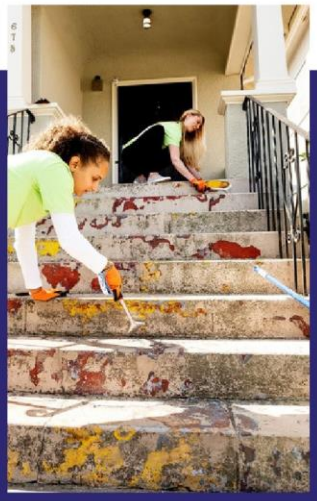
UCSF Benioff Children's Hospital
Oakland







2025 Community Health Needs Assessment

ACKNOWLEDGMENTS

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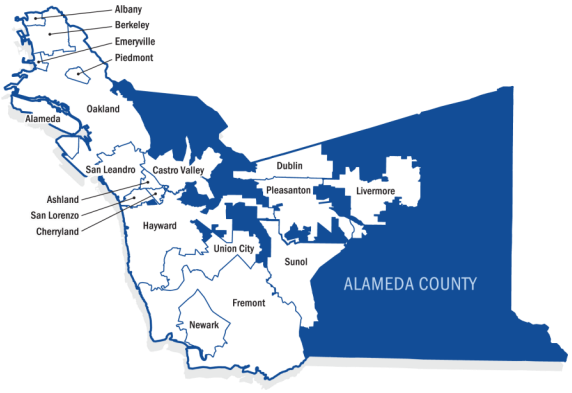
EXECUTIVE SUMMARY

1. EXECUTIVE SUMMARY

COMMUNITY HEALTH NEEDS ASSESSMENT GUIDING PRINCIPLES

- ✓ Through community voice and statistical data, identify community priority health needs—including social determinants of health—and resources available to address them.
- ✓ Serve as a tool for guiding policy, advocacy, and program-planning efforts to address critical community needs and to improve equity, health, and well-being of communities' members.
- ✓ Support the development of community benefit plans mandated by California State Senate Bill 697.
- ✓ Meet the IRS requirements for Community Health Needs Assessment (CHNA) and Implementation Strategies mandated by the 2010 Affordable Care Act.

The assessment covered Alameda County.



Map credit: Alameda County Transportation Commission

CHNA PROCESS AND METHODS

The process involved data collection, data synthesis, and community prioritization, culminating in this report.

PRIORITIZED 2025 COMMUNITY HEALTH NEEDS

Economic security. Economic security, including education and food security, was the highest-priority health need in interviews and focus group discussions. The high cost of living was a key theme among CHNA participants. There are substantial disparities in median income by race/ethnicity within the county, and educational statistics differ by race/ethnicity as well.

Behavioral health. Behavioral health was also identified as one of the highest-priority health needs, with key informants and focus group participants expressing strong concern about poor mental health and substance use. Statistics also suggest that substance use is an issue of concern in Alameda County.

CHNA Health Needs in Priority Order

- Economic security
- Behavioral health
- Housing/homelessness
- Structural racism/ discrimination
- Healthcare access and delivery
- Community/family safety
- Climate/natural environment
- Other health issues

Housing & homelessness. Housing was similarly one of the highest-priority health needs in interviews and focus group discussions. CHNA participants emphasized the lack of housing affordability and other ongoing barriers to housing; and some indicated that homelessness is also increasing. Data show that BIPOC populations are disproportionately represented among those who are rent-burdened.

Structural racism/discrimination. CHNA participants explained how pervasive structural racism can be and described how it can affect health. They indicated that addressing structural racism requires broader systemic changes across multiple sectors, including housing, healthcare, education, and employment.

Healthcare access & delivery. CHNA participants focused on barriers to healthcare access, including economic obstacles. Some expressed concerns about quality of care, citing issues such as long wait times and perceived bias from healthcare providers. Racial/ethnic disparities in health statistics (e.g., preventable hospitalizations) may suggest inequitable access to quality care.

Community & family safety. Community and family safety was seen as a concern by CHNA participants. Overall, they stated that long-standing systemic issues such as lack of access to resources, poor infrastructure, discrimination, and inadequate policing tend to exacerbate safety concerns. Statistics show that the homicide and firearm mortality rates are notably higher in Alameda County compared to California's rates. Further, firearm mortality is suffered disproportionately by the Black population in the county. Certain youth safety statistics are also somewhat worse compared to California overall.

Climate & natural environment. Indicators of air quality were poor in Alameda County, and its overall traffic volume statistic was also higher than the statewide measure. These factors supported participants' broader concerns related to environmental justice.

Health issues.

> ***Cancer.*** Cancer was the #1 cause of death in Alameda County in 2022. Countywide statistical data for cancer incidence and mortality by race/ethnicity indicate substantial disparities. Community members' personal accounts illustrated potential gaps in timely and comprehensive cancer screenings, including the financial burden of cancer treatment.
>
> ***Heart disease/stroke.*** Heart disease and cerebrovascular diseases ranked among the top five causes of death in 2022, while hypertension ranked separately in the top 10 causes of death. Mortality rates for heart disease are much higher among the county's Black population than other ethnic groups. Additionally. stroke mortality is somewhat worse among county residents compared to Californians overall.
>
> ***Maternal & infant health.*** Certain maternal and infant health statistics are worse for particular populations in comparison to the state rates, including the proportion of premature births, low birth-weight births, and infant mortality. In Alameda County, the rate of severe maternal morbidity (unexpected and life-threatening events that can occur during childbirth) was considerably higher than the state rate.
>
> ***Sexual health.*** Incidence rates of chlamydia and gonorrhea among youth aged 15-19 are much higher in Alameda County than the rates of these STIs statewide. The rising rates of STIs in the

county was a shared concern among some CHNA participants. Teen births are much higher among Latinas in Alameda County compared to their peers of other ethnicities.

Unintended injury. In 2022, accidents were ranked among the top five causes of death in Alameda County. The proportion of traumatic injury hospitalizations among the county's children is somewhat higher compared to children in California overall. The mortality rate by race from all unintended injuries was highest for the Black population. Further, pedestrian death rates are notably higher in the county than the state. Finally, motor vehicle crash mortality rates by race are highest for the Black population, followed by the Latinx population.

NEXT STEPS

1. **Board Approval & Publication**: Upon BCH Oakland board approval, publish the 2025 CHNA report on the BCH Oakland website by June 30, 2025; open for public comment until subsequent CHNA reports are released.
2. **Implementation Plan Development**: Develop and finalize an implementation plan aligned with the identified priorities by November 15, 2025, ensuring it is ready for submission to the IRS as part of the FY25 reporting requirements.
3. **Approval from UC Regents:** The implementation plan requires approval from the UC Regents. To meet this timeline, the plan must be submitted to UC Health by end of Summer 2025 for inclusion in the UC Regents Health Services Committee meeting scheduled for October or November 2025.

2025 Community Health Needs Assessment

Alameda County

UCSF Benioff Children's Hospital Oakland

BACKGROUND

2. CHNA REGULATORY REQUIREMENTS AND PURPOSE

This CHNA, completed in fiscal year 2025 and described in this report, meets and exceeds all current federal (IRS) requirements.

Federal Requirements[1]

501(c)(3) hospitals must conduct a CHNA every three years and must document:

- Community served
- Partners involved
- Process and methods
- Identified and prioritized needs

State Requirements[2]

Private, nonprofit hospitals must conduct a CHNA every three years and annually describe in a report:

- How community was involved in identifying and prioritizing needs
- Activities hospital has taken to address identified needs

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT PURPOSE

The goals of the 2025 Community Health Needs Assessment (CHNA) are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, BCH Oakland will develop strategies to tackle critical health needs as well as improve the health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts.

The 2025 CHNA builds upon the findings of the 2022 CHNA (see below for evaluation of 2023–2025 implemented strategies) and previous assessments conducted by BCH Oakland. The 2025 report documents how the current CHNA was conducted and describes the related findings. As with prior CHNAs, this assessment also highlights the district's assets and resources (see Section 7: Community Resources).

Note that for the purposes of this assessment, "community health" was not limited to traditional health measures. BCH Oakland considered indicators relating to the quality of life (e.g., access to healthcare, 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 hospital's philosophy that many factors affect community health, and that community health cannot be adequately understood without consideration of trends outside the realm of healthcare.

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[1] U.S. Federal Register. (2014). Department of the Treasury, Internal Revenue Service, 26 CFR Parts 1, 53, and 602. Vol. 79, No. 250, December 31, 2014. See *Attachment 8* for IRS Regulations Compliance Checklist. The CHNA serves as the basis for implementation strategies that are required to be filed with the IRS as part of Stanford Health Care's Form 990, Schedule H, four and a half months into the next taxable year.

[2] California Department of Health Care Access and Information (formerly OSHPD). (1998). *Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697), Report to the Legislature.*

In addition to helping generate shared priorities around community health, BCH Oakland also used the 2025 CHNA to fulfill key state and federal mandates.

BRIEF SUMMARY OF THE PRIOR (2022) CHNA CONDUCTED

In 2021–2022, BCH Oakland assessed community health needs in its service area. The 2022 CHNA report is posted on the Community Health Needs Assessment page of the hospital's website.[3] The community health needs identified and prioritized through the 2022 CHNA process were:

- Behavioral Health
- Housing and Homelessness
- Healthcare Access and Delivery
- Community and Family Safety
- Economic Security
- Structural Racism
- Food Security
- Transportation

EVALUATION FINDINGS FROM 2022–2024 IMPLEMENTED STRATEGIES

Purpose of Implementation Strategy Evaluation

A Community Health Needs Assessment (CHNA) for UCSF Benioff Children's Hospital Oakland was conducted in 2021–2022, according to guidelines proposed in the Affordable Care Act. Results of the CHNA revealed high-priority populations, geographic locations, diseases and conditions, and negative health drivers (i.e., risk factors). The methodology and results are described in detail in UCSF Benioff Oakland's 2022 CHNA Report.

UCSF Benioff Children's Hospital Oakland's 2022–2024 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2022 CHNA. This section of the CHNA report describes and assesses the impact of these activities.

The 2022 CHNA health needs that were prioritized to be addressed by UCSF Benioff Children's Hospital Oakland in the Implementation Strategy Report were:

1. Structural Racism
2. Mental and Behavioral Health
3. Access to Care
4. Community Safety
5. Economic Security

[3] https://www.ucsfbenioffchildrens.org/-/media/project/ucsf/ucsf-bch/pdf/community-health-needs-assessment-2022.pdf

Structural racism served as the overarching framework for UCSF Benioff Children's Hospital Oakland's 2022–2024 Community Health Needs Assessment (CHNA) Implementation Strategy by guiding how all identified needs were contextualized, prioritized, and addressed. Rather than treating structural racism as a standalone issue, BCH Oakland recognized it as a root cause that intersects with and exacerbates other community health challenges—such as behavioral health disparities, housing insecurity, limited access to care, and economic inequality. By reorganizing the implementation priorities to elevate structural racism as the central lens, BCH Oakland acknowledged that inequities in education, patient experience, workforce, and care delivery are systemically embedded and must be addressed through anti-racist and equity-driven strategies. This framing informed cross-cutting actions across domains like behavioral health, access to care, and economic security, ensuring that initiatives were not only responsive to community needs but also targeted the underlying systems and policies that produce and perpetuate inequitable outcomes

UCSF Benioff Children's Hospital Oakland is monitoring and evaluating progress to date on its 2022–2024 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. Tracking metrics for each prioritized health need include the number of grants made/received, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and BCH Oakland in-kind resources. In addition, Children's Oakland tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA report in June 2025, BCH Oakland had impact information on activities from 2023 and 2024 and will continue to monitor impact for strategies implemented in 2025.

2022 Implementation Strategy Evaluation of Impact

According to the Affordable Care Act, the CHNA is intended to guide the hospital's community benefit programs. Since health needs of communities typically do not change dramatically within a few years, it is noteworthy that BCH Oakland is already dedicating significant resources to many of the prioritized issues and populations identified in the CHNA. These issues include preventable injuries, obesity, asthma, diabetes, child abuse and domestic violence, and dental care.

UCSF Benioff Oakland also has a substantial focus on specific subpopulations highlighted in the CHNA including youth, homeless children, foster children, the uninsured, and children living in poverty. With limited and in some cases declining funding for these efforts, UCSF Benioff Oakland's Community Benefit Implementation Plan includes the goal of sustaining key programs that are successfully addressing one or more of the prioritized community needs. Additionally, the CHNA has identified several community needs that represent opportunities to better serve children and families in its community.

CHNA Priorities, Strategies, and Outcomes in FY2023 and FY2024

Structural Racism

Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms.

Objective: To embed equity, anti-racism, and inclusion into all hospital operations by advancing workforce diversity, improving culturally responsive care, and expanding access to digital tools—ultimately reducing disparities in patient outcomes and staff representation.	
Implementation Strategies	**Key 2023-2024 Outcomes**
Focused DEI/Anti-Racism (AR) Action Plan in 5 areas: Education, Patient Experience, Quality & Safety, Workforce Equity, and Enterprise Synergy.	**Structural Change Initiatives**: • Participated in BCH Oakland's **community impact strategic planning**, identifying three transformational priorities: 1. Inclusive Access to Care 2. Adolescent and Young Adult Support 3. Dimensions of Safety • These areas were co-developed with community leaders and BCH partners to sustain anti-racist transformation **Youth and Workforce Pipeline Initiatives**: • Expansion of the CHAMPS program and introduction of the Youth Mental Health Pipeline (planned Summer 2025). • Over 77 students served through health pathway programs in 2024 **Digital Equity (MyChart Access)**: • MyChart enrollment rose from 50% in 2023 to 63% in 2024, a 13% increase. • Racial/ethnic disparities narrowed by 3%, driven by multilingual access tools and focused outreach **Culturally Responsive Care**: • BLOOM Clinic for Black infants and toddlers delivered 651 visits in 2024 with a 98% satisfaction rate. • Staffed by racially concordant providers, BLOOM addresses systemic inequities in early pediatric care **Workforce Diversity**: • In 2023, +4.4% increase in BIPOC staff; • +8.1% increase in BIPOC representation in officials/managers; and • +5.2% increase in BIPOC professionals

Mental and Behavioral Health

Behavioral health refers to both mental health and substance use. Anxiety, depression, and suicidal ideation are on the rise particularly among Black/African American and Latinx community members.

Objective: To expand equitable access to timely, trauma-informed behavioral health care for underserved children and youth through integrated primary care services, school-based programs, and crisis response initiatives that prioritize vulnerable populations.	
Implementation Strategies	**Key 2023-2024 Outcomes**
• **FQHC and TEEN Clinics**: Expand short-term therapy and screening services for children and adolescents. • **Encore Clinic (Claremont Primary Care)**: Deliver targeted mental health support for homeless and transitional youth through the Pediatric Psychology Program (PPP) and Family Outreach and Support Clinic (FOSC). • **Behavioral Health Outpatient Crisis Response & Bridge Clinic (CRBC)**: Offer rapid intervention, therapy, psychiatric assessment, and follow-up to reduce ER visits and improve continuity of care. • **Preventing Youth Suicide Initiative**: Enhance screening, staff training, and timely intervention in pediatric EDs and outpatient settings. • **Center for Child Protection**: Provide forensic and trauma-informed medical and mental health services for youth impacted by abuse and exploitation. • **School-Based and LGBTQIA+ Services**: Operate two youth-led LGBTQIA+ drop-in centers; trained peer wellness interns and engaged student-led advisory boards through the CYBHI grant.	**Youth Suicide Screening** • 11,122 youth screened; 600 at moderate risk; 286 at imminent risk; 100% screening rate achieved in summer 2024 **CRBC (Crisis Clinic)** • 511 therapy sessions delivered to 93 unique patients in 2024 **Center for Child Protection** • 1,249 consults for child abuse and trauma-related cases in 2024 **LGBTQIA+ Drop-In Centers** • 18 youth-led events; 4 peer wellness interns trained; 5–7 weekly visitors at "United in Colors" center; 134 attendees at Q2 events in 2024 **FQHC Mental Health Visits** • 1,060 short-term therapy visits conducted by LCSWs to FQHC patients as of 2023 **Encore Clinic, PPP, FOSC** • 428 consults and 590 therapy sessions in 2023 delivered to vulnerable youth, including those in foster care and experiencing homelessness **Behavioral Health Team** • 75 full-time staff delivering ~28,000 visits annually with a trauma-informed and culturally responsive approach as of 2023

Access to Care

Access to comprehensive, quality healthcare, including insurance coverage, number of primary and specialty care providers, timeliness of care, quality of care and cultural humility. Populations highly impacted include LGBTQIA+, people with disabilities, non-English speakers, and undocumented residents.

Objective: To improve equitable access to high-quality, culturally relevant pediatric health services by expanding digital engagement, deploying mobile care units, and increasing inclusive care for marginalized populations such as newcomers, Black children, and LGBTQ+ youth.	
Implementation Strategies	**Key 2023-2024 Outcomes**
• **Establish a Medical Home for Newcomer Youth:** Provide comprehensive, culturally responsive primary care for 80–100 recently arrived children through UCSF's Federally Qualified Health Centers (FQHCs), ensuring timely access to services regardless of immigration or insurance status. • **Launch a Mobile Medical and Mental Health Unit:** Develop and deploy a fully equipped mobile clinic, featuring two exam rooms and lab capabilities to serve unhoused families, schools, and underserved neighborhoods, increasing access to integrated care. Launch anticipated in **Summer 2025**. • **Advance Digital Health Equity through MyChart Expansion:** Increase MyChart enrollment and usability across all racial, ethnic, and language groups, with emphasis on enhancing self-scheduling features and ensuring equitable patient access to personal health information.	**MyChart Enrollment and Functionality** • MyChart usage increased from 50% (start of FY23) to 69% in 2024 • Enrollment among African American and Latinx patients increased by 3% on average • Digital equity toolkits and multilingual support implemented **Establish a Medical Home for Newcomer Youth** • 80 newcomer children received care through BCH FQHCs in 2023 • Over 9,000 children and youth served annually through BCH's four FQHC sites in 2023 **Mobile Medical and Mental Health Unit** • Mobile unit under development with two exam rooms and lab space • Funded by $530K HRSA grant + $100K FQHC funds • Launch planned for Summer 2025

Community Safety

Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries. The CHNA identified two key measures of community and family safety that were higher in our communities: violent crime and injury deaths

Objective: To promote community and family safety by delivering rapid trauma response, supporting victims of violence and abuse, and scaling evidence-based prevention programs that reduce pediatric injury, support safe environments, and foster healing.	
Implementation Strategies	**Key 2023-2024 Outcomes**
• **Youth Violence Intervention Program (YVIP):** Immediate and long-term support for youth impacted by violence • **Childhood Injury Prevention Program (IPP):** Education, resources, and equipment to reduce preventable injuries • **Safe Sleep and Firearm Safety Initiatives:** Distribution of cribs and gun locks to promote home safety • **Stop the Bleed and Trauma Preparedness Training:** Community training in life-saving emergency response techniques • **Trauma-Informed Bedside Crisis Support:** On-site intervention and care coordination for youth experiencing violence or trauma	**Youth Violence Intervention Program (YVIP)** • 76 youth referrals total ○ 57 referrals in 2024 (a 196% increase from 2023) • Bedside crisis support and care coordination for youth impacted by gun violence, stabbings, and assaults • In partnership with Youth ALIVE!, BCH Trauma Services, and Social Work **Child Passenger and Injury Prevention** • 976 car seats distributed over two years • 22 families participated in child safety restraint education in 2023 • 15 formal car seat safety classes hosted in 2023 • Over 85% of families at events had incorrect car seat installation **Stop the Bleed & Trauma Response** • 170 individuals trained in Stop the Bleed in 2024. Trainings conducted with educators, youth groups, and community providers • Stop the Bleed kits distributed to schools and youth-serving organizations **Firearm Safety & Safe Sleep** • 45 gun locks distributed to families identifying need in 2024 • 41 cribs provided through the Cribs for Kids partnership in 2024 • Coordination with NICU and BLOOM Clinic to support at-risk families

Economic Security

People with steady employment are less likely to have an income below poverty level and more likely to be healthy. The CHNA reported residents struggle to find living wage jobs given the county's extremely high cost of living. Latinx and Black/African American residents in Oakland face significant income and employment disparities.

Objective: To address the root causes of health inequity by connecting families to essential resources such as housing, food, transportation, and employment opportunities—leveraging BCH Oakland's role as an anchor institution to build long-term community resilience.	
Implementation Strategies	**Key 2023-2024 Outcomes**
• **Advance Anchor Institution Mission (AIM):** Lead strategic planning for BCH Oakland to align efforts in workforce development, local procurement, and community investment. • **Integrate Housing Referrals:** Utilize the FINDConnect platform to screen for housing needs and connect patients to appropriate services. • **Enhance Food Security Initiatives:** Provide food referrals through the Alameda County Food Bank; operate Food Farmacies and a rooftop garden to improve access to healthy food. • **Sustain Transportation Access:** Maintain free transportation services to reduce barriers to care and social services. • **Promote Local Employment:** Implement anchor institution strategies to expand local hiring and support community-based workforce development.	**FINDConnect Social Referrals** • Over 800 families enrolled across both years, resulting in more than 3,000 referrals total referrals to housing, food, and other social services. **Food Security and Nutrition Access** • As of 2024, distributed a combined total of 136,121 lbs. of food to 3,381 households through partnerships with the Alameda County Food Bank, Food Farmacies, and other community-based strategies. **Urban Agriculture** • Produced 2,500 lbs. of organic produce from the rooftop garden in 2024, expanding access to fresh, local food. **Anchor Institution Mission (AIM)** • Developed and presented strategic recommendations on workforce, procurement, and investment priorities to the UC Regents, senior leadership, and community stakeholders. **CHAMPS Youth Workforce Program** • Engaged 77 youth interns, delivered 455 mentorship hours, and celebrated 13 program graduates, advancing workforce equity in 2024. **Future Pipeline Development** • Designed a Youth Mental Health Workforce Pipeline initiative launching in Summer 2025, in collaboration with UCSF AIM, CHAMPS, and the UCSF Center for Science, Education and Outreach (CSEO).

WRITTEN PUBLIC COMMENTS

BCH Oakland welcomes and encourages written public comments about its CHNA and implementation strategy reports. Feedback may be emailed directly to anchor@ucsf.edu.

At the time this CHNA report was completed, BCH Oakland had not received any written comments about the 2022 CHNA report.[4] The hospital will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate staff members.

[4] https://www.ucsfbenioffchildrens.org/-/media/project/ucsf/ucsf-bch/pdf/community-health-needs-assessment-2022.pdf

2025 Community Health Needs Assessment

Alameda County

UCSF Benioff Children's Hospital Oakland

ABOUT BCH OAKLAND

3. ABOUT BCH OAKLAND

UCSF Benioff Children's Hospital Oakland (BCH Oakland) is a not-for-profit, acute care pediatric hospital committed to providing the highest-quality healthcare to all children, regardless of race, religion, immigration status, or ability to pay. Guided by a mission of caring, healing, teaching, and discovery, BCH Oakland delivers a comprehensive range of inpatient, outpatient, and community-based services, with more than 30 pediatric subspecialties.

Located in the city of Oakland, BCH Oakland serves as a pediatric safety-net hospital for both Alameda and Contra Costa Counties, which do not have public hospital beds designated for children. BCH Oakland serves approximately 86,000 unique patients annually from across the Bay Area and Northern California. Over 70% of BCH Oakland patients are covered by government-sponsored insurance, reinforcing its critical role in serving low-income and medically underserved communities.

The hospital operates the largest pediatric Federally Qualified Health Center (FQHC) in the Bay Area, which includes comprehensive school-based health centers and a clinic at the Alameda County Juvenile Justice Center. BCH Oakland also collaborates with public schools and shelters to provide mobile medical and behavioral health services to children and families with limited access to care.

BCH Oakland's robust research enterprise reflects its commitment to innovation and discovery. Through grants and contracts with private research institutions, government agencies, and universities, BCH Oakland is dedicated to translating scientific findings into tangible health benefits for children.

In 2014, BCH Oakland formally affiliated with UCSF, creating a durable strategic partnership to build an integrated healthcare system and improve pediatric care throughout the Bay Area. Though aligned with UCSF, BCH Oakland remains a separately licensed and incorporated nonprofit entity governed by its own board of directors. It retains ownership of its assets, employs its own staff, and maintains an independent medical staff.

COMMUNITY BENEFITS PROGRAM

UCSF Benioff Children's Hospital Oakland (BCH Oakland) has one of the most comprehensive community benefit programs among children's hospitals in California. BCH Oakland defines community benefit as a planned, managed, and measurable approach to meeting documented community needs with the goal of improving access to care, health outcomes, and overall quality of life—particularly for vulnerable children and families.

The BCH Oakland community benefit strategy is driven by a strong commitment to advancing health equity and addressing structural racism as a root cause of health disparities. BCH Oakland uses a social determinants of health framework and engages in community-based partnerships to address the most pressing pediatric health needs in its service area.

BCH Oakland's community benefit activities include:

- **Federally Qualified Health Center (FQHC) services**, including pediatric primary care, mental healthcare, school-based health centers, and care for youth at the Juvenile Justice Center.
- **Mobile medical and mental health units** that bring services to shelters, schools, and neighborhoods experiencing significant unmet needs.
- **Behavioral health**, such as short-term therapy, integrated care within primary care, and services targeted to children experiencing housing instability or trauma.

- **Economic security and anchor institution efforts**, including workforce pipeline development and collaboration with community stakeholders to support job access, housing referrals, food security, and transportation assistance.
- **Trauma-informed care** and support for child abuse survivors through the Center for Child Protection and the Pediatric ACEs and Related Life Events Screener (PEARLS) initiative.
- **Health equity efforts**, supported by the hospital's Diversity, Equity, Inclusion, and Anti-Racism (DEI/AR) Council, which focuses on workforce equity, patient experience, quality and safety, and institutional culture change.

Programs and services offered as part of BCH Oakland's community benefit portfolio typically meet one or more of the following criteria:

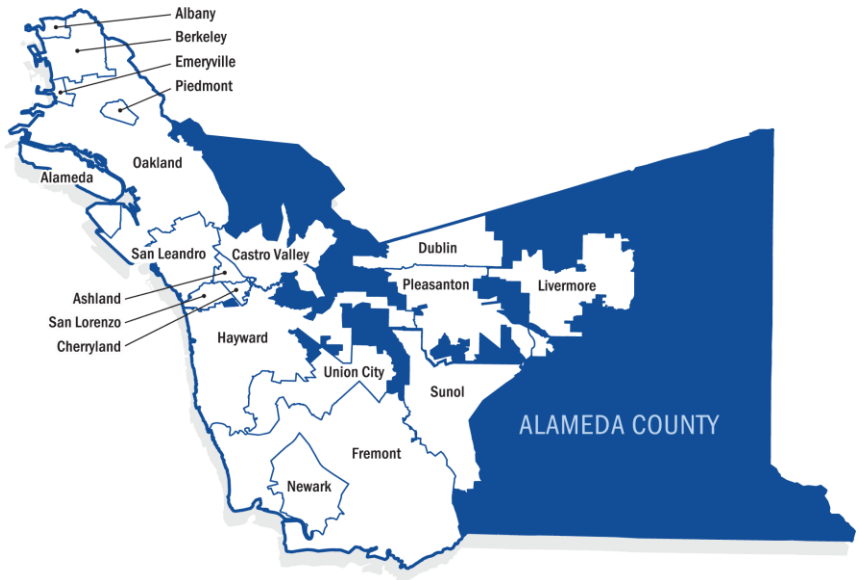
- Respond to public health needs
- Address the needs of vulnerable or at-risk populations
- Improve access to care
- Operate at a financial loss or no profit margin
- Would likely be discontinued if evaluated solely on a financial basis

By investing in long-term partnerships and locally informed strategies, BCH Oakland aims to be not just a provider of pediatric care, but also a trusted community anchor, advancing policies and systems that create equitable conditions for all children to thrive.

COMMUNITY SERVED

The IRS 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. BCH Oakland's primary service area is Alameda County. In 2023, the estimated population of the county was approximately 1.65 million.[5]

BCH Oakland's primary service area is Alameda County.

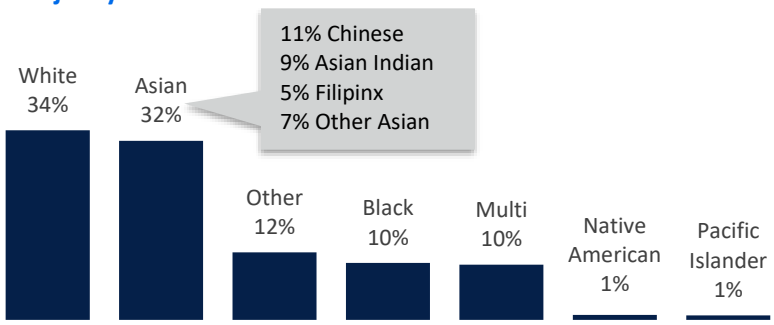


Map credit: Alameda County Transportation Commission, 2025.

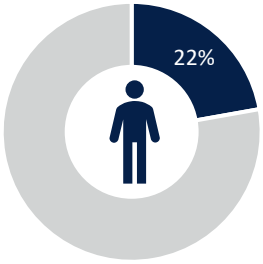
[5] U.S. Census Bureau, American Community Survey, 5-year estimates, 2019-2023.

Demographics, Alameda County

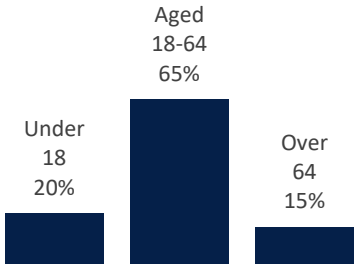
A majority of residents are non-White.



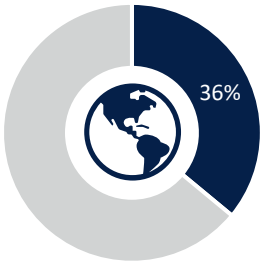
Over one in five are Latinx.



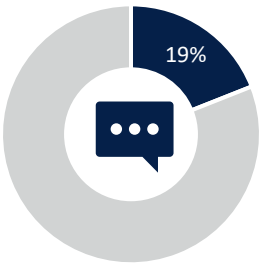
One in five residents are children.



Over one-third of residents are foreign-born.



About one in five over age 5 speak limited English.



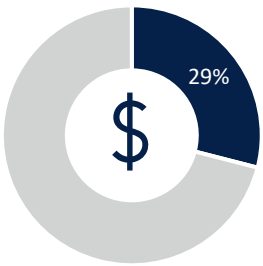
$121,703

household Real Cost Measure (RCM)

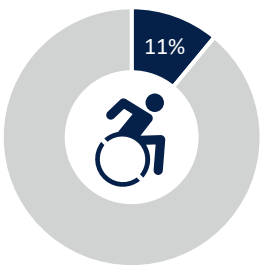
$1.0M

median home sale price

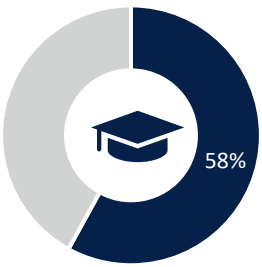
On average, close to one in three households lives below the Real Cost Measure.*



Over one in ten residents lives with a disability.



Nearly three in five residents aged 25+ have earned at least a Bachelor's degree.



*Note: The Real Cost Measure factors in the costs of housing, food, health care, child care and other basic needs.
Sources: United Way: Real Cost Measure, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: demographics, 2019–2023.

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ASSESSMENT TEAM

4. ASSESSMENT TEAM

HOSPITALS, OTHER PARTNER ORGANIZATIONS, AND CONSULTANTS

BCH Oakland collaborated with the following health systems and organizations to prepare the 2025 CHNA:

- John Muir Health
- St. Rose Hospital
- Stanford Health Care Tri-Valley
- Washington Health

This group (collectively, "the collaborative") all contracted with the same consulting firm (see below for details). Collaborative members also partnered informally with the following health systems and organizations on activities such as exchanging transcripts of interviews and focus groups in order to extend their mutual reach and reduce the assessment burden on the community:

- Alameda County Health
- Applied Survey Research
- Kaiser Permanente (Kaiser Foundation Hospitals: Fremont, Oakland, San Leandro)
- Sutter Health (Alta Bates-Summit and Eden Medical Centers)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights, LLC, an independent local research firm, conducted the CHNA on behalf of the collaborative. This consulting firm managed the assessment process from planning and conducting primary and secondary research through facilitating the identification and prioritization of community health needs and ultimately writing this report. Actionable Insights also shared data collection protocols and secondary qualitative data with CHNA consultants serving other hospitals in the same service areas in order to extend the reach of the assessment while not increasing community burden.

Actionable Insights specializes in community health needs assessments, conducting 12 CHNAs for hospitals in the greater Bay Area during the 2024–2025 cycle. The firm also specializes in research and evaluation, helping organizations discover and act on data-driven insights. More information about Actionable Insights is available on the company's website.[6]

[6] https://actionablellc.com/

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PROCESS AND METHODS

5. PROCESS AND METHODS

The hospitals and health systems listed in Section 4 partnered together on the primary and secondary data requirements of the CHNA. Together, these entities planned the CHNA, including making collective decisions on qualitative and quantitative data sources and analysis. The group also came to agreement on the set of criteria to be used in identifying community health needs. The hospitals' goal was to gather community feedback, understand existing data about health status, and learn how the community prioritizes local health needs. By collaborating, the group of hospitals and the public health department were able to obtain and share data efficiently, and to reduce the data-gathering burden on the community.

BCH Oakland's data collection process took place over nine months in 2024 and culminated in the composition of this report, written in the first half of 2025. The phases of the CHNA process are depicted below and described in this section.

The CHNA process involved data collection, synthesis, and community prioritization, culminating in this report.

SECONDARY STATISTICAL DATA COLLECTION

Data sources were selected to better understand general county-level health, specific vulnerable populations, and to fill previously identified information gaps. Additional data on potential health disparities by geographic area and ethnicity were also analyzed when available.

BCH Oakland and its consultants (collectively, "the team") analyzed over 350 quantitative health indicators to assist with understanding health needs in Alameda County and assessing priorities of the communities. The team collected statistical data from existing sources using County Health Rankings & Roadmaps, which is a public dataset supported by the Robert Wood Johnson Foundation and developed by the University of Wisconsin Population Health Institute.[7] Supplementary data, including sub-county data when available, were collected from other online and public health sources, such as:

- California Department of Public Health
- KidsData.org
- U.S. Census Bureau
- Alameda County Public Health Department
- A variety of secondary reports and presentations (see table below)

[7] County Health Rankings & Roadmaps. (2024). Health Data. Retrieved from https://www.countyhealthrankings.org/health-data

Secondary Reports and Presentations Consulted for 2025 CHNA
Alameda County 2024 Point-in-Time Count Tableau Dashboard, 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

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 following questions were asked:

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

Alameda County Community Assessment, Planning, and Evaluation unit (AC CAPE) provided 2019-2023 mortality rates overall and by race/ethnicity for requested causes. However, public health departments face difficulty in providing comparable California rates because the specific diagnoses codes used in some published California mortality rates are not always available. In some cases, Actionable Insights used California mortality rates from the Public Health Department's 2024 report listed below and some California benchmarks provided by Santa Clara County's public health department.

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 Santa Clara 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 ED visits and hospitalizations (e.g., drug overdoses, asthma) in assessing the statistical data.

INFORMATION GAPS AND LIMITATIONS

In this CHNA cycle, our 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 CHNA process:

1. **Differing local measures.** Overall, the study team was challenged with comparing local Emergency Department (ED) visit rates and hospitalization rates to readily available California benchmarks due to differing local measures. However, the local public health department 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 by county. While California is among the 10 states with the highest prevalence of AD/dementia (12%), there is no indication that prevalence in the Bay Area 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 Bay Area counties.

3. **Childhood diabetes prevalence.** Because childhood obesity has been a topic of concern in previous cycles, hospitals continue to seek data about childhood diabetes as well, but these data are not publicly available.

4. **Oral health data.** The county also lacked sufficient data pertaining to oral health, including the number of dentists per capita who accept Denti-Cal, individuals with dental insurance, and prevalence of recent dental visits.

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 our ability to understand disparities by income level.

PRIMARY/SECONDARY QUALITATIVE DATA COLLECTION (COMMUNITY INPUT)

Qualitative data was collected to better understand certain topics and subpopulations that are not well understood through the statistical data.[8] Qualitative data were also relied upon to fill previously identified information gaps for which statistical data remain unavailable.

- Primary research was conducted through 8 key informant interviews and 5 focus groups. Three strategies for collecting community input were used:
  - Key informant interviews with health experts and community service experts
  - Focus groups with professionals who represent and/or serve the community
  - Focus groups with community members

- In generating primary research protocols, prior CHNAs were consulted and built upon to focus and refine the protocol questions and topics.

- Transcripts of 37 interviews conducted by consultants to Sutter Health and Kaiser Foundation Hospitals and 8 focus groups conducted by Alameda County's Public Health Department were included in BCH Oakland's CHNA as secondary qualitative data. While discussion questions were substantively the same, participants were different from and enhanced community input collected by BCH Oakland.

- Both primary and secondary interviews and focus groups were recorded and transcribed into English.

- Individuals representing vulnerable populations[9] were included (e.g., unhoused, low-income, communities with inadequate access to clean air and safe drinking water, "minority" groups such as Black, LGBTQ+, or individuals with disabilities, and medically underserved[10]).

- Input from over 200 community members, community leaders, health experts and representatives of various organizations and sectors informed the 2025 CHNA. These 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.

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[8] For example, the experiences of the LGBTQ+ community in Bay Area counties are often obscured by statistics that represent an entire county's population rather than the LGBTQ+ community as a particular sub-group. This CHNA convened a focus group of LGBTQ+-identifying community members to better understand their needs.

[9] "Vulnerable" populations, communities, and individuals were formerly referred to as "high-need" populations, communities, and individuals. This term has changed due to statewide regulatory changes under AB 1204. See California Department of Health Care Access and Information. (2022). *HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations.* Retrieved from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf

[10] The IRS requires that community input include the "low-income, minority, and medically underserved populations." Retrieved from https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

CHNA Interviews and Focus Groups

Community members, leaders, and local experts/professionals 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 with vulnerable populations, such as unhoused individuals.

- From April to August of 2024, 45 key informant interviews were held with 59 experts from various organizations in Alameda County. Interviews were conducted virtually via Zoom for about one hour.

- Prior to each interview, participants were asked to complete a short online survey:
  - They were asked to identify the health needs they felt were the most pressing 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, or 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.11
  - Finally, participants were offered the option of being listed in the report and were asked, but not required, to provide basic demographic information.

- The discussions centered around five questions for each health need that was prioritized by interviewees 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, 13 focus groups were conducted with a total of 58 professionals and 109 community members/leaders between June and October 2024.

- Focus group participants also provided responses to a pre-survey,[12] 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 Attachment 1: Community Leaders, Representatives, and Members Consulted for a list of focus group and interview details. See Attachment 6: Qualitative Research Materials for protocols used.

[11] Only individuals who consented to be recorded were interviewed.

[12] 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 some cases, participants in the focus groups that were conducted by the public health departments were not asked to provide any demographic information.

List of Focus Groups Conducted for CHNA 2025

Topic/Population	Focus Group Host/Partner	Date	Number of Participants
Afghani community	Fremont Family Resource Center	8/6/24	15
Faith communities	Actionable Insights	6/25/24	6
Healthcare access, community health workers*	Vision y Compromiso	9/4/24	22
Healthcare access, safety net	Actionable Insights	6/11/24	12
Healthcare workforce development	Actionable Insights	8/12/24	8
Individuals with disabilities*	Regional Center of the East Bay / Disability Council	8/19/24	18
LGBTQ+ community*	LGBTQ Center	8/22/24	8
Older adults, Chinese community*	Korean Community Center	10/28/24	15
Parents, Black community*	Family Health Services	8/15/24	17
Parents, Spanish-speaking Latinx community*	Hayward YMCA	8/15/24	9
Social determinants of health	Actionable Insights	7/22/24	8
Substance use/addiction	Actionable Insights	6/12/24	9
Unhoused*	Fremont Family Resource Center	7/25/24	20

* Indicates resident/community member group.

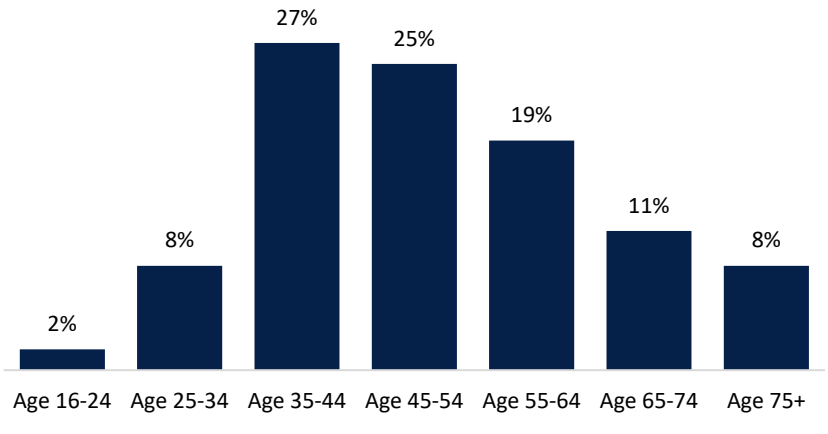
Community Assets and Resources

Professionals who participated in key informant interviews and focus groups were asked to review the assets list from the 2022 CHNA report as it related to their area of expertise and to provide updates. This feedback was consolidated by Actionable Insights and the updated assets list is provided in *Attachment 3: Community Assets and Resources.* This list, updated by CHNA participants, was consulted to assess the sufficiency of assets for each health need (see *Data Synthesis* section below).

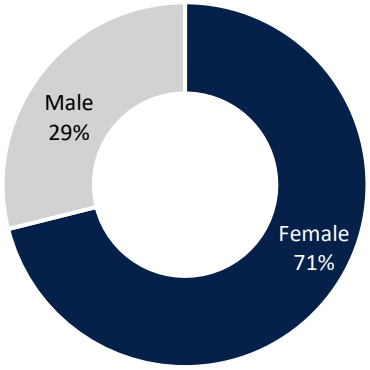
CHNA Participant Demographics

A total of 226 people participated in focus groups or interviews for the CHNA. About 80% of participants responded to a pre-survey asking simple demographics. The charts below show the age ranges, gender, and race of respondents (note that individuals could choose more than one race).[13]

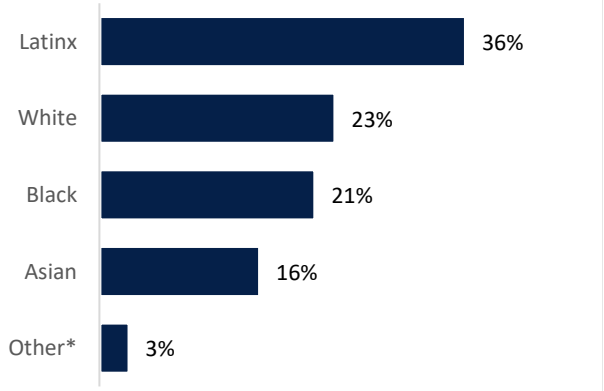
On average, CHNA participants were 51 years old.[14] (N=177)



Almost three-quarters of respondents identified as female. (N=83)



More than one in three respondents were of Hispanic/Latinx ethnicity. (N≅180)



*"Other" is Native American/Alaskan and Native Hawaiian/Pacific Islander. Percentages do not sum to 100 due to overlap.

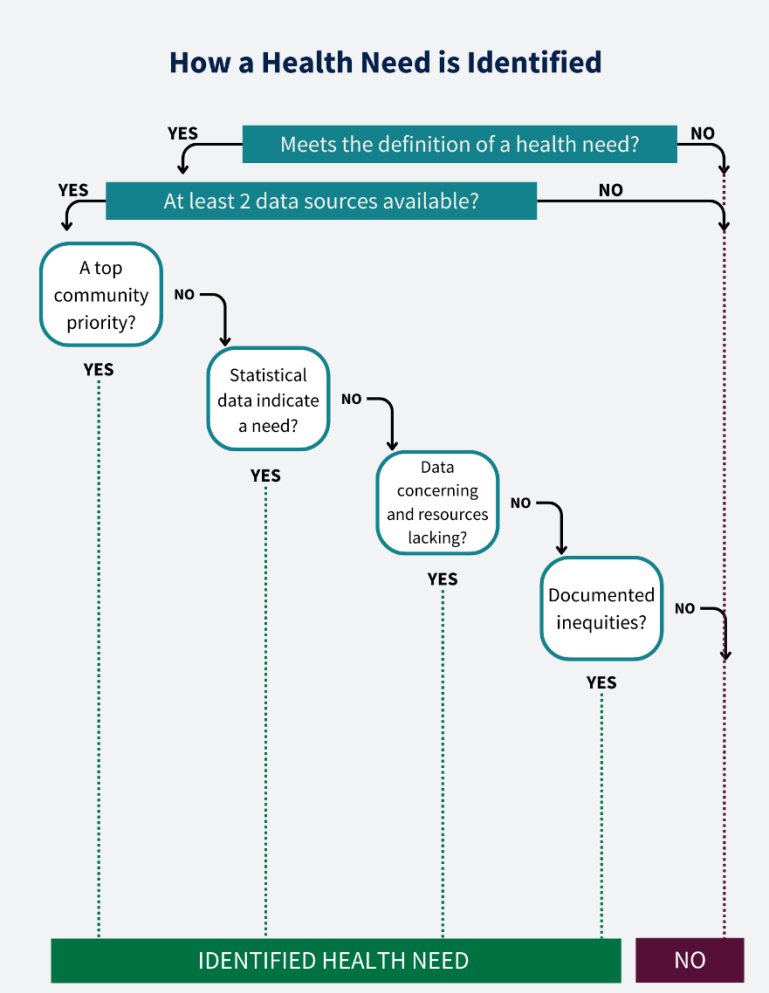
[13] For race/ethnicity, N=approximately 180; exact number of respondents not available because only summary data were available for some focus groups conducted by Alameda County Public Health.

[14] This report also draws on the findings from three focus groups with youth under age 20 that were conducted for the Eastern Alameda County Human Services Needs Assessment. The youth are not included in these demographics.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS (DATA SYNTHESIS)

During the course of analysis of quantitative and qualitative data, many health issues surfaced. To be identified as a community health need, an issue had to meet certain criteria, as shown below. All collaborating hospitals used the same criteria for needs identification. See the Definitions box for additional terms and definitions.

An issue must meet a variety of criteria in order to be identified as a health need for the purposes of the CHNA.



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.

Health Needs Identification Criteria

1. Meets the definition of a health need (see the Definitions box, below).
2. At least two data sources for the health issue are available for the service area.
3. Meets the community priority criterion: Prioritized (i.e., voted in top five to discuss) by at least one-third of all community input cases (interviews and focus groups combined).
4. Meets the statistical data criteria:
    a. Multiple indicators are worse than the state by 5% or more, or

b. At least one indicator is worse (or worsening) and there are few available resources, or
c. Multiple inequities by race/ethnicity are a concern.

The process described on the previous page led to the identification of eight community health needs that fit the criteria. That list of needs, in descending order of priority, appears below. See Section 6: 2025 Prioritized Community Health Needs for a summarized description of each need.

PRIORITIZATION OF HEALTH NEEDS

IRS requirements state that hospital facilities must identify and prioritize the significant health needs of the community. As described previously, Actionable Insights solicited qualitative input from focus group and interview participants about which needs they thought were the highest priority (i.e., most pressing). BCH Oakland used this feedback to identify and rank the significant health needs as follows:

1. Economic security
2. Behavioral health
3. Housing and homelessness
4. Structural racism/discrimination
5. Healthcare access and delivery
6. Community and family safety
7. Climate/natural environment
8. Health Issues:
    - Cancer
    - Maternal/infant health
    - Sexual health
    - Unintended injury

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PRIORITIZED COMMUNITY NEEDS

6. 2025 PRIORITIZED COMMUNITY HEALTH NEEDS

The processes and methods described in Section 5 resulted in the prioritization of eight community health needs (see the list at the end of the previous section). Each description below summarizes the data, statistics, and community input collected during the Community Health Needs Assessment.

As noted in the introduction to this report, the definition of "community health" in this assessment extends beyond traditional measures of the physical health of community members to include broader social determinants of health, such as access to healthcare, affordable housing, education, and employment. This more inclusive definition reflects the understanding that many factors impact community health.

The assessment found that social determinants of health underlie many of the physical and behavioral health needs in addition to being identified as needs in and of themselves. Many participants highlighted economic issues, including the high cost of living, income instability, and employment challenges as significant barriers to health. Housing insecurity and homelessness were also commonly identified as major factors by focus group and interview participants. Additionally, structural racism was recognized as a fundamental obstacle that can affect multiple aspects of health.

When describing those who were most greatly affected by the needs, participants in all areas consistently named low-income individuals and families, BIPOC (Black, Indigenous, and people of color, in particular Black and Latinx, but also Native American and Pacific Islander) communities, youth (especially foster youth), older adults, individuals experiencing homelessness, people with disabilities (including wheelchair users and those with intellectual and developmental disabilities), recent immigrants (including the undocumented and people not proficient in English), and LGBTQ+ communities as the primary populations disproportionately affected.

SUMMARIZED DESCRIPTIONS OF PRIORITIZED NEEDS

1 Economic Security

What is the issue?

Economic security has been defined as the ability of people to cover their basic needs sustainably, in a manner that allows them dignity and self-respect.[15] Higher income and social status, often achieved through attainment of higher education, have each been linked to greater health. Research shows that access to economic stability programs such as SNAP (formerly called food stamps) results in better long-term health outcomes.[16]

Why is it a health need?

Economic security, including education and food security, was the highest-priority health need in interviews and focus group discussions. The high cost of living was a key theme among CHNA participants in all areas. Participants stated that wages from full-time employment were often insufficient to meet the costs of basic needs like rent and living expenses. They indicated that this led to economic strain and forced people to work multiple jobs or cut back on essentials like healthy food. Many also pointed out the correlation between economic and food insecurity, with some noting a substantial increase in food insecurity since the 2020 pandemic.

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

– Community Leader Interviewee

The populations of highest concern included individuals on fixed incomes, BIPOC individuals, young adults, and families with children. Some participants were especially concerned with the impact of food insecurity on children, including poor physical and mental health.

Regarding other specific populations, it was mentioned that immigrants can face additional challenges due to documentation issues, which can consequently limit their employment opportunities. Some explained that other common economic challenges, such as families needing to work multiple jobs, hinder students' ability to focus on education, effectively deterring or diminishing their long-term economic prospects. A number also felt economic instability is linked to broader systemic issues, such as hiring discrimination and inadequate local resources.

"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."

– Community Leader Interviewee

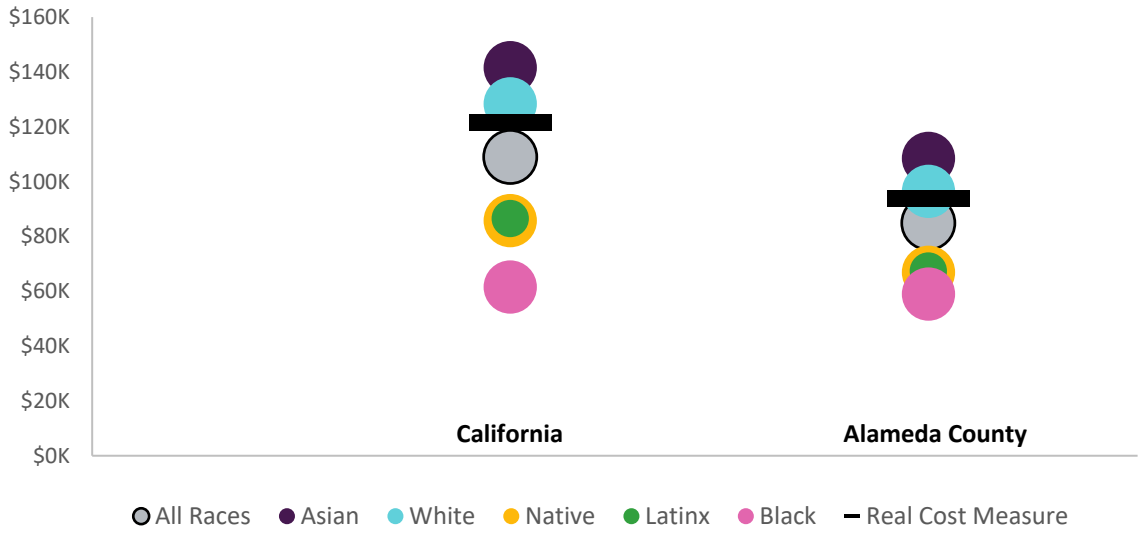
Data show that there are substantial disparities in median income by race/ethnicity; for example, an Alameda County Latinx household earns a median of $86,447, about one-third less than the Real Cost

[15] International Committee of the Red Cross. (2020). *Economic Security Strategy 2020-2023.*

[16] Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits*.

Measure. Alameda County women also face a slightly greater gender pay gap ($0.84 to the dollar) compared to California overall ($0.86).

Median household income varies substantially by race/ethnicity.

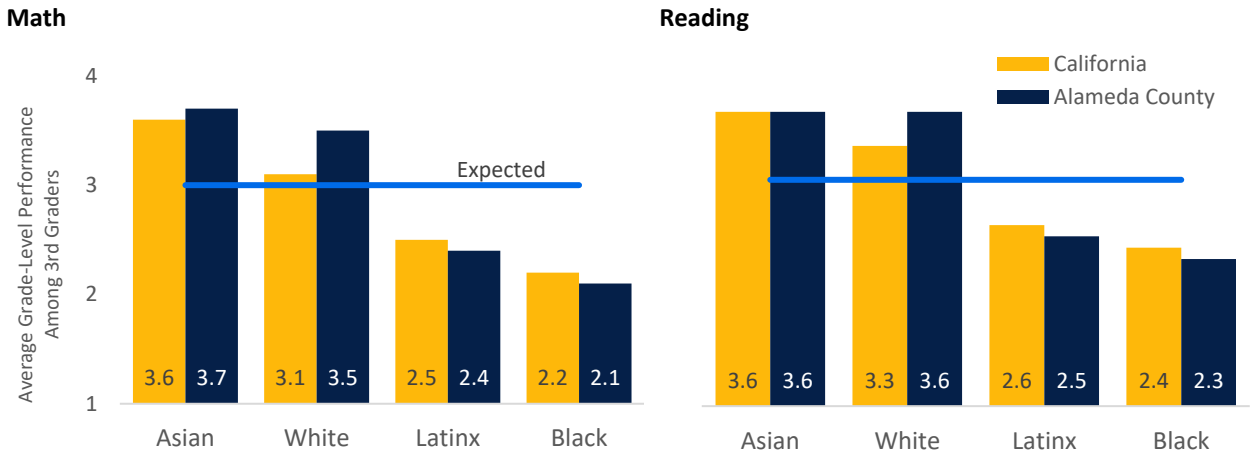


Notes: Dot size varies to show overlap. Source: U.S. Census Bureau Small Area Income and Poverty Estimates, 2021. Retrieved from County Health Rankings, June 2024.

High dropout rates and lower academic performance were highlighted by some CHNA participants. Several described barriers to education for youth in the county, including overcrowded or underfunded schools and teacher/staff shortages.

In Alameda County, Latinx students were more likely than students of other ethnic groups to drop out before graduation. Elementary school math and reading performance are also worse among the county's Black and Latinx children (see charts below). Educational statistics and disparities that differ by race/ethnicity are particularly concerning to CHNA participants; as some mentioned, education is linked to future income prospects.

Math and reading performance are both notably worse among Black and Latinx students.



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

2 Behavioral Health

What is the issue?

Behavioral health refers to both mental health and substance use. Mental health—defined as social, emotional, and psychological well-being—plays a key role in a person's overall wellness, ability to have healthy and maintain healthy relationships, and function in society.[17] 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.

Why is it a health need?

Behavioral health, including mental health and substance use, was the highest priority need across key informant interviews and focus groups. Most CHNA participants identified mental health as a top concern, highlighting issues such as anxiety, depression, trauma, and severe mental illnesses like schizophrenia and bipolar disorder. Many articulated that there is a significant mental health crisis among youth, exacerbated by COVID-19, social media, and other stressors. Issues such as anxiety, depression, and loneliness were also frequently mentioned. A greater proportion of children in Alameda County are hospitalized for mental diseases and disorders than children in California overall (see chart, next page).

"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

Participants highlighted the links among food insecurity, housing instability, violence, and mental health issues such as hopelessness. Several participants noted that trauma, including generational trauma and structural racism, can be a significant factor in worsening mental health issues.

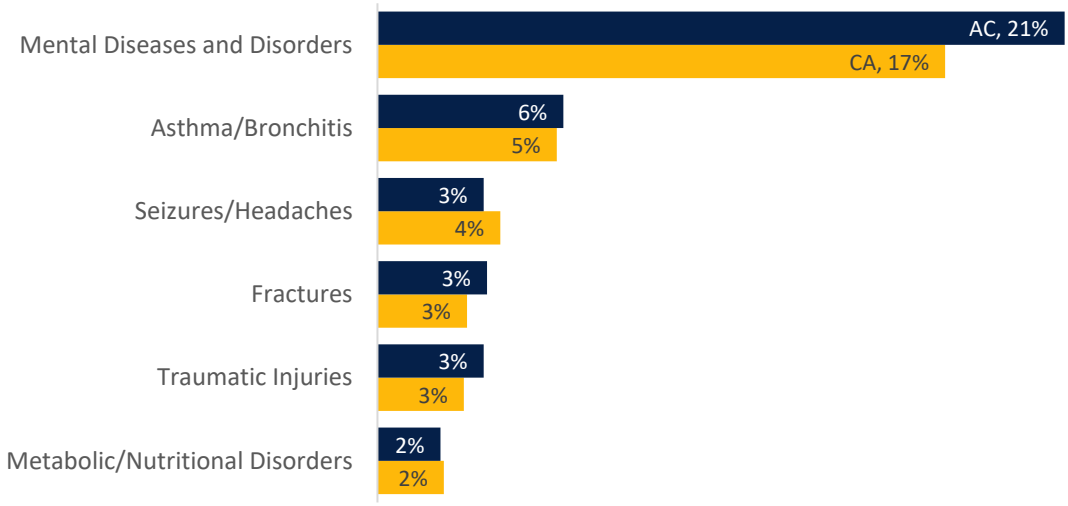
The limited availability of mental health practitioners and related services was frequently discussed, as were other barriers such as long wait times for appointments and inadequate insurance coverage. Some participants expressed particular concern with regard to mental healthcare access for young children.

"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

[17] Substance Abuse and Mental Health Services Administration. (2023). *What is Mental Health?* Retrieved from https://www.samhsa.gov/mental-health

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



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

Substance use, particularly among youth, was a major concern among participants. Experts who participated in the CHNA emphasized fentanyl and synthetic drugs as especially dangerous and noted an increase in substance use disorders overall.

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

– Expert, Focus Group Participant

Substance use and mental health were seen as being interconnected by CHNA participants, with many stating that substance use often serves as a coping mechanism for untreated mental health issues. Stigma tied to both was noted as a commonplace barrier to seeking help, with other cultural factors contributing as well.

Concern related to both mental health and substance use was specifically expressed for youth, particularly high school and college students, as well as low-income families, who experience high levels of economic stress. Unhoused individuals were also recognized in these discussions, as they often are susceptible to a combination of mental illness, substance use disorders, and other vulnerabilities that can have negative effects on mental well-being.

"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."

– Community Leader Interviewee

See more related to healthcare access and delivery, economic security, and housing in their respective descriptions.

3 Housing & Homelessness

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.[18] Poor health can lead to homelessness, and vice versa. People experiencing homelessness suffer from preventable illnesses at a greater rate, require longer hospital stays, and have a greater risk of premature death than their peers with housing security.[19]

Why is it a health need?

Housing was one of the highest-priority health needs in interviews and focus group discussions. CHNA participants emphasized the lack of housing affordability, noting that it has been a persistent issue for decades. Participants spoke to rising rent costs and lack of affordable housing options as major issues for many residents. Several participants described poor living conditions, including people living in vehicles or overcrowded housing situations.

"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 Interviewee

Barriers to housing were widely discussed, including how economic factors, such as wages not keeping up with housing costs and the difficulty of securing financing for affordable housing projects, exacerbate the housing crisis.

"The cost is incredibly high... people have to deal with it. So, the way they do it is they're overcrowded. They rent rooms."

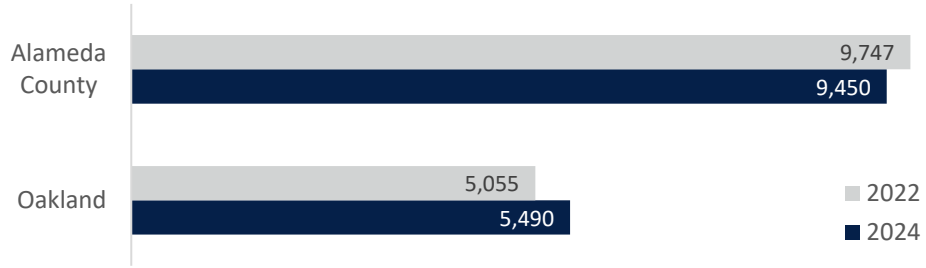
– Expert Interviewee

Many participants pointed out the increasing homeless population, which is particularly acute in urban areas like Oakland. While the total number of individuals experiencing homelessness in Alameda County decreased between 2022 and 2024, in Oakland the count rose by 9% during that same time period (see chart on following page).

[18] Pew Trusts/Partnership for America's Economic Success. (2008). The Hidden Costs of the Housing Crisis. See also: The California Endowment (2015). Zip Code or Genetic Code: Which Is a Better Predictor of Health?

[19] O'Connell, J.J. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. Nashville, TN: National Healthcare for the Homeless Council.

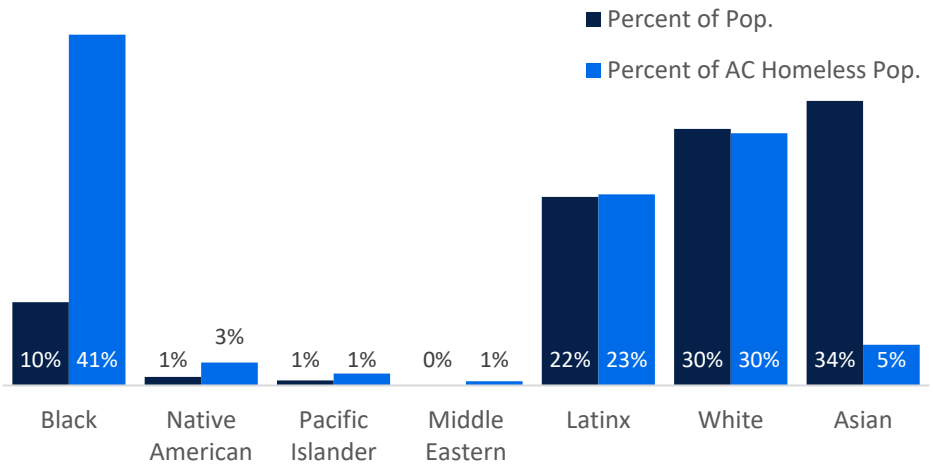
The number of individuals experiencing homelessness in Oakland rose between 2022 and 2025.



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

It was regularly underscored by focus groups and key informants that housing instability and homelessness are significant determinants of health, affecting both mental and physical well-being. Stable housing is seen as a foundation for addressing other health needs. Participants mentioned that systemic issues, including structural racism and economic inequities, contribute to the housing and homelessness crisis.

BIPOC communities are overrepresented in the Alameda County homeless population.



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

4 Structural Racism/Discrimination

What is the issue?

Racism and discrimination, both structural and interpersonal, has been shown to be one of the fundamental causes of health inequities, health disparities, and disease in the U.S. The impact of these inequities on the health of Americans 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 across a wide range of health conditions, especially when compared to their White counterparts.[20] 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.

Why is it a health need?

More than half of key informants and focus groups identified structural racism as a community priority to be addressed. CHNA participants explained that structural racism is a continuous and pervasive issue and can manifest in various forms, including the built environment (e.g., diesel truck corridors routed through predominantly Black neighborhoods) and over-policing of BIPOC neighborhoods, which negatively impact physical and mental health outcomes.

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

– CHNA Interviewee

Further, some participants indicated that structural racism in healthcare directly results in poorer health outcomes for marginalized groups, such as higher infant mortality rates among Black women or reduced life expectancy among BIPOC populations. Additionally, some noted that the lack of representation and inclusivity in hiring practices is a significant issue.

"For me, [being] Black, it's always discrimination. Discrimination is alive, and we're at the bottom of the totem pole."

– Community Member Focus Group Participant

CHNA participants also described experiencing discrimination as members of other marginalized populations, such as LGBTQ+, low-income individuals, and individuals with disabilities. Some participants indicated that low-income communities face neglect and poor living conditions, with landlords often retaliating against common concerns or complaints. Others said LGBTQ+ individuals experience discrimination in housing, with landlords making it difficult for them to secure rentals.

[20] Centers for Disease Control and Prevention (CDC). (2021). Racism and Health. Retrieved from https://www.cdc.gov/healthequity/racism-disparities/index.html

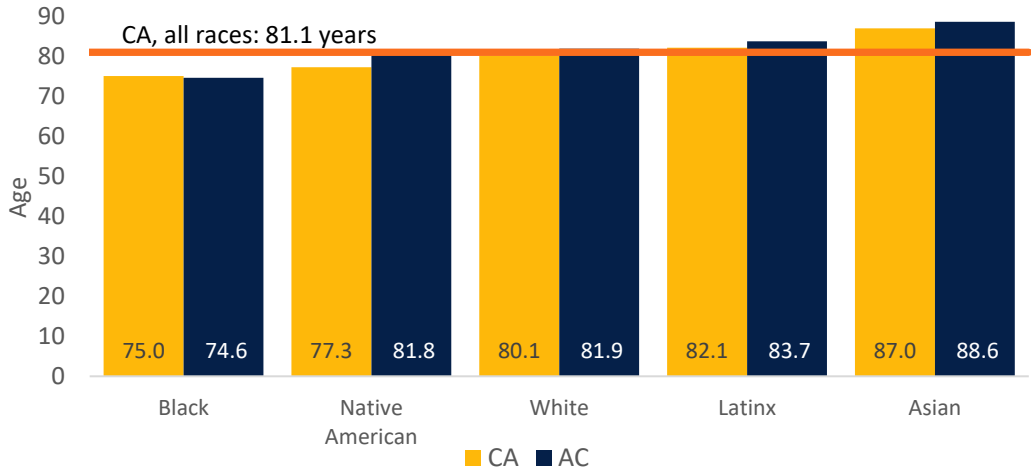
It was frequently mentioned that non-English speakers face additional challenges in accessing quality healthcare services, while others spoke about workplace discrimination against individuals with disabilities.

Multiple participants noted that discrimination often intersects across race, disability, economic status, and sexual orientation, compounding the challenges faced by individuals. Youth in particular expressed concern about various forms of discrimination they experience among students while at school.

> *"Another thing I wish would not be present at school is the homophobia, the transphobia, racism, 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 that anyone should have to experience."*
>
> *– Youth Participant, Eastern Alameda County Needs Assessment*

Some CHNA participants mentioned that historical policies like redlining have created long-lasting inequities between neighborhoods, leading to limited access to affordable housing, healthy food, and green spaces for BIPOC populations. Others spoke to the economic barriers that disproportionately affect communities of color. Several stated specifically that structural racism is embedded in the criminal justice system, leading to higher incarceration rates for people of color that disrupt family structures and later translate into worse economic outcomes, such as homelessness. Participants indicated that addressing structural racism requires broader systemic changes across multiple sectors, including housing, healthcare, education, and employment.

Life expectancy is lowest for Black residents in Alameda County.



Source: National Center for Health Statistics - Mortality Files, 2018-2020, as cited by Community Health Rankings (Robert Wood Johnson Foundation).

5 Healthcare Access & Delivery

What is the issue?

Access to affordable, comprehensive, quality healthcare is important for improving health and increasing quality of life.[21] For most people, access to care means having insurance coverage, being able to find an available primary or specialty care provider nearby and receiving timely delivery of care. Delivery of care involves the quality, transparency, and cultural competence/humility with which services are rendered. Limited access to care and compromised delivery affect people's ability to reach their full potential, diminishing their quality of life.

Why is it a health need?

Healthcare access and delivery was prioritized in more than one-third of all interviews and focus groups. CHNA participants focused on the ever-present barriers to healthcare access, including economic obstacles and shortages of providers.

> *"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."*
>
> *– Expert Interviewee*

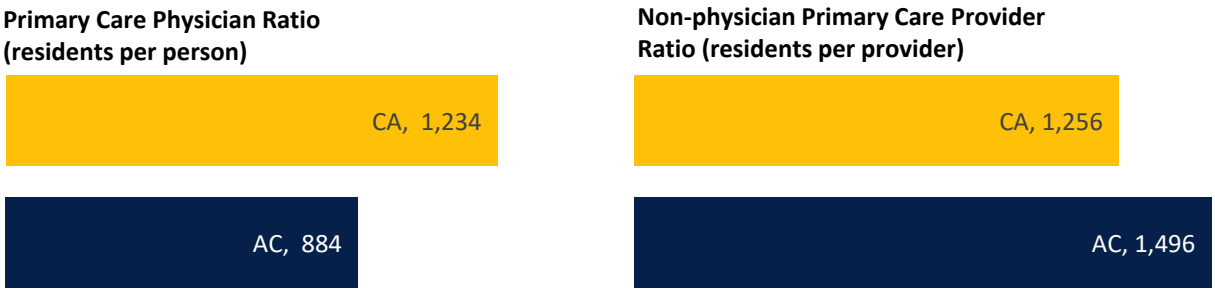
Some participants also mentioned bureaucratic hurdles that persist in navigating the healthcare system in general. Several described how existing staff is overburdened, naming this as another access issue. In addition, it was noted that undocumented immigrants face unique challenges in accessing healthcare due to legal and bureaucratic barriers.

Difficulties in accessing specialty care, including mental health services, were highlighted by the community as well. Experts who participated in the CHNA often highlighted the importance of integrating medical, dental, and behavioral health services in a single location to improve access.

Statistics show that in Alameda County, the ratio of community members to primary care providers is better (lower) than the ratio among Californians overall. However, the ratio of community members to other primary care professionals (e.g., physician assistants) is worse (higher) compared to the state (see charts on following page). Access among public school students to school nurses is also worse in Alameda County (3,385 students to each nurse) compared to such access statewide (2,410:1).

[21] County Health Rankings & Roadmaps. (2024). Access to Care. Retrieved from https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care

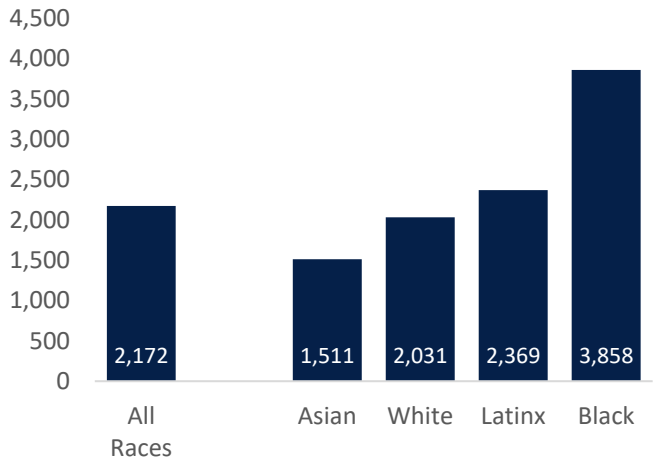
The ratio of community members to non-physician primary care providers is worse in Alameda County compared to California overall.



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

The rates of preventable hospitalizations are highest for BIPOC populations (especially Black and Latinx). A higher rate of preventable hospital stays may be an indicator of inequitable access to high-quality care.

In Alameda County, Latinx and Black older adults are hospitalized for preventable causes notably more often compared to older adults of all races/ethnicities.



Definition: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Source: Mapping Medicare Disparities Tool, 2020.

"Language is sometimes a barrier... when we are lucky enough to understand each other, that's good, isn't it? But when we are not—I have seen people who want to communicate with the doctors, the nurses, but they [the providers] just don't."

– Community Member Focus Group Participant

With regard to healthcare delivery, some CHNA participants asserted the need for healthcare services to be more culturally sensitive, alleging that some current practices often disregard cultural differences. There were also concerns expressed about the quality of care, citing issues such as long wait times, poor communication, and perceived indifference or blatant disrespect by healthcare providers.

6 Community & Family Safety

What is the issue?

Crime, violence, and intentional injury are related to poorer physical and mental health for the victims, the perpetrators, and the community at large.[22] As reported by the World Health Organization, even apart from any direct physical injury, victims of violence have been shown to suffer from a higher risk of depression, substance use, anxiety, reproductive health problems, and suicidal behavior.[23] Additionally, exposure to violence has been linked to negative effects on an individual's mental health, including post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior themselves.[24]

Why is it a health need?

Community and family safety was prioritized in more than two out of every five interviews and focus groups. Concerns were shared about community and family safety, including child and partner abuse. Economic instability and poverty were consistently mentioned as contributing factors to community violence and unsafe environments. Some noted that housing instability, such as families doubling up in homes, creates further stress and therefore could impact the safety of all individuals in such residences.

Gun violence, muggings, robberies, and other violent crimes were commonly reported issues affecting community safety as well. Safety concerns in public spaces such as parks and schools were additionally highlighted.

"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.'"

– Community Leader Interviewee

"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 where it's 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

Participants pointed out the lack of resources such as street lighting, adequate policing, and support services for victims of violence. Some participants felt that institutional racism is what has led to the creation of neighborhoods with high poverty and lack of resources, contributing to unsafe environments.

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[22] Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (2002). The World Report on Violence and Health. The Lancet, 360(9339), 1083–1088.

[23] World Health Organization. (2017). 10 Facts About Violence Prevention.

[24] Ozer, E.J. & McDonald, K.L. (2006). Exposure to Violence and Mental Health Among Chinese American Urban Adolescents. Journal of Adolescent Health, 39(1), 73–79.

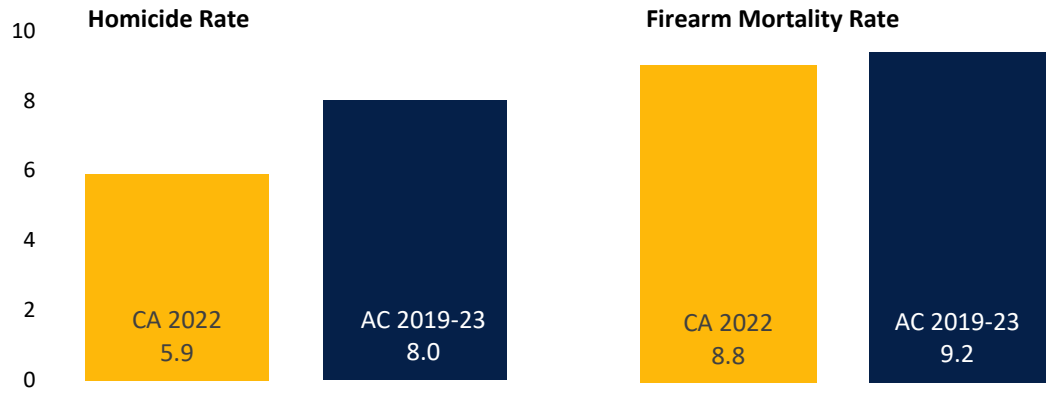
"By and large, I'd say communities of color... they all talk about violence. All of them. And being concerned about it and it being a problem."

– Expert Interviewee

The threat of violence and crime has significant mental health implications, affecting individuals' ability to thrive and feel safe in their environments. Lack of mental health support was mentioned as a factor that prevents individuals from breaking out of the cycle of violence.

Health experts in Alameda County felt community violence was a county-wide concern, with several interviewees in the Oakland area describing gun violence affecting youth and community-serving staff both directly and indirectly. Statistics show that the homicide rate is notably higher in Alameda County compared to California's rate overall. Firearm mortality is similarly higher compared to the state rate and is suffered disproportionately by the Black population (27.5 per 100,000). As with firearm mortality, homicide deaths also disproportionately occur among the Black population in Alameda County (50.7 per 100,000).

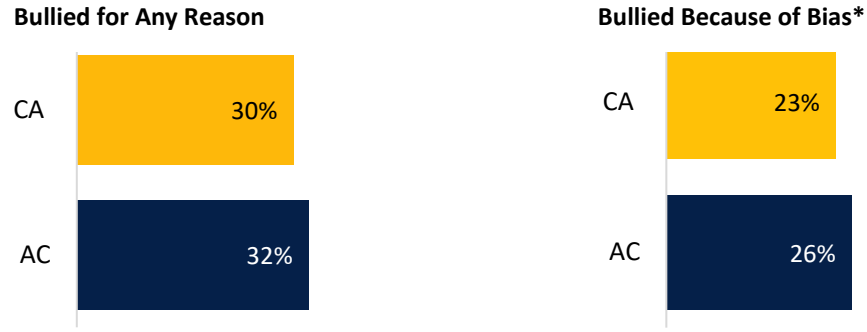
Homicide and firearm mortality rates are higher in Alameda County than they are statewide.



Source: National Center for Health Statistics - Mortality Files, 2016-2020

Youth gang membership among 11th graders is somewhat higher in Alameda County (4.4%) versus the state benchmark (4.1%). A slightly larger percentage of 9th graders also reported being bullied and harassed at school because of bias, compared to their statewide peers.

Higher proportions of Alameda County youth experience bullying or harassment than all CA youth.



Note: * Bias because of gender, race/ethnicity or national origin, religion, sexual orientation, or a physical/mental disability. Source: WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS California Dept. of Education, 2020, as cited in KidsData.org.

7 Climate/Natural Environment

What is the issue?

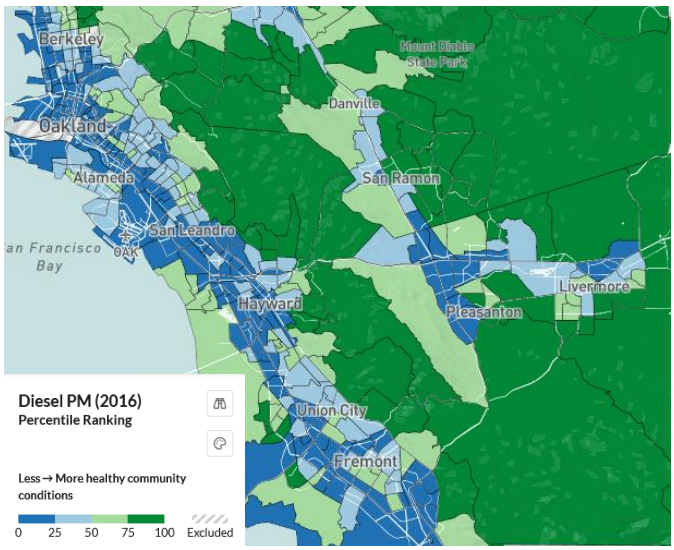
The Office of Disease Prevention and Health Promotion reports that, worldwide, nearly 12 million deaths each year can be attributed to environmental issues. Those issues include air, water, food, and soil contamination, as well as natural and technological disasters. For those whose health is already compromised, exposure to negative environmental issues can compound their problems.[25]

Why is it a health need?

Indicators of air quality were poor in Alameda County.[26] 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), as was its overall traffic volume statistic (1,791 vehicles per meter of road versus 1,391 statewide).

CHNA participants, primarily community members, spoke about climate change concerns. Those who mentioned it mainly referred to either poor air quality or an increasing number of days of extreme heat. One health expert that participated in this CHNA cycle tied both issues to increasing rates of asthma.

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



Source: California Health Places Index.

"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."

– Expert Interviewee

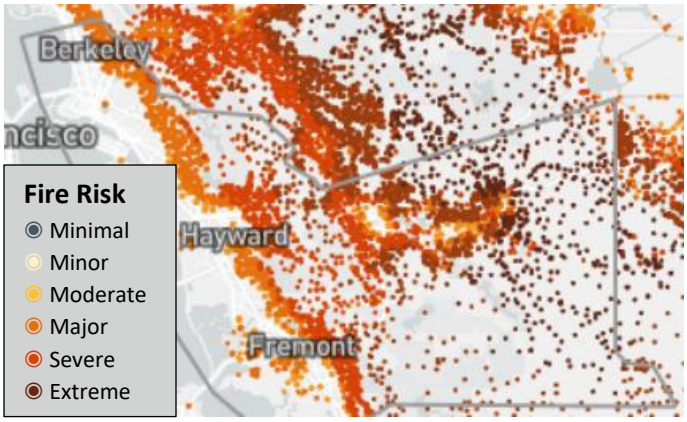
[25] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2024). Environmental Health. And: Morris, G. & Saunders, P. (2017). The Environment in Health and Well-Being, Oxford Research Encyclopedias.

[26] Although the latest diesel particulate matter data are from 2016, the California Healthy Places Index is the standard relied upon by HCAI in determining communities that are vulnerable to air pollution.

With regard to heat, Alameda County is expected to experience seven "hot" days (days in which the temperature feels as though it is over 88° F) in 2025. This number is expected to double to 14 days over the next 30 years.[27]

With regard to air quality, participants in Alameda County raised their concerns with industrial pollution, making a connecting with historical housing segregation (i.e., lower-income families are more likely to live in areas affected by such pollution). Some individuals also mentioned being affected by wildfire smoke. Alameda County is at major risk of wildfire, with a history of 10 wildfires in the past 35+ years, including the SCU Lightening Complex fire of 2020, which burned nearly 1,650 square miles of land and affected than 1,400 buildings. Nearly 50% of all properties in the county are at some risk of being affected by wildfire in the next 30 years.[28]

More properties are at risk from fire in Eastern Alameda County than in other parts of the county.



Note: Risk of fire within 30-year window starting in 2025.
Source: First Street Technology, Inc.

CHNA participants expressed concerns around environmental justice. For example, they noted that low-income communities and communities of color are often disproportionately affected by extreme weather and environmental hazards and have fewer resources to cope with the impacts. Participants expressed a sense of limitation to their ability to make significant changes at the local level. They noted that while individual actions are important, broader systemic changes are necessary to address the root causes of climate change effectively.

[27] Heat data obtained from First Street Technology, a public benefit corporation connecting climate risk to financial risk via advanced climate science: https://firststreet.org/county/alameda-county-ca/6001_fsid/heat

[28] Fire data obtained from First Street (see footnote above): https://firststreet.org/county/alameda-county-ca/6001_fsid/fire

8 Health Issues

What are the issues?

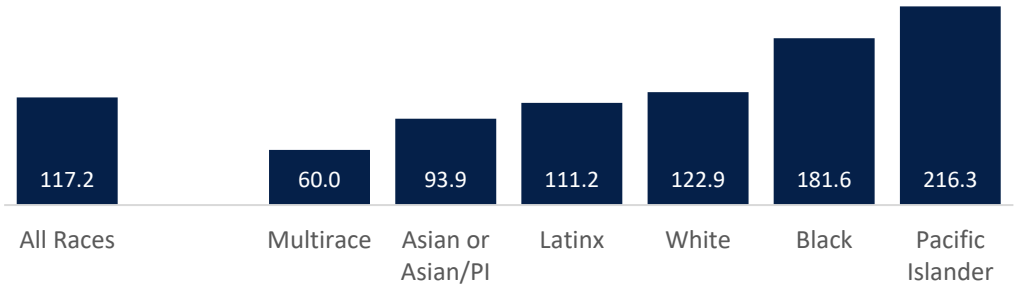
- **Cancer** is the second leading cause of death in the U.S., following heart disease.[29]
- **Heart disease** is the #1 cause of death in the U.S.,[30] while **stroke** is #5.[31]
- Improving the well-being of **mothers and infants** remains an important goal, as U.S. women now have a higher mortality rate from childbirth than their peers in other developed countries.[32]
- **Sexual health** is dependent on unconditional access to sexual healthcare and information about sex and sexuality, including knowledge of the risks and consequences of unprotected sex like sexually transmitted infections (STIs)..[33]
- **Unintentional injury** is the third leading cause of death for all ages in the U.S.[34]

Why are they health needs?

Cancer

Cancer was the #1 cause of death in Alameda County in 2022. Although overall cancer mortality rates are on par or better than the state, statistical data for cancer mortality by race/ethnicity indicates substantial disparities. For instance, the overall cancer mortality rate among Alameda County's Pacific Islander population is much higher compared to their White or Latinx counterparts.

Pacific Islanders and Blacks have notably higher cancer mortality rates than other racial/ethnic groups.



Source: Alameda County Public Health Department (by personal correspondence), 2019–2023.

[29] Centers for Disease Control and Prevention. (2017). Leading Causes of Death.

[30] Centers for Disease Control and Prevention. (2017). Heart Disease Facts.

[31] Centers for Disease Control and Prevention. (2018). Stroke.

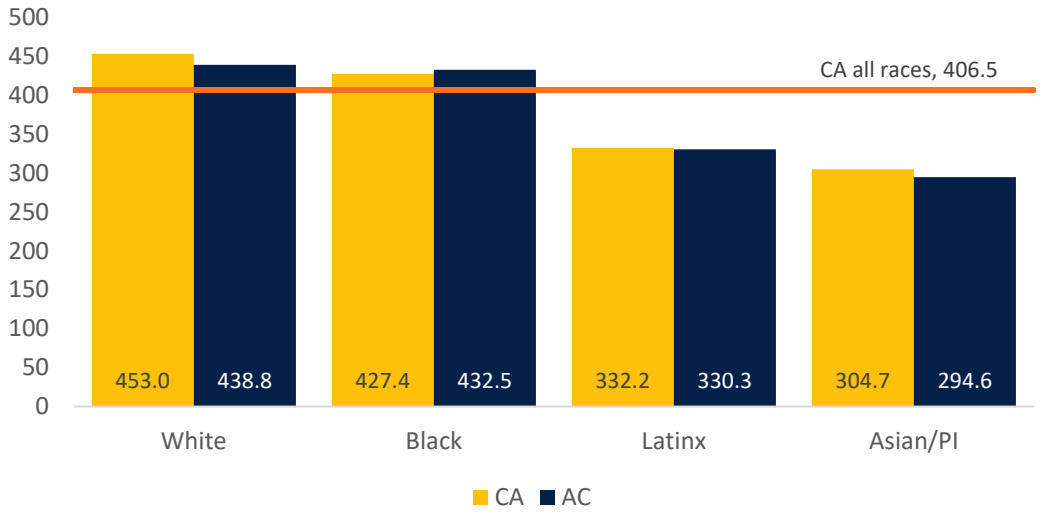
[32] Healthy People 2030. (2024). Office of Disease Prevention and Health Promotion.

[33] Centers for Disease Control and Prevention. (2024). Sexually Transmitted Infections (STIs).

[34] Centers of Disease Control and Prevention, National Center for Health Statistics. (2022). Accidents or Unintentional Injuries.

Countywide statistical data indicate that at least one racial or ethnic group also experiences significantly higher overall cancer incidence rates and worse rates for various types of cancer compared to the total population's rates in Alameda County.

Whites and Blacks have higher overall cancer incidence rates than other racial/ethnic groups.



Source: California Health Maps, 2012-2021.

With respect to specific forms of cancer, Latinx residents in Alameda County have the highest incidence of liver cancer compared to their non-Latinx peers, while Asians have the highest incidence of thyroid cancer compared to any other group. The county's Whites have a higher incidence of breast, lymphatic, melanoma (skin cancer), and urinary tract cancer than any other group. Further, Blacks have the highest incidence rates of lung, pancreatic, prostate, and uterine cancer compared to other racial/ethnic groups in the county.

Site-specific cancer incidence rates are more often worse for Blacks and Whites in Alameda County than for other racial/ethnic groups.

Cancer Site	All Races	White	Latinx	Asian	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**

Source: California Health Maps, 2012–2021.

While cancer was rarely prioritized on its own, community members' personal accounts illustrated potential gaps in timely and comprehensive cancer screenings. Access to specialized cancer care and resources was raised as an issue; some participants mentioned long waiting lists and limited availability of services. The financial burden of cancer treatment was a significant concern, with participants noting how it affects economic stability, both short- and long-term, for patients and their families.

> *"I had prostate cancer. That's expensive, you know what I mean? Doctors ain't gonna want to treat you for it. Because if you ain't got no insurance, they don't want to see you, man."*
>
> *– Community Member Focus Group Participant*

When cancer was discussed, participants frequently mentioned that cancer carries with it an emotional toll on both patients and their families, and that mental health support is needed in addition to physical treatment. Participants also spoke of the need for more cancer education within the community at large.

The National Cancer Institute has acknowledged socioeconomic and racial/ethnic disparities that exist in cancer detection, treatment, and outcomes. It attributes these disparities to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role geography plays in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, community members are more likely to be obese, which is a cancer risk factor). 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/or institutional inequalities."[35]

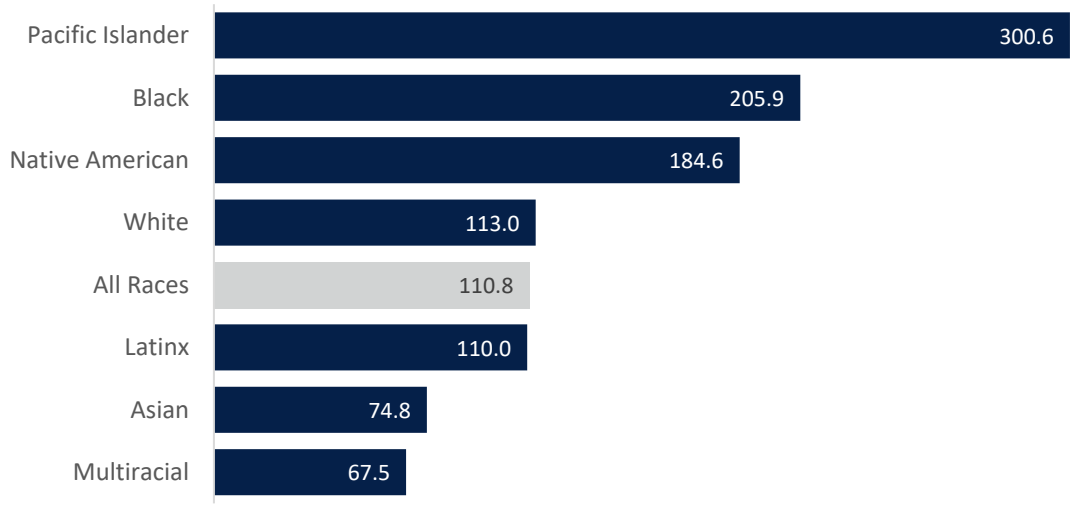
Heart Disease/Stroke

Heart disease and cerebrovascular diseases ranked among the top five causes of death in Alameda County in 2022, although stroke mortality is only slightly worse among county residents (43.4 per 100,000) than their statewide peers (42.1) and the cardiovascular disease (CVD) mortality rate is lower than the state's. However, the mortality rate for heart disease is much higher among the county's Pacific Islander and Black populations than other ethnic groups. Although Whites in Alameda County also have a high CVD mortality rate, their rate is not as high as certain BIPOC populations (see chart on next page). Heart disease and stroke were prioritized by a small proportion of key informants and focus group participants; of these, several CHNA participants noted a high prevalence of hypertension and diabetes within their communities, which are significant risk factors for heart disease and stroke. In Alameda County, hypertension ranked separately in the top 10 causes of death.

> *"Hypertension and stroke is generally one of the areas where you do see a cultural implication. Our Hispanics and our African Americans are the ones most at risk."*
>
> *– CHNA Interviewee*

[35] National Cancer Institute. (2020). Cancer Disparities.

Pacific Islanders and Blacks have notably higher heart disease mortality rates than other racial/ethnic groups.



Source: Alameda County Public Health Department, 2019-23.

Some participants who discussed heart disease highlighted the role that stress and mental health issues have in poor cardiovascular health outcomes, while others identified various social determinants of health (economic insecurity, lack of healthcare access, and poor-quality healthcare) as contributing factors. Poor diet due to food insecurity was linked by several experts to higher rates of diabetes and heart disease, especially among youth. Participants saw effective management of chronic illnesses like diabetes and hypertension as crucial for preventing heart disease and stroke.

Maternal/Infant Health

Certain maternal and infant health statistics were worse for particular populations compared to the state rates, including the proportion of premature births, low birth-weight births, and infant mortality. For example, infant mortality is substantially higher among Alameda County's Black population (8.4 per 1,000) compared to infants of other ethnicities (3.3 for all races/ethnicities).

> *"We have seen that infant mortality and some of the sicknesses that infants are having is high amongst Native children… When they are getting the care that they need, we see less infant mortality and less children getting sick."*
>
> *– CHNA Interviewee*

In Alameda County, the rate of severe maternal morbidity (unexpected and life-threatening events that can occur during childbirth) was notably higher than the California rate and was highest for Black mothers (229.2 per 100,000).

The severe maternal morbidity rate is higher in Alameda County compared to the state.

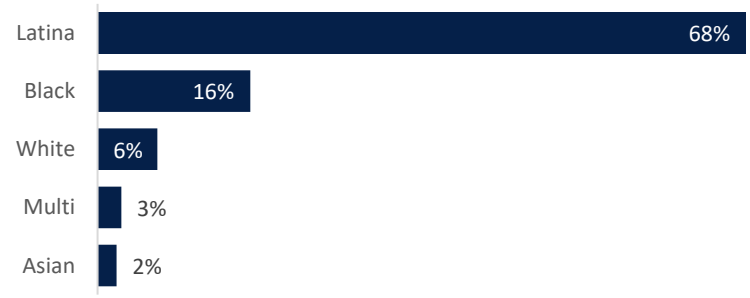
Source: California Department of Public Health, 2020-2022.

While maternal and infant health was rarely prioritized on its own, CHNA participants noted that low-income and BIPOC (especially Black) mothers face more challenges in accessing maternal/infant healthcare. Affordability of healthcare services was a major concern, with some participants revealing that economic constraints prevented them from accessing necessary prenatal and postnatal care. Another common theme shared throughout discussions was the need for cultural sensitivity and more effective communication from healthcare providers, specifically with patients from diverse backgrounds.

Sexual Health

Although the rate of teen births in Alameda County (7.0 per 1,000) is better than the state (13.0), there are disparities by race/ethnicity.

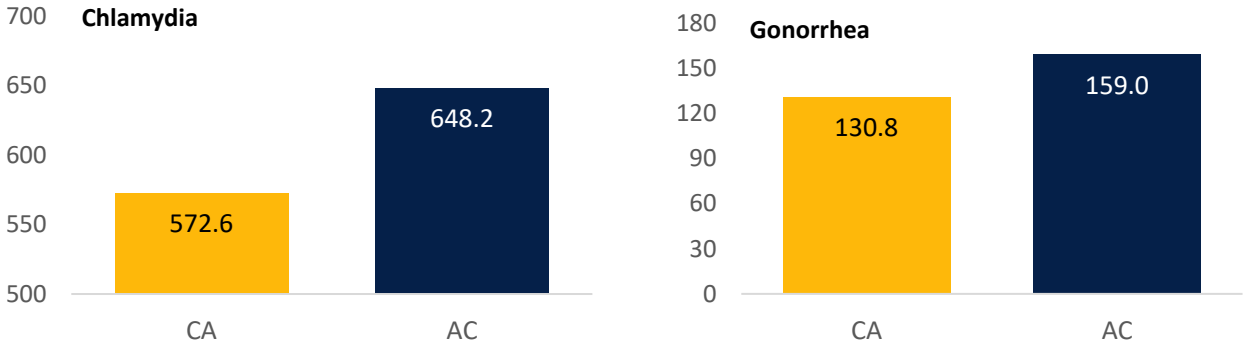
Among teens who gave birth in Alameda County, there was a much higher proportion of Latinas than teens of other ethnicities.



Source: California Department of Public Health, Adolescent Births Dashboard, 2020-2022. Ages 15-19.

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

Chlaymydia and gonorrhea rates for youth in Alameda County are higher than California rates.



Source: California Department of Public Health, 2020.

Some CHNA participants expressed a concern regarding the rising rates of STIs like syphilis and chlamydia. It was pointed out by a participant in an LGBTQ+ focus groups that current messages conveyed by health providers and public health departments about sexual health often misses certain individuals who do not identify strictly as gay, bisexual, or heterosexual but still engage in high-risk behaviors. This gap in messaging leads to a lack of awareness and preventive care measures among these groups.

"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 things because they don't see themselves fitting into the category [of people at risk]."

– Community Member Focus Group Participant

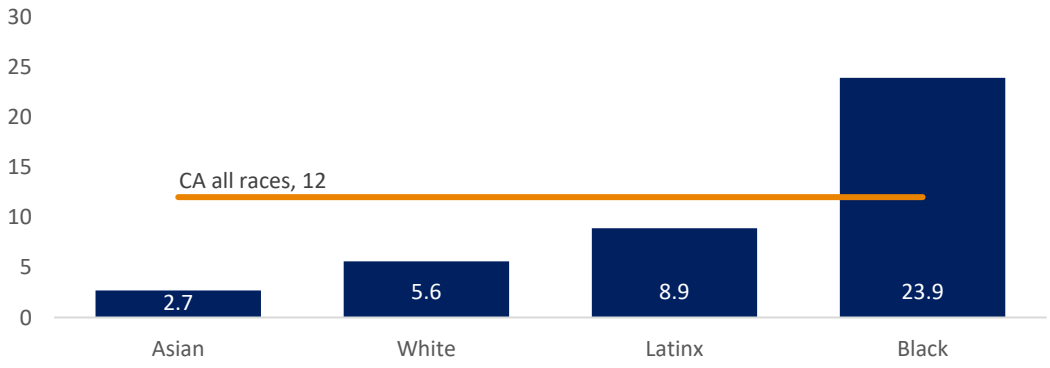
The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, lower levels of education, and distrust of the healthcare system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to "stay sexually healthy."[36]

Unintended Injury

In Alameda County, the rate of mortality by race from all unintended injuries was highest for the Black population, followed by the Native American population. Further, the share of traumatic injury hospitalizations among children in Alameda County was somewhat higher (3.2% of all hospitalizations) compared to children in California overall (2.6%).

Accidents (unintentional injuries) were ranked among the top five causes of death in Alameda County in 2022. Compared to the statewide benchmark (0.4 per 100,000), the rate of pedestrian deaths was notably higher for the county (2.1). Alameda County motor vehicle crash mortality rates by race were highest for the Black population, followed by the Latinx population.

Death rates due to motor vehicle crashes are highest among the Black population.



Source: Alameda County Public Health, 2021.

Racial inequity in accident rates has been found nationwide and is attributed in part to unequal access to safe transportation.[37] The absence of sidewalks in low-income neighborhoods is another factor related to national pedestrian accident rates.[38]

[36] Centers for Disease Control and Prevention. (2020). STD Health Equity.

[37] Hamann, C., Peek-Asa, C., & Butcher, B. (2020). Racial disparities in pedestrian-related injury hospitalizations in the United States. BMC Public Health, 20(1), 1-7.

[38] Lu, W., McKyer, E.L.J., Lee, C., Ory, M.G., Goodson, P., & Wang, S. (2015). Children's active commuting to school: an interplay of self-efficacy, social economic disadvantage, and environmental characteristics. International Journal of Behavioral Nutrition and Physical Activity. 12(1):29.

2025 Community Health Needs Assessment

Alameda County

UCSF Benioff Children's Hospital Oakland

CONCLUSION

7. CONCLUSION

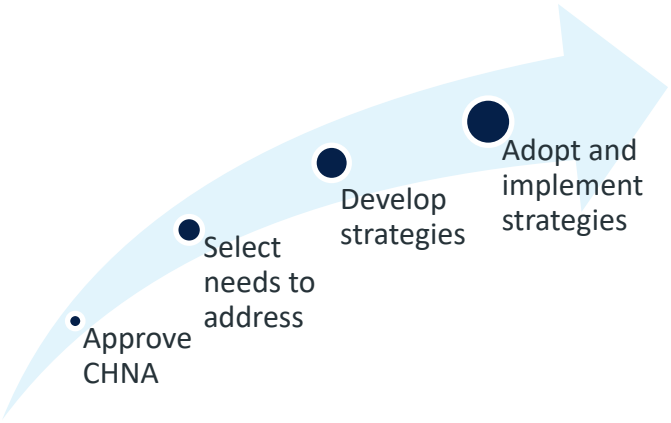
UCSF Benioff Children's Hospital Oakland worked with local partners, combining expertise, guidance, and resources to conduct the 2025 Community Health Needs Assessment. By gathering secondary data and conducting new primary research with other healthcare facilities and local public health departments, the hospitals gained a shared understanding of how health indicator data for BCH Oakland's service area compared to state benchmarks as well as the community's perception of health needs. This extensive base of information informed the hospital's prioritization of health needs.

The 2025 CHNA, which builds upon prior assessments, dating back to 1995, meets federal (IRS) and California state requirements.

NEXT STEPS

Next steps for BCH Oakland:

- Ensure CHNA is approved by the hospital board and made publicly available on BCH Oakland's website by June 30, 2025.[39]
- Monitor community comments on the CHNA report submitted to anchor@ucsf.edu (an ongoing effort).
- Select priority health needs to address.
- Develop strategies to address priority health needs.
- Ensure strategies are adopted by the hospital board and filed with the IRS by November 15, 2025.



ATTACHMENTS

Attachments to this report are as follows:

1. Community Leaders, Representatives, and Members Consulted
2. Secondary Data Indicator Index
3. Community Assets and Resources
4. Qualitative Research Materials
5. IRS Checklist

To request attachments, please email anchor@ucsf.edu.

[39] See https://anchor.ucsf.edu/bch-oakland

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