CHNA

2016 COMMUNITY HEALTH NEEDS ASSESSMENT

St. Rose Hospital

St. Rose HOSPITAL

ASR

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1. EXECUTIVE SUMMARY

Community Health Needs Assessment (CHNA) Background

The Affordable Care Act (ACA), enacted by Congress on March 23, 2010, stipulates that nonprofit hospital organizations complete a community health needs assessment (CHNA) every three years and make it widely available to the public. This assessment includes feedback from the community and experts in public health, clinical care, and others. This CHNA serves as the basis for implementation strategies that are filed with the Internal Revenue Service (IRS).

The IRS requires that the hospital conduct a CHNA and adopt an implementation strategy for each of its facilities by the last day of its taxable year, which for St. Rose Hospital is September, 30th, 2016. The CHNA assessment itself was conducted in 2015, meeting the requirement that the assessment be conducted in the same tax year it is due, or in the two years immediately preceding that year.

This 2016 assessment is the second such assessment conducted since the ACA was enacted and builds upon the information and understanding that resulted from the 2013 CHNA. This 2016 CHNA report documents how the CHNA was conducted and describes the related findings.

Process & Methods

Twelve local hospitals in Alameda and Contra Costa Counties ("the Hospitals") began the second CHNA cycle in 2015. The Hospitals' goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs.

Community input was obtained during the summer and fall of 2015 via key informant interviews with local health experts, focus groups with community leaders and representatives, and focus groups with community residents. Secondary data were obtained from a variety of sources – see Attachment 2 for a complete list. Secondary data were available for Alameda County, and in many cases also for the northern and southern parts of St. Rose's service area separately; the northern part of St. Rose's service area includes the cities of Hayward, San Leandro, San Lorenzo, and Union City, and the southern part includes the cities of Fremont and Newark.

In November 2015, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then prioritized by a subgroup of hospitals and community representatives using a second set of criteria. The results of the prioritization are included on the next page.

Prioritized Needs

Based on community input and secondary data, the Hospitals generated a list of health needs, and then community representatives and representatives of the local participating hospitals prioritized them via a multiple-criteria scoring system. These needs are listed below in St. Rose Hospital's priority order, from highest to lowest.

Health Needs Identified by CHNA Process, in Order of Priority

Health need	Why is it important?	What does the data say?
Obesity, diabetes, and healthy eating/active living	Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives.	In the St. Rose service area, youth consume inadequate amounts of fruits and vegetables, a very small proportion of the adult population walks or bikes to work, and there are fewer WIC-authorized food stores than in the state overall. In the northern St. Rose service area, youth are less active than in the state overall, and the area has fewer recreation and fitness facilities per capita than the state. A little more than one third of the youth population in the northern St. Rose service area are overweight, a larger proportion than the state overall. In the southern St. Rose service area, a larger proportion of residents live in areas designated as a food desert than in the state overall, and there are more fast food establishments per capita than in the state overall. Residents reflect these issues with their concern about access to healthy foods.
Mental health	Mental health is a state of successful performance of	In the St. Rose service area, the rate of Emergency Room (ER)

Health need	Why is it important?	What does the data say?
	mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health.	visits for injury due to intentional self-harm among youth is higher than the state and Healthy People 2020 (HP2020) objective. The suicide rate in the service area is higher than the state among Whites; the rate of severe mental-illness related ER visits in the service area is much higher than the state among Blacks. The community feels there are not enough providers, and insurance coverage is limited.
Violence and injury prevention	Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth.	In the St. Rose service area, indicators of violence such as homicide, domestic violence, rape, assault injury, and school suspension/expulsion rates are all worse than state rates. The community expressed concern about unsafe streets and domestic violence.
Cardiovascular disease and stroke	Nationally, more than 1 in 3 adults (81.1 million) live with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death respectively,	In the St. Rose service area, mortality rates due to ischaemic heart disease and stroke are higher than the Healthy People 2020 (HP2020) objectives, and some ethnic groups have

Health need	Why is it important?	What does the data say?
	heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease.	disproportionately higher rates of death than others. Also, the percentage of those with hypertension in the county is slightly higher than the state average. In addition to remarking on the lack of access to healthy food and open spaces for exercise, the community expressed concern about heart disease and its risk factors among certain ethnic populations.
Economic security	Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve.	In the St. Rose service area, nearly one in six residents experience food insecurity, and some ethnic groups have higher proportions living in poverty than others. Also, in northern St. Rose service area, fourth-grade reading proficiency is worse than both the Healthy People 2020 (HP2020) objective and the state average. The community expressed concern about low wages, access to employment, and lack of affordable housing.
Substance abuse, including alcohol, tobacco, and other drugs	Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to	Data about illegal drug use are not available, but the rate of ER visits for substance abuse in Alameda County is higher than the state and community expressed concern about drug use and the lack of treatment services available to address this problem. Data available on alcohol use show that St. Rose service area residents may be using alcohol more frequently

Health need	Why is it important?	What does the data say?
	costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime and suicide.	than Californians overall.
Healthcare access & delivery, including primary & specialty care	Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life.	Wide disparities exist across multiple racial and ethnic groups among the uninsured population in the St. Rose service area. The percentages of people in the county who delayed or had difficulty obtaining care are both worse than the Healthy People 2020 (HP2020) objective. The downstream indicator of preventable hospital events shows that northern St. Rose service area residents are far more likely to be hospitalized for preventable issues than Californians overall. The community expressed concern about the cost of care and insurance as well as a lack of care providers.
Communicable diseases, including STIs	Communicable diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood or semen). Communicable diseases remain a major cause of illness, disability, and death. People in the United States continue to	In the St. Rose service area, the statistics on HIV prevalence and HIV-related hospitalizations are worse than the state, and show disparities for Black residents. Also, the tuberculosis rate is much higher than the Healthy People 2020 (HP2020) objective, and pertussis cases have been rising in the county. The

Health need	Why is it important?	What does the data say?
	get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection.	community expressed concern related to education of adolescents about sexual health.
Maternal and infant health	The topic area of maternal and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birth-weight, infant mortality, teen births, breastfeeding, and access to prenatal care. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.	In the St. Rose service area, the statistics on low birthweight, Head Start Program enrollment, and food insecurity are worse than the state. Also, the infant mortality rate shows ethnic disparities. In the northern (but not southern) St. Rose service area, a larger proportion of children are born at low birthweight than the state overall.
Cancer	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues. It is the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality	In the St. Rose service area, cancer incidence rates are close to state rates and Healthy People 2020 (HP2020) targets, but incidence and mortality rates show ethnic disparities. In the northern (but not southern) St. Rose service area, the overall cancer mortality rate is worse than the state. Available data on cancer screening show service area rates that are

Health need	Why is it important?	What does the data say?
	screening.	similar or better than the state.
Asthma	Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life-threatening. Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and overweight. Asthma is considered a significant public health burden and its prevalence has been rising since 1980.	In the St. Rose service area, nearly one in six adults and fully one in five children have asthma. Black asthma patients account for a larger proportion of service area hospital discharges than at the state level. Also, air quality in the northern St. Rose Service area is worse than in the state overall. The community expressed concern about childhood asthma.

Next Steps

After making this CHNA report publicly available in 2016, each hospital will develop individual implementation plans based on this shared data.

2. INTRODUCTION/BACKGROUND

Purpose of CHNA Report & Affordable Care Act Requirements

Enacted on March 23, 2010, the Affordable Care Act (ACA) provides guidance at a national level for CHNAs for the first time. Federal requirements included in ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations 501(r), one of which is conducting a community health needs assessment (CHNA) every three years. The CHNA report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. Final requirements were published in December 2014. The 2016 CHNA meets both state (SB697) and federal (ACA) requirements.

The federal definition of community health needs includes the social determinants of health in addition to morbidity and mortality. This broad definition of health needs is indicative of the wider focus on both upstream and downstream factors that contribute to health. Such an expanded view presents opportunities for nonprofit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health, including the social determinants of health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, ACA created more incentives for health care providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

Impact of the Affordable Care Act on CHNA

The last CHNA report conducted was in 2013, before the full implementation of the Affordable Care Act (ACA). Healthcare access was a top concern for the community and nonprofit hospitals and remains so in 2016.

The federal definition of community health needs includes social determinants of health in addition to morbidity and mortality. This broad definition of health needs is indicative of the wider focus on both upstream and downstream factors that contribute to health. Such an expanded view presents opportunities for non-profit hospitals to look beyond immediate presenting factors to identify and take action on the larger constellation of influences on health, including the social determinants of health. In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, ACA created more incentives for health care providers to focus on prevention of disease by including lower

or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

The intent of ACA is to increase number of insured and make it affordable through Medi-Cal expansion and healthcare exchanges implemented by participating states. While the ACA has expanded coverage of care for many people and families, there still exits a large population of people who remain uninsured as well as those who experience barriers to healthcare, including costs of healthcare premiums and services and getting access to timely, coordinated, culturally appropriate services.

State and County Impacts

Following the institution of the ACA in January 2014, Medi-Cal was expanded in California to low-income adults who were not previously eligible for coverage. Specifically, adults earning less than 138% of the Federal Poverty Level (approximately $15,856 annually for an individual) are now eligible for Medi-Cal. In 2014, "Covered California," a State Health Benefit Exchange, was created to provide a marketplace for healthcare coverage for any Californian. In addition, Americans and legal residents with incomes between 139% and 400% of the Federal Poverty Level can benefit from subsidized premiums.[1]

Between 2013 and 2014 there was a 12% drop in the number of uninsured Californians aged 18-64 years old,[2] according to data cited by the California Healthcare Foundation. According to the California Health Interview Survey, in 2013 19% of the population aged 18-64 in Alameda County was not insured (191,000 people).[3] Previous years (2011 and 2012) had seen the uninsured rate at 14%, demonstrating an unexpected increase between 2011 and 2013 in Alameda County.[4] Also according to the California Health Interview Survey, in 2014 18% of the population aged 18-64 in Contra Costa County was not insured (122,000 people). This continues the unexpected increasing trend, beginning in 2012 when 15% of the 18-64 population in Contra Costa County was uninsured, and continuing in 2013, when 16% of that population was uninsured.[5]

Although some Alameda County residents may have obtained health insurance for the first time, health insurance costs, the cost of care, and access to timely appointments, remains a concern. As discussed later in this report, residents (including those whose

[1] http://www.healthforcalifornia.com/covered-california
[2] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411/
[3] Insured/uninsured figures for Alameda County for 2014 are not considered statistically stable.
[4] California Health Interview Survey (CHIS), 2011-2014. Retrieved Dec. 11, 2015 from http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography
[5] California Health Interview Survey (CHIS), 2011-2014. Retrieved Dec. 11, 2015 from http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography

insurance plans did not change since ACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. Indeed, professionals who participated in this assessment also expressed concern about the lack of a sufficient number of doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance. This is supported by evidence that there was an increase in the proportion of people who said they had forgone care because they could not get an appointment (from 5% in 2013 to 8% in 2014).[6]

While 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports. While health care access is important in achieving health, a broader view takes into consideration the influence of other factors including income, education, and where a person lives. These factors are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves influenced by policy choices. These underlying social and economic factors cluster and accumulate over one's life, and influence health inequities across different populations and places.[7] According to the Robert Wood Johnson Foundation's approach of what creates good health, health outcomes are largely shaped by social and economic factors (40%), followed by health behaviors (30%), clinical care (20%) and the physical environment (10%).[8] In order to address the bigger picture of what creates good health, health care systems are increasingly extending beyond the walls of medical offices to the places where people live, learn, work, and play.

[6] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411/
[7] Santa Clara County Public Health Department, 2014 *Santa Clara County Community Health Assessment*.
[8] http://www.countyhealthrankings.org/our-approach

3. 2013 CHNA Summary & Results

In 2013, St. Rose Hospital identified community health needs in a process that met the IRS requirements of the CHNA. During this first CHNA study, the research focused on identifying health conditions, and secondarily the drivers of those conditions (including healthcare access). Our hospital identified the health needs found in the list below. In the 2016 study, the Hospitals, including our hospital, built upon this work by using a combined list of identified needs from 2013 to ask about any additional important community needs, and delving deeper into questions about healthcare access, drivers of prioritized health needs and barriers to health, and solutions to the prioritized health needs. We also specifically sought to understand how the Affordable Care Act implementation impacted residents' access to healthcare, including affordability of care. The health needs are listed in alphabetical order below.

2013 St. Rose Hospital CHNA Health Needs List (in alphabetical order)

Health Need
Dental
Health literacy/education
Healthcare access
Healthy eating (nutrition)
Mental health
Pollution/clean environment

The section below describes the health needs our hospital chose to address and the strategies we identified to address them. For a description of evaluation findings for these strategies, please see Section 8.

Mental Health

Need Statement	Issues arising from living in a state of stress, living in a stressful environment due to limited economic resources, safety concerns for self and family.
Strategy 1	The FACES for the Future (FACES) program at St. Rose Hospital provides internships, academic support, and direct mental health services to 4550 at-risk high school students per year. Using both Hospital resources and a grant from the Vesper Society, FACES identifies teens in need and ensures their access to mental and behavioral health resources. The FACES program partners with La Familia Counseling Services

	(LFCS) to provide psychosocial support to both students and their families, as well as whole-group mental health and wellness workshops for students.
Strategy 2	Case Management Mental Health Evaluation/Referrals: St. Rose Hospital is not psychiatric facility, therefore cannot address many of the community mental health needs, but there is a process in place to get mental health evaluations/referrals to patients that are seen at the hospital. The following are procedures that are followed to give patients in need of mental health assistance adequate support: • Patient are transferred to John George or other Psychiatric Facility are medically stable patient who are a threat to self or others including altered level of consciousness/incoherent and that are incapable of making good decision for him or herself. These patients are sent from the ER. • Inpatients transferred to John George or Willow Rock (Psychiatric for Teens) are patients who continuously have suicidal ideation. • MD usually refers patients who are admitted for Drug or Alcohol related diagnosis (Overdose, Gastrointestinal Bleeding, and Cirrhosis) to Social Services for consult. • Social Worker offers resources to different drug & Alcohol Program in the community. The patient must be independent, ambulatory and agreeable to sign up and check themselves in for the program. • For patient who are admitted under 5150 or Suicidal Ideation and if MD believes that patient is depressed, MD calls the Psychiatric Consultant. The Psychiatric Consultant provides phone consults or if available, he will see the patient in-house. The consultant makes recommendation such as medication dose adjustments or clearing patient as not suicidal. • All healthcare personnel are mandated reporter if abuse is suspected. Adult Protective Services & Child Protective Services Report are available online. Once the report is filed, APS and CPS will follow-up and will make the determination on where is the safest place for patient to discharge to. • Types of Abuse for APS: - Physical - Sexual

	- Neglect by Others - Abandonment - Financial - Isolation - Self-Neglect • Types of Abuse for CPS: - Substance Abuse (Usually a baby that was born from a positive drug moms) - Physical - Mental - Sexual - Neglect

Access to Health Resources

Need Statement	Inability to address basic healthcare needs due to a lack of access to resources to maintain and/or improve one's health, including primary, specialty, and preventative care
Strategy 1	Community Health Fairs: St. Rose Hospitals plans to participate in community health fairs structured by other organizations. At the fairs the hospital will plan to give out informational flyers of where community members can get medical services, such as OB/GYN, and women's imaging services, orthopedic services, gastroenterology services and cardiology services.
Strategy 2	Patient Assistance Fund – St. Rose Hospital Foundation: The St. Rose Hospital Foundation assists in providing funds to support hospital services and patient care. The Patient Assistance Fund is an annual appeal dedicated to providing direct support to patients and families who have no insurance or means to pay for medications, equipment, treatments and supplies when they are discharged for the hospital.

Nutrition

Need Statement	Poor dieting habits resulting from living in an unhealthy food environment with limited access to fresh and healthier foods.

Strategy 1	Farm Stand: St. Rose Hospital will be working with Dig Deep Farms to bring a farm stand on the hospital's campus for the community. Along with the farm stand, St. Rose intends to have its own booth once a month giving attendees demonstrations of healthy recopies and giving out health tip flyers/educational material.
Strategy 2	Patient Nutrition Services: Unhealthy diets can lead to the development of chronic disease. The St. Rose Hospital Dietitians provide patients and their families with diet education and nutritional resources in regards to diabetes and cardiovascular disease, as well as diet education for other health related diseases such as obesity, Chronic Kidney Disease, and Congestive Heart Failure. The goal of providing diet education and counseling is to promote lifestyle changes to control or prevent further disease specific complications.

Health Literacy

Need Statement	Inability to improve one's health due to limited health literacy and education, including how to maintain and improve one's health through healthy behaviors such as diet and physical activity
Strategy 1	St. Rose Hospital Annual Health Fair: Every year St. Rose Hospital hosts a community health fair on campus that offers the public free health screens, health care demonstrations and health exhibits form various health and community organizations. This offers the community opportunity to receive vast amount of education on different health topics, such as back safety, bike helmet safety, and nutrition & healthy eating tips. The following screenings are anticipated to be offered: - Cholesterol Screening - Glucose Screening - Blood Pressure Screening - Bone Density Screening - BMI (Body Mass Index) Testing - Adult & Pediatric Dental Screenings - Flu Vaccines The fair's admission is free

Strategy 2	St. Rose Hospital – Community Classes/Support Groups: St. Rose sponsors a number of support group organizations to provide encouragement and education to the community. The following classes/support groups are offered: - Overeaters Anonymous - Myasthenia Gravis Support Group - Harmony, Acceptance, Peace & Serenity - Lamaze Series Class - Breastfeeding Basics Class - Diabetes Class - Co-Dependents - Look Good Feel Better Class - St. Rose Better Breathers Club - Mommy and Me Class - UFANDA – United Filipino American Nutritionist Dietitian Association

Written Public Comments to 2013 CHNA

St. Rose Hospital provided the public an opportunity to submit written comments on the facility's previous CHNA report through http://www.strosehospital.org/contact-us/. This site will continue to allow for written community input on the hospital's most recently conducted CHNA report.

As of the time of this CHNA report development, St. Rose Hospital had not received written comments about previous CHNA reports. St. Rose Hospital will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate hospital staff.

Evaluation Findings of Previously Implemented Strategies

Purpose of 2013 Implementation Strategy Evaluation of Impact

St. Rose Hospital's 2013 Implementation Strategy Report (ISR) was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA report describes and assesses the impact of these activities. For more information on St. Rose Hospital's ISR, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing implementation strategies, please visit http://www.strosehospital.org/wp-content/uploads/2013/10/SRH-Implementation-Plan-2013-2015-FINAL.pdf. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by St. Rose Hospital in the 2013 ISR.

1. Mental health
2. Access to health resources
3. Nutrition
4. Health literacy

St. Rose Hospital is monitoring and evaluating progress to date on its 2013 implementation strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs.

As of the documentation of this CHNA report in March 2016, St. Rose Hospital had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, St. Rose Hospital will continue to monitor impact for strategies implemented in 2016.

2013 Implementation Strategy Evaluation of Impact, by Health Need

Mental Health

- The St. Rose Youth Volunteer and Shine Programs met the goal by increasing the total number of students to 39 who volunteered a total number of 6,957 hours.
- The FACES Program continued to provide health careers exploration, academic enrichment, wellness support and youth Leadership Development to 30 at-risk students. Program internships at St. Rose strengthened existing partnerships. The new pilot mentorship program in partnership with the Physician Assistant program at Samuel Merritt University (SMU) continues to be successful.

Nutrition

- Individual and community classes, support group classes, education and training classes have increased. Over 5000 classes were held in FY 14/15.

Access to Health Resources

- St. Rose Hospital continues to participate with Alameda County Public Health Department and other Hayward community-based organization such as the South Hayward Neighborhood Collaborative to address the health needs of the Harder/Tennyson.

Health Literacy

- Individual and community classes, support group classes, education and training classes have increased. Over 5000 classes were held in FY 14/15.
- The St. Rose Health Fair was held administering 850 free flu shots to our community on October 12, 2014. In addition, the hospital also provided 203 blood pressure screens, 170 glucose screenings, and 75 cholesterol screenings. St. Rose Hospital also participated in a variety of community health fairs providing 1220 additional flu shots.

4. About Our Hospital

St. Rose Hospital, an independent community hospital located in Hayward, has been an integral part of the local community for over 50 years. The hospital, accredited by the Joint Commission, has built a strong reputation for outstanding cardiology, emergency, diagnostics and women's services. Through innovation and strategic partnerships, St. Rose Hospital has helped create a healthier community. As one of Hayward's largest employers, St. Rose Hospital also plays a vital economic role in the community, providing nearly 900 jobs and an outstanding quality of life for its employees. Over 300 highly-skilled physicians practice at St. Rose Hospital, along with an experienced staff to provide high quality, yet cost-effective health care to the community, regardless of income or insurance status.

Mission

St. Rose Hospital provides quality health care to our community with respect, compassion and professionalism. We work in partnership with our highly valued physicians and employees to heal and comfort all those we serve.

Vision

St. Rose Hospital will be the health care provider of choice in central and southern Alameda County. We actively seek partnerships with all groups and individuals dedicated to improving the overall health of the diverse community we serve.

About Our Hospital's Community Benefits Program

Each year, St. Rose Hospital provides a host of innovative and impactful community benefit programs and services to underserved and underinsured residents. St. Rose Hospital community benefit programs and activities are designed to:

- Meet the specific health care needs of targeted populations
- Expand availability of health care to those who need it most
- Provide health information and education resources
- Teach participants about healthier lifestyles and the importance of staying healthy

These programs were developed to ensure that we meet the needs of the community.

Community Served

The Internal Revenue Service defines the "community served" by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

St. Rose collaborated on the 2016 CHNA with other hospitals in the Greater Southern Alameda County area. KFH-San Leandro and KFH-Fremont shared their service area data with St. Rose, and where applicable, these data are used in this report as the northern and southern St. Rose service area, respectively.

Geographic description of the community served (towns, counties, and/or zip codes)

Although St. Rose patients come from all around Alameda County, the majority reside in the southern part of the Alameda County. The St. Rose service area mainly covers the cities of San Leandro, Hayward, San Lorenzo, Union City, Newark and Fremont.

Alameda County consists of the following major cities and towns: Alameda, Albany, Berkeley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, Pleasanton, San Leandro, and Union City.

According to the County of Alameda,[9] the following unincorporated towns and areas are also included in Alameda County: Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol.

Demographic Profile of Community Served

The U.S. Census estimates a population of 1,535,248 in Alameda County (U.S. Census Bureau, American Community Survey, 2009-2013). Over one fifth (22%) of the population in Alameda County is under the age of 18, while 12% is 65 years or older, leaving approximately two thirds who are adults under the age of 65. Alameda County is also very diverse, with only 46% of the population White alone. Nearly 6% of the population is of two or more races.

Asians comprise nearly half of the service population in southern St. Rose service area (47%) and one fourth (25%) in the northern St. Rose service area which is almost similar in percentage to the Alameda County (26.8%). The northern St. Rose service area has higher percentages of Latino population (34%) compared to Alameda County overall (22.5%).

[9] https://www.acgov.org/about/cities.htm

Demographics

Race/Ethnicity (alone or in combination with other races)	**Percent of County**	**Percent of Northern St. Rose Service Area**	**Percent of Southern St. Rose Service Area**
White	45.6%	40%	32%
Asian	26.8%	25%	47%
Black	12.1%	13%	4%
Pacific Islander/Native Hawaiian	0.8%	2%	0%
American Indian/Alaskan Native	0.6%	1%	1%
Some other race	8.3%	13%	9%
Multiple races	5.9%	6%	7%
Latino (of any race)	22.5%	34%	18%

Note: Percentages do not add to 100% because they overlap.
Data source: U.S. Census Bureau, American Community Survey, 2009-2013

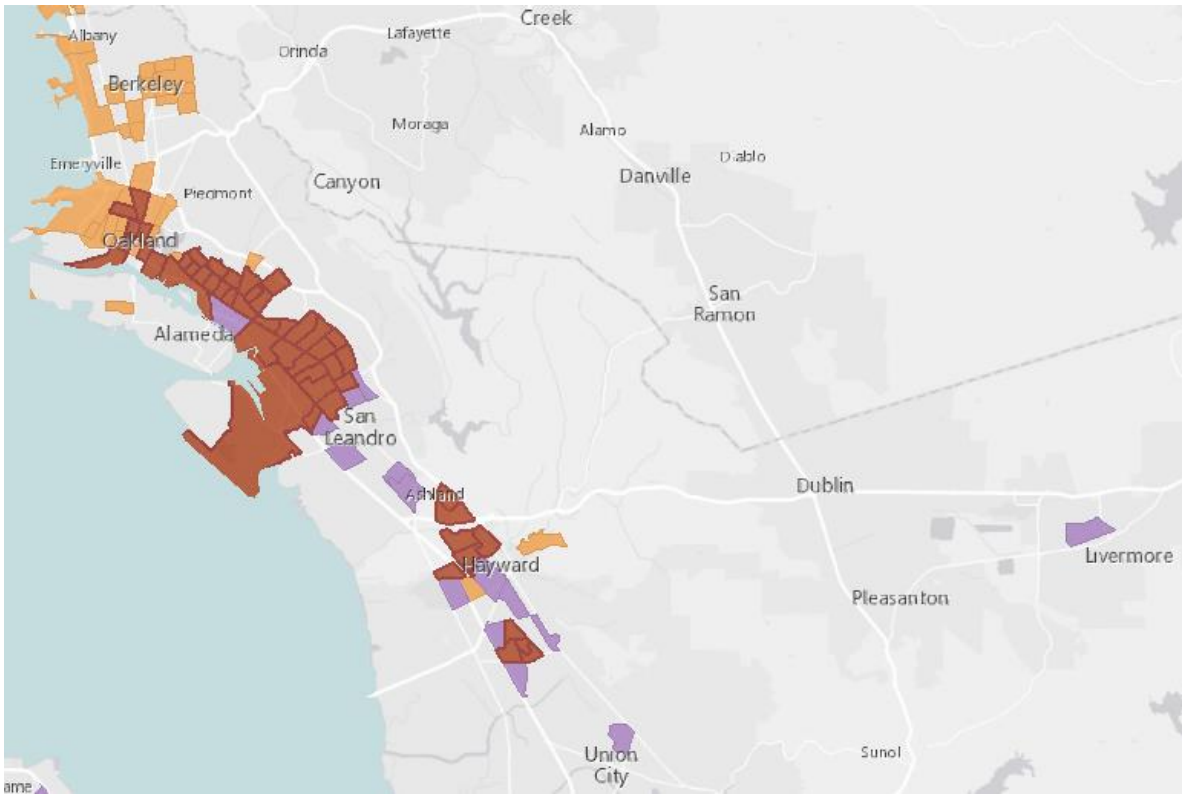
One in ten (10.4%) Alameda County residents age five or older are linguistically isolated; that is, they "live in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speaks a non-English language and speaks English 'very well'" (U.S. Census Bureau, American Community Survey, 2009-2013). A larger proportion of this population (18.7%) has limited English proficiency; that is, they "speak a language other than English at home and speak English less than 'very well.'" According to the Community Commons data platform, this indicator is relevant because "an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education."

Social Determinants of Health

Two key social determinants, poverty and education, have a significant impact on health outcomes.

More than one in four Alameda County residents (27.8%) lives below 200% of the federal poverty level, and close to half (43.1%) of households are overburdened by housing costs (i.e., housing costs exceed 30% of total household income). The map below displays where vulnerable populations live by identifying where high concentrations of population living in poverty and population living without a high school diploma overlap. Data are from the U.S. Census Bureau 2009-13 American Community Survey.

Alameda County Vulnerability Footprint

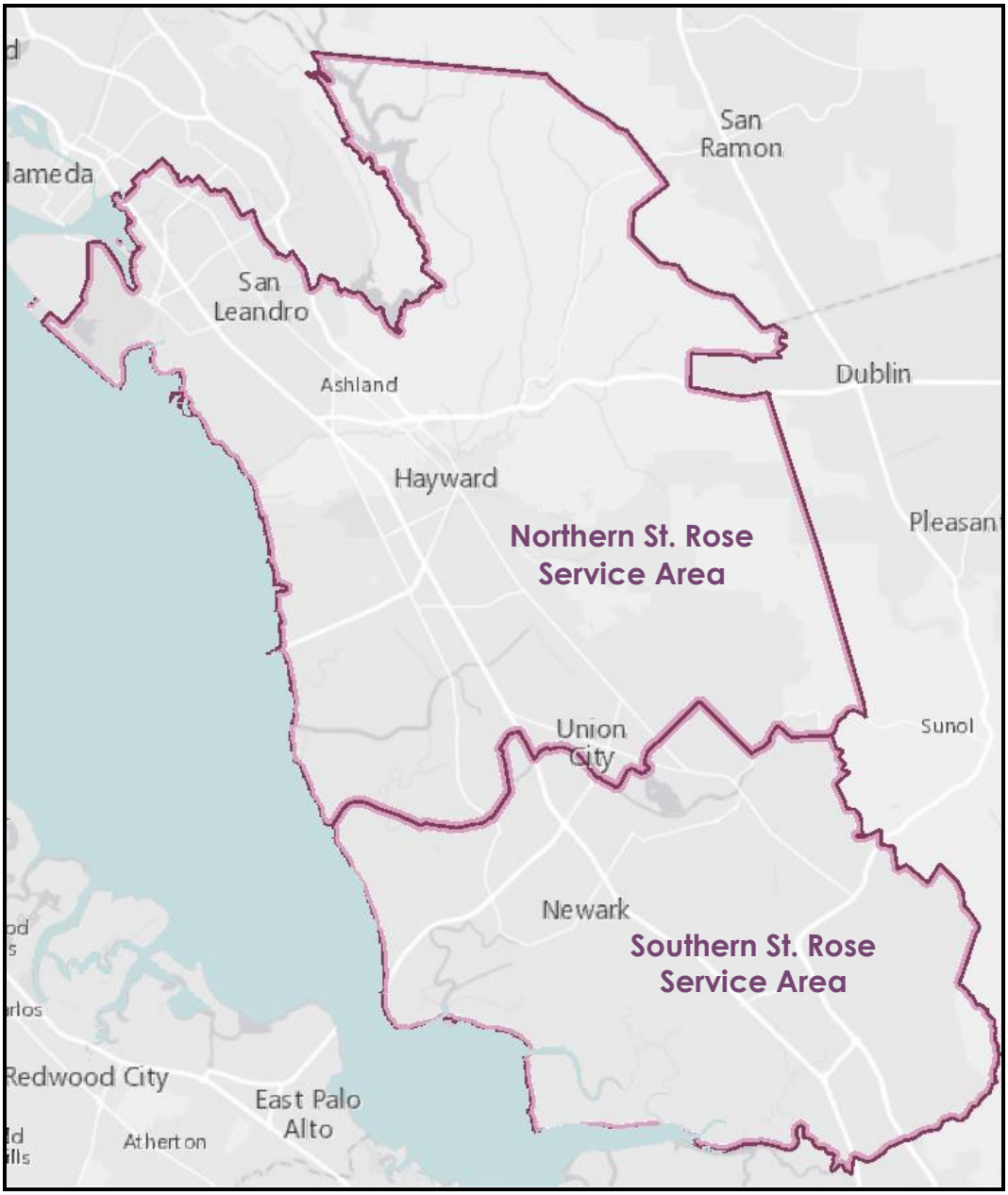


The orange shading shows areas where the percentage of population living at-or-below 100% of the Federal Poverty Level (FPL) exceeds 25%. The purple shading shows areas where the percentage of the population with no high school diploma exceeds 25%. Educational attainment is determined for all non-institutionalized persons age 25 and older. Dark red areas indicate that the census tract is above these thresholds (worse) for both educational attainment and poverty.

Close to half (43.9%) of the children in Alameda County are eligible for Free & Reduced-Price lunch (NCES Common Core of Data 2013-14), while nearly one in six children (15.7%) lives in a household with income below 100% of the Federal Poverty level (U.S. Census Bureau, American Community Survey, 2009-2013). Over one in 10 people (12.6%) in the community are uninsured (U.S. Census Bureau, American Community Survey, 2009-2013).

Map of Community Served

St. Rose Service Area Map



5. Assessment Team

Hospitals & Other Partner Organizations

Community benefit managers from twelve local hospitals in Alameda and Contra Costa Counties ("the Hospitals") contracted with Applied Survey Research in 2015 to conduct the Community Health Needs Assessment in 2016. The Hospitals were comprised of:

- John Muir Health
- Kaiser Permanente Diablo (Antioch and Walnut Creek hospitals)
- Kaiser Permanente East Bay (Oakland and Richmond hospitals)
- Kaiser Permanente Greater Southern Alameda (Fremont and San Leandro hospitals)
- St. Rose Hospital
- San Ramon Regional Hospital
- Stanford Health Care – ValleyCare
- UCSF Benioff Children's Hospital Oakland
- Washington Hospital Healthcare System

Identity & Qualifications of Consultants

The community health needs assessment was completed by Applied Survey Research (ASR), a nonprofit social research firm. For this assessment ASR conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the process of identification of community health needs and assets and of prioritization of community health needs, and documented the process and findings into a report.

ASR was uniquely suited to provide the Hospitals with consulting services relevant to conducting the CHNA. The team that participated in the work –Dr. Jennifer van Stelle, Abigail Stevens, Angie Aguirre, Samantha Green, Martine Watkins, Chandrika Rao, Melanie Espino, Kristin Ko, James Connery, Christina Connery, Emmeline Taylor, Paige Combs, and sub-contractors Dr. Julie Absey, Robin Dean, Lynn Baskett, and Nancy Ducos – brought together diverse, complementary skill sets and various schools of thought (public health, anthropology, sociology, social ethics, psychology, education, public affairs, healthcare administration, and public policy).

In addition to their research and academic credentials, the ASR team has a 35-year history of working with vulnerable and underserved populations including young children, teen mothers, seniors, low-income families, and immigrant families, families who have experienced domestic violence and child maltreatment, the homeless, and children and families with disabilities.

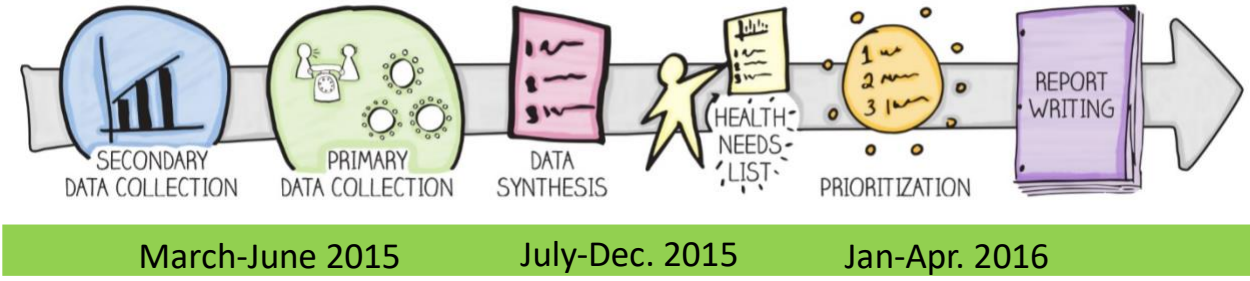
ASR's expertise in community assessments is well-recognized. ASR won a first place award in 2007 for having the best community assessment project in the country. They accomplish successful assessments by using mixed research methods to help understand the needs in question and by putting the research into action through designing and facilitating strategic planning efforts with stakeholders.

Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Alameda, Contra Costa, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties, Marin County, Nevada County, Pajaro Valley, and Solano and Napa Counties.

6. Process & Methods

The Hospitals worked in collaboration on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over five months and culminated in a report written for the Hospitals in spring of 2016.

Alameda and Contra Costa Counties – Hospitals' CHNA Process



Primary Qualitative Data (Community Input)

The Hospitals contracted with Applied Survey Research (ASR) to conduct the primary research. They used three strategies for collecting community input: key informant interviews with health experts, focus groups with professionals, and focus groups with residents.

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulated all health needs that were mentioned, along with health drivers discussed. ASR then tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in key informant interviews. This tabulation was used in part to assess community health priorities.

Community Leader Input

In all, ASR consulted with 44 community representatives of various organizations and sectors. These representatives either work in the health field or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- County Public Health (5)
- Other health centers or systems (11)
- Mental/Behavioral health or violence prevention providers (12)
- School system representatives (2)

- City or county government representatives (3)
- Nonprofit agencies providing basic needs (11)

See Attachment 4 for the titles and expertise of key stakeholders along with the date and mode of consultation (focus group or key informant interviews).

See Attachment 5 for key informant interview and focus group protocols.

Key Informant Interviews

ASR conducted primary research via key informant interviews with 18 Alameda County experts from various organizations. Between June and October 2015, experts including the public health officers, community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

Experts were interviewed in person or by telephone for approximately one hour. Informants were asked to identify the top needs of their constituencies, including specific groups or areas with greater or special needs; how access to healthcare has changed in the post-Affordable Care Act environment; drivers of the health needs they identified and barriers to health; and suggested solutions for the health needs they identified, including existing or needed resources.

Stakeholder Focus Groups

Three focus groups with stakeholders were conducted between August and October 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, health care access and barriers thereto, and assets and resources that exist or are needed to address the community's top health needs, including policies, programs, etc.

Details of Focus Groups with Professionals

Focus	Focus Group Host/Partner	Date	Number of Participants
Mental health	National Alliance on Mental Illness	08/20/15	8
Minority (Asian)	Washington Hospital	09/02/15	8
Veterans	U.S. Department of Veterans Affairs, Oakland Vet Center	09/23/15	10

Please see Attachment 4 for a full list of community leaders/stakeholders consulted and their credentials.

Resident Input

Resident focus groups were conducted between August and October 2015. The discussion centered around four sets of questions, which were modified appropriately for the audience. The discussion included questions about the community's top health needs, the drivers of those needs, the community's experience of health care access and barriers thereto, and assets and resources that exist or are needed to address the community's top health needs.

In order to provide a voice to the community it serves in Alameda County, the study team targeted participants who were medically underserved, in poverty, and/or socially or linguistically isolated. One focus group was held with community members. This resident group was held in Union City, a relatively central location in southern Alameda County. Residents were recruited by the nonprofit host, Centro De Servicios, who serves uninsured residents.

Details of Focus Groups with Residents

Population Focus	Focus Group Host/Partner	Date	Number of Participants
Immigrant population	Centro De Servicios	09/18/15	10

2016 Resident Participant Demographics

Ten community members participated in the focus group discussions in Alameda County. All participants were asked to complete an anonymous demographic survey, the results of which are reflected below.

- 100% of participants (10) completed a survey.
- 100% (10) of participants were Latino.
- 100% (10) were between the ages of 18 and 64 years old. 50% were younger than 40, and 50% were 40 or older.
- 10% (1) were uninsured, while 40% had benefits through Medi-Cal or Medicare. The rest had private insurance.
- Residents lived in various areas of southern Alameda County: Hayward (7), Union City (2), and Cherryland (1).
- 80% (8) reported having an annual household income of under $45,000 per year, which is not much more than the 2014 California Self-Sufficiency Standard for Alameda County for two adults with no children ($38,817). This demonstrates a fair level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

Secondary Quantitative Data Collection

ASR analyzed over 150 health indicators to assist the Hospitals with understanding the health needs in Alameda County and prioritizing them. Data from existing sources were collected using the Community Commons data platform customized for Kaiser Permanente, the UCLA data platform for the California Health Interview Survey (AskCHIS), and other online sources. In addition, ASR collected data from the Alameda County Public Health Department.

As a further framework for the assessment, the Hospitals requested that ASR address the following questions in its analysis:

- How do these indicators perform against accepted benchmarks (Healthy People 2020, statewide and national averages)?
- Are there disparate outcomes and conditions for people in the community?

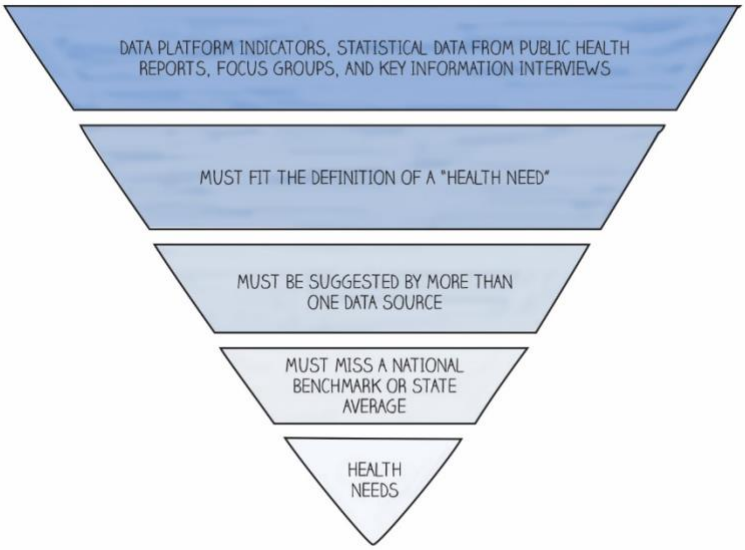
Information Gaps & Limitations

ASR and the Hospitals were limited in their ability to assess some of the identified community health needs due to a lack of secondary data. Such limitations included data on sub-populations, such as foreign born, the LGBTQ population and incarcerated individuals. Health topics in which data are limited include: bullying, substance abuse (particularly, use of illegal drugs and misuse of prescription medication), use of e-cigarettes and related behaviors such as vaping, dental health (particularly dental caries), consumption of sugar-sweetened beverages (SSBs), elder health, disabilities, flu vaccines, quality of life and stressors, police-associated violence, human trafficking, discrimination and perceptions related to race, sexual behaviors, and extended data on breastfeeding.

7. Identification & Prioritization of Community Health Needs

To identify the community's health needs, ASR and the Hospitals followed these steps:

1. Gathered data on 150+ health indicators using the Community Commons platform[10], public health department reports, Healthy People 2020 objectives, and qualitative data. See Attachment 3 for a list of indicators on which data were gathered.



2. Narrowed the list to "health needs" by applying criteria.

3. Used criteria to prioritize the health needs.

These steps are further defined below.

Identification of Community Health Needs

As described in Section 5, a wide variety of experts and community members were consulted about the health of the community. Community members were frank and forthcoming about their personal experiences with health challenges and their perceptions about the needs of their families and community.

Collectively, they identified a diverse set of health conditions and demonstrated a clear understanding of the health behaviors and other drivers (environmental and clinical) that affect the health outcomes. They spoke about prevention, access to care, clinical practices that work and don't work, and their overall perceptions of the community's health.

[10] Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system, found at www.communitycommons.org

In order to generate a list of health needs, ASR used a spreadsheet (known as the "data culling tool") to list indicator data and evaluate whether they were "health needs." The indicator data collected included Community Commons web platform data, secondary data from county public health department reports, and qualitative data from focus groups and key informant interviews.

In order to be categorized as a prioritized community health need, all four of the following criteria needed to be met:

1. The issue must fit the definition of a "health need."
2. The issue is suggested or confirmed by more than one source of secondary and/or primary data.
3. At least one related indicator performs poorly against the Healthy People 2020 ("HP2020") benchmark or, if no HP2020 benchmark exists, against the state average.
4. The need must meet a minimum community prioritization threshold (by at least five of fourteen key informant interviews or one of four focus groups).

DEFINITIONS

Health **condition:** A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

Health **driver:** A behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health.

Health **need:** A poor health *outcome* and its associated health *driver*, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

Health **outcome:** A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality.

Health **indicator:** A characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly). and can be used to describe one or more aspects of the health of an

Any health needs that did not reach the primary data threshold in criterion #4 above needed to meet the following more stringent criteria to rise to the list:

(a) Three or more indicators must miss a state or national benchmark by 5% or more from target

(b) At least one indicator must show an ethnic disparity.

A total of eleven health conditions or drivers fit all four criteria or conditional criteria and were retained as community health needs. The list of needs, in priority order is found below.

Summarized Descriptions of Health Needs (2016)

Healthy diets and achievement and maintenance of healthy body weights reduce the risk of chronic diseases and promote health. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and

communities. Creating and supporting healthy food and physical environments allows people to make healthier choices and live healthier lives. **Obesity, diabetes, and healthy eating/active living** are health needs locally as marked by youth who consume inadequate amounts of fruits and vegetables, a very small proportion of the adult population walks or bikes to work, and fewer WIC-authorized food stores than in the state overall. In the northern St. Rose service area, youth are less active than in the state overall, and the area has fewer recreation and fitness facilities per capita than the state. A little more than one third of the youth population in the northern St. Rose service area are overweight, a larger proportion than the state overall. In the southern St. Rose service area, a larger proportion of residents live in areas designated as a food desert than in the state overall, and there are more fast food establishments per capita than in the state overall. Residents reflect these issues with their concern about access to healthy foods.

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community and society. Mental health plays a major role in people's ability to maintain good physical health, and conversely, problems with physical health can have a serious impact on mental health. Mental health is a health need locally as illustrated by the rate of Emergency Room (ER) visits for injury due to intentional self-harm among youth, which is higher than the state and Healthy People 2020 (HP2020) objective. The suicide rate in the service area is higher than the state among Whites; the rate of severe mental-illness related ER visits in the service area is much higher than the state among Blacks. The community feels there are not enough providers, and insurance coverage is limited.

Violence and intentional injury contributes to poorer physical health for victims, perpetrators, and community members. In addition to direct physical injury, victims of violence are at increased risk of depression, substance abuse, anxiety, reproductive health problems, and suicidal behavior. Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. Witnessing and experiencing violence in a community can cause long term behavioral and emotional problems in youth. Violence and injury prevention are health needs locally as demonstrated by indicators of violence such as homicide, domestic violence, rape, assault injury, and school suspension/expulsion rates that are all worse than state rates. The community expressed concern about unsafe streets and domestic violence.

Nationally, more than 1 in 3 adults (81.1 million) live with one or more types of cardiovascular disease. In addition to being the first and third leading causes of death respectively in the nation, **heart disease and stroke** result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. It is imperative to address risk factors early in life to prevent complications of chronic cardiovascular disease. Cardiovascular disease and stroke are health needs locally as demonstrated by mortality rates due to ischaemic heart disease and stroke that are

higher than the Healthy People 2020 (HP2020) objectives, and some ethnic groups having disproportionately higher rates of death than others. Also, the percentage of those with hypertension in the county is slightly higher than the state average. In addition to remarking on the lack of access to healthy food and open spaces for exercise, the community expressed concern about heart disease and its risk factors among certain ethnic populations.

Research has increasingly shown how strongly social and economic conditions determine population health and differences in health among subgroups, much more so than medical care. For example, research shows that poverty in childhood has long-lasting effects limiting life expectancy and worsening health for the rest of the child's life, even if social conditions subsequently improve. **Economic security** is a health need locally as illustrated by the fact that nearly one in six residents experience food insecurity, and some ethnic groups have higher proportions living in poverty than others. Also, in northern St. Rose service area, fourth-grade reading proficiency is worse than both the Healthy People 2020 (HP2020) objective and the state average. The community expressed concern about low wages, access to employment, and lack of affordable housing.

Substance abuse has a major impact on individuals, families, and communities. For example, smoking and tobacco use cause many diseases, such as cancer, heart disease, and respiratory diseases. Substance abuse is now understood as a disorder that can develop into a chronic illness for some individuals. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to: teenage pregnancy, domestic violence, child abuse, motor vehicle crashes, HIV/AIDS, crime, and suicide. Substance abuse (including tobacco and alcohol) is a health need as evidenced by the rate of ER visits for substance abuse in Alameda County, which is higher than the state. Data about illegal drug use are not available, but the community expressed concern about drug use and the lack of treatment services available to address this problem. Data available on alcohol use show that St. Rose service area residents may be using alcohol more frequently than Californians overall.

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Components of access to care include: insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include: quality, transparency, and cultural competence. Limited access to health care and compromised healthcare delivery impact people's ability to reach their full potential, negatively affecting their quality of life. **Healthcare access & delivery, including primary and specialty care**, is a health need locally in part because wide disparities exist across multiple racial and ethnic groups among the uninsured population in the St. Rose service area. The percentages of people in the county who delayed or had difficulty obtaining care are both worse than the Healthy People 2020 (HP2020) objective. The downstream indicator of preventable hospital events shows

that northern St. Rose service area residents are far more likely to be hospitalized for preventable issues than Californians overall. The community expressed concern about the cost of care and insurance as well as a lack of care providers.

Communicable diseases are diseases that are primarily transmitted through direct contact with an infected individual or their discharge (such as blood or semen). Communicable diseases remain a major cause of illness, disability, and death. People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection. Communicable diseases, including sexually transmitted infections (STIs), are health needs locally as demonstrated by the fact that the statistics on HIV prevalence and HIV-related hospitalizations are worse than the state, and show disparities for Black residents. Also, the tuberculosis rate is much higher than the Healthy People 2020 (HP2020) objective, and pertussis cases have been rising in the county. The community expressed concern related to education of adolescents about sexual health.

The topic area of **maternal and child health** addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. Data indicators that measure progress in this area include low birth weight, infant mortality, teen births, breastfeeding, and access to prenatal care. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Maternal and infant health are health needs locally as evidenced by the statistics on low birthweight, Head Start Program enrollment, and food insecurity, which are all worse than the state. Also, the infant mortality rate shows ethnic disparities. In the northern (but not southern) St. Rose service area, a larger proportion of children are born at low birthweight than the state overall.

Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues. It is the second most common cause of death in the United States. Behavioral and environmental factors play a large role in reducing the nation's cancer burden, along with the availability and accessibility of high-quality screening. Cancer is a health need locally as evidenced by incidence rates that are close to state rates and Healthy People 2020 (HP2020) targets, but which show ethnic disparities. In the northern (but not southern) St. Rose service area, the overall cancer mortality rate is worse than the state. Available data on cancer screening show service area rates that are similar or better than the state.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life-threatening. Risk factors for asthma currently being investigated include having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and being overweight. Asthma is considered a significant public health burden and its prevalence has been rising since

1980. Asthma is a health need locally as marked by the fact that nearly one in six adults and fully one in five children have asthma. Black asthma patients account for a larger proportion of service area hospital discharges than at the state level. Also, air quality in the northern St. Rose Service area is worse than in the state overall. The community expressed concern about childhood asthma.

For further details, please consult the Health Needs Profiles appended to this report as Attachment 8.

Prioritization of Health Needs

Before beginning the prioritization process, St. Rose Hospital and its hospital partners chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

Severity of need: This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

Magnitude/scale of the need: The magnitude refers to the number of people affected by the health need.

Clear disparities or inequities: This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

Multiplier effect: A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

Community priority: The community prioritizes the issue over other issues on which it has expressed concern during the CHNA primary data collection process. ASR rated this criterion based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.

Scoring Criteria 1-3: The score levels for the prioritization criteria were:

- **3:** Strongly meets criteria, or is of great concern
- **2:** Meets criteria, or is of some concern
- **1:** Does not meet criteria, or is not of concern

A survey was then created, listing each of the health needs in alphabetical order and offering the first four prioritization criteria for rating. Community representatives and representatives of the local, participating hospitals rated each of the health needs on each of the first four prioritization criteria via an online survey in the first quarter of 2016. ASR assigned ratings to the fifth criterion based on how many key informants and focus groups prioritized the health need.

Combining the Scores: For each of the first four criteria, group members' ratings were combined and averaged to obtain a combined score. Then, the mean was calculated based on the five criteria scores for an overall prioritization score for each health need.

List of Prioritized Needs

The need scores ranged between 1.82 and 2.90 on a scale of 1-3 with 1 being the lowest score possible and 3 being the highest score possible. The needs are ranked by prioritization score in the table below. The specific scores for each of the five criteria used to generate the overall community health needs prioritization scores may be viewed in Attachment 6.

2016 St. Rose Hospital Health Needs by Prioritization Rank

Rank	Health Need	Overall Average Priority Score
1	Obesity, diabetes, & healthy eating/active living	2.90
2	Mental health	2.80
3	Economic security	2.67
4	Cardiovascular disease & stroke	2.66
5	Substance abuse, including alcohol, tobacco, and other drugs	2.58
6	Violence/injury prevention	2.56
7	Healthcare access & delivery, including primary & specialty care	2.43
8	Cancer	2.17
9	Infectious diseases, including STIs	1.97
10	Asthma	1.89
11	Maternal & child health	1.82

8. CONCLUSION

The Hospitals worked in collaboration to meet the requirements of the federally required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and doing new primary research as a team, the Hospitals were able to collectively understand the community's perception of health needs and prioritize health needs with an understanding of how each compares against benchmarks.

After making this CHNA report publicly available in 2016, each hospital will develop individual implementation plans based on this shared data.

9. List of Attachments

1. Glossary
2. Secondary Data Sources
3. List of Indicators on Which Data Were Gathered
4. Persons Representing the Broad Interests of the Community
5. CHNA Qualitative Data Collection Protocols
6. 2016 Health Needs Prioritization Scores: Breakdown by Criteria
7. Community Assets & Resources
8. 2016 CHNA Health Needs Profiles