2013

Community Health Needs Assessment
ValleyCare Health System

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ValleyCare Health System

2013 Community Health Needs Assessment Report

I. EXECUTIVE SUMMARY

ValleyCare Health System (VHS) is submitting this Community Health Needs Assessment (CHNA) in response to the federal requirements described in section 501(r)(3) of the Internal Revenue Code and related excise tax and reporting obligations, applicable to hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) of the Code. The CHNA requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which was added to the Code by section 9007(a) of the Patient Protection and Affordable Care Act ("Affordable Care Act"), enacted March 23, 2010.

ValleyCare Health System has been providing medical care in the Tri-Valley area of Alameda County, California since 1961 and has a long-standing commitment to the communities in which we operate In 2010, VHS, in conjunction with the Hospital Council of Northern and Central California, completed a community needs assessment to identify the most pressing local public health issues affecting our local communities. The September 2010 report identified a particular need for health care coverage and access for the uninsured population, most of whom are eligible for Medi-Cal. This 2013 CHNA continues the VHS commitment to understanding our communities, their needs and the assets and resources available to meet them as we define where and how VHS community investments can have the greatest impact.

As a result of a collaborative 2013 CHNA process, we have developed the following list of community health needs with particular relevance for vulnerable populations in the VHS service area (listed in priority order)

1. Primary care services and information (health literacy), including adequate Spanish capacity
2. Economic security
3. Affordable, local mental health services
4. Affordable, local substance abuse treatment services
5. Asthma prevention
6. Healthy Eating
7. Specialty care
8. Parenting skills and support

VHS collaborated with Kaiser Foundation Hospital Walnut Creek in the 2013 CHNA process. The process included comprehensive review of secondary data on health outcomes, drivers, conditions and behaviors as well as collection and analysis of primary data through community conversations with members of vulnerable populations in our service area. Input on the identified community health needs, and the relative priority among them, was gathered through a convening of public and community health leaders, advocates and experts. The resulting prioritized list represents a community understanding that is informed by both data and experience.

II. BACKGROUND AND INTRODUCTION

ValleyCare Health System has provided high quality, not-for-profit health care to the Tri-Valley and surrounding communities since 1961. Through highly skilled physicians, nurses and staff, and state-of-the art technology, ValleyCare offers a wide range of health care services at its Livermore, Pleasanton and Dublin medical facilities. ValleyCare in not publicly owned or operated, nor is it supported by taxes. ValleyCare reinvests any profits it makes into new services, equipment, and facilities. A 13-member Board of Directors, which is elected by its corporate members, governs the ValleyCare Corporation. Corporate members exercise certain reserve rights with respect to governance decisions.

Through SB 697, the State of California requires all not-for-profit hospitals in California to complete and submit an annual Community Benefit Report. Although hospitals bring numerous benefits to their local economies, these reports are intended to document the ways in which each hospital goes above and beyond the core functions of a hospital to support the health needs of its community. To inform the Community Benefit Report and community benefit activities, every three years non-profit hospitals in California must conduct a needs assessment to identify the greatest health needs affecting their respective communities.

In 2010, ValleyCare Health System, in conjunction with the Hospital Council of Northern and Central California, completed a community needs assessment to identify the most pressing local public health issues affecting the local communities. VHS has been a participant in a local collaborative of hospitals that contracted with the Alameda County Health Department Community Assessment, Planning, and Education Unit for a comprehensive review of data on health outcomes, access and conditions. The September 2010 report identified a particular need to work on health care coverage and access for the uninsured population, most of whom are eligible for Medi-Cal.

The Patient Protection and Affordable Care Act (PPACA), enacted March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the health needs identified through the assessments. Through collaborative community partnerships, VHS recently completed the Community Health Needs Assessment in accordance with the provisions of the PPCAA . As a community-based organization, VHS understands the value of continuously evaluating the health needs of the community it serves. By doing so, we are able to establish a systematic process for identifying community health needs that will guide thoughtful and effective community investment for years to come.

A. About ValleyCare Health System

Mission
The mission of ValleyCare Health System is to assume the leadership role for the health of the communities of the Tri-Valley.

Vision
ValleyCare Health System is a center of clinical and service excellence.

Credo
ValleyCare Health System is a place where the genuine care, comfort and dignity of our patients is our highest commitment. The ValleyCare experience promotes healing and well-being, and anticipates the wishes and needs of the community. Every employee commits to make a difference in every instance, every time, every day.

B. Community Served

The **Tri-Valley** region is based around the four suburban cities of Livermore, Pleasanton, Dublin and San Ramon in the three valleys from which it takes its name: Amador Valley, Livermore Valley and San Ramon Valley. Livermore, Pleasanton and Dublin are in Alameda County, while San Ramon is in Contra Costa County.

ValleyCare's primary service area is the Tri-Valley. ValleyCare has facilities in Pleasanton, Livermore, and Dublin. The Tri-Valley accounts for over 80% of ValleyCare's inpatient discharges

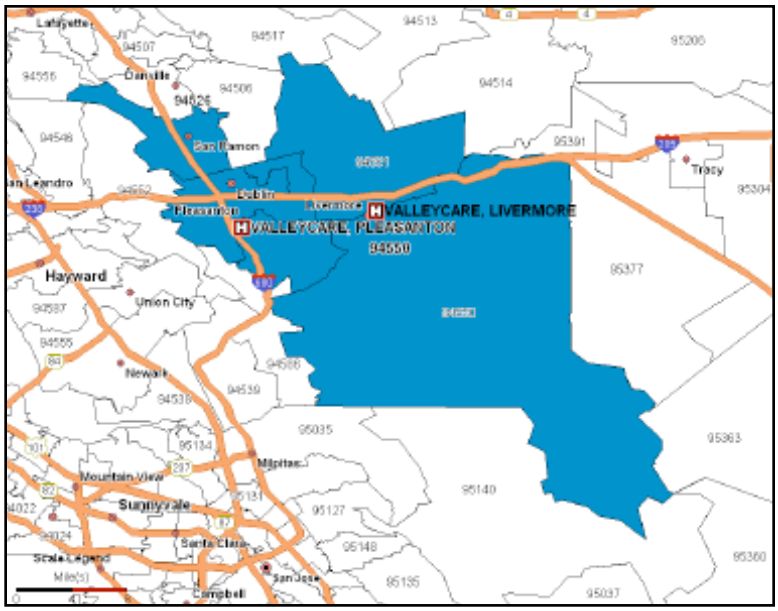

TABLE 1: DEMOGRAPHIC PROFILE OF VALLEYCARE HEALTH SYSTEM SERVICE AREA (CITIES OF DUBLIN, LIVERMORE AND PLEASANTON)[1]

	Dublin	Livermore	Pleasanton	San Ramon
Total population	46,036	80,968	70,285	69,241
Under 18 years old	22%	25%	27%	22%
Ages 18 - 34	28%	21%	15%	18%
Ages 35 - 64	43%	44%	47%	46%
Age 65+	7%	10%	11%	7%
White	51%	75%	67%	53%
Black	9%	2%	2%	2%
Asian	27%	8%	23%	36%
Hispanic	14%	21%	10%	10%
% Below Poverty	3.5%	6%	4.2%	3.6%
% over age 25 with HS Diploma or Equivalent	92.5%	92%	94.9%	97.2%

[1]http://factfinder2.census.gov

C. Collaboration for the 2013 Community Health Needs Assessment

This Community Health Needs Assessment was conducted through collaboration between ValleyCare Health System and Kaiser Permanente Walnut Creek, both of which serve the Tri-Valley communities of Livermore, Pleasanton and Dublin (in Alameda County, California).

ValleyCare Health System, along with Kaiser Permanente Walnut Creek contracted with Caroline McCall dba Arete Consulting to complete the data analysis required for the Community Health Needs Assessment. Ms. McCall also designed and facilitated primary data collection and supported a prioritization session that engaged public and community health experts from the Tri-Valley. Ms. McCall subcontracted with Nancy Shemick to conduct primary data collection in Spanish.

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

D. Process and Methods Used to Conduct the CHNA

Secondary data

The majority of the secondary data used in this CHNA were made available through the Kaiser Permanente (KP) Community Health Needs Assessment (CHNA) Data Platform, powered by the Center for Applied Research and Environmental Systems (CARES), and the Institute for People, Places, and Possibility (iP3). These data were organized into six distinct categories:

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

Social and Economic Factors. These data were from the following sources:

- US Census Bureau, American Community Survey 2006-2010 5-year estimates and 2008-2010 3-year estimates
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
- US Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2009-2010 and Local Education Agency (School District) Universe Survey Drop-out and Completion Data, 2008-2009
- States' Department of Education, Student testing Reports, 2011
- US Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009
- US Bureau of Labor Statistics, July 2012 Local Area Unemployment Statistics
- US Federal Bureau of Investigation, Uniform Crime Reports, 2010

Physical Environment, including data from the following sources:

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

Clinical Care data from the following sources:

- California Health Interview Survey (CHIS) 2005, 2007, and 2009
- US Health Resources and Services Administration Area Resource File 2009 (as reported in the 2012 County Health Rankings) and Health Professional Shortage Area File 2012
- Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality 2003-2007,
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
- US Health Resources and Services Administration Centers for Medicare and Medicaid Services, Provider of Service File, 2011
- California Department of Public Health Birth Profiles by ZIP code, 2010
- California Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2010

Health Behaviors data from the following sources:

- California Health Interview Survey (CHIS) 2009
- Nielsen Claritas SiteReports Consumer Buying Power, 2011
- California Department of Public Health, In-Hospital Breastfeeding Initiations Data, 2011
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
- California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011

Health Outcomes data, based on incidence and mortality.

- California Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2010
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
- Centers for Disease Control and Prevention and the National Cancer Institute: State Cancer Profiles, 2005-2009
- California Department of Public Health, Death Statistical Master File, 2008-2010
- Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009
- Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
- California Health Interview Survey (CHIS) 2009
- California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011
- Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As reported in the 2012 County Health Rankings)

The statisticians at the Center for Applied Research and Environmental Systems (CARES) used data from the sources listed above to create the Kaiser Permanente CHNA data platform. The platform analysis of data by geographic areas is limited by the geography for which the data were originally collected.

Health Outcomes data from the platform were downloaded for Alameda County, and whenever possible, for the communities in the Tri-Valley area. These data were compared to benchmarks defined either by Healthy People 2020 or State-level rates. After identifying those health outcomes indicators for which the population in the VHS service area were seen to compare poorly to benchmarks, associated indicators of health (health behaviors, clinical care, physical environment and social and economic factors) were reviewed and analyzed to see where these indicators also showed poor performance relative to benchmarks.

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

Community input

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

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

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

Community Conversations

Two groups of community members were recruited by community agencies serving the relevant populations. One of the community conversations was held at an elementary school and engaged 12 Spanish-speaking female parents and the second conversation included 16 low-income community members who were recruited through a community-based counseling center. Participants were recruited from populations with high rates of poverty, low rates of high school graduation and relatively low rates of insurance coverage. The community agencies with whom ValleyCare and Kaiser Permanente partnered for these community conversations recruited the individuals and provided space, while ValleyCare and Kaiser Permanente shared the cost of food and thank-you gifts for the participants. The table below shows the specific partner agencies, the language in which the conversation was held, the number of individuals present and the target populations from which they were drawn (minority, low-income, chronic conditions, etc...).

TABLE 2: COMMUNITY CONVERSATIONS IN EASTERN ALAMEDA COUNTY

Partner Agency	Language	Number of Participants	Age Range	Populations Represented
Marilyn Avenue School (October 16, 2012)	Spanish	12	30-47	Latino Low Income Chronic Conditions
Horizon Family Counseling (October 25, 2012)	English and Spanish	16	18 - 63	Latino Low-income Chronic Conditions

Expert Stakeholders

The second means of gathering community input was through a group of public health and social service professionals who were gathered to discuss and prioritize among the community health needs that emerged from the synthesis of the secondary data and community conversations. The stakeholder meeting was held on November 27, 2012. The meeting format included an opening presentation followed by small group and large group discussions. Participants were provided with demographic data for Eastern Alameda County as well as health outcomes data and other related health indicators for all of the health concerns that emerged from analysis of the primary and secondary data. As a result of the small and large group conversations, the stakeholders offered recommendations regarding the relative priority of each defined community health need.

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

TABLE 3: PUBLIC AND COMMUNITY HEALTH EXPERTS
CONVENED ON NOVEMBER 27, 2012

Name	Agency Represented	Area of Expertise
Aaron Ortiz	East Bay Youth & Family Initiatives	Low-income Populations Latino populations
Ann King	Tri-Valley Haven	Homeless, low-income, families
Bernadette Revak	ValleyCare	Infectious disease
Brian Edwards	ValleyCare	Emergency and specialty care
Jean Prasher	City of Livermore	Low income populations
Jesus Verduzco	Alameda County Health Care Services Agency	Public health
Juliana Schirmer	Tri-City Health Center	Low-income populations Latino populations
Linda McKeever	Open Heart Kitchen	Low-income populations Latino populations Chronic Conditions
Lynn Gardner	Horizons Family Counseling	Low-income populations Latino populations
Marlene Petersen	Senior Support Program of the Tri-Valley	Chronic Conditions Low-income populations
Sharon Grant	Livermore Area Recreation and Park District	Low-income populations
Valerie Jonas	Axis Community Health	Community Health Center Low-income populations Latino populations Chronic Conditions

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

Identification and Prioritization of Community Health Needs

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

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

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

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

TABLE 4: EASTERN ALAMEDA COUNTY POOR HEALTH OUTCOMES AND BENCHMARKS

Health Outcome	**Alameda County (East County where available)**	**Benchmark**
Adult asthma prevalence	15.84% (county)	State 13.12%
Asthma Discharges – age-adjusted/10,000	9.6/10,000 (Livermore)	State 8.9/10,000
Asthma Discharges as % of Total Discharges	10.77% (Livermore)	State .88%
Breast cancer incidence per 100,000	128.3/100,000 (county)	State 123.3/100,000
Colorectal cancer incidence per 100,000	45.1/100,000 (county)	HP 2020 <=38.6/100,000
Prostate cancer incidence per 100,000	150.8/100,000 (county)	State 143/100,000
Suicide death rate per 100,000	11.4/100,000 (Dublin and Pleasanton)	HP 2020 <=10.2
Self-report poor mental health	14.78% (county)	State 14.21%
Preventable Hospital Discharges — Age-adjusted rate per 10,000	86.64/10,000 (Livermore)	State 83.17/10,000

TABLE 5: POOR HEALTH OUTCOMES AND RELATED HEALTH DRIVERS, BEHAVIORS AND CONDITIONS IN EASTERN ALAMEDA COUNTY

Health Outcomes	Related Health Drivers, Behaviors and Conditions Seen in the Tri-Valley
Adult asthma prevalence and asthma discharges	Poor Air Quality – Percent of days with particulate matter emissions above standard ranged from 3.5% - 6% throughout the Tri-Valley.
Breast cancer incidence	Heavy alcohol consumption – 18-22% of adults above age 18 in the Tri-Valley are considered heavy drinkers. The state rate is 16.6%
Colorectal cancer incidence	Inadequate fruit and vegetable consumption – 72% of adults in the Tri-Valley consume too few fruits and vegetables. The state rate is 70% Heavy alcohol consumption – (see above). Fruit and vegetable expenditures – Percent of total household expenditures = 1.39%. State benchmark is 1.64% Fast food restaurant access Fast food establishments per 100,000 population = 117.28 in Livermore and above 80 in the rest of the Tri-Valley. The state rate is 69.37. WIC-authorized food store access – WIC authorized food stores per 100,000 is 12.5. The state rate is 15.8.
Prostate cancer incidence	Inadequate fruit and vegetable consumption – (see above) Fruit and vegetable expenditures– (see above) WIC-authorized food store access– (see above)
Suicide death rate	Heavy alcohol consumption — (see above)
Poor mental health	Heavy alcohol consumption — (see above)

CRITERIA USED TO PRIORITIZE AMONG COMMUNITY HEALTH NEEDS

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

PRIORITIZED LIST OF COMMUNITY HEALTH NEEDS

- Primary care services and information (health literacy), including adequate Spanish capacity
- Economic security
- Affordable, local mental health services
- Affordable, local substance abuse treatment services
- Asthma prevention
- Healthy eating
- Specialty care
- Parenting skills and support

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

TABLE 6: SIGNIFICANT COMMUNITY ASSETS AND RESOURCES RELATED TO CHNS

Community Health Needs	Existing Community Assets and Resources
Primary care services and information (health literacy), including adequate Spanish capacity	Axis Community Health
Economic security	City of Dublin Senior Center Tri-Valley Community Foundation
Affordable, local mental health services	National Alliance on Mental Illness – Tri-Valley Axis Community Health Adult Behavioral Health Services Horizon Family Counseling
Affordable, local substance abuse treatment services	Axis Community Health Adult Behavioral Health Services
Asthma prevention	
Healthy eating	Children's Emergency Food Bank
Specialty care	
Parenting skills and support	LARPD Extended Student Services Tri-Valley Haven Love Never Fails Mentors for Positive Change Child Care Resources and Referral Line Cal-SAFE Horizon School-Age Parent Program

APPENDIX: COMMUNITY HEALTH NEED PROFILES

<table>
<tr><td colspan="4">1. Primary care services and information (health literacy), including adequate Spanish capacity, are needed to improve primary care outcomes, including chronic conditions prevention and management.</td></tr>
<tr><th>Rationale</th><th>Indicators and Health Outcomes</th><th>Health Outcomes Benchmarks</th><th>Contributing Factors</th></tr>
<tr><td rowspan="3">Many health outcomes indicate a need for accessible primary care information and intervention in vulnerable populations.
Community members indicated that both
access to care and availability of health information limited their ability to receive consistent primary care</td><td>Asthma Prevalence = 15.84%</td><td>Asthma Prevalence = 13.12%</td><td>Poor Air Quality (Particulate Matter)</td></tr>
<tr><td>Asthma discharges (age-adjusted) = 9.6/10,000 (Livermore)
Asthma discharges as % of total discharges = 10.77% (Livermore)</td><td>Asthma discharges (age-adjusted) = 8.9/10,000
Asthma discharges as % of total discharges = 0.88%</td><td></td></tr>
<tr><td>Preventable hospital discharges (age-adjusted) = 86.64/10,000 (Livermore)</td><td>Preventable hospital discharges (age-adjusted) = 83.17/10,000</td><td></td></tr>
</table>

Primary Data Summary:

- Need for affordable primary care relationships that are stable and comprehensive.
- More accurate information about health care and health concerns would help community members know how to identify health issues early and how to prevent them.

2. Economic security is needed because the stress related to economic insecurity plays a significant role in mental health, suicide, as well as poor eating and exercise habits (lack of money and time).			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
All community groups and the public health experts felt this would have a meaningful impact across ALL health outcomes.	Areas of Livermore and Dublin show between 25% and 30% without High School diploma	NA	NA
	Areas of Livermore show poverty rates above 12%	NA	NA
	Self-reported poor mental health = 14.78%	Self-reported poor mental health = 14.21%	Heavy alcohol consumption
	Asthma Prevalence = 15.84%	Asthma Prevalence = 13.12%	Poor Air Quality (Particulate Matter)

Primary Data Summary:

- Economic stresses leads to anger, anxiety, depression and violence.
- Parents who are trying to make ends meet will purchase cheap and unhealthy food.
- Community activities, particularly youth sports, are too expensive – they are working long hours and cannot afford to pay for anything extra.

3. Affordable, local mental health services are needed to support families and youth and to limit the negative impact from poor mental health status (including violence). Primary data collected in the Tri-Valley implied that this need is greatest there.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
Both suicide rates and poor mental health status are higher than benchmark rates. Community members and PH experts in the feel that there are not enough available affordable mental health services in the community.	Suicide Death rate = 11.4	Suicide Death rate <= 10.2	Heavy alcohol consumption
	Poor Mental Health = 14.78%	Poor Mental Health = 14.21%	

Primary Data Summary:

- There are not enough providers of low-cost or free mental health services.
- If you have a crisis need in the Tri-Valley, you have to go to Highland Hospital.
- Parents need mental health support to keep an even keel and support children without resorting to alcohol or violence.

4. Affordable, local substance abuse treatment services are needed to address alcohol use as well as the use of other drugs. Primary data collected in the Tri-Valley implied that this need is significant among low-income and at-risk populations.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
Heavy alcohol consumption is associated with several of the poor health outcomes. Community members indicate that illegal drug use is also common and related to poor mental health.	Poor Mental Health = 14.78%	Poor Mental Health = 14.21%	Heavy Alcohol Consumption
	Suicide Death rate = 11.4	Suicide Death rate <= 10.2	

Primary Data Summary:

- Teens and adults all drink – it is acceptable.
- In the Tri-Valley there are a lot of vineyards, creating societal acceptance of drinking alcohol the norm and easy to get.
- There are drugs available and used in the schools.

5. Asthma prevention is needed to decrease the prevalence of asthma, which is over 15% throughout the Tri-Valley.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
Chronic asthma contributes to a decreased sense of well-being, and can result in decreased time at school, decreased exercise and activity, and decreased productivity. Community groups all indicated that asthma prevalence is a community health issue and that poor air quality is one of the contributing factors.	Asthma Prevalence = 15.73%	Asthma Prevalence = 13.12%	Poor Air Quality (Particulate Matter)
	Asthma discharges (age-adjusted) = 9.6/10,000 (Livermore) Asthma discharges as % of total discharges = 10.77% (Livermore)	Asthma discharges (age-adjusted) = 8.9/10,000 Asthma discharges as % of total discharges = 0.88%	

Primary Data Summary:

• Asthma is an issue related to polluted air as well as pollen in the Tri-Valley.

6. Healthy eating would improve health outcomes in the Tri-Valley, particularly those related to cancer incidence. Although poor health outcomes related to overweight and obesity are not seen in the secondary data, residents of the Tri-Valley feel that unhealthy eating habits and unhealthy weight are issues for their communities.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
The data for the Tri-Valley show high rates of incidence for cancers that are associated with a lack of healthy eating.	Cancer Incidence per 100,000: Breast cancer = 128.3/100,000 Colorectal cancer = 45.1/100,000 Prostate cancer = 150.8/100,000	Breast Cancer = 123.3/100,000 Colorectal cancer <= 38.6/100,000 Prostate cancer = 143/100,000	Inadequate fruit and vegetable consumption Fruit and vegetable expenditures Fast food restaurant access WIC authorized food store access Heavy alcohol consumption

Primary Data Summary:

- Healthy food is more expensive and less convenient than fast food.
- Healthy food (fresh food) takes more work to prepare.
- Community members know what they should eat, but they do not limit their diets consistently either because of cost, convenience, or knowledge of how to prepare healthier food.

7. Specialty Care is a significant need for low-income residents in the Tri-Valley area. Improved specialty care access could have a positive effect on several of the poor health outcomes, particularly preventable hospitalizations.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
Community members in the Tri-Valley indicate that they have to travel long distances to get specialty care – most often to Highland Hospital. Public health experts confirm that specialty care access is limited by available providers who will take low-income individuals, particularly in the Tri-Valley	Preventable hospital discharges (age-adjusted) = 86.64/10,000 (Livermore)	Preventable hospital discharges (age-adjusted) = 83.17/10,000	

Primary Data Summary:

- If primary care services were adequate, there would not be as much need for specialty care services.
- Community members in the Tri-Valley have to drive or pay for transportation to Highland hospital to receive most specialty care services.

8. Parenting skills and support were identified as a need by all of the community groups. The need relates to understanding how to raise children in a healthy way, using effective discipline as well as good cooking and eating habits. Parents also wanted skills and support in addressing mental health and substance use/abuse issues with their children.			
Rationale	**Indicators and Health Outcomes**	**Health Outcomes Benchmarks**	**Contributing Factors**
Parents feel that improved skills and support are a critical need in families that are isolated (immigrants in particular) or where parents are struggling to manage jobs, commutes and child-rearing.	Poor Mental Health = 14.78%	Poor Mental Health = 14.21%	Heavy Alcohol Consumption
	Suicide Death rate = 11.4/100,000	Suicide Death rate <= 10.2/100,000	

Primary Data Summary:

- Parents are struggling to keep above water economically and do not have enough support to also be good parents. It is easier to give in to their children when they are tired and under stress. If they do not give in, they get angry.
- They are worried about the stress that their lack of money and availability places on their children.
- Parents are concerned that they do not have the resources or knowledge to keep their children safe and healthy.

Serving the Tri-Valley with Medical Facilities in Livermore, Pleasanton and Dublin.

www.valleycare.com