

2025–2027

Alameda County

Community Health Assessment



**Public Health
Department**

Alameda County Health



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Renato Almanzor, PhD, Collaborator

The Public Health Department of Alameda County Health convened an Internal CHA Advisory Board where staff from different divisions participated to inform and guide the CHA process. Participating staff in the CHA process are as follows.

Kimi Watkins-Tartt, Director, Public Health Department

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John Virata, Quality Improvement Associate, QIA Division

Linda Franklin, Management Analyst, QIA Division

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Matthew Beyers, Supervising Epidemiologist, CAPE



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Letter from Public Health Department Director, Kimi Watkins-Tartt



January 2026

Community Health Assessment – Building a Healthier Alameda County Together

Dear Community Members,

On behalf of the Alameda County Public Health Department, I am pleased to share the results of our **Community Health Assessment (CHA)**. This report reflects the voices, experiences, and data that tell the story of health in our county—where we are making progress and where challenges remain.



The CHA is more than a document; it is a foundation for action. It brings together community input, public health data, and insights from our partners to highlight key health needs and inequities across Alameda

County. The findings underscore the importance of addressing not only access to care, but also the broader conditions that shape health—such as housing, employment, education, and safety.

As we move forward, the CHA will directly inform our **Community Health Improvement Plan (CHIP)**, guiding our collective priorities and strategies. We remain committed to advancing health equity, listening to the wisdom of our residents, and working side by side with community partners to create lasting change.

I want to extend my deep gratitude to all who participated in this process—residents, community organizations, health care providers, and county staff. Your voices and partnership are essential in shaping a healthier, more just Alameda County.

We invite you to review the Community Health Assessment and join us in the next phase of this work. Together, we can build a county where every person has the opportunity to live a long, healthy, and fulfilling life.

With appreciation,

Kimi Watkins-Tartt
Director
Alameda County Public Health Department

1. Executive Summary

Executive Summary

Purpose of the Community Health Assessment

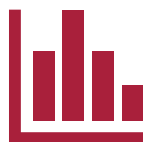
- ✓ **Tell the community’s story** by collecting both numbers and personal experiences from different sources to better understand what affects people’s health.
- ✓ **Find differences in health outcomes** between groups and learn what causes them, to support fair and equal health for everyone.
- ✓ **Use this information** to guide the Alameda County Public Health Department’s planning, programs, and policies, and to work with community partners to improve health and well-being.
- ✓ **Meet public health accreditation standards** by following clear and evidence-based practices.

Community Health Assessment (CHA) Process and Methods

Figure 1. The main part of the CHA process is gathering and studying information to make a list of problems that affect the community's health.



Talk to community members



Collect numbers and read reports



Study all the information



Make a list of community health needs

Key Findings: Top Community Health Needs, 2025–2027

- Social Determinants of Health:
 - Health Care Access & Quality
 - Economic Stability
 - Peaceful Communities
 - Housing and Homelessness
 - Built Environment, Including Unintended Injuries
 - Climate/Natural Environment
 - Racism/Discrimination
- Behavioral Health
- Chronic Conditions:
 - Asthma
 - Cancer
 - Cognitive Decline
 - Diabetes & Obesity
 - Heart Disease & Stroke
- Communicable Diseases
 - Sexually Transmitted Infections
 - Respiratory Infections
 - Other Communicable Diseases

Major Conclusions

- Community members are very concerned about social determinants of health, which are the conditions that affect people's daily lives, like being able to afford housing and food.
- African American/Black and Pacific Islander people in Alameda County have more health problems and die from major diseases more often, especially when they are younger.
- People in the community, no matter their race, ethnicity, sexual orientation, gender identity, age, disability, or where they live, say they have problems with their mental and behavioral health.

Next Steps for Alameda County Public Health in 2026

- Make the 2025–2027 Community Health Assessment report publicly available on the Alameda County Public Health Department's website. Also, send it to the group that gives the department its accreditation.
- Share the report with people who are affected by it and people who live in the county by giving presentations, publishing it, and using social media.
- Work with people in the community and other departments in the agency to create a Community Health Improvement Plan based on what the assessment shows. This plan will be published in 2027.
- Monitor the progress of the Community Health Improvement Plan and share regular updates with the community.

2. Introduction

Introduction

This Community Health Assessment (CHA) takes a broad view of health conditions and status in Alameda County. It provides local disease and death rates alongside data and information on social determinants of health such as social structures and economic systems, including health services and the social and physical environment.



The CHA is conducted in collaboration with Alameda County’s nonprofit hospitals’ comprehensive community health needs assessments (CHNAs) and is one of the requirements for public health accreditation. This document will inform the work of Alameda County Public Health Department (ACPHD) work to better serve the people of Alameda County. Understanding why health disparities exist enables ACPHD to address root causes and develop better interventions, policies, and infrastructure.

Community Health Assessment Purpose

The goals of the 2025–2027 CHA are to:

- Tell the community’s story through a mixture of data collection methods, including listening to community voices, reviewing existing reports, and gathering statistics from a variety of sources, as the foundation to improve population health.
- Identify disparities among different subpopulations and their contributing factors (including root causes) to support efforts to achieve health equity.
- Serve as the basis for priority setting, planning, program development, policy changes, funding applications, coordination of community resources, and development of new ways to collaboratively use community assets to improve the equity, health, and well-being of communities’ members.
- Meet the Public Health Accreditation Board (PHAB) requirements for reaccreditation, including specific requirements for the CHA.

ACPHD, in partnership with local communities and the other Alameda County Health departments, will respond to the information in the 2025–2027 CHA by developing a Community Health Improvement Plan (CHIP). This plan aims to address the community’s critical health needs and protect and improve the health and well-being of its members, especially those who are the most affected by health disparities and inequities.

About Public Health Accreditation Board (PHAB) Recognition

PHAB accreditation is grounded in evidence-based standards that help health departments establish their effectiveness and show accountability to communities, policymakers, and others. Its national program evaluates a department’s ability to deliver the 10 Essential Public Health Services¹ and the Foundational Capabilities.²

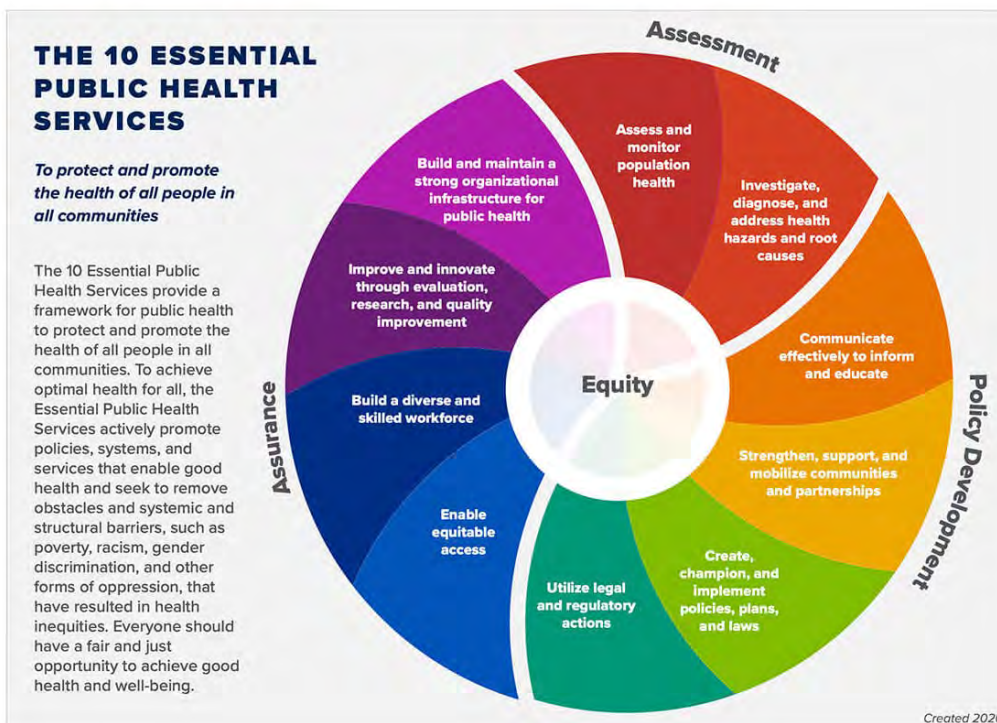


When a health department earns PHAB accreditation, it builds public trust and shows its continuing commitment to quality and performance improvement. Every 5 years, ACPHD undergoes the reaccreditation process through PHAB’s evaluation of the department against a set of national standards. For more information, see PHAB’s [website](#).

The CHA is the product of the *Assessment* pillar of the 10 Essential Public Health Services framework and the first step in the *Policy Development* pillar (see Figure 2). The CHA specifically addresses three Essential Services:

1. Assess and monitor population health
2. Investigate, diagnose, and address health hazards and root causes
3. Communicate effectively to inform and educate

Figure 2. PHAB’s 10 Essential Public Health Services framework centers on equity.



Source: PHAB. (2020). Retrieved from <https://phaboard.org/infrastructure/public-health-frameworks/the-10-essential-public-health-services/>

What Is Included in the 2025–2027 CHA Report

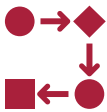
This report documents the following:



A description of the demographics of the population served by ACPHD, including percentages by race and ethnicity and languages spoken within the jurisdiction.



A description of inequities in factors contributing to the identified health needs, which must include social determinants of health.



The process that ACPHD and its partners collaboratively followed to develop the CHA.



Comprehensive, broad-based data, including primary and secondary data from two or more different sources.



A description of health needs and challenges faced by the population, based on primary and secondary data listed above, which includes an examination of health status and health behavior disparities among subpopulations or sub-geographic areas.



Participating partners in the CHA process. This includes multiple organizations representing sectors other than governmental public health, including community members representing populations disproportionately affected by conditions that contribute to poorer health outcomes.



Community assets or resources beyond health care and ACPHD that can be mobilized to address health needs.

3. Community Served

Community Served

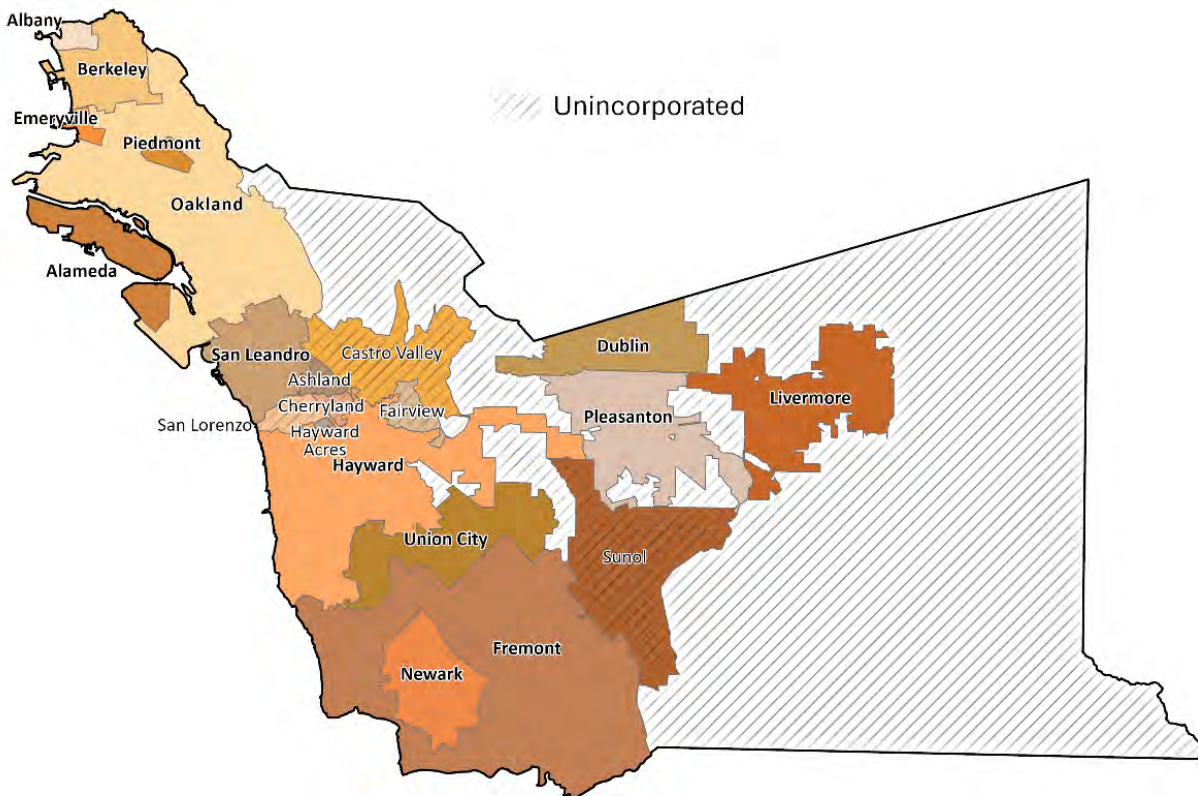
Alameda County is one of nine counties that make up the San Francisco Bay Area in California. It is rich in arts, political activism, world-famous higher education institutions, entrepreneurship, and breathtaking natural terrain. It also boasts an enviable Mediterranean climate. According to the U.S. Census Bureau, the county is home to approximately 1.65 million people³ living within 738 square miles of land⁴ originally inhabited by members of the Muwekma Ohlone Tribe.⁵ The charts on the following pages describe these demographics in greater detail.

Alameda County is the 7th most populous county in California⁶ and one of the most ethnically diverse regions in the nation.⁷ In 2023, people living in Alameda County had an income of \$63,442 per capita.³ Nearly 1 in 10 Alameda County residents live below the federal poverty level.³

People who live in or are interested in moving to Alameda County can choose from 14 incorporated cities and six Census-Designated Places to reside. A map of the county is shown below.

9%
People living below
federal poverty level
in 2023

Figure 3. The map of Alameda County shows cities and unincorporated areas.



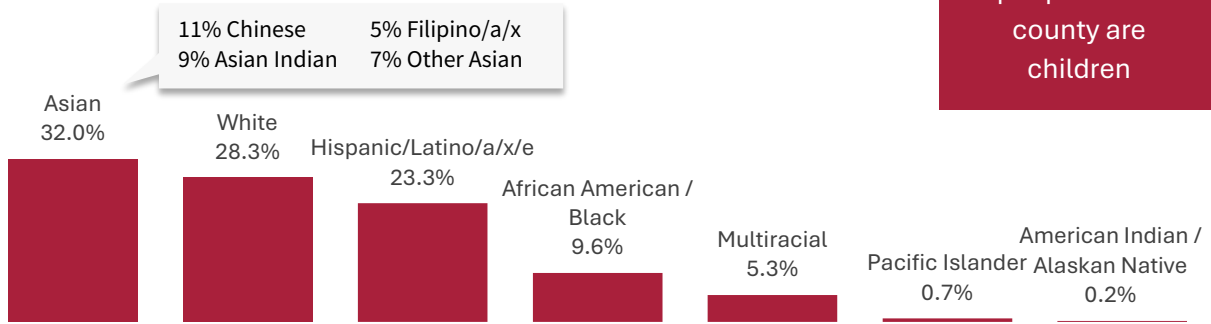
Map credit: ACPHD Community Assessment, Planning, and Evaluation (CAPE), 2026.



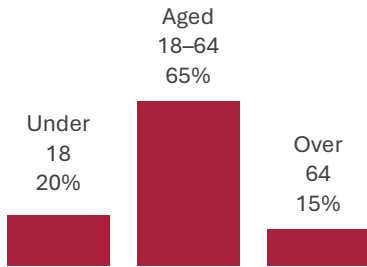
Demographics of Alameda County

The county's population is extremely diverse.

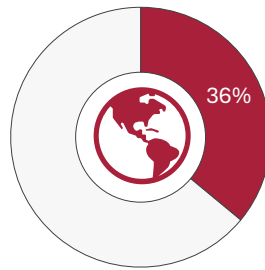
1 in 5
people in the county are children



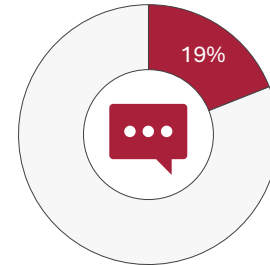
One in 5 people in the county are children.



More than 1 in 3 people are immigrants.



About 1 in 5 people over age 5 speak limited English.



\$121,703

Real Cost Measure (RCM) for 4-person household; factors in the costs of housing, food, health care, child care, and other basic needs



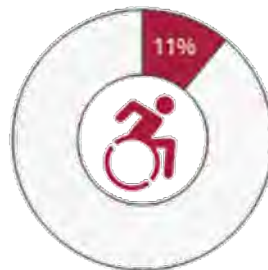
\$1.0M

median home sale price

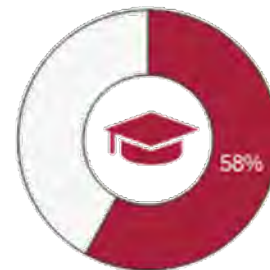
On average, close to 1 in 3 households here live below the Real Cost Measure.



Over 1 in 10 people in the county live with a disability.



Nearly 3 in 5 people here aged 25+ have at least a bachelor's degree.

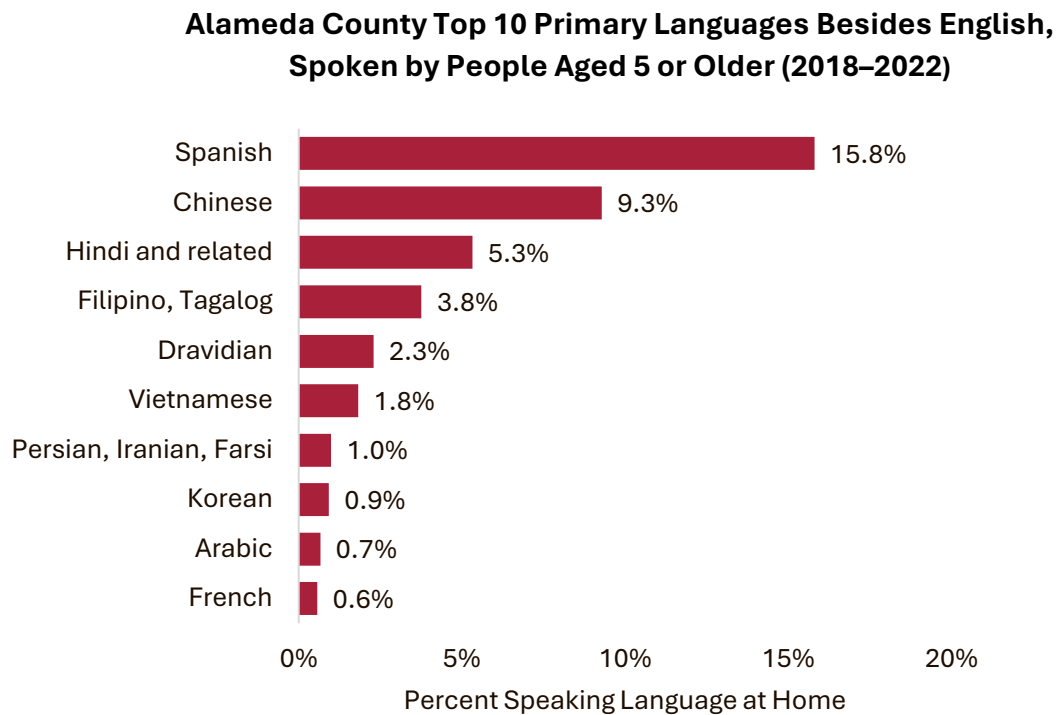


Sources: United Ways of California: Real Cost Measure, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: demographics, 2019-2023.

Languages Spoken in Alameda County

Alameda County is not only highly ethnically diverse but also linguistically diverse. Aside from English, the threshold languages—those spoken by at least 5% of the county’s population—include Spanish and Chinese.

Figure 4. Many languages are spoken in Alameda County.



Source: U.S. Census Bureau, American Community Survey, 5-year estimates, 2018–2022.





Inequities in the County

The health and well-being of people living in Alameda County has generally improved over time, but, as this report illustrates, not all population subgroups have felt these benefits equally. The county has large and persistent health inequities, with deep-seated roots that reach back to California and the United States' early history. People of color—African American/Black, Asian and Pacific Islander, American Indian/Alaskan Native, and Hispanic/Latino/a/x/e people—have faced overlapping structural barriers created by discriminatory, genocidal, and violent practices and policies throughout the 19th, 20th, and 21st centuries. Some examples include:

- Historical redlining and racially restrictive covenants limited housing options for African American, Asian American and Pacific Islander, and Hispanic/Latinx people. Segregated zoning codes contribute to a lack of affordable housing today.
- Employment discrimination further concentrated racialized poverty by limiting certain groups of workers to low-paying jobs and industries. These jobs often left employees vulnerable to workplace exploitation and discrimination.
- Many communities of color, but especially African American/Black people, experienced forms of social discrimination that were often government-approved, including segregation and exclusion from public spaces and educational opportunities. This unfair treatment made these communities susceptible to increased violence and criminalization.
- Government agencies have also left a legacy of harm and oppression toward American Indian/Alaskan Native and Indigenous communities. This has contributed to intergenerational trauma and a lack of mental and physical health services in this population.
- Policies and practices aimed at restricting language access have created barriers for Asian American and Pacific Islander, Indigenous, and Latino/a/x/e people with limited English proficiency. These obstacles are particularly extreme when navigating public services and health care networks originally designed only for English speakers.

People with multiple, or “intersecting,” identities often experience greater health inequities. For example, when racial health inequities are combined with structural inequities facing sexual minorities or people with disabilities, these inequities get even deeper. Current (2025–2026) changes to federal policies and rhetoric will likely worsen population health and health equity.

Overall, Alameda County does much better than the rest of California. On average, its residents enjoy higher incomes and educational attainment. But despite the county having substantial resources (see Attachment 8: Community Assets and Resources), significant inequities persist. There are specific data on disparities in the section on 2025–2027 Prioritized Community Health Challenges/Needs and Attachment 4: Statistical Data Collection and Community Health Charts.



4. Process and Methods



Process and Methods

Alameda County Public Health Department partnered with the Hospital Council—Northern and Central California and local hospitals on the primary and secondary data requirements of their Community Health Assessments (CHNAs) and our Community Health Assessment. CHNAs are to nonprofit hospitals what CHAs are to public health departments: They are community health assessments that have comparable purposes and are conducted very similarly.

ACPHD coordinated with John Muir Health, Kaiser Permanente, St. Rose Hospital, Stanford Health Care Tri-Valley, Sutter Health, UCSF Benioff Children’s Hospitals, and Washington Health and their consultants during the planning of the CHA. This involved making collective decisions on qualitative data sources (people and groups they would talk to) and sharing both quantitative data (statistics) and qualitative data (community feedback). By collaborating in these ways, these hospitals and ACPHD were able to collect data efficiently and reduce the data-gathering burden on the community.



Data Collection

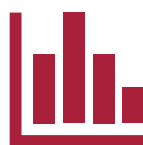
The department, its partners and consultants collected data over 12 months during 2024 and 2025. ACPHD then communicated the findings in this report, written in late 2025 and early 2026. Figure 5 shows the phases of the CHA process that are described in this section.

With its partners, ACPHD selected a wide variety of secondary and primary data sources. The group chose sources that would allow a better understanding of county-level health needs and challenges in terms of health status and health behaviors and to examine disparities in those two elements among subpopulations and neighborhoods (i.e., sub-geographic areas). ACPHD assessed inequities in the factors that contribute to health needs, including social determinants of health such as economic stability and the built environment.

Figure 5. The main part of the CHA process is gathering and studying information to make a list of problems that affect the community's health.



Talk to community members



Collect numbers and read reports



Study all the information



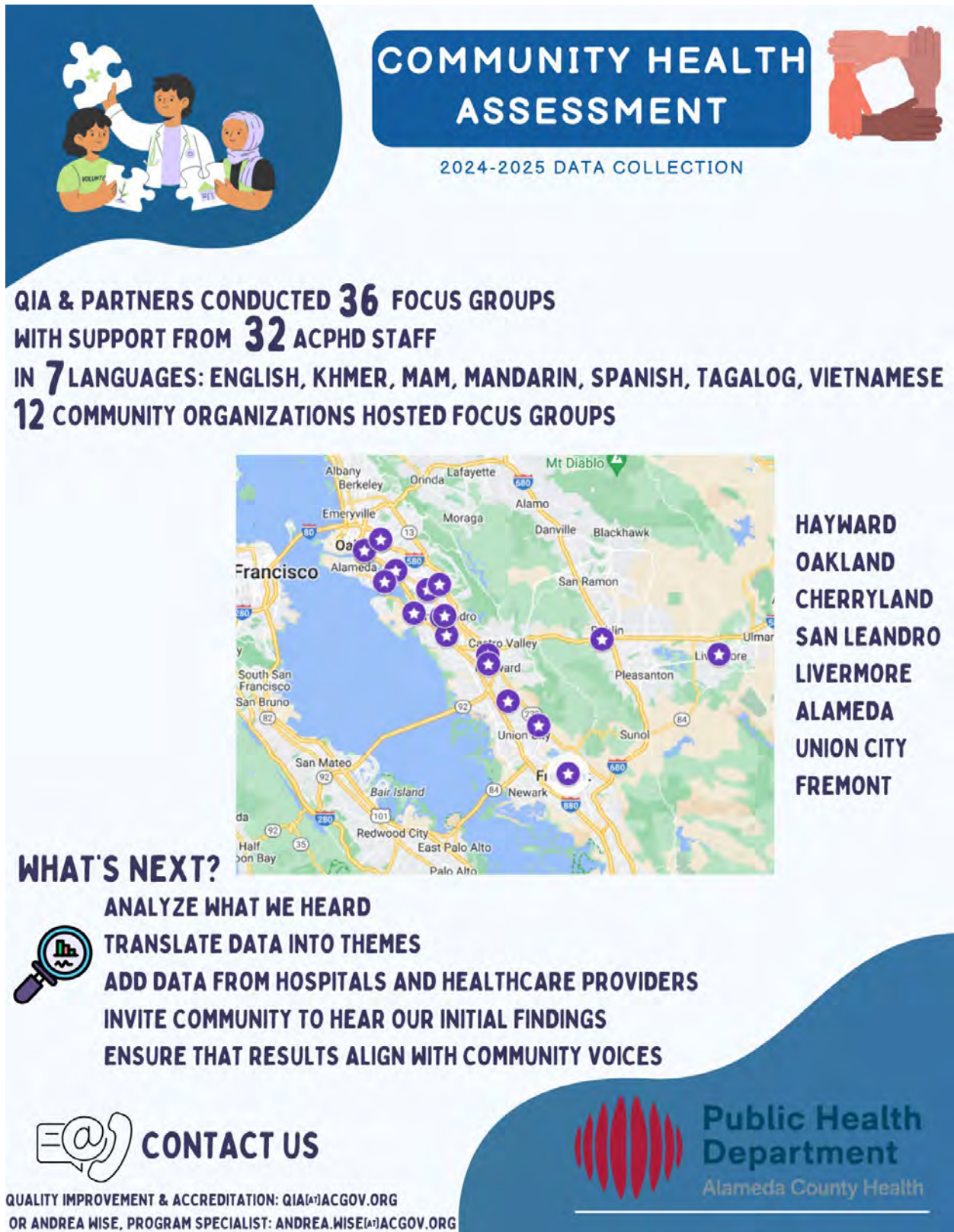
Make a list of community health needs

ACPHD and its consultant, Actionable Insights, (“the team”) analyzed over 350 quantitative health indicators from many different sources to help understand health needs in Alameda County and to assess community priorities. For more information about statistical data collection, see Attachment 5: Secondary Reports and Presentations Consulted.

Collectively, the team and ACPHD’s hospital/health system partners conducted nearly 50 “key informant” interviews with local health experts and community service providers. ACPHD and its partners also led thirty-six (36) focus groups with community members, community leaders, and professionals representing or serving the community. In all, over 470 people were consulted for the CHA. For more information about this primary qualitative data collection, see Attachment 7: Qualitative Research Materials. The next chapter describes health needs and challenges.

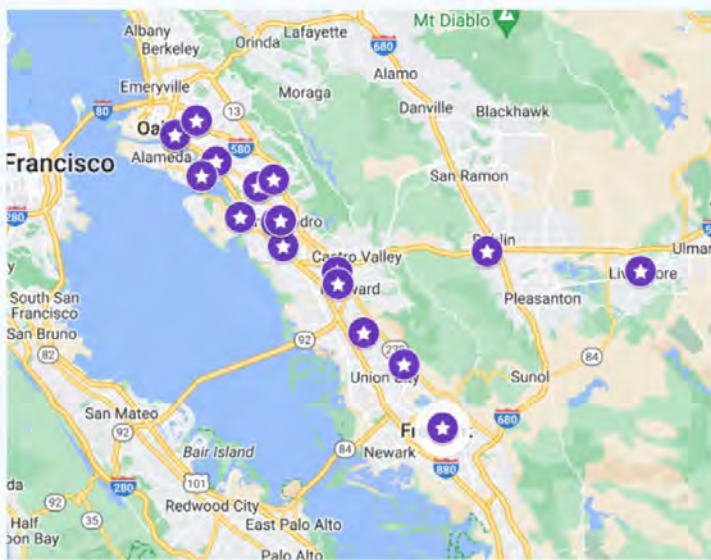


Figure 6. Qualitative data collection for the CHA was wide-ranging.



COMMUNITY HEALTH ASSESSMENT
2024-2025 DATA COLLECTION

QIA & PARTNERS CONDUCTED 36 FOCUS GROUPS
WITH SUPPORT FROM 32 ACPHD STAFF
IN 7 LANGUAGES: ENGLISH, KHMER, MAM, MANDARIN, SPANISH, TAGALOG, VIETNAMESE
12 COMMUNITY ORGANIZATIONS HOSTED FOCUS GROUPS



HAYWARD
OAKLAND
CHERRYLAND
SAN LEANDRO
LIVERMORE
ALAMEDA
UNION CITY
FREMONT

WHAT'S NEXT?

- ANALYZE WHAT WE HEARD**
- TRANSLATE DATA INTO THEMES**
- ADD DATA FROM HOSPITALS AND HEALTHCARE PROVIDERS**
- INVITE COMMUNITY TO HEAR OUR INITIAL FINDINGS**
- ENSURE THAT RESULTS ALIGN WITH COMMUNITY VOICES**

CONTACT US

QUALITY IMPROVEMENT & ACCREDITATION: QIA.ACGOV.ORG
OR ANDREA WISE, PROGRAM SPECIALIST: ANDREA.WISE@ACGOV.ORG

Public Health Department
Alameda County Health

CHA Participant Demographics

Over 470 people participated in focus groups or interviews for the CHA. About 76% of participants responded to a pre-survey that asked for simple demographics. The charts below show the age ranges, gender, and race/ethnicity of respondents (individuals could choose more than one race).⁸

Figure 7. CHA participants' median age was 47.⁹ (N=261)

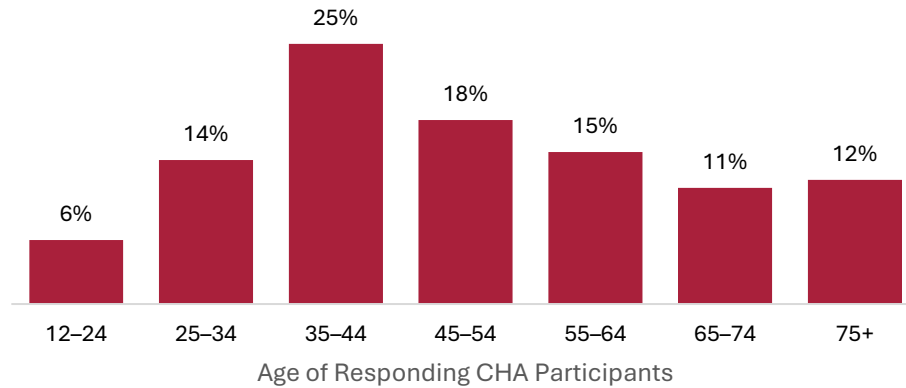


Figure 8. Almost two-thirds of respondents identified as female. (N=116)

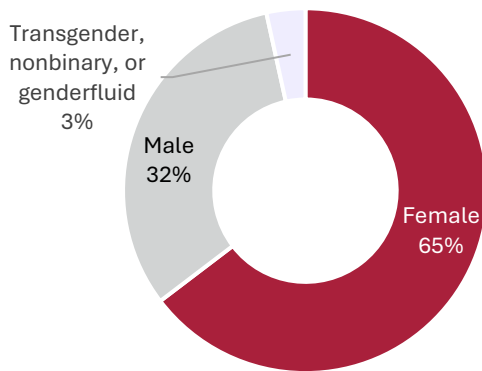
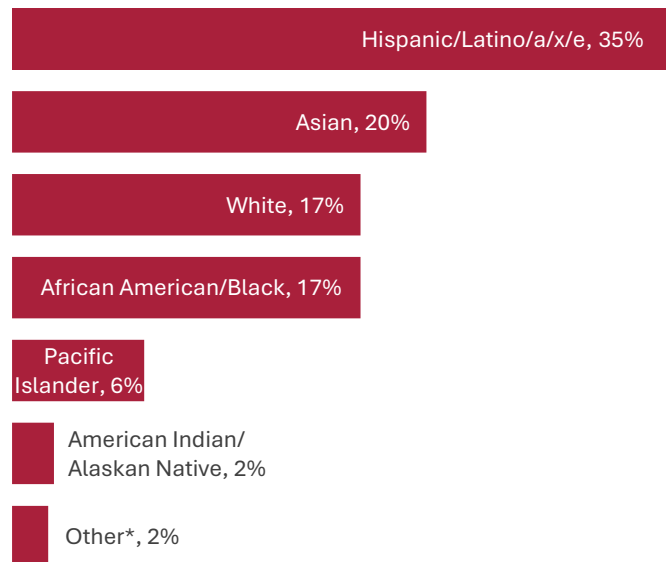


Figure 9. More than 1 in 3 respondents were of Hispanic/Latina/o/x/e ethnicity. (N≈340)



* "Other" represents Middle Eastern and blank responses. Percentages do not sum to 100 due to overlap.

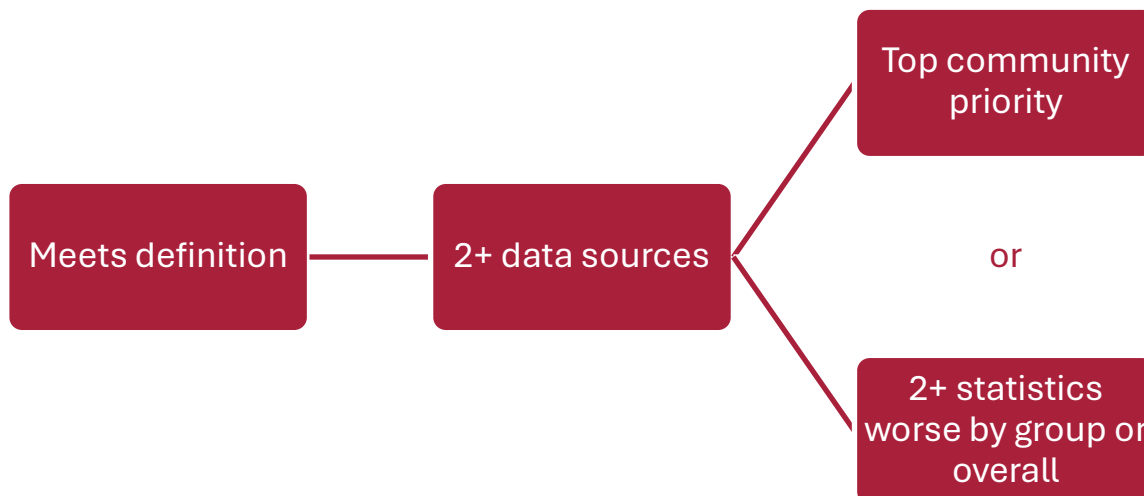
How ACPHD Identified Community Health Needs

ACPHD discovered many health needs in the quantitative and qualitative data. ACPHD and many of the collaborating hospitals and health systems used the same criteria for needs identification, with a poor health outcome being a CHA health need if it met specific criteria. See Attachment 2: Definitions for additional terms and definitions.

ACPHD identified a poor health outcome as a health need in the CHA if it met specific criteria described below and depicted in Figure 10. An example is available on the next page.

1. **Meets definition:** It meets the definition of a health need, and
2. **Two or more data sources:** At least two data sources for the issue are available, and
3. **Top community priority:** It meets the community priority criterion: It was prioritized (i.e., voted as one of the top five to discuss) by at least one-third of all interviews and focus groups combined,
or
4. **Two or more statistics:** If it does not meet the community priority criterion above, it meets either of the following statistical data criteria:
 - a. **By group:** Clear disparities or inequities in the need exist for two or more statistics by Zip code, race/ethnicity, or other subpopulation, **or**
 - b. **Overall:** Two or more statistics related to the need are worse (greater or more severe) than the California rate by 5% or more.

Figure 10. Health Need Identification Criteria



Example: Applying Health Need Identification Criteria

Here is an example of how ACPHD applied these criteria in identifying respiratory infections as a health need in the Communicable Diseases category:

1. **Meets definition:** Several different communicable diseases **met the definition of a health need**, including respiratory infections.
2. **Two or more data sources:** There were data on respiratory infections from **three data sources:** (i) community members' input (qualitative data), as well as (ii) COVID-19 mortality rates from ACPHD, and (iii) rates of older adult influenza vaccinations from the Centers for Medicare and Medicaid.
3. It **did not meet the community priority criterion:** Less than one-third of all interviews and focus groups combined voted to have respiratory infections be one of the top five health needs to discuss.
4. However, respiratory infections **did meet one of the two statistical data criteria:**
 - a. Neither of the statistics, COVID-19 mortality rates nor rates of older adult influenza vaccinations, were worse overall in Alameda County compared to statewide rates.
 - b. But **clear disparities or inequities exist by race/ethnicity** for both COVID-19 mortality rates and rates of older adult influenza vaccinations.

By meeting criteria #1, #2, and #4b, ACPHD identified respiratory infections as a health need in the CHA. This need was grouped with sexually transmitted infections and other communicable diseases into the larger health need category of Communicable Diseases.

In 2026, this process led to the identification of four categories of community health needs that fit the criteria. That list of needs, in descending community priority order, appears below.

- Social Determinants of Health
- Behavioral Health
- Chronic Conditions
- Communicable Diseases

Within each need, specific health challenges rose to the top. See the next section for a summary of each need and related health challenges.

5. 2025–2027 Prioritized Community Health Needs



2025–2027 Prioritized Community Health Needs

The processes and methods described in the previous section led ACPHD to identify four prioritized community health needs and related challenges. They are listed below in the order in which they appear in this section.

- Chronic Conditions
- Social Determinants of Health
- Behavioral Health
- Communicable Diseases

Each section below summarizes the data, statistics, and community input collected during the CHA. For more figures, see Attachment 5: Secondary Reports and Presentations Consulted.

What Shapes Health?

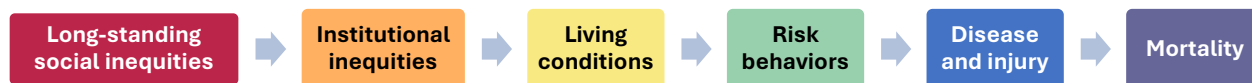
ACPHD knows that health outcomes are shaped by:

- physical, social, and economic environments
- stigma, discrimination, hateful rhetoric, and violence
- individual behaviors and risk factors

ACPHD sees profound and persistent inequities by race/ethnicity and socioeconomic status. Structural inequities are fundamental obstacles that can affect one’s health and quality of life. The assessment found that social determinants of health underlie many physical and behavioral health needs while also being needs themselves.

Many CHA participants repeatedly identified economic issues, including safe and affordable housing, food security, income/employment, and educational access, as key to community health. Another recurring concern across groups was access to health care—including affordability, insurance coverage, provider availability, and quality of care.

Figure 11. What Shapes Health?



CHA participants consistently prioritized mental health, often with co-occurring substance use, and linked them to stressors like economic hardship and housing instability. They also highlighted how having multiple unmet needs can have a compounding effect (e.g.,

homelessness leads to poor mental/physical health, which worsens due to limited health care access).

Participants viewed certain populations as being more affected than others by these overlapping needs, and participants in all areas consistently named the following groups as being the most impacted:

- people and families with low incomes
- BIPOC communities (Black, Indigenous, and people of color); of these groups, participants highlighted African American/Black, Hispanic/Latino/a/x/e, and Pacific Islander people
- older adults
- youth (especially foster youth)
- people experiencing homelessness
- people with disabilities
- recent immigrants (including the undocumented and people not proficient in English)
- LGBTQ+ communities

Participants also identified geographic disparities. They described southern Alameda County and eastern (i.e., Tri-Valley) parts of Alameda County, including unincorporated areas, as “service deserts,” where access to services, from childcare to substance use treatment, is limited. They noted that geographic areas with higher concentrations of low-income residents, such as East Oakland, West Oakland, and far eastern regions of Alameda County (e.g., Livermore), have greater health disparities and more unmet needs. In particular, they described Oakland as having “dense areas of homelessness” where the number of people needing behavioral health care services is greater than the supply.



Identified Health Need: Chronic Conditions

1. Chronic Conditions

According to the Agency for Healthcare Research and Quality, a chronic condition is an illness or health problem that continues for 12 months or more and either makes everyday activities harder or requires regular medical care and special equipment.¹⁰ Examples include asthma; cancer; cognitive decline, including Alzheimer’s disease and dementia; diabetes and obesity; and heart disease and stroke. These health issues may have multiple causes and may affect multiple systems in the body.

The Centers for Disease Control and Prevention recently noted that “chronic diseases account for most illness, disability, and death in the United States and are the leading drivers of health care costs.”¹¹ Risk factors for chronic conditions include poor nutrition, physical inactivity, cigarette smoking, and excessive alcohol use.¹² Prevention starts with avoiding these risks.

Healthiest Aspects of Communities. ACPHD and its partners asked CHA participants to describe the healthiest aspects of their communities:

- Some identified access to **safe spaces for physical activity**, such as parks and walkable areas, as a positive feature that encourages exercise and healthy lifestyles.
- A few also said that the area’s geographic location and **mild climate encourage outdoor activities** and supports active lives.
- Some CHA participants saw the community’s **prioritization of healthy eating and exercise** as a strength that distinguishes the area from other regions of the U.S.



“We have a lot of resources for people, spaces for activities and exercise; we really put priorities on exercise and healthy eating in the Bay Area.”

—Key Informant Interviewee

“We get reports back from participants [in our programs] that their food security is improving and that their health is improving as well. Their blood sugars are coming down. They’re losing weight. They’re feeling better in their bodies.”

—Key Informant Interviewee

Community Challenges. However, some CHA participants reported that they don’t have access to safe spaces for physical activity (see *the description of Social Determinants of Health: Built Environment, Including Unintended Injuries in the section on Social Determinants of Health*). Participants also expressed concerns about accessing healthy food (see *the description of Social Determinants of Health: Economic Stability in the section on Social Determinants of Health*).

Despite these challenges, both service providers and community members themselves reported positive health changes that had resulted from **community programs**, such as improved food security, better dietary habits, weight loss, and lower blood-sugar levels.



Challenges: Chronic Conditions

Data in this section illustrates that African American/Black and Pacific Islander people in Alameda County are affected by similarly staggering inequities in mortality rates across leading chronic conditions. Although these data are for Alameda County, this pattern of disparities across mortality due to chronic conditions is typical for the state and indeed the U.S. These data highlight the importance of addressing structural drivers of inequity, as described in the Social Determinants of Health section.

Information about the following chronic conditions may be found in this section:

- Asthma
- Cancer
- Cognitive decline
- Heart disease and stroke
- Diabetes and obesity



Chronic Conditions: Asthma

What is the issue?

Asthma is a common respiratory disorder that affects the ability to breathe. Inflammation causes airways to swell and narrow, with episodes of reversible breathing problems.¹³ Symptoms vary from mild to life-threatening. Asthma attacks cause issues ranging from wheezing to extreme breathlessness.¹⁴ Triggers include air pollution, wildfire or tobacco smoke, and mold.¹⁵ Research also shows that asthma can be aggravated by living where dampness, poor ventilation, pests, and/or pollutants are present.¹⁶ According to the American Lung Association, common risk factors for developing asthma are a parent with asthma, a severe respiratory infection in childhood, allergies, or for adults, exposure to certain chemicals at work.¹⁷

Community Assets

The county has a number of assets and resources to address asthma, namely:

- Local hospitals
- Federally Qualified Health Centers and other health clinics
- Alameda County Public Health: Asthma Start Program
- Breathe California
- Regional Asthma Management & Prevention (RAMP)

For a detailed list of the assets and resources available for all chronic conditions, please see Attachment 8: Community Assets and Resources.

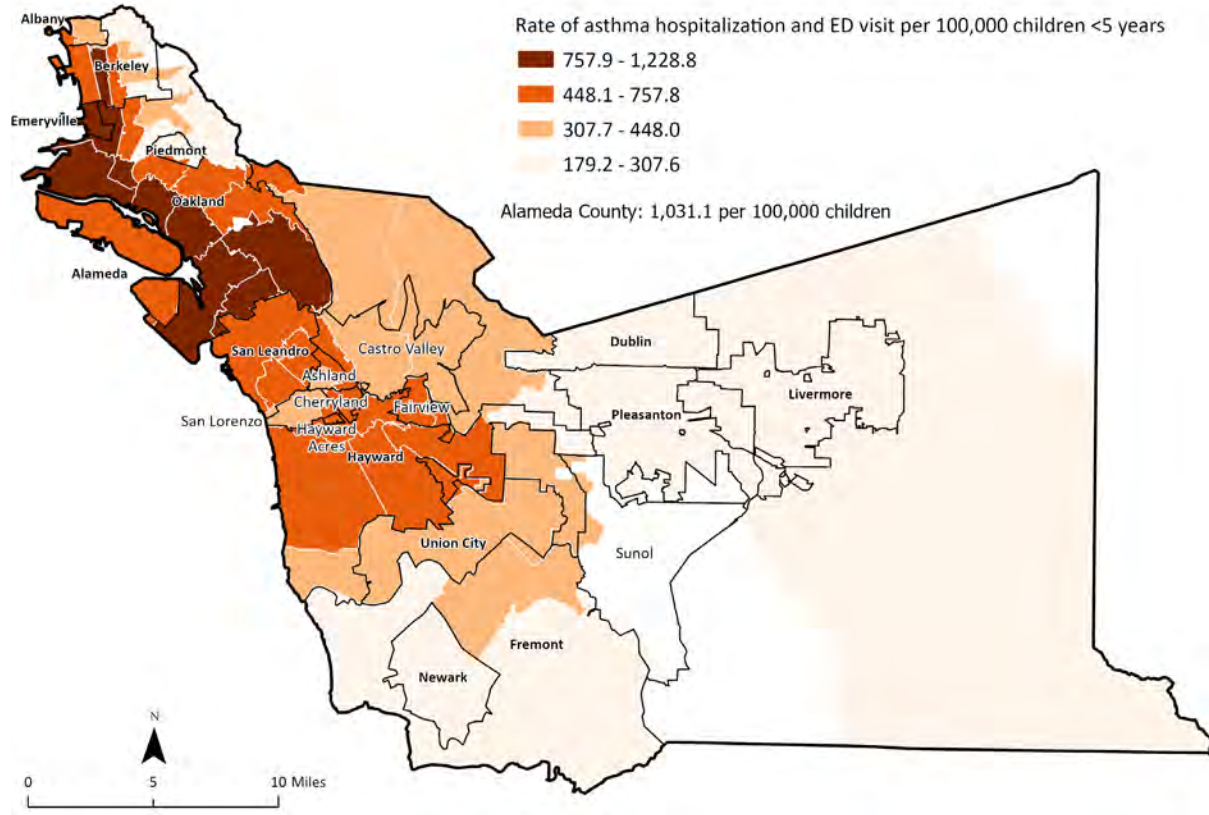
Health Impacts

Children Are Most Affected. Asthma is a concern, especially for children. A greater proportion of children have been diagnosed with asthma in Alameda County (17%) compared to California overall (12%). Further, the latest data show that the overall rate of children who were hospitalized for asthma is higher in Alameda County than the state.

Disparities Exist. Pacific Islander and African American or Black children under 5 are over 6 times more likely to be hospitalized or visit the emergency department with asthma relative to Asian children under 5, who have the lowest rate of hospital visits due to asthma by race and ethnicity. A map showing child asthma emergency department visits and hospitalizations (Figure 12, next page) is quite similar to the 1937 redlining map shown in Social Determinants of Health: Racism/Discrimination section.

Figure 12. Inequities in asthma are driven by structural inequities and environmental injustice.

Alameda County, Asthma ED Visits and Hospitalizations per 100,000 Children Under Age 5, 2018-2022



Source: ED visit and patient discharge data from CA Health Care Access and Information (HCAI), 2018-2022.

Impact of Natural and Built Environments. Although participants rarely singled out respiratory health as a priority, some described seeing an increase in asthma cases, particularly among children. They mentioned the importance of a healthy environment both indoors and out. Some pointed out that climate change and poor air quality, including wildfire smoke, can negatively impact respiratory health, including asthma.

For more information, see the sections describing Social Determinants of Health: Built Environment, Including Unintended Injuries, Social Determinants of Health: Climate / Natural Environment, and Social Determinants of Health: Housing and the Unhoused.

Chronic Conditions: Cancer

What is the issue?

Cancer is a generic term used to describe more than 100 conditions in which abnormal cells divide uncontrollably, invading and killing healthy tissue. These abnormal cells can spread (metastasize) to other parts of the body via the blood and lymph systems.¹⁸ Cancer in all of its forms is the 2nd leading cause of death in the U.S., following heart disease.¹⁹ High-quality screening can help reduce cancer rates. However, complex factors contribute to disparities in cancer incidence and in death rates across ethnic, socioeconomic, and otherwise vulnerable groups. Personal, behavioral, and environmental factors (e.g., smoking, exposure to carcinogens) can affect cancer risk, but the key risk factors are social determinants of health. These include lack of access to health care, low socioeconomic status, the natural and built environments where people live, and chronic stress caused by institutional racism.²⁰

Community Assets

The county has a number of assets and resources to address cancer, namely:

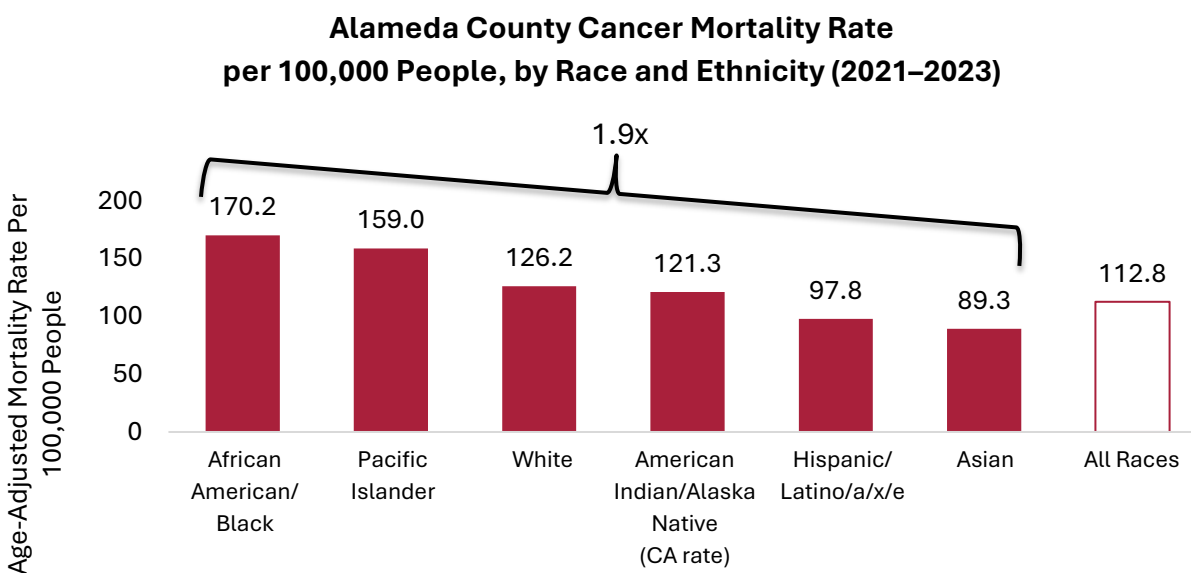
- Local hospitals
- Federally Qualified Health Centers and other health clinics
- CancerCare
- Every Woman Counts
- HERS Breast Cancer Foundation
- The Leukemia and Lymphoma Society
- Women's Cancer Resource Center

For a detailed list of the assets and resources available for all chronic conditions, please see Attachment 8: Community Assets and Resources.

Health Impacts

Disparities Exist. Cancer was the number 1 cause of death in Alameda County in 2024. Overall, the county’s cancer mortality rates are on par with or better than the state’s. However, statistical data indicate substantial disparities for cancer mortality by race/ethnicity in Alameda County. For instance, Figure 13 shows that the overall cancer mortality rate among the county’s Black population is close to double that of the county’s overall rate. However, various social determinants of health may drive some of the inequities in cancer diagnosis and treatment, as illustrated by cancer incidence (diagnosis) rates by race in Figure 14 , next page.²¹ See *Why Disparities Exist*, later in this section.

Figure 13. People who are African American/Black or Pacific Islander are more likely to die from cancer than people of other racial/ethnic groups in Alameda County.

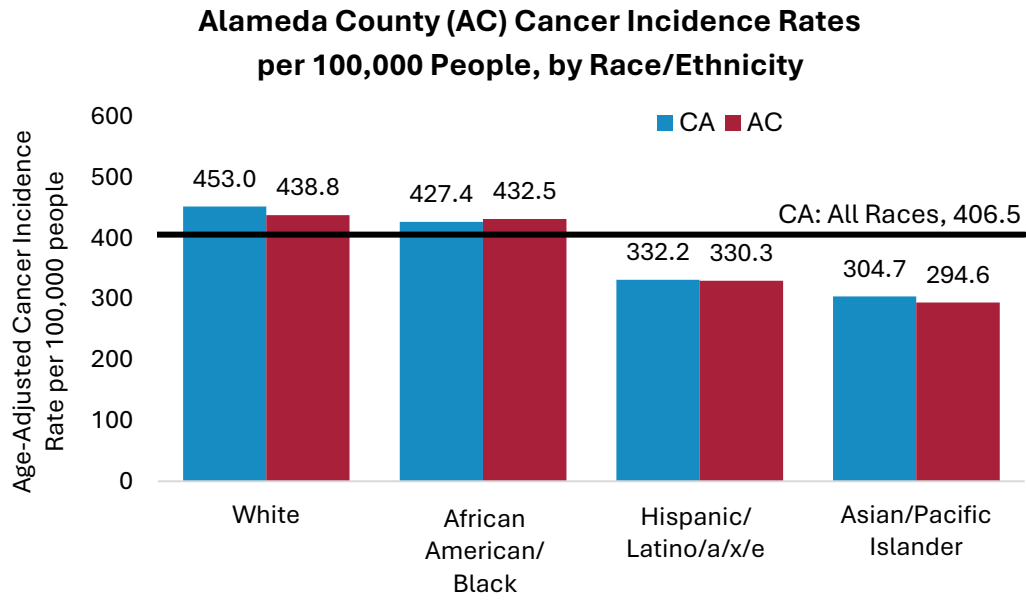


Source: ACPHD CAPE, with data from Alameda County Vital Statistics files and CDC Wonder, 2021–2023.

In terms of specific forms of cancer in Alameda County, people who are Hispanic/Latino/a/x/e have the highest incidence of liver cancer (14.2 per 100,000) compared to the countywide rate for all races/ethnicities (9.8). People who are Asian have the highest incidence of thyroid cancer (11.3 per 100,000) compared to any other racial/ethnic group. People who are White have a higher incidence of breast, lymphatic, melanoma (skin cancer), and urinary tract cancer than any other group. People who are African American/Black have the highest incidence rates of lung, pancreatic, prostate, and uterine cancer compared to other racial/ethnic groups in the county.²²

See *Attachment 4: Statistical Data Collection and Community Health Charts* for more information.

Figure 14. People who identify as White or African American/Black have higher overall cancer incidence rates than people of other races and ethnicities in Alameda County.



Source: California Health Maps, 2012–2021. Data for races/ethnicities not shown were suppressed by the source.



Barriers to Prevention, Detection, and

Treatment. Community member participants rarely prioritized cancer as an issue on its own, but their personal accounts revealed potential gaps in timely and comprehensive cancer screenings. While the financial burden of cancer treatment was a significant concern for participants, they were especially worried about people who are uninsured or have low incomes. CHA participants noted that cancer treatment affects economic stability, both short and long term, for patients and their families.

When participants discussed cancer, they talked about its emotional toll. They cited a need for better prevention strategies and more cancer education to increase the community's awareness.

Why Disparities Exist. The National Cancer Institute has acknowledged socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It has attributed these disparities to a variety of factors:

- Institutional racism and conscious or unconscious bias among care providers
- Low income
- Low health literacy
- Lack of insurance
- Lack of transportation
- Poor access to affordable healthy food

The Institute states, “Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and institutional inequalities.”²³

“If the illness doesn’t kill you, the debts kill you.”

—Spanish-Speaking Community Member Focus Group Participant

“I had prostate cancer. That’s expensive, you know what I mean? Doctors ain’t going to want to treat you for it. Because if you ain’t got any insurance, they don’t want to see you, man.”

—Community Member Focus Group Participant

“When you go to the hospital and they say, ‘Oh, you have cancer,’ it feels depressing. It’s scary to hear.”

—Community Member Focus Group Participant

“I just think it [cancer] is one of the more important health issues that’s out right now. You should be more aware of it.”

—Community Member Focus Group Participant

Chronic Conditions: Cognitive Decline

What is the issue?

Cognitive decline refers to a reduction—greater than expected for one’s age—in mental abilities. These include memory, problem-solving, navigation, ability to sustain attention, ability to follow social rules, and conversational expression.²⁴ Alzheimer’s disease (AD), one of the dementias underlying cognitive decline, is one of the top 10 leading causes of death in the U.S.²⁵ It is estimated that about 50% of AD cases have a genetic basis. However, research has indicated that this risk may be reduced by individuals making healthy choices related to diet, exercise, and other habits. This might mean doing enjoyable activities that challenge your brain, abstaining from tobacco, or getting regular medical check-ups. Building and maintaining social connections and developing practices that nurture emotional well-being may also decrease risk.^{24, 26}

Community Assets

The county has certain assets and resources to address cognitive decline, including:

- Age-Friendly Alameda County
- Alameda County Adult & Senior Services
- Alameda County Social Services Agency, Area Agency on Aging
- Alzheimer’s Services of the East Bay
- Bay Area Caregiver Resource Center
- Various cities’ aging & family services agencies

For a detailed list of the assets and resources available for all chronic conditions, please see Attachment 8: Community Assets and Resources.

“There aren’t many physicians who specialize in geriatric care...there’s a real difference between assessing an older person and a younger one.”

—Key Informant Interviewee

Health Impacts

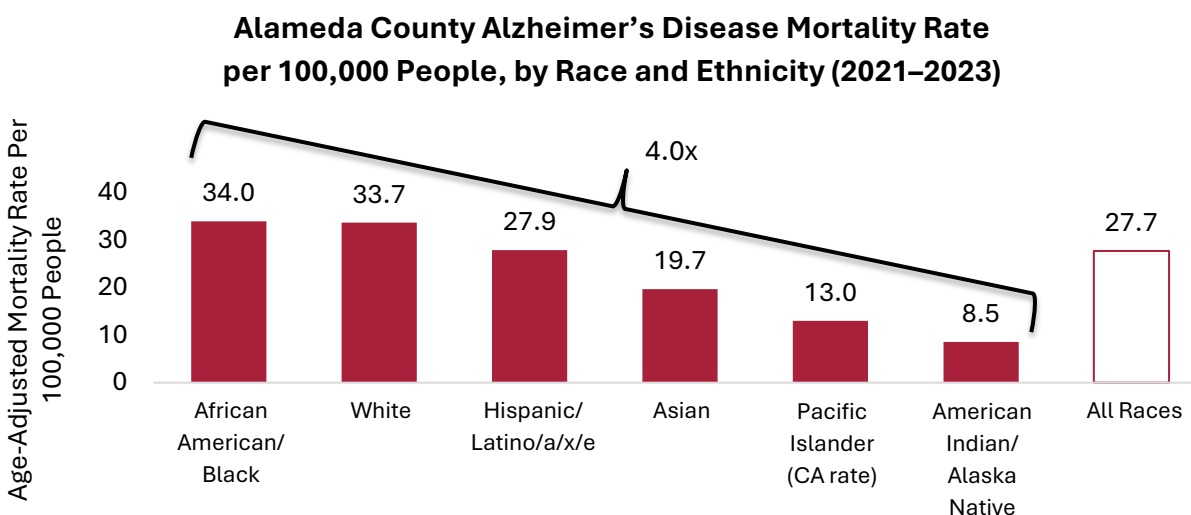
High Rates and Few Providers. Alzheimer’s disease (AD) is the 5th leading cause of death in Alameda County. Community members who identify as Pacific Islander or Black experience AD at greater rates and have higher rates of hospitalizations and emergency department (ED) visits than other groups.²⁷

Many participants identified older adults as a vulnerable population in regards to cognitive decline. They cited dementia and AD as concerns, as well as common health issues like arthritis, vision and hearing loss, and other age-related conditions. Some participants indicated a need for more geriatricians and other specialized care for older adults.

Isolation. People mentioned social isolation and lack of family support as factors that worsen cognitive decline among older adults. This is supported by research showing a link between social isolation and dementia.²⁸

Health Care Quality. Older adults consulted for the CHA said they want dignified delivery of treatment. They also seek better communication with their health care providers and with the staff of community organizations.

Figure 15. African American/Black people and White people are more likely to die of Alzheimer’s Disease than people of other racial/ethnic groups in Alameda County.



Source: ACPHD CAPE, 2021–2023.

“I want to talk about dementia ...to address it for our community. We came from Southeast Asia, from India particularly, and like China or other countries, they have a lot of family connections. And there’s very less depression cases in India. There’s very strong, close family structures, which we are missing here.”

—Community Member Focus Group Participant

Chronic Conditions: Heart Disease and Stroke

What is the issue?

Nationally, nearly 128 million people suffer from a form of cardiovascular disease.²⁹ Heart disease is the number 1 killer of both men and women, while stroke is the 4th leading cause of death³⁰ and a significant cause of serious disability for adults.³¹ Research has established that disparities in cardiovascular health outcomes exist between African American/Black, Hispanic/Latino/a/x/e, and certain Asian populations compared with the White population across the U.S.³² Although some risk factors for heart disease and stroke (e.g., age, race/ethnicity, and gender) are not controllable, others (blood pressure, cholesterol, weight, alcohol consumption, smoking, diet, physical activity) can be managed.³³ Left uncontrolled, these risk factors can lead to changes in the heart and blood vessels. Over time, those changes can lead to heart attacks, heart failure, strokes, and other forms of cardiovascular disease.³⁴ Addressing risk factors can help prevent chronic cardiovascular disease.³⁵

Community Assets

The county has a number of assets and resources to address heart disease and stroke, many of which address manageable risk factors underlying these issues. Some examples include:

- Local hospitals
- Federally Qualified Health Centers and other health clinics
- LIFE Eldercare, Inc., Senior Support Program of the Tri-Valley, and other nonprofits focused on older adult health
- Various cities' parks and recreation departments

For a detailed list of the assets and resources available for all chronic conditions, please see Attachment 8: Community Assets and Resources.

“Is there a class about how to prevent and reduce stroke? Because most of us have three things: high cholesterol, high blood pressure, diabetes.”

*—Vietnamese-Speaking
Community Member Focus Group*

“We know that stress is a contributor... People who live their life in a vise grip...are very vulnerable to hypertension and unmanaged hypertension.”

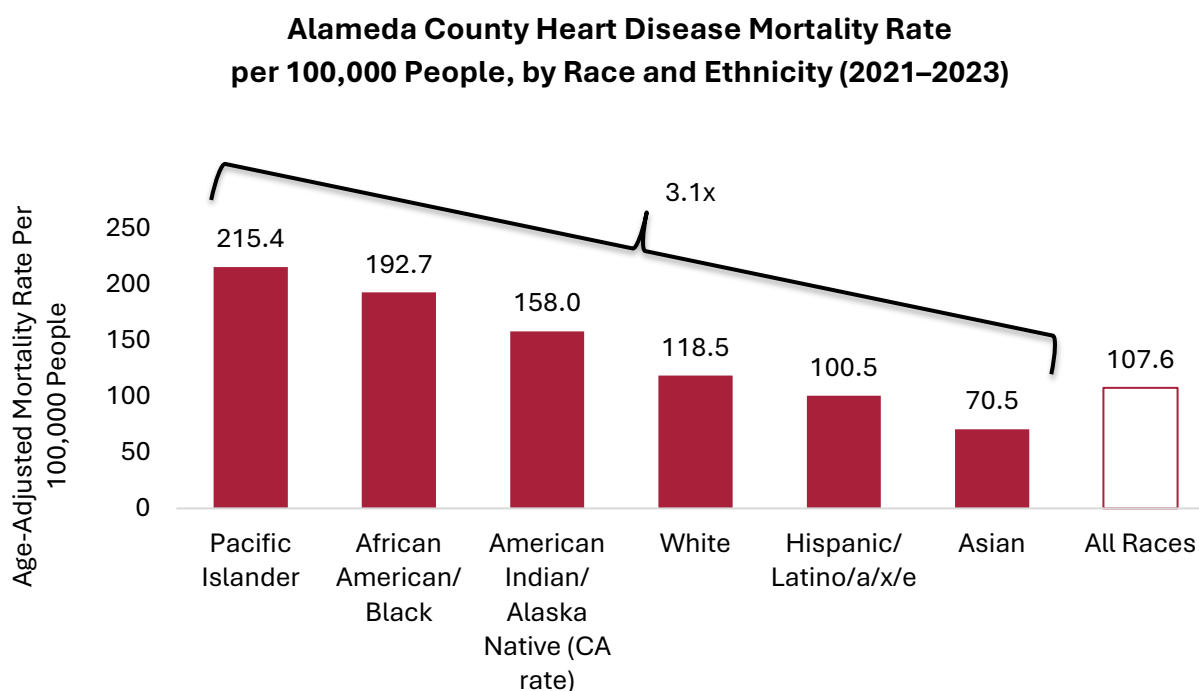
—Key Informant Interviewee

Health Impacts

Disparities Exist. Heart disease and cerebrovascular diseases ranked among the top 5 causes of death in Alameda County in 2022. However, stroke mortality is only slightly worse among county residents (43.4 per 100,000) than their statewide peers (42.1). The cardiovascular disease (CVD) mortality rate is lower than the state’s. It’s notable that the mortality rate for heart disease is much higher among the county’s Pacific Islander population than other ethnic groups.

A small proportion of key informants and focus group participants prioritized heart disease and stroke. Of these, several noted a high prevalence of hypertension and diabetes, significant risk factors for heart disease and stroke, within their communities. In Alameda County, hypertension ranked separately in the top 10 causes of death.

Figure 16. People identifying as Pacific Islander or African American/Black are more likely to die from heart disease than people of other racial/ethnic groups in Alameda County.

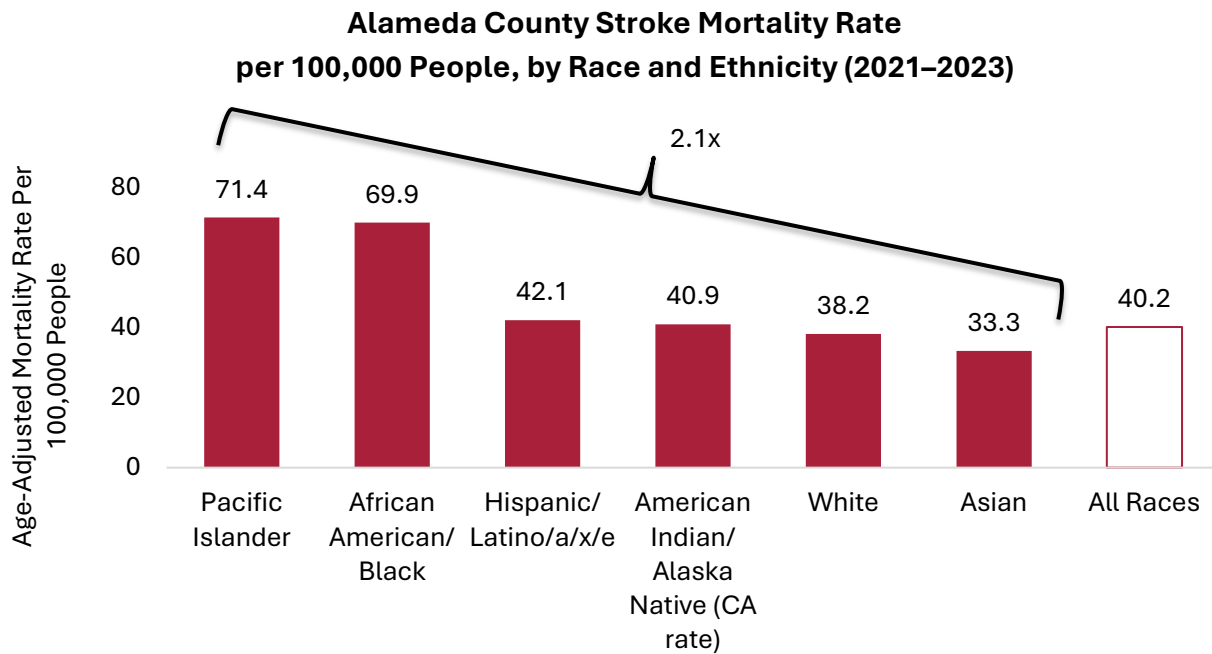


Source: ACPHD CAPE, with data from Alameda County Vital Statistics files and CDC Wonder, 2019–2023.

“Hypertension and stroke is generally one of the areas where you do see a cultural implication. Our Hispanics and African Americans are the ones most at risk.”

—Key Informant Interviewee

Figure 17. People identifying as Pacific Islander or African American/Black are more likely to die from stroke than people of other racial/ethnic groups in Alameda County.



Source: ACPHD CAPE, with data from Alameda County Vital Statistics files and CDC Wonder, 2019–2023.

Related Factors and Barriers. Some participants who discussed heart disease highlighted stress and mental health issues as factors. Others pointed to various social determinants of health, including economic insecurity, food insecurity, the built environment, homelessness, lack of health care access, and poor-quality health care.

For example, some noted that the cost of medication for heart disease and stroke is a significant barrier for people who are uninsured. This barrier makes it difficult for patients to follow prescribed treatments. Participants saw effective management of chronic illnesses like diabetes and hypertension as crucial for preventing heart disease and stroke. To do this requires access to health care, healthy foods, and safe and affordable places to exercise.

“When you do not have that home, you cannot eat healthy, your meals are going to be processed, and you are going to eat everything ready-made. So you can’t have control in any of the aspects: fat, sugars, salts, and all of that also leads to chronic diseases.”

—Key Informant Interviewee

Chronic Conditions: Diabetes and Obesity

What is the issue?

Diabetes refers to a category of chronic diseases that involve how your body handles glucose (blood sugar), its primary source of energy.³⁶ The Centers for Disease Control and Prevention estimates that more than 40 million people in the U.S. have diabetes and an additional 115 million adults in the U.S. are prediabetic.³⁷ Type 2 diabetes accounts for roughly 90 percent of all diagnosed cases, type 1 represents approximately 5 percent, and gestational diabetes covers the rest.³⁸

Serious complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations. Type 1 is believed to be caused by a combination of genetic and environmental factors and cannot be prevented. Type 2 and prediabetes (higher-than-normal blood sugar levels) result from the body becoming unable to generate enough insulin to maintain a healthy blood sugar level. Avoidable Type 2 risk factors include being physically inactive or overweight.³⁹

About 1 in 5 children and more than 2 in 5 adults in the U.S. are obese.⁴⁰ Risk factors include unhealthy diet, inactivity, genetic factors, poor sleep, excessive screen time, long-term stress, underlying medical issues, and the factors described in the section on Social Determinants of Health. Smoking cessation and medication side effects can also contribute.⁴¹ Being obese or overweight increases one's risk for type 2 diabetes, hypertension, stroke, and heart disease⁴⁰ and can contribute to poor mental health, stigma, and social isolation.

Community Assets

The county has a number of assets and resources to address diabetes and obesity, many of which address manageable risk factors underlying these issues. Some examples include:

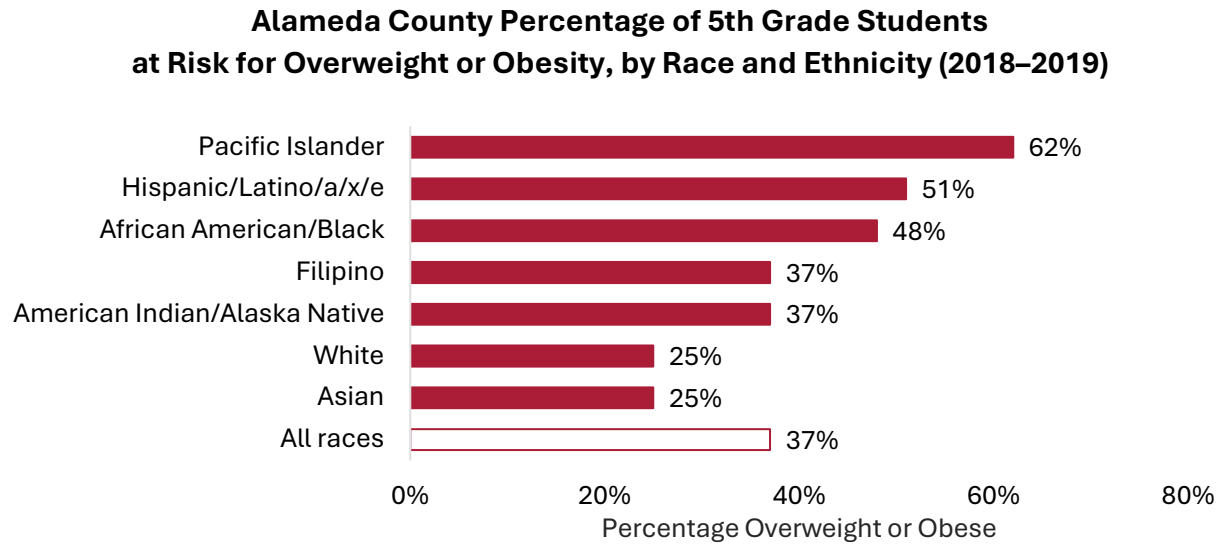
- Local hospitals
- Federally Qualified Health Centers and other health clinics
- Alameda County Nutrition Services – Women, Infants, and Children (WIC)
- Alameda County Public Health Department
- East Bay Regional Park District and various cities' parks and recreation departments
- Various cities' Family Resource Centers

For a detailed list of the assets and resources available for all chronic conditions, please see Attachment 8: Community Assets and Resources.

Health Impacts

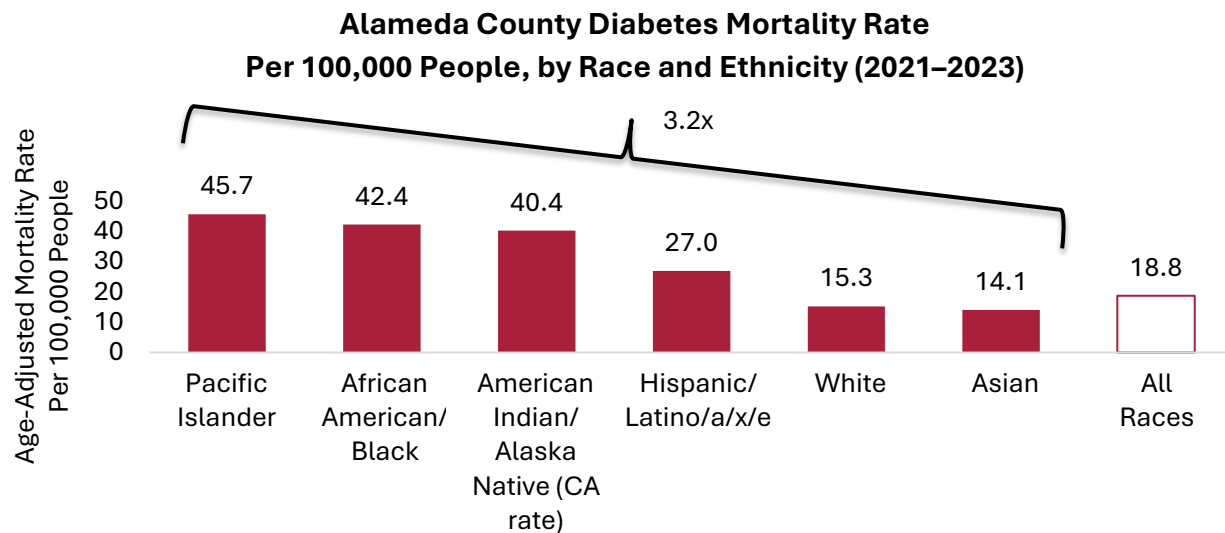
Disparities Exist. Alameda County statistics for overweight/obesity risk and for diabetes mortality show the same pattern as heart disease: People who are Pacific Islander or African American/Black have the highest risk and highest mortality rates. As discussed in the next section, people in these populations are also more at risk for many of the social determinants that underlie these chronic diseases.

Figure 18. Obesity risk, which is tied to a risk of Type 2 diabetes, begins early.



Source: California Department of Education, 2018–2019 (more recent data not available).

Figure 19. People identifying as Pacific Islander or African American/Black are more likely to die from diabetes than people of other racial/ethnic groups in Alameda County.



Source: ACPHD CAPE, with data from Alameda County Vital Statistics files and CDC Wonder, 2019–2023.

“[Diabetes is] a very common diagnosis in our community. And I think it just is related to the social determinants of health and having access to the right kind of food, having the information about what contributes to diabetes.”

—Key Informant Interviewee

“Everyone has diabetes. Especially seniors.”

—Tagalog-Speaking Community Focus Group Participant

“We need to eat and exercise, but we have to spend money every month to exercise outside [in safety]. I heard that medical insurance provides free exercise programs, but we don’t have those either.”

—Community Member Focus Group Participant

“People who actually have been diagnosed with hypertension, it’s almost everybody. The number of people who are prediabetic or who have already been diagnosed with diabetes is just over the top.”

—Key Informant Interviewee

Affects Many People. More than 1 out of every 4 interviews and focus groups prioritized diabetes, obesity, and healthy lifestyles. Many of the CHA participants who discussed diabetes and obesity noted their high frequency within their communities, among both adults and children. Diabetes prevalence is highest among older adults (19%) in Alameda County, significantly higher than all adults in the county overall (9%).⁴²

Related Factors and Barriers. Participants linked diabetes and obesity to poor diet and, less often, to inactive lifestyles. Such factors are themselves linked to economic challenges, such as food insecurity, or barriers in the built environment, such as being unable to access healthy foods or safe places to exercise. These obstacles, in turn, exacerbate diabetes and obesity rates.

Some people pointed out the role of structural racism in producing environments short on healthy food options and safe recreational spaces. A few tied high rates of diabetes and obesity to cultural dietary habits.

To support the management of chronic diseases, participants called for better education on nutritional and lifestyle changes. They spoke to the need for culturally sensitive health education. Some were concerned about health care access, including a lack of insurance, in relation to diabetes. Several noted being unhoused as a barrier to managing the disease, as it limits one’s access to proper nutrition and stable living conditions. For example, people noted that insulin (the primary means for controlling blood sugar levels) must be refrigerated to retain its viability, a much bigger challenge for people who are unhoused.

How does the community suggest chronic conditions are addressed?

- Expand health education and awareness around chronic disease prevention and management, including for diabetes, heart disease, stroke, cancer, dementia.
- Support aging populations with expanded programs for dementia and Alzheimer’s, including caregiver training, memory care services, and elder-focused housing. Develop neighborhood-based support networks (“village models”).
- Utilize community health workers and peer educators for trust-building and implement health fairs, workshops, culturally relevant trainings.



**Identified Health Need:
Social Determinants of Health**

2. Social Determinants of Health

According to the Healthy People 2030 initiative, “Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”⁴³ Examples include:

- Safe housing, reliable transportation, and other aspects of neighborhoods
- Clean air and access to safe drinking water
- Access to healthy foods and opportunities for physical activity
- Education, employment, and income
- Language proficiency and literacy
- Experiences of discrimination and exposure to violence

Figure 20. Social Determinants of Health



“What I really love about our community is the civic engagement and the interest in getting involved.”

—Key Informant Interviewee

“The healthiest characteristics of our community are the resilience of our community and how diverse we are.”

—Key Informant Interviewee

“Every time someone in our community needs something, we always support each other.”

—Spanish-Speaking Community Focus Group Participant



Social determinants of health drive health disparities and inequities. Promoting healthy choices alone isn't enough to close these gaps. Public health organizations, working with their partners in education, transportation, housing, and other sectors, must act to improve the conditions that shape people's everyday environments.

Healthiest Aspects of Communities. ACPHD and its partners asked CHA participants to name the healthiest aspects of their communities. Most of their responses were related to SDOH. They frequently mentioned a **strong sense of community and civic engagement**, citing examples such as a multigenerational commitment to their neighborhoods, parents' active involvement in schools, and older adults giving time and energy to support neighbors. Many recognized **community diversity** as a positive characteristic and noted the benefits of cultural richness, inclusivity, and exposure to different perspectives for children and adults.

Many participants highlighted **community resilience**. They described residents as strong, resourceful, and able to persevere through challenges including economic hardship, discrimination, and public safety concerns. Participants also identified **mutual aid and support networks** as strengths, particularly in times of need or crisis. They described how such networks foster unity within specific communities, such as the Latino population in Livermore.

When comparing this county to others, participants cited its access to **resources for healthy living** as a distinguishing feature. Such resources include spaces for physical activity, healthy food options, and supportive services

for older adults and people with disabilities. CHA participants especially valued **environments that promote safety** and well-being, including safe neighborhoods and public health initiatives that focus on exercise and healthy eating.

CHA participants saw **collaboration** among nonprofits, service organizations, and grassroots groups as a key asset, observing how it enabled more effective delivery of services and made it easier for groups to adapt to community needs. They felt that **lived experience in front-line workers**, especially those in health outreach (e.g., *promotores* / community health workers), was vital for removing barriers to care and fostering trust within their community.

Strengths and Challenges. Alameda County has much to celebrate, and it also faces many challenges. The CHA identified the greatest of these challenges, described in this report’s various major health need sections. ACPHD is gearing up to work to address these needs by developing and implementing the 2026–2030 Community Health Improvement Plan (CHIP). The challenges described in this section appear in this order:

- Health Care Access and Quality
- Economic Stability
- Peaceful Communities
- Housing and the Unhoused
- Built Environment
- Climate/Natural Environment
- Racism/Discrimination



Challenges: Social Determinants of Health

Social Determinants of Health: Health Care Access and Quality

What is the issue?

Access to affordable, comprehensive, and quality health care is important for health and quality of life.⁴⁴ For most people, access to care means having insurance coverage, being able to find an available primary or specialty care provider nearby, and receiving care when they need it. Quality health care is safe, effective, patient-centered, timely, efficient, and equitable.⁴⁵ Limited access to care and compromised care quality make it more difficult for people to reach their full potential and negatively affect their quality of life.

Community Assets

The county has many assets and resources to address health care access and quality issues. Some examples include:

- Local hospitals
- Federally Qualified Health Centers and other health clinics
- Alameda County Public Health: Family Health Services Black Infant Health Program
- Center for Healthy Schools and Communities
- Operation Access and other non-profit health resources
- Various transportation assets, including bus and train systems, bicycle coalitions, and paratransit providers

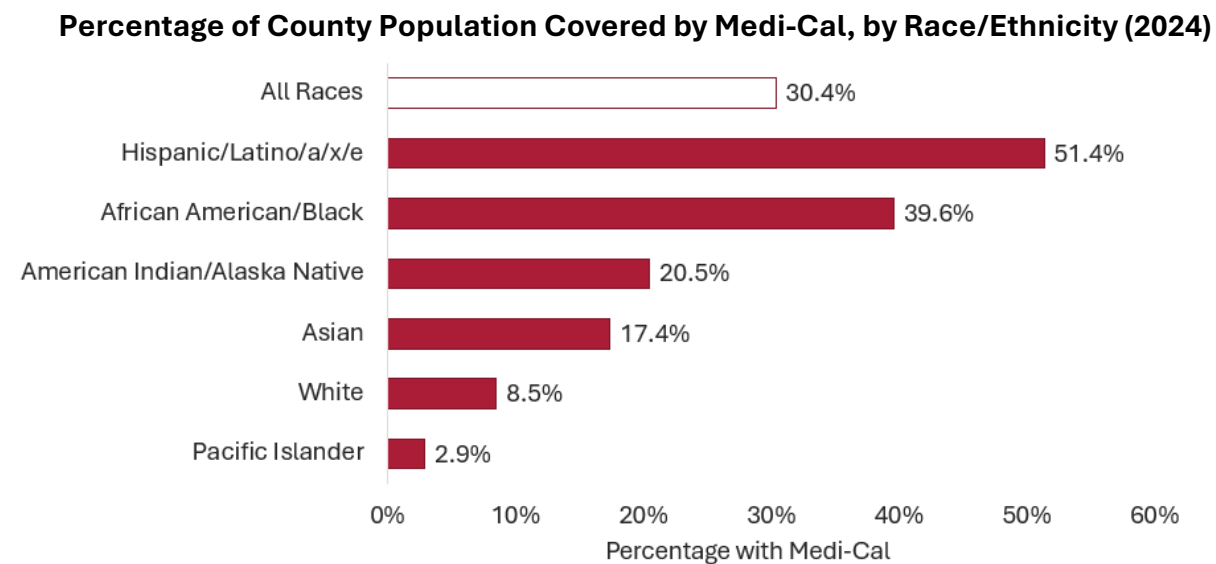
For a detailed list, please see Attachment 8: Community Assets and Resources.

Health Impacts

Cost of Care. Participants in about half of all interviews and focus groups named health care access and delivery (part of health care quality) as a priority. They focused on persistent barriers to accessing health care, such as difficulties paying for it. Many noted that not everyone has the same opportunity to receive health care: The high costs of care and medication keep many people from seeking necessary medical attention.

Approximately 500,000 people in Alameda County (about 30%) rely on Medi-Cal for their health insurance coverage.⁴⁶ The service is critical to preventing illness, injury, and premature death for the whole population and especially for marginalized and vulnerable groups. It is also important for children’s health. Medi-Cal pays for services for underserved children who have chronic conditions and complex health needs. It also pays for their preventative health care, which is critical to promoting overall health. Just under one-third of Alameda County community members overall rely on Medi-Cal for their health care, while more than half of the county’s Hispanic/Latino/a/x/e community members do.

Figure 21. More than half of the county’s Hispanic/Latino/a/x/e community members rely on Medi-Cal for their health care.



Source: CAPE analysis of AC Behavioral Health Medi-Cal enrollment data and CA Dept. of Finance denominators, 2024.

“The whole system of health insurance doesn’t meet the needs of low-income people, even when somebody has full insurance, because of the cost of copays and deductibles.”

— Key Informant Interviewee

Medi-Cal Facts⁴⁶



28% of Medi-Cal enrollees in Alameda County are children, and 27% of births in Alameda County are covered by Medi-Cal.



Over 64,000 Alameda County residents aged 65 or older are covered by Medi-Cal (about 25%).



85% of the homeless population in Alameda County is eligible for Medi-Cal-managed care.

“I also believe that dental health is important because it is too expensive to go to the dentist. Many people I know have to go to Mexico or other countries to get their teeth fixed because they can’t afford it here. You can’t even afford to pay for a dental cleaning. Oral health is very important because that is where other diseases come from. I think there should be more help and more affordable places for people to go to get their dental needs taken care of.”

— Spanish-Speaking Community Member Focus Group Participant

Several participants mentioned that existing insurance, such as Medi-Cal, often does not cover full dental services, which can lead to out-of-pocket expenses. California Health Interview Survey data show that nearly 22% of people in Alameda County do not have dental insurance, which is better than the statewide figure of about 28%.⁴⁷ But large disparities by race/ethnicity exist in these statistics. For example, more than 42% of people in Alameda County who identify as Hispanic/Latino/a/x/e live without dental insurance.⁴⁸

Other Barriers to Accessing Care.

Participants identified language barriers as a significant issue, particularly for immigrants struggling to progress through the health care system, including filling out Medi-Cal and Medicare applications.

Participants also brought up geographic obstacles and said too few community-based clinics are located in underserved areas. Some mentioned that accessible dental services are also not available close to where they live, forcing them to travel long distances or even go outside the U.S. for affordable care. A lack of convenient or safe transportation makes these shortages even more of a hurdle to accessing care.



The community also highlighted **difficulties in accessing specialty care**, including:

- Diagnostics such as cardiology studies, pulmonary testing, and MRIs
- Geriatric care
- Mental health services
- Oral/dental health care

Both mental health and oral health can greatly affect one's overall health. For example, related to oral health, the bacteria associated with gum disease has been linked to chronic diseases such as diabetes and Alzheimer's.⁴⁹ Quite a few participants noted that poor dental health can lead to health problems in other parts of the body and in the mind, such as nutritional deficiencies due to difficulty eating, and depression. Health experts who participated in the CHA frequently stressed how important it is to integrate medical, dental, and mental/behavioral health services in a single location and that doing so can make it easier for people to access care.



“People have waited months and months and months for appointments with their primary care provider.”

— Key Informant Interviewee

Too Few Providers. CHA participants said there were too few available providers. In Alameda County, the ratio of community members to primary care providers was lower (better) than the ratio among Californians overall, statistics showed. However, the ratio of community members to other primary care professionals (e.g., nurse practitioners) was higher (worse) compared to the state (see charts in Figure 22).⁵⁰

Figure 22. The ratio of community members to non-physician primary care providers was higher (worse) in Alameda County compared to California overall.

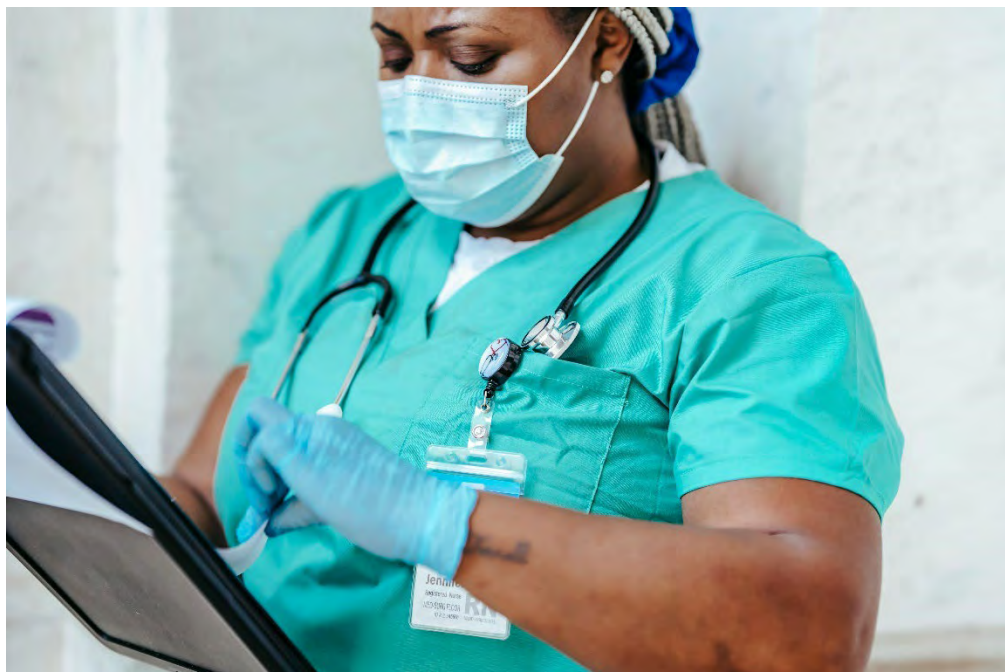
Primary Care Physician Ratio, 2020
(people per each provider)



Physician Assistants and Nurse Practitioners Ratio, 2020 (people per each provider)



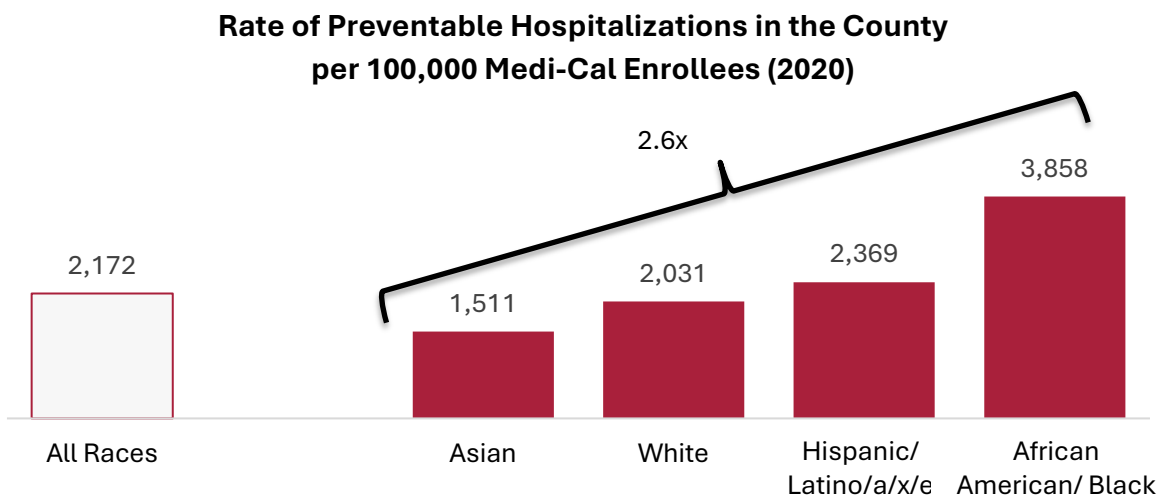
Source: Centers for Medicare and Medicaid, National Provider Identification, 2020.





Care Quality Inequities. The rates of preventable hospitalizations were highest for people who are African American/Black or Hispanic/Latino/a/x/e. A higher rate of preventable hospital stays may indicate inequitable access to high-quality health care.

Figure 23. Among older adults and people with disabilities, people who identify as African American/Black are hospitalized for preventable causes more often than their peers of all races/ethnicities.



Definition: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medi-Cal enrollees. Enrollees are aged 65+ and/or have at least one disability. Note: Data for races/ethnicities not shown were suppressed by the source. Source: Centers for Medicare & Medicaid, Mapping Medicare Disparities Tool, 2020.

“When I had private dental insurance, my dentist never ... suggested pulling any of my teeth because if he doesn't have that tooth to work on, he doesn't make any money. But... when you need to go to the dentist because you're a Medi-Cal or Denti-Cal patient, they want to pull your teeth.”

—Community Member Focus Group Participant

“It's really the quality of that care [in the hospital]. And then...once they're discharged, they go home, and there's such a lack of support. They're not monitored correctly, maybe they have to treat themselves, take care of their own wounds. It's a lot to ask.”

— Key Informant Interviewee, speaking about older adults

“We have noticed that many people have died because they think that if they [are admitted] into a hospital they will be deported ...because [hospitals] are asking for more and more information.”

—Spanish-Speaking Community Member Focus Group Participant

“Infant mortality ...is high amongst Native children. ...When they are getting the care they need, we see less infant mortality and less children getting sick.”

— Key Informant Interviewee

Participants were concerned about the quality of dental care provided by different insurance plans. For example, some felt that people with public insurance receive inferior treatment compared to people with private insurance.

Another common theme among participants was lack of trust in health care providers. Related to this, some participants raised issues of health care quality. They cited poor communication, misdiagnosis, a sense that providers did not care, and even obvious disrespect from them. They felt medical visits were often rushed and that their concerns were not adequately addressed. Participants emphasized how important it is for providers to listen to and understand the community they serve. Several noted that structural racism has produced disparities in health care access and health outcomes, such as biased treatment and more pregnancy-related deaths among Black women.

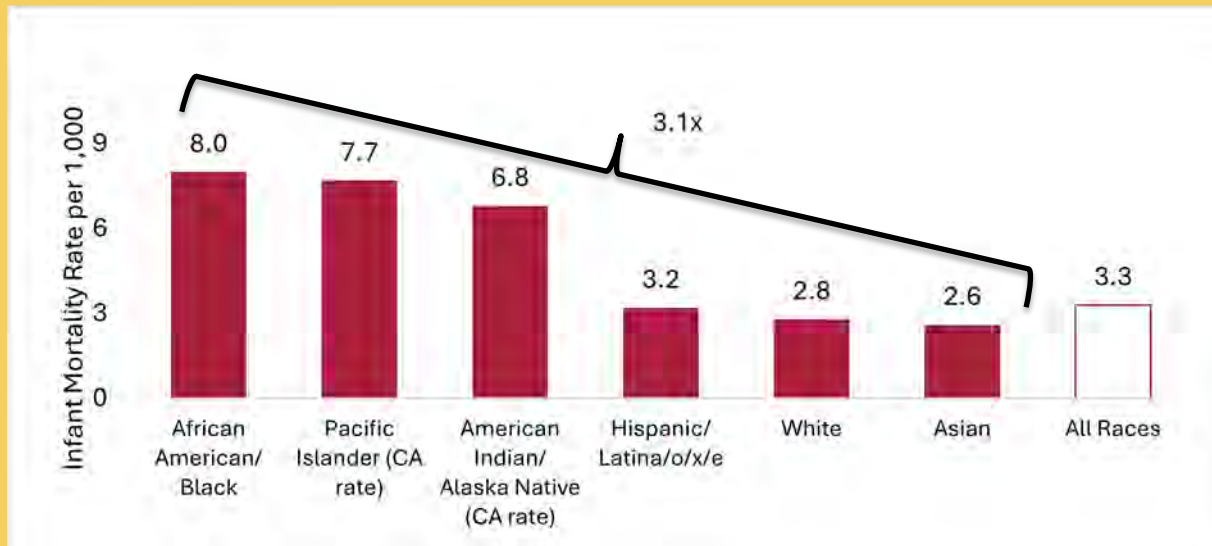


Case Study: Maternal/Infant Care Concerns

Maternal/infant health outcomes illustrate the issues of health care access and quality described above. Certain maternal and infant health statistics were worse for particular populations in the county versus state rates. For example, mortality is much higher among Alameda County’s Black infant population compared to infants of other races/ethnicities.

Figure 24. Inequities in health and mortality begin early in life.

Alameda County Infant Mortality by Race/Ethnicity (2020-2022)



Source: California Department of Public Health Infant Mortality Dashboard, 2020–2022.

Also, mothers had a notably higher rate of severe maternal morbidity (unexpected and life-threatening events that can occur during childbirth) than the California rate (136.7 vs.108.0 per 100,000 females aged 12-55), with the highest rate in Alameda County for Black mothers (229.2 per 100,000).

Participants noted that mothers who are low-income and BIPOC (especially Black mothers) face more challenges in securing quality maternal/infant health care. They identified racism and discrimination in health care settings as major issues that influence the quality of care given to mothers and infants. Another common theme shared in discussions was the need for health care providers to act with greater cultural sensitivity and to communicate more effectively, specifically with patients’ mothers who speak limited English.

Participants were very concerned about the affordability of maternal/infant health services. Some revealed that economic constraints had kept them from accessing the pre-/post-natal care they had needed. Some stressed how crucial it is that mothers receive mental health support, pointing out that a mother’s poor mental health can amplify other issues and affect the entire family.

How does the community suggest these issues are addressed?

- Increase number and capacity of clinics, bringing health services to communities (walk up, school-based, mobile models), expand specialty care (mental, dental, maternal services), improve transportation and telehealth access.
- Provide whole person care: integrate services like health care, benefits screenings, parental support, and job assistance in the same place. Provide education/outreach in plain language with simplified navigation for appointments and insurance.
- Provide culturally competent care: have staff that is diverse and reflects communities, hire local residents, value lived experience, expand roles for doulas/midwives/community health navigators.



Social Determinants of Health: Economic Stability

What is the issue?

Economic stability has been defined as people’s ability to sustainably cover their basic needs in a way that allows them dignity and self-respect.⁵¹ Higher income and social status, often achieved through higher education, have each been linked to greater health. Research has shown that when people have access to economic stability programs such as SNAP (formerly called food stamps), they have better long-term health outcomes.⁵²

Community Assets

The county has many assets and resources to address issues of economic stability. Some examples include:

Income/employment:

- Alameda County Social Services Agency
- Community Resources for Independent Living
- Centro de Servicios, Rubicon Programs, and other non-profit employment assets
- Various cities’ Family Resource Centers

Education:

- Public schools at all levels (PreK through college)
- Alameda County Early Head Start and Head Start
- Boys and Girls Clubs of San Leandro

Food security:

- Alameda County Community Food Bank and other food pantries
- Alameda County Nutrition Services–Women, Infants, and Children (WIC)
- Meals on Wheels of Alameda County
- Fresh Approach and other food-rescue non-profits

For a detailed list, please see Attachment 8: Community Assets and Resources.

Health Impacts

High Cost of Living Linked to Economic Instability. Economic stability includes education and food security. It was CHA participants' highest-priority health need in interviews and focus group discussions.

The high cost of living emerged as a key theme. Participants shared that wages from full-time employment are often insufficient to pay for basic needs like childcare, groceries, and medical supplies. This leads to economic strain, they added, and can require people to work multiple jobs and cut back on essentials. It can also force families to double or triple up in homes. These strains impact people's overall well-being.

Economic instability can result in an inability to pay rent, eviction, and subsequent homelessness.

Participants said the people most at risk of economic instability are:

- Individuals on fixed incomes, such as older adults and people living with disabilities
- Young adults
- Families with children
- People who face language barriers
- Immigrants
- People who lack documentation
- People affected by structural racism/discrimination

Some participants explained that economic pressures make it difficult for students to focus on education, discouraging or reducing their long-term economic potential.

“Parents I've worked with have been able to find employment, but the money they make doesn't meet all of their basic needs.”

— Key Informant Interviewee

“The safety net of welfare and food stamps doesn't help them get to a financially secure place. Once they get a job, having those benefits cut off is almost harder than not having that job.”

— Key Informant Interviewee

“Yesterday somebody who was a brain surgeon in Afghanistan, think they'll ever be able to work as a brain surgeon in the United States? Doubtful, right? You get these people who are highly skilled and they end up having to take much lesser jobs in terms of their skills. I mean they're all skillful, but I remember we had a judge [who] ended up having to drive a forklift in a warehouse.”

— Key Informant Interviewee

“If your economic situation is poor, then the thought about even going to free community college is difficult because it's time away from working.”

— Service Provider, Focus Group Participant

“What if you're working two jobs? When can you go to the doctor? Never.”

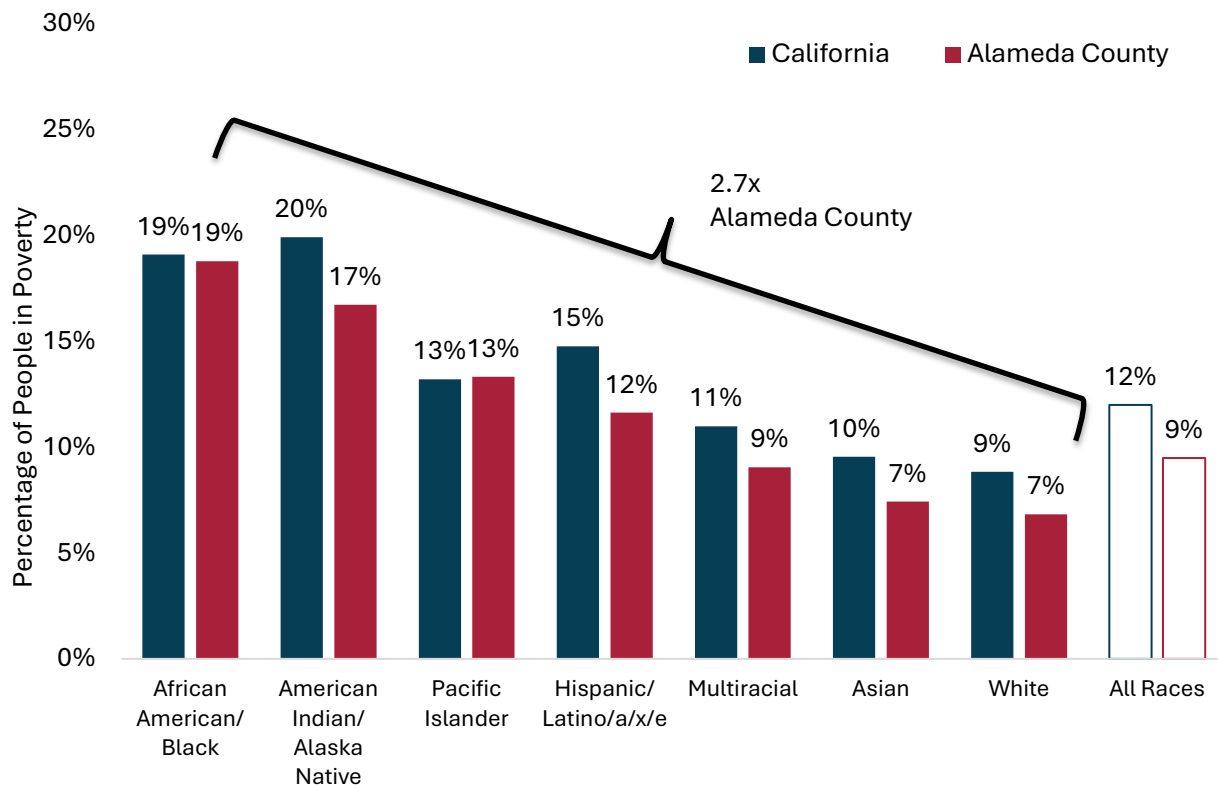
— Service Provider, Focus Group Participant

Differences in Income. Although participants did not discuss gender differences in wages, Alameda County women face a slightly greater gender pay gap (\$0.84 to the dollar) compared to all California women (\$0.86).⁵³ Quite a few participants noted how discrimination results in economic disparities and limits access to good jobs and economic opportunities.

Data show large disparities in median income by race/ethnicity. For example, an Alameda County Latine household earns a median of \$90,651, about 25% less than the countywide figure (\$119,600).

Figure 25. There are inequities in income across different ethnic groups.

Poverty Rate, by Race/Ethnicity, Alameda County and California (2019-2023)

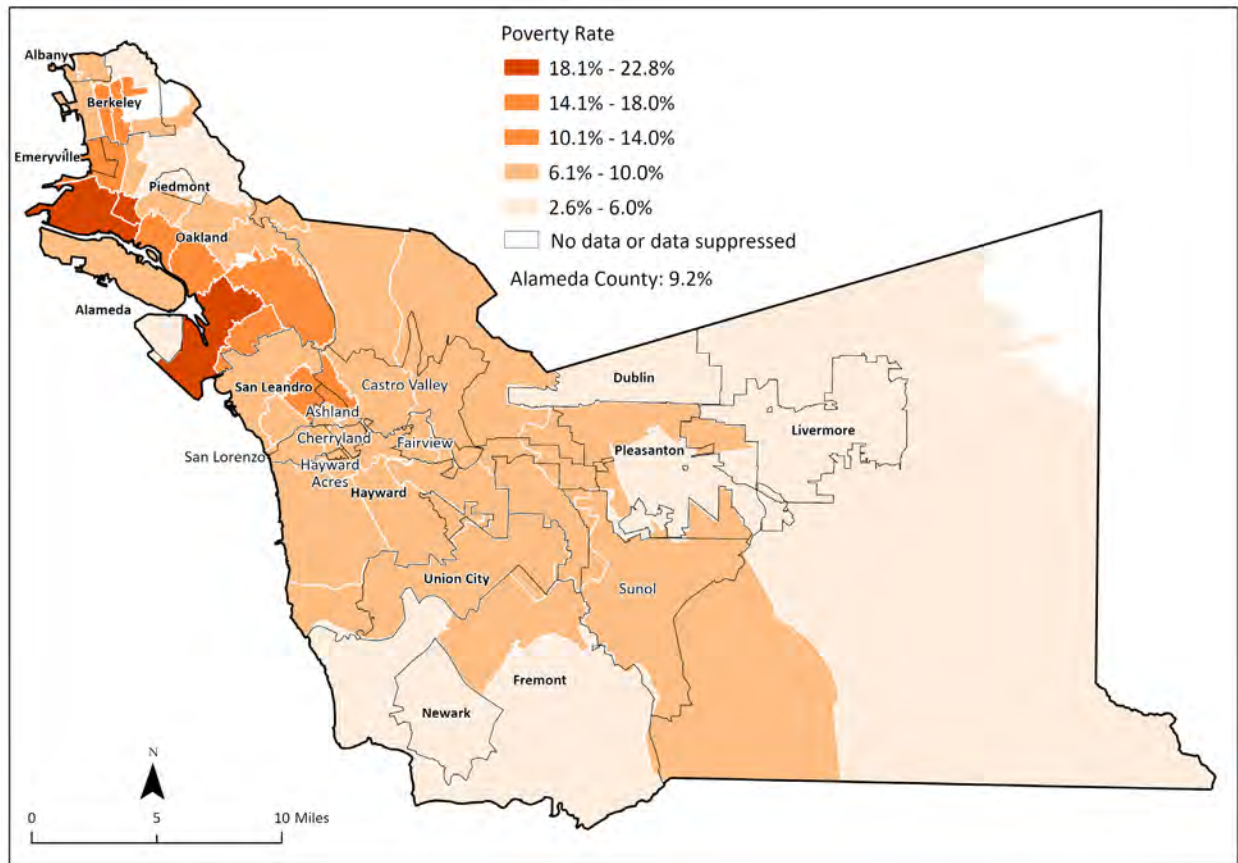


Source: U.S. Census Bureau, American Community Survey/Public Use Microdata Sample, 5-year estimates, 2019–2023.

Historical policies such as redlining still have an impact, evident in the notable differences in Zip code poverty metrics (Figure 26). People in poverty are more likely to live in areas that appear darker orange on the map below, including neighborhoods in Emeryville, Oakland, and San Leandro. In contrast, people in poverty are less likely to live in the areas that appear light orange.

Figure 26. Some areas with the poverty levels in Alameda County reflect historical redlining boundaries.

Poverty Rates in Alameda County, by Zip Code (2019–2023)



Note: Three Zip codes, two near the University of California, Berkeley, and one for Mills College in Oakland, are mostly students and have high poverty but not the deprivation normally associated with poverty, and are masked. Source: ACPHD CAPE, with data from U.S. Census Bureau, American Community Survey, 5-year estimates, 2019–2023.

There are also differences by disability status. In Alameda County, people living with disabilities experience poverty at over twice the rate of people not living with disabilities (18.5% versus. 9.1%).

“The price of healthy food, I think it’s very difficult. Especially when you’re on a fixed income. ... You have a McDonald’s app to get free fries, but it’s like \$4 for a salad or something.”

*—Community Member
Focus Group Participant*

“If the government didn’t help, we’d be starving every day in America.”

*—Khmer-Speaking Community
Focus Group Participant*

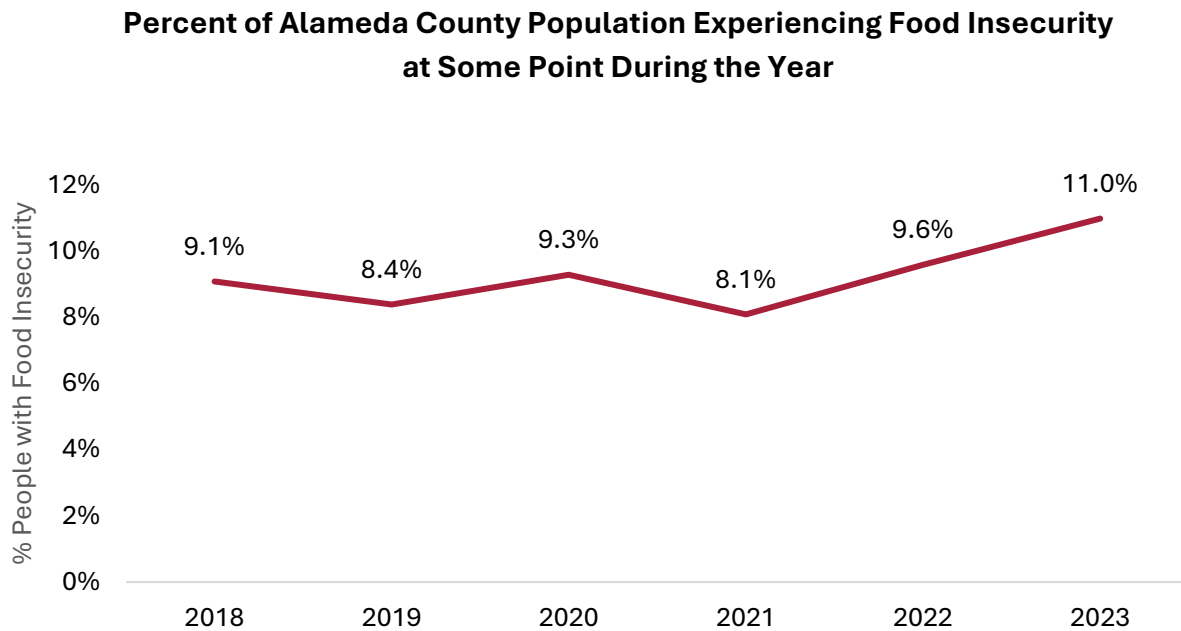
Food Insecurity. Food insecurity has been consistently going up in Alameda County since the start of the COVID-19 pandemic. Many participants described how economic insecurity and rising prices affect food access. They explained that economic insecurity forces individuals to prioritize other expenses over health and to neglect nutrition.

Quite a few participants mentioned that older adults and individuals with disabilities are particularly vulnerable to food insecurity due to fixed incomes. Some said these groups often run out of food before their next benefit payment.

Participants associated food insecurity with stress, hopelessness, and feelings of despair, and linked these feelings to broader mental health struggles.



Figure 27. Food insecurity rose after the COVID-19 pandemic and has not yet begun to stabilize or decrease.



Note: The U.S. Department of Agriculture (USDA) defines food insecurity as “limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways.” Source: Feeding America, 2018–2023, as provided by Conduent Healthy Communities Institute via the Healthy Alameda County platform.

Participants frequently described barriers to accessing healthy food, such as:

- Food deserts (areas where grocery stores are not easily accessible), and an oversupply of processed foods
- Poor food quality (e.g., items near their expiration date) and lack of culturally diverse choices from food banks and meal delivery services
- Some programs provide only two meals a day, which is not enough food
- A stigma around seeking food assistance, which can discourage people from getting help
- Eligibility requirements too strict

“[Food insecurity] numbers have not decreased in the last few years. The need is still very high. We are especially noting it with seniors.”

— Key Informant Interviewee

“I personally fought for my daughter, and it took me nine years to get an IEP [Individualized Education Program] for [her] ... you have to fight a lot, and many parents don’t even know where to guide you, or how to fight, or how to demand from the district ... that your child has special needs and that he or she has the right.”

— Spanish-Speaking Focus Group Participant

“With the education piece, I would like to tie that to economics. The majority of people who are educated are economically advantaged. They have the resources ...and know how to be more healthy, and they’re more likely to pass that down to their children versus the people who are disparate [not educated/ advantaged].”

— Black Community Member Focus Group Participant



Educational Inequities. Many people emphasized that education is critical to improving health outcomes and overall well-being. They saw education as foundational to understanding and accessing health resources.

Several stressed the need for better preschool and early childhood education. Participants also expressed concerns about the quality of K–12 education, citing a lack of guidance and support for students. Some mentioned overcrowded classrooms, insufficient funding, and an absence of after-school programs. They highlighted the inequitable distribution of resources in public schools, noting that schools in affluent areas had more resources than those in poorer, often racially segregated neighborhoods.

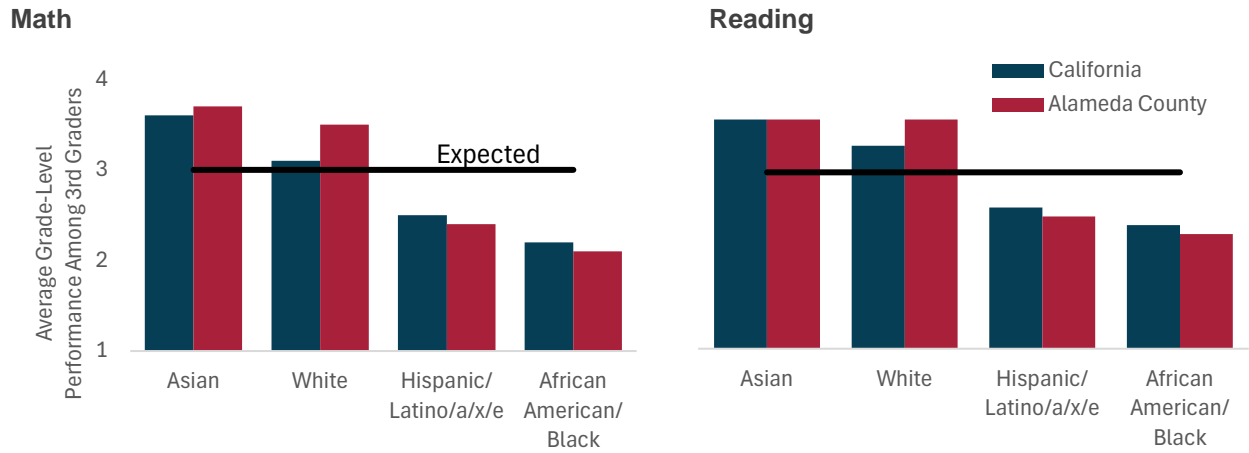
Participants viewed the path to getting a college education as challenging due to financial limitations and the need to balance work/school. Some noted that community colleges offering free tuition or stipends are helpful but do not address all barriers. They highlighted language barriers for non-English speakers as an obstacle to educational success.

Elementary school math and reading performance were lower among the county’s BIPOC children (see next page).

Disparities also existed in high school non-completion rates. CHA participants were particularly concerned about educational statistics and disparities that differed by race/ethnicity; some said that education can affect future income potential.

Figure 28. Math and reading performance were both notably lower among African American/Black and Hispanic/Latino/a/x/e students.

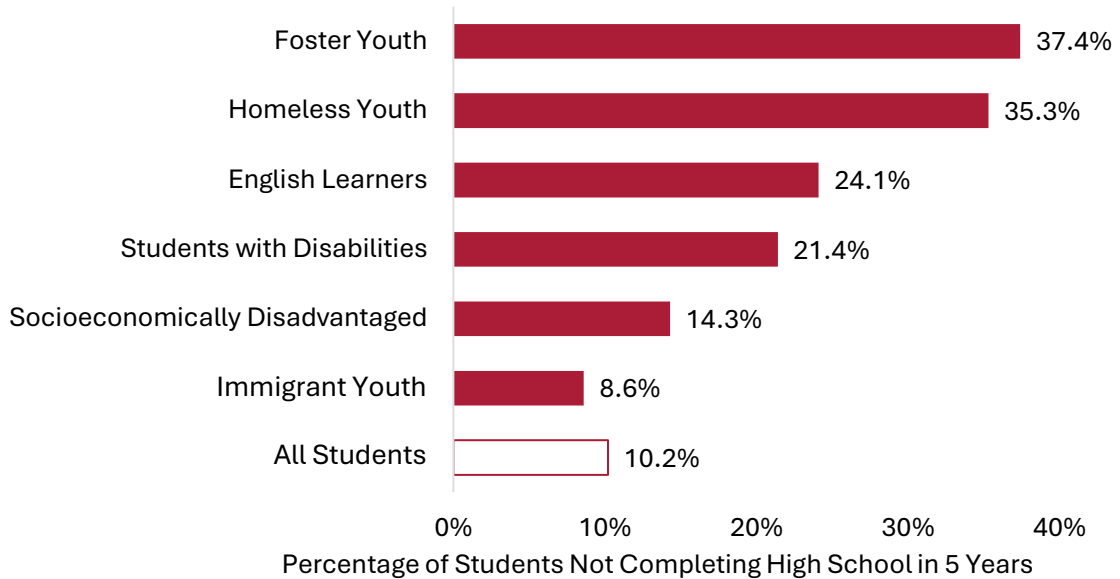
Math and Reading Test Results, 3rd Graders in Alameda County, by Race/Ethnicity (2022)



Source: California Department of Education, Test Results for California’s Assessments, 2022. As cited on KidsData.org.

Figure 29. Foster youth had a high school non-completion rate that was over 3 times that of students overall.

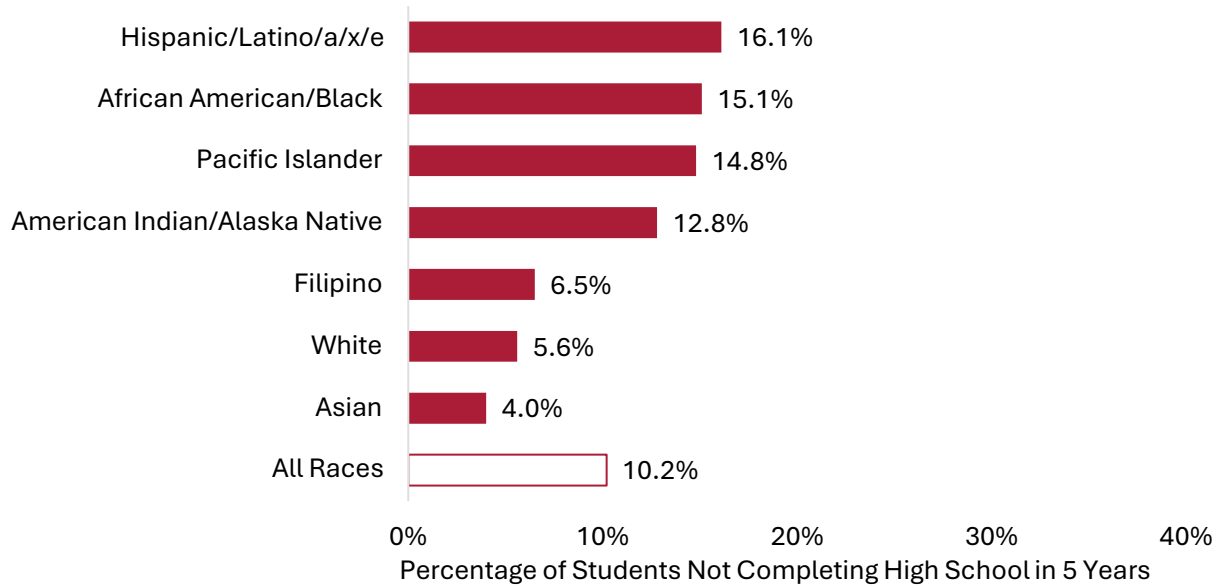
Alameda County 5-Year High School Non-Completion Rate, by Special Populations (2023–2024)



Source: AC CAPE Unit, sourced from California Department of Education dashboards, 2023–2024.

Figure 30. Hispanic/Latino/a/x/e students had a high school non-completion rate that was more than 4 times that of Asian students.

**Alameda County 5-Year High School Non-Completion Rate,
by Race/Ethnicity (2023–2024)**

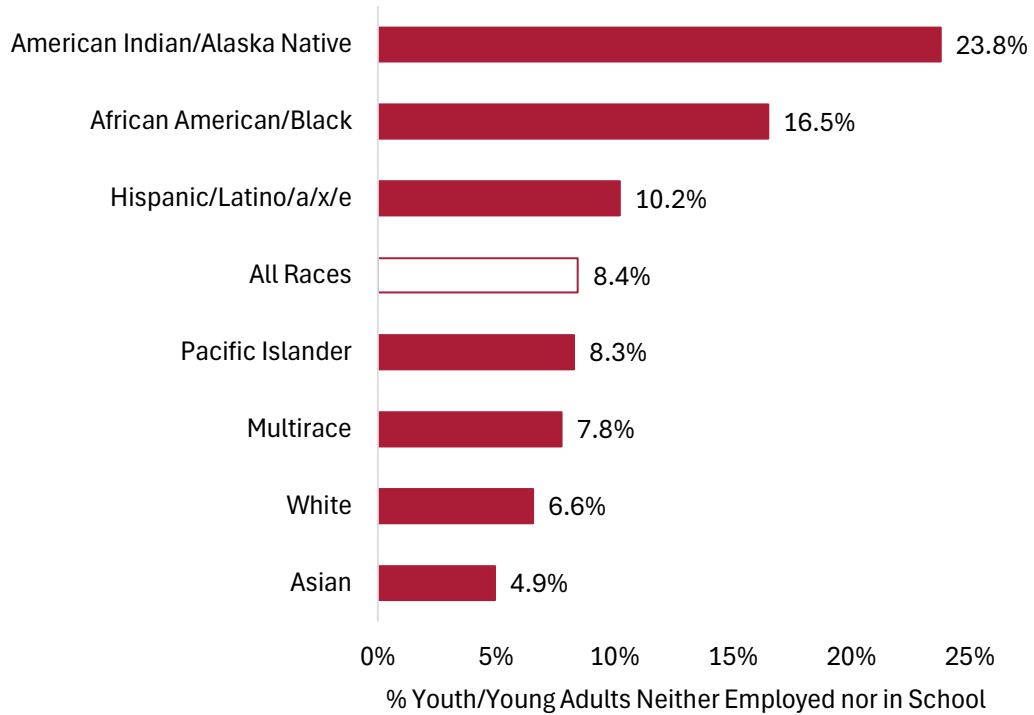


Source: AC CAPE Unit, sourced from California Department of Education dashboards, 2023–2024.



Figure 31. There were disparities in labor force participation data for youth and young adults: Asian and White youth and young adults are more likely to be in school or participating in the labor force than their peers of other races/ethnicities.

**Alameda County Youth Aged 16–24, Not Employed & Not in School,
Percentage by Race/Ethnicity**



Source: U.S. Census Bureau, American Community Survey, 5-year estimates, 2018–2022.

How does the community suggest these issues are addressed?

- Provide more support within schools (including on-site mental health counseling, medical screenings (vision, hearing), and therapy)
- Address living wage (increased minimum wage) and affordable housing, both of which also impact food insecurity
- Expand and improve job training programs, bridging gap between unemployment and employability and offer stipends or paid opportunities during job training (e.g., nursing, CNA, EMT)

Social Determinants of Health: Peaceful Communities

What is the issue?

While the desire for safety is universal, sustaining a peaceful community is far from simple. This is due to a complex mix of systemic, psychological, and social factors that include deep-seated inequalities, past resentments, and lack of long-term community investment. Research has found that community violence is more likely when difficult living conditions and under-resourced communities leave people's basic needs unmet.⁵⁴ Those needs include food, housing, health, education, and jobs. Violence and intentional injury are related to poorer physical and mental health for the people involved and the community at large.⁵⁵ Early violence prevention, including addressing the factors that underlie it, is the key to creating more peaceful and healthier communities.⁵⁴

Community Assets

The county has many assets and resources to support peaceful communities. Some examples include:

- Alameda County Court Appointed Special Advocates
- Alameda County Deputy Sheriffs' Activities League
- Alameda County Family Justice Center
- Fresh Lifelines for Youth and other youth-focused non-profits
- The Oakland Ceasefire Program, an initiative formed by partnerships between community-based organizations and law enforcement
- Hospital-based violence intervention programs, such as Youth Alive's Caught in the Crossfire program and Roots Community Health's ongoing violence intervention supports
- Ruby's Place, Safe Alternatives to Violent Environments, and other domestic violence shelters and service providers

For a detailed list, please see Attachment 8: Community Assets and Resources.

Health Impacts

Affects Everyone’s Well-Being. Participants in the CHA prioritized peace and safety from community and family violence in close to 2 out of every 5 interviews and focus groups. Many made it clear how important peaceful communities are for overall well-being.

People shared what has them concerned:

- Shootings
- Domestic violence
- Violent crimes

Some described how housing instability and overcrowding creates stress that can affect the peace and safety of all people in a residence. Community violence affects their daily lives, participants noted, and makes them feel unsafe in public spaces like parks and schools.

Participants spoke about wanting safer environments for their families. As noted in ACPHD’s 2025 *Promoting Peaceful Families and Communities* report, access to guns contributes to high levels of lethal violence. Both service providers and community members talked about how living in fear of violence and crime significantly impacts mental health and lessens peoples’ ability to thrive and feel safe.

Impact of Poverty. Participants frequently mentioned that the presence of unhoused people contributed to their feelings of insecurity in the community.

They consistently described how economic instability, poverty, and lack of resources, often described as driven by systemic racism, contribute to neighborhood unrest and community and family violence. As described

“We had a recent meeting where we talked about ... health priorities, and the stories that came from residents ... that really touched everybody’s heart were simple statements like, ‘I want to be able to walk my kid to the park without fear of them being injured or hurt.’”

— Key Informant Interviewee

“People’s sense of safety on BART, I think, is declining. So while the systems are there, and transit is available, I think that there’s a decreasing level of comfortability in using public transit.”

— Key Informant Interviewee

“By and large, I’d say communities of color... all talk about violence. All of them. And being concerned about it and it being a problem.”

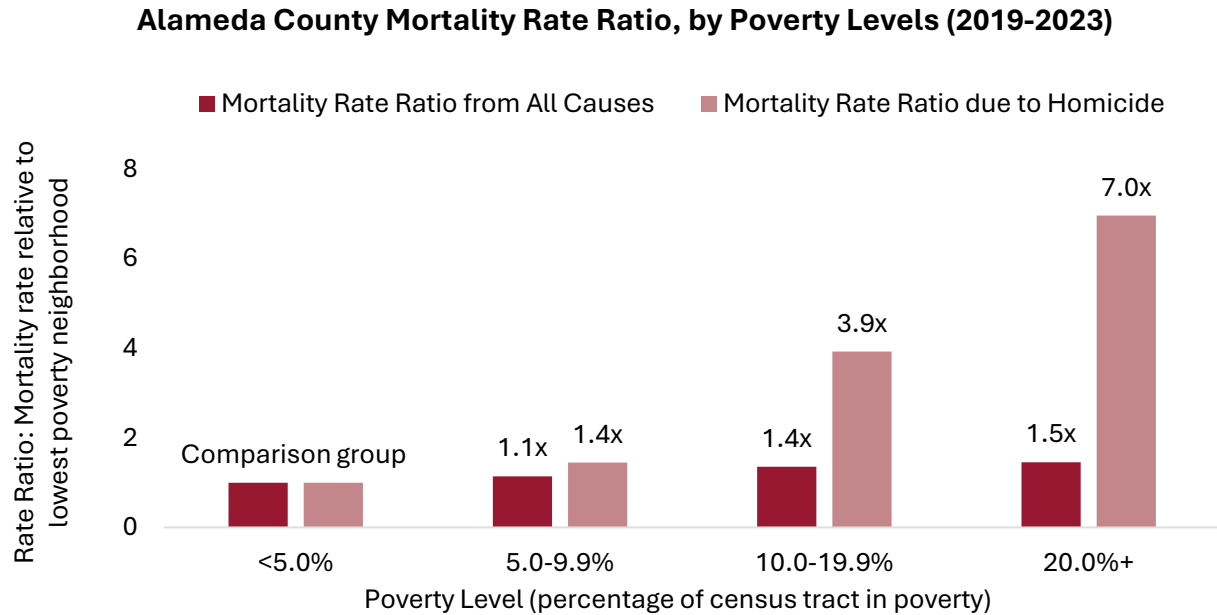
— Key Informant Interviewee

“[About Afghan] women, ...with the trauma and with the pressure of learning to live in America comes a lot of issues. We do see domestic violence. I don't know how often, but it’s frequent.”

— Key Informant Interviewee

in ACPHD’s report (see previous page), living in under-resourced communities increases residents’ risk for violence. Overall, homicide mortality rates in Alameda County are higher in neighborhoods where poverty rates are higher.

Figure 32. People in poorer neighborhoods are more likely to die from homicide.



Note: The comparison group is the lowest-poverty neighborhoods. Source: ACPHD CAPE, with data from Alameda County vital statistics data, 2019-2023.



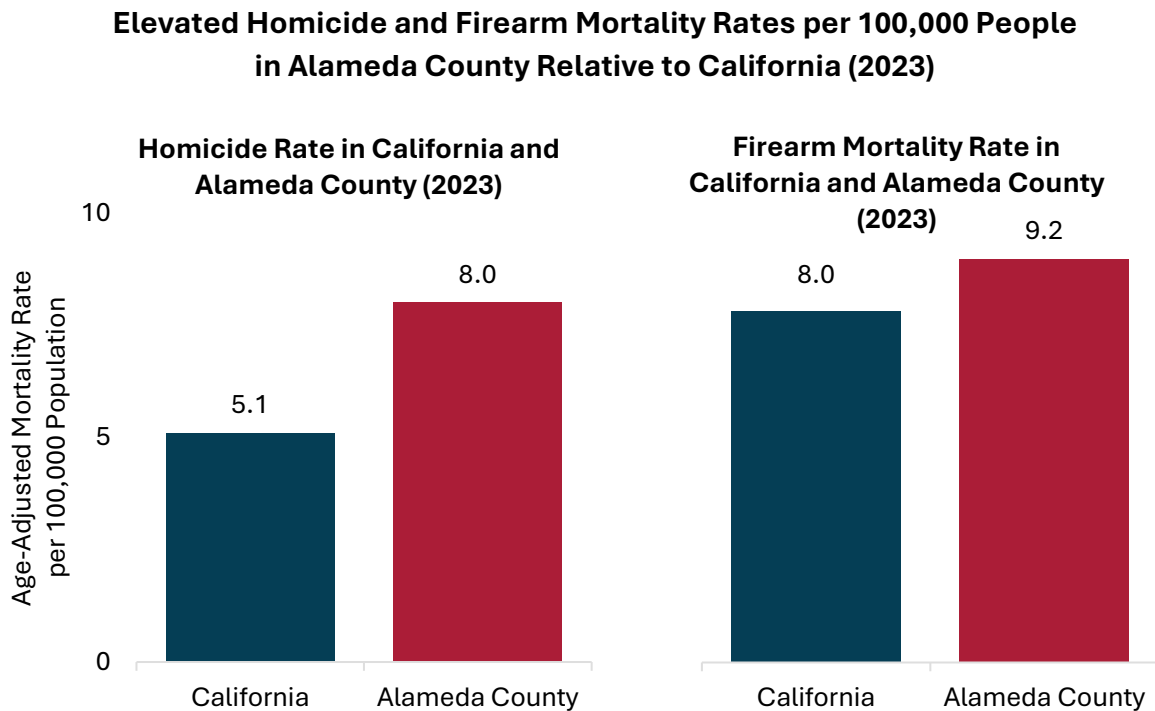
“I don’t know how much you can physically do... to make people feel safe. I carry pepper spray with me everywhere I go, even if it’s in the middle of the day, because there’s always that inkling in the back of your mind, like, if someone’s really determined to make things unsafe or dangerous, then there’s nothing I can do to stop them.”

— Youth Participant, Eastern Alameda County Needs Assessment

Gun Violence and Homicide. Health experts in Alameda County felt community violence is a county-wide concern. Oakland interviewees and focus group participants mentioned gun violence specifically and described the ways it has affected youth and community-serving staff both directly and indirectly.

Statistics have shown that the homicide rate is notably higher in Alameda County than in California overall. Specifically with regard to gun violence, although the county experienced increases in gun homicides during the COVID-19 pandemic, preliminary data indicates that there were in 119 gun homicides in 2024, reflecting a 16% decrease from the prior year. However, similar to the overall homicide rate, residents living in Alameda County’s poorest neighborhoods have a gun homicide rate 8 times higher than those living in the wealthiest neighborhoods.⁵⁶

Figure 33. Homicide and firearm mortality rates are higher in Alameda County than they are statewide.



Source: CAPE, with data from Alameda County Vital Statistics files and CDC Wonder, 2023.

Gun Violence and Race. Firearm mortality in the county is similarly higher than the state rate. The Black population in Alameda County disproportionately experiences both firearm mortality (27.5 per 100,000) and homicides (50.7 per 100,000). Comparatively, Black males make up roughly 5% of the county’s population but accounted for 48% of all gun homicide deaths from 2019 to 2023.⁵⁶

“I chose [to discuss] community safety because where I live there is a lot of violence. There are shootings at 7 at night, or at any time; there are a lot of shootings. There are a lot of homeless people that bother the people who live around there, plus there is a school, so it affects the people who walk to school. ...There is a lot of violence and shooting.”

— Spanish-Speaking Community Member Focus Group Participant

Violence and Children. In 2022–2023, homicide was among the top 3 causes of death in Alameda County for children and youth under 18 and for young adults aged 18–34. It was the 4th leading cause of death among adults aged 35–44. In particular, guns are the leading cause of death among children (ages 1–17) and transition-aged youth (ages 18–24) in Alameda County.⁵⁶

Additionally, youth gang membership among 11th graders in Alameda County was somewhat higher (4.4%) than the California benchmark (4.1%). Compared to their statewide peers, a slightly larger percentage of youth (9th graders) also reported being bullied and harassed at school because of bias related gender, race/ethnicity or national origin, religion, sexual orientation, or a physical/mental disability (26% in Alameda County versus 23% in California overall).⁵⁷

How does the community suggest these issues are addressed?

- Expand and strengthen victim support and intervention services, including hospital-based violence intervention programs, relocation support, legal advocacy, mental health care, accessible communication options, culturally/linguistically appropriate resources, and shelter capacity for domestic abuse survivors.
- Encourage education and prevention programs to build resilient communities, including afterschool programs, youth engagement initiatives, and community-based education.
- Ensure better coordination among hospitals, government agencies, schools, law enforcement, and community organizations to provide timely intervention and support for at-risk families.

Social Determinants of Health: Housing and the Unhoused

What is the issue?

The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the well-being, educational achievement, and economic success of those who live inside it.⁵⁸ Poor health can lead to homelessness, and vice versa. People experiencing homelessness suffer from preventable illnesses at a greater rate. They also require longer hospital stays and have a greater risk of premature death than their peers with housing security.⁵⁹

Community Assets

The county has many assets and resources to address housing issues. Some examples include:

- Alameda County Health Care for the Homeless
- Abode Services, First Place for Youth, and other nonprofits serving people who are unhoused or at risk of being unhoused
- Eden Housing, MidPen housing, and other nonprofit developers who own and manage quality affordable housing
- Homeless Action Center, Eden Council for Hope and Opportunity (ECHO), and other nonprofits that offer services related to fair housing and tenants' rights
- Open Heart Refuge, South Hayward Parish, and other shelters for people who are unhoused

For a detailed list, please see Attachment 8: Community Assets and Resources.

Health Impacts

Barriers to Housing. Housing was one of the highest-priority health needs mentioned by participants in interviews and focus groups. People emphasized the shortage of affordable housing in Alameda County, describing it as an ongoing, decades-old problem. They spoke about the challenges of buying and owning a home in the Bay Area.

Some participants pointed out that renters are a growing demographic in Alameda County. Participants cited rising rental costs and a shortage of affordable housing options as major issues for many. Affordable housing is a critical need, and many families are doubling or tripling up in single residences due to high housing costs. Despite this, some described how efforts to convert motels into low-income housing faced opposition from local residents concerned about safety.

Barriers to housing were a major topic of discussion. Participants spoke to individual economic stressors, such as wages failing to keep up with housing costs, and city-and county-level factors, such as how affordable housing projects have difficulty securing financing. They observed that both personal and societal economic factors exacerbate the housing crisis.

Poor Housing Conditions. Nearly 25% of Alameda County residents live in a household with one or more severe housing problems. These issues include overcrowding, high housing costs, the lack of a kitchen, or the lack of plumbing facilities. Severe housing problems are linked to other health needs such as communicable and chronic diseases. Several participants talked about observing

“They have all these new apartments and stuff being built, and it’s like, ... are you saving space for our disabled folks, our older folks, our parents [who] are retiring? Not everybody can afford a retirement home.”

—Community Member Focus Group Participant

“They’re living in two, three-bedroom apartments with like 10-plus people in it. I’ve been to homes when I was doing home visiting where they’re putting partitions in the living room to kind of, you know, section off, create more privacy for themselves.”

—Key Informant Interviewee

“I don’t care how good our staff is. They can provide [youth and young adults] with the most intensive independent living skills to tend to their mental health, but when the [young people] age out on their 25th birthday, unless they’re working a very high-paying tech job—and they’re not—it’s going to be very difficult for them to lock in housing and be able to support themselves.”

— Key Informant Interviewee

poor living conditions among the people they served, which included people residing in vehicles or overcrowded housing situations.

Effects of Housing Instability, Including Becoming Unhoused. Participants described how housing instability leads to frequent relocations with broad effects: Repeated moves impact children’s education, individuals’ job stability, and overall family stability. Some noted the substantial challenges faced by transition-age (i.e., 18–21 years old) youth exiting foster care when they try to secure stable housing and become responsible tenants.

Many participants spoke about the increasing unhoused population. They said increases are particularly acute in urban areas like Oakland. Although the number of people experiencing homelessness in Alameda County decreased from 2022 to 2024, in the City of Oakland the count rose by 9% during that period (see Figure 34, next page).

Housing instability and homelessness have major health effects. Focus group participants and key informants regularly underscored the impact these issues have on not just physical but mental well-being. They observed that mental and behavioral health issues can both result from and contribute to homelessness. Lack of access to resources and/or behavioral health care can make such issues more pronounced. Participants see stable housing as a foundation for addressing other needs.

“It’s gotten a lot worse, and what we’re seeing is a lot of people, half of our homeless population live in vehicles.”

—Community Service Provider Key Informant Interviewee

“We’ve had cases where folks have had to leave their housing for just a short period of time for some kind of skilled nursing facility or substance use rehab and not be able to return when they should have been able to return. So, not being able to discharge safely after getting health care.”

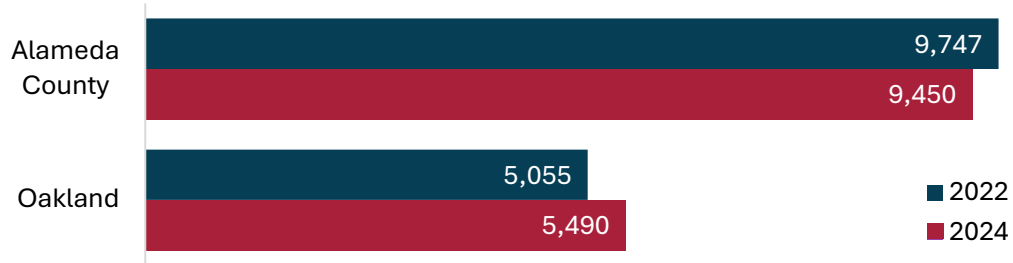
—Service Provider, Focus Group Participant

“Homelessness has changed so much. You get people that are working...there’s families, young people, there’s just aged people. I never knew there were so many senior homeless people.”

—Community Member Focus Group Participant

Figure 34. The number of individuals who are unhoused in Oakland rose between 2022 and 2024, while the overall figure for the county dropped slightly.

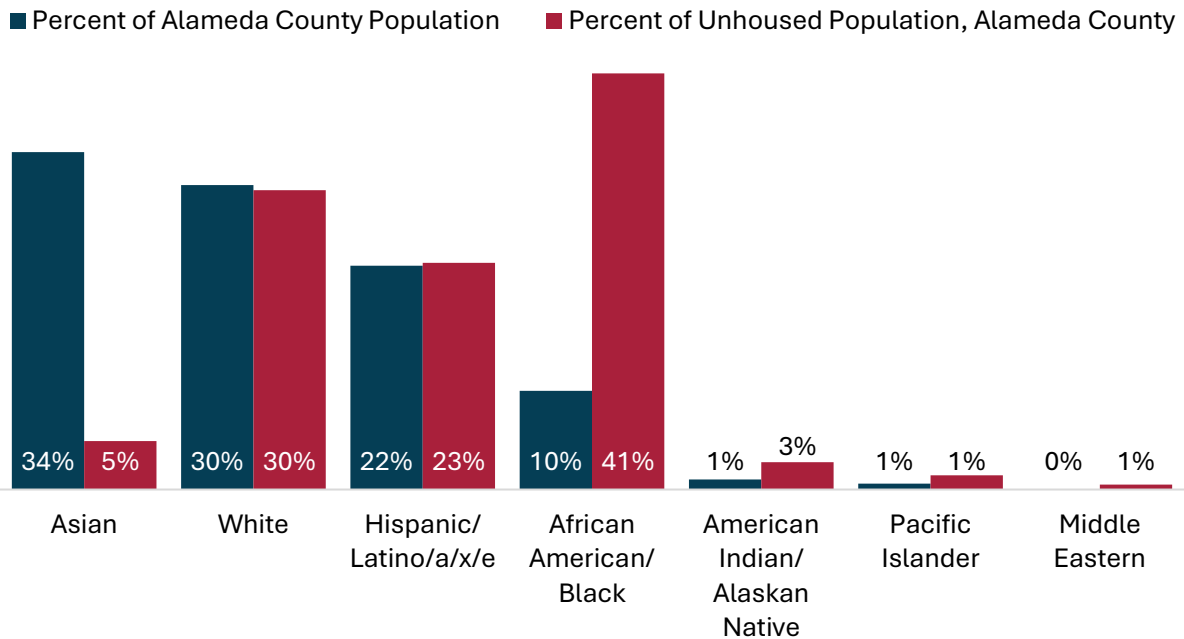
Number of People Who Were Unhoused in Alameda County Compared to the City of Oakland, 2022 Versus 2024



Source: Applied Survey Research. Alameda County Point-in-Time Count. 2022 and 2024.

Figure 35. BIPOC communities are overrepresented in Alameda County’s unhoused population.

Alameda County Population Percentage by Race/Ethnicity, All Residents Versus Unhoused (2024)



Source: Applied Survey Research. Alameda County Point-in-Time Count. 2024.

“There should be some kind of regulations for shelters to have to be able to accommodate folks with a disability.”

— Key Informant Interviewee

“If you're looking at why we selected this [to discuss], it's because of things like structural and institutional racism specific to our region, like redlining, the way that the cities were constructed. I think that is why we're identifying this as such a health problem.”

— Key Informant Interviewee

Addressing the Housing Crisis. Some service providers interviewed for the CHA described their focus on housing stability. They provide wraparound services, such as medical, behavioral health, and supportive care to foster individuals’ independence, and avoid evictions unless absolutely necessary.

When discussing housing instability and homelessness, participants cited structural racism and economic inequities as contributing factors. They identified the intersection of housing, health, and racial justice as critical to addressing the housing and homelessness crisis.

Participants expressed a sense that current government responses to the housing and homelessness crisis are inefficient and cost taxpayers too much. Structural issues, including decisions by governmental agencies and private organizations, contribute to inequitable housing conditions that disproportionately affect marginalized communities.



How does the community suggest these issues are addressed?

- Expand affordable housing!
- Address land use barriers, community resistance to new housing developments, and repurpose vacant/underutilized buildings to affordable housing (tax incentives, public investment).
- Offer housing solutions led by people who have experienced homelessness, provide better access to low income housing programs, including incentives or direct family assistance to those trying to secure housing and addressing any discriminatory practices preventing access to housing.



Social Determinants of Health: Built Environment, Including Unintended Injuries

What is the issue?

As UC Berkeley health expert Dr. Tony Iton has said, “When it comes to your health, your zip code matters more than your genetic code.”⁶⁰ The built environment refers to the places where people live and work, the neighborhoods in which they spend their time.⁶¹ This can include services and utilities, such as sewerage or transportation, housing quality, access to grocery stores, and elements such as sidewalks and streetlights.

The lack of sidewalks and streetlights can lead motor vehicle crashes and accidents involving pedestrians, causing unintended injuries and deaths. Although most unintended injuries are predictable and preventable, they are a major cause of premature death and lifelong disability.⁶²

Community Assets

The county has many assets and resources to address issues in the built environment. Some examples include:

- Alameda County Community Development Agency’s Healthy Homes Department, Lead Poisoning Prevention Program
- Alameda County Health’s Environmental Health Department
- Alameda County Transportation Commission’s Bicycle Safety Education Program
- Alameda County and cities' Public Works agencies
- Various local water agencies

For a detailed list, please see Attachment 8: Community Assets and Resources.

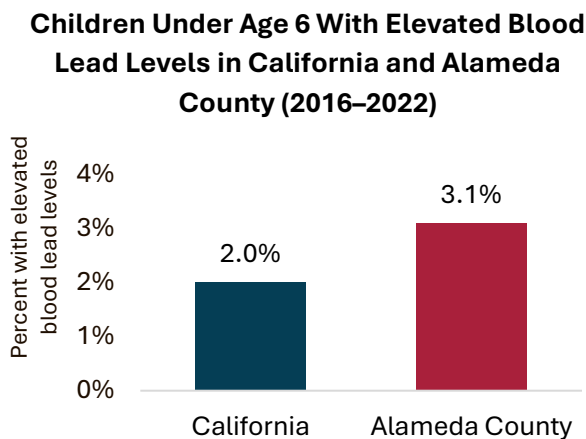
“Part of a healthy community is just the environment that you’re in and the simple things such as repairing the streets, picking up trash. That makes a difference with how people feel in their community, and it affects their health.”

—Key Informant Interviewee

“Transportation modalities are one of the heaviest contributors to pollution, air quality. We do know they also are connected with some diseases; people that are exposed to the gases ... more frequently, they also develop cardiovascular disease or cancer, for example, due to the heavy metals.”

—Key Informant Interviewee

Figure 36. High rates of elevated blood lead levels exist in Alameda County.



Note: High blood lead levels are defined as 3.5 µg/dL or above. Source: CA Dept. of Public Health Childhood Lead Poisoning Prevention Branch reports, 2016 to 2022.

Health Impacts

Neglected Public Infrastructure.

Describing their built environment, CHA participants pointed out how infrastructure (such as sidewalks and public buildings) in lower-income areas is neglected, and they saw this as related to systemic issues. For example, people said that the historical policy of redlining, which reinforced racial discrimination, has led to a long-term lack of resources to improve infrastructure in racialized poor neighborhoods.

Negative Health Effects of Contaminants.

Environmental contaminants are another built environment challenge. For example, elevated blood lead levels among children suggest lead contamination in places they spend the most time, such as their home, neighborhood, or school. Contamination can come from paint in older buildings, old water pipes, contaminated soil or dust, toys made with lead, some imported candies, and even some traditional folk remedies.

CHA participants noted the effect of environmental contaminants and unsafe drinking water on community health. Some reported using bottled water or boiling tap water because they don’t trust the water quality, whether due to old pipes or visible environmental contamination (e.g., industrial activity leading to poor air and soil quality). (See more in the subsection on *Climate / Natural Environment* and the section on *Chronic Conditions*.)

Food Deserts. Participants frequently mentioned the difficulty of accessing healthy food options in their communities. They reported challenges such as food deserts, where grocery stores are not easily accessible, and an abundance of processed foods. They mentioned that remote areas and certain neighborhoods have more food insecurity because residents have limited access to grocery stores and related resources.

“Geographically, where folks are living, certain things such as higher levels of air pollution, access to healthy grocery stores or healthy food options—a lot of it is a food desert; there’s a million corner stores, and occasionally some of them do have apples and things like that, but for the most part, the nutrition options that are available for folks in certain areas, it’s a part of that structure ... in terms of structural racism.”

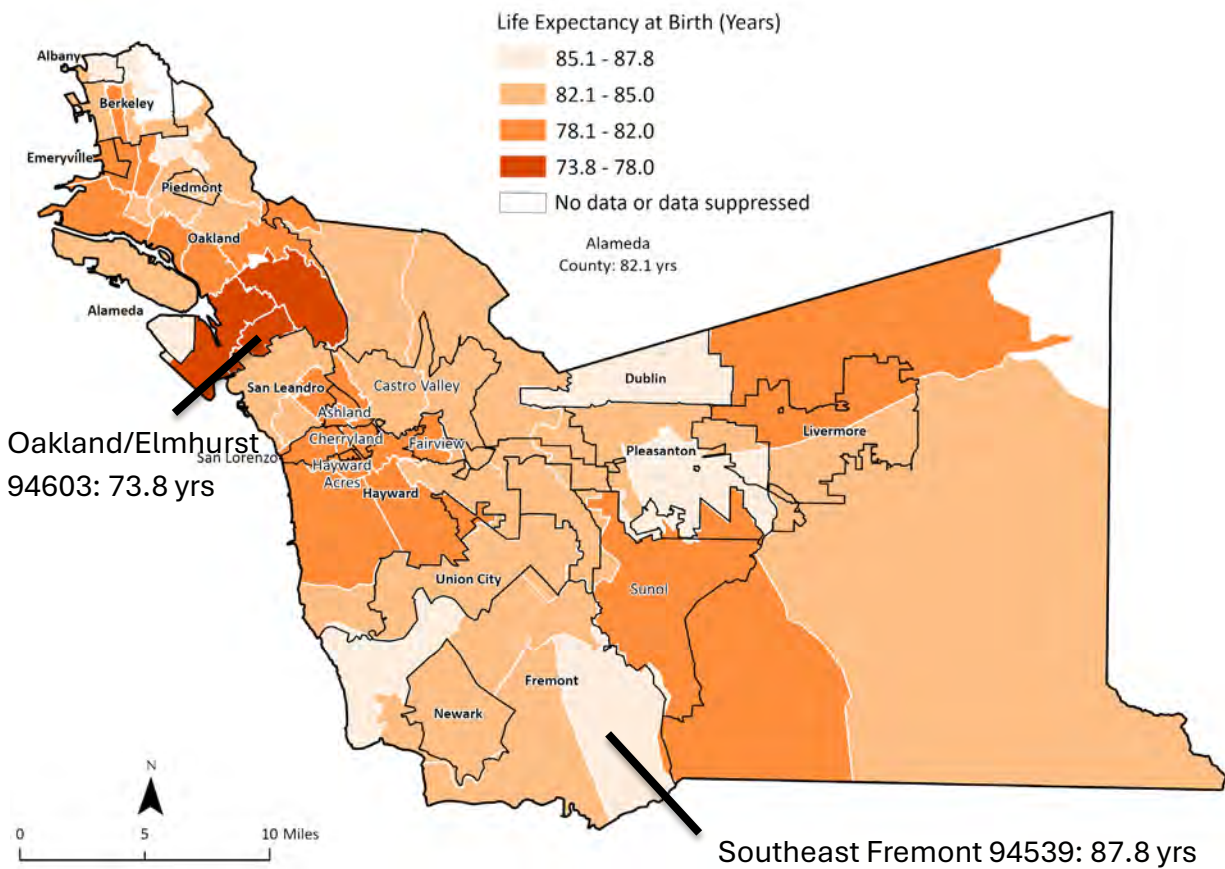
—Key Informant Interviewee



Differing Life Expectancy. The built environment has an effect on people’s lives and health. In Alameda County, the data show a substantial difference in life expectancy by zip code (see Figure 37, below). The highest life expectancy is 88 years in southeast Fremont. Less than 25 miles south, in east Oakland/Elmhurst, life expectancy is 14 years lower, at just 74 years.

Figure 37. Life expectancy rates vary substantially by geographic area.

Alameda County, Life Expectancy in Years, by Zip Code (2019–2023)

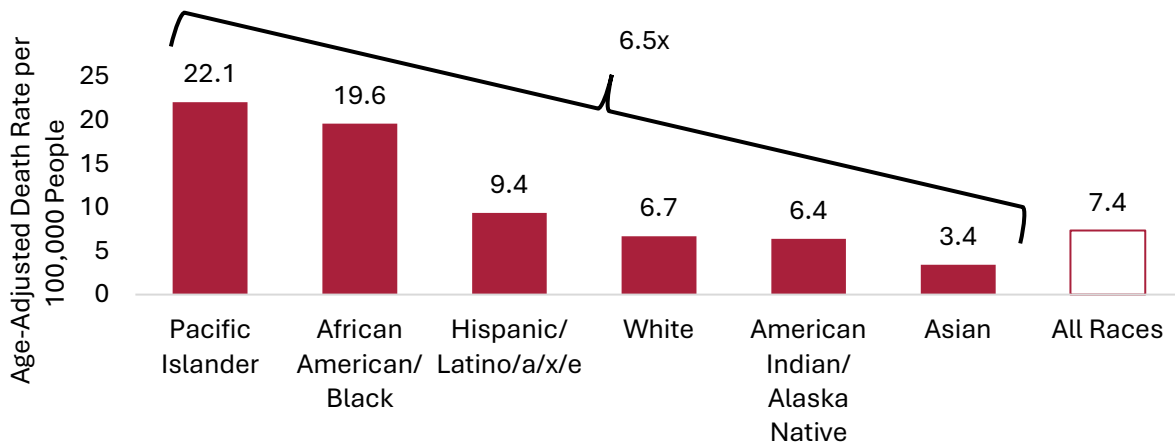


Source: ACPHD CAPE, with data from Alameda County vital statistics files, 2019–2023.

Motor Vehicle Accidents; Poor Access to Sidewalks and Public Transit. Accidents also present a big challenge. Among young adults aged 18–34 in Alameda County, unintended motor vehicle crash mortality was the 3rd leading cause of death in 2022–2023. The Pacific Islander population had the highest unintended motor vehicle crash mortality rates by race in the county; the African American/Black population had the second highest rate. The rate of death from unintended motor vehicle crashes in neighborhoods with high levels of poverty (30% or more of census tracts) is more than twice the rate of the wealthiest neighborhoods (12.6 per 100,000 compared to 5.6 per 100,000), according to county data.

Figure 38. The Pacific Islander population had the highest unintended motor vehicle crash mortality rates by race in the county.

Alameda County Motor Vehicle Traffic Mortality Rate per 100,000, by Race and Ethnicity (2019 to 2023)



Source: ACPHD CAPE, 2019–2023.

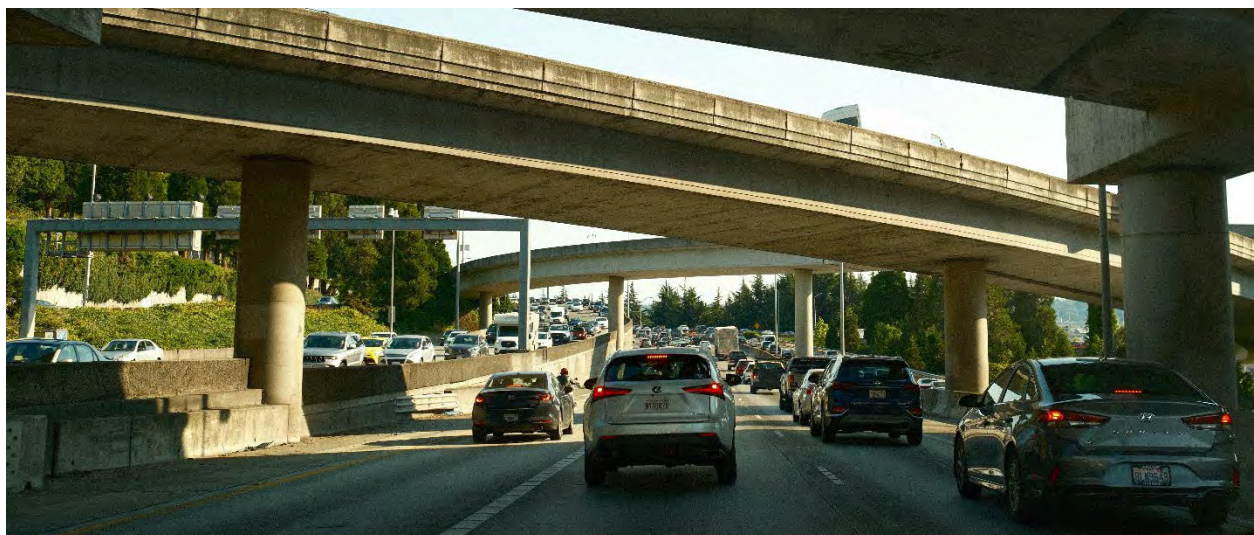
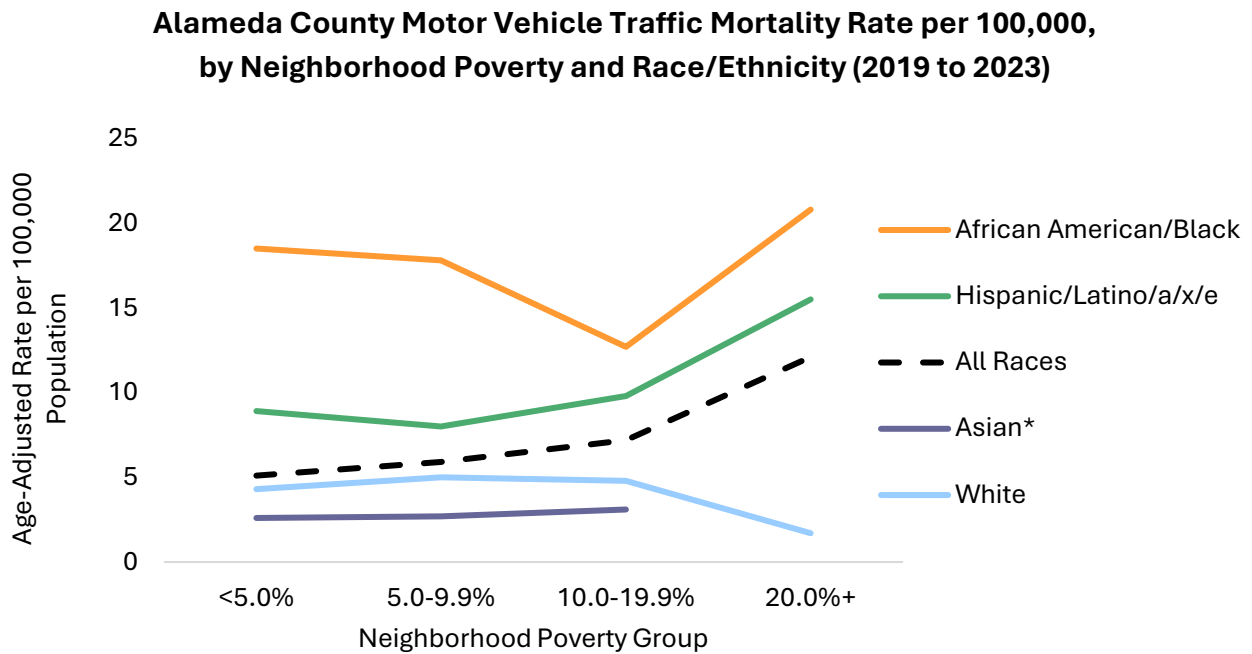


Figure 39. Higher-poverty neighborhoods in the county generally had higher unintended motor vehicle crash mortality rates.



Source: ACPHD CAPE, with data from Alameda County vital statistics files, 2019–2023. *Note: Data for Asians for 30%+ poverty are not included because the numbers of these residents are too small to report reliably. American Indian/Alaska Native and Pacific Islander rates were similarly not included.

Quite a few CHA participants expressed concerns about everyday safety in their neighborhoods, including the risk of motor vehicle accidents. They linked more traffic and poor-quality roads with a rise in traffic accidents and difficulties in commuting—affecting their ability to access work, health care, and other essential services.

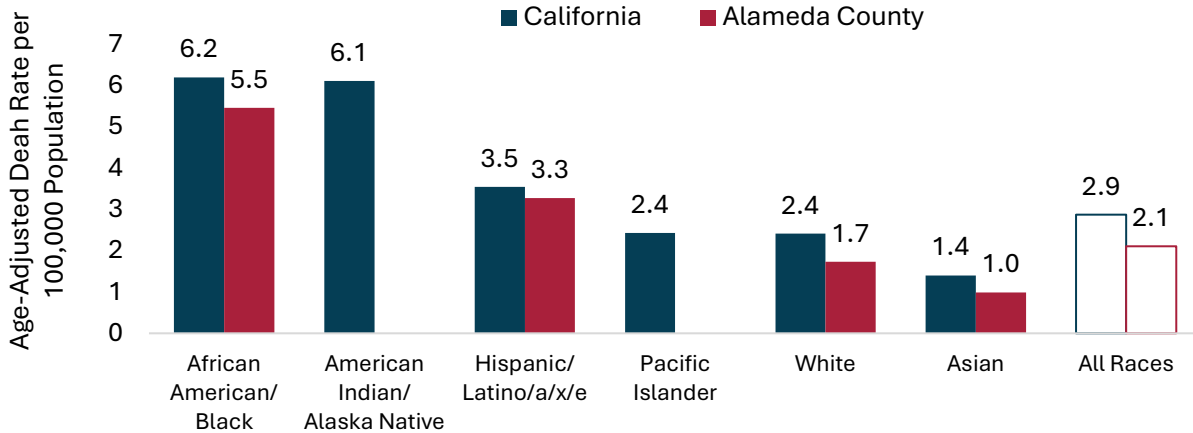
Some also voiced concerns about the risk of pedestrian injuries while performing routine activities in their neighborhood. Although the death rate from pedestrian–motor vehicle collisions in Alameda County is lower than the state’s, county pedestrians who are African American/Black or Hispanic/Latino/a/x/e die from these accidents at higher rates than their peers of other races/ethnicities. This racial inequity exists nationwide.

“...Too, our own sidewalks and having safe passages for seniors crossing the street. [Around] International [Boulevard]... the streets are too narrow, usually blocked by holes, or by equipment so that we cannot be seen. And then [not] being able to travel the streets and sidewalks because they're being blocked, it's not accessible to people. So basically we can't travel in our own neighborhood.”

—Community Member Focus Group Participant

Figure 40. County pedestrians who are African American/Black or Hispanic/Latino/a/x/e die from these accidents at higher rates than their peers of other races/ethnicities.

California and Alameda County Pedestrian Mortality Rate per 100,000, by Race/Ethnicity (2019–2023)



Source: ACPHD CAPE, with data from Alameda County vital statistics files and CDC Wonder, 2019–2023.

CHA participants cited numerous reasons for the risk of pedestrian accidents. They said:

- Most neighborhoods in Alameda County were designed primarily for automobiles, resulting in limited walkability.
- There are poorly maintained sidewalks that in some areas are blocked by garbage (e.g., in East Oakland, Fruitvale, and near International Boulevard). This makes the sidewalks inaccessible for people using walkers or wheelchairs.
- There is a lack of streetlights in some areas.
- Public transit options are inadequate; systems like BART are too linear, with scant coverage that leaves residents dependent on buses that can be too expensive and/or do not run often enough.

Together, these features make it more difficult and dangerous to access basic services like grocery stores and clinics. Relatedly, the absence of sidewalks in low-income neighborhoods is tied to national pedestrian injury rates,⁶³ and not having access to safe transportation is connected to racial inequities in those rates.⁶⁴

How does the community suggest these issues are addressed?

- Enhance and support alternative transportation methods and green spaces, making them safer, more accessible.
- Provide more grocery stores, community gardens, senior centers, and health clinics built in neighborhoods.
- Improve environmental safety and sanitation: ensure low income communities have participation in city climate action plans, access to clean drinking water, accessible bathrooms, showers.



Social Determinants of Health: Climate / Natural Environment

What is the issue?

The U.S. Office of Disease Prevention and Health Promotion reports that, worldwide, nearly 12 million deaths each year can be attributed to environmental issues.⁶⁵ These include air, water, food, and soil contamination, unhealthy materials in the built environment such as in people’s homes or workplaces, and natural or technological disasters. For people whose health is already compromised, exposure to negative environmental issues can add to or amplify their problems.⁶⁵

Community Assets

The county has many assets and resources to address issues related to the climate and natural environment. Some examples include:

- Alameda County Department of Environmental Health
- Alameda County Office of Sustainability
- Bay Area Climate Adaptation Network (BayCAN)
- Bay Area Air Quality Management District
- City of San Leandro: Hub Network and other cities' climate resilience hubs
- East Bay Regional Park District and various cities' departments of parks and recreation

For a detailed list, please see Attachment 8: Community Assets and Resources.

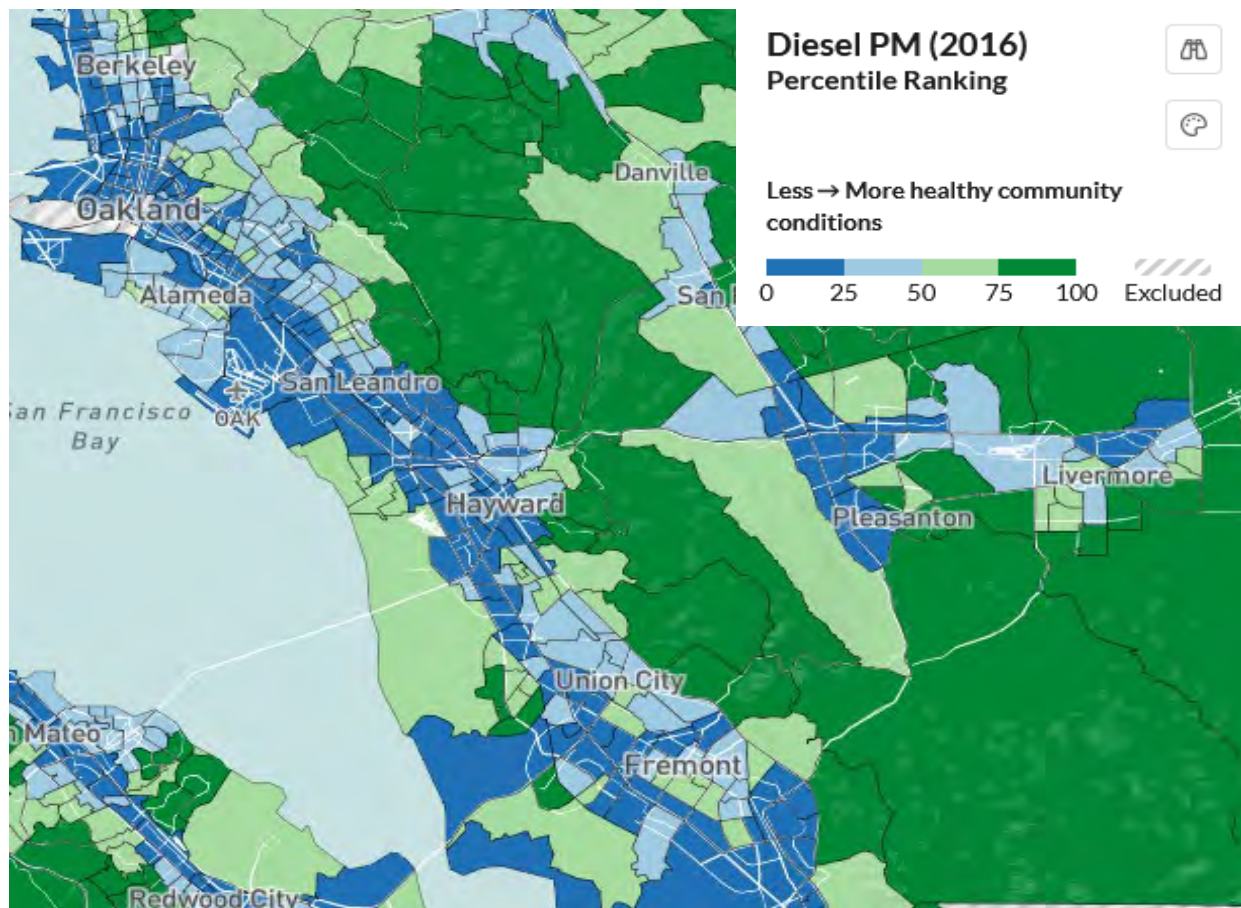
Health Impacts

Poor Air Quality. CHA participants discussed how the built environment affects air quality. They talked about how transportation-related pollution contributes to health issues such as cardiovascular diseases and cancer.

Indicators of air quality were poor in Alameda County.⁶⁶

- The county had a notably worse rate of particulate matter (PM2.5, 9.4 micrograms per cubic meter of air) versus California’s overall rate (7.1).
- Alameda County’s diesel air pollution (0.33 kilograms per day) was also higher than the statewide measure (0.22 kg/day).
- Its overall traffic volume statistic was also greater than the state’s (1,791 vehicles per meter of road versus 1,391 statewide).

Figure 17. Diesel air pollution is higher near major arteries and in industrial areas.



“Housing segregation that happens in the Bay Area ...pretty much tracks with the... proximity to industrial pollution, freeway pollution, soil and air and water contamination. These things usually align with housing segregation and structural racism.”

—Key Informant Interviewee

“What we’re experiencing, this heat, these fires are bringing us illnesses too ...all of this is affecting us.”

—Spanish-Speaking Community Member Focus Group Participant

“I’m thinking about all the wildfires, all the drought, the flooding... because of climate change, and how that is going to impact some of our lowest income, most marginalized communities the most. ...With the increase of wildfires, especially your lower-income folks... you have a fire and then you’re displaced, you can’t pay; it can all turn into more devastation.”

—Key Informant Interviewee

“It’s the folks who live in places where cranking up the AC isn’t a viable option for monetary reasons. It’s people who are living in housing that has its own health issues.”

—Key Informant Interviewee

Environmental Injustice. Participants in the CHA also raised concerns about industrial pollution and connected it with historical housing segregation. They cited redlining and historical placement of communities near heavy industry, freeways, and landfills as ongoing examples of environmental injustice.

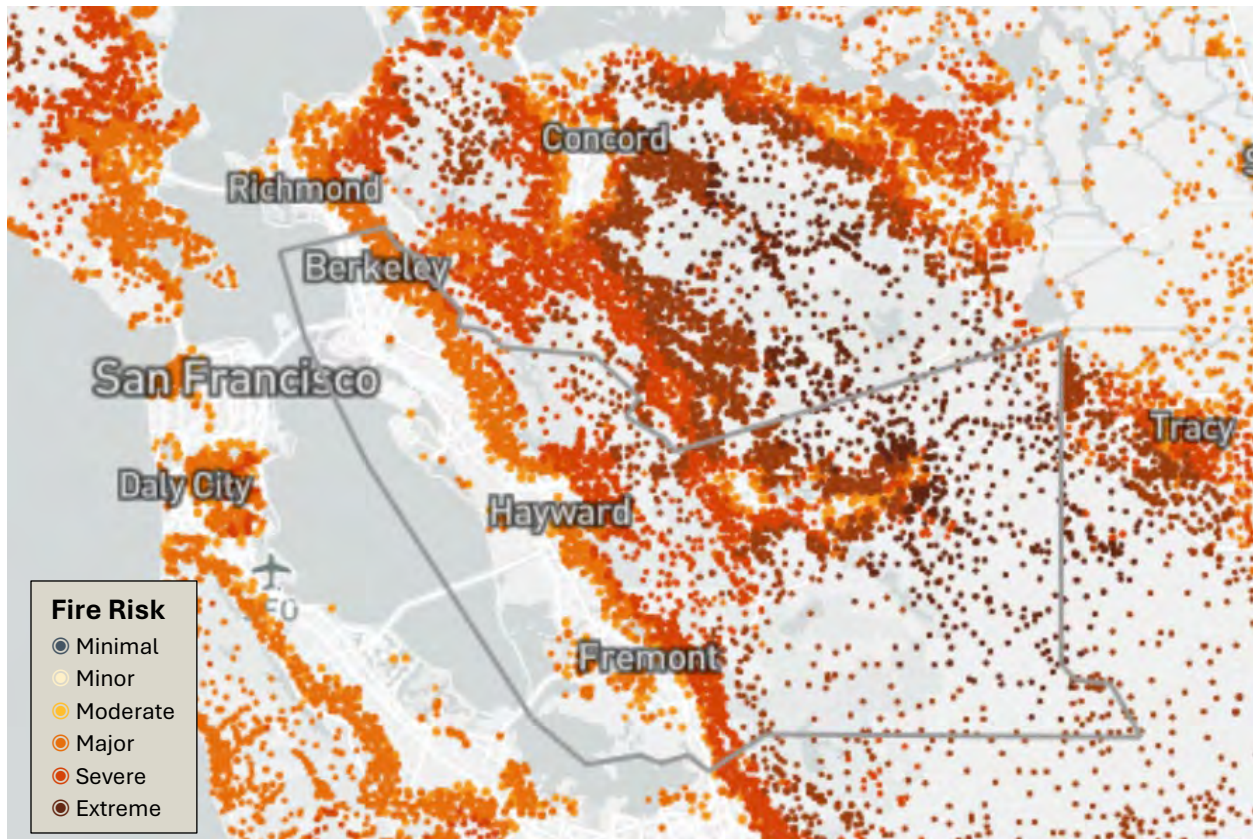
Participants also voiced their concerns about climate change. When discussing the climate, they frequently mentioned wildfires, flooding, droughts, and extreme heat as significant concerns. Participants explained how these events can lead to displacement, homelessness, and increased stress on already vulnerable populations. They noted that structural racism and economic inequities make these vulnerabilities more severe.

Participants also discussed environmental injustice in relation to climate change. Quite a number highlighted the unequal effect that climate change has on low-income and marginalized communities due to inadequate housing, lack of cooling centers, and economic constraints. They noted that low-income communities and communities of color are more affected by extreme weather and environmental hazards and often have fewer resources to cope with their impact.

Heat Risk. One health expert participant tied increasing asthma rates with poor air quality and an increasing number of days of extreme heat. In 2025, Alameda County was expected to experience 7 “hot” days (days when the temperature feels as though it is over 88 °F). This number is expected to double, to 14 days, over the next 30 years.⁶⁷

Wildfire Risk. Some CHA participants mentioned they have been affected by wildfire smoke. Alameda County is at major risk of wildfire and has had 10 wildfires in the past 35-plus years. These include the SCU Lightning Complex fire of 2020, which burned nearly 1,650 square miles of land and affected more than 1,400 buildings. Nearly 50% of all properties in Alameda County are at some risk of being affected by wildfire in the next 30 years.⁶⁸

Figure 18. More properties in eastern Alameda County are at high risk from wildfire than in other parts of the county.



Source: First Street, a public benefit corporation connecting climate risk to financial risk via advanced climate science. (2024). Properties at risk of being affected by wildfire over the next 30 years. Retrieved from https://firststreet.org/county/alameda-county-ca/6001_fsid/fire

“Depression and anxiety are widespread and exacerbated by global climate change.”

—Key Informant Interviewee

Need For Systemic Change. Regarding climate change, participants expressed feeling limited in their ability to make meaningful changes at the local level. They noted that individual actions are important but that only broader, societal changes can effectively address its root causes.

For data about lead contamination, see the subsection on Social Determinants of Health: Built Environment, Including Unintended Injuries in this Social Determinants of Health section.

How does the community suggest these issues are addressed?

- Work with hospitals, community-based organizations, government, and nonprofits to develop climate strategies, environmental justice organizations to develop climate strategies and adopt policies integrating health equity with climate action.
- Increase resource allocation toward climate adaptation measures, both at the individual and systemic level (e.g., clean mobility initiatives, addressing environmental disasters, etc.).
- Direct investment in health infrastructure: workforce development, living wage jobs, access to healthy food, wraparound services.

Social Determinants of Health: Racism/Discrimination

What is the issue?

Research has shown that racism and discrimination, both structural and interpersonal, are a fundamental cause of health inequities, health disparities, and disease in the U.S.⁶⁹ Their impact on Americans' health is as severe as it is extensive. Throughout the country and locally, racial and ethnic minority populations continue to experience higher rates of poor health and disease, especially compared to their White counterparts.⁷⁰ Other populations, such as individuals with disabilities or those identifying within LGBTQ+ communities, also experience varying degrees and forms of discrimination. This assessment considers systemic racism and discrimination as a root cause of health inequities, which are detailed in the other health need descriptions.

Community Assets

Many of the agencies in Alameda County that address the other health needs also address racism/discrimination. Some agencies specifically address it, such as:

- Alameda County District Attorney Accountability Table
- Ella Baker Center for Human Rights
- NAACP chapters in Hayward and Oakland
- Showing Up for Racial Justice Bay Area

For a detailed list, please see Attachment 8: Community Assets and Resources.



Health Impacts

Affects BIPOC Health and Well-Being. More than 2 in 5 key informants and focus groups called out structural racism and discrimination as a community priority to be addressed. Participants described structural racism as a continuous and pervasive force that takes different forms. These forms may include the built environment (e.g., diesel truck corridors routed through Black neighborhoods) and over-policing of Black and Brown communities such as Fruitvale and East Oakland.

People discussed how discrimination and racism affect health, saying that structural racism has a negative effect on both physical and mental health. Speaking about mental health specifically, they often mentioned how the stress and anxiety of living under systemic racism contributes to poor mental health outcomes in affected communities.

Affects Other Groups' Health and Well-Being. Participants connected bias within health care systems to inadequate care. They said inferior care directly results in poorer health outcomes for marginalized groups. Such groups include people of color (participants specifically mentioned people who identify as African American/Black or Hispanic/Latino/a/x/e), people with severe mental health issues, and people who identify as LGBTQ+.

CHA participants often mentioned that people who speak limited English face more challenges when trying to access quality health care services. They highlighted poor health outcomes among these groups, such as higher rates of chronic diseases (e.g., diabetes and hypertension), higher infant and maternal death rates, and shorter life expectancy.

“Structural racism plays out near constantly, and it’s pervasive...people of color experience a near-constant hypervigilance around our race.”

— Key Informant Interviewee

“Incidence of diabetes and hypertension are higher in Black and Brown communities. Some of that is stressors, and some is economic, and some is carrying racism as a stress in [our] bodies.”

— Key Informant Interviewee

“There is still a lot of discrimination; sometimes people are treated differently if they are Latina. In a hospital, they are not treated the same as White people. There is no cultural competency since there is discrimination. ...[Providers] don’t know the language, they don’t know the culture.”

— Spanish-Speaking Community Member Focus Group Participant

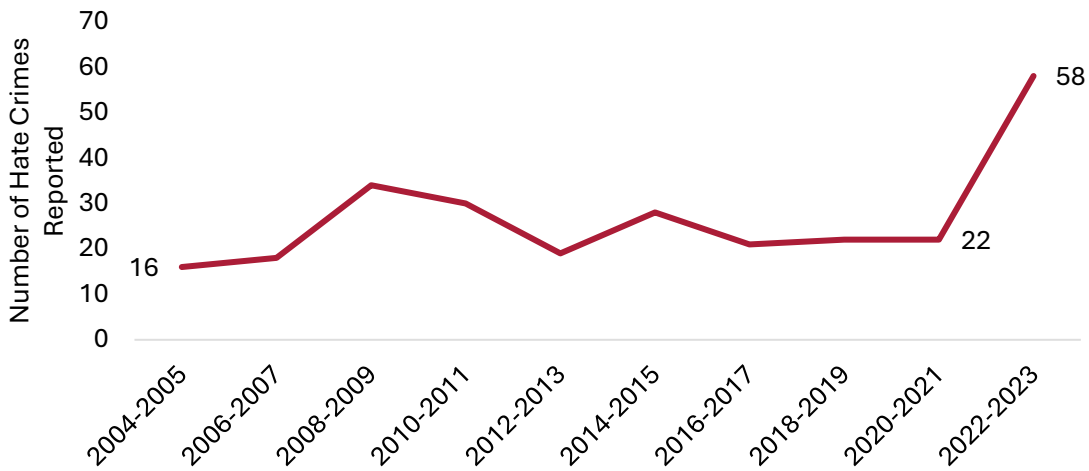


Participants also reported discrimination affecting multiple marginalized groups, including LGBTQ+ people, low-income individuals, and people with disabilities. Several described neglectful living conditions and landlord retaliation against immigrants, limited-English-speaking and BIPOC communities, complicating housing access.

Hate crimes have risen sharply against LGBTQ+ people and African Americans. Reports involving Asian Americans surged in 2021 amid anti-Asian rhetoric during the COVID-19 pandemic and, while declining, remain above pre-pandemic levels.

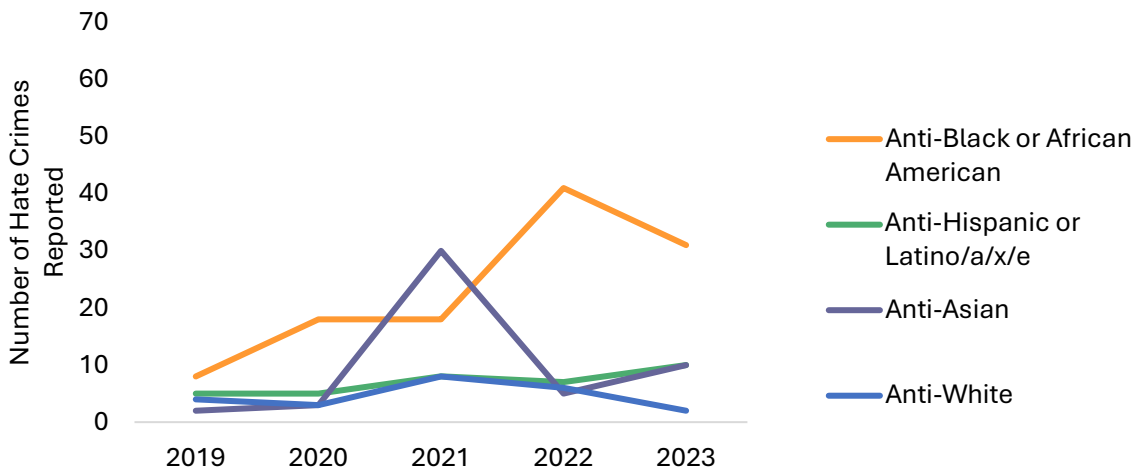
Figure 41. Rates of anti-LGBTQ+ and anti-Black hate crimes rose in the county.

Alameda County Anti-LGBT Hate Crimes Reported by Law Enforcement (2004–2023)



Source: California Department of Justice, 2004–2023.

Alameda County Trends in Hate Crimes Reported to Law Enforcement, by Targeted Race and Ethnicity (2019–2023)



Source: California Department of Justice, 2019–2023.

People living with disabilities described having many different negative experiences with discrimination. These included:

- Being mocked by nurses for needing to use accessible restrooms.
- Being told they could not participate in a program because it could not accommodate their disability.
- Not being seen as a competitive candidate for jobs they qualified for.
- Being ignored or served last in medical offices, restaurants, and other venues.

Affects Socioeconomic Outcomes. CHA participants said that discrimination restricts educational and employment opportunities for those who are affected. This includes people with disabilities, people of color (especially people who identify as Hispanic/ Latino/a/x/e or African American/Black), people who speak limited English, people who are low-income, and people who belong to other vulnerable populations.

Participants described how economic barriers that disproportionately affect vulnerable communities combine with structural racism to have a greater negative impact. Some participants pointed to a lack of racial/ethnic representation and inclusivity in hiring and career advancement as a significant issue. Some participants discussed the digital divide as a modern manifestation of structural racism. These restricted opportunities keep people in cycles of poverty and limit their ability to achieve higher education and incomes.

Affects Intersectional Populations. Multiple participants noted that discrimination often

“I’ve had people actually floor it and come screeching to a halt right up next to me because I wasn’t crossing the street fast enough in my wheelchair.”

—Community Member Focus Group Participant

“Employment ...is often still not available. I mean, legally, it is. But you’re not being sought after for positions and not competing. ...Employment, which is a way for people to thrive economically as well as emotionally, is often not available to people who are disabled.”

— Key Informant Interviewee

“If you [have] just enough factors to end up in the extremely low-income category, then these other factors [race, sexual orientation] make sure it’s multiplied.”

— Key Informant Interviewee



intersects across race/ethnicity, disability, language, economic status, and sexual orientation. When it does, it multiplies the challenges an individual may face. For example, youth expressed concern about the forms of discrimination they experience from students at school.

Effect of Historical Policies. Some CHA participants emphasized the historical roots of structural racism. This includes redlining (see Figure 42, next page) and lack of investment in communities of color, dynamics that continue to shape living conditions in affected communities. Several participants pointed out that these unjust historical policies have created long-lasting inequities between neighborhoods. This has led to residents having limited access to affordable housing, healthy food, green spaces, and other resources.

Others spoke to economic barriers that disproportionately affect communities of color. A few stated specifically that structural racism is embedded in the criminal justice system. They explained that this has led to higher incarceration rates for people of color. Increased incarceration disrupts family structures and contributes to cycles of poverty and trauma.

Finally, participants indicated that systemic change across multiple areas—housing, health care, education, criminal justice, and employment—is necessary to undo the causes and effects of structural racism and discrimination. Figure 43 and Figure 44 on the next page illustrate the effects of structural racism and related factors on Alameda County residents’ health.⁷¹



“Another thing I wish would not be present at school is the homophobia, the transphobia, the racism, and all of that hate. There’s so much promotion of ‘this is a safe space or inclusive.’

But then I have walked across campus and heard one of my friends be called [derogatory term for sexual orientation] five times. And that’s not something anyone should have to experience.”

— Youth Participant, Eastern Alameda County Needs Assessment

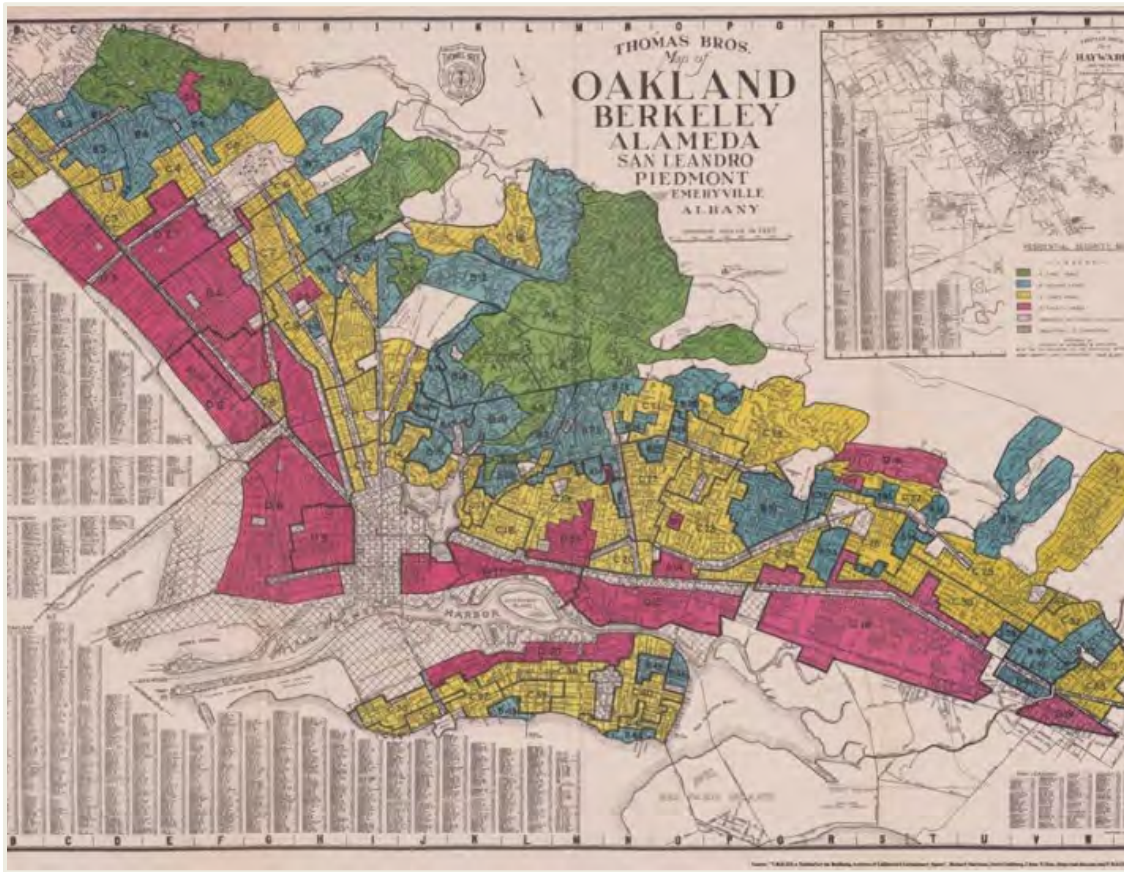
“For me, [being] Black, it’s always discrimination. Discrimination is alive.”

—Community Member Focus Group Participant

“We are at a disadvantage because of the color of our skin. Where we come from, the zip code we put down on the application, everything. Employers can say they don’t look at it, but they do.”

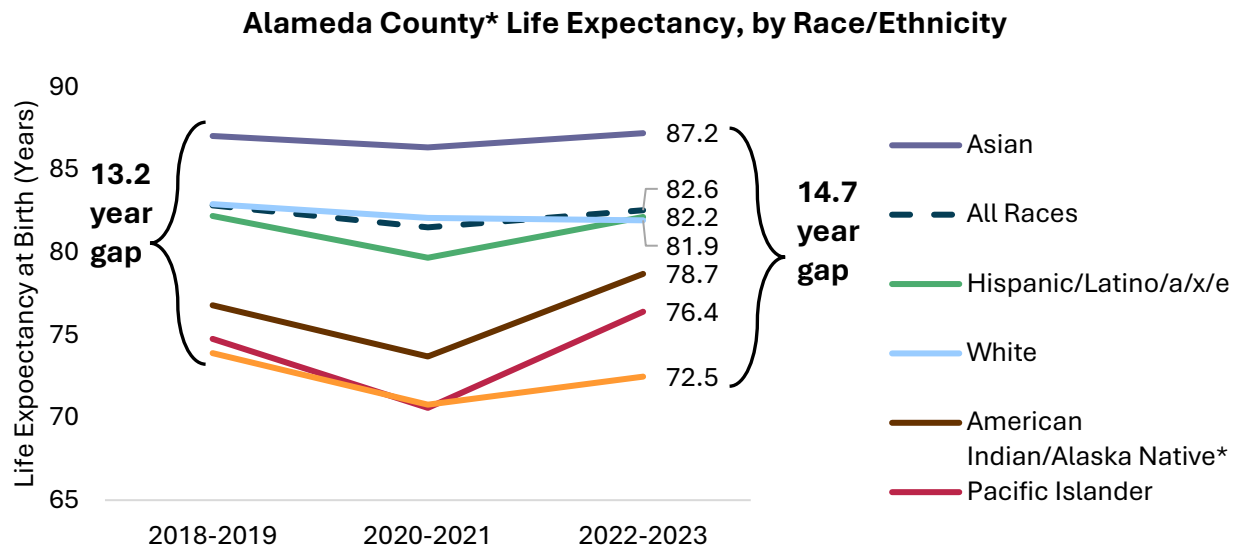
—Community Member Focus Group Participant

Figure 42. Alameda County map from 1937 showing redlining of BIPOC neighborhoods.



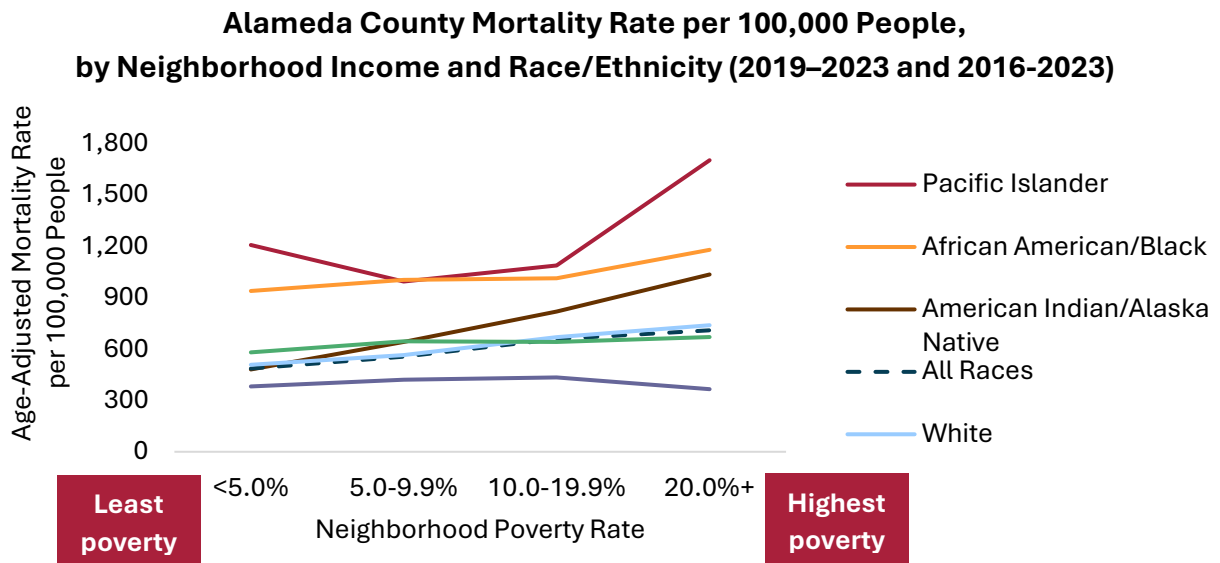
Source: Nelson, R.K. et al. (2023). Mapping Inequality: Redlining in New Deal America.

Figure 43. There are concentrated inequities in life expectancy by race and ethnicity.



Note: *American Indian / Alaska Native data are provided for California to generate more stable estimates due to the small population size in Alameda County. Statewide all-races life expectancy for 2022–2023 is 81.1 years. Source: CAPE analysis of Alameda County & California vital statistics files, 2018–2023.

Figure 44. Even with neighborhood poverty levels taken into account, African American/Black and Pacific Islander populations still have the highest mortality rates.



Source: ACPHD CAPE, with data from 2019–2023, and data from 2016–2023 for smaller populations (American Indian / Alaska Native and Pacific Islander).

“Every single topic we discussed is a result of structural racism. Everything from education, housing and homelessness, the health outcomes, you name it, it’s tied to it. And I think until we address it head on and people are not afraid to call it out, we’re going stay in the same situation we are in.”

— Key Informant Interviewee

How does the community suggest these issues are addressed?

- Advance racial equity through representation (hiring, valuing, fairly compensating people with lived experience, advocating for workforce diversity initiatives), and ensure care providers and service staff reflect cultural backgrounds of communities.
- Address structural racism by targeting investment, addressing discriminatory practices, supporting reparations.
- Advocate for and support advocacy campaigns of programs that support communities of color—especially people who identify as African Americans/Black—about existing supportive programs (e.g., Healthy Black Families, Black Infant Health), and partner with these organizations to improve access and advocacy.

**Identified Health Need:
Behavioral Health**

3. Behavioral Health

What is the issue?

Behavioral health refers to both mental health and substance use. Mental health is defined as social, emotional, and psychological well-being. It plays a key role in a person’s overall wellness, ability to have and maintain healthy relationships, and function in society.⁷² The use of substances such as alcohol, marijuana, and other legal or illegal drugs affects not only the individuals who use them, but also their families and communities.

“The connections, the love—that they care about each other, that even though there’s [tension]... we can work through some of that because parents and guardians care about the kids and want what’s best for them.”

—Key Informant Interviewee



“Societal views have changed. ...Before, it was really a negative if anyone sought out a therapist. Now... it’s becoming a positive thing to have somebody to talk to.”

—Key Informant Interviewee

Healthiest Aspects of Communities. When ACPHD and its partners asked CHA participants to describe the healthiest parts of their communities, they described **emotional connections**—such as love, care among families, and authentic self-expression. Participants understood these things as foundational to the community’s overall health. They also saw active parental and **community involvement** in schools and local organizations as a protective factor (i.e., something that acts as a buffer against negative outcomes) for mental health. They viewed such involvement as an important network of care and engagement for both youth and adults.

As described in the section on Social Determinants of Health, many participants highlighted strong community support and **unity** as a community asset. They noted that people come together and help each other in times of need, and this fosters a **sense of belonging** and emotional well-being. Several emphasized the **resilience** of community members in facing hardship, such as discrimination and other social challenges. Participants saw this strength as having a positive effect on collective mental health.

Built Environment and Mental Health. Participants reported valuing environments where **people feel safe** and secure in their homes and neighborhoods. They directly linked safety to better mental health outcomes. Some participants spoke about the importance of affordable housing that has intentional design and access to amenities. They described how this creates a **stable environment** that supports mental health. They also mentioned how having **access to green spaces**, walkable environments, and opportunities for physical activity is an asset and supports physical and mental well-being.

Access to Resources and Providers. Participants recognized the efforts of strong nonprofit sectors, grassroots organizations, and mutual aid groups in **reducing stressors** related to basic needs. They saw access to **mental and behavioral health providers with lived experience** as a positive step toward breaking down barriers to mental and behavioral health care. Lastly, some noted **reduced stigma** around seeking mental health care and believe that this has had a positive effect.

Community Assets

The county has many assets and resources to address behavioral and mental health issues. Some examples include:

Integrated Mental Health and Substance Use Services:

- Alameda County Behavioral Health Care Services
- Axis Community Health Behavioral Health Services
- Cronin House and other residential treatment centers

Mental Health:

- Alameda Health System John George Psychiatric Hospital
- Axis Bridge Mental Health Urgent Care, Crisis Support Services of Alameda, and others providing mental health crisis care
- Hively Mental Health, La Familia Counseling Services, and other service providers
- National Alliance on Mental Illness (NAMI) local chapters
- Afghan Coalition, Boldly Me, and other nonprofits working with specific populations
- Various cities' youth and family services departments

Substance Use:

- Alameda County Medical Center Substance Abuse Program
- Horizon Treatment Services' Project Eden, and other outpatient treatment options
- Second Chance Centers, Cherry Hill Detox, and other residential treatment sites

For a detailed list, please see Attachment 8: Community Assets and Resources.

“A lot of our youth and a lot of underserved folks, mostly Black and Brown communities, got hit very hard with COVID, not just getting COVID but a lot of death. That adds to the mental crisis that our youth are experiencing.”

—Key Informant Interviewee

“We work really closely with Afghans. I think being a refugee, we have focused a lot on mental health ... And the trauma of being a refugee and coming from a war.”

— Key Informant Interviewee

“Young people are in a mental health crisis. They are dealing with skyrocketing rates of anxiety and depression and loneliness. There are Black and Brown kids living in Oakland, where the impact of institutional racism has affected how they’ve grown up.”

—Key Informant Interviewee

“I’m mostly alone, I don’t really have anyone to talk to. It’s hard to find friends or ... anyone to discuss anything with outside school.”

—Youth Participant, Eastern Alameda County Needs Assessment

Challenges: Behavioral Health

Although community members across the county celebrated the positive elements described above, they also faced many mental and behavioral health challenges.

Health Impacts

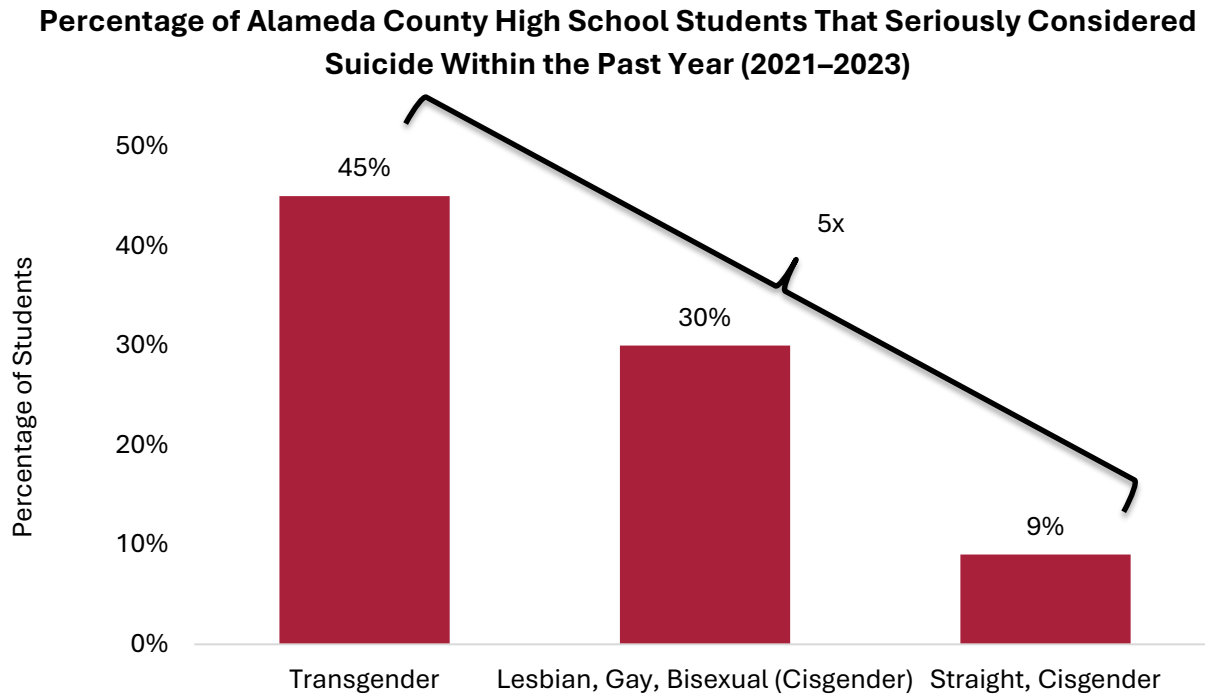
Mental Health Worsening. Across key informant interviews and focus groups, participants named behavioral health, including mental health and substance use, as one of the highest-priority needs. Most identified mental health as a top concern. They highlighted issues such as anxiety, depression, trauma, loneliness, grief, and social isolation. Some felt the COVID-19 pandemic and other stressors had exacerbated mental health challenges and substance use, causing it to increase in severity among those already struggling and introducing new cases.

Affects All People; Crisis Among Youth.

Participants described the links among food insecurity, housing instability, violence, and mental health issues such as hopelessness. A number noted that trauma, including the experiences of refugees, generational trauma, and structural racism, can play a large role in worsening mental health issues.

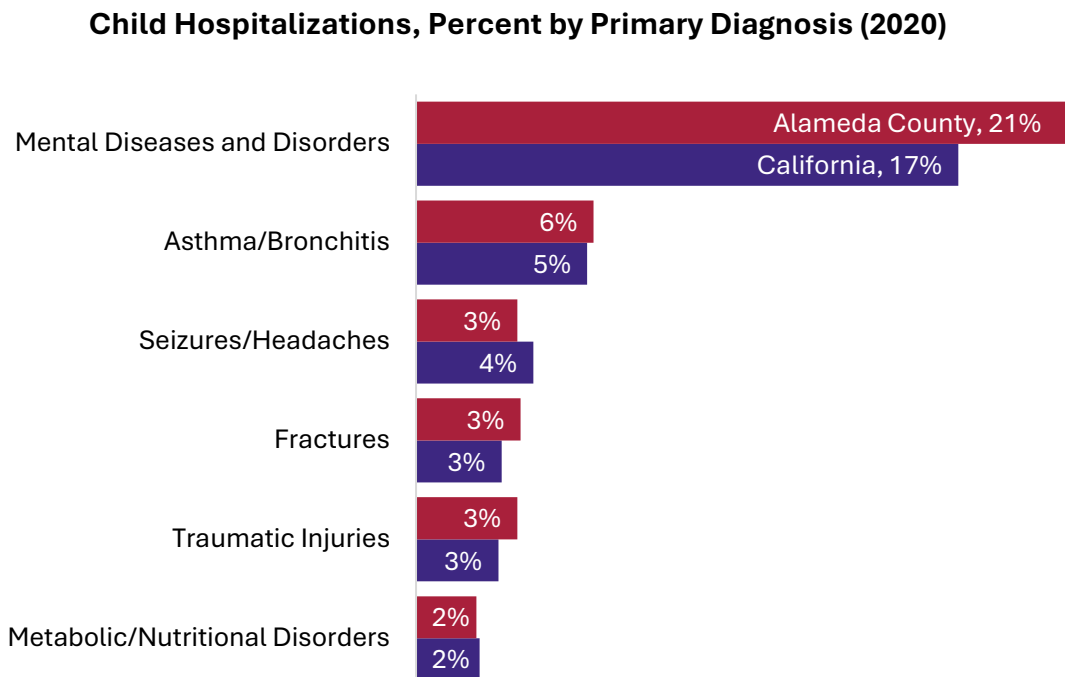
Many identified a significant mental health crisis among youth. A greater proportion of children in Alameda County are hospitalized for mental diseases and disorders than children in California overall (see Figure 46, next page). Others felt there is a growing crisis among people of all ages, including children, youth, adults, and older adults. In 2022–2023, suicide was among the top 5 causes of death for adults aged 18–44 in Alameda County.

Figure 45. There are inequities by sexual orientation in youth suicidal ideation.



Source: CAPE analysis of California Healthy Kids Survey (CHKS), 2021–2023.

Figure 46. The top reason for child hospitalizations is mental diseases and disorders.



Source: California Department of Health Care Access and Information custom tabulation, 2020. As cited in KidsData.org.

“We have kids who have self-harming behaviors that they’re undergoing. Could be cutting or could be eating disorders or other kinds of things as examples, but just kids with a lot of anxiety and depression in general.”

—Key Information Interviewee



“If I am mentally well, I can help my children if they are going through some stress or something. But if I’m not mentally well, I cannot help.”

*—Community Member
Focus Group Participant*



Barriers to Access. Participants frequently discussed the limited availability of mental health practitioners and related services. They described barriers such as long wait times for appointments, inadequate insurance coverage, and high costs of services. They also highlighted how stigma and stereotyping posed a commonplace barrier to seeking help.

“There is not much access to mental health, appointments take very, very long [to get], and an appointment cannot be arranged when a person is already in crisis.”

—Spanish-Speaking Community Focus Group Participant

“There’s a crisis when it comes to mental health providers. We don’t have enough, and we don’t have enough that speak non-English languages or...have the cultural sort of understandings and competence for some of these communities.”

—Key Informant Interviewee



Concerns About Substance Use. Many participants emphasized the strong connection between mental health and substance use. They often recognized substance use as a coping mechanism for unaddressed mental health issues. Substance use, particularly among youth but also among adults, was a major concern for participants.

Substance use treatment experts who participated in the CHA noted an increase in substance use disorders overall and emphasized that fentanyl and synthetic drugs are especially dangerous. Unintentional overdose was the top cause of death for adults aged 18–44 in Alameda County in 2022–2023. For adults aged 45–64, it was among the top 3 causes of death. Some treatment experts noted that opioid use rates may be similar across income strata but that such use is often kept quiet in affluent communities.

“I think health care professionals, by and large, do not understand the issue of addiction. [They] often come from religious traditions that suggest that substance use is a moral failure.”

—Key Informant Interviewee

“Danville, we’re a more affluent community, so a lot of our substance use and abuse is ...not necessarily out in the open. So we see it in our clients,... but it’s not as widely spoken about, particularly things like fentanyl or opiate use. It’s more hidden in this community.”

—Substance Use Treatment Expert, Focus Group Participant

Table 1. Across a recent five-year period, the top three leading causes of mortality in Alameda County for adults ages 18–64 included unintentional overdose.

Rank	<1	1-17	18-29	30-44	45-64	65-74	75+	All Ages
1	Perinatal conditions 145 deaths	Homicide 42	Unintentional drug overdose 261	Unintentional drug overdose 628	Cancer 2,324	Cancer 2,999	Heart disease 6,493	Cancer 11,137
2	Congenital anomalies 61 deaths	All other diseases 34	Homicide 227	Heart disease 261	Heart disease 1,689	Heart disease 2,008	Cancer 5,481	Heart disease 10,504
3	All other diseases 24 deaths	Motor vehicle crash 29	Motor vehicle crash 153	Cancer 255	Unintentional drug overdose 740	Stroke 569	Stroke 2,913	Stroke 3,956

Source: Alameda County vital statistics data, 2020–2024.

“[I] imagine that’s why there are so many homeless people or people who live on the street: because of mental health problems, because their families practically can’t cope with them anymore, because they don’t have the resources for insurance to take care of them.”

—Community Member Focus Group Participant

“Alcohol is a coping mechanism for a lot of men in our community [who] don’t access resources, don’t talk about the ...feelings they’re experiencing. ...I think alcoholism is socially accepted, but problematic drinking behaviors—I think there’s a lot of it and the domestic violence that goes along with it.”

—Key Informant Interviewee

Differences Among Various Populations.

Participants voiced concern about mental health and substance use among youth, particularly high school and college students. They also expressed concern for substance use among unhoused individuals. Participants identified them as particularly susceptible to a combination of mental illnesses, substance use disorders, and other vulnerabilities that can negatively affect mental well-being. They also noted that people of color are especially vulnerable. Some participants mentioned that men are more likely to have substance use issues than women.

Inequities exist among the county’s subpopulations in relation to mental health. For example, the county’s young adults and adults who identify as bisexual have significantly higher rates of likely serious psychological distress (35% and 58%, respectively) compared to all adults in the county (17%). Data by race show that the county’s Asian community members have significantly lower proportions of adults with likely serious psychological distress (10%) compared to adults of other races and ethnicities in the county.

See more related to Social Determinants of Health: Health Care Access and Quality, Social Determinants of Health: Economic Stability, and Social Determinants of Health: Housing and the Unhoused in their respective descriptions in the section on Social Determinants of Health.



“I work a lot with youth... I have personally a really high concern for the lack of awareness and education surrounding substance use, but in particular, the fentanyl issue we see out there.”

“I work in adult substance use [treatment;] it is astonishing to me how little knowledge is out there. We’ll do an [educational] group about alcohol. We’ll do a group about methamphetamines. And there does not seem to be an awareness of substances at all, really, and their impact on your body and your health.”

—Substance Use Experts, Focus Group Participants

How does the community suggest these issues are addressed?

- Use telehealth, street-level outreach, client-centered service design.
- Center community-centered approaches like promotoras, peer educators, community health workers, including group therapies and peer support models (community gatherings, life skills workshops, employment programs).
- Address stigma around mental illness and substance use.

Identified Health Need: Communicable Diseases

4. Communicable Diseases

Infectious diseases are caused by germs, such as viruses and bacteria, that can infect the body. These germs are spread through direct or indirect physical contact with bodily fluids like saliva, mucus, or blood. Various forms of protection from communicable diseases include hygiene, vaccination, and protective barriers such as condoms (for STIs) or face masks (for respiratory infections). At a more basic level, sanitation (effective sewer systems) and a clean water supply are key to preventing the spread of infectious diseases.

Access to Clean Environment and Accurate Information. When ACPHD and its partners asked CHA participants to name the healthiest parts of their communities, some highlighted the importance of **clean surroundings** for community health. Others emphasized the need for **access to clean water** for health and hygiene.

Some participants were concerned about community members who do not have access to clean water, including people who are unhoused. They were also concerned about the lack of accurate, publicly available information and education on the frequency and treatment of communicable diseases. On the next pages, some of the issues affecting people in Alameda County are described.

“There are folks from our community who want to collaborate and give folks a very basic need in order to survive because it’s not just food, it’s clean water.”

—Key Informant Interviewee

Community Assets

The county has many assets and resources to address communicable diseases, including:

- Alameda County Public Health Department, Division of Communicable Disease Control & Prevention
- Local hospitals, Federally Qualified Health Centers and other health clinics
- East Bay Getting to Zero
- Hep B Free Alameda County Collaborative
- HIV Education and Prevention Project of Alameda County
- I Know
- Immunization Partnership of Alameda County (IPAC)
- Long Covid Families
- STI testing clinics

For a detailed list, please see Attachment 8: Community Assets and Resources.

Challenges: Communicable Diseases

Communicable Diseases: Sexually Transmitted Infections

What is the issue?

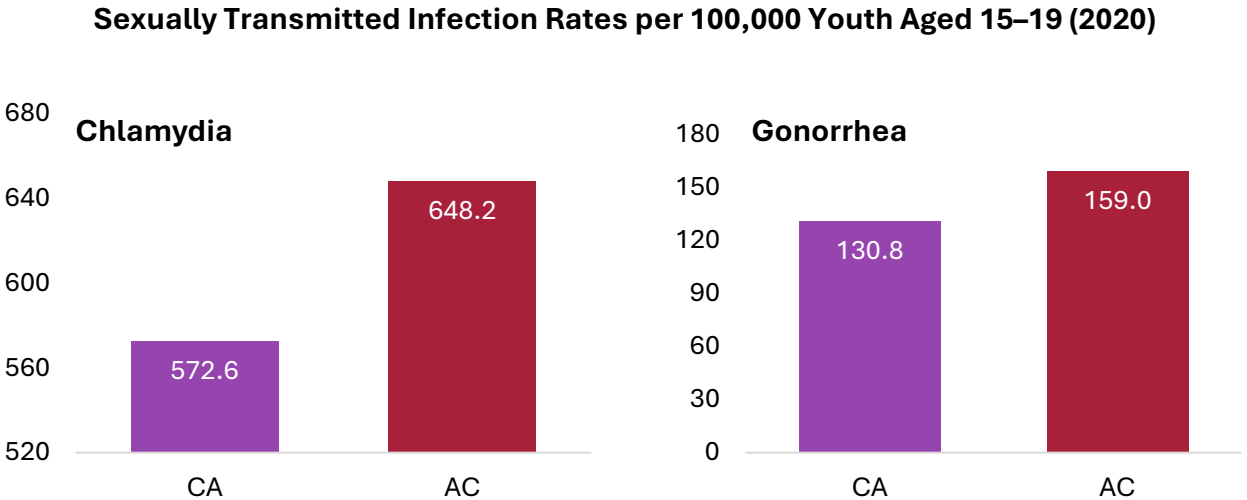
Sexual health depends on people having access to complete and factual information about sex and sexuality. It requires that people have access to sexual health care and know the risks and consequences of unprotected sex. These include sexually transmitted infections (STIs). An environment that supports sexual health enables this access and knowledge. STIs are caused by germs that are mainly passed through direct sexual contact (e.g., human papilloma virus, or HPV, is transmitted this way). Some STIs, like herpes or HIV/AIDS, are also blood-borne. All STIs can be treated with medication, but not all can be cured. Protective barriers like condoms are the primary means of prevention, but vaccination is a strong deterrent against some STIs, notably HPV and hepatitis B.⁷³

Health Impacts

Vulnerable Populations. Incidence rates of chlamydia and gonorrhea among Alameda County youth aged 15–19 are much higher than the rates of these STIs statewide.

Some CHA participants expressed concern over the rising rates of STIs like syphilis and chlamydia, especially among young people. Separately, one health expert linked damage to the body from heavy substance use to an increased risk of STIs.

Figure 47. Chlamydia and gonorrhea rates for youth in Alameda County are higher than California rates.



Source: California Department of Public Health. 2020. Rates per 100,000 population.

Communication Issues. CHA participants were concerned about limited public/community education on STIs.

One participant pointed to health providers' and public health departments' current messages about sexual health. They noted that such messages often don't reach individuals who do not identify strictly as a particular sexual orientation but who engage in high-risk behaviors. This gap in messaging, the participant thought, may be linked to a lack of awareness and an absence of preventive care measures in this group.

Other Factors. The Centers for Disease Control and Prevention suggests that various social factors affect individuals' ability to "stay sexually healthy."⁷⁴ These include:

- Income inequality
- Poverty and/or lack of employment
- Lower levels of education
- Distrust of the health care system due to shame, stigma, experience or fear of discrimination.

"You know, when you combine sexuality and substance use, the chances of exposure increase, and the chances of conversion in the case of exposure increase because substance use affects the immune system."

—Key Informant Interviewee

"From my personal observation, STDs are more serious now compared to before. [I believe] the increasing acceptance of different sexual orientations has contributed to the spread of STDs. For older people, it doesn't seem to be an issue. But ... it affects our younger generation."

—Khmer-Speaking Community Member Focus Group Participant

"There's a whole group of folks just kind of roaming about, who it doesn't even cross their mind that they're at risk for certain [STIs] because they don't see themselves fitting into the [risk] category."

—Community Member Focus Group Participant

"You don't see a lot of information on HIV and AIDS that's publicly out there anymore. People are just not as aware of it still being an epidemic. And it is. It's still an active epidemic."

—Key Informant Interviewee

Communicable Diseases: Respiratory Infections

What is the issue?

Respiratory infections are diseases caused by germs that can infect the nose, throat, lungs, and other parts of the respiratory system. The germs are spread from an infected person's nose or mouth through small airborne particles of mucus and saliva.⁷⁵ Respiratory infections include many vaccine-preventable diseases (VPDs), infections that can be prevented or significantly reduced in severity through vaccination. Respiratory VPDs include coronavirus (COVID-19), tuberculosis, pertussis (whooping cough), and influenza.

Lack of vaccination (also called immunization) creates greater health risks for individuals, their families, and their communities, up to and including death. The American Lung Association reviewed the CDC's data on COVID-19. It found that in 2023, people who were unvaccinated were 6 times more likely to require hospitalization and 12 times more likely to die from COVID than individuals who were fully vaccinated and boosted.⁷⁶ Long-term effects from COVID-19 infection (called long COVID) include chronic tiredness, memory issues ("brain fog"), fast or irregular heartbeat, and problems with taste or smell.⁷⁷

Other respiratory VPDs have similar disparities between those who are immunized against them and those who are not. Getting vaccinated is one of the best ways to protect against contagious and sometimes deadly diseases like flu, COVID-19, pneumonia, and whooping cough.

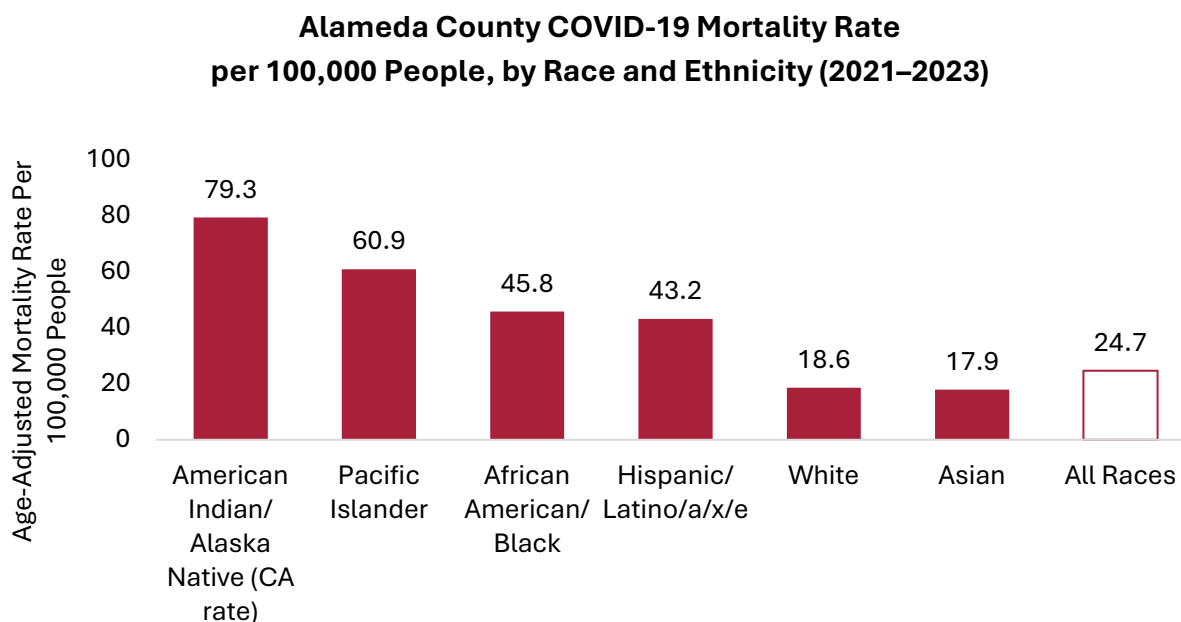
Health Impacts

Relatively High Case Rates. Chronic lower respiratory diseases are among the top 10 causes of death in Alameda County. The county's annual tuberculosis (TB) incidence rate is higher than the state's (although it is trending downward). During winter 2024, the county, and the rest of the U.S., saw a huge increase in whooping cough cases, mostly among youth. Whooping cough is cyclical in nature, with cases peaking every 3 to 5 years. When more community members are vaccinated, cases tend to be lower overall.

Disparities Exist. Although CHA participants rarely prioritized respiratory infections alone, a number highlighted the significant impact COVID-19 has had on their communities. They mentioned severe illness, long-term symptoms like loss of smell, and ongoing health issues such as kidney problems. Pacific Islanders in the county experienced higher COVID mortality rates than their peers (see Figure 48, next page). Some Hispanic/Latino/a/x/e community members discussed the role COVID vaccine misinformation and distrust in health care systems had in differences among COVID mortality rates.

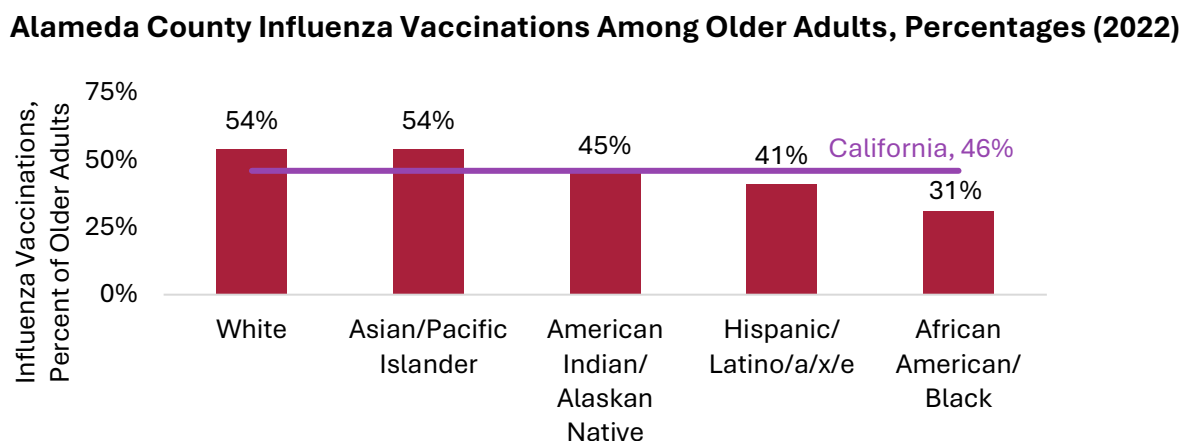
Some CHA participants reported their perception that certain respiratory diseases, such as influenza, have been worse in recent years. While overall deaths from the flu in Alameda County have been trending down over time, disparities exist in vaccination rates (see Figure 49).

Figure 48. Due to COVID-19, people died at higher rates in 2020–2021, but racial/ethnic disparities were still seen.



Source: Alameda County Public Health Department, 2021. Rates per 100,000 population.

Figure 49. Older adults who are Black or Latino/a/x/e are the least likely of all ethnic groups to get a flu shot.



Source: Centers for Medicare and Medicaid. 2022.

How does the community suggest these issues are addressed?

See suggested solutions for all communicable diseases at the end of this health need category's section.

“One thing that we have noticed ...in the spaces where we work is misinformation. Many people do not receive true or valid information, and sometimes that stops them from continuing to sign up or taking the step to go and investigate. Sometimes they are misinformed, like their neighbor said, ‘No, don’t get the vaccine, it has a baby fetus and everything [in it].’ ”

“We also work with Mam families, and there’s a lack of trust because they have been deceived, because they’ve been victims not only in their own country, but also here, and the abuse and discrimination and all of that make them distrustful and isolate themselves, whether they like it or not.”

*—Discussion among Spanish-Speaking Community Leaders,
Community Focus Group Participants*



Communicable Diseases: Vaccine-Preventable Diseases

What is the issue?

Vaccine-preventable diseases (VPDs) that are not respiratory or sexually transmitted include measles, polio, hepatitis A and B, chicken pox, and shingles. Vaccines, also called immunizations, are meant to be administered on a schedule. For example, the shingles vaccine is administered in two doses, 6 months apart, for people over age 50.⁷⁸ Many vaccines are scheduled for young children. This is to protect them from VPDs like measles or polio, which can be life-threatening to them. It is also to contribute to “herd immunity.” This term refers to enough people being vaccinated in a community that it prevents the spread of infectious diseases within it.⁷⁹

Structural inequities contribute to immunization barriers. For example, National Immunization Survey data has shown racial/ethnic disparities in child immunization rates in California and nationwide. It has also indicated that children without health insurance coverage have especially low rates of immunization coverage.⁸⁰ Continued support for vaccination programs is key to addressing these disparities.

Health Impacts

Barriers to Vaccination. Maintaining high rates of childhood immunization is essential to ensuring population health and health equity. This is especially the case in the current context of the increasing spread of measles and other vaccine-preventable diseases. Participants identified distrust within communities and misinformation as barriers to vaccination. People said that rumors and false information (e.g., about vaccine ingredients) can discourage parents from vaccinating their children. Youth who participated in the CHA also spoke to their ability to get vaccinated.

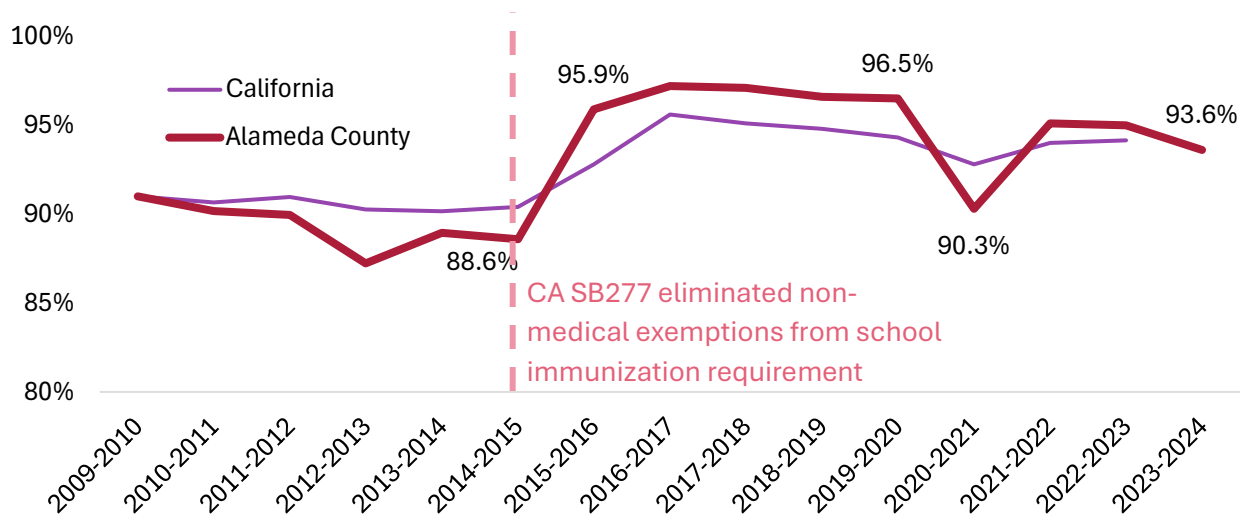
Figure 50 depicts trends in the percentage of kindergarteners fully immunized at school entry over time in Alameda County and in California. State policies eliminated nonmedical vaccine exemptions in 2014. Such policies were associated with an increase in immunization rates across those states, which helps protect the people who live there.

“I [wasn’t able to] schedule me a doctor’s appointment [for a vaccination], just a routine check-up. Because at the time I was still under 18. ...So I feel, instead of focusing on the parent’s consent [when teens are] trying to get some type of health care, we can focus a little bit more on the person that’s [trying to] get ...the treatment. They should focus the consent on them more than the parents.”

*—Youth Community Member Focus Group Participant,
speaking about minor consent*

Figure 50. Most children in Alameda County and in California are now fully immunized at the time they start elementary school, due in part to a change in state policy.

Kindergarteners Fully Immunized at School Entry, Trends Over Time in Alameda versus California



How does the community suggest communicable diseases are addressed?

- To address communicable diseases, bring health services to where people are (pop up vaccination clinics, mobile testing, community health centers, free/low cost STD testing/vaccines/prevention screenings).
- Expand comprehensive, inclusive, culturally responsive sexual education, including robust, visible, stigma-free education on sexual and communicable disease prevent.
- Ensure providers are trained to offer sex-positive, age-appropriate, culturally relevant framework (in schools and communities) and include early prevention efforts.



6. Community Comments

Community Comments

The research team of Alameda County Public Health Department (ACPHD), Actionable Insights, and Jones Psychological Services (JPS) facilitated community forums around Alameda County. This phase of the research was intended to validate the assessment findings with the community. It was also meant to create room for additional feedback from initial focus groups that may have been missed. ACPHD conducted six 2-hour sessions (see Table 2). The sessions included a presentation of the CHA methods and findings for the identified health needs. Participants received handouts with health need summaries. These were provided in English, Spanish, Chinese, and Vietnamese. Live interpretation was also provided in these languages. Following the presentation, the team facilitated small group discussions (described further, below). Attendees were provided with a meal, childcare, and a \$50 gift card at the end of each session.

Table 2. Community Engagement Sessions

Location	Host	Date (2025)	Number of Community Attendees*
San Leandro	ACPHD	June 3	32
Oakland	Serenity House	June 12	30
Dublin	Dublin Library	June 17	8
Countywide (virtual)	--	June 26	29
Fremont	Fremont Family Resource Center	July 8	17
Oakland	Asian Community Mental Health Services (ACMHS)	August 27	32

* Sessions were also attended by community partner staff and other ACPHD staff.

Community Feedback

Before the presentation, staff provided participants with worksheets to track their reactions and write questions about the information presented to them (see *Attachment 7: Qualitative Research Materials*). Worksheets and discussions focused on the following questions for each of the health needs:

- What confirms your experience?
- What community input or concerns stood out for you? Why?
- What surprised you, or what is different from your experience?
- What are you still wondering?

What Resonated and What Was Surprising (What Stood Out)

ACPHD staff scribed these sessions. Actionable Insights analyzed the worksheets and staff notes. Overall, the data confirmed the participants' lived experiences. Based on the worksheets that some participants filled out, there was no sense that the data presented were different from what participants know or experience. The most common things that participants said resonated were:

- **health care access issues** including long appointment times, a lack of close facilities and specialists, and language barriers that make even scheduling appointments difficult
- **health care quality** barriers such as lack of attention from doctors
- **mental health issues** including depression, anxiety, isolation, and adverse child experiences (ACES)
- family or personal experiences with **drug use** disorders
- lack of **economic stability** and its negative impact on mental health
- personal experiences of **homelessness** or observations about the increase in seeing people living on the street
- **violence** in their intimate partnerships and their neighborhoods (and the connection to poor mental health)
- **Chinese and Vietnamese elder adults** attributing the relative healthy outcomes among the Asian community to their preparedness (e.g., high vaccination rates), use of herbal remedies and acupuncture, and their belonging to tight-knit communities

Very few people commented on the qualitative feedback presented (e.g., from focus groups). However, some statistical data surprised participants, including:

- motor vehicle and pedestrian mortality
- mental health emergency department visits among children
- sexually transmitted infection rates

The most commonly expressed surprise was about **racial inequities** in the data. Several people said they did not know about racial inequities in areas such as COVID mortality, poverty, and life expectancy. Many comments from participants expressed empathy for people from groups who experience worse health outcomes (i.e., people from the Black and Pacific Islander populations).

“Nothing surprised me [about the CHA] aside from the fact that we have so many people experiencing these things and no change coming forward.”

—Community Engagement Session Participant

“I was surprised to see such racial disparities in terms of COVID mortality rates.”

—Community Engagement Session Participant

“Can Alameda County help bring education to our communities?”

—Community Engagement Session Participant

“Why is there such a stigma around those who have mental health issues, and how do we get away from the stigma and get to making sure those who are [in] need of services [are] able to receive them at little to no cost?”

—Community Engagement Session Participant

“I have to go all the way to Hayward to see a doctor for my knee. There are specialists in Oakland, why can’t I see them?”

—Community Engagement Session Participant



What People Are Wondering About

Participants' responses to this question usually included recommendations for action or expressed the sense that these needs are the "same old story." People voiced that they want to know how ACPHD can help with these problems. Multiple participants used this opportunity to list their suggestions for action. These are described below.

Action-Oriented Feedback

Participants want more information on matters that affect their health. They most often found information lacking for mental health. Others mentioned wanting information on medications and their side effects, including substance use disorders and the effects of drugs; Medi-Cal qualification information; and English as a Second Language (ESL) classes.

Recommendations/requests for ACPHD around sharing information and effective program delivery included:

- Build trust with the community. Some participants said they've received misinformation from other sources, and others indicated that many people are vulnerable to scams.
- Broadcast information to specific communities.
- Help community members understand the resources ACPHD is providing, rather than just list them. This will help people better use them.
- Provide information in non-English languages, especially about mental health.
- Make bilingual staff available (Chinese was mentioned) so that community members can schedule appointments over the phone.
- Provide services in languages other than English or provide interpreters

Solutions External to Public Health

- Use schools to engage youth about mental/behavioral health and safe sex.
- Offer substance use disorder rehabilitation. Some participants said the state should have a drug rehabilitation model and that insurance should cover it.
- Build more affordable housing.
- Provide financial literacy education and training for careers.
- Improve cleanliness of neighborhoods (e.g., more frequent trash pickup). Some believe this can help reduce community violence.

Summary of Community Engagement Sessions

The identified health needs resonated with the 148 residents who attended the public forums. Forum participants were highly engaged and eager to understand how Alameda County Health’s Public Health Department and others can improve health. They offered specific action steps that they want to see the department take. They were most concerned and surprised about health inequity, and most of their suggestions focused on the need for health education. These suggestions will be taken into account during the Community Health Improvement Plan process.



7. Community Resources

Community Partners and Resources

Alameda County has a strong history of community activism and leadership. The county is a tapestry of diverse residents, organizations, faith-based organizations, businesses, and institutions representing the rich, intersecting identities of the region.

ACPHD wants to highlight all of the partners that contributed to CHA. The partners listed below represent just a fraction of the network of community-based organizations delivering culturally affirming care, lifting up the needs of communities most impacted by health inequities, and building trust with them. Their partnership is key to removing health inequities and improving community health for all Alameda County residents.



Strength of Community Partnerships

- Alameda County Probation
- Allen Temple Arms
- Asian Health Services
- E. C. Reems Community Services
- Eden Youth & Family Center
- El Timpano
- EmbraceHer
- Family Health Services
- Fremont Family Resource Center
- Hayward YMCA
- Helping Hands East
- Korean Community Center
- La Familia
- LGBTQ Center / Gay Bi Trans Men of Color Roundtable
- REACH
- Regional Center of the East Bay / Disability Council
- Regional Pacific Islander Task Force
- Roots Health Center
- Rotary District 5170, Area 5
- Tri-Valley Non-Profit Alliance
- Vision y Compromiso



Community Resources

Various hospitals and clinics, other community-based organizations, government departments/ agencies, and other resources in Alameda County are engaged in addressing the community health needs and challenges identified by this assessment. Community health and services providers who participated in key informant interviews and focus groups were asked to review the resources list from partner hospitals' 2022 assessments as it related to their area of expertise and provide updates. This feedback was consolidated by Actionable Insights. The updated assets list is provided in Attachment 8: Community Assets and Resources.

8. Conclusion

Conclusion

The Alameda County Public Health Department worked with local partners, combining expertise, guidance, and resources to conduct the 2025–2027 Community Health Assessment. By gathering secondary data and conducting new primary research with local hospitals, ACPHD gained a shared understanding of how health indicator data for Alameda County compared to state benchmarks and learned about the community’s perception of health needs and challenges. This extensive base of information informed the identified health needs.

One of the major conclusions of this report is that African American/Black and Pacific Islander people in Alameda County are disproportionately affected by all leading causes of death, especially at younger ages.

How can ACPHD address these inequities?



Support policies and programs that promote economic, food, and housing security, access to health care, and educational attainment to reduce health inequities



Support programs and funding for populations specifically affected by concentrated inequities alongside programs that serve everyone



Continue to improve language access for all programs and services



Continue to expand and invest in culturally affirming programs and services



Support disaggregated data collection (by race & ethnicity, sexual orientation/gender identity, age, and disability status) to better identify and meet people’s different needs



Continue to address inequities that may be rendered less visible as data availability changes due to policy (i.e., measurement by sexual orientation and gender identity)

The other major conclusions of this report are:



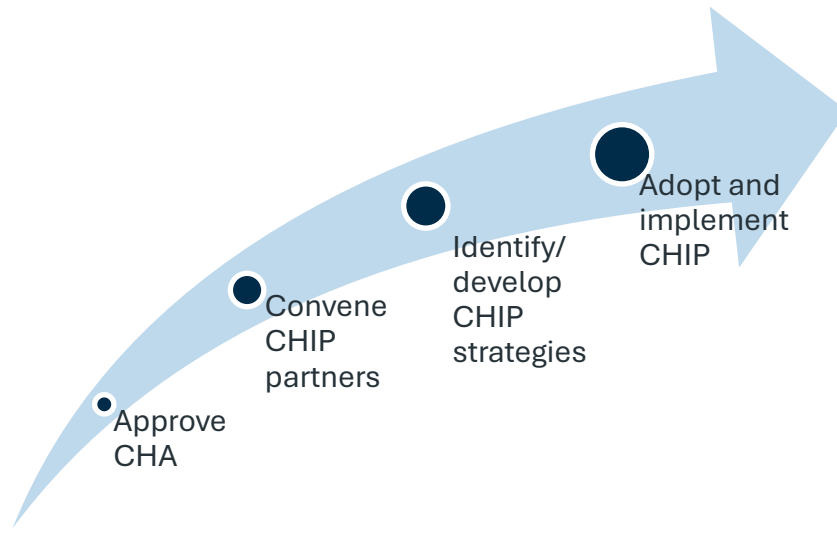
Social determinants of health, the conditions that shape people’s everyday environments, are of great concern to the community.



Community members, regardless of race/ethnicity, sexual orientation/gender identity, age, disability status, or neighborhood, report experiencing behavioral health challenges.

ACPHD will collaborate with the community and other agency departments to develop a Community Health Improvement Plan (CHIP); see Figure 51, following page. Through implementing the CHIP, ACPHD and its community and agency partners can work collectively to address the community’s health needs and close the health equity gap.

Figure 51. Next Steps



Next steps for ACPHD:

- Make final 2025–2027 CHA report publicly available on ACPHD’s website and submit the report to the Public Health Accreditation Board in 2026.
- Convene community partners and other Alameda County Health departments to review the CHA results and begin working on the CHIP.
- Using the CHA results, develop a CHIP in collaboration with the community and other agency departments, to be published in 2027.
- Monitor progress of the CHIP and share regular updates with the community.

9. Attachments

Attachments

1. List of Community Partner Organizations
2. Definitions
3. Primary/Secondary Qualitative Data Collection (Community Input)
4. Statistical Data Collection and Community Health Charts
5. Secondary Reports and Presentations Consulted
6. Secondary Data Indicator Index
7. Qualitative Research Materials
8. Community Assets and Resources
9. PHAB Checklist
10. Endnotes

Attachment 1: List of Community Partner Organizations

The Alameda County Public Health Department is especially grateful to the following community-based organizations for their partnership in recruiting participants and providing space as hosts for ACPHD's focus groups with community members.

- Alameda County Probation
- Allen Temple Arms
- Asian Health Services
- E. C. Reems Community Services
- Eden Youth & Family Center
- El Timpano
- EmbraceHer
- Family Health Services
- Fremont Family Resource Center
- Hayward YMCA
- Helping Hands East
- Korean Community Center
- La Familia
- LGBTQ Center / Gay Bi Trans Men of Color Roundtable
- REACH
- Regional Center of the East Bay / Disability Council
- Regional Pacific Islander Task Force
- Roots Health Center
- Rotary District 5170, Area 5
- Tri-Valley Non-Profit Alliance
- Vision y Compromiso

Attachment 2: Definitions

The definitions below relate to the criteria used by ACPHD to identify the health needs for this CHA report.

DEFINITIONS

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

Health need: A poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

Attachment 3: Primary/Secondary Qualitative Data Collection

ACPHD and its partners collected qualitative data to better understand certain topics and subpopulations that are not well understood through the statistical data.⁸¹ They also relied on qualitative data to fill previously identified information gaps for which statistical data remain unavailable.



- These are three of the strategies used for collecting community input for this CHA:
- key informant interviews with health experts and community service providers
- focus groups with professionals who represent and/or serve the community
- focus groups with community members

Primary research was conducted by ACPHD and its partners through 36 focus groups.



- In generating primary research protocols, ACPHD and its partners consulted and built upon prior assessments to focus and refine the protocol questions and topics.



- ACPHD included in this CHA as secondary qualitative data transcripts of 36 interviews conducted by Kaiser Foundation Hospitals (Fremont, Oakland, San Leandro) and Sutter Health Medical Centers (Alta Bates Summit and Eden). This CHA also includes 12 interviews conducted by John Muir Health, St. Rose Hospital, Stanford Health Care Tri-Valley, UCSF Benioff Children’s Hospitals, and Washington Health. While discussion questions were the same, participants were different across sessions and enhanced community input collected by ACPHD.



- Both primary and secondary interviews and focus groups were recorded, and, if needed, translated, and transcribed into English.



- The CHA included individuals who represent the following vulnerable populations:
 - people with disabilities
 - people who identify as Black/African American, Hispanic/Latino/a/x/e, American Indian/Alaskan Native, or Pacific Islander
 - people whose primary language is not English, including people who speak Khmer (Cambodian), Korean, Mam, Mandarin, Spanish, Tagalog, or Vietnamese
 - people who identify as LGBTQ+
 - people with low incomes
 - people who are unhoused
 - people from communities with inadequate access to clean air and safe drinking water
 - people who are medically underserved



- Input from over 470 community members, community leaders, health experts, and representatives of various organizations and sectors informed the 2025–2027 CHA. The latter representatives either work directly in the health field or in a community-based organization that focuses on improving health and quality-of-life conditions by serving those of vulnerable populations.

CHA/CHNA Interviews and Focus Groups

Community members, leaders, local health experts and service providers participated in interviews and focus groups. Some interviews and focus groups gathered local information on a certain topic, such as substance use, and some were held with vulnerable populations, such as unhoused individuals.



- From April to September of 2024, 48 key informant interviews were held with a total of 69 health experts/service providers from various organizations in Alameda County. Interviews were conducted virtually via Zoom for about 1 hour.



- Before each interview, people were asked to complete a short online survey:
 - They were asked to identify what they felt were the most-pressing health needs among the people they serve. Interviewees could choose up to five needs from the list presented to them, which had been identified in their county in 2022. Alternatively, they could submit needs that were not on the 2022 list.
 - The survey also explained to interviewees how their data would be used and asked them to consent to participate and be recorded.⁸²
 - Finally, they were offered the option to be listed in the report, and they were asked, but not required, to provide basic demographic information.



- The discussions centered around five questions for each health need that interviewees prioritized in the online pre-survey:
 1. How do you see this need playing out; what do you think creates these issues here?
 2. Which populations or geographic areas in the community are affected more than others?
 3. How has this community need changed in the past few years?
 4. What are the biggest challenges to addressing this need?
 5. What is needed in the community (including models / best practices / key resources) to better address this need?



- Across Alameda County, 36 focus groups were conducted with almost 100 health experts/service providers and over 370 community members/leaders between June 2024 and April 2025.



- Focus group participants also provided responses to a pre-survey,⁸³ and discussions centered on the needs that had received the most votes from prospective participants in the pre-survey. The questions were identical to those asked of key informants, but language was modified appropriately for each audience.

See next page for a list of focus group and interview details. See Attachment 7: Qualitative Research Materials for protocols used.

Community Leaders, Representatives, and Members Consulted

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of vulnerable populations.

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Key Informant Interviews						
Interview-Secondary	Arzelia Lopez, Nurse-Family Partnership Nurse Manager, Alameda County Public Health	Maternal/infant health	1	Medically underserved	Alameda County	4/26/2024
Interview-Secondary	Karen Grimsich, Administrator Aging & Family Services, City of Fremont	Older adults	1	Low-income, older adults	Alameda County, Fremont	4/29/2024
Interview-Secondary	Christine Dillman, Executive Director, Tri-Valley Haven	Peaceful communities	1	Low-income, BIPOC	Tri-Valley	5/3/2024
Interview-Secondary	Paris Davis, Intervention Programs Director, YOUTH ALIVE!	Peaceful communities	1	Low-income, BIPOC	Alameda County	5/3/2024
Interview-Secondary	Ella Baker Center	Climate	1	Low-income, people with inadequate access to clean air and safe drinking water	Northern Alameda County	5/15/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	Kimi Watkins-Tartt, Public Health Director, Alameda County Public Health Department	Public health	1	Low-income, medically underserved, BIPOC	Alameda County	5/16/2024
Interview-Secondary	Evette Brandon, Division Director, Alameda County Public Health Department	Public health	1	Low-income, medically underserved, BIPOC	Alameda County	5/16/2024
Interview-Secondary	Aaron Ortiz, Chief Executive Officer, The Alliance For Community Wellness	Mental health	1	Medically underserved	Alameda County	5/30/2024
Interview-Secondary	Health Equity Policy and Systems Manager, Health Equity Division, Behavioral Health Department, Alameda County Health	Equity	1	Low-income, BIPOC, medically underserved	Alameda County	5/22/2024
Interview-Secondary	Aislinn Bird, Director of Integrated Care, Psychiatrist, Alameda County Health Care for the Homeless	Homelessness, substance use disorder	1	Low-income, unhoused, medically underserved	Alameda County	6/11/2024
Interview-Secondary	Lucy Kasdin, Director, Alameda County Health Care for the Homeless	Homelessness, substance use disorder	1	Low-income, unhoused, medically underserved	Alameda County	6/11/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	Matt Vander Sluis, Managing Director, Policies and Programs, Bay Area, Bay Area Regional Health Inequities Initiative (BARHII)	Climate/ sustainability	1	Low-income, BIPOC, medically underserved, people with inadequate access to clean air and safe drinking water	Alameda County	7/29/2024
Interview-Secondary	Eden United Church of Christ	Food insecurity	1	Low-income	Central Alameda County	5/16/2024
Interview-Secondary	Greenlining Institute	Climate	1	Low-income, people with inadequate access to clean air and safe drinking water	Northern Alameda County, Tri-Valley	5/29/2024
Interview-Secondary	Davis Street Community Center	Unhoused	1	Low-income, unhoused, medically underserved	Central Alameda County	5/30/2024
Interview-Secondary	Open Heart Kitchen	Food insecurity	1	Low-income	Tri-Valley	6/5/2024
Interview-Secondary	East Bay Asian Local Development Corporation	Housing	3	Low-income, unhoused	Alameda County	6/6/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	(EBALDC)/Berkeley Food and Housing Project/Bay Area Community Services (BACS)					
Interview-Secondary	Destiny Arts	Multi: youth	1	Low-income, youth	Northern Alameda County	6/10/2024
Interview-Secondary	Bay Area Community Health Center/Tiburcio Vasquez Medical Center	Access to health care	4	Low-income, BIPOC, medically underserved	Central and Southern Alameda County	6/10/2024
Interview-Secondary	Rising Sun Center	Income and employment	1	Low-income	Northern Alameda County	6/12/2024
Interview-Secondary	Abode Services	Housing	1	Low-income	Alameda County	6/13/2024
Interview-Secondary	Native American Health Center	Mental/ behavioral health, Native American population	2	Indigenous population, medically underserved	Northern Alameda County	6/13/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	NAMI	Mental/behavioral health	1	Medically underserved	Alameda County	6/13/2024
Interview-Secondary	Rubicon	Income and employment, justice-involved population	1	Low-income, justice-involved population	Northern and Southern Alameda County	6/13/2024
Interview-Secondary	Planting Justice	Food insecurity	1	Low-income	Northern Alameda County	6/18/2024
Interview-Secondary	Aliados Health AKA Community Clinic Consortium/Alameda Health Consortium/La Clinica de la Raza	Access to health care	2	Low-income, BIPOC, medically underserved	Alameda County	6/18/2024
Interview-Secondary	Eden Housing Resident Services, Inc.	Income and employment	1	Low-income	Alameda County	6/18/2024
Interview-Secondary	Alameda County Community Food Bank	Food insecurity	1	Low-income	Northern and Central Alameda County	6/26/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	Asian Health Services	Access to health care, Asian population	1	Asia population, medically underserved	Alameda County	6/26/2024
Interview-Secondary	J-Sei	Multi: Asian American/ Pacific Islander older adults	1	Low-income, older adults, Asian population, Pacific Islander population, medically underserved	Alameda County	6/26/2024
Interview-Secondary	Downtown Streets	Housing	1	Low-income, unhoused	Northern and Central Alameda County	6/27/2024
Interview-Secondary	Union City Family Center and Fremont Family Resource Center	Multi: southern Alameda County	2	Low-income	Southern Alameda County	6/27/2024
Interview-Secondary	Oakland Unified School District	Youth/children, education	1	Low-income, youth, children	Northern Alameda County	7/3/2024
Interview-Secondary	Unity Council	Income and employment	1	Low-income	Northern Alameda County	7/12/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	East Oakland Youth Development Center	Income and employment, youth	1	Low-income, youth	Northern Alameda County	7/15/2024
Interview-Secondary	Trybe	Food insecurity	1	Low-income	Northern Alameda County	7/15/2024
Interview-Secondary	Side by Side	Transition aged youth	3	Low-income, young adults, transition aged youth	Central Alameda County	7/15/2024
Interview-Secondary	Alameda County Age-Friendly Coalition & Day Break Adult Day Center	Access to health care, older adults	1	Low-income, older adults, medically underserved	Alameda County	7/16/2024
Interview-Secondary	Life Long Medical Care	Access to health care	1	Low-income, medically underserved	Northern Alameda County	7/17/2024
Interview-Secondary	Afghan Coalition	Afghani population, peaceful communities	3	Afghani population	Southern Alameda County	7/18/2024
Interview-Secondary	Pacific Center for Human Growth	Mental/behavioral health	1	Medically underserved	Alameda County	7/23/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	Roots Health Center	Access to health care	1	Medically underserved, BIPOC	Northern Alameda County	7/30/2024
Interview-Secondary	Hayward Unified School District	Youth/children, education	1	Low-income, youth, children	Central Alameda County	8/6/2024
Interview-Secondary	Livermore Valley Joint Unified School District	Youth/children, education	3	Low-income, youth, children	Tri-Valley	8/12/2024
Interview-Secondary	Latina Center	Hispanic/ Latino/a/x /e population, peaceful communities	1	Low-income, Hispanic/ Latino/a/x/e population	Northern Alameda County	Unknown
Interview-Secondary	GRID Alternatives Bay Area	Climate	5	Low-income, people with inadequate access to clean air and safe drinking water	Alameda County	5/23/2024
Interview-Secondary	Fresh Approach	Food insecurity	1	Low-income	Northern Alameda County	6/5/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Interview-Secondary	Chief Executive Officer, Axis Community Health	Health care access, Tri-Valley community	1	Medically underserved, Tri-Valley residents	Tri-Valley	6/20/2024
Interview-Secondary	Ed Diolazo, Deputy Superintendent, Pleasanton Unified School District	Youth/ children, education, Tri-Valley community	1	Low-income, Tri-Valley residents	Tri-Valley	6/26/2024
Interview-Secondary	Christine Beitsch-Bahmani, Chief Executive Officer, City Serve of the Tri-Valley	Older adults, Tri-Valley community	1	Low-income, Tri-Valley residents	Tri-Valley	7/24/2024
Interview-Secondary	Matt Campbell, Assistant Superintendent, Dublin Unified School District	Youth/ children, education, Tri-Valley community	1	Low-income, Tri-Valley residents	Tri-Valley	9/6/2024
Focus Groups						
Focus Group-Secondary	Host: Actionable Insights	Safety net clinics	12 ⁸⁴	Medically underserved, low-income	Alameda County	6/11/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Attendees:					
	Asian Health Services					
	Dawnell Moody, Chief Medical Officer, Axis Community Health					
	Janet Escudero, Clinic Manager, Bay Area Community Health					
	Adriana Lopez, Special Assistant Promotores Program, City of Newark					
	Freedom Community Clinic					
	Licensed Clinical Social Worker; Job position: Program Supervisor, La Familia Counseling Services					
	Elvia Guevara, Director, Medical Operations, Native American Health Center					
	Susan Fernyak, MD, Medical Director, Order of Malta Clinic					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Mary Alvarez Nutting, Senior Clinical Services Manager, Roots Community Health					
	Alejandro Lopez Munoz, Medical Site Manager, San Antonio Neighborhood Health Center					
	Martha Estrella, Resource Specialist, Tiburcio Vasquez Health Center					
Focus Group-Secondary	Host: Actionable Insights	Substance use/addiction	9	Medically underserved	Alameda County	6/12/2024
	Attendees:					
	Esther Veronika Rodriguez, Substance Use Disorder / Medication Assisted Treatment Program Supervisor, Bay Area Community Health					
	City of Fremont, Youth and Family Services					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Christopher Duerrmeier, Clinical Director, Discovery Counseling Center of the San Ramon Valley					
	Omar Malik, Program Manager, HAART Hayward					
	Sanjay Patel, Pharmacy Director, Haller's Pharmacy and Medical Supply					
	Asceneth Paez-Arroyo, Clinical Manager, Horizons Family Counseling					
	Caitlin Wallace, Program Supervisor - Adult Outpatient Substance Use, La Familia					
	Program Director, Lifelong					
	April Rovero, Executive Director, National Coalition Against Prescription Drug Abuse					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Focus Group-Secondary	Host: Actionable Insights	Faith leaders	6	Minority	Alameda County	6/12/2024
	Attendees:					
	Former Board President, Berkeley Zen Center					
	Gideon Lee, Pastor, Crosspoint Church					
	Youngmi Jung, Pastor, First United Methodist Church of Fremont					
	Mary Scott, Reverend, GraceWay Church					
	Kashmir Singh Shahi, Community Outreach Coordinator, Gurdwara Sahib Fremont					
	Rabbi Jackie Mates-Muchin, Senior Rabbi, Temple Sinai					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Focus Group-Secondary	Host: Actionable Insights	Social services	8	Low-income	Alameda County	7/22/2024
	Attendees:					
	Suzanne Shenfil, Human Services Director, City of Fremont					
	Christine Beitsch-Bahmani, Chief Executive Officer, City Serve of the Tri-Valley					
	Program Director, East Bay Agency for Children					
	Senior Director, Fred Finch Youth & Family Services					
	Mary Hekl, Chief Executive Officer, Hively					
	John Bost, Executive Director, Open Heart Kitchen					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Leticia Galyean, Chief Executive Officer, Seneca Family of Agencies					
	Union City Family Center/New Haven Unified School District					
Focus Group	Host: Fremont Family Resource Center, service providers	Social services, southern Alameda County	8	Low-income, residents of southern Alameda County	Southern Alameda County	7/30/2024
Focus Group	Host: Fremont Family Resource Center, Tri-City Afghan refugee service providers	Afghani community	15	Afghani population, Farsi-speaking	Southern Alameda County	8/6/2024
Focus Group	Host: Tri-Valley Non-Profit Alliance	WIC recipients, Tri-Valley area	6	Low-income, Tri-Valley residents	Tri-Valley	8/12/2024
Focus Group-Secondary	Host: Actionable Insights	Workforce development	8	Low-income, young adults	Alameda County	8/12/2024
	Attendees:					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Amy Garlin, Medical Director, Alameda County Health Care for the Homeless					
	Eva Jennings, EdD, Interim Vice President of Instruction, College of Alameda					
	Cristo Rey De La Salle East Bay High School					
	Blaine Torpey, Superintendent, Eden Area Regional Occupational Program					
	Jeff Oxendine, Founder, Chief Executive Officer, Health Career Connection					
	Carrie Dameron, Director of Registered Nursing Program, Ohlone College					
	Alcian Lindo, Program Manager, Tri-Valley Career Center					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
	Angel-Max Guerrero, Pathway Programs Manager, UC San Francisco					
Focus Group	Host: EmbraceHer, doulas	Maternal/ infant health	3	Black birthing people	Central Alameda County	8/17/2024
Focus Group	Host: Vision y Compromiso, community health workers & domestic workers	Health care access, Spanish-speaking	22	Low-income, medically underserved, Spanish-speaking population	Alameda County	9/4/2024
Focus Group	Host: Fremont Family Resource Center	Unhoused	20	Low-income, unhoused, medically underserved	Southern Alameda County	7/25/2024
Focus Group	Host: El Timpano	Mam-speaking community	8	Mam-speaking population	Alameda County	7/30/2024
Focus Group	Host: Allen Temple Arms	Black community, older adults	27	Black population, older adults	Alameda County	8/7/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Focus Group	Host: Allen Temple Arms	Spanish-speaking community, older adults	2	Spanish-speaking population, older adults	Northern Alameda County	8/7/2024
Focus Group	Host: Asian Health Services	Vietnamese-speaking community	10	Vietnamese-speaking population	Alameda County	8/13/2024
Focus Group	Host: Family Health Services	Parents, Black community	17	Black population	Alameda County	8/15/2024
Focus Group	Host: Family Health Services	Parents, Spanish-speaking community	2	Spanish-speaking population	Alameda County	8/15/2024
Focus Group	Host: Hayward YMCA	Spanish-speaking community, Hispanic/Latino/a/x/e community, parents	9	Spanish-speaking population, Hispanic/Latino/a/x/e population, parents of children/teens	Central Alameda County	8/15/2024
Focus Group	Host: Regional Center of the East Bay / Disability Council	Disability community	5	Medically underserved, people with disabilities,	Alameda County	8/19/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
				people caring for people with disabilities		
Focus Group	Host: Regional Center of the East Bay / Disability Council	Disability community, Spanish-speaking community	13	Spanish-speaking population, people with disabilities, people caring for people with disabilities, medically underserved	Alameda County	8/19/2024
Focus Group	Host: Asian Health Services	Khmer-speaking community, Cambodian community	13	Khmer-speaking population, Cambodian population	Alameda County	8/21/2024
Focus Group	Host: Korean Community Center	Older adults, Korean-speaking community	15	Older adults, Korean-speaking population, Korean population	Alameda County	8/22/2024
Focus Group	Host: LGBTQ Center / Gay Bi Trans Men of Color Roundtable, service providers and community members	LGBTQ+ community	8	Medically underserved, LGBTQ+ community	Northern Alameda County	8/22/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Focus Group	Host: Helping Hands East	Disability community, Vietnamese-speaking community	12	People with disabilities, people caring for people with disabilities, medically underserved, Vietnamese-speaking population	Northern and Central Alameda County	8/27/2024
Focus Group	Host: Asian Health Services	Tagalog-speaking community, Filipino/a/x community	7	Tagalog-speaking population, Filipino/a/x population	Northern Alameda County	8/28/2024
Focus Group	Host: La Familia	Bilingual Hispanic/Latino/a/x/e community, Cherryland community	23	Spanish-speaking population, Hispanic/Latino/a/x/e population, parents of children/teens	Central Alameda County, Cherryland	9/6/2024
Focus Group	Host: Eden Youth & Family Center	Spanish-speaking community, Hispanic/Latino/a/x/e	17	Spanish-speaking population, Hispanic/Latino/a/x/e	Alameda County	9/12/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
		community, parents		population, parents of children/teens		
Focus Group	Host: AC Probation	Justice-involved community	13	Justice-involved population	Alameda County	9/18/2024
Focus Group	Host: E. C. Reems Community Services	Black/African American/ Caribbean community	18	Black/African American/ Caribbean population	Alameda County	9/21/2024
Focus Group	Host: Korean Community Center	Older adults, Chinese community, Chinese-speaking community	15	Older adults, Chinese population, Mandarin-speaking population	Central Alameda County	9/24/2024
Focus Group	Host: Rotary District 5170, Area 5	Southeast Asian community, Tri-Valley residents	7	Southeast Asian community, Tri-Valley residents	Tri-Valley	10/3/2024
Focus Group	Host: Roots Health Center	Black/African American community, 40x40 zone	4	Black population, residents of Oakland's 40x40 zone	Oakland's 40x40 zone	10/8/2024

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Cities/Areas Represented	Date Input Was Gathered
Focus Group	Host: Roots Health Center	Spanish-speaking community, 40x40 zone	4	Spanish-speaking population, residents of Oakland's 40x40 zone	Oakland's 40x40 zone	10/8/2024
Focus Group	Host: Korean Community Center	Youth, Chinese community	9	Chinese population, youth	Alameda County	10/28/2024
Focus Group	Host: REACH	Youth	9	Youth	Central and Northern Alameda County	4/24/2025
Focus Group	Host: Regional Pacific Islander Task Force	Pacific Islander population	18	Pacific Islander population	Central and Northern Alameda County	4/30/2025

Attachment 4: Statistical Data Collection and Community Health Charts

Secondary Statistical Data Collection

ACPHD and its consultant, Actionable Insights, (collectively, “the team”) analyzed over 350 quantitative health indicators from many different sources to assist with understanding health needs in Alameda County and assessing community priorities. The team gathered statistical data from the Alameda County Public Health Department’s Community Assessment, Planning, and Evaluation unit (AC CAPE). The team also gathered statistical data from existing sources using County Health Rankings & Roadmaps, a public dataset supported by the Robert Wood Johnson Foundation and developed by the University of Wisconsin Population Health Institute.⁸⁵ The team collected supplementary data from other online sources such as the U.S. Census Bureau, KidsData.org, and the California Department of Public Health. The team used subcounty data when it was available and a variety of reports and presentations (see Attachment 5: Secondary Reports and Presentations Consulted).

Local quantitative data were compared to state benchmarks (California averages and rates) to help determine the severity of a health issue and to identify disparities. The team asked:

- How do these indicators perform against accepted benchmarks?
- What are the inequitable outcomes and conditions for community members?

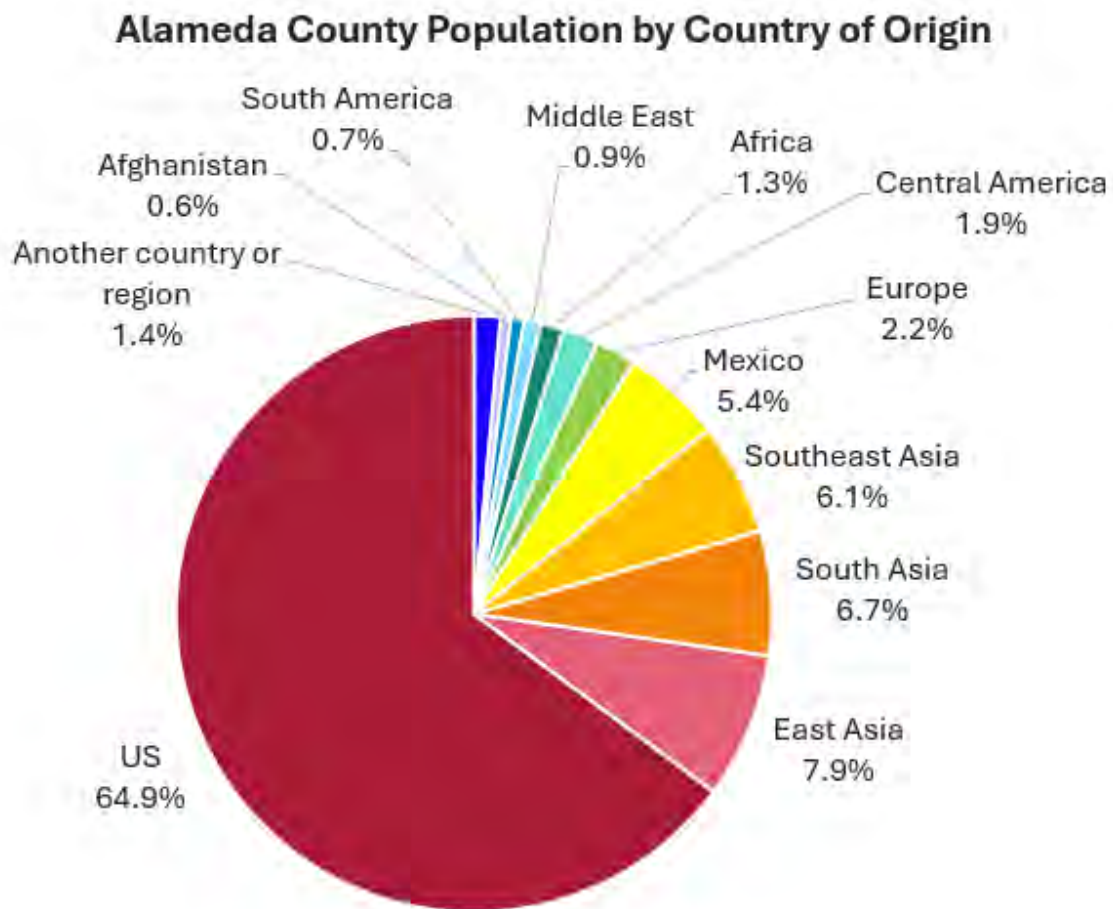
AC CAPE provided 2019–2023 mortality rates overall and by race/ethnicity for requested causes. However, many public health departments face difficulty in providing comparable California rates. This is because the specific diagnoses codes used in some published California mortality rates are not always available. In some cases, Actionable Insights used California mortality benchmarks provided by another county’s public health department. Actionable Insights also used ACPHD’s 2024 report, *Examining Increases in Mortality and Disparities from 2018–2019 to 2020–2021*, to gather rates that are comparable to California.

AC CAPE also provided rates for birth outcomes, emergency department visits, and hospitalization discharges (all by race/ethnicity). Again, in some cases Actionable Insights used corresponding California benchmarks provided by another county’s health department. When benchmarks were missing for emergency department visit and hospitalization rates, Actionable Insights followed the guidance provided by AC CAPE to give priority to the top preventable reasons for emergency department visits and hospitalizations (e.g., drug overdoses, asthma) in assessing the statistical data.

Note that for the purposes of this assessment, “community health” was not limited to traditional health measures. The team considered indicators relating to the quality of life (e.g., access to health care, affordable housing, food security, education, and employment) and to the physical, environmental, and social factors that influence the health of the county’s residents. This broader definition reflects the understanding that many factors affect community health and that community health cannot be adequately understood without considering trends outside the realm of health care.

A Further Look

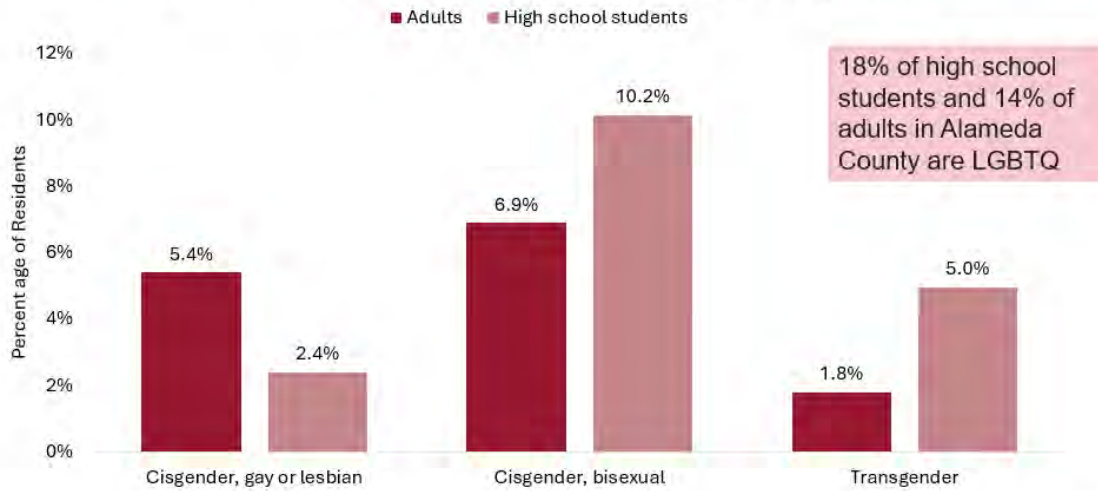
The charts and figures in this attachment provide a further look at the statistical data provided by AC CAPE.



Source: Decennial census 2000, 2020; CA DOF projections file P-3 vintage 2023 (2024.3.8)

Sexual Orientation and Gender Identity

Sexual orientation and gender identity among Alameda County residents

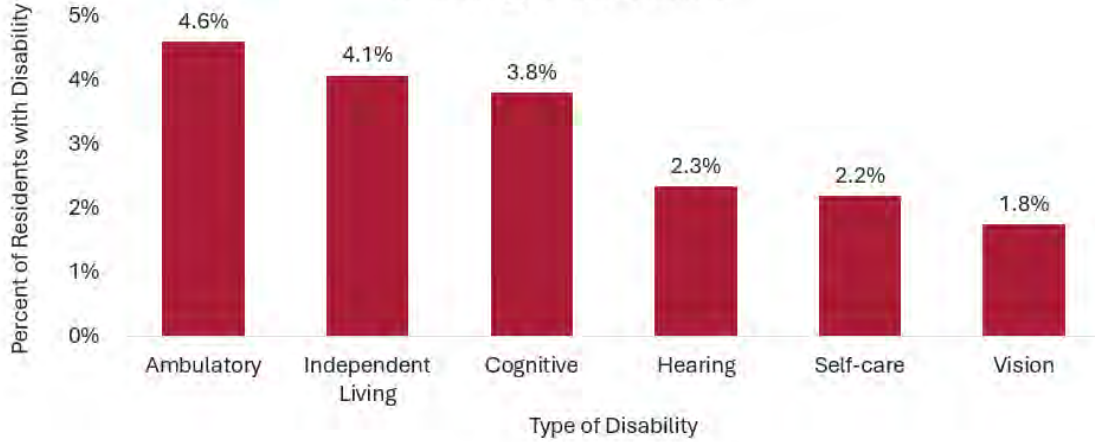


Source: California Health Interview Survey, 2021-2022; California Healthy Kids Survey, 2021-2023

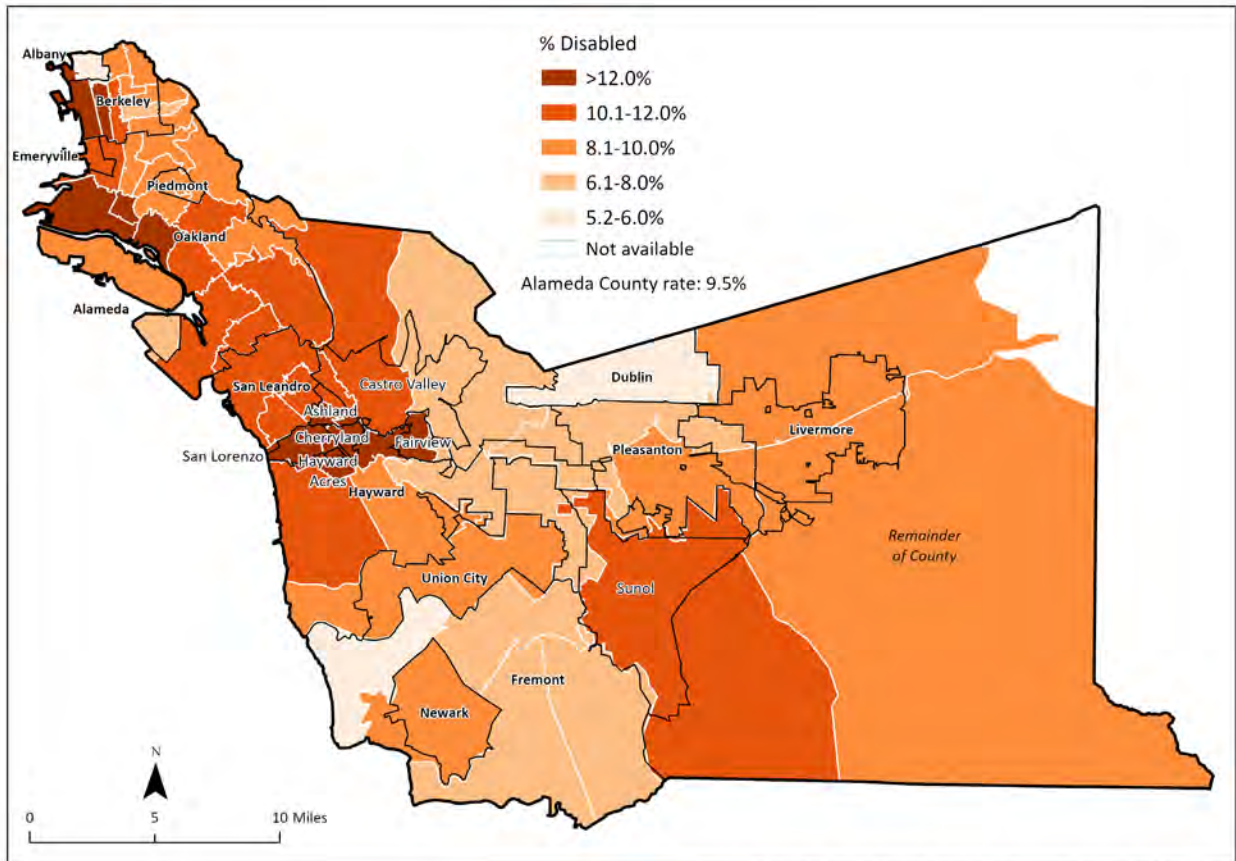


Prevalence of Disabilities in Alameda County

Alameda County percent of residents living with different types of disabilities

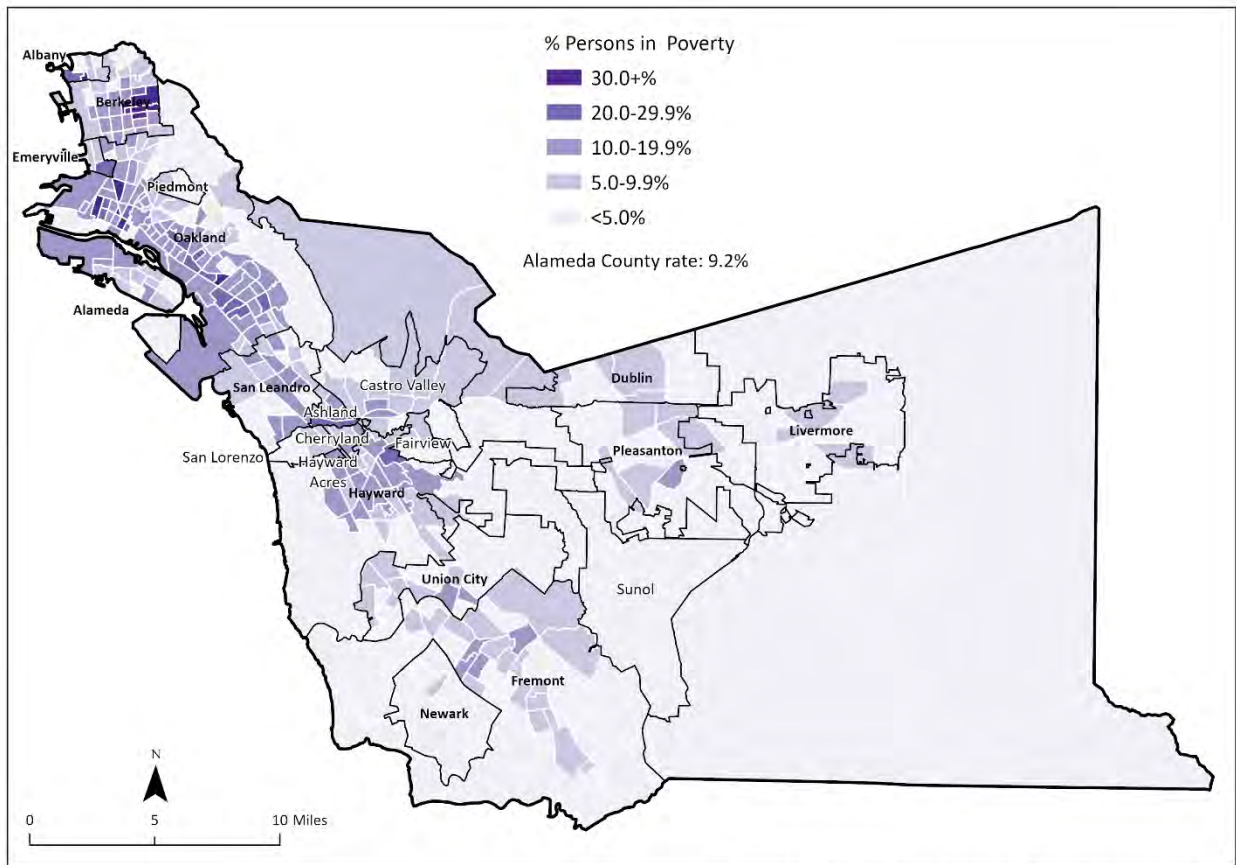


Source: ACS 2022 5-year files



Source: ACPHD CAPE, with data from American Community Survey 2022 5-year files.

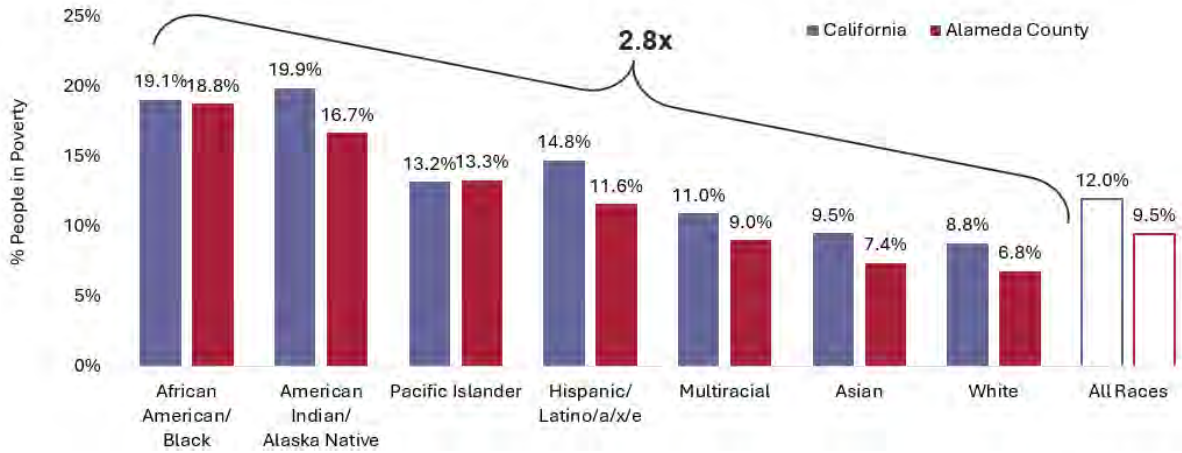
Percent of People Living At or Below Federal Poverty Level



Source: ACPHD CAPE, with data from American Community Survey 2018-2022.
 Note: The high-poverty tracts in Berkeley are mostly UC Berkeley student housing.

Inequities in Poverty

Poverty Rate, by Race/Ethnicity, Alameda County and California (2019-2023)

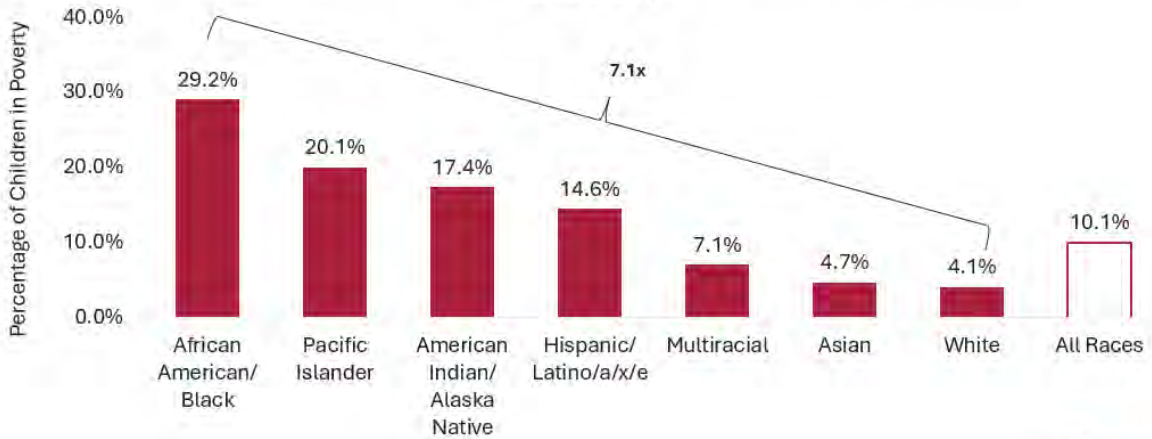


Source: American Community Survey/Public Use Microdata Sample, 2019-2023.



Concentrated inequities in child poverty

Alameda County Children (<18 Years Old) who are in Poverty, by Race/Ethnicity (2019-2023)

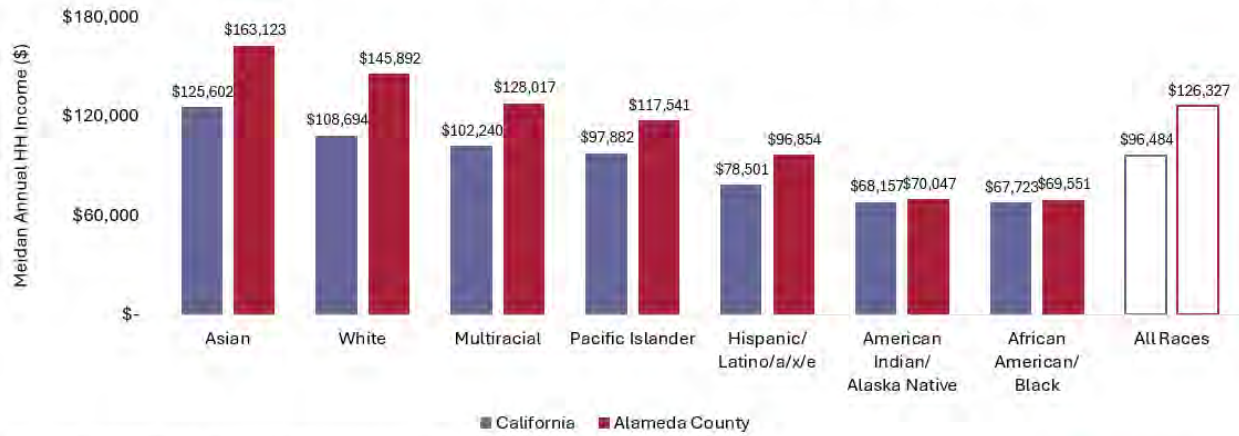


Source: American Community Survey 5-year data analysis by CAPE



Inequities in Median Income

Median Household Income (\$) by Race/Ethnicity, Alameda County and California (2019-2023)

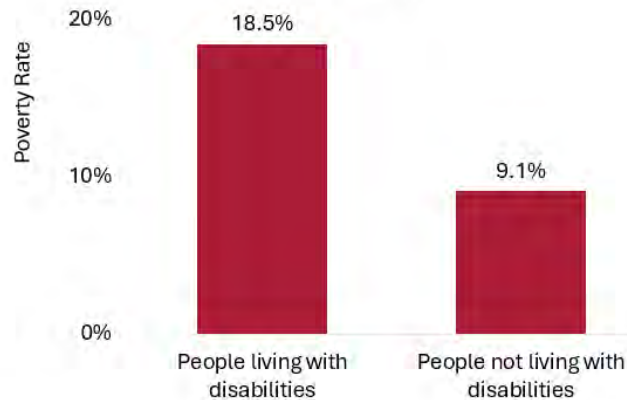


Source: ACPHD/CAPE with data from the American Community Survey, Public Use Microdata Sample (2019-2023)



Disproportionate Burden of Poverty Among People Who are Living with Disabilities

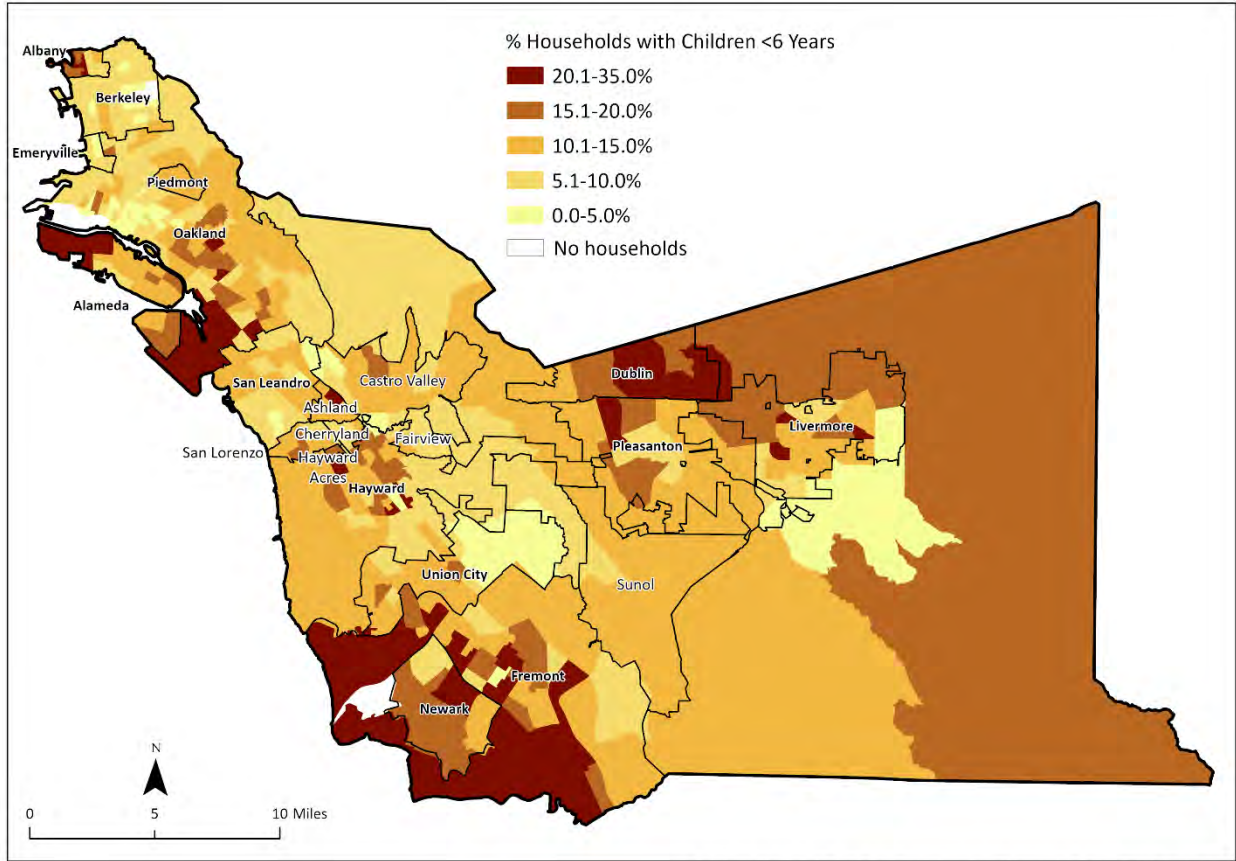
Alameda County percent of people living in poverty among people who are and are not living with disability



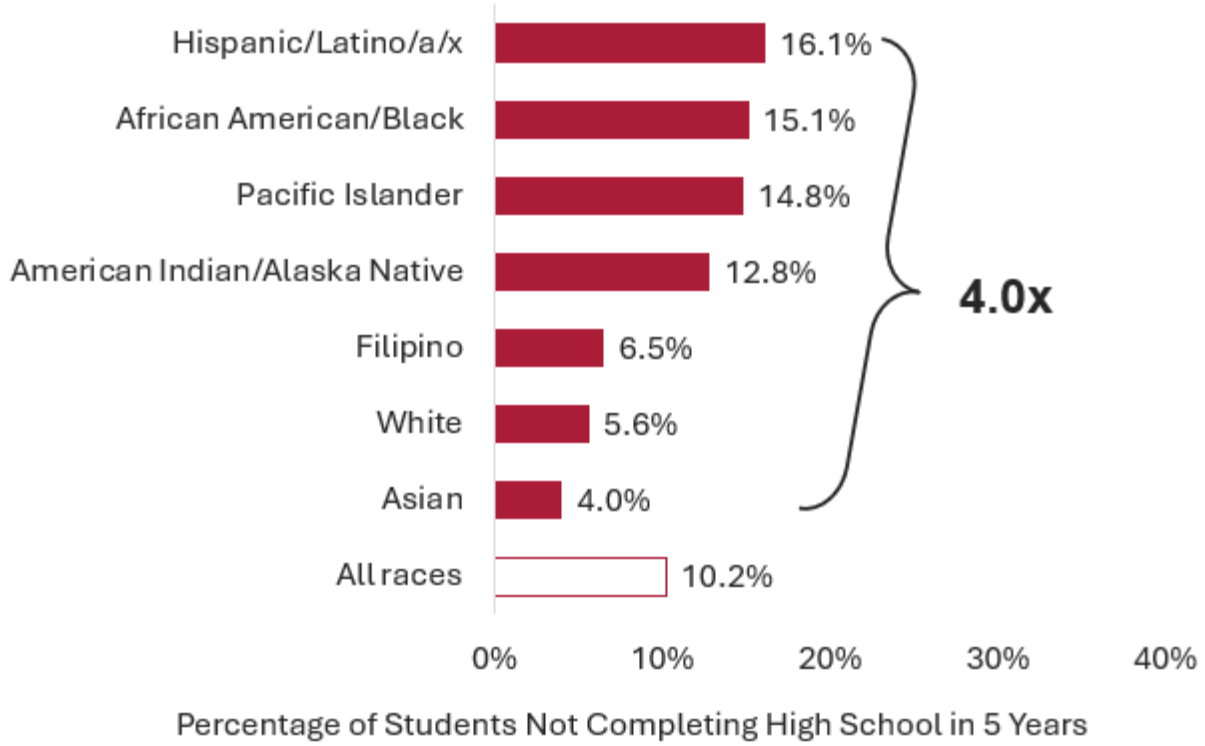
Source: ACS PUMS 2021 5-year files
Note: People living in group quarters are not included.



Percent of younger children (aged 0-6) in households

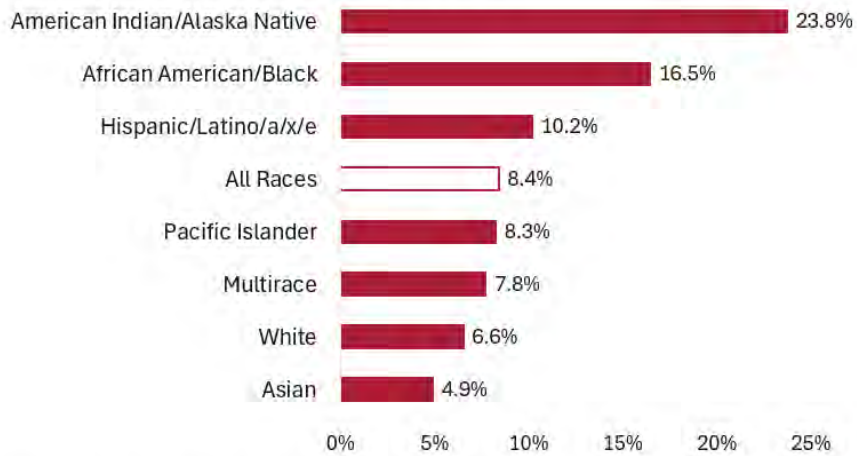


Alameda County 5-year High School Non-Completion Rate, by Race/Ethnicity (2023-2024)



Inequities in school and labor force participation

Alameda County Percentage Youth Aged 16 to 24 Not Employed and Not in School

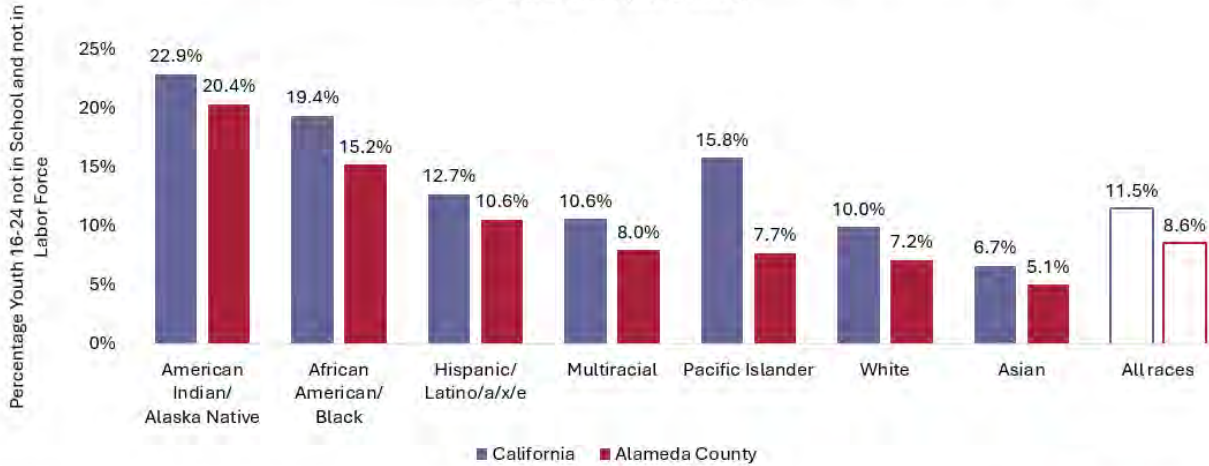


Source: American Community Survey 5-year data, 2022



Inequities in School and Labor Force Participation

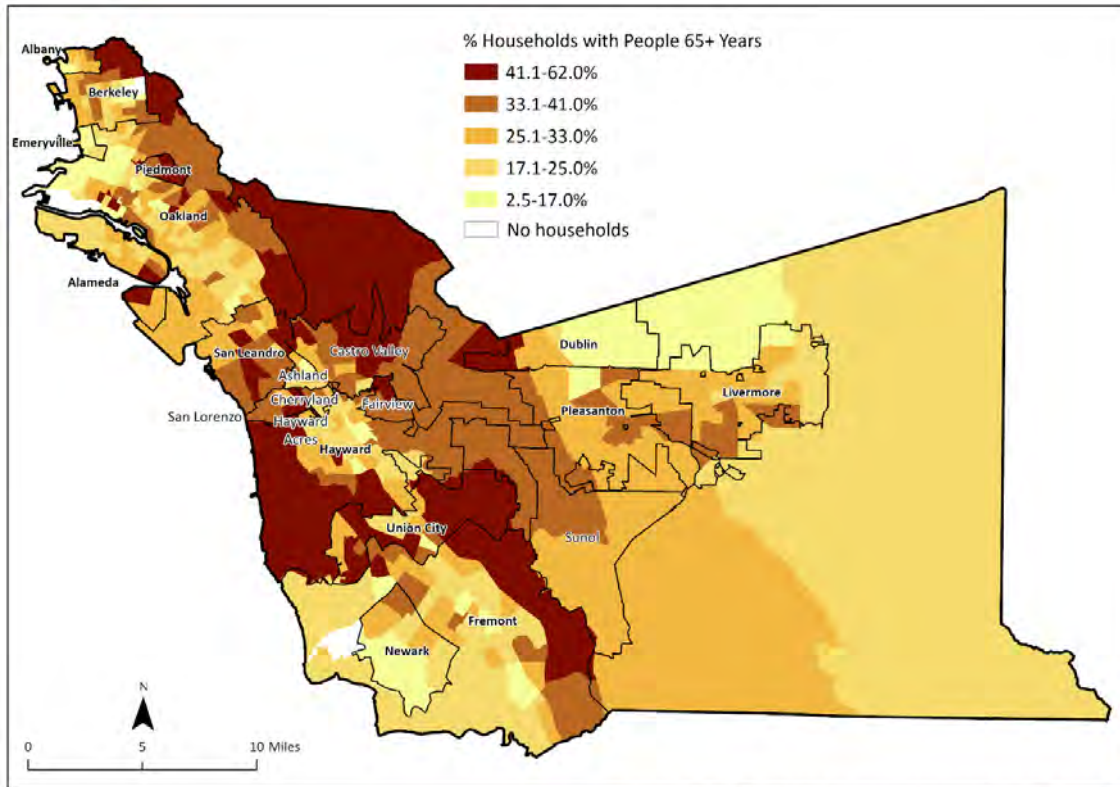
Youth Age 16-24 Who Are Not In School and Are Not Employed/Looking for Work, Alameda County and California (2019-2023)



Source: ACPHD/CAPE with data from the American Community Survey, Public Use Microdata Sample (2019-2023)

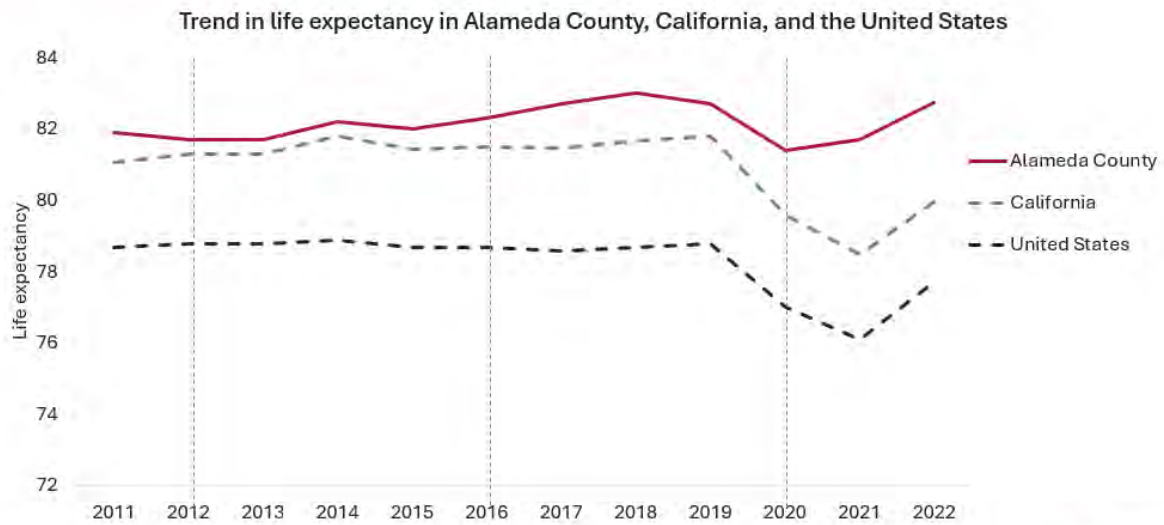


Percent of Older Adults (Aged 65+) in Households



Source: ACPHD CAPE, with data from American Community Survey 2022 5-year files.

Life Expectancy in Alameda County

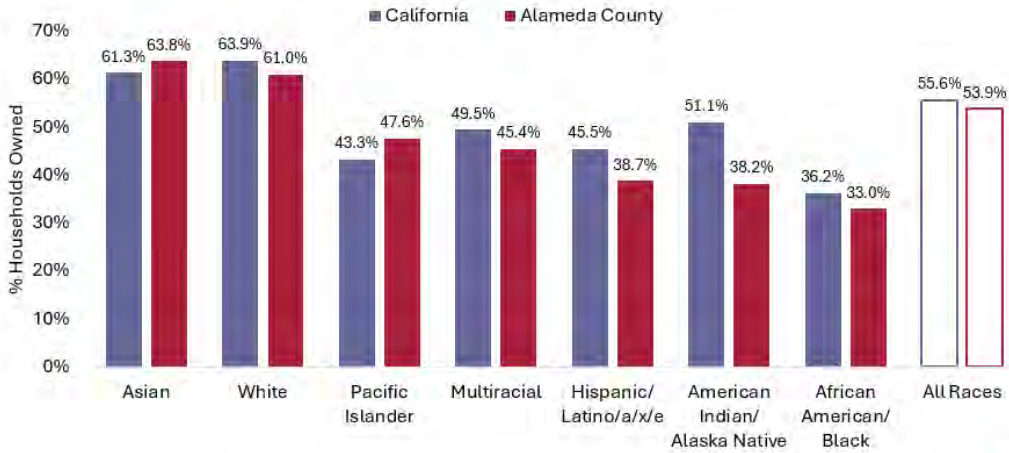


Source: CAPE analysis of Alameda County vital statistics files and CDC Wonder, 2011-2022.



Inequities in Home Ownership

Home Ownership Rate, by Race/Ethnicity, Alameda County and California (2019-2023)

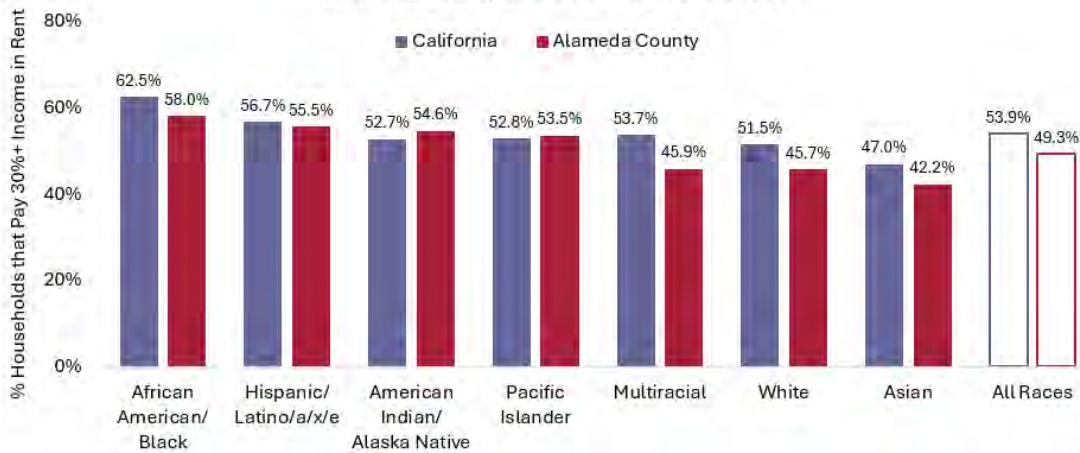


Source: American Community Survey/Public Use Microdata Sample, 2019-2023.



Inequities in Rent Burden

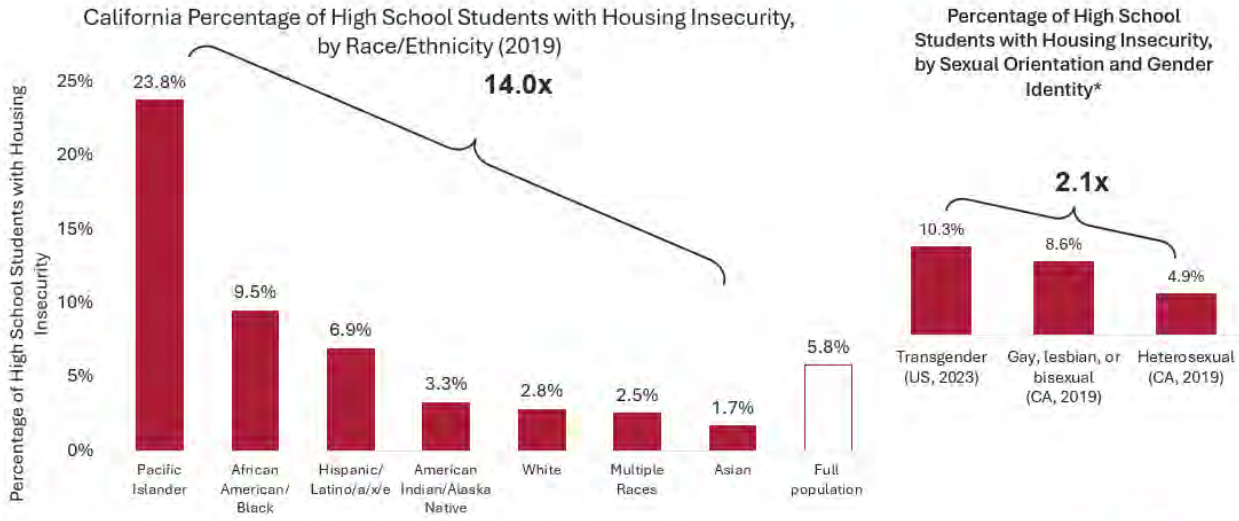
Rent-Burdened Households, by Race/Ethnicity, Alameda County and California (2019-2023)



Source: American Community Survey/Public Use Microdata Sample, 2019-2023.



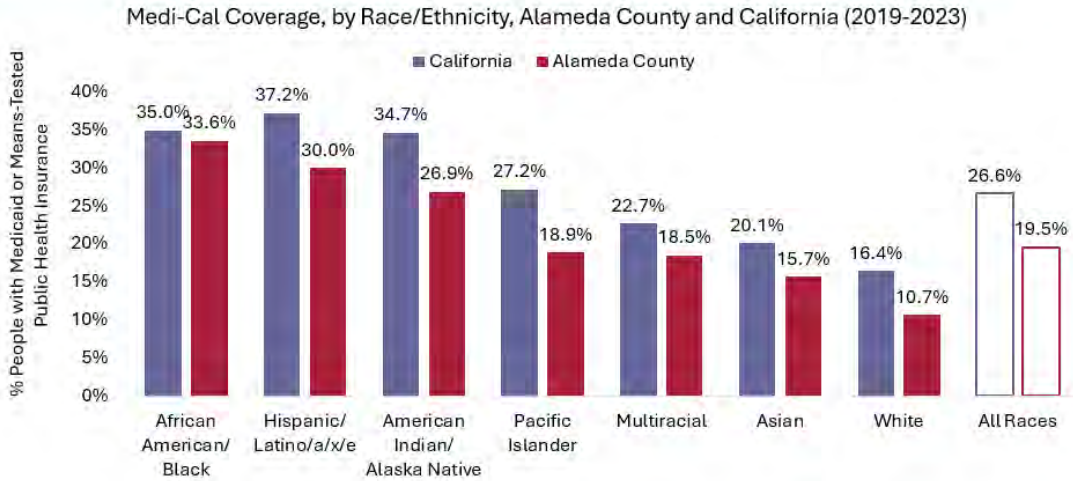
Housing Insecurity of High School Students



Sources: Youth Risk Behavior Surveillance Survey, CA 2019 and US 2023.
 Note: Transgender data are provided for the US because data on gender identity were not collected in CA



Medicaid is Key to Health Care Access in Alameda County

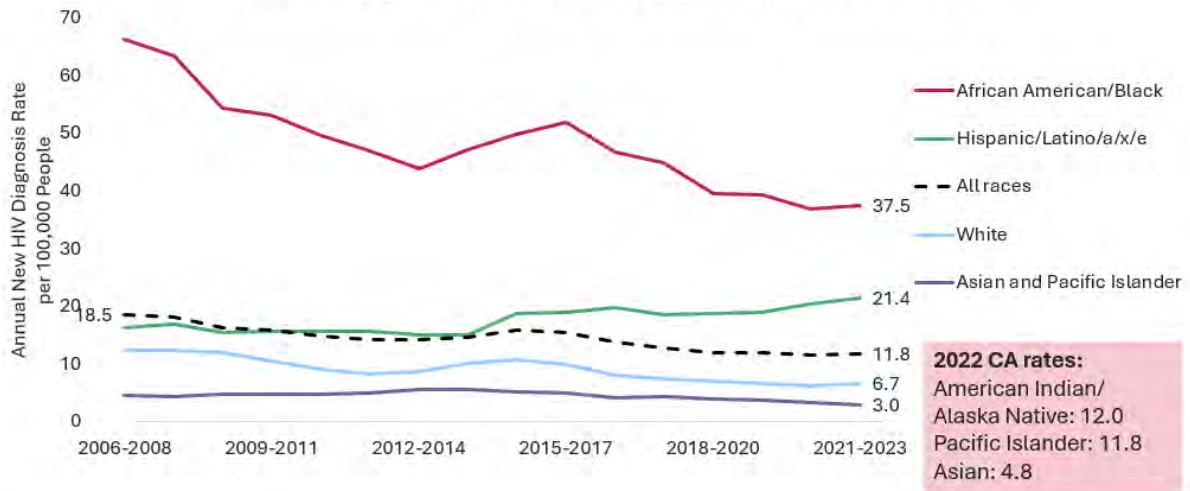


Source: American Community Survey, Public Use Microdata Sample, 2019-2023.



New HIV Diagnoses in Alameda County

Alameda County trends in new HIV diagnosis rates, by race and ethnicity



Source: ACPHD Department of Communicable Disease Prevention and Control, California HIV Surveillance Report, 2022



**Alameda County Selected Site-Specific Cancer Incidence Rates
per 100,000 Population, by Race and Ethnicity**

Cancer Site	All Races	White	Hispanic/ Latino/a/x/e	Asian/ Pacific Islander	African American/ Black
Breast	65.5	73.7	48.8	58.9	69.4
Colorectal	32.6	33.6	30.1	28.2	41.2
Kidney	12.6	12.8	16.3	7.8	19.2
Liver	9.8	7.3	14.2	11.0	11.0
Lung	38.5	39.6	27.6	34.1	54.9
Lymph	18.4	21.1	18.8	14.6	16.0
Mela (Skin)	19.2	40.6	5.2	1.0	1.2
Pancreas	12.1	12.6	12.3	9.7	15.8
Prostate	43.4	45.9	37.4	25.7	68.1
Thyroid	10.3	11.2	9.3	11.3	4.9
Urinary	14.6	20.0	11.4	8.1	11.7
Uterine	14.3	15.4	14.2	12.1	16.8

Note: Blue text denotes rates higher than the county average. Source: California Health Maps, 2012–2021. According to California Department of Public Health guidelines, cancer incidence rates cannot be reported if based on <15 cancer cases and/or a population of <10,000 to ensure confidentiality and stable statistical rates.

Information Gaps and Limitations

In this CHA cycle, the study team had access to more statistical data than ever before. This was due in part to local public health departments' efforts to make their data readily accessible to the public, and their partnership in working with us to obtain that information in a format that was easy to use. However, there are some limitations to the data, which affect the ability to fully assess some health issues that were identified as community needs during the 2025 CHA process:

1. **Differing local measures.** Overall, the study team was challenged with comparing local emergency department visit rates and hospitalization rates to readily available California benchmarks due to differing local measures. However, ACPHD is working on these issues for future assessments.
2. **Cognitive decline data.** In this assessment, the team was able to access Alzheimer's disease (AD)/dementia mortality rates, but not data on the prevalence of cognitive decline. While California is among the 10 states with the highest prevalence of AD/dementia (12%), there is no indication that prevalence in Alameda County is higher than in the state overall. Although the Alzheimer's Association recently studied prevalence in certain counties, it only published data on the five with the highest prevalence, none of which are Alameda County.
3. **Childhood diabetes and prediabetes prevalence.** Because childhood obesity has been a topic of concern previously, ACPHD and the hospitals continue to seek data about childhood diabetes as well, but current local data are not available.
4. **Oral health data.** The team also lacked sufficient data pertaining to oral health, including the number of dentists per capita who accept Denti-Cal, and data on prevalence of recent dental visits was irregular due to the recency of the pandemic.
5. **Emerging or difficult-to-measure topics.** Lastly, some indicators are difficult to measure or are just emerging. For example, statistical information related to adult marijuana use is scarce. Additionally, health-related data are rarely broken out by income/socioeconomic status, limiting the team's ability to understand disparities by income level.

Attachment 5: Secondary Reports and Presentations Consulted

The assessment team consulted the reports and presentations listed below to further understand the community health needs.

- Alameda County 2024 Point-in-Time Count Tableau Dashboard, 2024, Alameda County Public Health Department
- Alameda County Healthy Brain Initiative: Preliminary Community Needs Assessment, 2024, Alameda County Public Health Department
- Eastern Alameda County Human Services Needs Assessment, 2024, John Snow, Inc.
- Examining Increases in Mortality and Disparities from 2018-2019 to 2020-2021, 2024, Alameda County Public Health Department
- Maternal, Paternal, Child, & Adolescent Health (MPCAH), 2024, Alameda County Public Health Department
- Promoting Peaceful Families and Communities: Maintaining Progress in Reducing Gun Violence in Alameda County, 2025, Alameda County Public Health Department

Attachment 6: Secondary Data Indicators Index

This list is categorized. It begins with general health, and follows by alphabetical health topic. Note that measures of violence are found under “Peaceful Communities.”

Category	Indicator	Description	Source	Year(s)
GENERAL HEALTH LIFE/MORTALITY	All-Cause Mortality, Alameda County	Mortality for all causes, age-adjusted rate per 100,000	Alameda County Public Health Department, CAPE Unit	2019–2023
GENERAL HEALTH LIFE/MORTALITY	Child Mortality	Number of deaths among residents under age 18 per 100,000 population	National Center for Health Statistics - Mortality Files	2017–2020
GENERAL HEALTH LIFE/MORTALITY	Child/Youth Mortality (Ages 1-24)	Deaths among Children and Youth Ages 1-24	California Dept. of Public Health, Death Statistical Master Files; California Dept. of Finance, Population Estimates and Projections; CDC WONDER Online Database, Underlying Cause of Death	2020
GENERAL HEALTH LIFE/MORTALITY	Kids Ages 0-17 Living in LEP (limited English-speaking) Households	Children Ages 0-17 living in limited English-speaking households	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata	2024
GENERAL HEALTH LIFE/MORTALITY	Life Expectancy	Average number of years a person can expect to live	National Center for Health Statistics - Mortality Files, as cited by County Health Rankings	2018–2020
GENERAL HEALTH LIFE/MORTALITY	Life Expectancy, Alameda County	Average number of years a person can expect to live	Alameda County Public Health Department, CAPE Unit	2019–2023
GENERAL HEALTH LIFE/MORTALITY	Mortality Rates and Rank, Alameda County	Mortality counts and age-adjusted rates per 100,000, by age, race/ethnicity	Alameda County Public Health Department, Alameda County: Examining Increases in Mortality and Disparities from 2018-2019 to 2020-2021	2020–2021
GENERAL HEALTH LIFE/MORTALITY	Mortality Rates and Rank, California and by County	Mortality counts and age-adjusted rates per 100,000, ranked	California Dept. of Public Health, Death Statistical Master Files	2022
GENERAL HEALTH LIFE/MORTALITY	Percent Not Proficient in English	Percentage of population aged 5 and over who reported speaking English less than “well”	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021

Category	Indicator	Description	Source	Year(s)
GENERAL HEALTH LIFE/MORTALITY	Percent of Population by Age 65 and Older	Percentage of population ages 0-18, 65 and older.	U.S. Census Population Estimates	2021
GENERAL HEALTH LIFE/MORTALITY	Percent of Population by Gender	Percentage of population by gender	U.S. Census Population Estimates	2021
GENERAL HEALTH LIFE/MORTALITY	Percent of Population by Race	Percentage of population self-identifying as American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black, or White	U.S. Census Population Estimates	2021
GENERAL HEALTH LIFE/MORTALITY	Percent of Population, Hispanic	Percentage of population self-identifying as Hispanic	U.S. Census Population Estimates	2021
GENERAL HEALTH LIFE/MORTALITY	Percent Rural	Percentage of population living in a rural area	U.S. Census Population Estimates	2010
GENERAL HEALTH LIFE/MORTALITY	Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted)	CA Behavioral Risk Factor Surveillance System	2020
GENERAL HEALTH LIFE/MORTALITY	Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	CA Behavioral Risk Factor Surveillance System	2020
GENERAL HEALTH LIFE/MORTALITY	Population	Resident population	U.S. Census Population Estimates	2021
ASTHMA	Asthma/Bronchitis as Reason for Child Hospitalization	Based on percentage of hospital discharges among children ages 0-17 for the 11 most common primary diagnoses, excluding childbirth.	California Dept. of Health Care Access and Information custom tabulation, as cited on KidsData.org	2021
ASTHMA	Asthma Deaths, Alameda County	Deaths from asthma	Alameda County Public Health Department, CAPE Unit	2019–2023
ASTHMA	Asthma ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): J45	Alameda County Public Health Department, CAPE Unit	2020–2022
ASTHMA	Asthma Hospitalizations Among Children Ages 0-4	Asthma Hospitalizations among Children Ages 0-4	California Breathing, tabulation of data from the California Dept. of Health Care Access and Information, as cited on KidsData.org	2021
ASTHMA	Asthma Hospitalizations Among Children Ages 5-17	Asthma Hospitalizations among Children Ages 5-17	California Breathing, tabulation of data from the California Dept. of Health Care Access and Information, as cited on KidsData.org	2021
ASTHMA	Asthma Prevalence, Children	Children Ages 1-17 Ever Diagnosed with Asthma	UCLA Center for Health Policy Research, California Health Interview Survey, as cited on KidsData.org	2022

Category	Indicator	Description	Source	Year(s)
BEHAVIORAL HEALTH	Deaths of Despair, Alameda County	NIH defines as suicide, alcohol-related liver disease and cirrhosis, and drug/alcohol poisoning. Age-Adjusted Rate per 100,000 Population. Regex Code(s): K70[0-4] K7[3-4] X4[0-5] X[6-7] X8[0-4] Y1[0-5] Y4[5,7,9] Y870	Alameda County Public Health Department, CAPE Unit	2019–2023
BEHAVIORAL HEALTH: ATOD ⁸⁶	Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement	National Highway Traffic Safety Administration, Fatality Analysis Reporting System	2016–2020
BEHAVIORAL HEALTH: ATOD	Chronic Liver Disease and Cirrhosis Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File	2024
BEHAVIORAL HEALTH: ATOD	Current Adult Smokers	Percent of adults currently smoking (age-adjusted)	California Health Interview Survey (CHIS), as cited in Community Health Rankings	2020
BEHAVIORAL HEALTH: ATOD	Drug/Alcohol Abuse & Dependence ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): F1[0-6,8-9]	Alameda County Public Health Department, CAPE Unit	2020–2022
BEHAVIORAL HEALTH: ATOD	Drug Poisoning (Overdose) Deaths	Number of drug poisoning deaths per 100,000 population	National Center for Health Statistics - Mortality Files	2018–2020
BEHAVIORAL HEALTH: ATOD	Drug Poisoning (Overdose) Deaths Involving Any Opioid Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): T40[0-4,6]	Alameda County Public Health Department, CAPE Unit	2019–2023
BEHAVIORAL HEALTH: ATOD	Drug Poisoning (Overdose) Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): X4[0-4] X6[0-4] X85 Y1[0-4]	Alameda County Public Health Department, CAPE Unit	2019–2023
BEHAVIORAL HEALTH: ATOD	Drug Poisoning (Overdose) ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): T40[0-9]..(A \$\b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BEHAVIORAL HEALTH: ATOD	Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	CA Behavioral Risk Factor Surveillance System	2020
BEHAVIORAL HEALTH: ATOD	Opioid Poisoning (Overdose) ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((T40[0-4]. T406[09])[1-4])(A \$\b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BEHAVIORAL HEALTH: ATOD	Sequelae Of Drug and Alcohol Abuse & Dependence Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): F1	Alameda County Public Health Department, CAPE Unit	2019–2023
BEHAVIORAL HEALTH: ATOD	Student Drinking	Students Who Have Consumed Alcohol 7 or More Times in Their Lifetimes (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020

Category	Indicator	Description	Source	Year(s)
BEHAVIORAL HEALTH: ATOD	Student Recent Alcohol or Drug Use	Students Who Used Alcohol or Drugs in the Previous Month (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
BEHAVIORAL HEALTH: ATOD	Students Recent Marijuana Use	Students Who Used Marijuana 20-30 Days in the Previous Month (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
BEHAVIORAL HEALTH: MH ⁸⁷	Adult Depression	Percent of adults with depression (prevalence)	CDC BRFSS PLACES as cited in Eastern Alameda County Human Services Needs Assessment	2021
BEHAVIORAL HEALTH: MH	Adults with 1-3 Adverse Childhood Experiences	Percent of adults with 1-3 adverse childhood experiences	UC Davis Violence Prevention Research Program, tabulation of data from the CA Behavioral Risk Factor Surveillance System and American Community Survey, as cited by KidsData.org	2011–2017
BEHAVIORAL HEALTH: MH	Adults with 4 or More Adverse Childhood Experiences 2017	Percent of adults with 4 or more adverse childhood experiences	UC Davis Violence Prevention Research Program, tabulation of data from the California Behavioral Risk Factor Surveillance System, as cited by KidsData.org	2011–2017
BEHAVIORAL HEALTH: MH	Children with 2 or More Adverse Experiences	Percent of children Ages 0-17 with 2 or More Adverse Experiences (Parent Reported)	Population Reference Bureau, analysis of National Survey of Children's Health and the American Community Survey, as cited by KidsData.org	2017–2021
BEHAVIORAL HEALTH: MH	Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted)	CA Behavioral Risk Factor Surveillance System	2016–2019
BEHAVIORAL HEALTH: MH	Mental Health Hospitalizations among Children	Mental Health Hospitalization Discharges among Children Ages 5-14, 15-19	KidsData.org	2021
BEHAVIORAL HEALTH: MH	Mental Health Provider Shortage Areas	Designated Healthy Provider Shortage Areas within counties	U.S. Department of Health & Human Services, Health Resources and Services Administration	2022
BEHAVIORAL HEALTH: MH	Mental Health Providers	Ratio of population to mental health providers	Centers for Medicare & Medicaid Services, National Provider Identification	2022

Category	Indicator	Description	Source	Year(s)
BEHAVIORAL HEALTH: MH	Poor Mental Health	Percent of adults with poor mental health (prevalence)	CDC BRFSS PLACES as cited in Eastern Alameda County Human Services Needs Assessment	2021
BEHAVIORAL HEALTH: MH	Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	CA Behavioral Risk Factor Surveillance System	2020
BEHAVIORAL HEALTH: MH	Ratio of Students to School Psychologists	Ratio of Students to School Psychologists	California Dept. of Education, Staff Assignment and Course Data & DataQuest	2019
BEHAVIORAL HEALTH: MH	Ratio of Students to School Social Workers	Ratio of Students to School Social Workers	California Dept. of Education, Staff Assignment and Course Data & DataQuest	2019
BEHAVIORAL HEALTH: MH	Self-Harm ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((T3[6,7,9]9 T414 T427 T4[3,5,7,9]9)2. (?!(T3[6,7,9]9 T414 T427 T4[3,5,7,9]9))(T3[6-9] T4[0-9] T50)..2 ((T5[1-4,6-9] T6[0-3,5])9 (T58 T61)[01] T64[08])2. (?!(T5[1-4,6-9] T6[0-3,5])9 (T58 T61)[01] T64[0,8]))(T5[1-9] T6[0-5])..2 (X7[1-9] X8[0-3])... T71..2 T1491.{0,1})(A \$\ b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BEHAVIORAL HEALTH: MH	Severe Mental Illness ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): F2[0-9] F30[1-3,8-9] F31[0-6] F317[0-1,3,5,7] F31[8-9] F32[2-4] F32[8-9] F33[1-3] F334[0-1] F33[8-9] F34 F39 F400 F4[1-2] F431 F4[4-5] F48[1-2] F60 F50 F53 F91	Alameda County Public Health Department, CAPE Unit	2020–2022
BEHAVIORAL HEALTH: MH	Severe Mental Illness ED Visits and Hospitalizations	ED Visits or Hospitalizations per 100,000 population. ICD-10 Codes: F2[0-9] F30[1-3,8-9] F31[0-6] F317[0-1,3,5,7] F31[8-9] F32[2-4] F32[8-9] F33[1-3] F334[0-1] F33[8-9] F34 F39 F400 F4[1-2] F431 F4[4-5] F48[1-2] F60 F50 F53 F91	California Department of Health Care Access and Information (HCAI), Patient Discharge Data	2017–2021
BEHAVIORAL HEALTH: MH	Severe Mental Illness Related to Drug and Alcohol ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): F1[01,3-6,89][129][4-5] F1[0,2-6,89]80 F12150 F12[29]5	Alameda County Public Health Department, CAPE Unit	2020–2022

Category	Indicator	Description	Source	Year(s)
BEHAVIORAL HEALTH: MH	Severe Mental Illness Related to Drug and Alcohol ED Visits and Hospitalizations	ED Visits or Hospitalizations per 100,000 population. ICD-10 Codes: F101[4-5] F10180 F102[4-5] F10280 F109[4-5] F10980 F111[4-5] F112[4-5] F119[4-4], F12150 F12180 F1225 F12280 F1295 F12980 F131[4-5] F13180 F132[4-5] F13280 F139[4-5] F13980 F141[4-5] F14180 F142[4-5] F14280 F149[4-5] F14980 F151[4-5] F15180 F152[4-5] F15280 F159[4-5] F15980 F161[4-5] F16180 F162[4-5] F16280 F169[4-5] F16980 F181[4-5] F18180 F182[4-5] F18280 F189[4-5] F18980 F191[4-5] F19180 F192[4-5] F19280 F199[4-5] F19980	California Department of Health Care Access and Information (HCAI), Patient Discharge Data	2017–2021
BEHAVIORAL HEALTH: MH	Social Associations	Number of membership associations per 10,000 population	U.S. Census, County Business Patterns	2020
BEHAVIORAL HEALTH: MH	Student Depression	Students Who Had Depression- Related Feelings in the Previous (Year 7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
BEHAVIORAL HEALTH: MH	Student Suicidal Ideation the Previous Year	Students Who Seriously Considered Attempting Suicide in the Previous Year (9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
BEHAVIORAL HEALTH: MH	Students with a Low Level of Caring Relationships with Adults at School	Students with a Low Level of Caring Relationships with Adults at School (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
BEHAVIORAL HEALTH: MH	Suicide Among Leading Causes of Death	Rank among reasons for death within counties	California Department of Public Health, Death Statistics File.	2024
BUILT ENVIRONMENT	Blood Lead Levels, Kids 0-5	Children Ages 0-5 with moderate/very high blood lead levels among those tested. Moderate: 4.5-9.49 mcg/dL Very high: at least 9.5 mcg/dL	California Dept. of Public Health, Childhood Lead Poisoning Prevention Branch, California Blood Lead Data & California's Progress in Preventing and Managing Childhood Lead Exposure	2022
BUILT ENVIRONMENT	High Blood Lead Levels, Kids/Youth	Children/youth Ages 6-20 with moderate/very high blood lead levels among those tested. Moderate: 4.5-9.49 mcg/dL Very high: at least 9.5 mcg/dL	California Dept. of Public Health, Childhood Lead Poisoning Prevention Branch, California Blood Lead Data &	2022

Category	Indicator	Description	Source	Year(s)
			California's Progress in Preventing and Managing Childhood Lead Exposure	
BUILT ENVIRONMENT	Injury Deaths	Number of deaths due to injury (including assault and unintentional injuries) per 100,000 population	National Center for Health Statistics - Mortality Files, as cited in Community Health Rankings	2016–2020
BUILT ENV: ⁸⁸ UNINTENDED INJURIES	Crash Fatalities	Number and rate of fatal crashes (bicycle, pedestrian, and vehicle) per 100 vehicle miles driven	Metropolitan Transportation Commission and Association of Bay Area Governments, Vitalsigns.mtc.ca.gov	2022
BUILT ENV: UNINTENDED INJURIES	Drowning Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): W6[5-9] W7[0-4] X71 X92 Y21	Alameda County Public Health Department, CAPE Unit	2019–2023
BUILT ENV: UNINTENDED INJURIES	Drowning ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): (T751.. W16[49]1. (?!W16[49]) W16..1 W22041 (V9[02] W6[5-9] W7. X71 X92 Y21)...)(A \$\ b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BUILT ENV: UNINTENDED INJURIES	Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population	National Center for Health Statistics - Mortality Files	2014–2020
BUILT ENV: UNINTENDED INJURIES	Motor Vehicle - Pedestrian ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((V0[2-4][19] V09[23] Y0[23]0)..)(A \$\ b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BUILT ENV: UNINTENDED INJURIES	Motor Vehicle Transport Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): V0[2-4][1,9] V092 V1[2-4][3-9] V19[4-6] V2[0-8][3-9] V29[4-9] V[3-7][0-9][4-9] V80[3-5] V811 V821 V8[3-6][0-3] V87[0-8] V892	Alameda County Public Health Department, CAPE Unit	2019–2023
BUILT ENV: UNINTENDED INJURIES	Motor Vehicle Transport ED Visits and Hospitalizations	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((V0[2-4][19] V09[23] V1[2-4][3-5,9] V19[4-69] V2[0-8][3-5,9] V29[4-9] V[3-7].[4-9] V8[3-6][0-3] V80[3-5] V8[12]1 V87[0-8] V892 X810 Y020).. (X82 Y03 Y32)...)(A \$\ b)	Alameda County Public Health Department, CAPE Unit	2020–2022
BUILT ENV: UNINTENDED INJURIES	Pedestrian Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): V0[2-4][1,9] V092	Alameda County Public Health Department, CAPE Unit	2019–2023

Category	Indicator	Description	Source	Year(s)
BUILT ENV: UNINTENDED INJURIES	Share of Hospitalizations among children Ages 0-17 for Poisoning	Share of Hospitalizations among children Ages 0-17 for Poisoning	California Dept. of Health Care Access and Information custom tabulation	2021
BUILT ENV: UNINTENDED INJURIES	Share of Hospitalizations among children Ages 0-17 for Traumatic Injuries	Share of Hospitalizations among children Ages 0-17 for Traumatic Injuries	California Dept. of Health Care Access and Information custom tabulation	2021
BUILT ENV: UNINTENDED INJURIES	Unintentional Injuries (Accidents) Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
BUILT ENV: UNINTENDED INJURIES	Unintentional Injury Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): V W X[0-5] Y85 Y86	Alameda County Public Health Department, CAPE Unit	2019–2023
BUILT ENV: UNINTENDED INJURIES	Unintentional Injury ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): (T1[5-9]... (T3[679]9 T414 T427 T4[3579]9)1. (?!(T3[679]9 T414 T427 T4[3579]9)) (T3[6-9] T4[0-9] T50)..1 ((T5[1-46-9] T6[0-35])9 (T58 T61)[01] T64[08])1. (?!(T5[1-46-9] T6[0-35])9 (T58 T61)[01] T64[08]))(T5[1-9] T6[0-5])..1 (V W)\d.... X[0-5]... T71..1 T712[019]. T719.. T73... T75[0234]..)(A \$\ b)	Alameda County Public Health Department, CAPE Unit	2020–2022
CANCER	Breast Cancer (Female) Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Cancer Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File	2024
CANCER	Cancer Incidence Among Children Ages 0-19	Cancer Incidence among Children Ages 0-19	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data; U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool	2018
CANCER	Cancer Incidence, All Sites	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Colorectal Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021

Category	Indicator	Description	Source	Year(s)
CANCER	Kidney Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Liver Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Lung Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Lymph Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening	Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool	2020
CANCER	Melanoma Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Pancreas Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Prostate Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Thyroid Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Urinary Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CANCER	Uterine Cancer Incidence	Age-Adjusted Incidence Rate (AAIR) of new cancers per 100,000 for this site	University of California, San Francisco. California Health Maps website.	2012–2021
CHRONIC CONDITIONS	Chronic Lower Respiratory Diseases Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
CHRONIC CONDITIONS	Chronic Lower Respiratory Diseases Deaths, Alameda County	Deaths from chronic lower respiratory disease	Alameda County Public Health Department, CAPE Unit	2019–2023
CHRONIC CONDITIONS	Chronic Lower Respiratory Diseases ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): J4[0-7]	Alameda County Public Health Department, CAPE Unit	2020–2022
CLIMATE & NATURAL ENV	Air Pollution - Diesel	Average daily amount of particulate pollution from diesel sources	California Office of Environmental Health Hazard Assessment, CalEnviroScreen 4.0	2016
CLIMATE & NATURAL ENV	Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	Environmental Public Health Tracking Network	2019

Category	Indicator	Description	Source	Year(s)
CLIMATE & NATURAL ENV	Air Pollution - Particulate Matter	Annual average amount of fine particulate matter (PM2.5)	National Institute for Minority Health and Health Disparities.	2015–2017
CLIMATE & NATURAL ENV	Air Quality (Poor)	The likely number of days with air quality considered to be “Unhealthy” or “Unhealthy for Sensitive Groups,” based on the U.S. Environmental Protection Agency’s Air Quality Index (AQI), for both today and 30 years in the future under the influence of climate change	First Street Technology	2025
CLIMATE & NATURAL ENV	Change in Average Daily Temperature	Change in Average Daily Temperature (Degrees Fahrenheit)	First Street Technology	2025
CLIMATE & NATURAL ENV	Commuting Alone	Percentage of the workforce that drives alone to work	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
CLIMATE & NATURAL ENV	Commuting Alone – Long Commutes	Among workers who commute in their car alone, the percentage that commute more than 30 minutes	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
CLIMATE & NATURAL ENV	Drinking Water Contaminants	Index score combining information about 13 contaminants and 2 types of water quality violations found during drinking water sample testing. California Environmental Protection Agency (CalEPA) and is included in the CalEnviroScreen (CES).	California Environmental Protection Agency (CalEPA)	2011–2019
CLIMATE & NATURAL ENV	Drinking Water Violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	U.S. EPA, Safe Drinking Water Information System	2021
CLIMATE & NATURAL ENV	Extreme Heat Days (Projected)	Projected number of extreme heat days annually for 2050 and 2085. Extreme heat refers to 90 degrees or more.	CDPH California Building Resilience Against Climate Effects (CalBRACE)	2022
CLIMATE & NATURAL ENV	Flood Risk	Flood risk now and in 30 years (minor to severe) by type (residential, commercial, infrastructure, social, and roads)	First Street Technology	2025
CLIMATE & NATURAL ENV	High Temperature Days	Number of Days in excess of 95° (Projected)	First Street Technology	2025
CLIMATE & NATURAL ENV	Traffic Volume	Regional Studies	EJSCREEN: Environmental Justice Screening and Mapping Tool, as cited by Community Health Rankings	2019

Category	Indicator	Description	Source	Year(s)
CLIMATE & NATURAL ENV	Wildfire Risk	Wildfire risk now and in 30 years (1=minimal; 10=extreme)	First Street Technology	2025
COGNITIVE DECLINE	Alzheimer's Disease Deaths	Deaths from Alzheimer's disease	Alameda County Public Health Department, CAPE Unit	2019–2023
COMMUNICABLE DISEASES	Kindergarteners with All Required Immunizations	Kindergarteners with All Required Immunizations	California Dept. of Public Health, Immunization Branch, Reporting Data for Kindergarten and 7th Grade	2022
COMMUNICABLE DISEASES: RESPIRATORY	Covid-19 Deaths, Alameda County	Deaths from COVID-19	Alameda County Public Health Department, CAPE Unit	2019–2023
COMMUNICABLE DISEASES: RESPIRATORY	Covid-19 Deaths, ED Visits and Hospitalizations, Alameda County	Age-adjusted rate per 100,000 Population. Regex Code(s): U071	Alameda County Public Health Department, CAPE Unit	2019–2023
COMMUNICABLE DISEASES: RESPIRATORY	Flu Vaccinations	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	Centers for Medicare & Medicaid, Mapping Medicare Disparities Tool	2020
COMMUNICABLE DISEASES: RESPIRATORY	Influenza and Pneumonia Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
COMMUNICABLE DISEASES: RESPIRATORY	Tuberculosis Case Rate	Tuberculosis Cases, Rates per 100,000 Population, and Rank	California Department of Public Health, Tuberculosis Control Branch	2022
COMMUNICABLE DISEASES: RESPIRATORY	Tuberculosis Case Rate and Rank	Tuberculosis Cases, Rates per 100,000 Population, and Rank	California Department of Public Health, Tuberculosis Control Branch	2022
DIABETES/ OBESITY	Diabetes Deaths, Alameda County	Deaths from diabetes	Alameda County Public Health Department, CAPE Unit	2019–2023
DIABETES/ OBESITY	Sufficient Fruit and Vegetable Consumption, Children Ages 12-17	Children Ages 12-17 Who Ate 5 or More Servings of Fruits and Vegetables in the Previous Day	UCLA Center for Health Policy Research, California Health Interview Survey	2020
DIABETES/ OBESITY	Sufficient Fruit and Vegetable Consumption, Children Ages 2-11	Children Ages 2-11 Who Ate 5 or More Servings of Fruits and Vegetables in the Previous Day	UCLA Center for Health Policy Research, California Health Interview Survey	2020
ECON ⁸⁹ STABILITY	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	California Child Care Resource and Referral Network, California Child Care Portfolio	2023

Category	Indicator	Description	Source	Year(s)
ECON STABILITY	Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center	Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center	California Child Care Resource and Referral Network, California Child Care Portfolio	2023
ECON STABILITY	Child Care Cost Burden	Child care costs for a household with two children as a percent of median household income	The Living Wage Calculator; Small Area Income and Poverty Estimates	2022 & 2021
ECON STABILITY	Children Ages 0-17 Living in Food Insecure Households	Children Ages 0-17 Living in Food Insecure Households	USDA Food Environment Atlas; Map the Meal Gap from Feeding America	2021
ECON STABILITY	Children Ages 0-17 without Secure Parental Employment	Children Ages 0-17 without Secure Parental Employment	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata	2022
ECON STABILITY	Children Eligible for Free or Reduced-Price Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch	National Center for Education Statistics, as cited by County Health Rankings	2020–2021
ECON STABILITY	Children in Poverty	Percentage of people under age 18 in poverty.	U.S. Census Bureau, Small Area Income and Poverty Estimates, as cited by County Health Rankings	2021
ECON STABILITY	Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
ECON STABILITY	Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar"	United States Census Bureau, American Community Survey, 5-year estimates, as cited by County Health Rankings	2017–2021
ECON STABILITY	Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	United States Census Bureau, American Community Survey, 5-year estimates, as cited by County Health Rankings	2017–2021
ECON STABILITY	Kids in Working Families for Whom Licensed Childcare is Available	Children Ages 0-12 in Working Families for Whom Licensed Childcare is Available	California Child Care Resource and Referral Network, California Child Care Portfolio; U.S. Census Bureau, American Community Survey public use microdata	2022
ECON STABILITY	Median Household Income	The income where half of households in a county earn more and half of households earn less, by race/ethnicity	U.S. Census Bureau, Small Area Income and Poverty Estimates, as cited by Community Health Rankings	2021
ECON STABILITY	People Living in Poverty, Alameda County	People living at or below the federal poverty level, by ZIP Code	Alameda County Public Health Department, CAPE Unit	2018–2022

Category	Indicator	Description	Source	Year(s)
ECON STABILITY	People with Disabilities Living in Poverty, Alameda County	People living at or below the federal poverty level, by ZIP Code. Excludes people living in group quarters.	United States Census Bureau, American Community Survey, 5-year estimates provided by Alameda County Public Health Department, CAPE Unit via personal correspondence September 3, 2025.	2021
ECON STABILITY	Real Cost Measure	Funds needed to afford the cost of living based on the cost of housing, childcare, food, health care, transportation, taxes and other miscellaneous things	United Ways of California, Real Cost Measure Interactive Data Dashboard. https://unitedwaysca.org/realcost	2023
ECON STABILITY	Unemployment	Percentage of population ages 16 and older unemployed but seeking work	U.S. Bureau of Labor Statistics	2021
ECON STABILITY	Youth Labor Force Participation	Percentage of Youth Aged 16-24 Not Employed and Not in School, by Race	American Community Survey 5-year data, provided by Alameda County Public Health Department, CAPE Unit via personal correspondence September 3, 2025.	2022
ECON: EDUC ⁹⁰	Child Care Centers	Number of child care centers per 1,000 population under 5 years old	Homeland Infrastructure Foundation-Level Data, as cited by County Health Rankings	2010–2022
ECON: EDUC	High School Completion, Adult Population	Percentage of adults ages 25 and over with a high school diploma or equivalent	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
ECON: EDUC	High School Completion, Students and Special Student Populations.	Five-Year Cohort Graduate Rate: The number of students who graduated from high school within five years with a regular high school diploma divided by the number of students who form the final four-year adjusted cohort from the preceding year, plus any new students who transfer to and graduate from the selected entity-level during the five-year cohort outcome period. Special populations include youth who are homeless, English learners, have disabilities, immigrant, in the foster system, and socioeconomically disadvantaged	California Dept. of Education, DataQuest. Provided by Alameda County Public Health Department, CAPE Unit via personal correspondence September 3, 2025.	2023–2024
ECON: EDUC	High School Graduates Completing College Preparatory Courses	High School Graduates Completing College Preparatory Courses	California Dept. of Education, Adjusted Cohort Graduation Rate and Outcome Data	2020

Category	Indicator	Description	Source	Year(s)
ECON: EDUC	High School Graduation	Percentage of ninth-grade cohort that graduates in four years	U.S. Department of Education, EDFacts	2019–2020
ECON: EDUC	Math Scores	Average grade level performance for 3rd graders on math standardized tests	Stanford University, Stanford Education Data Archive	2018
ECON: EDUC	Ratio of Students to School Counselors	Ratio of Students to School Counselors	California Dept. of Education, Staff Assignment and Course Data & DataQuest	2019
ECON: EDUC	Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests	Stanford University, Stanford Education Data Archive	2018
ECON: EDUC	School Funding Adequacy	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district	Albert Shanker Institute, University of Miami School of Education and Human Development, and the Rutgers University Graduate School of Education: School Finance Indicators Database	2020
ECON: EDUC	School Segregation	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. Index 0 to 1; 0=school composition that approximates race and ethnicity distributions in the student populations within the county;1=more segregation	National Center for Education Statistics	2021–2022
ECON: EDUC	Some College	Percentage of adults ages 25-44 with some post-secondary education	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
ECON: EDUC	Students Meeting English Language Standards	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	California Dept. of Education, Test Results for California's Assessments	2022
ECON: EDUC	Students Meeting Math Standards	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	California Dept. of Education, Test Results for California's Assessments	2022
ECON: EDUC	Students Not Completing High School	Students Not Completing High School	California Dept. of Education, Dropouts by Race and Gender & Adjusted Cohort Graduation Rate and Outcome Data	2022

Category	Indicator	Description	Source	Year(s)
ECON: EDUC	Students with a Low Level of Meaningful Participation at School	Students with a Low Level of Meaningful Participation at School (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
ECON: EDUC	Students with a Low Level of School Connectedness	Students with a Low Level of School Connectedness (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
HEALTH CARE ACCESS & QUAL ⁹¹	Children in Limited English Households	Percent of Children Living in Limited English-Speaking Households	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata, as cited on KidsData.org	2021
HEALTH CARE ACCESS & QUAL	Children with Health Insurance Coverage	Children Ages 0-18 with Health Insurance Coverage	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata	2024
HEALTH CARE ACCESS & QUAL	Health Provider Shortage Areas: Primary Care	Designated Healthy Provider Shortage Areas within county	U.S. Department of Health & Human Services, Health Resources and Services Administration	2022
HEALTH CARE ACCESS & QUAL	Limited English Proficiency by ZIP Code	Map of Zip Codes Where the Proportion of Residents is More or Less than 20% of the California Benchmark	Center for Community Health & Evaluation, Kaiser Permanente Community Health Data Platform	2021
HEALTH CARE ACCESS & QUAL	Medi-Cal Eligibility, Homeless Population	Percent of homeless population eligible for Medi-Cal (Medicaid) managed care	Alameda County Health, CAPE Unit. Personal correspondence, September 3, 2025.	2025
HEALTH CARE ACCESS & QUAL	Medi-Cal Enrollment	Percent of population enrolled in Medi-Cal (Medicaid), by age, race/ethnicity	Alameda County Health, CAPE Unit. Personal correspondence, September 3, 2025.	2025
HEALTH CARE ACCESS & QUAL	Medi-Cal Enrollment, Birthing Mothers	Percent of births to mothers enrolled in Medi-Cal (Medicaid)	Alameda County Health, CAPE Unit. Personal correspondence, September 3, 2025.	2025
HEALTH CARE ACCESS & QUAL	Non-Physician Primary Care Providers Ratio	Ratio of population to primary care providers other than physicians	Centers for Medicare & Medicaid Services, National Provider Identification	2022
HEALTH CARE ACCESS & QUAL	Preventable Hospital Stays	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, as cited by County Health Rankings	2020
HEALTH CARE ACCESS & QUAL	Primary Care Physician Ratio	Ratio of population to primary care physicians	Area Health Resource File/American Medical Association	2020

Category	Indicator	Description	Source	Year(s)
HEALTH CARE ACCESS & QUAL	Ratio of Students to School Speech/Language/Hearing Specialists	Ratio of Students to School Speech/Language/Hearing Specialists	California Dept. of Education, Staff Assignment and Course Data & DataQuest	2019
HEALTH CARE ACCESS & QUAL	School Nurses Ratio	Ratio of Students to School Nurses	California Dept. of Education, Staff Assignment and Course Data & DataQuest	2019
HEALTH CARE ACCESS & QUAL	Uninsured	Percentage of population under age 65 without health insurance	U.S. Census Bureau, Small Area Health Insurance Estimates	2020
HEALTH CARE ACCESS & QUAL	Uninsured Adults	Percentage of adults under age 65 without health insurance	U.S. Census Bureau, Small Area Health Insurance Estimates	2020
HEALTH CARE ACCESS & QUAL	Uninsured Children	Percentage of children under age 19 without health insurance	U.S. Census Bureau, Small Area Health Insurance Estimates	2020
HEALTH CARE ACCESS: MAT ⁹² / INFANT HEALTH	Babies Breastfed in Hospital	Babies Breastfed in Hospital	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data, as cited by KidsData.org	2021
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Babies Breastfed in Hospital Exclusively	Babies Breastfed Exclusively in Hospital	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data, as cited by KidsData.org	2021
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Early Prenatal Care	Babies Born to Mothers Who Received Prenatal Care in the First Trimester	California Dept. of Public Health, California Vital Data (Cal-ViDa) Query Tool and Birth Statistical Master Files	2022
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Experiences Of Racism and Discrimination in Health Care	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Infant Mortality	Number of infant deaths (within 1 year) per 1,000 live births	National Center for Health Statistics - Mortality Files, as cited in KidsData.org	2014–2020
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Infant Mortality, Alameda County	Number of infant deaths (within 1 year) per 1,000 live births	Alameda County Public Health Department, CAPE Unit	2019–2023
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Low Birthweight Babies	Percentage of live births with low birthweight (< 2,500 grams)	National Center for Health Statistics - Natality files, as cited by County Health Rankings	2014–2020
HEALTH CARE ACCESS: MAT/ INFANT HEALTH	Maternal Mortality by Race, by County	Rate per 10,000 live births. Pregnancy-related death is a death while pregnant or within one year of the end of pregnancy – regardless of	California Department of Public Health, The California Pregnancy Mortality Surveillance System (CA-PMSS)	2021

Category	Indicator	Description	Source	Year(s)
		the outcome, duration or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.		
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Severe Maternal Morbidity by Race (per 10,000 labor hospitalizations)	Rate of SMM events per 10,000 labor hospitalizations among females, aged 12 to 55 years	California Department of Public Health, The California Pregnancy Mortality Surveillance System (CA-PMSS)	2021
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Singleton Low Birth Weight, Alameda County	Percentage of live births with low birthweight (< 2,500 grams)	Alameda County Public Health Department, CAPE Unit	2019–2023
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Singleton Premature Birth, Alameda County	Singleton Preterm birth = Live birth with estimated gestational age < 37 weeks, excluding all multiple births	Alameda County Public Health Department, CAPE Unit	2020–2021
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Adolescent Health	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Child Health	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Children/Youth with Special Health Care Needs	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Paternal Health	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Perinatal/Infant Health	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Top 3 Priorities for Women/Maternal Health	Among Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) population	Alameda County Title V Local MPCAH Needs Assessment	2024
HEALTH CARE ACCESS: MAT/INFANT HEALTH	Teen Birth Rate, Alameda County	Number of births per 1,000 female population ages 15-19	Alameda County Public Health Department, CAPE Unit	2019–2023

Category	Indicator	Description	Source	Year(s)
HEALTH CARE ACCESS: ORAL HEALTH	Dental Insurance - Uninsured	Percent of population without dental insurance	UCLA Center for Health Policy Research. AskCHIS Dashboard.	2023
HEALTH CARE ACCESS: ORAL HEALTH	Dentists	Ratio of population to dentists	U.S. Department of Health & Human Services, Health Resources & Services Administration, Area Health Resource File/National Provider Identifier Downloadable File	2021
HEALTH CARE ACCESS: ORAL HEALTH	Health Provider Shortage Areas: Dental Health	Designated Healthy Provider Shortage Areas within County	U.S. Department of Health & Human Services, Health Resources and Services Administration	2022
HEART DISEASE/STROKE	Acute Myocardial Infarction Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I2[1-2]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/STROKE	Acute Myocardial Infarction ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I2[1-2]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/STROKE	All Heart Disease Deaths, Alameda County	Deaths from heart disease	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/STROKE	Cardiac Dysrhythmia Deaths, Alameda County	Deaths from cardiac dysrhythmia	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/STROKE	Cardiac Dysrhythmia ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I4[7-9]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/STROKE	Cardiovascular Disease Deaths	Deaths from cardiovascular disease	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/STROKE	Cardiovascular Disease ED Visits and Hospitalizations	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I[0-6]I7[0-8]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/STROKE	Cerebrovascular Diseases Among Leading Causes of Death,	Rank within county	California Department of Public Health, Death Statistics File.	2024
HEART DISEASE/STROKE	Cerebrovascular Diseases Deaths, Alameda County	Deaths from cerebrovascular disease	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/STROKE	Essential Hypertension and Hypertensive Renal Disease Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
HEART DISEASE/STROKE	Heart Disease ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I0[0-9]I1[1,3]I[2-4]I5[0,1]	Alameda County Public Health Department, CAPE Unit	2020–2022

Category	Indicator	Description	Source	Year(s)
HEART DISEASE/ STROKE	Heart Diseases Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
HEART DISEASE/ STROKE	Heart Failure ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I0981 I1[1,3]0 I132 I50[1-4,8-9]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/ STROKE	Heart Failure MCODE Deaths, Alameda County	Multiple causes of death: Age-Adjusted Rate per 100,000 Population. Regex Code(s): I50	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Hemorrhagic Stroke Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I6[0-2]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Hemorrhagic Stroke ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I6[0-2]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/ STROKE	High Blood Pressure Prevalence	Percent (Crude Prevalence) of Population with High Blood Pressure	Centers for Disease Control & Prevention, Interactive Atlas of Heart Disease and Stroke (BRFSS)	2021
HEART DISEASE/ STROKE	Hypertension Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I1[0-3]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Hypertension ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I1[0-5]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/ STROKE	Hypertension MCODE Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I1[0-5]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Ischemic Heart Diseases Deaths, Alameda County	Per Mayo clinic: A life-threatening condition that occurs when blood flow to the brain is blocked. This prevents brain tissue from getting oxygen and nutrients, which can lead to brain cell death. Ischemic strokes are the most common type of stroke. Age-Adjusted Rate per 100,000 Population. Regex Code(s): I2[0-5]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Ischemic Heart Diseases ED Visits and Hospitalizations	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I2[0-5]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/ STROKE	Ischemic Stroke Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I6[3,5-6]	Alameda County Public Health Department, CAPE Unit	2019–2023
HEART DISEASE/ STROKE	Ischemic Stroke ED Visits and Hospitalizations	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I6[3,5-6]	Alameda County Public Health Department, CAPE Unit	2020–2022
HEART DISEASE/ STROKE	Stroke ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): I6	Alameda County Public Health Department, CAPE Unit	2020–2022

Category	Indicator	Description	Source	Year(s)
HOUSING & THE UNHOUSED	Broadband Access	Percentage of households with broadband internet connection.	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
HOUSING & THE UNHOUSED	Children Ages 0-17 Living in Crowded Households	Children Ages 0-17 Living in Crowded Households	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata	2022
HOUSING & THE UNHOUSED	Homelessness, Alameda County	Point-in-time count of homeless individuals, sheltered and unsheltered, with demographics (e.g. race and age.)	Alameda County Homeless Census & Survey Executive Summaries, 2022 and 2024	2022 2024
HOUSING & THE UNHOUSED	Homeownership	Percentage of owner-occupied housing units	United States Census Bureau, American Community Survey, 5-year estimates, as cited by Community Health Rankings	2017–2021
HOUSING & THE UNHOUSED	Point-in-Time Count of Homeless Children	Point-in-Time Count of Homeless Children Ages 0-17 (multiple counties and California)	U.S. Dept. of Housing and Urban Development, Point-In-Time Estimates of Homelessness in the U.S.	2023
HOUSING & THE UNHOUSED	Point-in-Time Count of Homeless Youth	Point-in-Time Count of Homeless Youth Ages 18-24 (multiple counties and California)	U.S. Dept. of Housing and Urban Development, Point-In-Time Estimates of Homelessness in the U.S., as cited in KidsData.org	2023
HOUSING & THE UNHOUSED	Point-in-Time Count of Unsheltered Homeless Children	Point-in-Time Count of Unsheltered Homeless Children Ages 0-17 (multiple counties and California)	U.S. Dept. of Housing and Urban Development, Point-In-Time Estimates of Homelessness in the U.S., as cited in KidsData.org	2023
HOUSING & THE UNHOUSED	Point-in-Time Count of Unsheltered Homeless Youth	Point-in-Time Count of Unsheltered Homeless Youth Ages 18-24 (multiple counties and California)	U.S. Dept. of Housing and Urban Development, Point-In-Time Estimates of Homelessness in the U.S., as cited in KidsData.org	2023
HOUSING & THE UNHOUSED	Rent-Burdened	Percent of residents who are rent-burdened, including severely rent-burdened (by race, socioeconomic status)	California Housing Partnership	2022
HOUSING & THE UNHOUSED	Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
HOUSING & THE UNHOUSED	Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities	U.S. Department of Housing & Urban Development, Comprehensive Housing Affordability Strategy (CHAS) data	2015–2019

Category	Indicator	Description	Source	Year(s)
HOUSING & THE UNHOUSED	Students Recorded as Homeless at Some Point during the School Year	Students Recorded as Homeless at Some Point during the School Year	California Dept. of Education, Coordinated School Health and Safety Office custom tabulation & DataQuest	2023
PEACEFUL COMMUNITIES	Assault Deaths (Homicide)	Number of deaths due to homicide per 100,000 population.	National Center for Health Statistics - Mortality Files, as cited by County Health Rankings, as cited by County Health Rankings	2014–2020
PEACEFUL COMMUNITIES	Assault Deaths (Homicide) Among Leading Causes of Death	Rank within county	California Department of Public Health, Death Statistics File.	2024
PEACEFUL COMMUNITIES	Assault ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((T3[679]9 T414 T427 T4[3579]9)3. (?!(T3[679]9 T414 T427 T4[3579]9))(T3[6-9] T4[0-9] T50)..3 ((T5[1-46-9] T6[0-35]9 (T58 T61)[01] T64[08])3. (?!(T5[1-46-9] T6[0-35]9 (T58 T61)[01] T64[08]))(T5[1-9] T6[0-5])..3 T71..3 (X9[2-9] Y0[0-68] T7[46])... Y07.{1,3} Y09)(A \$\ \\b)	Alameda County Public Health Department, CAPE Unit	2019–2023
PEACEFUL COMMUNITIES	Child Abuse or Neglect	Number of children under 18 years of age that experienced abuse or neglect in cases per 1,000 children. Rates are based on children with a substantiated maltreatment allegation.	California Child Welfare Indicators Project, CCWIP Reports. University of California at Berkeley & California Dept. of Social Services, as cited by KidsData.org	2020
PEACEFUL COMMUNITIES	Domestic Violence-Related Calls	Domestic Violence-Related Calls for Assistance among Adults Ages 18-69	California Dept. of Justice, Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance	2021
PEACEFUL COMMUNITIES	Felony Arrests among Juveniles Ages 10-17	Felony Arrests among Juveniles Ages 10-17	California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections	2021
PEACEFUL COMMUNITIES	Firearm-Related Deaths	Number of deaths due to firearms per 100,000 population	National Center for Health Statistics - Mortality Files, as cited by County Health Rankings	2016–2020
PEACEFUL COMMUNITIES	Firearm-Related ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population. Regex Code(s): ((W3[23][01] (X74 X95 Y24)[89] Y384).. ((X7 Y2)[23] X9[34])... W34[01][09]. Y350[0-39].)(A \$\ \\b)	Alameda County Public Health Department, CAPE Unit	2019–2023

Category	Indicator	Description	Source	Year(s)
PEACEFUL COMMUNITIES	Foster Care - Length of Stay	Median Length of Stay in Foster Care among Children Ages 0-17 Entering Foster Care	California Child Welfare Indicators Project, CCWIP Reports. University of CA at Berkeley & California Dept. of Social Services	2024
PEACEFUL COMMUNITIES	Foster Care, Ages 0-21	Children Ages 0-21 in Foster Care	California Child Welfare Indicators Project, CCWIP Reports. University of CA at Berkeley & California Dept. of Social Services.	2024
PEACEFUL COMMUNITIES	Juvenile Arrests	Rate of delinquency cases per 1,000 juveniles	Easy Access to State and County Juvenile Court Case Counts, as cited by Community Health Rankings	2019
PEACEFUL COMMUNITIES	Student Gang Affiliation	Students Who Consider Themselves Gang Members (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
PEACEFUL COMMUNITIES	Students Bullied or Harassed at School	Students Bullied or Harassed at School in the Previous Year (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
PEACEFUL COMMUNITIES	Students Bullied or Harassed at School because of Race/Ethnicity or National Origin	Students who were bullied or harassed at school in the previous year on the basis of their race/ethnicity or national origin, by race/ethnicity and number of occasions (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2017–2019
PEACEFUL COMMUNITIES	Students Cyberbullied	Students Cyberbullied 4 or More Times in the Previous Year (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
PEACEFUL COMMUNITIES	Students Fear Being Beaten Up at School	Students Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
PEACEFUL COMMUNITIES	Students Who Feel Very Unsafe at School	Students Who Feel Very Unsafe at School (7 th Graders, 9 th Graders, 11 th Graders)	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education	2020
PEACEFUL COMMUNITIES	Violent Crime Rate	Definition not found	County Health Rankings	2007–2016
RACISM/ DISCRIMINATION	Life Expectancy by Race/Ethnicity	Average number of years a person can expect to live	National Center for Health Statistics - Mortality Files, as cited by County Health Rankings	2018–2020

Category	Indicator	Description	Source	Year(s)
RACISM/ DISCRIMINATION	Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	National Center for Health Statistics - Mortality Files, as cited by County Health Rankings	2018–2020
RACISM/ DISCRIMINATION	Premature Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted)	National Center for Health Statistics - Mortality Files	2018–2020
RACISM/ DISCRIMINATION	Residential Segregation	Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents	United States Census Bureau, American Community Survey, 5-year estimates	2017–2021
SEXUALLY TRANSMITTED INFECTIONS	Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation; Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance.	2020
SEXUALLY TRANSMITTED INFECTIONS	Chlamydia Incidence, Youth Ages 10-19	Number of newly diagnosed chlamydia cases per 100,000 population ages 10-19	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2023
SEXUALLY TRANSMITTED INFECTIONS	Gonorrhea Incidence, Youth Ages 15-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation; Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance; U.S. Census Bureau, National Population by Characteristics & National Intercensal Tables (Apr. 2023).	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation; Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance.	2020
SEXUALLY TRANSMITTED INFECTIONS	HIV Disease Deaths, Alameda County	Age-Adjusted Rate per 100,000 Population due to Human Immunodeficiency Virus. Regex Code(s): B2[0-4]	Alameda County Public Health Department, CAPE Unit	2019–2023
SEXUALLY TRANSMITTED INFECTIONS	HIV Disease ED Visits and Hospitalizations, Alameda County	Age-Adjusted Rate per 100,000 Population due to Human Immunodeficiency Virus. Regex Code(s): B20	Alameda County Public Health Department, CAPE Unit	2020–2022
SEXUALLY TRANSMITTED INFECTIONS	HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2020

Attachment 7: Qualitative Research Materials

English-language pre-surveys and qualitative protocols are included on the following pages of this attachment. For pre-surveys and protocols in other languages, please contact Actionable Insights, LLC (inquiries@ActionableLLC.com).



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Welcome!

Thank you for clicking through to this survey. It will take less than 10 minutes to complete. **Please respond at least two days before your scheduled interview or focus group.**

Non-profit hospitals in the East Bay, including John Muir Health, St. Rose Hospital, Stanford Health Care Tri-Valley, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System, are conducting a community health needs assessment (CHNA) in accordance with IRS guidelines for non-profit hospitals. For the 2025 CHNA, a combination of statistical data and community input are being collected by these hospitals and their consultants, Actionable Insights. This research will generate a list of community health needs.

The survey you are about to complete briefly presents a list of health needs, including all that were prioritized by the community in Alameda County in 2022. You are welcome to add any needs you feel are missing. As a local expert/community leader, **you are being asked to choose up to five needs that you feel are the biggest health issues and/or conditions for the people whom you serve.** The results of this survey will be shared with Actionable Insights and the hospitals, and may also be shared with a limited number of additional non-profit hospitals, community-based organizations, and/or agencies such as the County's Public Health Department. During your upcoming interview/focus group, the Actionable Insights facilitator will ask you to discuss the top needs you chose.

To proceed, please enter your name below and click "Next."

* 1. Your name:



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

List of Health Needs to Select

* 2. Below is a list of health needs. The ones in bold were prioritized by the community during the 2022 Community Health Needs Assessment in Alameda County. They are presented in alphabetical order. Feel free to add any needs you feel may be missing. Please choose up to five needs that you feel are the biggest issues or conditions now for the people whom you serve. There may be overlap; please choose the five that best represent the needs you have in mind.

- Cancer**
- Climate**/healthy environment (including extreme weather; environmental contaminants, safe air and drinking water)
- Communicable Diseases (including TB, COVID, flu, salmonella; not including sexually transmitted infections)
- Community and family safety**/intentional injury (including child/partner abuse, hate crimes, bullying and school safety, human trafficking, violent crime, arrest rates, and deaths in custody)
- Diabetes and obesity**, AKA healthy lifestyles (including fitness and places to exercise; diet, nutrition, and access to fresh food)
- Disabilities (including vision, hearing, and mobility; neurodivergence such as autism or ADHD; and cognitive disabilities/developmental delays)
- Economic security/stability** (including income, employment, child care, and digital access)
- Education** (including pre-school, school test scores, learning gaps, vocational training, educational attainment, and wealth)
- Food insecurity** (including anxiety about food insufficiency, household food shortages, reduced quality, variety, or desirability of food, diminished nutrient intake, and disrupted eating patterns)
- Healthcare access and delivery** (including health insurance, costs of care and medicine, availability of primary and specialty care providers, wait times for appointments, quality of care, and linguistic/cultural competence in care delivery)
- Healthy aging (including arthritis, cognitive decline/dementia, Alzheimer's disease, aging-related vision and hearing loss, loss of mobility, falls)
- Heart disease and stroke** (including heart attack, high cholesterol, and high blood pressure)
- Housing and homelessness** (including safe, clean, and affordable housing, overcrowding, and tenant protections)
- Maternal and infant health (including prenatal care, premature births, and infant mortality)
- Mental health** (including stress, anxiety, isolation, and depression; life satisfaction; eating disorders; trauma; and mental health disorders such as schizophrenia)
- Oral/dental health
- Respiratory health** (including asthma, allergies, COVID-19, and COPD)
- Sexual health (including family planning and sexually-transmitted infections such as gonorrhea, chlamydia, or HIV)
- Structural racism** (social, economic and political systems and institutions that perpetuate racial inequities through policies, practices and norms)
- Substance use** (including vaping; the use of alcohol, tobacco, opioids, and other substances; addiction; and outcomes such as kidney or liver disease)
- Transportation** (including safety and reliability, overall infrastructure, and access)
- Unintended injuries/accidents (including drownings, poisonings, and bicycle, pedestrian, and motor vehicle accidents)
- Other (please specify)

When you are done responding to the questions above, please click "Next" for your responses to be tallied.



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Consent

* 3. In order to capture your words accurately, your interview/focus group will be recorded and the recording will be transcribed. A transcript of the interview/focus group discussion will be sent to the health care organizations and their consultants, and may also be shared with a limited number of additional non-profit hospitals, community-based organizations, and/or agencies such as the County's Public Health Department. If a quote from your transcript is used in the report, you will not be identified by name; only as a "local expert." Please indicate that you understand and agree to be recorded.

- Yes, I understand and agree to be recorded.
- No, I do not agree to be recorded. I will not participate in the interview/focus group.



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Report Acknowledgment

* 4. An appendix to the report will contain a list of experts consulted. Please indicate how you would like to be listed:

- By name, title, and organization
- Only my title and organization, not my name
- Only my organization, not my name or role
- Do not include me in the list at all

5. Please fill in the fields that correspond to your response above. If you agreed to be listed by name, we will use your name as you entered it at the beginning of this survey.

Title

Organization

* 6. In a few sentences, please tell us what your organization does and how it serves the community.

* 7. In a sentence or two, how would you describe the geographic areas and populations you serve or represent?



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Question about Climate

* 8. In the past three years, have the people you serve been impacted by any of the following climate hazard events? (Please check all that apply.)

- Extreme heat (too hot to perform routine activities such as work or be at rest)
- Wildfire and/or wildfire smoke (exposure to unsafe conditions or difficulty breathing due to air quality)
- Drought (not enough access to clean water)
- Extreme rainfall/flooding (too much water)
- None. The people I serve were not impacted by a climate hazard event in the past three years.
- I prefer not to answer.
- Other (e.g., water quality issues, power outages, insect infestations, or diseases from parasites/bacteria/viruses):



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Climate Follow-Up

9. Please tell us how the climate hazard(s) impacted the quality of life and well-being of the people you serve (e.g., poor physical or mental health, economic or housing instability, etc.)



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Demographics

The IRS would like the hospitals to describe who participated in the interviews and focus groups. We would appreciate it if you would answer the questions below, but responding is optional. We will only report these answers for experts as a group, not for individual participants.

10. What is your age? *(Please enter a number only.)*

11. Are you of Hispanic/Latinx ethnicity?

Yes

No

12. What is your race? (Please choose all that apply.)

- American Indian/Alaskan Native
- Asian (indicate specific ancestry, e.g., "Chinese," in Other field below)
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White
- Some other race (please specify)

13. Which of the following most accurately describes you?

- Female
- Male
- Non-binary
- Transgender
- Intersex
- Let me type...



2024 CHNA Survey to Identify Health Needs - Experts/Leaders (Alameda County)

Thank you!

Thank you for responding to the survey. Your facilitator will review your responses prior to your scheduled interview/focus group. If you are finished with this survey, please click "Done."



2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Welcome!

Thank you for clicking through to this survey. It will take less than 10 minutes to complete. **Please respond at least two days before your scheduled focus group discussion.**

Health care organizations in the East Bay, including John Muir Health, St. Rose Hospital, Stanford Health Care Tri-Valley, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System, would like to understand the needs of the community better, including its physical, emotional, and environmental health. For this Community Health Needs Assessment, these organizations are collecting thoughts and opinions from people in the community with the help of their consultants and the Alameda County Public Health Department. This will help to make a list of community health needs.

This survey has a list of health needs. It includes the ones that were found in 2022 for Alameda County. You are welcome to add any needs you feel are missing. As a community member, **you are being asked to choose up to five needs that you feel are the most important for your community right now.** The Public Health Department, the health care organizations, and their consultants will receive the answers from this survey and then summarize them. They may also share them with a small number of other community based organizations and health care organizations, **without using your name or email address.** The Public Health Department's facilitator will lead a conversation about the needs that were rated as the most important, or pressing, in your upcoming focus group.

To proceed, please enter your email address below and click "Next."

≈ 1. Your email address:

≈ 2. At the end of the focus group, you will receive a gift card as a "thank you" for participating. Which company's gift card would you like?

- Amazon
- Safeway
- Target

≈ 3. In order to get everyone's words exactly right, your focus group will be recorded. A written copy of the discussion without people's names will be sent to the County's Public Health Department, the healthcare organizations and their consultants. They may also share it with a small number of other community based organizations and health care organizations. If you are quoted, you will be identified only as a "community member" -- no names will be used. Please indicate that you understand and agree to be recorded.

- Yes, I understand and agree to be recorded.
- No, I do not agree to be recorded. I will not participate in the focus group.



2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

List of Health Needs to Select

* 4. Below is a list of health needs. The ones in bold were identified by the community in Alameda County in 2022. They are presented in random order. Please think about how important each need is for your community right now. Then, please choose up to five needs that you feel are the most important now for your community. There is a space at the bottom where you can add anything you feel may be missing. There may be overlap, but please do the best you can.

- Cancer**
- Climate/healthy environment** (including extreme weather, environmental contaminants, safe air and drinking water)
- Communicable Diseases (including TB, COVID, flu, salmonella; not including sexually transmitted infections)
- Community and family safety/intentional injury** (including child/partner abuse, hate crimes, bullying and school safety, human trafficking, violent crime, arrest rates, and deaths in custody)
- Diabetes and obesity, AKA healthy lifestyles** (including fitness and places to exercise; diet, nutrition, and access to fresh food)
- Disabilities (including vision, hearing, and mobility; neurodivergence such as autism or ADHD; and cognitive disabilities/developmental delays)
- Economic security/stability** (including income, employment, childcare, and digital access)
- Education** (including pre-school, school test scores, learning gaps, vocational training, educational attainment, and wealth)
- Food insecurity** (including anxiety about food insufficiency, household food shortages, reduced quality, variety, or desirability of food, diminished nutrient intake, and disrupted eating patterns)
- Healthcare access and delivery** (including health insurance, costs of care and medicine, availability of primary and specialty care providers, wait times for appointments, telehealth access, quality of care, and linguistic/cultural competence in care delivery)
- Healthy aging (including arthritis, cognitive decline/dementia, Alzheimer's disease, aging-related vision and hearing loss, loss of mobility, falls)
- Heart disease and stroke** (including heart attack, high cholesterol, and high blood pressure)
- Housing and homelessness** (including safe, clean, and affordable housing, internet/WiFi access, overcrowding, and tenant protections)
- Maternal and infant health (including prenatal care, premature births, and infant mortality)
- Mental health** (including stress, anxiety, isolation, and depression; life satisfaction; eating disorders; trauma; and mental health disorders such as schizophrenia)
- Oral/dental health

- Respiratory health** (including asthma, allergies, COVID-19, and COPD)
- Sexual health** (including family planning and sexually-transmitted infections such as gonorrhea, chlamydia, or HIV)
- Structural racism** (social, economic and political systems and institutions that perpetuate racial inequities through policies, practices, and norms)
- Substance use** (including vaping; the use of alcohol, tobacco, opioids, and other substances; addiction; and outcomes such as kidney or liver disease)
- Transportation** (including safety and reliability, overall infrastructure, and access)
- Unintended injuries/accidents (including drownings, poisonings, and bicycle, pedestrian, and motor vehicle accidents)
- Other need (please describe)

When you are done responding to the questions above, please click "Next" for your responses to be tallied. You will soon receive an invitation with details about the focus group. We look forward to meeting you!



Alameda County Public Health Department
Celebrating Healthy People in Healthy Communities

2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Questions About Climate

Please answer this question and the one on the next screen. You will be helping the University of California with research on climate and health.

≈ 5. In the past three years, were you impacted by any of these climate hazard events? (Check all that apply.)

- extreme heat (too hot to perform routine activities or be at rest)
- Wildfire and/or wildfire smoke (being in unsafe conditions or finding it hard to breathe because of air quality)
- Drought (not enough access to clean water)
- extreme rainfall/flooding (too much water)
- None. I was not impacted by a climate hazard event in the past three years.
- I prefer not to answer
- Other climate events that impacted you (for example, problems with water quality, or being in a power outage)



2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Climate Follow-Up Question

6. Please tell us how the event(s) you experienced impacted your life. For example, you could have had poor physical or mental health, lost your income or housing, etc.



2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Demographics

Thank you for providing your responses to the survey questions! The IRS would like the hospitals to describe who participated in the interviews and focus groups. We would appreciate it if you would answer the questions below. Answering is not required. We will only report these answers for community members as a group, not for individual participants.

7. What city do you live in right now?

8. What is your age? *(Please enter a number only.)*

9. Do you think of yourself as: *(Check all that apply)*

- Lesbian or gay
- Straight or heterosexual (that is, not gay or lesbian)
- Bisexual
- Queer
- Pansexual
- Don't know
- Prefer not to answer
- Something else (please specify)

10. What is your current gender identity? *(Check all that apply)*

- Female/woman/girl
- Male/man/boy
- Nonbinary, genderqueer, or not exclusively female or male
- Transgender female/woman/girl
- Transgender male/man/boy
- Don't know
- Prefer not to answer
- Another gender (please specify)

11. Which category/categories describe you? *Mark all that apply AND add details on the next screen. You may report more than one group.*

- Asian
- Black or African American
- Latino/Latina/Latinx, Hispanic
- Middle Eastern or North African
- Native American, American Indian, or Alaska Native
- Native Hawaiian or Other Pacific Islander
- White
- Don't know
- Prefer not to answer

Please click "Next" for your answers to be tallied.



2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Specific Demographics

12. Asian: Provide details below.

- Asian Indian
- Bangladeshi
- Chinese
- Filipino
- Hmong
- Indonesian
- Japanese
- Korean
- Pakistani
- Sinhalese
- Taiwanese
- Thai
- Vietnamese
- Specify (for example, Afghani, Burmese, Cambodian, Kyrgyz, etc.):

13. Black or African American: Provide details below.

- African American
- Ethiopian
- Haitian
- Jamaican
- Nigerian
- Somali
- Specify (for example, Ghanaian, South African, Barbadian, Congolese, etc.):

14. Latino/Latina/Latinx, Hispanic: Provide details below.

- Cuban
- Dominican
- Guatemalan
- Mexican or Mexican American
- Puerto Rican
- Salvadoran
- Venezuelan
- Specify (for example, Colombian, Ecuadorian, Argentine, etc.):

15. Middle Eastern or North African: Provide details below.

- Algerian
- Egyptian
- Iranian/Persian
- Lebanese
- Moroccan
- Syrian
- Specify (for example, Israeli, Iraqi, Tunisian, etc.):

16. Native American, American Indian, or Alaskan Native: Provide details below.

- American Indian
- Alaskan native
- Central or South American indigenous
- Mam
- Ohlone, including Chochenyo, Karkin, Ramaytush, Yokuts, or Muwekma
- Specify (for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat, Nome Eskimo Community, etc.):

17. Native Hawaiian or Other Pacific Islander: Provide details below.

- Chamorro
- Fijian
- Guamanian
- Marshallese
- Native Hawaiian
- Samoan
- Tongan
- Specify (for example, Palauan, Tahitian, Chuukese, etc.):

18. White: Provide details below:

- English
- German
- Irish
- Italian
- Polish
- Spanish/Spaniard
- Tongan
- Specify (for example, Scottish, Norwegian, Dutch, French, etc.):

Please click "Next" for your answers to be tallied.



Alameda County Public Health Department
Celebrating Healthy People in Healthy Communities

2024 CHNA Survey to Identify Health Needs - Community Members (Alameda County)

Thank you!

Thank you for responding to the survey. Your facilitator will review your responses prior to your scheduled focus group. Again, you will soon receive an invitation with details about the focus group.

If you are finished with this survey, please click "Done."

CHA/CHNA KII Protocol - Professionals (60 min.)

PREP

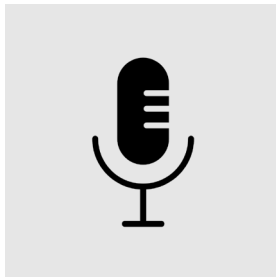
- Schedule call, send background, needs, consent, and demographics survey and main topics from page 2 [*minimum: 1 week ahead of time*]. [Insert QR code for survey]
- 48 hours before:
 - Review the individual's background on LinkedIn and/or their organization's website; review their survey response (health needs they identified).
 - Send reminder email; remind them of their survey response (most pressing needs among those they serve) and the main questions.
 - If they didn't respond to the survey, include the link and ask them to respond ASAP before the interview.

INTRODUCTION (5 MIN.)

[Start recording from the beginning of the session.]

- WELCOME: Thank you for agreeing to do this interview today. My name is [NAME] with Actionable Insights. I will be conducting the interview today on behalf of local health care organizations as part of the Community Health Needs Assessment process for them in [___ County or Counties].
- [*If they didn't submit survey: In order to go ahead, we'll need you to take the survey we sent you. Here's the link; I'll wait while you complete it [place in Zoom chat]*]
- What the project is about:
 - Local nonprofit hospitals are conducting a Community Health Needs Assessment. It is a systematic examination of health indicators in [___ County or Counties] that will be used to identify key problems and assets in a community and develop strategies to address community health needs. You are an important contributor to this assessment because of your knowledge of the needs in the community you serve or represent. The hospitals greatly value your input.
 - A CHNA is required of all non-profit hospitals in the U.S. every three years. The report based on this assessment will be a snapshot in time; this report will be published next year (in 2025) and consulted through 2028.
- We expect this interview to last no longer than 1 hour; does that still work for you?
- Today's main topics:
 - Better understand the needs you identified as most pressing in your area
 - Which populations are experiencing inequities related to the needs
 - How things may have changed in the past few years (trends)
 - The biggest challenges you see in addressing the needs
 - Key resources and any models or best practices you know of for addressing the needs
 - Other areas of concern
 - [*If not one of the needs identified:] Your expertise as it relates to the community's needs*]

- What we'll do with the information you tell us today:
 - Will record so that we can get the most accurate record possible
 - Will not share the audio itself; transcript will go to the health care organizations and their consultants, like me.
 - Hospitals will make decisions about which needs they can best address
 - We can keep anything confidential; just let me know any time.
 - The information you provide today will not be reported in a way that would identify you. *[Next part depends on their survey response:]* We plan to name *you/your organization* in the report where we list all the health experts/service providers we consulted, but will not attach your name to any quotes we might use.
- Do you have any questions before we get started? *[If we don't have the answer, commit to finding it and sending later via email.]*



Kick on Zoom recording!

HEALTH NEEDS DISCUSSION (35 MIN.)

Could you please pronounce your name and share your preferred pronoun? OK, [name], before we get down to the issues you identified, I'd like to ask you:

1. What are the healthiest characteristics of this community? *[Prompt if needed: For example, a strong transportation system, an active arts and culture sector, safe and accessible spaces for physical activity]*
 - a. What strengths in the community amplify or support these healthy characteristics?

Thank you. Now, you identified *[read list from survey]* as the biggest health issues or conditions your community struggles with. For each of these needs, I'll ask you six things *[read only **bold text** to introduce this section]*:

1. Please briefly describe **how you see the need playing out**. What does it look like among the people you serve or represent?
2. **What do you think creates these issues?** *[Prompts for barriers if they are having trouble thinking of any: Income/economic issues, language, culture/stigma, lack of awareness/education,*

policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

3. This may overlap the previous question, but **are there certain people or geographic areas that have been affected by the issues** we've been talking about **more than others**? If so, in what ways? In other words, which specific groups of the population, if any, should the hospitals focus on to reduce disparities and inequities related to race or other factors? *[Prompts for populations if they are having trouble thinking of any: income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location; intersectionality of any of these]*
4. Next, **how things may have changed** in the last few years (since we know that the data always lag what is happening now)? What emerging trends or areas of concern have you seen since 2021? How has COVID recovery influenced the characteristics of these needs?
5. What are one or two of the biggest challenges to addressing the need?
6. *[1st time through only: As you know, the hospitals will make decisions about which needs they can best address, and develop strategies to address them.]* **What do you feel is needed to better address this need**, including **any models, best practices, or key community resources for addressing the need**? In other words, what are effective strategies to reduce health disparities and inequities in your community? *[Prompts if needed: Is there work underway that is promising? Who is doing that work? Are there any best practices you have observed within your health system or organization, in our county agencies, national practices you've heard about, or practices you've read about in literature?]*

Probes: How would you like to see health care organizations like these hospitals address these needs? Who are the individuals or organizations that are important in connecting the sub-groups most affected by disparities to community resources that support this need?

OK, let's get started. For [name first need], [start at Q1; address all six questions, then go back to Q1-6 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:
FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [topic, e.g., substance use disorder, maternal health, or homelessness]. Let's talk a little about that; how does it relate to the community's health needs? *[Probe: What services does your organization provide to help meet those needs?]*

Only if structural inequities were not already discussed:

FURTHER DISCUSSION: STRUCTURAL INEQUITIES (5-10 min.)

I know you didn't identify structural inequities as a specific need; would you mind...

- Speaking to any particularly detrimental structural inequities that are affecting the people you serve? How do those structural inequities show up?
- Identifying any equity initiatives or strategies you know of, which have momentum – that is, they seem to be making a positive impact?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs that we haven't already discussed? Any recent reports we should consult? Any other thoughts or comments we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** *[Pause]* For example, we may ask whether the resources seem sufficient or if there are gaps; or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2025. If anything occurs to you later that you would like to add to this interview, please feel free to send me an email.

Thank you so much for contributing your expertise and experience to the CHNA.

CHA/CHNA FG Protocol - Professionals (90 min.)

PREP

- Schedule group of 8-10 participants.
- Ahead of time [*minimum: 1 week ahead of time*], send participants:
 - Pre-focus group **consent/demographics & health needs survey** [INSERT LINK] [depending on group] and QR code for survey: [insert QR CODE]
 - FG date, time, and Zoom login information
 - Advise that the session will be recorded
- Prepare:
 - Slide of agenda/questions
 - Review pre-survey responses + create slide of top needs
- 48 hours before:
 - Send reminder email.
 - If they didn't respond to the survey, include the link and ask them to respond ASAP before the interview.

INTRODUCTION (10 MIN.)

- Hello everyone. Thank you for agreeing to participate in this focus group today. Today we are hosting a discussion about health here in [____ County or Counties]. This session will run until [*time*] (one hour).
- My name is ____ and I'm with [*organization name and description, e.g., "a local consulting firm"*]. My colleague will also introduce [her/him/their]self. [*Pause for their introduction.*] We are doing this focus group on behalf of local health care organizations as part of the Community Health Needs Assessment process for them in [COUNTY OR COUNTIES]. When we start our discussion in a few minutes, we will ask you to say your first name and your pronouns before speaking.
- What the project is about:
 - Local nonprofit hospitals are conducting a Community Health Needs Assessment. It is a systematic examination of health indicators in [COUNTY or COUNTIES] that will be used to identify key problems and assets in a community and develop strategies to address community health needs. You are an important contributor to this assessment because of your knowledge of the needs in the community you serve or represent. The hospitals greatly value your input.
 - A CHNA is required of all non-profit hospitals in the U.S. every three years. The report based on this assessment will be a snapshot in time; this report will be published next year (in 2025) and consulted through 2028.
- **Today's main topics:** show slide or point to agenda
 - Better understand the needs you identified as most pressing in your area

- Which populations are experiencing inequities related to the needs
- How things may have changed in the past few years (trends)
- The biggest challenges you see in addressing the needs
- Key resources and any models or best practices you know of for addressing the needs
- Confidentiality:
 - Like you saw in the survey, we asked everyone if it was OK to record this discussion, and you all said yes. We are recording so that we can make sure to take down your words as accurately as possible.
 - We will only use first names here. (If you want to use a pseudonym, that's OK too!)
 - We can keep anything confidential; just let me know any time and we can delete it from the recording.
- What we'll do with the information you tell us today:
 - Hospitals will make decisions about which needs they can best address
 - The information you provide today will not be reported in a way that would identify you. We plan to name *you/your organization* in the report where we list all the health experts/service providers we consulted unless you told us in the pre-survey that you didn't want us to be included, or only wanted your organization to be listed. We will not attach your name to any quotes we might use.
 - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospitals can read your own words. We will not use your name when we give them those quotes.
 - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
 - We know you have other things to do and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
 - We understand that you may have other things going on your end; we ask that you do the best you can to stay present, and let us know through the chat if you absolutely need to step away.
 - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and thoughts, even – especially! – if they aren't the same as everyone else's.
- Do you have any questions before we get started? [If we don't have the answer, commit to finding it and sending later via email.]



Kick on Zoom
recording!

HEALTH NEEDS DISCUSSION (35 MIN.)

OK, you identified *[read list from survey on PPT slide]* as the biggest health issues or conditions your community struggles with. For each of these needs, I'll ask this group six things *[read only **bold text** to introduce this section]*:

1. Briefly describe **how you see the need playing out**. What does it look like among the people you serve or represent? Remember, please say your name and your pronouns before speaking.
2. What do you think creates these issues? *[Prompts for barriers if they are having trouble thinking of any: Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]*
3. This may overlap the previous question, but **are there certain people or geographic areas that have been affected by the issues** we've been talking about **more than others**? If so, in what ways? *In other words*, which specific groups of the population, if any, should the hospitals focus on to reduce disparities and inequities related to race or other factors? *[Prompts for populations if they are having trouble thinking of any: income/ed level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender ID, disability status, geographic location; intersectionality of any of these]*
4. Next, **how things may have changed** in the last few years (since we know that the data always lag what is happening now)? What emerging trends or areas of concern have you seen since 2021? How has the COVID recovery influenced the characteristics of these needs?
5. What are one or two of the biggest challenges to addressing the need?
6. What do you feel is needed to better address this need, including any models, best practices, or key community resources for addressing the need? *[Prompts if needed: Is there work underway that is promising? Who is doing that work? Are there any best practices you have observed within your health system or organization, in our county agencies, national practices you've heard about, or practices you've read about in literature?]* *[Probe: How would you like to see health care organizations like these hospitals address these needs?]*

- a. What are effective strategies to reduce health disparities and inequities in your community?
[Probe: Who are the individuals or organizations that are important in connecting the sub-groups most affected by disparities to community resources that support this need?]

OK, let's get started. For [name first need], [start at Q1; address all six questions, then go back to Q1-6 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [topic, e.g., substance use disorder, maternal health, or homelessness]. Let's talk a little about that; how does it relate to the community's health needs? [Probe: What services do your organizations provide to help meet those needs?]

Only if structural inequities were not already discussed:

FURTHER DISCUSSION: STRUCTURAL INEQUITIES (5-10 min.)

I know the group didn't prioritize structural inequities as a specific need; would you mind...

- Speaking to any particularly detrimental structural inequities that are affecting the people you serve? How do those structural inequities show up?
- Identifying any equity initiatives or strategies you know of, which have momentum – that is, they seem to be making a positive impact?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs that we haven't already discussed? **Any recent reports we should consult?** Any other thoughts or comments we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. Would you be willing to review a list at that time, related to your area of expertise, and give us feedback? [Pause] For example, we may ask whether the resources seem sufficient or if there are gaps; or if there are resources available that we have missed. [Launch Zoom poll.]

CLOSING (1 min.)

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2025.

If anything occurs to you later that you would like to add, please feel free to send me [or my colleague] an email.

Thank you so much for contributing your expertise and experience to the CHNA.

CHA/CHNA FG Protocol - Community Members (90 min.)

PREP

- Work with host to schedule group of 8-10 participants. If needed, create recruitment email/flier for host. Ahead of time, have host send participants:
 - Pre-focus group **consent/demographics & health needs survey** [INSERT LINK] [depending on group] QR code for survey: [insert QR CODE]
 - FG date, time, and location [or Zoom login information]
 - Advise that the session will be recorded
- Prepare:
 - PDF [or flipchart] of agenda/questions
 - PDF [or flipchart] of prior cycle health needs list (including definition of health care access) **[if no pre-survey]**
 - Review pre-survey responses [depending on group] + create slide of top needs
 - If in person: consent + demographics survey & health needs paper survey **[if no pre-survey]**
 - If virtual: consent language & Zoom poll of health needs **[if no pre-survey]**

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Thank you for agreeing to participate in this focus group today. Today we are hosting a discussion about health here in [____ County or Counties]. This session will run until [time] (90 minutes).
- My name is ____ and I'm with [organization name and description, e.g., "a local consulting firm"]. My colleague will also introduce [her/him/their]self. [Pause for their introduction.] We are doing this focus group for local hospitals, including [list names of participating hospitals in the area]. When we start our discussion in a few minutes, we will call on you and ask you to say your name and your pronouns before speaking.
- Purpose:
 - You are here today to let nonprofit hospitals [if applicable: and the health department] know what the biggest health needs are in your community. These can include health conditions and the things that make those conditions better or worse.
 - This is called the Community Health Needs Assessment (CHNA), which is required every three years by the IRS, so it is an official, public report.
 - Hospitals will look at the numbers (statistics) and at **what you say**, to plan how they will use their resources to improve health and wellness in your county. So your thoughts are really important to them.
- Today's questions: show slide or point to agenda
 - What are the needs?
 - Which groups of people are doing better or worse when it comes to the needs?

- What can hospitals/health systems do to improve health in the community?
 - Lastly, we will get your perspective about equity and cultural competence when it comes to health care.
- Confidentiality:
 - Like you saw in the survey, we asked everyone if it was OK to record this discussion, and you all said yes. We are recording so that we can make sure to get your words right.
 - We will only use first names here -- you will be anonymous. (If you want to use a fake name, that's OK too!)
 - Will not share the audio [and video, if on Zoom]; just the transcript will go to the health care organizations and their consultants [*if applicable*: like me].
 - When we are finished with all of the focus groups, [we *or* the consultants] will read all of the transcripts and summarize the things [we/they] learn. [We/They] will also use some quotes so that the hospitals can read your own words. [We/They] will not use your name when [we/they] give them those quotes.
 - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
 - We know you have other things to do and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
 - We understand that you may have other things going on [on your end]; we ask that you do the best you can to stay present, and let us know [through the chat] if you absolutely need to step away.
 - If no pre-survey: You have a choice of a \$50 credit to Amazon or [XYZ]. Please [mark your choice on the sign-in sheet *or* chat your email address to my colleague [*name*] now, along with your choice]. If you don't tell [him/her/them] which one you prefer, we'll [give *or* send] you an Amazon credit.
 - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and thoughts, even – especially! – if they aren't the same as everyone else's.
- Any questions before we begin? [If we don't have the answer, commit to finding it and sending later via email.]

HEALTH NEEDS DISCUSSION (50-60 MIN.)

If no pre-survey: Here's a list of health needs in your area from 2022. [*show slide or point to flip chart list*] You'll see that there are regular physical health conditions, like cancer, and other kinds of needs, like a healthy climate, and housing. We're going to read the needs, then take a poll for you to choose the five you think are the most important, or

pressing, in your community. *[Read off needs, then: launch zoom poll or give five sticky dots to each person in the room. Give people a few minutes to complete.]*

*If collected by pre-survey, start here: As a group, you identified [read list] as the most important needs in your community -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you three things [read only **bold text** in Q1-3 on the next page to introduce this section].*

But before we get down to the needs you all chose, I'd like to ask you to share:

What is one thing that you are proud of about your community? How might that relate to the overall health of your community? *[Prompt if needed: For example, maybe your community is a place where the people are welcoming to everyone, which could mean people feel safe living there; or maybe there are lots of ways to enjoy nature here, which could mean it's easy for people to be physically active; or there are good services for people who are in need, which could mean people generally have their basic needs taken care of.]*

After each participant who wants to share has done so: OK, let's move on to talk about the needs you chose.

1. *[If on Zoom, facilitators call on participants one by one.]* "Please say your first name, and then describe **what the need looks like in your community, including what might get in the way** for people to [live healthier lives / have better outcomes: use "have better outcomes" language if need is homelessness, economic stability, violence/safety, or transportation; use "live healthier lives" for all other needs]. You can choose to pass if you didn't vote for the need and don't have anything to say about it." *[Prompts for barriers if they are having trouble thinking of any: Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime, poor access to resources]*
2. This may overlap the previous question, but I'll ask you to identify **what groups of people are better or worse off than others** for that need and explain how or why. *[Prompts for populations if they are having trouble thinking of any: income/education level, housing status, language, immigration status, age, ethnicity [get specific], sexual orientation, gender identity, disability status, geographic location]*
3. Finally, I'll ask you to describe, for that issue, **what you think is most needed** to help your community become healthier / improve everyone's lives *[use "improve lives" language if need is homelessness, economic stability, violence/safety, or transportation; use "help become healthier" for all other needs].*
 - a. What is working already, that could be continued or expanded?
 - i. What would make it easier for people to access these resources?

- b. Formal resources like government agencies and community organizations can help [pause]; so can informal resources like community elders, faith leaders, teachers, and coaches [pause]. They can support good programs that are already happening. Or they can help bring services to your community, that aren't here already.
- c. Thinking of all these organizations and people in your community, **which ones do you think could best help** when it comes to this need?
- d. If you could choose a program, service, or other strategy that's not already here in your community, that you think could help, what would it be? [*Probe if necessary: How could it help?*]

OK, let's get started. For [name first need], [start at Q1; address all three questions, then go back to Q1-3 with second need, then again with third, then go on to the questions below.]

YOUR PERCEPTION OF EQUITY ISSUES (20-25 min.)

You have probably heard the words “cultural competence” before; they mean being able to understand the values and beliefs of people who are different from yourself, so you can communicate with them respectfully.

- 1. We've heard that not all providers know how to care for people in a **culturally competent and respectful** way. What do you think those providers are missing? What do you think they need to learn?

As you probably know, people have been talking about issues of equity now more than ever. “Equity” means fairness and unbiased treatment. When it comes to health care, we'd like to ask about your opinion on equity and cultural competence:

- 2. What do you think gets in the way of everyone having the **same access** to health care?
- 3. What do you think gets in the way of everyone getting the **same quality** of health care?
- 4. What can **hospitals and health systems** do to best address equity for you and the people in your community?

OTHER COMMENTS (time permitting)

Are there any other thoughts or information you would like to share that we have not already talked about?

CLOSING (1 min.)

Thank you for contributing your opinions and experience to the CHNA. The hospitals' CHNA reports will be available on their websites in the second half of 2025. After the assessment, they will be working on their plan for how they will use their resources to improve health and wellness in your county, and those plans will be available in late 2025 or early 2026.

You can contact us if you want any more information about the assessment. If anything occurs to you later that you would like to add, please feel free to send us an email.



Group Name:

Date:

Choose five health-related issues that seem most important to you in your community.

Cancer (of the lungs, breasts, uterine, etc.)	Access to health care (insurance, drug costs, doctor costs)
Climate and environment (heat, polluted air, pollution)	Aging (arthritis, dementia, poor vision, and hearing loss, etc.)
Infectious diseases (flu, COVID, tuberculosis)	Heart disease and stroke (high blood pressure, high cholesterol)
Family and community safety (including intimate partner violence)	Housing, homelessness, eviction, etc.
Diabetes (insulin, diet, vision, amputation, etc.)	Maternal health (prenatal care, high-risk pregnancies)
Income/economy (jobs, childcare, internet access)	Mental health (depression, anxiety, loneliness, isolation)
Education (preschool, vocational education, trainings)	Oral/Dental Health
Food hunger or insecurity (lack of income to buy food, the cost of food, etc.)	Asthma and allergies
Tobacco use (smoking or vaping)	Alcoholism and other drug use
Transportation (public, safe, available, cheap)	Accidents including car accidents, falls, breaks, etc.
Racism and discrimination	Other issues/concerns?



Alameda County Public Health Department Community Forum Worksheet

June –July 2025

Name: _____

Date: _____

Health Needs

Social Determinants of Health		
What Confirms Your Experience?	What Surprised You, or what is different from your experience?	What Are You Wondering?

Behavioral Health		
What Confirms Your Experience?	What Surprised You, or what is different from your experience?	What Are You Wondering?

Chronic Diseases		
What Confirms Your Experience?	What Surprised You, or what is different from your experience?	What Are You Wondering?

Communicable Diseases		
What Confirms Your Experience?	What Surprised You, or what is different from your experience?	What are you wondering?

What Community Input or Concerns Stood Out for You?	
Community Input or Concern	Why did it stand out to you?

Attachment 8: Community Assets and Resources

Health Care Facilities and Agencies

The following health care facilities are available in Alameda County.

HOSPITALS

- Alameda Health System, Alameda Hospital
- Alameda Health System, Fairmont Hospital
- Alameda Health System, Wilma Chan Highland Hospital
- Alameda Health System, John George Psychiatric Hospital
- Alameda Health System, San Leandro Hospital
- Kaiser Foundation Hospital–Fremont
- Kaiser Foundation Hospital–Oakland
- Kaiser Foundation Hospital–San Leandro
- Stanford Health Care Tri-Valley
- Sutter Health Alta Bates Summit Medical Center
- Sutter Health Eden Medical Center
- UCSF Benioff Children’s Hospital Oakland
- Washington Health

FEDERALLY QUALIFIED HEALTH CENTERS

- Asian Health Services (multiple sites)
- Axis Community Health (multiple sites in the Tri-Valley)
- Bay Area Community Health (multiple sites and Mobile Clinics)
- Baywell Health
- Brighter Beginnings
- Davis Street Community Center
- La Clínica (multiple locations)
- LifeLong Medical Care (multiple locations)
- Native American Health Center
- Tiburcio Vásquez Health Center (multiple sites)

OTHER HEALTH CLINICS

- Alameda Health System:
 - Creedon Advanced Wound Care

- Eastmont Wellness
- Fairmont Rehabilitation and Wellness
- Hayward Wellness
- Highland Wellness
- Marina Wellness & Surgical Associates
- Newark Wellness
- Park Bridge Rehabilitation and Wellness
- South Shore Rehabilitation and Wellness
- Ashland Free Medical Clinic
- Center for Elder Independence
- Fremont Hospital mental health clinic
- Kindred long-term acute care and specialized rehabilitation facility
- Order of Malta Clinic
- Roots Community Health Center
- Sutter Health Palo Alto Medical Foundation, Fremont Center
- Washington Township Medical Foundation (multiple sites)

OTHER ORGANIZATIONS

- Alameda County Health Care Services: HealthPAC
- Alameda County Social Services Agency
- Assistance League of the Amador Valley
- East Bay Agency for Children
- Eden I & R, Inc.
- Family Resource Center, Fremont
- George Mark Children's House
- Operation Access
- Rubicon Programs Wellness Services
- Union City Family Center
- Washington Women's Center

Assets and Resources by Identified Health Need/Challenge

The following tables provide the names, summary descriptions, and websites for various health care assets and resources available in Alameda County to address identified health needs. The sets of tables follow the same order as the health needs and challenges are listed in the main body of the report.

CHRONIC CONDITIONS

Asthma

Resource Name	Summary Description	Website	Area
Alameda County Public Health: Asthma Start Program	Works with families of children with asthma by providing in-home case management services, education and support, and developing an action plan to assist families in controlling their children's asthma.	https://acphd.org/asthma/	AC
Breathe California	Promotes lung health through education, advocacy, and support.	https://lungsrus.org/alameda-county/	AC
Regional Asthma Management & Prevention (RAMP)	Advocates for policy and systems changes targeting the root causes of asthma disparities.	https://rampasthma.org/	AC

Cancer

Resource Name	Summary Description	Website	Area
American Cancer Society	Aims to freeing the world from cancer by funding and conducting research, sharing expert information, supporting patients, and spreading the word about prevention.	https://www.cancer.org/	AC
CancerCare	Professional oncology social workers provide free emotional and practical support for people with cancer, caregivers, loved ones and the bereaved.	https://www.cancercare.org/	AC

Resource Name	Summary Description	Website	Area
Every Woman Counts	Run by the California Department of Health Care Services, provides free breast and cervical cancer screening and diagnostic services to California's underserved populations.	https://www.dhcs.ca.gov/services/Cancer/ewc/Pages/default.aspx	AC
HERS Breast Cancer Foundation	Supports all individuals healing from breast cancer by providing post-surgical products and services regardless of financial status.	https://hersbreastcancerfoundation.org/	South, Mid, TV
The Leukemia and Lymphoma Society	Strives to find a cure for leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families.	https://www.lls.org/	AC
Tobacco Control Coalition of Alameda County	Grassroots coalition of educators, professionals, and community members that works to prevent, reduce, and limit tobacco use in Alameda County through education, advocacy, and policy.	https://tobaccofreealamedacounty.org/	AC
Women's Cancer Resource Center	Helps women with cancer improve their quality of life through education, practical assistance, and support services.	https://www.wcrc.org/	AC

Cognitive Decline

Resource Name	Summary Description	Website	Area
Age-Friendly Alameda County	Website provides access to local services, information about current programmatic and policy efforts to support older adults in the county, and resources to learn more about public policy and ways be heard.	https://agefriendly.acgov.org/index.page	AC

Resource Name	Summary Description	Website	Area
Alameda County Adult & Senior Services	Central repository for links to resources and services for older adults, including hotline for elder abuse.	https://www.acgov.org/adults/adults.htm	AC
Alameda County Social Services Agency, Area Agency on Aging	Provides Adult Day Care, Family Caregiver Support programs, Food and Nutrition programs, Legal Assistance, Senior Information and Assistance, Long Term Care Ombudsman Services, Senior Center Services and Visiting.	https://www.alamedacounty-socialservices.org/our-services/Seniors-and-Disabled/Area-Agency-on-Aging/Area-agency-on-aging	AC
Alameda County Social Services Agency, Department of Adult & Aging Services	Coordinated service delivery system that protects, supports, and advocates for an aging population.	https://socialservices.alamedacountyca.gov/our-services/Seniors-and-Disabled/Seniors-and-Disabled	AC
Alameda County Social Services Agency, In-Home Supportive Services Program	Provides assistance to older adults and individuals with disabilities, who without this care, would be unable to remain safely in their home.	https://socialservices.alamedacountyca.gov/our-services/Seniors-and-Disabled/IHSS/In-Home-Supportive-Services	AC
Alzheimer's Association (Northern California & Northern Nevada chapter)	Offer support to anyone facing Alzheimer's, advocates for the needs and rights of those facing dementia, and advances critical research, to work toward methods of treatment, prevention, and ultimately, a cure.	https://www.alz.org/ https://www.alz.org/norcal	AC
Alzheimer's Services of the East Bay	Provides services for individuals with dementia, as well as for their families, including Adult Day Care, Family Support, and Education & Community Outreach Services.	https://aseb.org	AC

Resource Name	Summary Description	Website	Area
Bay Area Caregiver Resource Center	Provides services to family caregivers of adults with physical and cognitive impairments, such as Parkinson's, stroke, Alzheimer's and other types of dementia. Services include assessment, care planning, direct care skills, wellness programs, respite services, and legal/financial consultation vouchers.	https://www.caregiver.org/	AC
Various cities' Aging & Family Services agencies	Advocate for and provide assistance to older adults and individuals with disabilities.		AC

Diabetes and Obesity

See Social Determinants of Health, Economic Security: Food Security for free food resources.

Resource Name	Summary Description	Website	Area
Alameda County Women, Infants, and Children (WIC)	Promotes healthy eating via nutrition advice, help with breastfeeding, referrals to services, and special checks to buy healthy food items.	http://www.acphd.org/wic.aspx	AC
Alameda County Public Health Department – Nutrition Services	Promotes and supports healthy eating and physical activity.	https://acphd.org/nutrition-services/programs/	AC
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh (“food stamps”), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance.	https://socialservices.alameda-county.ca.gov/our-services/Health-and-Food/index	AC

Resource Name	Summary Description	Website	Area
American Diabetes Association	Educates people about ways to live healthier lives and support friends and loved ones living with diabetes.	https://diabetes.org/local/northern-california	AC
California State University, East Bay, Hayward Promise Neighborhood	Through collaborative partnership, offers over 35 programs that serve residents, families, children, and students in the Hayward area to ensure educational success and a safe, healthy, thriving community	http://www.csueastbay.edu/haywardpromise	Mid
Centro de Servicios	Offers weekly food distribution to the hungry.	https://centrouc.org/	South
East Bay Regional Park District	Conserves open space resources and provide outdoor recreational opportunities for present and future generations.	https://www.ebparks.org/	AC
Fremont Family Resource Center	Combines the best efforts of multiple social services programs, including food assistance and referrals to older adult services	https://www.fremont.gov/government/department/s/human-services/fremont-family-resource-center	South
Senior Support Program of the Tri-Valley	Provides programming and referrals for older adults, including case management, 1:1 counseling and emotional support, and wellness education (e.g., nutrition, fitness).	https://seniorservicescoalition.org/senior-support-program-of-the-tri-valley/	TV
Solid Rock Community Services, Newark	Provides resources, food, health/wellness and family reunification services to improve the quality of life for families in Alameda County to ensure basic needs are met.	https://solidrockcommunityservices.org/	South
Union City Family Center	Provides multiple supports including food distribution and partners with mobile health clinic.	https://www.unioncityfamilycenter.org/	South

Resource Name	Summary Description	Website	Area
Viola Blythe Community Service Center of Newark	Distributes emergency food and clothing, makes referrals to other social services agencies.	https://www.violablythe.org/	South
Various cities' Parks and Recreation Departments	Promote healthy living by providing accessible, free, or low-cost opportunities for physical activity.		AC

Heart Disease and Stroke

See Economic Security: Food Security for free food resources.

Resource Name	Summary Description	Website	Area
Alameda County Public Health Department – Nutrition Services	Promotes and supports healthy eating and physical activity.	https://acphd.org/nutrition-services/programs/	AC
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh (“food stamps”), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance.	https://socialservices.alamedacountyca.gov/our-services/Health-and-Food/index	AC
American Heart Association	Strives to prevent and cure heart disease.	https://www.heart.org/en/affiliates/california/northern-california	AC
American Stroke Association	Resource for evidence-based information on stroke, post-stroke recovery, and caregiver info.	https://www.stroke.org/en/	AC
California State University, East Bay, Hayward Promise Neighborhood	Through collaborative partnership, offers over 35 programs that serve residents, families, children, and students in the Hayward area to ensure educational success and a safe, healthy, thriving community.	http://www.csueastbay.edu/haywardpromise	Mid

Resource Name	Summary Description	Website	Area
Centro de Servicios	Offers weekly food distribution to the hungry.	https://centrouc.org/	South
East Bay Regional Park District	Conserves open space resources and provides outdoor recreational opportunities for present and future generations.	https://www.ebparks.org/	AC
Fremont Family Resource Center	Combines the best efforts of multiple social services programs, including food assistance and referrals to older adult services.	https://www.fremont.gov/government/department/s/human-services/fremont-family-resource-center	South
Senior Support Program of the Tri-Valley	Provides programming and referrals for older adults, including case management, 1:1 counseling and emotional support, and wellness education (e.g., nutrition, fitness).	https://seniorservicescoalition.org/senior-support-program-of-the-tri-valley/	TV
Solid Rock Community Services, Newark	Provides resources, food, health/ wellness and family reunification services to improve the quality of life for families in Alameda County to ensure basic needs are met.	https://solidrockcommunityservices.org/	South
Union City Family Center	Provides multiple supports including food distribution and partners with mobile health clinic.	https://www.unioncityfamilycenter.org/	South
Viola Blythe Community Service Center of Newark	Distributes emergency food and clothing, makes referrals to other social services agencies.	https://www.violablythe.org/	South
Various cities' Parks and Recreation Departments	Promote healthy living by providing accessible, free, or low-cost opportunities for physical activity.		AC

Heart Disease and Stroke, Healthy Lifestyles: Senior Centers in Alameda County

Name	Location	Website
Age Well Center at South Fremont	Fremont	https://www.fremont.gov/government/departments/human-services/age-well-centers
Age Well Center at Lake Elizabeth	Fremont	https://www.fremont.gov/government/departments/human-services/age-well-centers
Alameda Mastick Senior Center	Alameda	https://www.alamedaca.gov/Departments/Recreation-Parks/Mastick-Senior-Center
Albany Senior Center	Albany	https://www.albanyca.org/recreation/senior-center
City of Dublin Senior Center	Dublin	https://www.dublin.ca.gov/1053/Senior-Center
City of Union City	Union City	https://www.unioncity.org/289/Ralph-and-Mary-Ruggieri-Senior-Center
Downtown Oakland Senior Center	Oakland	https://www.oaklandca.gov/topics/downtown-oakland-senior-center
East Bay Korean Senior Citizen Center	Oakland	https://eastbaykoreanamericanseniorcenter.org/index.html
East Oakland Senior Center	Oakland	https://www.oaklandca.gov/topics/east-oakland-senior-center
Emeryville Senior Center	Emeryville	https://www.emeryville.org/Recreation/50-Adults-Services
Fruitvale-San Antonio Senior Center	Oakland	https://unitycouncil.org/program/senior-center/
Hayward Area Senior Center	Hayward	https://www.haywardrec.org/Facilities/Facility/Details/Hayward-Area-Senior-Center-93
Judge Henry Ramsey Jr. South Berkeley Senior Center	Berkeley	https://berkeleyca.gov/community-recreation/seniors/senior-centers/judge-henry-ramsey-jr-south-berkeley-senior-center
Kenneth C. Aitken Senior Center	Castro Valley	https://haywardrec.org/facilities/facility/details/Kenneth-C-Aitken-Senior-Community-Center-89

Name	Location	Website
LARPD Senior Services Center	Livermore	https://www.larpd.org/senior-services
North Berkeley Senior Center	Berkeley	https://berkeleyca.gov/community-recreation/seniors/senior-centers/north-berkeley-senior-center
North Oakland Senior Center	Oakland	https://www.oaklandca.gov/topics/north-oakland-senior-center
Pleasanton Senior Center	Pleasanton	https://www.cityofpleasantonca.gov/your-community/recreation/senior-services/
San Leandro Senior Community Center	San Leandro	https://www.sanleandro.org/517/Senior-Services
West Oakland Senior Center	Oakland	https://www.oaklandca.gov/topics/west-oakland-senior-center

SOCIAL DETERMINANTS OF HEALTH

Health Care Access and Quality

See also Health Care Facilities and Agencies listed on the second page of this attachment.

Resource Name	Summary Description	Website	Area
Alameda County Health Care for the Homeless	Increases access to quality health care for homeless individuals through free health centers and mobile clinics that provide primary care, substance abuse treatment, and other services.	https://www.achch.org/	AC
Alameda County Health Care Services, School Health Services	Provides school districts an array of school-based, school-linked health and wellness services for youth and families, and partner with school districts to build school-based health and wellness systems.	https://achealthyschools.org/	AC
Alameda County Public Health: Family Health Services Black Infant Health Program	Helps reduce stress, build resilience, promote healthy behaviors, and increase social support among pregnant and mothering Black women, and build a community that stands up against the injustices towards African-American women and their birthing experiences.	https://acphd.org/programs-and-services/black-infant-health/	AC
Bay Area Legal Aid	Improves access to the civil justice system through legal assistance for low- income individuals.	https://baylegal.org/	AC
Baywell Health	Parent organization of West Oakland Health Center, FQHC with multiple locations that offers medical and dental care as well as behavioral health and other services.	https://baywellhealth.org/	North
California Department of Health Care Services	Helps low-income and disabled people get access to affordable, integrated, high- quality health care, including medical, dental, mental health, and substance use	https://www.dhcs.ca.gov/	AC

Resource Name	Summary Description	Website	Area
	treatment services, as well as long-term care.		
Center for Healthy Schools and Communities	Provides integrated health and wellness services (medical, dental, behavioral health, health education, and youth development) in 29 school health centers throughout Alameda County.	https://achealthyschools.org/project_s	AC
DayBreak Adult Care	Assists Alameda County seniors with accessing and navigating their care needs.	www.daybreakac.org	AC
Eden I&R, Inc.	Connects individuals in need with human services agencies.	http://edenir.org/	Mid
George Mark Children's Home	Provides pediatric nursing and other support services to children with complex medical conditions.	https://georgemark.org/	Mid
Jewish Family and Community Services East Bay	Promotes the well-being of individuals and families of all ages, races, and religions with essential mental health and social services at every stage of life.	https://jfcs-eastbay.org/	AC
Operation Access	Enables Bay Area health care providers to donate surgical and specialty care to people in need.	https://www.operationaccess.org/	AC
Ronald McDonald Care Mobile Dental Clinic	Provides pediatric health services for underserved populations through health education and treatment and referral services.	https://rmhcbayarea.org/what-we-do/ronald-mcdonald-care-mobile/	AC
United Seniors of Oakland and Alameda County	Offers programs for older adults to educate, mobilize and enable seniors and their supporters to address the issues that affect their quality of life.	https://www.usoac.org/	AC / North

Access: Transportation

Resource Name	Summary Description	Website	Area
Alameda Alliance For Health Medi-Cal Transportation Benefit	Transportation services offered via the Alliance's transportation provider, ModivCare. There is no cost when transportation is authorized by the Alliance.	https://alamedaalliance.org/members/medi-cal/benefits-and-covered-services/	AC
Alameda–Contra Costa Transit District (AC Transit)	Provides regional bus service.	http://www.actransit.org/	AC
Bay Area Rapid Transit (BART)	Provides elevated and subway rail travel across Bay Area counties.	https://www.bart.gov/	AC
Bay Wheels	Offers an affordable, accessible mode of transportation via a bicycle-sharing service (operated by Lyft), with discounted memberships for low-income individuals.	https://www.lyft.com/bikes/bay-wheels	AC
Bike East Bay	Promotes a healthy, sustainable community by making cycling safe, fun and accessible.	https://bikeeastbay.org/	AC
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information	http://edenir.org/	Mid
Paratransit	Provides public transit service for people who are unable to use regular buses or trains because of a disability or a disabling health Condition.	https://www.eastbayparatransit.org/	AC
Ride-On Tri-City!	Provides a number of transportation and mobility support services for seniors and people with disabilities residing in Fremont, Newark, and Union City.	https://www.fremont.gov/government/departments/human-services/transportation-mobility	South

Resource Name	Summary Description	Website	Area
Union City Transit	Local, city-run bus system.	https://www.unioncity.org/170/Union-City-Transit	South

Economic Stability

See Food Security sub-section for free food resources.

Resource Name	Summary Description	Website	Area
Abode Services: Project Independence	Provides young adults leaving the foster care system with supportive housing and services aimed at helping them achieve self-sufficiency and stability in their lives, including case management, education and vocational training, employment placement, and financial literacy training.	https://abode.org/services	AC
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh (“food stamps”), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance.	https://www.alamedasocialservices.org	AC
America Works	Provides work readiness training, vocational training, career placement, career advancement, and employment retention services. Serves individuals in both San Francisco and Alameda County.	https://americaworks.com/	AC
Bay Area Legal Aid	Increases access to the civil justice system through legal assistance for low-income individuals.	https://baylegal.org/ Legal advice line: 1-800-551-5554	AC

Resource Name	Summary Description	Website	Area
Berkeley City College CalWORKs Program	Provides academic support for CalWORKs participants to succeed in both their educational and employment goals, including childcare assistance and work-study opportunities.	https://www.berkeleycitycollege.edu/calworks/	North
Building Opportunities for Self-Sufficiency	Operates programs and services designed to empower homeless, poor, and disabled individuals to become self-sufficient.	https://self-sufficiency.org/	AC
California State University, East Bay, Hayward Promise Neighborhood	Through collaborative partnership, offers over 35 programs that serve residents, families, children, and students in the Hayward area to ensure educational success and a safe, healthy, thriving community.	http://www.csueastbay.edu/haywardpromise	Mid
Centro de Servicios	Weekly food distribution to the hungry, community thrift store, assistance for veterans, job placement assistance.	https://centrouc.org/	South
Citizens for Better Community	Student internship program; business networking for Chinese community.	https://www.cbcsfbay.org/	South
Clausen House	Provides housing, wellness programs, and advocacy for developmentally disabled adults in Oakland and the surrounding East Bay area.	https://clausenhouse.org/	North
Community Resources for Independent Living	Focuses on providing disabled individuals with peer-based resources and advocacy to improve their lives and their ability to navigate their environment.	http://www.crilhayward.org/	AC
DeafPlus	Integrated adult day program that serves deaf adults with disabilities, including support	https://deafplus.us/	South

Resource Name	Summary Description	Website	Area
	necessary to gain access to employment and education.		
Davis Street Community Center	Provide programs and services encompassing: primary care (including medical, dental, pediatric, behavioral health and women’s health services), child care, programs for adults living with developmental disabilities, free food and clothing, housing information, utility assistance and more.	https://www.davisstreet.org	Mid
East Bay Asian Local Development Corporation	EBALDC assists families and individuals to stabilize their financial situations and develop asset-building tools as part of its work with and for the diverse populations of the East Bay to build healthy, vibrant, and safe neighborhoods through community development.	https://ebaldc.org/	AC
East Bay Community Foundation	Supports entrepreneurs of color through community-controlled and democratically governed loan fund for businesses with a strong social mission; funds economic justice nonprofits and impact investing.	https://www.ebcf.org/	AC
East Bay Community Law Center	Addresses the underlying causes of poverty and economic and racial inequality to improve opportunities in economic security, education, health and welfare, housing, and immigration.	https://ebclc.org/	AC
East Bay Works	Partners with job centers, economic developers, support service providers, and educational entities to provide benefits and services to	http://www.eastbayworks.com/	AC

Resource Name	Summary Description	Website	Area
	employers, job seekers and youth ages 16–24 at no cost.		
East Oakland Collective	Supports various programs including lending circles and financial literacy education.	https://www.eastoaklandcollective.com/	North
East Oakland Youth Development Center	Develops the social and leadership capacities of youth and young adults ages 6–24 so that they are prepared for employment, higher education, and leadership roles.	http://eoydc.org/	North
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information.	http://edenir.org/	Mid
First Place for Youth	Supports youth, particularly those in foster care, in developing self-sufficiency and a sense of purpose by offering housing and case-management services.	https://www.firstplaceforyouth.org	AC
Give Teens 20 / Nav Z	Website with self-sufficiency resources for teens.	https://gt20.org/	AC
Hidden Genius Project	Focuses on increasing diversity in the workforce and transforming communities by mentoring black male youth in technology creation, entrepreneurship, and leadership skills.	https://www.hiddengeniusproject.org/	AC
Hively	Provides help with affordable child care options and offers basic children’s necessities (clothing, shoes, diapers, wipes) to families in need.	https://behively.org	North, TV
The Hub Family Resource Center	Assistance with obtaining Medi-Cal, Cal Fresh (food stamps), health insurance, CalWORKs, job search, child support paperwork, application	https://www.husd.us/departments/sfs/student-and-parent-support-programs/the-hub	Mid

Resource Name	Summary Description	Website	Area
	assistance with EDD, USDI, SSI, Family Leave, etc.		
Lao Family Community Development	Extensive menu of quality specialized jobs and career and employment programs.	https://lfcd.org/	North
Narika Seed Program	Job training program to foster economic independence and self-reliance among survivors of domestic violence and new immigrant populations that are particularly vulnerable to abuse and exploitation.	https://www.narika.org/seed-program-1	AC
One-Stop Career Center (EDD)	Offers free help to job seekers, including employment and training assistance, and serves a range of specialized clients including veterans, youth, laid-off workers, and employers.	https://www.careeronestop.org/LocalHelp/AmericanJobCenters/find-american-job-centers.aspx	multi
Rising Sun Center for Opportunity	Provides green training, employment, and residential energy-efficiency services.	https://risingsunopp.org	AC
Rubicon Programs	Equips East Bay residents with resources to break the cycle of poverty.	http://rubiconprograms.org/	AC
Solid Rock Community Services	Solid Rock Community Services provides resources, food, health/wellness and family reunification services to improve the quality of life for families in Alameda County to ensure basic needs are met.	https://solidrockcommunityservices.org/	South
Tri-Valley Haven	Offers services to survivors of domestic violence, sexual assault and homelessness, including financial assistance for survivors.	https://trivalleyhaven.org/	TV
Tri-Valley Seek and Save	Providing for utilities, rent, groceries, clothing, and other	https://www.trivalleyseekandsave.org/	TV

Resource Name	Summary Description	Website	Area
	living essentials on a case-by-case basis.		
United Way: SparkPoint Centers	Centers assist families and individuals with financial stability, employment and skills training, and more. Locations in Alameda County include Fremont, Hayward, Oakland, and Union City.	https://uwba.org/what-we-do/sparkpoint-program/	AC
Unity Council	Helps families and individuals build wealth and assets through sustainable economic, social, and neighborhood development programs.	https://unitycouncil.org/	AC
Youth Spirit Artworks	Engages homeless and low-income individuals in artistic jobs and training to help them develop skills, experience, and self-confidence.	http://youthspiritartworks.org/	AC
Various cities' Human Services Departments	Agencies may foster employment by offering job readiness training, career counseling, resume building, and interview preparation to help residents find work; and may promote economic independence and reduce poverty by partnering with agencies to provide job placement, vocational training, and support services such as childcare and transportation for eligible individuals.		AC

Economic Stability: Education

Also see overall Economic Stability for resources.

Resource Name	Summary Description	Website	Area
Alameda County Early Head Start and Head Start	Provides child development and family support services to facilitate children's health and education.	https://www.alamedafsa.org/early-childhood-and-family-support	AC
Alameda County Library	Offers family literacy days and free 1:1 learning for reading, writing, and speaking English better.	https://aclibrary.org/	AC
Alameda County Office of Education	Oversees school districts' budgets and educational plans, serves as a school district, and provides programs to the county's most vulnerable students. Also provides training and support services for educators.	https://www.acoe.org/	AC
Alameda County Tri-City Children and Youth Service	Trains current graduate students in counseling and social work.	https://www.acbhcs.org/plan-administration/intern-and-trainee-programs-acbh-tri-city-children-and-youth-services/	South
Berkeley City College	Community college that provides instruction, student support and learning resources which enable students to earn associate degrees and certificates, and to attain college competency, careers, transfer, and skills for lifelong success.	https://www.berkeleycitycollege.edu/	North
Boys and Girls Clubs of San Leandro	Provides a variety of recreational programs for children and youth, also after-school kinder care in elementary schools.	http://bgcsl.org/	Mid

Resource Name	Summary Description	Website	Area
Brighter Beginnings: Family Partnership Program	Home visiting program designed to help families in CalWORKs who have infants and children under 3 years old participate.	https://www.brighter-beginnings.org/programs/parenting-and-child-development/family-partnership-program/	AC
Center for Early Childhood Connections	Social groups for parents and children, parent coaching and mentorship, assessments for 0-5, educational and non-clinical services for 0-8 and their caregivers.	http://www.thececc.org	North
Chabot College	Community college that offers educational programs and experiences for students to succeed in their education, progress in the workplace, and engage in the civic and cultural life of the community.	https://www.chabotcollege.edu/about/	Mid
College of Alameda	Community college that provides comprehensive and flexible programs and resources that empower students to achieve their goals.	https://alameda.edu/	North
Castro Valley Education Foundation	CVEF provides resources and programs that support academic opportunities in Castro Valley Unified School District.	https://www.cvef.org/	Mid
California State University, East Bay, Hayward Promise Neighborhood	Through collaborative partnership, offers over 35 programs that serve residents, families, children, and students in the Hayward area to ensure educational success and a safe, healthy, thriving community.	http://www.csueastbay.edu/haywardpromise	Mid
Catholic Charities of the East Bay	Offers services to aid youth, children, and families facing difficulties with immigration, eviction, literacy, or surviving traumatic violence.	https://www.cceb.org/	AC

Resource Name	Summary Description	Website	Area
Community Child Care Council (4C's) of Alameda County	Strengthens children and families by helping parents find and pay for affordable child care.	https://www.4c-alameda.org	AC
DayBreak Adult Care	Provides education, training, and support for family caregivers.	www.daybreakac.org	AC
Eden Area ROP	Provides Career Technical Education (CTE) to high school students in CVUSD, HUSD, SLUSD, and SLzUSD. Provides CTE for Adults throughout Bay Area.	https://www.edenrop.org/	Mid
Davis Street Community Center	Supports children and families through State Subsidized Alternative Payment Program (APP) and child development centers.	https://www.davisstreet.org	AC
Eden Youth and Family Center	Provides services to promote the health and socioeconomic well-being of children, youth, and families.	http://www.eyfconline.org/	Mid
First 5 Alameda	Provide funding and programming for childcare and learning (e.g., parenting classes, childcare provider training), as well as advocacy and partnership.	https://first5alameda.org/	AC
Fremont Education Foundation	Provides grants to classroom teachers, music education, and other efforts in Fremont Unified School District.	https://www.fremont-education.org/	South
Fremont Family Resource Center	Combines the best efforts of multiple social services programs, including educational events and child care information and subsidies.	https://www.fremont.gov/government/departments/human-services/fremont-family-resource-center	South

Resource Name	Summary Description	Website	Area
Friends of Children with Special Needs	Provides information and assistance to children with special needs, adults with special needs, and their communities.	https://fcsn1996.org/	South
Give Teens 20 / NavZ	Website with self-sufficiency resources for teens, including information on funding for college.	https://gt20.org/	AC
Hidden Genius Project	Focuses on increasing diversity in the workforce and transforming communities by mentoring black male youth in technology creation, entrepreneurship, and leadership skills.	http://www.hiddengeniusproject.org/	
Hively	Provides education and training to child care providers and helps families find and pay for child care that promotes early childhood development and learning.	https://behively.org/	AC
Laney College	Community college that provides certificates, degrees, transfer pathways, career education, and lifelong learning opportunities.	https://laney.edu/	North
Las Positas College	Community college that offers curriculum for students seeking career preparation, transfer to a four-year college or university, or personal enrichment.	https://laspositascollege.edu/	TV
Merritt College	Community college that provides rigorous and engaging in-person and remote learning experiences that support students' desired academic and personal achievements.	https://www.merritt.edu/	North

Resource Name	Summary Description	Website	Area
Mission Valley ROP	Provides career training for successful business, medical, and technical careers.	https://www.mvrop.org/	South
New Haven Schools Foundation	Administers an annual grant program that provides funding for innovative classroom and enrichment programs in the New Haven School District.	https://nhsfoundation.org/	South
Newark Education Foundation	Supports major initiatives and programs in Science, Technology, and the Arts for the Newark Unified School District.	https://newarkeducationalfoundation.org/	South
Ohlone Community College	Community college that provides excellent instruction and support services, awards associate degrees and certificates, and promotes university transfer.	https://www.ohlone.edu/	South
San Leandro Education Foundation	Funds positive youth development activities in the San Leandro community.	https://www.sledfund.org/	Mid
Tri-Valley ROP	Offers high school students in the Tri-Valley hands-on career-technical education classes that explore careers and/or college majors and develop job skills and a robust Middle College High School Program.	https://www.tvrop.org/	TV
Union City Family Center	Bilingual story time, kinder readiness programs for families with children ages 0-5 who reside in Union City and New Haven Unified School District boundaries.	http://www.unioncityfamilycenter.org	South

School Districts in Alameda County

School District	Location	Website
Alameda USD	Alameda	https://www.alamedaunified.org
Albany USD	Albany	https://www.ausdk12.org/
Berkeley USD	Berkeley	https://www.berkeleyschools.net/
Castro Valley USD	Castro Valley	https://www.cv.k12.ca.us/
Dublin USD	Dublin	https://www.dublin.k12.ca.us/
Emeryville USD	Emeryville	https://emeryusd.k12.ca.us/
Fremont USD	Fremont	https://fremontunified.org/
Hayward USD	Hayward	https://www.husd.us/
Livermore Valley Joint USD	Livermore	https://www.livermoreschools.org/
Newark USD	Newark	https://www.newarkunified.org/
New Haven USD	Union City	https://mynhusd.org/
San Leandro USD	San Leandro	https://www.sanleandro.k12.ca.us/
San Lorenzo USD	San Lorenzo	https://www.slzsd.org/
Oakland USD	Oakland	https://www.ousd.org/
Piedmont USD	Piedmont	http://www.piedmont.k12.ca.us/
Pleasanton USD	Pleasanton	https://www.pleasantonusd.net/

Economic Stability: Food Security

Also see overall Economic Stability for resources.

Resource Name	Summary Description	Website	Area
18 Reasons	Empowers community members with the confidence to buy, cook, and eat good food every day.	https://18reasons.org/	AC
Acta Non Verba	Provides urban farming opportunities for children, youth, and families in East Oakland to deepen their understanding of nutrition, food production, and healthy living, and strengthen their ties to the community.	https://anvfarm.org/	North
Alameda County Community Food Bank	Pursues a hunger-free community by conducting food distribution services, CalFresh outreach, youth and student nutrition programs, and mobile produce stands at health-delivery centers.	https://www.accfb.org/	AC
Alameda County Food Resources	Lists community groups providing food assistance.	https://www.needhelppayingbills.com/html/alameda_county_food_banks.html	AC
Alameda County Deputy Sheriffs' Activities League	Collaborates with Alameda County adults and youth on initiatives to reduce crime and improve community health.	https://www.acdsal.org/	AC
Alameda County Public Health Department	Offers community-based activities that engage residents and local partners in the planning, evaluation, and implementation of health activities.	http://www.acphd.org/	AC
Alameda County Public Health Department – Nutrition Services	Promotes and supports healthy eating and physical activity.	https://acphd.org/nutrition-services/	AC

Resource Name	Summary Description	Website	Area
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh (“food stamps”), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance.	https://www.alamedasocialservices.org	AC
Alameda County Women, Infants, and Children (WIC)	Promotes healthy eating via nutrition advice, help with breastfeeding, referrals to services, and special checks to buy healthy food items.	http://www.acphd.org/wic.aspx	AC
Axis Community Health WIC Program	Provides eligible women and children with programming that supports better nutrition, offers supplemental food, and makes referrals to health care and other community services.	https://axishealth.org/wic/	TV
Catholic Charities of the East Bay	Offers services to aid youth, children, and families facing difficulties with immigration, eviction, literacy, or surviving traumatic violence.	https://www.cceb.org/	AC
Daily Bowl	Recovers excess food that would otherwise go to waste and delivers it to Bay Area agencies that feed families who are hungry.	https://dailybowl.org/	AC
Davis Street Community Center	Provides emergency food, clothing, utility assistance and housing support.	https://www.davisstreet.org	AC
First 5 Alameda County	Provide funding, programming, advocacy, and partnership to support children aged 0-5 and their families, including ensuring basic resources such as food.	https://first5alameda.org/	AC
Fremont Family Resource Center	Combines the best efforts of multiple social services programs, including food assistance.	https://www.fremont.gov/government/departments/human-services/fremont-family-resource-center	South

Resource Name	Summary Description	Website	Area
Fresh Approach	Improves healthy food access in the community through farmers markets, community gardens, and cooking and nutrition classes.	https://www.freshapproach.org/	AC
Mandela MarketPlace	Builds health, wealth, and assets in low- income communities by creating local food enterprises.	https://www.mandelapartners.org/	AC
Meals on Wheels of Alameda County	Delivers nutritious meals to, and performs wellness checks on, frail and/or homebound seniors.	https://www.feedingseiors.org/	AC
Open Heart Kitchen	Provides equitably access to nutritious food today, while building a food secure tomorrow. Community meals, senior center meals, pop-up pantries, and Open Heart Food Bank.	https://www.openheartkitchen.org/	TV
Senior Support Program of the Tri-Valley	Provides programming and referrals for older adults, including case management, 1:1 counseling and emotional support, and wellness education (e.g., nutrition, fitness).	https://seniorservicescoalition.org/senior-support-program-of-the-tri-valley/	TV
Solid Rock Community Services	Solid Rock Community Services provides resources, food, health/wellness and family reunification services to improve the quality of life for families in Alameda County to ensure basic needs are met.	https://solidrockcommunityservices.org/	South
South Hayward Parish Emergency Food Pantry	Food pantry serves thousands of pounds of food per month.	https://www.southhaywardparish.org/food-pantry	Mid/ South
Spectrum Community Services: Meals on Wheels, Senior Meals	Meals on Wheels offers healthy, home-delivered meals for seniors who are unable to prepare their own food and have difficulty with mobility; Senior Meals distributes freshly prepared, nutritious meals to various Alameda County	https://www.spectrumcs.org/senior-services	AC

Resource Name	Summary Description	Website	Area
	locations where registered seniors can pick them up.		
The East Oakland Collective	Supports various programs including food distribution.	https://www.eastoklandcollective.com/	North
Tri-City Volunteers Food Bank & Thrift Store	Provides food assistance to the residents of Alameda County; largest client-direct food bank in the area, with marketplace, mobile pantry, and bag lunch program.	https://tcfvfoodbank.org/	South
Tri-Valley Haven for Women: Food Pantry	Provides free groceries, fresh fruit and veggies to low-income Tri-Valley residents.	https://trivalleyhaven.org/food-pantry/	TV
Tri-Valley Seek and Save	Providing for groceries and other living essentials on a case-by-case basis.	https://www.trivalleyseekandsave.org/	TV
United Way: SparkPoint Centers	Centers assist families and individuals with financial stability, food security, and more. Locations in Alameda County include Fremont, Hayward, Oakland, and Union City.	https://uwba.org/what-we-do/sparkpoint-program/	AC
Union City Family Center	Provides multiple supports including food distribution.	https://www.unioncityfamilycenter.org/	South
Viola Blythe Community Service Center of Newark	Distributes emergency food and clothing, makes referrals to other social services agencies.	https://www.violablythe.org/	South

Peaceful Communities

Resource Name	Summary Description	Website	Area
A Safe Place	Provides domestic violence shelter and services.	https://www.asafeplace.org/	AC
Afghan Coalition	Supports and empowers Afghani refugee families, women, and youth to achieve health and wellness.	https://www.afghancoalition.org/	AC

Resource Name	Summary Description	Website	Area
Alameda County Court Appointed Special Advocates	Promotes and supports quality volunteer advocates to speak for the best interests of abused and neglected children in the dependency court system.	https://casaofalamedacounty.org/	AC
Alameda County Deputy Sheriffs' Activities League	Collaborates with residents on initiatives that reduce crime and improve community health.	https://www.acdsal.org/	AC
Alameda County District Attorney Accountability Table	Coalition of Alameda County-based organizations that work together to advance public safety solutions.	https://acaccountability.org	AC
Alameda County Family Justice Center	Ensures the safety, healing, and self-empowerment of victims of interpersonal violence through supportive services related to counseling, trauma recovery, and resource referral.	http://www.acfjc.org/	AC
Alameda Family Services	Offers programs to improve the emotional, psychological, and physical health of children, youth and families.	https://www.alamedafs.org/	AC
Alternatives in Action	Offers school and community programs for youth.	https://www.alternativesinaction.org/	AC
Bananas	Supports families and individuals with children by providing referrals to childcare, education around reimbursement for childcare, and workshops for parents.	https://bananasbunch.org/	AC
Alameda Health System, Sexual Assault & Domestic Violence Program (SARRT)	Extends 24/7 trauma-informed comprehensive support to survivors of sexual assault, domestic violence, and human trafficking, aged 14 and above, including their families.	https://www.alamedahealthsystem.org/sarrt/	AC
Berkeley Youth Alternatives	Helps at-risk youth through programs that emphasize education, health and well-	https://www.byasonline.org/	North

Resource Name	Summary Description	Website	Area
	being, and economic self-sufficiency.		
Boys and Girls Clubs	Provide mentorship, programming (including sports, arts, wellness, and leadership), and safe places for young people.	https://www.bgca.org/	Mid, North
Building Futures	Provides a continuum of care through residential programs, crisis lines, and case management to help county residents build a future free of violence and homelessness.	http://www.bfwc.org/	AC
Calico Center	Works with law enforcement officers, child welfare workers, prosecutors, and other professionals to achieve justice for abused children by investigating abuse allegations and eliciting testimony from children.	https://www.calicocenter.org/	AC
Catholic Charities of the East Bay	Offers services to aid youth, children, and families facing difficulties with immigration, eviction, literacy, or surviving traumatic violence.	https://www.cceb.org/	AC
Center for Human Development	Facilitates the growth and strengthening of communities by providing services for at-risk youth, individuals, and families.	http://chd-prevention.org/	AC
Community Violence Solutions	Works to end sexual assault and family violence by providing services to survivors of sexual assault or abuse and their families.	https://cvsolutions.org/	AC
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information.	http://edenir.org/	Mid

Resource Name	Summary Description	Website	Area
Eden Youth and Family Center	Provides services to promote the health and socioeconomic well-being of children, youth, and families.	http://www.eyfconline.org/	Mid
Ella Baker Center for Human Rights	Organizes to shift resources away from prisons and punishment towards opportunities that make our communities safe, healthy, and strong.	https://ellabakercenter.org/	North
Exonerated Nation	Helps exonerated formerly incarcerated individuals transition to life outside prison.	https://exoneratednation.org/	AC
Family Support Services	Assists families who face serious challenges in successfully caring for their children.	https://fssba.org/	AC
Family Violence Law Center	Helps diverse communities in Alameda County heal from domestic violence and sexual assault, advocating for justice and healthy relationships.	https://fvlc.org/	AC
Fresh Lifelines for Youth	Prevents juvenile crime and incarceration through legal education, leadership training, and one-on-one mentoring.	https://flyprogram.org/	AC
Girls, Inc.	Runs programs designed to empower and inspire girls and young women.	https://girlsinc.org/	AC
Highland Hospital Sexual Assault Response and Recovery Team	Provides comprehensive services to victims of domestic violence and sexual assault.	https://www.alamedahealthsystem.org/sarrt/	AC
Hively	Hively helps families find and pay for child care, offers mental health support and provides basic necessities to families in	https://behively.org/	AC

Resource Name	Summary Description	Website	Area
	need, helping to disrupt neglect and abuse.		
Immigration Institute of the Bay Area	Helps immigrants, refugees, and their families settle in the community by providing legal-aid services as well as education and community engagement opportunities.	https://iibayarea.org/	AC
KidPower International	Provides resources and training to support education on safety, including bullying solutions, sexual assault prevention, child abuse prevention, self-defense, and online safety.	https://www.kidpower.org/	AC
Koreatown Northgate (KONO)	Ensures the district (Telegraph Avenue from 20th to 35th Streets in Oakland) is safe, clean, and promoted.	https://www.koreatownnorthgate.org/	North
Narika	Helps domestic violence survivors with advocacy, support, and education.	https://www.narika.org/	AC
Oakland Unite!	Targets the highest-risk community members and neighborhoods, with programs focused on interrupting violence as it occurs and preventing future violence.	https://rootscommunityhealth.org/oakland-unite-violence-prevention-navigation/	North
OneChild	Helps youth take action against sex trafficking through education, advocacy, mobilization, and survivor care and empowerment.	https://www.onechild.ca/	AC
Project Avary	Runs a program that meets the unique emotional needs of children with a parent in prison, starting at ages 8–11 and continuing for 10 years.	http://www.projectavary.org/	AC
REACH Ashland Youth Center	Provides youth programs in the areas of arts, recreation,	https://reachashland.org/	Mid

Resource Name	Summary Description	Website	Area
	education, career development, and health and wellness.		
Reentry Success Center	Supports formerly incarcerated individuals in transitioning back into the community.	http://reentrysuccess.org/	AC
Restorative Pathways (formerly Ruby's Place)	Offers women, men, transgender people, and accompanied minors who have been affected by domestic violence or human trafficking with shelter, case management, therapy, and housing services.	https://restorativepathways.org/	Mid
Safe Alternatives to Violent Environments	Supports victims of domestic violence through providing shelter, support and educational opportunities.	https://save-dv.org/ 24-hour crisis line: (510) 794-6055	South
STAND! for Families Free of Domestic Violence	Strives to break the cycle of violence in families impacted by domestic violence and child abuse by providing services around therapy, crisis lines and educational opportunities.	http://www.standffov.org/	AC
Tri-Valley Haven	Offers services to survivors of domestic violence, sexual assault and homelessness, including restraining order assistance, counseling groups, financial assistance for survivors, groceries, and more.	https://trivalleyhaven.org/	TV
Youth Alive!	Works to prevent violence, and helps violently wounded people heal themselves and their community.	http://www.youthalive.org/	AC
Youth Uprising	Engages youth in East Oakland in leadership opportunities to drive the health and economic growth of the community.	https://www.youthuprising.org/	North

Housing and the Unhoused

Resource Name	Summary Description	Website	Area
Abode Services	Works with government, supporters, landlords, and clients to provide housing for people experiencing homelessness.	https://www.abodeservices.org/	AC
Alameda County Health Care for the Homeless	Increases access to quality health care for homeless individuals through free health centers and mobile clinics that provide primary care, substance abuse treatment, and other services.	https://www.achch.org/	AC
Alameda County Housing and Community Development	Leads the development of housing and programs to serve low- and moderate- income households, people experiencing homelessness, and disabled individuals.	http://www.acgov.org/cda/hcd/	AC
Alameda Point Collaborative	Permanent supportive housing community for individuals experiencing homelessness, which aims to break the cycle of poverty by providing supportive services around education, employment, nutrition, and entrepreneurship.	https://apcollaborative.org/	North
Bay Area Community Services	Provides behavioral health and housing services for teens, adults, older adults, and their families across the Bay Area.	https://www.bayarceacs.org/	AC
Bay Area Legal Aid	Increases access to the civil justice system through legal assistance for low-income people.	https://baylegal.org/	AC
Building Futures	Provides a continuum of care through residential programs, crisis lines, and case management to help county residents build a future free of violence and homelessness.	http://www.bfwc.org/	AC

Resource Name	Summary Description	Website	Area
Building Opportunities for Self-Sufficiency	Operates a variety of programs and services targeted towards empowering homeless, poor and disabled individuals to be self-sufficient.	https://self-sufficiency.org/	AC
Catholic Charities of the East Bay	Offers a wide variety of services to aid youth, children and families facing eviction including rent assistance and funds for housing deposits.	https://www.cceb.org/housing-services/	AC
CityServe of the Tri-Valley	Provides counseling, mental health support, job training, and health services for individuals and families.	https://cityservecares.org/	TV
Clausen House	Provides housing, wellness programs, and advocacy for developmentally disabled adults in Oakland and the surrounding East Bay area.	https://clausenhouse.org/	North
DayBreak Adult Care	Offers housing navigation and support for vulnerable seniors in Alameda County.	www.daybreakac.org	AC
DeafPlus	Integrated adult day program that serves deaf adults with disabilities, including support necessary to develop independent living skills.	https://deafplus.us/	South
East Bay Asian Local Development Corporation	Works with and for the diverse populations of the East Bay to build healthy, vibrant, and safe neighborhoods through community development.	https://ebaldc.org/	AC
East Bay Community Law Center Housing Program	Defends low-income tenants in eviction lawsuits brought against them.	https://ebclc.org/n-eeed-services/housing-services	AC
East Bay Housing Organizations	Works through organized campaigns focused on policy or a	http://ebho.org/looking-for-housing/	AC

Resource Name	Summary Description	Website	Area
	geographic community through ongoing committees.		
Eden Council for Hope and Opportunity (ECHO) Housing	Supports fair housing, tenant rights, and offers other services.	https://www.echofairhousing.org/	Mid
Eden Housing	Creates and sustains affordable housing for very low, low and moderate-income families, seniors, veterans, people living with physical, mental, or developmental disabilities, and the formerly homeless.	https://edenhousing.org/	Mid
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information.	http://edenir.org/	Mid
Everyone Home	Supports collaborative projects to end homelessness.	http://everyonehome.org/	AC
FESCO	Provides low/extremely low-income homeless families with food, emergency, transitional, permanent housing, and supportive services.	https://www.fescofamilyshelter.org/	AC
First Place for Youth	Supports youth, particularly those in foster care, in building self-sufficiency and a sense of purpose by offering housing and case management services.	https://www.firstplaceforyouth.org/	AC
Goodness Village	An affordable tiny home program that provides the Tri-Valley's formerly unhoused neighbors a safe and supportive community to live independently, heal, and thrive.	https://gvlivermore.org/	TV
Homeless Action Center	Makes it possible for people who are experiencing severe homelessness, poverty, or disability to access social safety net programs through free,	http://homelessactioncenter.org/	AC

Resource Name	Summary Description	Website	Area
	culturally sensitive legal representation.		
HOPE Project Mobile Health Clinic	Homeless Outreach for People Empowerment Project is a mobile clinic that brings services to those in need. It provides health and social services to homeless people in five locations throughout southern and eastern Alameda County, in partnership between Abode Services and Bay Area Community Health.	https://bach.health/homeless-programs	TV/ South
Lao Family Community Development	Operates a range of housing for families, seniors, and adults in need.	https://lfcd.org/	North
MidPen Housing	Nonprofit developer that owns and manages high-quality affordable housing for low-income families, seniors and people with special needs.	https://www.midpen-housing.org/	AC
Open Heart Refuge	20-bed overnight shelter for unhoused folks and individuals experiencing crisis. Located at the Vineyard Resource Center in Livermore. Open 365 days a year.	https://www.openheartkitchen.org/refuge	TV
Rebuilding Together East Bay Network	Provides free rehabilitation and critical repairs to the homes of income qualified seniors, veterans, and people with disabilities.	https://rtebn.org/	North
Rubicon Programs	Equips East Bay residents with resources to break the cycle of poverty.	http://rubiconprograms.org/	AC
Satellite Affordable Housing Associates (SAHA)	Offers quality affordable homes and services that empower people and strengthen neighborhoods.	https://www.sahahomes.org/	AC
Shepherd's Gate	Provides housing and job skill training for women in transition as well as programs for their children.	https://shepherdsgate.org/	TV

Resource Name	Summary Description	Website	Area
South County Homeless Project	Offers emergency housing, including special needs housing, and various support services.	https://www.self-sufficiency.org/schp	Mid, South
South Hayward Parish	Shelter guests receive a nightly foldable mat, sleeping bag, as well as a hot dinner and breakfast.	https://www.southhaywardparish.org/shelter	Mid
The East Oakland Collective	Supports various programs including advocacy for the rights of unhoused individuals, research on alternative housing models, and improvement of hygiene at encampments.	https://www.eastoklandcollective.com/	North
Tri-Valley Haven	Offers services for homeless individuals and families in severe economic need, including shelter, a food pantry, and transitional housing.	https://trivalleyhaven.org/	TV
Tri-Valley Seek and Save	Provides permanent housing application assistance, occasional relocation funding.	https://www.trivalleeyseekandsave.org/	TV
United Way: SparkPoint Centers	Centers assist families and individuals with financial stability, rental support, and more. Locations in Alameda County include Fremont, Hayward, Oakland, and Union City.	https://uwba.org/w hat-we-do/sparkpoint-program/	AC
Unity Council	Helps families and individuals build wealth and assets through sustainable economic, social, and neighborhood development programs.	https://unitycouncil.org/	AC
Women's Daytime Drop-In Center	Empowering women and children to move from the streets to a home by providing housing problem solving services and support, housing case management and referral services, and a transitional housing program.	http://www.womensdropin.org	North

Resource Name	Summary Description	Website	Area
Various cities' Housing and Human Services Departments	Provide various support for housing needs, which can include emergency shelter, rental assistance, housing navigation, and specialized aid for unhoused, veterans, older adults, and disabled individuals.		AC

Built Environment

Resource Name	Summary Description	Website	Area
Alameda County Community Development Agency: Healthy Homes Dept., Lead Poisoning Prevention Program	Provides grants for lead hazard removal and offers guidelines for lead poisoning prevention and risk reduction.	https://www.achhd.org/leadpoisoning/leadp.htm	AC
Alameda County Health, Emergency Medical Services: Injury Prevention Programs	Operates and supports several programs designed to prevent injuries and emergencies from occurring among children and older adults.	https://health.alameda-county.ca.gov/prevention/	AC
Alameda County Health, Environmental Health Department	Protects and enhances the health and quality of life by ensuring food and recreational safety, reducing exposures to toxins and pests, protects the quality of water, air, the physical environment and more.	https://deh.acgov.org/index.page	AC
Alameda County Public Health Department	Works to reduce barriers to health in the built environment, including causes of asthma and other challenges.	https://acphd.org/	AC
Alameda County Public Works Agency	Aims to provide safe, well-maintained and lasting public works infrastructure for the residents of Alameda County.	https://www.acpwa.org/index.page	AC

Resource Name	Summary Description	Website	Area
	Serves mainly unincorporated areas.		
Alameda County Transportation Commission: Bicycle Safety Education Program	Educates approximately 4,000 adults, teenagers and children annually in safe bicycle riding techniques. Encourages bicycle riders to ride their bicycles with greater control and awareness to enhance their travel safety.	https://www.alamedactc.org/programs-projects/bicycle-and-pedestrian/bicycle-safety-education	AC
Child Passenger Safety Program	Supports the standardization and quality- control course with content and instructors to ensure that information and materials being taught and disseminated are up-to-date, accurate, and consistent.	https://www.in.gov/cji/traffic-safety/occupant-protection/children/child-passenger-safety/	AC
City of Berkeley Department of Health Services	Provides a wide array of services to monitor the health of the community, to prevent epidemics and the spread of disease, to protect against environmental hazards, to respond to disasters, and to encourage healthy behaviors.	https://www.cityofberkeley.info/publichealth/	North
First 5 Alameda County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children ages 0–5 and their families.	http://www.first5alameda.org/	AC
Safe Kids Alameda County	Coalition implements evidence-based programs, such as car-seat checkups, safety workshops and sports clinics, that help parents and caregivers prevent childhood injuries.	https://www.safekids.org/coalition/safe-kids-alameda-county	AC
Various cities' Public Works agencies	Address illegal dumping, storm drainage and sewer/wastewater systems maintenance, streetlights, sidewalk		AC

Resource Name	Summary Description	Website	Area
	maintenance, tree-planting, capital contracts, etc.		
Various local water agencies	Provide drinking water to community residents and monitor water quality.		AC

Climate/Natural Environment

Resource Name	Summary Description	Website	Area
Alameda County Department of Environmental Health	Ensures food and recreational safety, reduces exposures to toxics and pests, protects the quality of local water, air, and physical environment.	https://deh.acgov.org/index.page	AC
Alameda County Office of Sustainability	Leads implementation of county's Climate Action Plan.	https://www.acgov.org/sustain/	AC
Asian Pacific Environmental Network	Supports environmental justice movement with work focused on Asian immigrant and refugee communities.	https://apen4ej.org/	AC
Bay Area Climate Adaptation Network (BayCAN)	A collaborative network of local government staff and partnering organizations working to help the Bay Area respond effectively and equitably to the impacts of climate change on human health, infrastructure, and natural systems.	https://www.baycanadapt.org/	AC
Bay Area Air Quality Management District	Oversees and implements policies and regulations for the control of air pollution within the nine counties that surround San Francisco Bay.	https://www.baaqmd.gov/	AC
City of San Leandro: Hub Network	This network of sites – including places of worship, community centers, and neighborhoods – will center the most vulnerable populations and focus on disaster	https://www.sanleandro.org/1173/Hubb-Sites-in-San-Leandro	Mid

Resource Name	Summary Description	Website	Area
	preparedness, community care, and belonging, and climate mitigation and adaptation to be “ready for anything.”		
Climate Protection Planning Program	Supports development and implementation of Comprehensive Climate Action Plan, a roadmap for meeting regional near- and long-term greenhouse gas (GHG) reduction targets by reducing GHG emissions and enhancing carbon sinks in the Bay Area.	https://www.baaqmd.gov/en/plans-and-climate/climate-planning/bay-area-regional-climate-action-planning-initiative	AC
Collective Resilience	Supports the development of resilience hubs.	https://collectivere silencenow.org	AC
East Bay Regional Park District	Conserves open space resources and provides outdoor recreational opportunities for present and future generations.	https://www.ebpar ks.org/	AC
Friends of Lincoln Square Park	Supports the building of a community resilience center in Oakland’s Chinatown.	https://www.friendsofcolinsquarepark.org/	North
Local Clean Energy Alliance	Membership organization to promote the development and democratization of local renewable energy resources.	https://localcleanenergy.org/	AC
Sierra Club	Grassroots organization that supports efforts to appreciate and protect the environment and create a more sustainable future.	https://www.sierraclub.org/sfbay	AC
West Oakland Environmental Indicators Project	Conducts participatory environmental research and engages in environmental justice advocacy.	https://woeip.org/	North
Various cities’ Environmental Services Divisions	Agencies’ work may include managing core ecological and utility functions, including solid waste/recycling, wastewater treatment, stormwater management, and water conservation, and protecting		AC

Resource Name	Summary Description	Website	Area
	public health and safety by enforcing environmental regulations, managing hazardous waste, and leading climate action plans/sustainability initiatives.		

Racism/Discrimination

Many of the agencies/organizations addressing the other health needs also address racism/discrimination. The agencies/organizations listed below specifically address it.

Resource Name	Summary Description	Website	Area
Alameda County District Attorney Accountability Table	Coalition of Alameda County-based organizations working together to advance public safety solutions.	https://acaccountability.org	AC
Ella Baker Center for Human Rights	Organizes to shift resources away from prisons and punishment towards opportunities that make our communities safe, healthy, and strong.	https://ellabakercenter.org/	North
NAACP Hayward South Alameda County	Seek the enactment and enforcement of federal, state and local laws securing civil rights, and inform the public of the adverse effects of racial discrimination.	https://naacphayward.org/advocacy	Mid, South
NAACP Oakland	Seek the enactment and enforcement of federal, state and local laws securing civil rights, and inform the public of the adverse effects of racial discrimination.	https://www.naacp.oakland.org/	North
Showing Up for Racial Justice Bay Area	Through community organizing, mobilizing, and education, SURJ moves white people to act as part of a multi-racial majority for justice.	https://www.surjbayarea.org/	North

BEHAVIORAL HEALTH

Resource Name	Summary Description	Website	Area
A Better Way Inc.	Assessment/referral and parenting support and education through group classes, topic-specific trainings, and through peer-led support groups.	https://www.abetterwayinc.net/	AC
Afghan Coalition	Supports and empowers Afghani refugee families, women, and youth to achieve health and wellness.	https://www.afghancoalition.org/	AC
Alameda County Behavioral Health Care Services	Provides services to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.	http://www.acbhcs.org/	AC
Alameda County Medical Center Substance Abuse Program	Offers high quality treatment and prevention services for residents seeking recovery from drug and alcohol addictions.	https://www.acbhcs.org/substance-use-treatment/	AC
Alameda County Social Services Agency	Provides benefits programs through cash assistance and CalFresh (“food stamps”), CalWORKs (assistance for families with children), General Assistance, and Medi-Cal Health Insurance.	https://www.alamedasocialservices.org	AC
Alameda Health System	Aims to extend care, wellness, and prevention to all members of the community.	http://www.alamedahealthsystem.org/	AC
Alameda Health System John George Psychiatric Hospital	Provides psychiatric emergency and acute care services to adults experiencing severe and disabling mental illnesses.	https://www.alamedahealthsystem.org/locations/john-george-psychiatric-hospital/	AC

Resource Name	Summary Description	Website	Area
Al-Anon	12-step program for adult relatives and friends of alcoholics or someone coping with alcoholism.	https://al-anon.org/	AC
Alateen	12-step program for teen relatives and friends of alcoholics or someone coping with alcoholism.	https://al-anon.org/for-members/group-resources/alateen	AC
Alcoholics Anonymous	12-step program for individuals who need help with alcohol addiction or excessive drinking.	https://www.aa.org/	AC
Asian Health Services - Specialty Mental Health	Provide children and youth ages 0-8 (early childhood) and 5-21 (children & youth) living in Alameda County with social-emotional support through screening, assessment, education, early intervention, medication support, and individual and family therapy.	http://www.asianhealthservices.org	AC
Axis Bridge Mental Health Urgent Care	Provides rapid access to mental health treatment to patients ages 5 and up.	https://axishealth.org/axis-bridge-mhuc/	TV
Axis Community Health Behavioral Health Services	Integrated behavioral health, providing mental health and substance use counseling for adults, teens, couples, families and children.	https://axishealth.org/ibh/	TV
Bay Area Community Services	Provides behavioral health and housing services for teens, adults, older adults, and their families across the Bay Area.	https://www.bayareacs.org	AC
Baywell Health	Parent organization of West Oakland Health Center, FQHC with multiple locations that offers medical and dental care as well as behavioral health and other services.	https://baywellhealth.org/	North

Resource Name	Summary Description	Website	Area
Beats, Rhymes and Life	Engages youth in Oakland to use hip-hop and self-expression as a form of therapy to facilitate healing.	http://brl-inc.org/	North
Boldly Me	Helps people with differences due to birth conditions, medical treatments, injury, disease, and self-perception heal from emotional trauma.	http://www.boldlyme.org/	AC
Building Futures	Provides a continuum of care through residential programs, crisis lines, and case management to help county residents build a future free of violence and homelessness.	http://www.bfwc.org/	AC
California Smokers Helpline	Free telephone program that helps smokers quit..	1-800-BUTTS	AC
The Center for Early Childhood Connections	Child and family therapy, assessments for 0-5, perinatal emotional support during infertility, pregnancy, adoption and postpartum.	http://www.thececc.org	North
Cherry Hill Detox	Sobering Unit assists those needing immediate sobering services for 23 hours or less; Detox Unit residential program serves men and women who are withdrawing from the effects of alcohol or drug use.	https://www.horizonservices.org/cherry-hill/	Mid
Chrysalis	Residential treatment program for women age 18+ living with mental health and substance use disorders.	https://www.horizonservices.org/chrysalis/	North
City of Berkeley Department of Health Services	Provides services to monitor the health of the community, prevent epidemics and the spread of disease, protect against environmental hazards, respond to disasters, and	https://www.cityofberkeley.info/publichealth/	North

Resource Name	Summary Description	Website	Area
	promote and encourage healthy behaviors.		
City of Union City Youth and Family Services	Provides youth violence prevention and intervention services (ages 8-24).	https://www.unioncity.org/182/Youth-Family-Services	Mid/South
City of Fremont Youth and Family Services Clinic	Family-focused behavioral health services for children and youth ages 0 to 21 years old to improve social-emotional well-being, strengthen family relationships, reduce delinquency, and increase school achievement.	https://www.fremont.gov/government/departments/human-services/mental-health-services/family-counseling	South
Crisis Support Services of Alameda, County 24-Hour Crisis Line	Gives round-the-clock telephone support to people coping with difficult circumstances or emotions, or suicidal thoughts or feelings.	https://www.crisissupport.org/crisis-services 24-hour line: 988 (call or text)	AC
Cronin House	Residential treatment program for men age 18+ living with mental health and substance use disorders.	https://www.horizonservices.org/cronin-house/	Mid
CURA, Inc.	Helps individuals experiencing difficulties with substance abuse achieve sobriety, health, and wellness.	https://www.curainc.com/Home.html	AC
DeafPlus	Integrated adult day program that serves deaf adults with disabilities, including addressing social isolation.	https://deafplus.us/	South
Davis Street Community Center	Behavioral Health Services for adults and children.	https://www.davisstreet.org	Mid
East Bay Agency for Children	Offers comprehensive services designed to reduce the incidence/impact of adverse childhood experiences and other traumas.	http://www.ebac.org/	AC

Resource Name	Summary Description	Website	Area
Eden I&R, Inc.	Serves as a centralized source of health, housing, and human services information.	http://edenir.org/	Mid
Family Education and Resource Center	Offers educational information on health, family relationships and well-being.	http://askferc.org/	AC
Family Paths 24-Hour Parenting Stress Hotline	Provides free, confidential counseling and information to anyone in need of parenting support as well as referrals to nearly 900 community resources. Staffed by professional and volunteer counselors, who support parents and caregivers around a variety of parenting issues.	https://www.familypaths.org/ 1-800-829-3777	AC
First 5 Alameda County	Offers continuous prevention and early intervention programs that promote optimal health and development, narrow disparities and improve the lives of children ages 0–5 and their families.	http://www.first5alameda.org/	AC
Flourish Agenda	Strives to help youth of color flourish.	https://flourishagenda.com/	AC
Fred Finch Youth & Family Services	Comprehensive behavioral health services for children, youth, young adults, and their families to address challenges that may include mental or emotional impairment, developmental disability, early trauma and abuse.	https://www.fredfinch.org	AC
Fremont Family Resource Center	Combines the best efforts of multiple social services programs, including providing mental health services for all ages and substance use intervention for teens.	https://www.fremont.gov/government/department/s/human-services/fremont-family-resource-center	South

Resource Name	Summary Description	Website	Area
Friends of Children with Special Needs	Provides information and assistance to children with special needs, adults with special needs, and their communities.	https://fcsn1996.org/	South
Gamblers Anonymous	12-step program for people coping with a gambling addiction.	http://www.gamblersanonymous.org/ga/	AC
George Mark Children's Home	Offers round-the-clock skilled pediatric nursing, fun activities for children with complex medical conditions, transitional care, end-of-life care, respite care, and bereavement care.	https://georgemark.org/	Mid
Girls, Inc.	Runs programs designed to empower and inspire girls and young women.	https://girlsinc.org/	AC
Hively	Hively Mental Health provides counseling services to individuals, families and children via MediCal and private payment options. We serve ALL ages.	https://behively.org/mental-health-services/	AC
Horizon Services, Inc.	Provides preventive, educational, and therapeutic services and environments for individuals, families, and the community.	https://www.horizonservices.org/	AC
Hume Center	Provides mental health prevention, intervention, and support.	http://www.humecenter.org	TV, SAC
Jewish Family and Community Services East Bay	Promotes the well-being of individuals and families of all ages, races, and religions with essential mental health and social services at every stage of life.	https://jfcs-eastbay.org/	AC
Kidango, Inc.	Runs free and reduced-cost pre-school/ child care centers.	https://www.kidango.org/	AC

Resource Name	Summary Description	Website	Area
La Familia Counseling Services	Supplies mental health and community support services to underserved multicultural communities.	https://livelafamilia.org/	Mid
Lambda Project Eden Drop-In Center	Provides mental health services and support to young people aged 12-24 who identify as LGBTQIA+.	https://www.horizonservices.org/project-eden/lambda-youth-project/	Mid
Lincoln Families	Provides children with support and services, from an early age through high-school graduation.	http://lincolnfamilies.org/	AC
Mindful Life Project	Empowers underserved children to gain self-awareness, confidence, self-regulation, and resilience through mindfulness and other transformative skills.	https://www.mindfullifeproject.org/	AC
Narcotics Anonymous	12-step program for individuals coping with substance abuse or drug addiction.	https://www.na.org/	AC
National Alliance on Mental Illness (NAMI)	Offers education, support, and advocacy for people affected by mental illness.	http://www.namiacs.org/	AC
Niroga	Offers programs in schools to strengthen resilience and empathy, using trauma-informed Dynamic Mindfulness.	https://www.niroga.org/	AC
OneChild	Helps youth take action against sex trafficking through education, advocacy, mobilization, and survivor care and empowerment.	https://www.onechild.ca/	AC
Overeaters Anonymous	12-step program for people coping with compulsive overeating, undereating, food addiction, anorexia, bulimia, binge eating and/or excessive exercising.	https://oa.org/	AC

Resource Name	Summary Description	Website	Area
Pacific Center for Human Growth	Delivers LGBTQ-proficient mental health and wellness services to enhance the well-being of community members.	http://pacificcenter.org/	AC
Partnership for Trauma Recovery	Addresses the psychosocial impacts of trauma among international survivors of human rights abuses through culturally aware, trauma-informed, and linguistically accessible mental-health care, clinical training, and policy advocacy.	https://traumapartners.org/	AC
Project Eden	Provides adult outpatient addiction recovery treatment.	https://www.horizonservices.org/project-eden-adult-outpatient/	TV
RAMS: Pacific Islander Wellness Initiative	Screening, individual and group counseling, workshops, and other services for all ethnicities and populations, with a special focus on Pacific Islanders.	https://ramsinc.org/programs/prevention-early-intervention/pacific-islander-wellness-initiative/	Mid
REACH Ashland Youth Center	Provides youth programs in the areas of arts, recreation, education, career development, and health and wellness.	https://reachashland.org/	Mid
Second Chance, Inc.	Offers individual and group substance abuse treatment.	https://secondchanceinc.com/	AC
Seneca Center	Provides a comprehensive continuum of school, community-based and family-focused treatment services for children and families experiencing high levels of trauma who are at risk for family disruption or institutional care for the children.	https://www.senecafoa.org/	AC
Senior Support Program of the Tri-Valley	Provides programming and referrals for older adults, including case management, 1:1 counseling and emotional support, and wellness	https://seniorservicescoalition.org/senior-support-program-of-the-tri-valley/	TV

Resource Name	Summary Description	Website	Area
	education (e.g., nutrition, fitness).		
Side by Side	Helps youth overcome traumas caused by adversity and embrace resilience.	https://www.sidebysideyouth.org/	AC
Through the Looking Glass	Home-based support for parents with intellectual disability and their children. Adaptations (e.g. cognitive adaptations, adaptations in communication) and case management.	http://www.lookingglass.org	AC
Tobacco Control Coalition of Alameda County	Grassroots coalition of educators, professionals, and community members that work to prevent, reduce, and limit tobacco use in Alameda County through education, advocacy, and policy.	https://tobaccofreealamedacounty.org/	AC
Tri-Valley Haven	Offers services to survivors of domestic violence, sexual assault and homelessness, including restraining order assistance, counseling groups, financial assistance for survivors, groceries, and more.	https://trivalleyhaven.org/	TV
Tri-Valley Seek and Save	Marriage & Family Christian Therapists available to support women and men in crisis.	https://www.trivalleyseekandsave.org/	TV
Twins by the Bay: Daytime Support Group for New and Expectant Parents of Multiples	Support group for new or expectant parents of multiples.	http://www.twinsbythebay.org	North
Union City Family Center	Connects youth, families and community members to urgent living resources, and offers support groups and empowerment workshops.	https://www.unioncityfamilycenter.org/	Mid/ South

Resource Name	Summary Description	Website	Area
Wellness Together	Partners with K-12 school districts and colleges to provide mental health services for students, families, and educators.	https://www.wellnesstogether.org/	AC
Willow Rock Center	24-hour mental health crisis stabilization and outpatient services for youth.	https://www.telecarecorp.com/willow-rock-center	Mid
Women and Men on the Way	Provides an alcohol and drug free environment and recovery services in a home like setting for a period of 6-12 months with an ongoing aftercare plan.	https://womenandmenontheway.org/	AC
Women on the Way Recovery Center	Helps women who have limited resources or are experiencing homelessness recover from substance abuse through housing, treatment, and aftercare support.	https://www.rehab.com/women-on-the-way-recovery-center/	AC
YMCA of the East Bay	Offers a variety of programs through its five health and wellness centers, 20-plus childcare sites, a teen center, and three camps.	https://ymcaeastbay.org/	AC

COMMUNICABLE DISEASES

Respiratory Infections

Resource Name	Summary Description	Website	Area
Alameda County Public Health Department (ACPHD)	Monitors and makes efforts to prevent and reduce the spread of respiratory viruses, including COVID-19, influenza (flu), and respiratory syncytial virus (RSV). Supports community vaccination clinics (calendar and locations available at website).	https://covid-19.acgov.org/	AC
ACPHD, Div. of Communicable Disease Control & Prevention, Pertussis	Monitor pertussis (whooping cough) cases, provides education and vaccination resources to the public.	https://acphd.org/pertussis/	AC
ACPHD, Div. of Communicable Disease Control & Prevention, Tuberculosis Control	Monitor tuberculosis (TB) cases and determine steps that need to be taken to control TB in the county. This includes education, connection to physicians, medication compliance efforts, tracing contacts to prevent TB spread, and help with basic needs.	https://acphd.org/tb/tb-control/	AC
Long COVID Alliance	Network of patient-advocates, scientists, disease experts, and drug developers who have joined together to leverage their collective knowledge and resources to educate policy makers and accelerate research to transform the understanding of post-viral illness.	https://longcovidalliance.org/resources/patients/	AC
Long Covid Families	Improve the quality of life for families affected by Long COVID and work towards a future where every family receives the support they deserve.	https://longcovidfamilies.org/resources/	AC

Sexually Transmitted Infections (STIs)

Resource Name	Summary Description	Website	Area
Alameda County Health, Div. of Communicable Disease Control & Prevention	Multiple programs to address STIs: <ul style="list-style-type: none"> • Chronic Hepatitis Program • Immunization Program • MPox • Perinatal Hepatitis B Prevention Program • Office of HIV Care and Prevention • Sexual Health Capacity Building 	https://acphd.org/about/our-organization/dcdcp/	AC
East Bay Getting to Zero	Bring people together to collaborate on creative ways to implement the East Bay HIV strategic plan, supporting community members to have more equitable access to HIV testing, prevention and treatment services.	https://www.ebgtz.org	AC
Hep B Free Alameda County Collaborative	Community collaborative to end hepatitis B through testing, educating and treating.	https://acphd.org/hep-b/hep-b-free-alameda-county-collaborative/	AC
HIV/AIDS Care and Treatment Program (CA Dept. of Public Health)	Includes primary medical care and essential support services for people living with HIV who are low income and uninsured or underinsured.	https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_program.aspx	AC
HIV Education and Prevention Project of Alameda County	Provide harm reduction-based services in Alameda County and Contra Costa County, serve people who are at increased risk for HIV, hepatitis C and other infectious diseases.	https://heppac.org/	North
I Know	Free home test kit program is a simple and confidential way for young women, girls, transmen, and any person with a vagina to test for chlamydia and gonorrhea in the privacy of their own home.	https://alameda.dontthinkknow.org/frequently-asked-questions/home-test-kit-faq	AC

Resource Name	Summary Description	Website	Area
Oakland TGA	Network of comprehensive services for people living with HIV.	https://oaklandtga.org/	AC
STI testing clinics directory	Maintains an extensive list of public and private STD testing locations and in-home STD testing options.	https://www.safersdttesting.com	AC

Other Vaccine-Preventable Diseases

Resource Name	Summary Description	Website	Area
Alameda County Family Justice Center: Immunization Clinic	Offers free vaccinations by appointment only for children and adults who are county residents and are either low-income or uninsured.	https://acfjc.org/family-justice-immunization-clinic/	North
Alameda County Health, Div. of Communicable Disease Control & Prevention	Multiple programs to address infectious diseases: <ul style="list-style-type: none"> • Chronic Hepatitis Program • Immunization Program 	https://acphd.org/about/our-organization/dcdcp/	AC
Immunization Partnership of Alameda County (IPAC)	Collaborative of private and public organizations interested in improving vaccine protection rates for all people of Alameda County, focusing on education and training for medical providers, school and child care personnel and parent groups.	On hiatus / rebuilding	AC

Attachment 9: Public Health Accreditation Board Checklist

Community Health Assessment Requirements by the Public Health Accreditation Board, v 5.13.2024.

Required Documentation	PDF Page Number(s)	Notes for Reviewer (optional)
1 Community health assessment (CHA) that must include all of the following elements:		
A list of participating partners involved in the CHA process. Participation must include:	Page 132 (Chapter 7), page 142 (Attachment	Ch. 7 and Att. 1 list the agencies and organizations that hosted focus groups; most were not associated with the governmental public health sector.
1a i. At least 2 organizations representing sectors other than governmental public health.	1), and pages 147–168 (in Attachment 3)	Att. 3’s final section lists all organizations participating in interviews and focus groups and the populations represented , and provides counts of community members who participated in each focus group.
ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.	Page 142 (Attachment 1), and pages 147–168 (in Attachment 3)	
1b The process for how partners collaborated in developing the CHA.	Pages 24–28 (in Chapter 4)	Ch. 4 describes the collaborative process for developing the CHA.
Comprehensive, broad-based data. Data must include:	Pages 24–28 (in Chapter 4), and pages	More information on primary data is provided in Att. 3 (see 1a) and Att. 7 (pages 210-241). The latter provides the English-language versions of interview and focus group surveys and guides. More information on secondary data is provided in Att. 4 (pages 169-184, further secondary statistical data and a summary of limitations), Att. 5 (page 185, list of secondary reports), and Att. 6 (pages 186-209, index of secondary statistical data and sources).
i. Primary data.	201–241 (Attachment 7)	
1c ii. Secondary data from two or more different sources.	Pages 24–28 (in Chapter 4), and pages 169–209 (Attachments 4, 5, and 6)	

Required Documentation	PDF Page Number(s)	Notes for Reviewer (optional)
<p>A description of the demographics of the population served by the health department, which must, at minimum, include:</p> <p>1d</p> <ul style="list-style-type: none"> i. The percent of the population by race and ethnicity. ii. Languages spoken within the jurisdiction. iii. Other demographic characteristics, as appropriate for the jurisdiction. 	<p>Pages 17–22 (Chapter 3)</p> <p>Pages 17–22 (Chapter 3)</p> <p>Pages 17–22 (Chapter 3)</p>	<p>Ch. 3 covers the county’s demographics, including race/ethnicity (page 19), languages (page 20), and other demographic characteristics.</p>
<p>A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following:</p> <p>1e</p> <ul style="list-style-type: none"> i. Health status. ii. Health behaviors. 	<p>Pages 30–126 (Chapter 5)</p>	<p>Ch. 5 (pages 30-126) contains descriptions of the identified health needs, including examination of disparities of health status and health behaviors.</p>
<p>A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment.</p> <p>1f</p>	<p>Pages 30–126 (Chapter 5)</p>	<p>Ch. 5 (pages 30-126) contains descriptions of the identified health needs, including contributing inequities. Pages 52-107 specifically cover social determinants of health.</p>
<p>Community assets or resources beyond health care and the health department that can be mobilized to address health challenges.</p> <p>1g</p>	<p>Page 135 (Chapter 7), and pages 242–299 (Attachment 8)</p>	<p>Att. 8 contains a substantial list of community assets and resources that can be mobilized to address the identified needs and challenges.</p>

PDF Page Number with Date: Pages 300–301, January 5, 2026

The CHA must address the jurisdiction as described in the description of Standard 1.1.

Additional explanatory notes for reviewers (optional): **See right-most column of table above.**

Attachment 10: Endnotes

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- ⁸² Only individuals who consented to be recorded were interviewed.
- ⁸³ Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members are not listed in the report. Participants in community-member focus groups could take the pre-survey online or on paper. In a few cases, participants in the focus groups conducted by the Public Health Department were not asked to provide any demographic information.
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- ⁹⁰ EDUC stands for Education.
- ⁹¹ QUAL stands for Quality.
- ⁹² MAT stands for Maternal.