2026-28

Community Health Improvement Plan

Responding to the 2025 Community Health Needs Assessment

Washington Health

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Introduction

The Community Health Improvement Plan (CHIP) describes how Washington Health (WH) plans to address health needs identified in the 2025 Community Health Needs Assessment (CHNA). This implementation plan lays out a plan of work to implement strategies that will improve the health of District residents in fiscal years 2026 through 2028.

The 2025 CHNA and the 2026 – 2028 Community Health Improvement Plan were undertaken by the hospital to understand and address community health needs, and in accordance with California state law and Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. WH reserves the right to amend this plan as circumstances warrant. Beyond the initiatives and programs described, the hospital also addresses community health needs by providing health care to the community, regardless of patients' ability to pay.

WH welcomes comments from the public on the 2025 Community Health Needs Assessment and 2026 – 2028 Health Improvement Plan. Feedback may be submitted through the online Contact form (https://www.washingtonhealth.com/contact-us/) or emailed directly to communityoutreach@washingtonhealth.com.

Executive Summary

Washington Health was founded as an independent health care district in 1948 to provide health care close to home for residents in southern Alameda County. In 1958, the health care district opened a 150-bed hospital. As the community has grown, Washington Health has evolved into a comprehensive health system with an affiliated medical group, a network of clinics, and nationally recognized clinical programs.

With a publicly elected Board of Directors, the Health System serves a population of 340,642 residents living in Fremont, Newark, Union City, southern Hayward, and unincorporated Sunol.

Each year, Washington Health provides innovative and impactful community benefit programs and services to underserved and underinsured residents. The hospital's community benefit programs and activities are designed to:

- Meet the specific healthcare needs of targeted populations;
- Expand access to healthcare to those who need it most;
- Provide health information and education resources; and
- Teach participants about healthy lifestyles.

Washington Health conducted research for the 2025 Community Health Needs Assessment in collaboration with other local hospitals and Alameda County Public Health. WH's goal was to gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the spring and summer of 2024 through key informant interviews with local health and community experts, focus groups with community leaders and representatives, and focus groups with community residents. Secondary data were obtained from a variety of sources and were gathered in winter and spring of 2024–2025.

Ten health needs were identified in the 2025 CHNA. The full 2025 Community Health Needs Assessment conducted by WHHS is available at: https://www.washingtonhealth.com/about-us/community-connection/community-health-needs-assessment/

Significant Health Needs Identified in the 2025 CHNA

The following significant health needs were identified in the 2025 CHNA (listed in priority order):

- **Economic Security.** Economic security, including income, employment, education, housing and food security, was the highest-priority health need in interviews and focus group discussions. Economic security statistics vary substantially by race/ethnicity, with Black households earning the least across all three cities compared to people of other races/ethnicities. Black and Native American individuals are also overrepresented among the unhoused population.
- **Behavioral Health.** This need includes mental health, substance use, and violence. Behavioral health was one of the highest-priority health needs in interviews and focus group discussions. Participants expressed concern about youth and young adults, domestic violence, and stigma as a barrier to access. Newark has a significantly higher rate of severe mental illness Emergency Department (ED) visits compared to the county's rate.
- **Healthcare Access & Delivery.** Access to healthcare and the experiences of receiving care were prioritized in more than half of all interviews and focus groups. Participants were concerned about language barriers. The Latino population has lower rates of adult health insurance than their countywide peers of all ethnicities. Nearly one in five South County residents have difficulty accessing care, and this proportion has been slowly rising.
- **Inequity/Discrimination.** Racism and discrimination was prioritized by close to half of all interviewees and focus group participants. Structural racism is a continuous and pervasive issue and can manifest in various ways, which negatively impact physical and mental health outcomes for marginalized groups. Participants discussed how multiple forms of discrimination (e.g., race, gender, economic status, immigration status) can intersect, compounding disadvantages for affected people.
- **Cognitive Decline.** Union City experiences a higher mortality rate from Alzheimer's disease (AD) and other dementias compared to the county, and a higher ED visit rate from AD as well. In Fremont and Union City, AD mortality is substantially higher among both Blacks and Whites compared with their peers of other races. In Newark, Latinos and Whites have the highest AD mortality rates. Concerns were raised by some CHNA participants about AD and other dementias.
- **Diabetes & Obesity.** The proportions of children and teens who are overweight or obese are higher in Newark and Union City than in the county overall. Diabetes prevalence is highest among the White population in Union City, and among the Latino population in Fremont. The rate of deaths from diabetes is higher in Union City compared to the county.
- **Heart/Stroke.** Cerebrovascular issues such as stroke, heart disease, and hypertension are among the top causes of death in the county. Service area cities fare worse than the

county overall. Notably, in Union City, residents have worse rates than other service area cities and the county overall for emergency department visits (heart diseases, hypertension, and acute myocardial infarction), hospitalizations (heart diseases, acute myocardial infarction), and mortality (heart diseases, hypertension, and acute myocardial infarction). Stroke mortality rates are higher in Newark and Union City than for the county as a whole.

- **Cancer.** Cancer qualifies as a health need because of statistical data in Newark, as well as racial/ethnic disparities that are evident countywide. Newark has a higher mortality rate due to lung cancer compared to Alameda County overall, and higher hospitalization rates for colorectal cancer and breast cancer versus the county.
- **Maternal/Infant Health.** Fremont, Newark, and Union City have higher rates of infant mortality than Alameda County overall. Both Fremont and Union City have higher proportions of low birthweight babies compared to the county, and Union City has a higher proportion of premature births than the county overall. Certain statistics were worse for particular populations compared to the state rates, including the proportion of premature births (worst for Black babies), low birth-weight births (highest among Black babies), and teen births (highest among Latinas).
- **Unintended Injuries.** Accidents (unintentional injuries) were the number one reason for preventable ED visits/hospitalizations in all three cities and the county. Where data were available by race on unintended injuries mortality, the rate was often highest for the Black population.

2026 – 2028 Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) describes how WH plans to address the health needs identified in the 2025 CHNA and reduce health disparities that the data reveal. The CHIP describes actions WH intends to take, including:

- Programs and resources it will commit to improve the health of District residents
- Collaborations it will pursue with other organizations in the community to improve health outcomes

WH leadership and Community Outreach staff reviewed the 2025 CHNA report and based upon the data and findings selected four community health needs that the hospital can most effectively address. The following health needs will be the primary area of focus for health improvement for 2026-2028:

- Healthcare Access & Delivery
- Healthy Lifestyles (includes Diabetes/Obesity, Heart/Stroke, and Cognitive Decline)
- Cancer
- Unintended Injuries

Please note that the Ongoing Initiatives listed in the following section is not an exhaustive inventory of all the health-education outreach activities that WH is engaged in. The list is intended to highlight initiatives that are current priority areas. Likewise, WH may begin additional education and prevention programs in the next three years, as health needs evolve in the District.

Key Health Need: Healthcare Access & Delivery

Key CHNA Findings:

- **District residents expressed a need for culturally and linguistically relevant care with providers who understand and reflect the identities and cultures of patient populations.**
- **Despite over 90% of South County residents being insured, about 1 in 4 district residents report having difficulty obtaining care.**

Goals:

- **Improve access to affordable, high-quality healthcare services and prevention programming for community members.**
- **Increase access to linguistically and culturally-aligned healthcare services**.

Strategies to Address Healthcare Access & Delivery

Ongoing Strategies:

- Continue operating Level II Trauma Center, working towards full trauma ACS verification.
- Participate in the government-sponsored Medi-Cal program and the county managed care health plan, Alameda Alliance for Health.
- Promote Health Insurance Information Service, including services to find a doctor and navigate the healthcare system.
- Host and participate in health education programming through education seminars, speaker's bureau and community wellness fairs.
- Host a Community Advisory Board comprised of District residents to promote diverse perspectives and feedback from constituents.
- Host a Patient Family Advisory Council comprised on former patients and family members to drive positive changes in patient experience.
- Collaborate with ReCARES on community DME program for vulnerable, low-income patients.
- Support free Community Lymphedema Garment Program for underserved patients.
- Provide financial assistance through the Washington Health Financial Assistance and Charity Care Policy to support low-income, uninsured and underinsured individuals who receive services at Washington Health.

New Strategies:

- Open new Urgent Care center in Fremont in 2025 to increase access to medical services for non-life threatening injuries and illnesses.
- Continue development of Warm Springs Outpatient Center, increasing healthcare access for patients in South Fremont.
- Analyze patient health outcomes data by race, ethnicity, age, and language to reduce readmission rates and increase patient satisfaction.
- Increase culturally competent delivery of care for all populations (for example: disability community, LGBTQIA+, non-English speaking) by educating WH staff across the health system on diversity, equity, and inclusion best practices.
- Increase use of translation technologies across the organization, including WHMG outpatient clinics and inpatient settings.
- Create health education materials and flyers in multiple languages.
- Broaden health education offerings and in-person speaking events to include programming in non-English languages.
- Collaborate with Alameda Alliance to provide perinatal services to patients after the closure of the Saint Rose Hospital Labor & Delivery.
- Strengthen collaboration with District Federally Qualified Health Centers to ensure continuity of care post-discharge.

Key Health Need: Healthy Lifestyles

Key CHNA Findings:

- **Diabetes prevalence has almost doubled in the District in the last 14 years, with Union City having the highest rates of diabetes.**
- **Diabetes prevalence is the highest among the white population in Union City and Latino population in Fremont.**
- **Childhood obesity rates are consistently worse in Newark and Union City than the County overall.**
- **Union City continues to be most impacted by cardiac health outcomes, with Newark now starting to show concerning data related to cardiac health as well.**
- **Risk factors associated with cognitive decline (ex: diabetes, high blood pressure, obesity) are of concern in the District.**

Goals:

- **Increase healthy eating, active living, and wellness activities across the Healthcare District.**
- **Improve health outcomes of preventable chronic illness across the Healthcare District.**

Strategies to Address Healthy Lifestyles

Ongoing Strategies:

- Host and participate in health education programming through health education seminars and community wellness fairs.
- Ongoing Speakers Bureau presentations for community groups, schools, businesses, senior centers, and senior living communities
- Host Diabetes Matters and diabetes support groups.
- Host Mended Hearts support group for patients with history of heart surgery and cardiac rehabilitation.
- Host Better Breathers support group for patients with respiratory conditions.
- Continue Union City Heart Smart Walking Challenge, including monthly health education from a clinical expert.
- Collaborate with Fremont Community Ambassador Program for Seniors (CAPS)

New Strategies:

- Host Healthy Lifestyles Health Fair to promote education and resources for heart disease, stroke, nutrition, and diabetes.
- Expand Heart Smart Walking Challenge to other District cities, particularly Newark.
- Conduct targeted outreach and education in Newark USD and New Haven USD on Nutrition and Healthy Eating.
- Provide focused diabetes education with partners that serve the Latino population in Fremont.
- Offer stroke and heart disease education for students and families in Newark USD and New Haven USD schools.
- Explore partnership with Alcoholics Anonymous to provide space for an onsite Women's AA Meeting.
- Explore partnership with Alzheimer's Association, OnLok, and other Program of All-Inclusive Care for the Elderly (PACE programs)
- Restart stroke support group.

Key Health Need: Cancer

Key CHNA Findings:

- **Cancer was the number one cause of death countywide in 2022.**
- **Newark has higher lung cancer mortality rates than the county.**
- **Union City has higher hospitalization rates for colorectal cancer and breast cancer than the county.**
- **Cancer mortality rates are highest for the Black population, especially in Union City and Fremont. Cancer mortality rates for the White population in all cities is also higher than the county's rate.**

Goals:

- **Improve access to high-quality cancer care services and prevention programming for community members.**
- **Decrease health disparities seen across the District for cancer outcomes.**

Strategies to Address Cancer

Ongoing Strategies:

- Host and participate in health education programming through health education seminars and community wellness fairs that focus on cancer risk factors, prevention, and treatment of cancer.
- Host annual oncology events, Celebration of Life and Think Pink, to promote education and wellness for cancer survivor community.
- Host annual free Skin Cancer Screening program in partnership with the Fremont Center for Dermatology.
- Continue hosting HERS Breast Cancer Foundation on campus, support HERS events, and provide board leadership.
- Support Community Mammogram Program that offers free screenings to patients from local Federally Qualified Health Centers.
- Host monthly Breast Cancer Support Group.
- Communication campaign with Washington Health Medical Group Medi-Cal patients for cervical, colorectal, and breast cancer screening.
- Upgraded CT scanner to 4D CT technology with respiratory gating to track patient breathing patterns.
- Offer lung cancer screening tool for Low Dose CT through PCPs and pulmonologists.

New Strategies:

- Complete the expansion of the UCSF-Washington Cancer Center by early 2026 to increase access to comprehensive cancer services.
- Encourage current oncology staff to sub-specialize by diagnosis.
- Explore partnership with local non-profit agencies to host oncology support group.
- Offer smoking and vaping health education in schools across the District, particularly with Newark USD.
- Create local partnerships with non-profits and faith organizations to reach underserved racial and ethnic groups (Tiger Lily Foundation, Promotores, Afro-American Cultural & Historical Society).
- Offer targeted breast cancer education to underserved populations in Union City.
- Offer targeted colorectal and prostate cancer prevention and screening education to Black residents in the District.
- Recruitment of additional oncology providers to increase access to care for oncology patients.

Key Health Need: Unintended Injuries

Key CHNA Findings:

- **Unintended injuries, such as falls, motor vehicle crashes, and drownings, were the number one reason for preventable emergency department visits and hospitalizations in all three district cities and the county.**
- **The black population has the highest frequency of death in Fremont and Union City from unintended injuries.**

Goals:

- **Improve access to high-quality trauma care services and injury prevention programming for community members.**
- **Decrease health disparities seen across the District for unintended injury outcomes.**

Strategies to Address Unintended Injuries

Ongoing Strategies:

- Continue operating Level II Trauma Center, working towards full trauma ACS verification.
- Host injury prevention programming through health education seminars, PSA videos and community wellness fairs, including fall prevention, stop the bleed, distracted driving, and choking education.
- Utilize evidence-based, multi-session programming such as Bingocize and Matter of Balance to promote physical activity, movement, and fall prevention in the elderly population.
- Work collaboratively with nursing, case management and social work to create screening and intervention programs for alcohol abuse.
- Work collaboratively with nursing, case management and social work to create screening and referral programs for trauma patients at risk of developing PTSD and depression post-injury.

New Strategies:

- Host onsite health fair promoting safety and injury prevention in partnership with local fire, police, and EMS.
- Create local partnerships with non-profits and faith organizations to reach underserved racial and ethnic groups (Promotores, Afro-American Cultural & Historical Society, OnLok, Gurdwara Sahib Fremont, Arunay Foundation, etc.).
- Establish a trauma survivor network to build community support networks and reduce negative health outcomes of trauma patients.
- Partner with first responders (fire, police, EMS) on injury prevention education efforts.
- Partner with Youth Alive! on recidivism reduction efforts with violent injury patients.

Community Needs that WH Plans to Address Indirectly and Through Partnership

No health system by itself can directly address all of the health needs present in its community. Many of the social determinants of health that affect residents' wellbeing are beyond the scope of WH's activities. Washington Health leadership was careful to select health needs for the CHIP that could make an impact in the community. The remaining health needs will be addressed indirectly in the outlined outreach strategies or through collaboration with other community-based organizations that more directly address these social issues.

- **Economic Security:** WH plans to indirectly address this need through Healthcare Access & Delivery strategies. WH also plans to support and work with other community organizations in the housing and homelessness and economic development space such as:
    - Abode Services
    - Avanzando
    - Alameda County Social Services Agency
    - Bay Area Community Services (BACS)
    - Centro de Servicios
    - Citizens for Better Community
    - CURA
    - Daily Bowl
    - Fremont Education Foundation
    - Fremont Family Resource Center
    - Fremont Unified School District
    - Mission Valley ROP
    - New Haven Schools Foundation
    - New Haven Unified School District
    - Newark Education Foundation
    - Newark Family Resource Center
    - Ohlone College
    - Second Chance
    - Tri-City Volunteers
    - Union City Family Resource Center

- **Behavioral Health:** WH plans to indirectly address this need through Healthcare Access & Delivery strategies. WH also plans to support and work with other community organizations on Behavioral Health strategies by convening the bi-monthly South County Partnership group. Members of this group include:
    - Abode Services
    - Bay Area Community Health (BACH)
    - Behavioral Health Collaborative of Alameda County
    - City of Fremont
    - City of Newark
    - City of Union City
    - Centro de Servicios
    - Fremont Family Resource Center
    - HUME Center
    - Mental Health Association for Chinese Communities (MHACC)
    - Narika
    - RCoz

- SAVE
- Tiburcio Vasquez Health Center (TVHC)
- Union City Family Center

- **Inequity/Discrimination:** WH plans to use information on racial and ethnic disparities and discrimination when responding to all health needs. Information on health disparities will allow WH to create targeted partnerships with groups that work closely with specific populations to better address health outcomes in our district. WH is also committed to capturing diverse community voice and input through quarterly meetings with our Community Advisory Board.

- **Maternal/Infant Health:** WH has achieved Baby-Friendly designation since 2013. This honor recognizes the highest standards of care for breastfeeding mothers and their babies. Washington Health Medical Group, Maternal and Child Health, and Labor and Delivery work collaboratively to ensure birthing patients receive the highest level of care. Findings in the CHNA highlighted residents' difficulty accessing prenatal care. WH plans to address this need globally through Healthcare Access & Delivery strategies. WH also plans to research why rates of infant mortality in the District are higher than the Alameda County average. By partnering with Alameda county, local FQHCs, the Washington Health Medical Group, and Maternal/Child Health and Labor and Delivery clinical teams, we intend to understand this finding and pursue strategies to address it.

Approval by the Board of Directors

The Washington Township Health Care District Board of Directors adopted the 2026-2028 Health Improvement Plan on September 10, 2025.