COMMUNITY PRIORITY – SAFETY & VIOLENCE

Strategic Issue: How can the public health community ensure safe and violence-free neighborhoods across Alameda County?

How can the public health system be mobilized to collaborate in new ways that would effectively decrease current levels of violence in specific communities and neighborhoods in Alameda County?

Vision: Community and Public Safety that ensures crime and abuse prevention, neighborhood safety, and communities that are resilient to disasters and emergencies.

Voices From Community Discussions – Excerpts

Rise in violence among children. Impact of community violence downplayed by social workers, law enforcement and community residents. Mom’s over protect their children because of violence. Eliminate gang and gun violence. Youth & Family Services programs turn at-risk youth away from gang life – see city website. Community parks free of gangsters. Something happened at an early age (that festered anger and was not dealt with) to people who commit gun violence – these are our sons, brothers, cousins and they need to know they are loved. It takes a village to raise a child and stop the violence. No crime. Pre-assumption that certain people commit violent crimes. Community organizing fights crime and violence. Safer neighborhoods. Keep seniors safe from crime. Safe senior sanctuaries in the community. Street and traffic safety for seniors and people living with disabilities. Police presence in community (when there is a crime and when there isn’t to develop a relationship with residents). More safe places to socialize. Relationship exist between mental health and criminal/violent behavior. If deal with mental dysfunction then you deal with crime/violence. Lots of parks in Oakland (small and large) but they aren’t open and/or used because of safety issues and upkeep. Foster and transitioning kids are populations most vulnerable issues of safety and violence. Historical racial violence impacts present day violence. Safety impacts almost everything.

Community Health Status Assessment Data

County’s violent crime rate consistently higher than state & national rates the past decades

<table>
<thead>
<tr>
<th>Homicides</th>
<th>Assault-Related ED Visits</th>
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</thead>
<tbody>
<tr>
<td>• N=394 (rate: 8.4 per 100,000 residents)</td>
<td>• N=19,957 (rate: 426.7 per 100,000)</td>
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<tr>
<td>• Leading cause of death among ages 15-24</td>
<td>• Male and female rates are highest for ages 15-24; thereafter rates decrease with age</td>
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<tr>
<td>• Primarily occurs among males and is highest for youth and young adult males: 40 (age 15-24) and 31 (age 25-34)</td>
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Rate Disparities:
- 1.9 (Asian) to 43.7 (Afr. Am.)
- 2.7 (Fremont) to 18.7 (Oakland)
- 3.4 (low poverty neighborhoods) to 30.4 (very high poverty neighborhoods)

Trends:
- Rates are stable for Asians, Hispanics and
Forces of Change

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<tbody>
<tr>
<td>Gun control, if legislated, is an investment in violence prevention</td>
<td>Domestic violence is on the increase</td>
<td>Violence is an entrenched force, affecting the health and well-being of Alameda County residents</td>
<td>Decrease bioterrorism funding to local health departments</td>
</tr>
<tr>
<td>Increase drug resistant bacteria and emerging infectious diseases</td>
<td>Children are experiencing violence and PTSD at higher rates than before</td>
<td>Centralization of all violence prevention information</td>
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<tr>
<td></td>
<td>Internet access to guns and weapons</td>
<td>Reform incarceration policy</td>
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<td></td>
<td>Emergency preparedness</td>
<td>Climate change &amp; air quality</td>
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Local Public Health System Assessment

**Essential Public Health Services:** 1 (monitor health status), 2 (diagnose and investigate)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities for Immediate Improvement and Partnership</th>
<th>Priorities or Longer Term Improvement Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA has Disaster Health Volunteer system. Disaster Preparedness Health Coalition (DPHC) Disaster Prep. Health Coalition is growing (includes hospitals, clinics, Behavioral Health) Emergency Lab Response system in place Countywide drills for emergency response</td>
<td>Not clear how PH emerging threats like violence, sexual exploitation, are monitored or if surveillance exists Disaster Prep: we may not be able to continue operating in disaster due to outdated and inadequate technology Negative stigmatization during the emergency (e.g., Avian Flu, Ebola)</td>
<td>Connect Chronic Disease Prevention Plan to Public Safety budget Clarify resources for water testing (EH and water providers/partners) Investigate chemical &amp; radiologic testing resources within our LPHS and include in plans Develop and strengthen surge capacity resources/agreements Update the emergency directories Establish Agency emergency workgroup</td>
<td>Improve epi surveillance resources and expertise (initially CD, then PH non-CD threats (e.g., violence) Develop countywide medical surge plan with DPHC Develop epi capacity for disaster response &amp; investigation</td>
</tr>
</tbody>
</table>
1 Alameda County Health Data Profile, 2014; 2 Includes murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault; 3 Defined as affecting the Alameda County public health system, state, regional and national public health systems, and our community's and society's quality of life and well-being; 4 Includes new ways of thinking that are showing up on the horizon (thinking may or may not become accepted trends or practices; 5 Includes practices, ways of thinking, and factors which are picking up momentum and acceptance; 6 Includes mainstream or standard ways of operating, current best practices, dominant factors and events; 7 Includes ideas that are decreasing in influence, are less relevant, or are no longer the current thinking.
COMMUNITY PRIORITY – HEALTHCARE ACCESS

Strategic Issue: How can the public health community ensure access to population-based and personal healthcare services?

Vision: Accessible medical and mental health care that is high quality, comprehensive, affordable, culturally and linguistically appropriate and supports good health and the expectation for all to live a full and productive life.

Voices From Community Discussions - Excerpts

Coordinated care/services all in one place for accessibility  Most health insurance is through jobs – more education leads to more job access leads to healthcare benefits  Lack of access to healthcare is not okay even if not working – it should be a civil right  Invest in staff and resources to increase capacity  More free community-based clinics; free mental, behavioral, vision and dental health services for all  Mental health is ignored (no resources/sources, shame, fear)  Expand mental health & drug programs  Mental health not always associated with sexuality – LGBT community  Clear continuity and consistency for moms needing care and local accessible pediatric services  Doctors need sensitivity training on diverse topics  Cultural & linguistic appropriate care – build a language technology infrastructure  Gap in services for Asians/other ethnic groups (language, long distance travels for services)  Reform Medi-Cal (accepted by more doctors, more time with patients, more services)  Long waits (six months) to get in for services – need more local, same day clinics  Invest in healthcare and mental health services at public schools  Use fire stations as healthcare portal  Access/services available for formerly incarcerated  More health fairs  Care that fosters trust and confidence in providers  Repeated proof of permanent disability is a barrier  Not enough doctors, hospitals, urgent care centers  Medical care without having shame or stigma attached  Health coaches to help educate patient on eligibility requirements  Human contact (not just filling out papers, make font bigger)  Doctors that listen and are reflective  Profit trumps healthcare

Community Health Status Assessment Data

Usual Source of Care

- Similar for Alameda County (86.2%) and California (85.8%)

Disparity:
- 65.8% (Afr. Am.)
- 81.7% (API)
- 86.6% (Hisp./Latino)
- 92.4% (White)

Avoidable ED Visits

- N=167,107 (rate 3,653.0 per 100,000 population)
- Rate highest for children (age 1-5) and females (age 15-24)
- Female rates higher than male rates for all race/ethnic groups

Rate Disparities:
- 1,138.8 (Asian) to 9,978.9 (Afr. Am.)
- 1,429.8 (Albany) to 5,724.6 (Hayward)
- Asthma: 170.6 (Asian) to 1,899.1 (Afr. Am.); 220.2 (Pleasanton) to 777.6 (Oakland)
- Mental disorders: 255.3 (Asian) to 2,396.4 (Afr. Am.); 555.1 (Dublin) to

Preventable Hospitalizations

- Represent 8% of all adults who are hospitalized

Acute Disease: N=13,363 (rate 447.7 per 100,000 population)

Rate Disparities:
- 274.3 (API) to 681.5 (Afr. Am.)
- 273.7 (Albany) to 555.6 (Hayward)

Chronic Disease: N=24,156 (rate 787.5 per 100,000 population)

Rate Disparities:
- 425.2 (API) to 2,055.1 (Afr. Am.)
- 293.4 (Albany) to 1,195.3
## Forces of Change

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<thead>
<tr>
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<tbody>
<tr>
<td>Funding for insurance for those excluded from health care reform</td>
<td>ACA “Obamacare”</td>
<td>PH is reactive to biomedical model</td>
<td>The medical model</td>
</tr>
<tr>
<td>Invest in prevention by:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• increasing mental health funding</td>
<td>• Impact on “safety net”</td>
<td>• Long hospital stays</td>
<td></td>
</tr>
<tr>
<td>• insurance companies funding prevention</td>
<td>• Primary care access</td>
<td>• Focus on acute care</td>
<td></td>
</tr>
<tr>
<td>Health care funds for the undocumented</td>
<td>Increase use of electronic medical record</td>
<td>Fee-for-service</td>
<td>Use of licensed medical professionals providing all care</td>
</tr>
<tr>
<td>Decreasing workforce and retirement health benefits</td>
<td>School health clinics</td>
<td>Access to care for undocumented (?)</td>
<td>Contact with personal providers</td>
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<tr>
<td></td>
<td></td>
<td>Unknowns about the Affordable Care Act</td>
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</table>

## Local Public Health System Assessment

**Essential Public Health Services:** 7 (health care linkage/access), 8 (health care workforce), 9 (evaluation health care accessibility and effectiveness)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities for Immediate Improvement and Partnership</th>
<th>Priorities or Longer Term Improvement Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a lot of health care utilization data</td>
<td>Need to do more with utilization data</td>
<td>Increasing clinician outreach and presence</td>
<td>A database, a la SF model that collects data on individual folks and helps coordinate services but also rolls up to policy makers in summary and aggregate</td>
</tr>
<tr>
<td>School based health centers</td>
<td>Very fragmented, not coordinated</td>
<td>Review current data collection practices and data sharing agreements</td>
<td>One number to call for next appointment across the system</td>
</tr>
<tr>
<td>Data collection to identify needs is good (e.g., Pacific Islander women don’t access PNC at same rates as other groups)</td>
<td>Not all groups having trouble accessing services are identified</td>
<td>Require standard assessment for all contracts (i.e., ask clients about basic entitlement services, basic health problems, problem accessing health care, etc.)</td>
<td>Politicians address the hot spots in their districts</td>
</tr>
<tr>
<td>A lot of activity identifying needs even if we aren’t meeting those needs</td>
<td>We are not doing enough, going the extra mile to link people to ALL of the services they need</td>
<td>Expand community ambassador programs</td>
<td>Map services across the county</td>
</tr>
<tr>
<td>Have more folks signed up for health care insurance and medical home than any other county in the State. A variety of different clinics etc. that are meeting the unique needs of certain populations very well, like Asian Health Services, faith ministries, homeless, etc. Payment systems starting to pay closer attention to social determinants (e.g., hospitals not paid if homeless patients readmitted within 30 days).</td>
<td>We need to wean ourselves off categorical funding. Increase language and cultural capacity at health clinics. Provide cross training on social determinants of health (SOH).</td>
<td>Educate community about their power (i.e., voting and right to engage representatives). Participate in Alameda County Healthcare Pathways system.</td>
<td></td>
</tr>
</tbody>
</table>

1 Alameda County Health Data Profile, 2014
2 Defined as having a place that one usually goes to when sick or in need of health related advice
3 Defined as ED visits that could have been more appropriately managed by or referred to a primary care physician in an office or clinic setting (MediCal Managed Care Division of California).
4 Defined as inpatient hospital stays that could have been avoided with improved access to and quality of outpatient care and disease management (Agency for Healthcare Research and Quality (AHRQ)).
5 Defined as affecting the Alameda County public health system, state, regional and national public health systems, and our community's and society's quality of life and well-being.
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COMMUNITY PRIORITY – ECONOMIC INDEPENDENCE

**Strategic Issue:** How can the public health community address income inequality, poverty and economic conditions that affect health outcomes in across Alameda County?

How can the non-traditional partners, such as private businesses, share collaborative responsibility to ensure economic independence among residents of Alameda County?

**Vision:** Community economic development that supports the ability of all residents, regardless of race/ethnicity or place of residence, to pay for all of their basic needs (including housing, food, transportation, healthcare, and childcare) and build wealth.

**Voices From Community Discussions – Excerpts**

Focus on re-entry and job training  
- Connect high schools to businesses & allow students to learn trades and get experience
- Employment for all including youth
- Fund youth development programs, career technical & vocational training, art, music and incorporate at youth centers (including health and enrichment activities)
- Government support for and training to start new businesses
- Build locally owned & Black businesses that are health promoting
- Uncover hidden skills and train for jobs
- Employment training to improve hiring of transgender community
- Employability impacted by high criminal justice rate
- No jobs/unemployment creates delinquency
- Job layoffs creates homelessness
- Support “supportive employment” (living wage, childcare)
- Employment works against people living with disabilities – their benefits are impacted
- Good jobs are linked education
- Poverty wage/no benefits for In-Home Support Service providers
- Businesses in community (e.g., grocery stores) that have quality produces
- People are asked to make a choice about economics when they don't have no economics
- High cost of living
- Discounts (seniors & transportation)
- Community centered locally-owned economies/economic development
- Economic empowerment (financial management, credit repair)

**Community Health Status Assessment Data**

<table>
<thead>
<tr>
<th>Socioeconomic Indicators</th>
<th>Neighborhood Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-poverty (&gt; 20% of individuals are living in poverty) neighborhoods in East and West Oakland, and parts of central county</td>
<td><strong>Gradient</strong> – as poverty level increases:</td>
</tr>
</tbody>
</table>
| Education Disparity:  
  - High school or more: 66.3% (Hispanic/Latino) to 95.8% (White, Non-Hispanic/Latino)  
  - Bachelor degree or more: 17-18% (Hispanic/Latino and PI) 53.8% (Asian) |  
  - Life expectancy ↓  
  - Leading causes of death rates ↑  
  - ED visit rates for selected conditions ↑  
  - All cause mortality rates (ages 0-44) ↑  
  - All cause mortality rates (ages 45+) ↑  
  - Unemployment rate ↑ |
| Income Disparity:  
  - Median household income: $42,124 (African American) to $80,124 (Asian) |
**Forces of Change**

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</thead>
<tbody>
<tr>
<td>↑ globalization and the continued decline in unions</td>
<td>Student debt ↓ the quality of life</td>
<td>Income inequality (wealth gap)</td>
<td>Decrease in disposal income</td>
</tr>
<tr>
<td>Oligarchy (wealth concentration and impact on political power)</td>
<td>↑ in income disparity leads to ↓ in health</td>
<td>Resource allocation is not need based (programs follow dollars not need)</td>
<td></td>
</tr>
<tr>
<td>Increasing equity:</td>
<td>↓ workplace health benefits</td>
<td>Relevant work requires relevant training</td>
<td></td>
</tr>
<tr>
<td>o Living wage and employment reform</td>
<td>Lack of retirement benefits for retirees (impacts income, healthcare, housing)</td>
<td>Inadequate workforce:</td>
<td></td>
</tr>
<tr>
<td>o Social impact bonds</td>
<td></td>
<td>o Low high school graduation rate</td>
<td></td>
</tr>
<tr>
<td>o Insurance funding for those excluded from health care reform</td>
<td></td>
<td>o Not enough diversity/numbers in workforce</td>
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<tr>
<td></td>
<td></td>
<td>o No pipeline to ↑ workforce</td>
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</table>

**Local Public Health System Assessment**

Essential Public Health Services: 4 (community mobilization), 5 (policies and plans)

<table>
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<tr>
<th>Strengths</th>
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<th>Opportunities for Immediate Improvement and Partnership</th>
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</thead>
<tbody>
<tr>
<td>Innovative community that surrounds Alameda County (tech community abounds in the Bay Area)</td>
<td>Funding in health care “silohed”, prohibiting ability to work in social determinants of health</td>
<td>Institutionalize our cross-agency and cross-jurisdictional work that addresses the social determinants of health, such as Place Matters, Build Blocks, etc.</td>
<td>Leverage/coordinate work with health disparities and community partners and registries of vulnerable populations and resiliency work</td>
</tr>
<tr>
<td>Place Matters had a robust stakeholder engagement process to create a local policy agenda</td>
<td>Social Determinants of health are usually not measured</td>
<td>Seek out waivers to get us more flexibility in how we spend our funding</td>
<td>Develop simplified reports for the community such as Mark Mingoff style (SDOH health index card) that could be easily reported to public</td>
</tr>
<tr>
<td>HIAs have been used several times and done very well</td>
<td>No consistent, systemic methodology to assess or train staff in cultural competency and social determinates</td>
<td>Provide cross training to folks on social determinants of health</td>
<td>Take silo programs and encourage a policy/practice change that aligns funding/resources across</td>
</tr>
<tr>
<td>Legislative Council</td>
<td></td>
<td>Housing status and other</td>
<td></td>
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</tbody>
</table>
creates legislative platform on an annual basis
Place Matters writes letters and testifies on local policy issues that impact health

Successful partnerships within ACPHD and across to community partners, government

Not monitoring at all what happens after policies have been passed. No resources have been dedicated to this.

foundational issues should be addressed, tracked and resourced
Develop standards/measurements of SDOH.

Engage other organizations around “social threats” (e.g., housing crisis, foreclosures)

Make the SLEB system more accessible

Use our money differently so that it is more flexible and we can use it to address the priorities that are included in the CHIP

Need more private sector people involved in the process, such as businesses

agencies toward a common goal

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