics (15 percent) and Native Hawaiian/Pacific Islanders (13 percent).[15] Community members, including service providers, offered context on some of the key gaps in accessing services such as specific barriers for those who are undocumented, long wait times, unique challenges facing the aging population, and geographic disparities resulting in worse health outcomes in the north, south, and downtown areas.

7. **Behavioral Health:** The mental health of Vallejo service area residents shapes many aspects of their well-being, from substance use patterns to interactions with health services. The Vallejo service area rates more poorly than the state on several indicators related to substance use including the rate of excessive drinking, driving under the influence, and lung cancer (related to tobacco use). For example, the percent of impaired driving deaths is 34 percent in the service area compared to the state average of 29 percent.[16] The impacts of behavioral health are felt unevenly across populations, with Non-Hispanic Whites showing greater suicide mortality at a rate of 17 per 100,000 population—roughly twice the rate of Hispanic and Non-Hispanic Asian populations.[17] Focus group and interview respondents also raised concern about suicide deaths and depression among youth. Service providers are particularly concerned about the mental health needs of Native Americans and increased anxiety among the undocumented population. They highlighted the important role of counselors practicing trauma-informed care in addressing these needs, and the demand for culturally competent care across sectors, which is particularly important in health care environments.

8. **Maternal and Infant Health:** Mothers in the Vallejo service area face many barriers related to their own well-being and that of their children. The rate of infant deaths in the service area is higher than the California average, and infant mortality disproportionately impacts people of color. African American/Black mothers have the highest percentage of infants born at a low birth weight in Solano County at nearly 12 percent, followed by Asian/Pacific Islanders at 8 percent.[18] Solano County service providers noted that over the last ten years, health officials and community providers have made a concerted effort to increase prenatal care and have seen an increase in rates over time, especially for the Medi-Cal population. The Vallejo service area also does has a lower teen birth rate than the California average, which can indicate greater chances for economic security and pregnancy preparedness. However, community stakeholders described inconsistencies in reproductive health care such as

[14] State Cancer Profiles. (2010-2014).
[15] American Community Survey. (2012-2016).
[16] Fatality Analysis Reporting System. (2011-2015).
[17] National Vital Statistics System. (2011-2015).
[18] Kidsdata.org. (2013).

discrimination against African American residents. Napa county service providers also noted that the comprehensiveness of reproductive health care is inconsistent depending on the provider, with barriers to contraception and termination services. Some potential pathways forward related to maternal and infant health include more work- and community-based childcare options in addition to improved reproductive health services for teens.

D. Community resources potentially available to respond to the identified health needs

The service area for KFH-Vallejo contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

Examples of community resources available to respond to each community-identified health need, as identified in qualitative data, are indicated in each health need brief found in Appendix C. Health Need Profiles In addition, a list of community-based organizations and agencies that participated in the CHNA process can be found in Appendix B. Community input tracking form. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference https://www.211ca.org/ and enter the topic and/or city of interest.

VI. KFH-Vallejo 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Vallejo's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information KFH-Vallejo's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit www.kp.org/chna. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Vallejo in the 2016 Implementation Strategy Report.

1. Healthy Eating & Active Living
2. Access to Care and Coverage
3. Behavioral Health
4. Community & Family Safety

KFH-Vallejo is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-Vallejo tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-Vallejo had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report KFH-Vallejo will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-Vallejo awarded 258 grants amounting to a total of $11,614,062.17 in service of 2016 health needs. Additionally, KFH Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Vallejo service area. During 2017-2018, a portion of money managed by this foundation was used to award five grants totaling $5,349,449.40 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities, and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-Vallejo leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report below.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-Vallejo engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Examples of collaborations and partnerships are included in the section of the report below.

C. 2016 Implementation Strategy evaluation of impact by health need

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Access to Care and Coverage	*During 2017 and 2018, KFH-Vallejo awarded 59 grants totaling $4,200,274.27 that address Access to Care in the KFH-Vallejo service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 19,586 and 18,693 Medi-Cal members respectively totaling $42,901,096.50 worth of care. KP also provided a total of $11,306,523.27 of Medical Financial Assistance (MFA) to 5,844 individuals in 2017 and 3,807 individuals in 2018.
		Access to care programs. KFH-Vallejo awarded a $49,212 grant to La Clínica de La Raza to expand its promotores model to provide health care navigation support for vulnerable populations and increase their utilization of health care services. Through this funding, 515 people have received navigation support.
		Access to primary and specialty care: KFH-Vallejo awarded a $50,000 grant to Community Health Initiative Napa County (CHI) for a project that aims to increase access to medical, dental, vision, and mental health care for Napa County residents. CHI will screen people for potential mental health referrals, and train and certify key staff from partner agencies in affordable health insurance access. More than 5,000 residents have been screened year to date and 15 people have been trained and certified to support health insurance access.
		Operation Access: Operation Access received a $350,000 grant (evenly split between 15 KFH hospital service areas) to coordinate donated medical care and expand access to care for low-income uninsured adults in the Bay Area through its volunteer and hospital network. 669 staff/physician volunteers provided 650 surgical and diagnostic services at 11 facilities, reaching 521 adults.
		211: United Way of the Bay Area received a $95,000 grant (evenly split between 8 KFH hospital service areas) to support 211's services that provide health and human services resources and information for people who call, text, or visit the website. In the six Bay Area counties, it is expected that the 211 program will answer 50,000 calls and texts and 60,000 users will visit the 211 Bay Area website.
Healthy Eating Active Living	*During 2017 and 2018, KFH-Vallejo awarded 49 grants totaling $770,081.76 that address Healthy Eating Active Living in the KFH-Vallejo service area*	Food Insecurity: Community Action Napa Valley Food Bank received a $35,807 grant for its Aim for Health program to provide access to fresh produce for vulnerable populations. More than 67,547 pounds of food have been distributed, and the program is on target to exceed 100,000 pounds by the end of the grant term.
		Nutrition and physical activity classes: Vision y Compromiso was awarded a $30,000 grant to promote healthy eating and active living through 6 to 8 nutrition/cooking classes and 2 to 4 physical activity classes (bailoterapia) to reach 162 to 250 Latino adults in Napa County who are obese/overweight and/or at risk for chronic disease. In Q1 of grant funding, 27 residents completed a multi-session behavior modification program to reduce their risk for chronic disease. The goal is that at least 80% of participants will increase physical activity levels, and improve their blood pressure rate and body mass index.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		Boys and Girls Club: Boys and Girls Clubs of Napa Valley was awarded a $30,000 grant for The Triple Play program to improve Club members knowledge of healthy habits, good nutrition, and physical fitness; increase the number of hours per day they participate in physical activities; and strengthen their ability to interact positively with others and engage in healthy relationships. At this writing, 432 children are actively participating in the program at four locations.
		CalFresh: Ole Health received a $95,000 grant to build staff capacity to conduct CalFresh outreach and enrollment and strengthen the outreach and application assistance infrastructure. Populations of focus include low income families, seniors, and immigrants. Ole Health expects to provide training to 120 staff and reach 2,000 individuals through education and outreach.
		Parks: Play 4 All Park, Inc. received a $75,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to support the creation of an inclusive park facility that serves children of all abilities and disabilities ensuring that children have a safe place to play. The park will include two dog parks, two baseball fields, a splash pad, and an 8,000 square-foot play structure. Once completed, it is expected that parents and families will travel to this park from all over Solano County because of the unique play facilities.
Mental Health & Wellness	*During 2017 and 2018, KFH-Vallejo awarded 48 grants totaling $870,834.06 that address Mental Health and Wellness in the KFH-Vallejo service area*	Stigma: County of Solano Office of Family Violence Prevention (OFVP) received a $90,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to increase its capacity to respond to individuals within the Latino and African American communities that are victims of intimate partner violence (IPV). OFVP expects to reach 120 domestic violence survivors through outreach, awareness, trainings and linkages to services. As a result of the program, participants will be empowered to seek out mental health care for IPV.
		Resilience: A Better Way – Berkeley received a $98,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to partner with Fairfield High School to promote student success and resilience by providing intervention/prevention services, training, and consultation on school policies. To date, a core group of 9-12 school staff have attended monthly trainings. Twenty students have received trauma-informed treatment through individual and group counseling.
		Human trafficking: KFH-Vacaville provided a $20,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to 3Strands Global, Inc. to provide a trauma-informed education program to prevent human trafficking and to serve human trafficking victims. The program trained 1,100 educators, who support 25,000 students, in Solano County.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		Adverse childhood experiences: A $30,000 grant was awarded to Cope Family Center to support Resilient Napa, a coalition focused on awareness about adverse childhood experiences (ACEs). Though this multi-sector coalition, Resilient Napa will engage 1,500 behavioral and social services providers, and community members. At the end of the project, 85% of trained paraprofessionals will demonstrate greater knowledge about ACEs, their connection to health outcomes, their own ACEs score, and potential strategies for managing the impact of ACEs on their personal and professional lives.
Community & Family Safety	*During 2017 and 2018, KFH-Vallejo awarded 18 grants totaling $437,000.00 that address Community and Family Safety in the KFH-Vallejo service area*	Job training: A $40,000 grant to On the Move will provide education, job training, and enrichment programs for 210 low-income Napa County youth with a specific focus on the low-income Latino population, many of whom were impacted by the 2017 Wildfires. At least 90% of participants will report improvement in three program domains: college readiness, career exploration, and leadership readiness.
		After school programs: KFH-Vallejo provided a $50,000 grant to the Leaven Program (DBA The Leaven) to expand after-school programs for Vallejo youth. This funding enabled The Leaven to open two new after-school centers at low-income housing developments in Vallejo to help 60 low-income, at-risk youth achieve academic success through tutoring and mentoring.
		Vocational skills: The Robby Poblete Foundation received a $20,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to raise awareness about, and provide training in, vocational skills to equip young adults who don't have plans to go to college and reentry individuals in Solano County with skills that are in high demand in the workforce. This program will conduct outreach to 65,000 Solano County residents, focusing on public high school juniors and seniors, adult and alternative school students, and Solano County Superior Court’s parole reentry program participants.
		Financial literacy and workforce skills: Junior Achievement of Northern California received a $10,000 grant (evenly split between KFH-Vacaville and KFH-Vallejo) to support 250 low- to moderate-income middle and high school youth in Solano County develop financial literacy and 21st century workforce skills.

VII. Appendices

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
    ii. “Other” data platform secondary data sources
B. Community Input Tracking Form
C. Health Need Profiles

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1.	California Housing Consortium	2008-2014
2.	American Community Survey 5-Year Estimates	2011-2015
3.	American Community Survey 5-Year Estimates	2012-2016
4.	American Community Survey PUMS data analyzed by Bay Area Regional Health Inequities Initiative (BARHII) and Alameda County Public Health	2016
5.	Point-In-Time Survey, US Housing and Urban Development	2009-2017
6.	Solano County Oral Health Needs Assessment (unpublished)	2018
7.	Consolidated Planning/CHAS Data	2011-2015
8.	Look InsideKP Northern California	2011-2017
9.	California Department of Education	2016-2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Caminar (Executive Director and Director of Supported Housing for the Solano Region)	1	Medically-underserved, low-income	Service provider	8/08/18
2	Key Informant Interview	Solano County Department of Health and Social Services and Housing First Solano Board (Community Services Coordinator, mentally ill homeless outreach liaison)	1	Health department representative, medically-underserved, low-income	Service provider	8/21/18
3	Key Informant Interview	Solano County Public Health Department (Director of Public Health)	1	Health department representative, medically-underserved, low-income	Service provider	8/13/18
4	Key Informant Interview	Partnership HealthPlan of California (Chief Executive Officer - Administration Department)	1	Health department representative, low-income	Service provider	8/24/18
5	Key Informant Interview	Solano County Department of Health and Social Services (Director)	1	Health department representative, medically-underserved, low-income	Service provider	9/07/18
6	Key Informant Interview	Mentis (Executive Director)	1	Low-income, medically-underserved	Service provider	8/27/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
7	Key Informant Interview	Napa County Health & Human Services (Staff Services Analyst)	1	Health department representative	Service provider	8/08/18
8	Key Informant Interview	Napa County Public Health Department: - Deputy Director of HHSA, Public Health Officer - Public Health Manager and Epidemiologist)	2	Health department representative	Service provider	8/29/18
9	Key Informant Interview	Vallejo Christian Help Center (Board President)	1	Medically-underserved, low-income	Service provider	8/31/18
10	Key Informant Interview	Touro University Mobile Diabetes Education Center (MOBEC) Unit (Diabetes Program Coordinator; Operations Manager; Assistant Professor of Primary Care)	3	Medically-underserved, low-income	Service provider	10/26/18
11	Group Interview	First 5 Solano (Program Manager; Family Support and Program Manager) and partner organizations: - Rio Vista CARE (Executive Director) - Child Start Inc. (Executive Director) - Solano Family and Children's Services (Executive Director) - Solano County Mental Health Services (Manager, Child Support Services) - Solano County Office of Education (Director of Early Learning)	7	Medically-underserved, low-income, minority	Service providers	8/30/18
12	Group Interview	Workforce Development Board staff: -President/Executive Director	12	Health department representative, medically-	Service providers	9/20/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		-Planning and Industry Specialist -Industry and Community Engagement -Pathway to Success and Halfway to Employment Programs, Placement Coaches [6 staff] -Business Services Representative -Employability Specialist -Business Services Representative		underserved, low-income, minority		
13	Group Interview	Fighting Back Partnership staff: - Executive Director - Home Visitor / Case Manager [2 staff] - Civic Engagement Manager - Community Project Coordinator - Community Engagement Coordinator - Family Resource Center Manager - Program Manager - AmeriCorps member (home visiting support) - Administrative Clerk - Development Coordinator (youth programs) - Director of Programs - Class Facilitator	13	Medically-underserved, low-income, minority	Service providers	9/13/18
14	Group Interview	The Leaven (after-school mentoring and tutoring programs in low-income neighborhoods impacted by gangs and high dropout rates) staff: - Executive Director - Senior Site Director / Administrative Assistant - Regional Director (North Bay region) - Operations Director	4	Medically underserved, low-income, minority	Service providers	9/20/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
15	Group Interview	Live Healthy Napa County (LHNC) organizations: - UpValley Family Centers (Education Manager) - First 5 Napa County (Executive Director) - Cope Family Center (Executive Director) - Napa Valley Unified School District (Director of Student Services_ - VOICES and On the Move (Health and Wellness Program Manager) - On the Move (Director of LGBTQ Initiative) - On the Move (Neighborhood Initiative Director) - Napa County Public Health Department (Public Health Manager and Epidemiologist)[19]	8	Medically underserved, low-income, minority, health department representative	Service providers	9/06/18
16	Group Interview	NEWS (domestic violence and sexual abuse services) staff: - Executive Director - Program Director - Domestic Violence Shelter Manager - Marketing and Development Director - Program Manager (Safe Solutions program) - Bilingual Housing Case Manager	6	Low-income, minority, medically-underserved, health department representative	Service providers	9/24/18
17	Group Interview	Senior services providers:	5	Low-income, minority, medically underserved,	Service providers	9/28/18

[19] This participant helped to convene the group, and attended as a *silent observer* only as they had previously participated in a key informant interview.

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		- Older and Disabled Adult Services (Social Services Supervisor) - Food Bank of Contra Costa and Solano (Program Director) - North Bay Regional Center (Physician) - North Bay Regional Center (Diversity and Equity Specialist) - Share the Care (Director)		health department representative [20]		
Community residents						
18	Focus group	Black Infant Health clients (African-American/Black mothers, pregnant and post-partum)	14	Medically underserved, minority, low-income	Community members, service providers	9/26/18
19	Focus group	Napa Community Health Initiative clients (Spanish-speaking residents)	11	Minority, low-income, medically underserved	Community members	9/19/18
20	Focus group	American Canyon residents (attend Holy Family Roman Catholic Parish)	19		Community members, service providers	10/05/18
21	Focus group	La Clinica clients (Spanish-speaking residents)	7	Minority, low-income	Community members	9/28/18
22	Focus group	Christian Help Center clients (individuals experiencing homelessness)	19	Medically underserved, low-income	Community members	10/04/18
23	Focus group	Family service providers in Solano: - Vallejo Family Resource Center - SparkPoint Solano Program - Home Visitor Program	6	Low-income, minority	Service providers	9/25/18

[20] No surveys were completed; the target group representative categories refer to those mentioned on organizations' respective websites.

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		- Fighting Back Partnership				

*Focus group and group interview participants completed an optional survey).

This data was used to inform representation of the four target groups during data collection events using the criteria outlined below:

- **Medically-underserved:**
  Focus Groups: One or more participant indicated they have “No Insurance”
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.
- **Low-income:**
  Focus Groups: One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.
- **Minority:**
  Focus Groups: One or more participant indicated their race/ethnicity as non-White.
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the minority community.
- **Health department representative:**
  Focus Groups: N/A
  Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.

Appendix C. Health Need Profiles

Health need profiles include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics), and were developed prior to the prioritization meeting. The profiles do not reflect additional knowledge shared by individual stakeholders during that meeting. Additionally, statistics presented in the health need profiles were not analyzed for statistical significance and should be interpreted in conjunction with qualitative findings.

Each health need profile also includes a “spotlight on equity” section which features community members’, including service providers, concerns in regard to inequities in their communities; examples provided in this section relate to complex and deeply rooted issues, and should be considered within a broader system-level context of historical disinvestment as well as discriminatory policies, practices, and discourse.

Kaiser Foundation Hospital – Vallejo service area Community Health Needs Assessment

Access to Care

ACCESS TO CARE, TRANSPORTATION

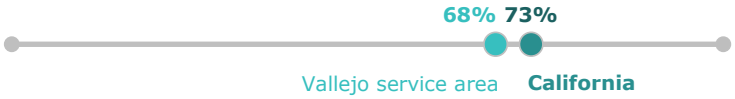
Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. It is also one of the key drivers in achieving health equity. The Vallejo service area fares worse than the state across important indicators, such as residents recently having a primary care visit and lung cancer incidence. However, the area performs better than the state average in terms of number of physicians proportional to the population. Additionally, existing racial disparities in accessing care are evident in the Vallejo service area. For example, White diabetic Medicare patients are more likely to receive a blood sugar test compared to their Black peers, and children of color are more likely to be uninsured when compared to White children. Community members, including service providers, provided context on some of the key gaps in accessing services such as: specific barriers for those who are undocumented, long wait times, unique challenges facing the aging population, and geographic disparities resulting in worse health outcomes in the North, South, and Downtown areas.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Recent Primary Care Visit (Medicare beneficiaries) (percent) [1]



Primary Care Physicians (per 100,000 population) [2]

Prostate Cancer Incidence (per 100,000 population) [3]

> Five readmissions for the same thing and each time, I mean we've become involved this time and said do not send her back to the same environment. She fell in the house twice and she has one caregiver who couldn't even lift her up.
> *- Service provider*

> Figure out what's wrong and stop trying to mask it with pain meds.
> *- Focus Group participant*

Community Identified Barriers

Barriers to Access to Care

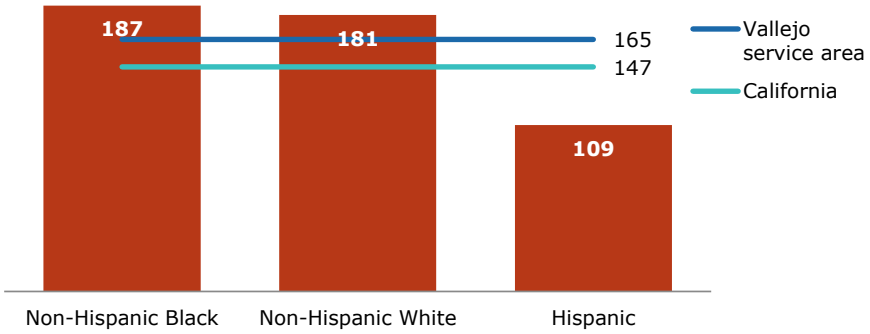
- Lack of awareness of services available
- Lack of affordable health care, and eligibility barriers
- Long waiting times, short appointments
- Lack of culturally competent care and bedside manner
- Lack of choice of provider (based on insurance plans), and shortage of specialists
- Health systems in siloes (e.g., primary care and mental health, senior services and hospitals)
- Increase in older adult population coupled with increasing health needs
- Over-medicating

Updated March 2019

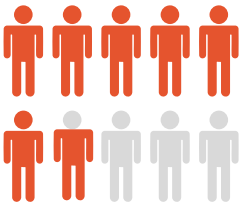
Populations Disproportionately Affected

Populations with Greatest Risk

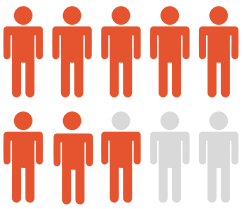
Lung Cancer Incidence (per 100,000 population)[4]



- Vallejo service providers that conduct community outreach noted the following chronic diseases as being prevalent in the region: **COPD, hypertension, asthma, heart disease.**
- Similarly, a Napa County provider noted that **cancer, diabetes, heart disease, stroke, and lung disease** cause a large percentage of deaths in the county.

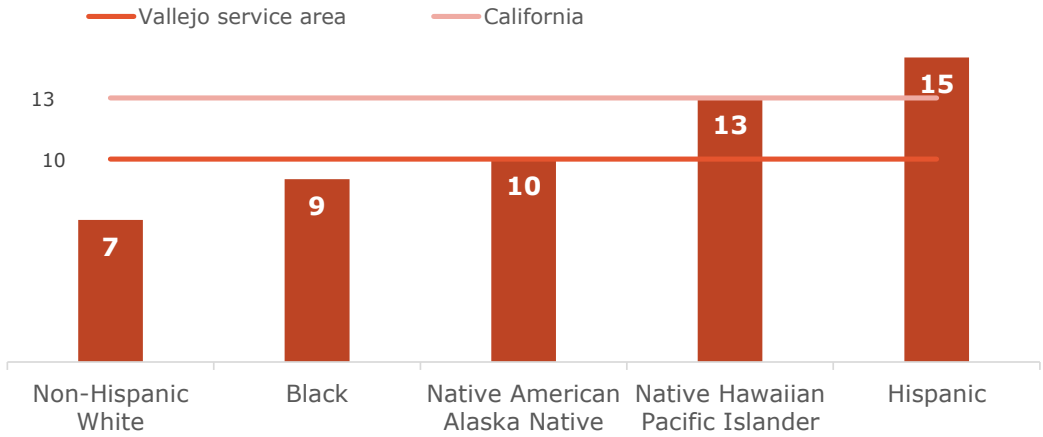


69% of **Black** diabetic Medicare patients had their hbA1c test of blood sugar administered by a health care professional[5]



79% of **White** diabetic Medicare patients had their hbA1c test of blood sugar administered by a health care professional[5]

Percentage of uninsured children[6]



> Those without documents don't go to the doctor. Or if you go, you don't have enough to pay for it…(original in Spanish).
> *- Focus Group participant*

> In terms of using Medi-Cal, with dentists like Western Dental, they say they have Medi-Cal but they cancel appointments. La Clinica you can only go there at a certain age or you can't be seen. A lot of stuff health-wise is available but you can't be seen. Insurance doesn't always help.
> *- Focus Group participant*

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

- The **Vallejo city region** is home to many people receiving **SNAP benefits**, with several census tracts having **20-40% of households** participating in the program.[7] (Circle size indicates the regional extent of disparities.)

The city services have been affected for several years now because of them going into bankruptcy, so there's just a general feel of things not being available in Vallejo. Which I think, you know luckily First Five is starting to really address some of that and put services there, but they have a way to go I think.
- Service provider

"You only have one small Alzheimer's Center in Fairfield, you have nothing in Vallejo, you have no place for people to go for adult day health care, you have no crisis care management, you have no crisis caregiver management. Alameda county has done so much more and has had so much more public investment in the community.
- Service provider

Vallejo [zip codes] 94589 and 94590 are the two other high areas, and that's that downtown or urban area of [Help Me Grow] calls and their requests are for basic needs. A lot of basic needs.
- Service provider"

- Solano county service providers identified that **North Vallejo, South Vallejo, and Downtown** seem to have the most prevalent health needs.

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- In Napa, service providers noted that smaller health care organizations have difficulty retaining staff because of salary competition with bigger health providers, and also mentioned that there are no new organizations serving low-income (e.g., uninsured) people despite high demand.
- A Solano County service provider noted that providing services for undocumented community members requires significant trust-building, even with Spanish-speaking staff in the case of Hispanic/Latino population. Other service providers added that ICE was arresting people in the region and this has instilled fear in community members.
- A Solano county service provider mentioned that people of color consistently have worse health outcomes, and there needs to be greater focus on social determinants of health such as housing and transportation.
- Vallejo service providers noted a shortage of dental health services specifically for low-income community members, and overall health disparities across populations particularly low-income, Black/African American, Native American, and Hispanic/Latino, additionally noting that the Native American population specifically lacks trust in government services.
- A service provider in Vallejo noted that low-income people who are not eligible for Medi-Cal do not have affordable insurance options, which may lead to self-medication.
- Materials translated in other languages are often poorly translated and unclear.

Assets and Ideas

Examples of Existing Community Assets

Whole-person Care program

Increasing focus on social determinants of health, and organizations incorporating human-centered and trauma-informed approaches

Co-location of community partners (e.g., health services, counseling, nonprofits)

Ideas from Focus Groups and Interview Participants

- Need all-inclusive care at home for older adults (e.g., PACE) and adult day health care facilities
- Offer alternative options to care rather than pain medications
- Invest in programs that reduce inappropriate utilization of hospital services like ERs
- More funding for whole-person care programs, more integration, "no wrong door" infrastructure
- Increase medical access for undocumented community members
- More team-based care, culturally competent care, reflective supervision, and service providers that represent diverse populations
- More county services, especially dental services, and broaden health service to outlying regions
- Increase focus on prevention and education
- Bring health services to communities through health fairs, mobile clinics, co-locating, and other initiatives to address barriers (e.g., transportation, child care), and offer more than basic services
- Need for more nurses and health services on school campuses
- Engage community members in decision-making
- Use de-aggregated data to identify experiences in different populations (e.g., LGBTQ population)
- Extend service hours

References

1. Dartmouth Atlas of Health Care. (2015-2016).
2. Area Health Resource File (Health Resources & Services Administration). (2014).
3. State Cancer Profiles. (2010-2014).
4. Same as above.
5. Dartmouth Atlas of Health Care. (2014).
6. American Community Survey. (2012-2016).
7. Same as above.

Kaiser Foundation Hospital – Vallejo service area
Community Health Needs Assessment

Behavioral Health

MENTAL HEALTH, SUBSTANCE USE/TOBACCO

The mental health of Vallejo service area residents shapes many aspects of their well-being, from substance use patterns to interactions with health services. The Vallejo service area rates more poorly than the state on several indicators related to substance use, including the rate of excessive drinking, driving under the influence, and lung cancer (related to tobacco use). The impacts of behavioral health are felt unevenly across populations, with Non-Hispanic Whites showing greater suicide mortality. Focus group and interview respondents also raised their concern in regard to suicide deaths and depression among youth. Service providers are particularly concerned about the mental health needs of Native Americans and increased anxiety among the undocumented population. They highlighted the important role of counselors practicing trauma-informed care in addressing these needs, and the need for culturally competent care across sectors, particularly important in health care environments.

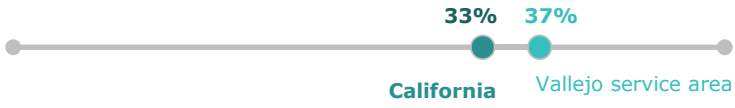
Key Data

Indicators

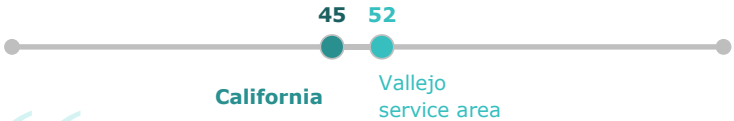
Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Impaired Driving Deaths (percent) [1]

Excessive Drinking (percent) [2]



Lung Cancer Incidence (rate per 100,000 population) [3]



> An issue that we're struggling with now is people feeling like they have to decide whether they focus on their physical health, or mental health.
> *- Service provider*

> So, if somebody is in crisis and they're suffering, it takes so long that they might end up doing something drastic like taking their life in the meantime while they are waiting, on a waiting list.
> *- Service provider*

Community Identified Barriers

Barriers to Behavioral Health

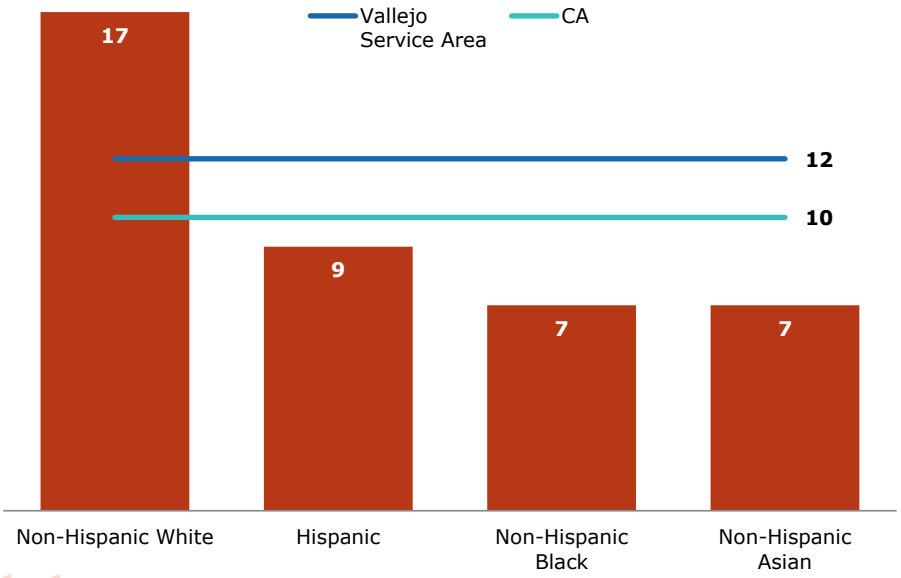
- Gap in mental health services for older adults
- Lack of integrated mental and physical health services, waiting lists for mental health services
- Undiagnosed depression
- Incidence of human trafficking and prostitution
- Substance abuse (e.g., meth., marijuana, alcohol, cocaine, heroine)
- Prevalence of liquor and tobacco stores, cannabis dispensaries
- Focus on medication rather than alternative care for mental health
- Stigma of seeking help

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Suicide Deaths (rate per 100,000 population)[4]

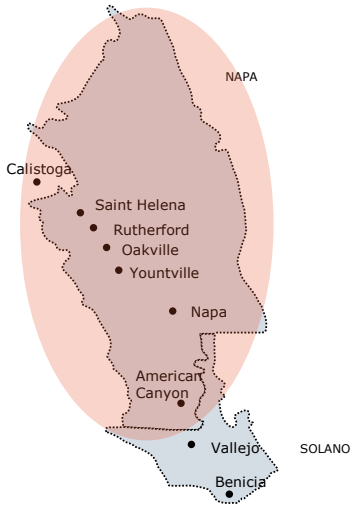


We're seeing a lot more tobacco use [in Napa County], especially among our youth in the form of electronic smoking devices and other flavored tobacco products.
- Service provider

Depression. Here in Napa, adolescents have [died by suicide] because of it.
- Focus Group participant

"Physical injury is leading to mental health issues and then, I have a gentleman who was in a car accident then he was depressed, then he got diabetes, because while he was depressed he was eating. So, I just think a doctor that actually can, you know, we call it multi-disciplinary team.
- Service provider

Geographic Areas with Greatest Risk



Beer, Wine, and Liquor Stores[5]

This indicator reports the number of beer, wine, and liquor stores per 10,000 population. Alcohol outlet density helps characterize policy and environmental factors that affect excessive alcohol use.

The majority of the region throughout **Napa County ranks much worse than average on this indicator**, with a rate of **3.22 per 10,000 population** which is nearly three times that of both state and national averages. The Solano County portion of the service area in the south has a rate of .75 comparatively. (Circle size indicates the regional extent of disparities.)

Emerging Needs

11.7% percent of U.S. high school students **used a vape** in **2017** compared to **1.5% in 2011**[6]

> Suicide and depression has gone up a lot [in Solano County]. We have heard of a lot of kids definitely attempting suicide, a lot of kids overdosing. Kids are getting prostituted out, and trafficked, and that creates more depression. There's starting to be rings now.
> *- Service provider*

> The legalization of marijuana, it's given perception to young people that it's totally safe, no problem, and they're getting a hold of edibles that they don't realize….. you can't eat a whole brownie in one sitting.
> *- Service provider*

- A Napa service provider described, "an **undercurrent of anxiety** and a sense of stress for people that wasn't there before, and specifically I mean Napa has endured a devastating earthquake in 2014; 2017, devastating fires; and in between those two things or actually in the spring of 2017, a high profile shooting in Yountville Veteran's Home, and smaller types of shootings along the way in the community".

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- A Solano County provider mentioned that many clients are experiencing substance abuse issues, and noted prevalence in rural communities (e.g., use of methamphetamines, access to farm fertilizers).*
- One Solano County service provider noted that Native American youth need more support in the context of mental health services which requires trust-building between providers and community members—acknowledging the historical trauma and disinvestment this community has experienced.
- A Napa County service provider noted, *"there's many undocumented immigrants who are a big part of the community. There's been ICE raids, crack downs in immigration [adding to stress and anxiety]".* Service providers in Solano county also noted a reduction in people reaching out for services that seems to be connected to the political climate [changes in policies and discourse impacting immigrants].

*The Center for Disease Control and Prevention has identified rising rates of drug overdose deaths in rural areas, surpassing rates in urban areas, and note that "understanding differences in illicit drug use, illicit drug use disorders, and drug overdose deaths in urban and rural areas can help public health professionals to identify, monitor, and prioritize responses".[7]

Assets and Ideas

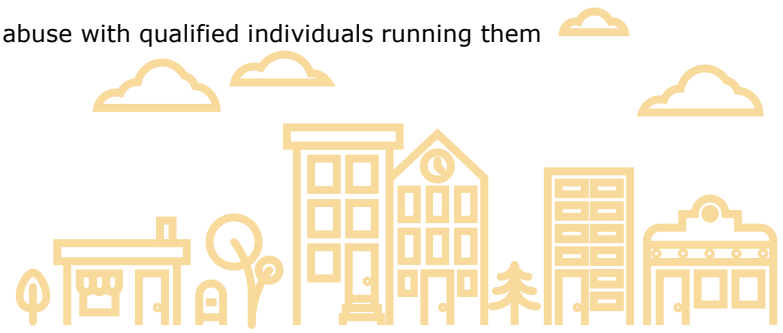
Examples of Existing Community Assets

Proposition 47

Diversion programs

Ideas from Focus Groups and Interview Participants

- Expand mental health services (including for youth and seniors)
- Leadership need to acknowledge and address human trafficking and prostitution rings
- Better attention to identify adverse circumstances in the family that may impact youth (e.g., abuse in the family, involvement with criminal justice system)
- More immediate availability of mental health support and not only crisis support
- Increase number and availability of licensed crisis service providers and counselors, and trauma-informed care providers
- More treatment centers for substance abuse with qualified individuals running them



1. Fatality Analysis Reporting System. (2011-2015).
2. California Health Interview Survey. (2015-2016).
3. State Cancer Profiles. (2010-2014).
4. National Vital Statistics System. (2011-2015).
5. County Business Patterns. (2015).
6. Look InsideKP Northern California. (2011-2017).
7. Drug Overdose in Rural America. (2017). Center for Surveillance, Epidemiology, and Laboratory Services (CSELS). *Center for Disease Control and Prevention.*

Kaiser Foundation Hospital – Vallejo service area Community Health Needs Assessment

Economic Security

ECONOMIC SECURITY, TRANSPORTATION

Economic security is one of the most widely recognized social determinants of health that has impacts on countless health needs for the Vallejo service area community. Even though the Vallejo service area has a lower degree of economic inequality than California as a whole, many community members noted the sizable low-income population that feels largely "unseen" within the wealthy counties, particularly Napa. Further, financial distress is concentrated among communities of color. The prevalence of Black children below the federal poverty line is higher than the California average of child poverty. Similarly, Black and Hispanic adults make up a disproportionate amount of supplemental nutrition assistance program (SNAP) recipients. Focus group and interview respondents also noted the unequal geography of economic troubles. Urban areas face the pressures of gentrification, while rural areas lack adequate public transportation to access employment opportunities.

Key Data

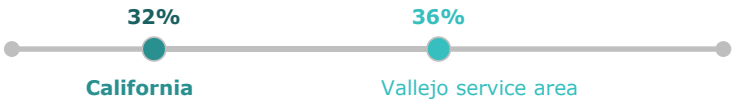
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

SNAP Beneficiaries (percent) [1]

Income Inequality (Gini Coefficient): where 0 is full equality [2]

Children in Single-Parent Households (percent) [3]



> I believe that there is more focus on tourists than in resources for those that are actually living here…there aren't things to do in family, with your kids, it's purely hotels (originally in Spanish)
> *- Focus Group participant*

Community Identified Barriers

Barriers to Economic Security

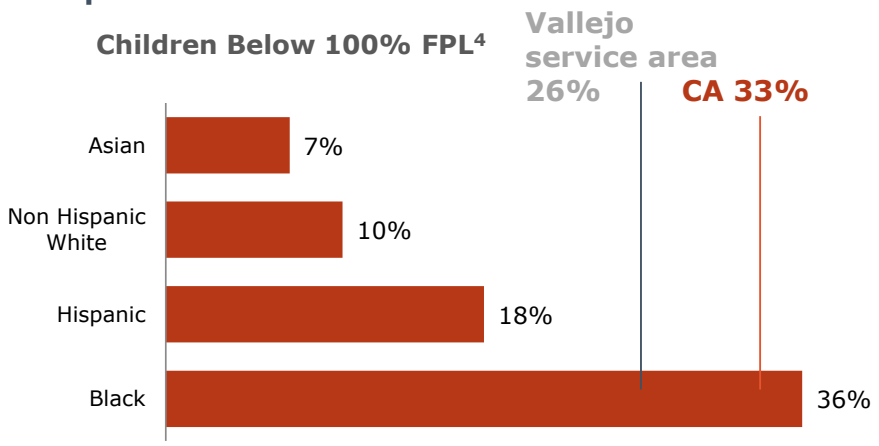
- Lack of accessible and timely public transit
- Long distances between major population centers
- Lack of good local employment options, stores closing (e.g., thrift stores)
- Lack of social activities that are free or low cost (e.g., for youth and families)
- Available employment options do not provide a living wage, or part-time only available
- Lack of philanthropic support (especially in Solano)
- Increasing housing costs, prevalence of multi-family housing arrangements

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

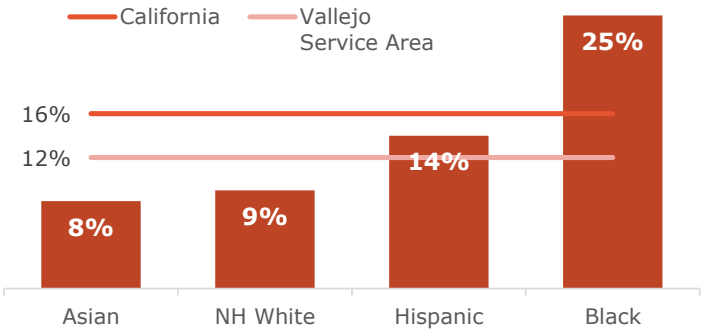
Children Below 100% FPL[4]



We are a pretty wealthy county when we compare the median income to other counties. We have a pretty sizeable low income population, so the cost of living is high here.
- Service provider

- One service provider noted that the "landscape is changing a bit now. So it is creating a few challenges for the folks that we tend to serve. So we see that sort of **urban influx**. Particularity in Vallejo, Fairfield areas. And then back of all Dixon, a stretch of it, tends to be a little more bedroom communities. You know, **less access for folks with smaller incomes** in terms of housing availability and things of that nature because the **building and infrastructure is often targeted towards single family homes** and you know, medium income families".

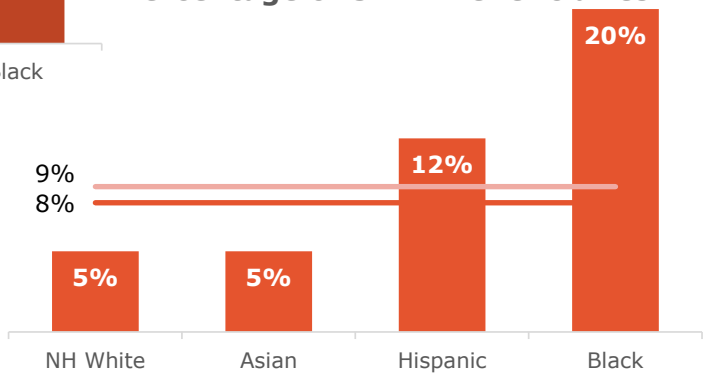
Population Below 100% FPL [5]



I do wonder if part of what we see is that, because Napa County has become more and more unaffordable for people, that we are displacing our lower income population and displacing people who tend to have worse health outcomes.
- Service provider

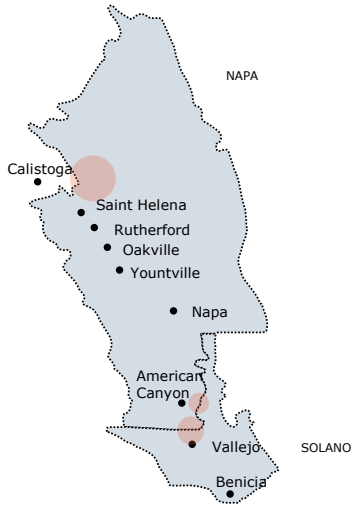
Transportation is a growing problem, and I think for Napa specifically that county services moved more Southern, so farther away. Public transit is less agreeable. And, the price of gas.
- Service provider

Percentage of SNAP Beneficiaries [6]



Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Social Associations [7]

This indicator reports the number of social associations (e.g., civic organizations, recreational clubs and facilities, political organizations, labor organizations, professional organizations) per 10,000 population and is relevant as a measure of community vitality. Communities with the lowest rate of social associations, by zip code, include (circle size indicates the regional extent of disparities):

- **Angwin, CA** (94508): rate of 2.7 per 10,000 population
- **Vallejo, CA** (94589): rate of 2.7 per 10,000 population
- **Vallejo, CA** (94591): rate of 4.9 per 10,000 population

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Vallejo region service providers noted that Benicia has an "unseen" but large population of low income community members.
- Spanish-speaking community members noted that some people are afraid to drive due to lack of proper immigration documentation, and also noted that public transit stops are far apart, which is difficult for those with mobility issues.
- Inability to vote due to immigration status leaves many without a voice, and a barrier to civic engagement.
- One Vallejo community member stated, *"there was a time in this city where they had more organizations to help you. Now it's like this city has turned into a rich city where the poor are getting poorer".*
- A Napa service provider noted that, following the October fires, county relief centers had separate entrances for nonprofit and government services so that any undocumented community members would feel comfortable accessing services.

Assets and Ideas

Examples of Existing Community Assets

Rich cultural and ethnic diversity

Multi-sector collaborative groups

New businesses coming to Mare Island

Ideas from Focus Groups and Interview Participants

- Improve public transportation (more accessible, more frequent stops)
- More resources and employment opportunities
- More training and education programs for youth
- More systematic collaboration to help sustain their services
- Affordable and healthy social activities for youth (e.g., sports, open mic night, creative outlets)
- Better use of abandoned buildings and open spaces
- Appropriate support across income brackets such as workforce opportunities for lower income, support of basic needs such as housing and food, etc.
- Better care coordination, educating public on the available resources, and bringing resources to community members
- Encourage civic engagement, and build advocacy efforts

Reference

1. American Community Survey. (2012-2016).
2. Same as above.
3. Same as above.
4. Same as above.
5. American Community Survey. (2012-2016).
6. Same as above.
7. County Business Patterns. (2015).

Kaiser Foundation Hospital – Vallejo service area Community Health Needs Assessment

Education

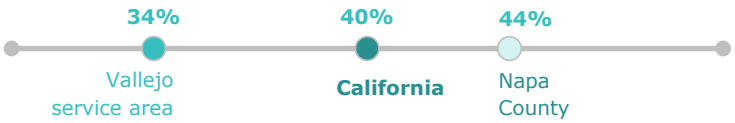
Education not only includes one's means to academic achievement but also the support and resources to enhance one's educational development which is connected to longer-term health outcomes. It is a key driver in achieving both health and economic equity. The Vallejo service area fares worse than the state across educational indicators such as reading proficiency, expulsions, and suspensions. Evident racial disparities exist, including that Hispanic, Black, and Asian adults were more likely to not have completed a high school diploma compared to Non-Hispanic Whites. Community members provided context in regard to educational gaps, and specifically mentioned barriers in translation services and the need for children/youth support programs outside of school.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Reading Proficiency (percent) [1]



Expulsions (rate per 100 students enrolled) [2]

Suspensions (rate per 100 students enrolled) [2]

Community Identified Barriers

Barriers to Education

- Absenteeism, and educators not following up to check on students
- Lack of parent involvement in school and lack of trust between parents, teachers, and students
- Lack of interpretation / translation services, and bilingual staff in schools
- Schools' physical infrastructure in decay

> Some kids can miss school 30 days and no one will check on them. - *Service provider*

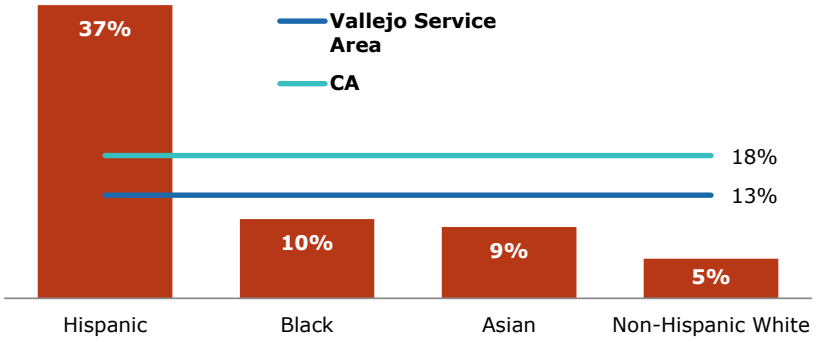
> You have students that aren't going to school, but what are the key factors of why they're not going to school? Like we have to look at these root factors, you know what I mean? It's not relevant to them if it doesn't make sense to them. You're just drilling it in and want them to spew it out for you on a test. That's not fun, and that's not helpful to learn. - *Service provider*

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Percent of adults with no high school diploma [3]



Percent of students eligible for Free and Reduced Price Lunch [4]

Vallejo (City) : CA

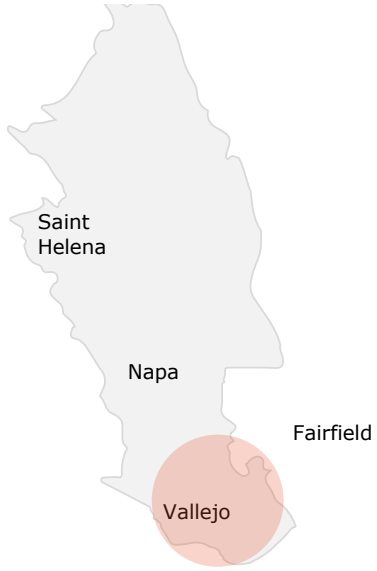
53% : 59%

- Spanish-speaking residents in **Vallejo** noted that bilingual high school students are pulled out of class to interpret for school counselors and that there is an **overall lack of bilingual staff and services.**

> I would love to see school transportation brought back. So another level of oversight for those children. It's another advocate. The bus driver often saw where that kid lived, where he was going, what was happening on the bus. It was just another set of community eyes.
> *- Service provider*

> Not everyone can afford to go to the Boys & Girls Club, which I think if we had one and they were entertained, there is a lot of kids that have parents that are working and they have nothing to do, no one to tell them what to do, or how to do it.
> *- Focus Group participant*

Geographic Areas with Greatest Risk



Suspensions (per 100 enrolled students) [5]

The rate of suspensions in the southern, Solano County portion of the Vallejo service area, extending **across Vallejo and Benicia** cities and towards Fairfield, are **much worse than the state average** (nearly double) compared to the larger Napa County portion of this service area, which is on average with the state. Expulsions also are higher than the state average in the same region, though not to the same extent. (Circle size indicates the regional extent of disparities.)

Exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcomes, including experiences of stress and trauma.

Assets and Ideas

Examples of Existing Community Assets

Data-sharing and discussion between service providers and schools

Communication between teachers and parents (in some schools)

Ideas from Focus Groups and Interview Participants

- Better communication between parents, students, and teachers in schools
- Higher pay for teachers
- Greater awareness, especially by community leaders and policy makers, of the needs across the population for different communities
- Bring more health education to schools
- Support older adults in computer-use and accessing information through the internet
- More oversight for youth from education sector (bus drivers, school, etc.)
- More relevant education that motivates youth
- Improve infrastructure of school buildings and create an environment that kids want to come to and learn
- More job skills training in schools
- Mentorship programs starting in middle school to get kids exited for college, and educate them on higher education options in the community

References

1. EDFacts. (2015-2016). *National Center for Education Statistics.*
2. California Department of Education. (2016-2017).
3. American Community Survey. (2012-2016).
4. Common Core of Data. (2015-2016). *National Center for Education Statistics.*
5. California Department of Education. (2016-2017).

Kaiser Foundation Hospital – Vallejo service area
Community Health Needs Assessment

Healthy Eating and Active Living

HEAL, OBESTIY, DIABETES, CVD, STROKE

Healthy Eating and Active Living (HEAL) relates to Vallejo service area residents' ability to shape health outcomes through a focus on nutrition and physical activity. The Vallejo service area scores more poorly than the state of California on many HEAL indicators such as diabetes management, the rate of physical inactivity, and proximity to walkable destinations. Blacks have the highest rate of heart disease mortality followed by Whites, Asians, and then Hispanic/Latino populations. This clearly racialized pattern similarly describes the rate of stroke mortality. Service providers highlighted the relationship between economic deprivation and obesity, which is correlated with cardiovascular disease, stroke, and diabetes. Both focus group and interview respondents pointed to equitable solutions like improving built environments, increasing access and affordability of healthy food, and increasing education on nutrition.

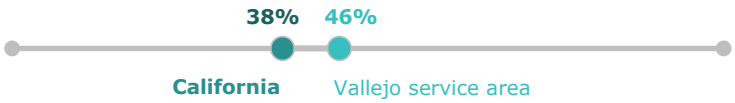
Key Data

Indicators

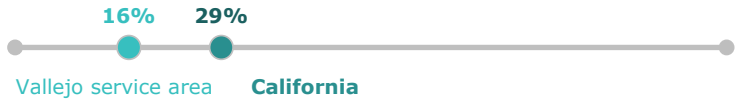
Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Obesity (Adult) (percent) [1]

Physical Inactivity (Youth) (percent) [2]



Walkable Destinations (percent) [3]



Community Identified Barriers

Barriers to HEAL

- Food desserts (especially North and South Vallejo)
- Prevalence of fast food
- Limited understanding of chronic diseases (especially diabetes)
- Alcohol use at public parks, and lack of law enforcement
- Unaffordable healthy food options

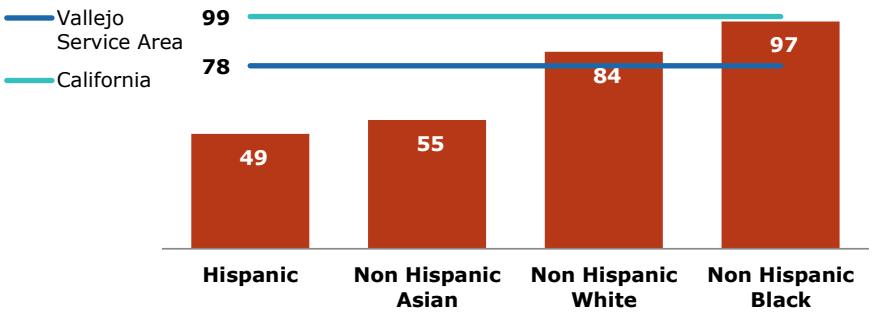
> More walkable and bikeable communities doesn't exactly fall to priority of an agricultural area that's trying to maintain vineyards.
> *- Service provider*

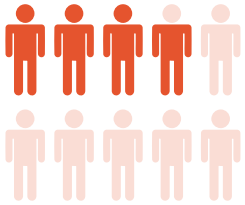
> We need to work across many different sectors if we're going to make changes that really move the needle, some of our intractable health problems, like the obesity, the chronic diseases. It's not just one sector that is going to implement things that make those changes. It needs to be across the board.
> *- Service provider*

Updated March 2019

Populations with Greatest Risk

Heart Disease Deaths (rate per 100,000 population[4])

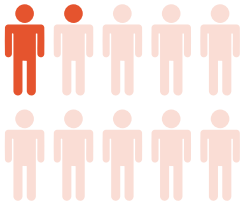




36% of **NH Black** have BMI > 30.0 [5] in **Vallejo City**

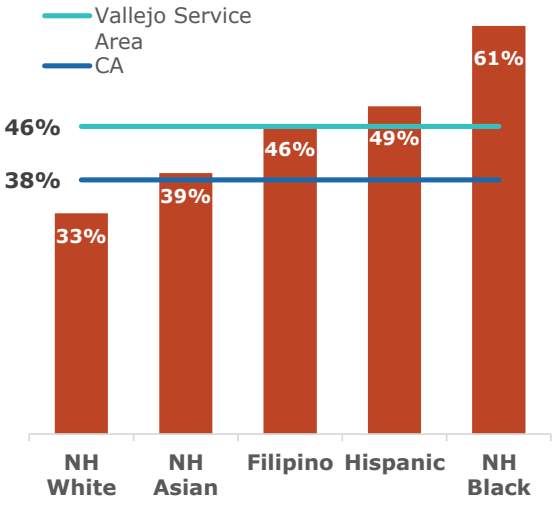
> We've got a park in Calistoga that families just won't go to anymore, because that's where the men drink.
> *- Service provider*

> [Older adults] come with their own medical issues because of their age. We see a lot of diabetes, we see COPD, we see heart issues. Those are the primary ones.
> *- Service provider*

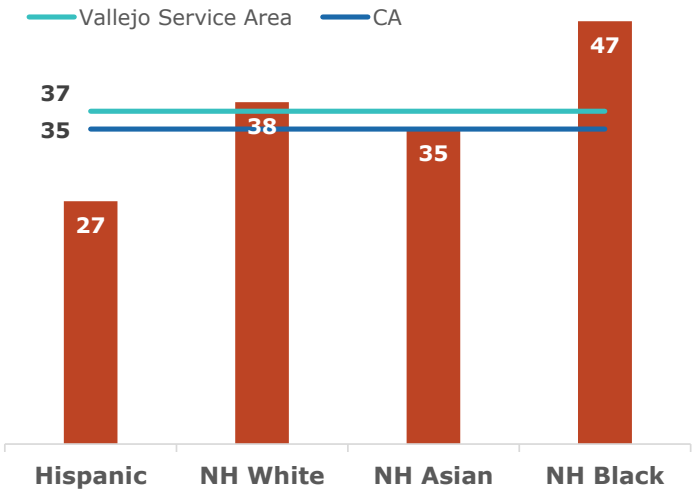


11% of **NH Asian** have BMI > 30.0 [5] in **Vallejo City**

Physical Inactivity (youth) (percent) [6]



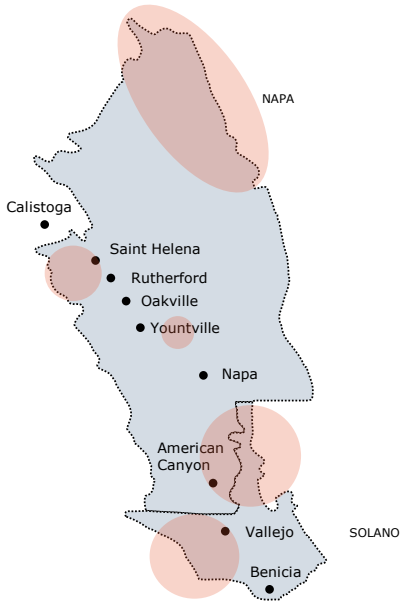
Stroke Deaths (rate per 100,000 population) [7]



- Service providers working on chronic disease issues in Vallejo noted that **younger community members are entering pre-diabetes sooner in life.** Other service providers also mentioned high rates of pre-diabetes and links to obesity.

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Healthy Food Stores (Low Access)[8]

Communities across the Vallejo service area lack access to healthy food as they **do not live in close proximity to a large grocery store** or supermarket.

In the **SW region of Solano County** (Census Tract 2508.01) **93%** of the population face this barrier. In the **NW of Napa County** (Census Tract 2015) **65%** of individuals have low access to healthy food stores. (Circle size indicates the regional extent of disparities.)

Good access to healthy food retailers promotes heathier eating behaviors and associated health benefits, including lower risk for obesity and related chronic diseases.

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Spanish-speaking residents in Vallejo mentioned that many public parks are unsafe (e.g., crime, needles, vandalism) while other parks are pristine depending on the neighborhood and the investment in that community.
- Napa County service providers mentioned that middle and high school students from economically disadvantaged families have higher percentages of obesity compared to students in the same grades from higher income families—and obesity rates are overall high for Hispanic/Latino adult and youth.

> "There's nothin' for [youth] to do. There's nothing to occupy their time. Where I'm from, we have skating rinks, bowling alleys ... we don't have stuff like that in Vallejo.
> *- Focus Group participant*

> [In a study in Napa County], communication really came up as the biggest barrier to accessing healthy food, if people just weren't aware of the universe of options, in terms of free and reduce cost food, or they were afraid that they were going to be asked about their immigration status."
> *- Service provider*

Assets and Ideas

Examples of Existing Community Assets

Community Gardens

Cross-sector partnerships (private and public sectors, hospitals, etc.)

Ideas from Focus Groups and Interview Participants

- Increase nutrition services and education (e.g., family cooking classes)
- Access to safe parks
- Improve built environments to improve health (e.g., obesity)
- Develop culturally competent and inclusive communication among service providers
- Increase access and affordability of healthy food
- Cross-sector partnerships to impact policy, systems, and environmental changes

References

1. National Center for Chronic Disease Prevention and Health Promotion. (2013).
2. FITNESSGRAM® Physical Fitness Testing. (2016-2017).
3. Center for Applied Research and Environmental Systems. (2012-2015).
4. National Vital Statistics System. (2011-2015).
5. California Health Interview Survey (2014); Note: Obesity is defined as BMI of 30 or greater.
6. FITNESSGRAM® Physical Fitness Testing. (2016-2017).
7. National Vital Statistics System. (2011-2015).
8. USDA - Food Access Research Atlas. (2014).

Kaiser Foundation Hospital – Vallejo service area Community Health Needs Assessment

Housing

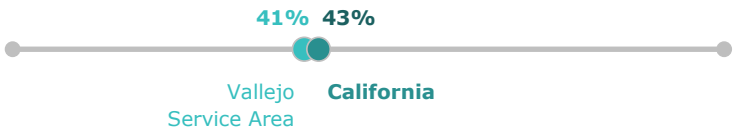
Access to safe, secure, and affordable housing is an important social determinant of health. Families with fewer financial resources are more likely to experience sub-standard housing conditions and the associated risks. The Vallejo service area has a lower proportion of cost-burdened households and a less severe housing problem when compared to the state of California. However, the region reflects clear disparities across race and ethnicity, and at the census tract level. Across the region, many families with young children are paying more than 30 percent of their income on housing; this is most pronounced for the Hispanic/Latino population in Napa County and African American/Black population in Solano County. Focus group and interview respondents provided additional insights; they identified social tensions and stigma on the issue of homelessness, cost-prohibitive rental fees on top of rising housing costs, as well as an influx of residents from other regions that seems connected to less available low-income housing options (e.g., Section 8). Housing barriers are also a concern for the increasing older adult population.

Key Data

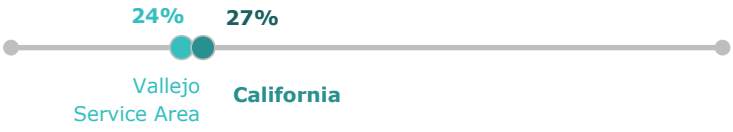
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Cost-burdened Households (percent) [1]



Severe Housing Problem (percent) [2]



> There's the chicken or the egg, but usually it's the mental health issue, substance abuse issue that leads to criminal activity often that leads to homelessness.
> *- Service provider*

> I can't speak for other [homeless] shelters, but this one is basically the last safety net to a lot of the folks out there. It's a free fall, and without this to catch them then, I don't know, where you're going to land?
> *- Service provider*

Community Identified Barriers

Barriers to Housing

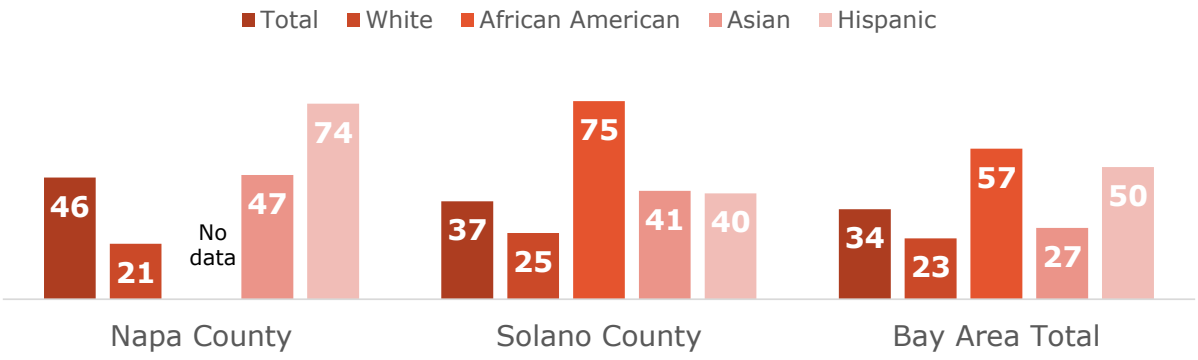
- Increase in older adult population, and many older adults losing housing
- Lack of long-term sustainable support for people experiencing homelessness
- Increasing housing costs, prevalence of multi-family housing arrangements
- Lack of rental options including low-income housing
- Influx of community members from other regions (e.g., following fires in Santa Rosa)
- Closing of homeless shelters (especially in Solano)

Updated March 2019

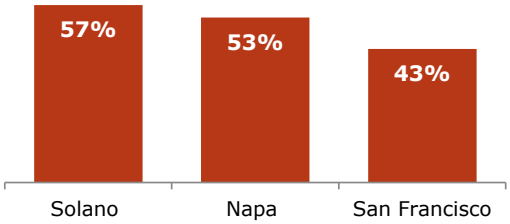
Populations Disproportionately Affected

Populations with Greatest Risk

Percentage of families with children under 5 years old, paying more than 30% income on housing, by county [3]



Percent of renters that pay 30% or more of their income on rent comparison by county [4]



Percentage of individuals by race/ethnicity that spend 30% or more of their income on rent, Solano County [5]

69% Black/African American

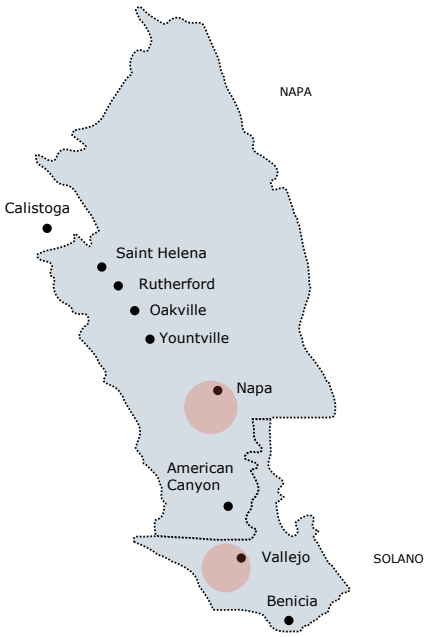
70% American Indian/Alaska Native

> Folks are moving further and further away from the major populations centers just to get in a house they can afford. We're seeing a lot of growth in areas that are really, typically haven't been high growth areas.
> *- Service provider*

- Community members noted that **homelessness** is a problem everywhere in the region, and particularly **downtown and N. Vallejo.**

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Severe housing problems [6]

Communities wherein **housing or quality of life is considered substandard**—low quality kitchen/plumbing, overcrowded, and/or severely cost-burdened at more than 50% of monthly income—are concentrated in census tracts within and around Vallejo (Solano County) and Napa. Census tracts with the highest percentage of households experiencing severe housing problems include (circle size indicates the regional extent of disparities):

- **Napa:** 2008.04 (38% of households), 2005.03 (38% of households)
- **Vallejo:** 2516 (42% of households), 2512 (39% of households), 2503 (39% of households)

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Vallejo residents discussed the issue of homelessness in the region and inequities they perceive. One participant stated, "nobody should be homeless in my opinion, but when you see babies on the street, it should be different. And then I also think…I wonder if those babies looked different. I wonder if those families looked different, would there be a different approach?"
- Spanish-speaking residents in Vallejo mentioned that, in addition to rising housing prices, extra fees (e.g., rental application fees) are unjust and cost-prohibitive for many.
- Napa County service providers mentioned that a few years ago, *"neighbors were opposing the opening of this homeless respite center which would enable homeless that are discharged from the hospital to be there until they recover from the illness that prevents them from being able to live on the streets"* and remarked on social tensions and stigma that exist around this issue. Other service providers mentioned the same issues of stigma.
- A Solano County service provider noted that the influx of people moving from the Bay Area because housing is more affordable in Solano has led to less acceptance of Section 8 housing, which leads to more people experiencing homelessness.

Assets and Ideas

Examples of Existing Community Assets

Commitment of public officials to "Housing First" model (e.g., tiny home/tough shed initiative, shelters accepting pets, women and children only housing)

Grants dedicated to housing initiatives (e.g., Prop 47) and cross-sector collaborations (e.g., police, shelter staff, case manager)

Organizations providing access to showers, laundry, computer-use, etc. for people experiencing homelessness

Ideas from Focus Groups and Interview Participants

- Develop home-sharing programs for older adult population
- Develop Mare Island for affordable housing, community resources, support /shelter or individuals experiencing homelessness, etc.
- Continue moving toward a "continuum of housing" model that incorporates housing options for those experiencing mental health or substance abuse issues
- Rent control, especially in low-income communities
- Reduce housing application costs to ensure more equitable access
- Facilitate housing access for undocumented families
- Employ staff at shelters, food banks, etc. who have experience and can relate to people experiencing homelessness
- Facilitate participatory initiatives that engage community in decision-making
- Partner with churches, including using parts of property for affordable housing or shelters
- More support for first-time home buyers (e.g., managing credit)
- Mobile units offering services (e.g., laundry, showers) for people experiencing homelessness

1. American Community Survey. (2012-2016).
2. Consolidated Planning/CHAS Data. (2011-2015).
3. Housing Stability and Family Health: An Issue Brief; Bay Area Regional Health Inequities Initiative (BARHII), Federal Reserve Bank of San Francisco; extra analysis by BARHII and Alameda County Public Health of the American Community Survey PUMS data. (2016).
4. American Community Survey 5-Year Estimates. (2012-2016).
5. American Community Survey 5-Year Estimates. (2011-2015).
6. Consolidated Planning/CHAS Data. (2011-2015).

Kaiser Foundation Hospital – Vallejo service area
Community Health Needs Assessment

Maternal and Infant Health

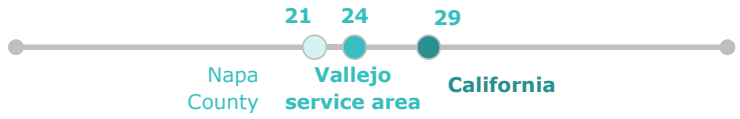
Mothers in the Vallejo service area face many barriers related to their own well-being and that of their children. The rate of infant deaths in the service area is higher than the California average, and infant mortality disproportionately impacts people of color. The Vallejo service area does have a lower teen birth rate than the California average, which can indicate greater chances for economic security and pregnancy preparedness. However, community stakeholders described inconsistencies in reproductive health care such as discrimination against African American residents. Some potential pathways forward related to maternal and infant health include more work- and community-based childcare options in addition to improved reproductive health services for teens. Solano County service providers noted that over the last ten years, health officials and community providers have made a concerted effort to increase prenatal care and have seen an increase in rates over time, especially for the Medi-Cal population.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Teen Births (rate per 100,000 population) [1]



Infants Born at Low Birthweight (percent) [2]

Preschool Enrollment (percent) [3]

Community Identified Barriers

Barriers to Maternal and Infant Health

- Lack of culturally competent care
- Economic insecurity
- Prevalence of teen pregnancy
- Lack of affordable childcare options
- Lack of consistent, comprehensive reproductive health care services across providers

> I'm working and I feel like I live paycheck to paycheck, and there are times, I feel like if my baby needs something I won't be able to pay for it. You know? Because there's mortgage due, electricity fluctuates…and so that leads back to health issues as well ... stress ... I'm constantly stressed out.
> *- Focus Group participant*

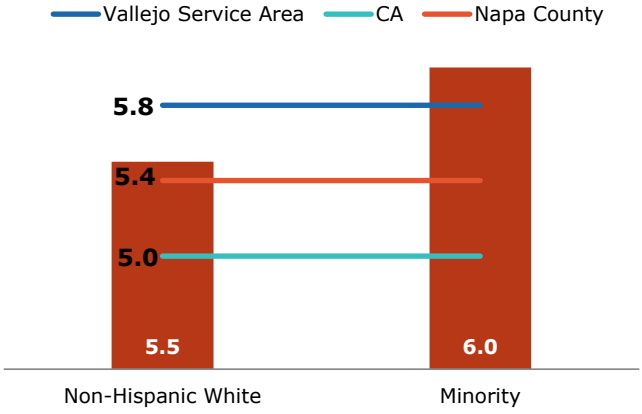
> I just had my daughter two months ago. They [Kaiser staff] attended to me very well, later they gave me a bed and all of the nurses were very friendly, they checked on me often (originally in Spanish).
> *- Focus Group participant*

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

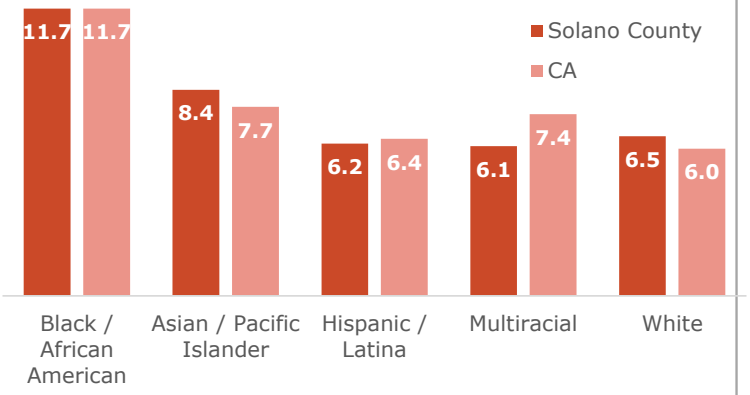
Infant Deaths (rate per 100,000 population) [4]



> In talking to the principal [High School in Vallejo] last she mentioned, "We need some nurses on our campus. We have so many kids, and we don't have the proper services to help them." Let alone, they had a ton of pregnant youth.
> *- Service provider*

> It was something recently that the County was looking into, to figure out what's happening in Vallejo, that they had the highest infant mortality rate, especially amongst women of color.
> *- Service provider*

Infants Born at Low Birthweight, by Race/Ethnicity of Mother (percent)[5]



Infants whose mothers received prenatal care in the first trimester [6]

Solano County : CA

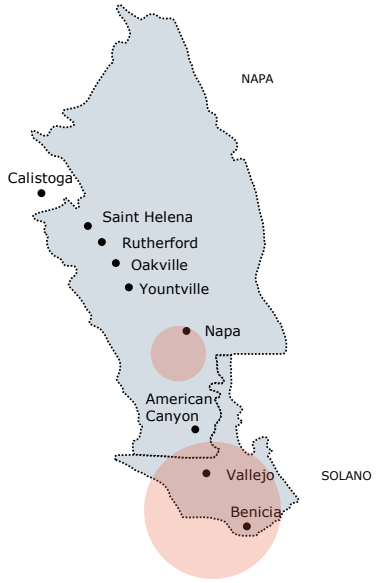
79.9% : 83.6%

> We need to be able to extend our time [and] extend our services for prenatal or postpartum appointments.
>
> *- Service provider*

> What I've been hearing too, is you see a lot of grandparents now raising their grandchildren because they'd be sons and daughters that become addicted to some kind of substance; be it methamphetamine, or opiates.
> *- Service provider*

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Percentage of children in single-parent households [7]

Communities **in southern Napa, Vallejo, and Benicia** have more children living in households with only one parent present. There are several census tracts much worse than the state average across these three regions including (circle size indicates the regional extent of disparities):

- **48%** in census tract 2008.02 (**Napa**)
- **68%** in census tract 2517.01 (Vallejo, **Solano**)
- **46%** in census tract 2520 (Benicia, **Solano**)

Children from single-parent households are at increased risk for presenting emotional and behavioral problems, developing depression, using tobacco, alcohol and other substances, and for all-cause morbidity and mortality.

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Napa county service providers noted that the comprehensiveness of reproductive health care is inconsistent depending on the provider, with barriers to contraception and termination services.
- A service provider in Solano County who works closely with Black/African American mothers described **discrimination of clients in medical settings** and provided the following example:

  "[A client] was recently in the hospital for a pre-term labor and we encourage our moms to do so. But she had gone a couple times and she happened to leave her food on the table and a nurse came to her and said, 'Oh you didn't eat your food. We assumed you came so often because you were homeless and wanted to eat'."

  So we have comments like that. It just reinforces the idea that I don't want to seek medical treatment or that you avoid actual medical emergencies based on experiencing conversations like that."

Assets and Ideas

Examples of Existing Community Assets

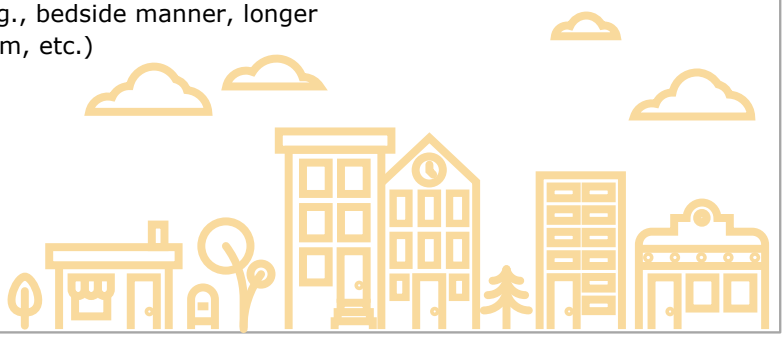
Support for post-partum depression

Programs create social networks among pregnant women and mothers (e.g., Black Infant Health Solano)

Public assistance (e.g., food stamps, cash aid)

Ideas from Focus Groups and Interview Participants

- Need reproductive health services for youth and programs for teen mothers
- Increase school and health sector integration of services, and equitably across schools
- Offer child care at more community services (e.g., food banks), and employers
- Improve culturally competent care (e.g., bedside manner, longer appointments, less time in waiting room, etc.)



References

1. Kidsdata.org. (2008-2014).
2. Same as above.
3. American Community Survey. (2012-2016).
4. Area Health Resource File. (2006-2010).
5. Kidsdata.org. (2013).
6. Same as above.
7. American Community Survey. (2012-2016).

Kaiser Foundation Hospital – Vallejo service area
Community Health Needs Assessment

Violence and Injury Prevention

Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. The Vallejo service area overall has a slightly higher rate of violent crime than the state average. Focus group and interview respondents discussed a deeply embedded environment of trauma and violence in the community, including among youth, and with disparities across regions and demographics. Domestic violence is particularly prevalent in the Solano County portion of the service area, and service providers in Napa County also commented on the depth of impacts that domestic violence can have on one's health and daily routine, including when using public transportation. Economic insecurity can also increase cases of both violence and injury. Deaths due to injury, impaired driving, motor vehicle crashes, and suicide are also all higher than the state average. Mobile advocates and restorative justice programs are a few of the approaches leaders have implemented to address and prevent violence and injury.

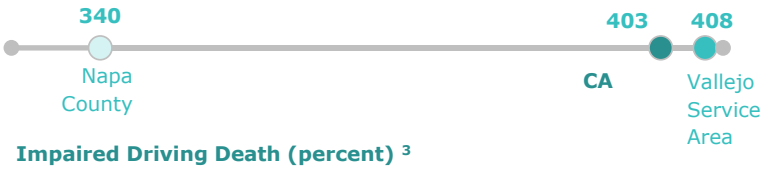
Key Data

Indicators

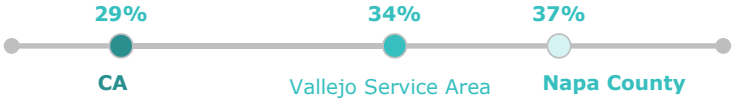
Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Injury Deaths (rate per 100,000 population) [1]

Violent Crimes (rate per 100,000 population) [2]



Impaired Driving Death (percent) [3]



Community Identified Barriers

Barriers to Violence and Injury Prevention

- Childhood trauma, domestic violence
- Economic insecurity, and substance use, increase cases of violence and injury
- Individuals experiencing homelessness and mental health issues can impact safety of communities
- Unsafe public parks (e.g., needles, crime, vandalism)
- Lack of police protection, delayed response times

> We just had a murder a week ago, I think, or maybe two weeks ago, in one of the high schools. I think what we've seen is that the clusters of particularly youth crime and a lot of it is gang related or gang oriented.
> *- Service provider*

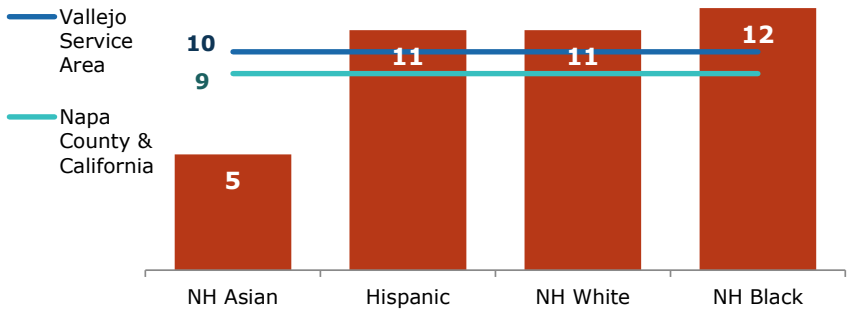
> Even the police say so, 'how can we stop the violence together as a community and people better themselves?' It's gonna have to take someone or something to actually stand up and take the initiative to help better Vallejo.
> *- Focus Group participant*

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Motor Vehicle Crash Death (rate per 100,000 population) [4]

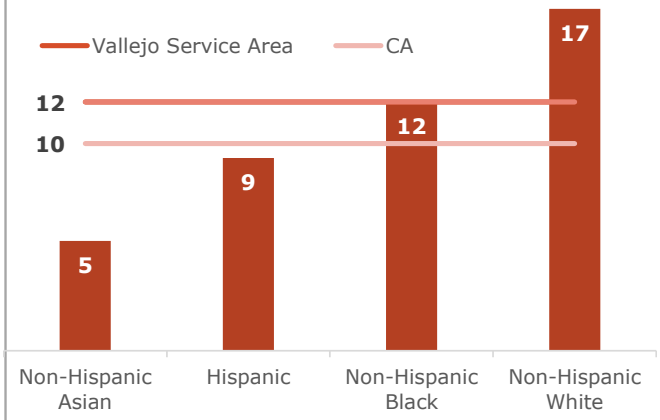


We've heard stories of a lot of our clients, two hours from Calistoga I think if you hit all of the buses correctly, and the likelihood of seeing the batterer or friend of family member of a perpetrator, or something you don't want to see on one particular bus route that loops all day has higher odds of happening than you would imagine.
- Service provider

"I was also at this special event this morning and in the afternoon, and it was very emotional, it was also real life individuals that experienced health issues, mental health issues, abusive issues at an early age, seven years old, 12 years old. And the environment that they were involved with, it all centered upon family. And also families that are locked up in incarceration. What about that population, right?
- Service provider

- Spanish-speaking residents in Napa County mentioned not wanting to let kids go out on their own because of local violence and crime.

Suicide Deaths (rate per 100,000 populations)[5]



Domestic Violence Hospitalization (rate per 100,000 populations) [6]

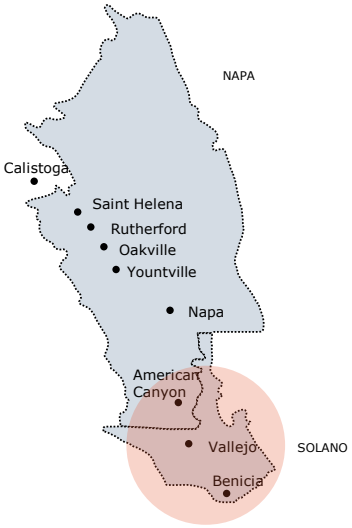
CA : Vallejo service area : Napa County : Solano County

4.9 : 7.5 : 2.8 : 11.6

I think one trend is fear with a lot of the shootings going on. People are more fearful about their safety, with the changes in the politics. People are more fearful and are not sure what's going to happen. A lot of our immigrant communities are more fearful. So I think that's one of the trends in the past few years that I've seen.
- Service provider

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Obviously concentrations of [crime] is in the [Country Club] Crest neighborhood in Vallejo which has a long history of gang related violence. The more rural that you go, I'm not going to say that there's less crime, but I don't think it's more gang oriented than you see in the urban pockets.
- Service provider

- **North Vallejo** was identified by service providers as a particularly unsafe region.
- The **Solano County** portion of the Vallejo service area has the highest **rate of non-fatal emergency visits for domestic violence incidents**[7] (among females aged 10 and older per 100,000 population) at **11.6**, compared to 2.8 in the more northern region of Napa County, and is more than twice the state average of 4.9. As a proxy measure of intimate partner and domestic violence, this indicator may signal broader issues in the community, such as economic insecurity and substance misuse. (Circle size indicates the regional extent of disparities.)

Spotlight on Equity

Community members discussed the following concerns in regard to equity and discrimination:

- Spanish-speaking residents in Vallejo mentioned that many public parks are unsafe (e.g., crime, needles, vandalism) while other parks are pristine depending on the neighborhood and the investment in that community. This group also mentioned a lack of trust with police and that discrimination occurs.
- Service providers, also residents of Vallejo, noted that gangs are prevalent in the region, particularly in Latino/Hispanic communities. Another service provider observed that the juvenile hall is largely made up of youth of color.*
- Napa county service providers noted that national politics and immigration changes has impacted some community members in not feeling included or respected.
- A Napa county resident noted that there aren't enough supports for individuals who want to change [from crime], that they are stigmatized.
- Solano County service providers, when discussing the incidence of human trafficking and prostitution rings, noted that *"it's not just Medi-Cal clients, people are definitely confused about that. They think oh, that's what happens in the poor families. But no, we're seeing it happen to the police chief's kids, the attorney's kids; [it's happening] regardless of class and economics".*

*Conditions that increase the likelihood of involvement with the juvenile justice system include **family poverty**, **separation from family members** including parental incarceration, a **history of maltreatment**, and **exposure to violence.** Youth who have contact with the juvenile justice system are at **increased risk** for a number of negative long-term outcomes, such as **injury, substance use** and dependency, **dropping out of school**, and **early pregnancy**. [8]

Assets and Ideas

Examples of Existing Community Assets

Mobile advocates providing care coordination and support (e.g., school, legal, and medical appointments)

Restorative justice programs

Ideas from Focus Groups and Interview Participants

- Access to safe parks
- Need domestic violence shelters (one recently closed)
- Gun control/reform
- Increase restorative justice programs for both youth and adults
- Improve respect and social inclusion of all community members (e.g., from public officials)

References

1. National Vital Statistics System. (2011-2015).
2. FBI Uniform Crime Reports. (2012-2014).
3. Fatality Analysis Reporting System. (2011-2015).
4. National Vital Statistics System. (2011-2015).
5. Same as above.
6. California EpiCenter. (2013-2014).
7. Same as above.
8. Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center. (2018).