2016 Community Health Needs Assessment

Kaiser Foundation Hospital San Francisco
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Approved by KFH Board of Directors
September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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Acknowledgements

This Community Health Needs Assessment (CHNA) was conducted by Kaiser Foundation Hospital-San Francisco (KFH-SF) in collaboration with San Francisco's other nonprofit hospitals through the San Francisco Health Improvement Partnership (SFHIP). The KFH-SF Community Benefit Program worked with consultant Lynn H. Baskett to compile the data and write the report with guidance from Kaiser Foundation Hospitals. Lynn H. Baskett participated in the SFHIP community health assessment development meetings along with James M. Illig on behalf of Kaiser Permanente. The SFHIP collaborative partners worked with the Population Health Division of the San Francisco Department of Public Health (SFDPH) to review and analyze neighborhood-specific primary and secondary data, led by Epidemiologist Michelle Kirian, MPH, REHS.

San Francisco Health Improvement Partnership Steering Committee

Private Nonprofit Hospitals:

- Abbie Yant, Dignity Health - Saint Francisco Memorial Hospital
- Barry Lawlor, Dignity Health - St. Mary's Medical Center
- Cecilia Thomas, Sutter Health - California Pacific Medical Center
- James M. Illig, Kaiser Permanente – KFH San Francisco
- Stuart Fong, Chinese Hospital

San Francisco Department of Public Health:

- Tomas Aragon, MD, Director of Population Health
- Colleen Chawla, Director of Policy and Planning

University of California at San Francisco:

- Kevin Grumbach, MD, Clinical & Translational Science Institute

Community Coalitions:

- Amor Santiago, Asian & Pacific Islander Health Parity Coalition, APA Family Support Services
- Estela Garcia, Chicano/Latino/Indigena Health Equity Coalition, Instituto Familiar de la Raza
- Perry Lang, African American Community Health Equity Coalition, Rafiki Wellness

Community Clinics: Deena Lahn, San Francisco Community Clinic Consortium
Nonprofits: Jacob Moody, SF Human Services Network
Education: Kim Coates, San Francisco Unified School District
Government: Lani Kent, San Francisco Mayor's Office
Philanthropy: Shalini Iyer, Metta Fund
Small Business: Scott Hauge, CAL Insurance
Faith Community: Tessa Rouverol Callejo, FAITHS Program, The San Francisco Foundation

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The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

In San Francisco County, the triennial CHNA is undertaken by the city's nonprofit hospitals in a collaborative effort now called the San Francisco Health Improvement Partnership (SFHIP). The SFHIP Steering Committee oversees the ACA-required CHNA for the hospitals, as well as the Department of Public Health's accreditation process and compliance with the San Francisco Health Care Services Master Plan.

B. Summary of Prioritized Needs

Based on extensive data review, community input meetings and key informant interviews, the San Francisco Health Improvement Partnership (SFHIP) collaborative, which includes many public health experts in its membership, identified the following health needs, in ranked order based on pre-established criteria including the results of 11 community conversations:

1. Psychosocial health
2. Healthy eating
3. Safety and crime prevention
4. Access to coordinated, culturally and linguistically appropriate care across the continuum
5. Housing stability
6. Substance abuse
7. Physical activity

C. Summary of Needs Assessment Methodology and Process

The San Francisco CHNA was produced by the San Francisco Health Improvement Partnership (SFHIP), a collaborative that includes both the San Francisco County Health Department (SFDPH) and all of the acute care hospitals in the County. Regular meetings throughout 2015 resulted in robust data collection and analysis, thoughtful community engagement and consensus on the prioritized community health needs.

Using the KP CHNA Data Platform and additional neighborhood-specific data, the SFDPH produced secondary data reports covering 29 social determinants of health and health outcomes. Eleven facilitated community conversations were held to obtain primary data from vulnerable populations, especially where secondary data was not available. The health need themes from the community conversations were added to the SFDPH data reports. In addition to the input of the public health

experts on the SFHIP, two formal key informant interviews were also conducted. See Appendix B for a list of community conversations and key informant interviews.

SFHIP identified community needs using the following criteria: severity of need, communities disproportionately affected by the need, community priority. These same criteria plus the potential for feasible and effective interventions were used to prioritize the community health needs.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term,

sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

D. Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH San Francisco will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

III. COMMUNITY SERVED

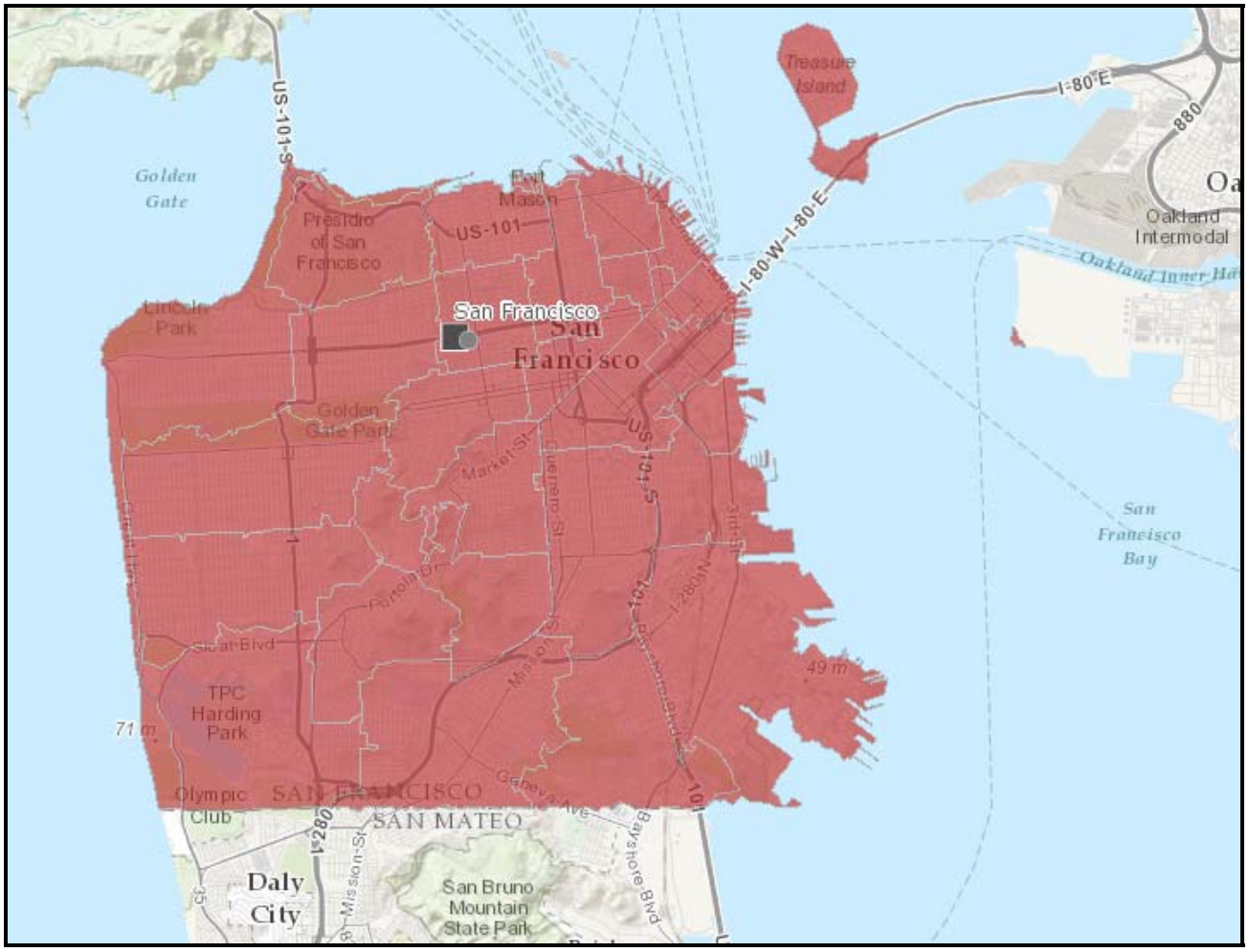
A. Kaiser Permanente's Definition of Community Served

Kaiser Permanente 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 surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and Description of Community Served

i. Map

KFH-SAN FRANCISCO SERVICE AREA MAP



ii. Geographic description of the community served

The community served includes the City and County of San Francisco. The primary focus of KFH San Francisco's Community Benefit Programs is on the needs of vulnerable populations, which include low-income residents with health disparities and significant barriers to care.

iii. Demographic profile of community served

Demographic Data	
Total Population	829,268
White	49.48%
Black	5.74%
Asian	33.57%
Native American/ Alaskan Native	0.38%
Pacific Islander/ Native Hawaiian	0.43%
Some Other Race	5.98%
Multiple Races	4.43%
Hispanic/Latino	15.26%

Socio-economic Data	
Living in Poverty (<200% FPL)	28.25%
Children in Poverty	12.75%
Unemployed	5%
Uninsured	10.01%
No High School Diploma	13.3%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

Since 1995, KFH-San Francisco has collaborated with the other nonprofit hospitals in the county to produce a triennial CHNA. KFH-San Francisco was a founding member of this collective effort, which has grown over time as other partners joined. The project became known as the Building a Healthy San Francisco collaborative, then in 2012, the San Francisco Health Improvement Partnership. SFHIP's membership includes representatives of a range of organizations concerned about the health of the community, and this collaborative is sustained through the backbone support of the Hospital Council, the Department of Public Health and UCSF. SFHIP conducts the triennial CHNA to meet the requirements of the nonprofit hospitals, the San Francisco Health Care Services Master Plan, and the San Francisco Department of Health accreditation process, then develops the Community Health Improvement Plan (CHIP) to guide the strategies to address the identified health needs. James M. Illig, Community Benefit Manager, KFH-San Francisco serves on the SFHIP Steering Committee.

A. Identity of Hospitals That Collaborated On the Assessment

- Chinese Hospital
- Dignity Health - Saint Francis Memorial Hospital
- Dignity Health - St. Mary's Medical Center
- Kaiser Permanente – KFH San Francisco
- Sutter Health - California Pacific Medical Center
- University of California San Francisco Medical Center

B. Other Partner Organizations That Collaborated On the Assessment

- Organizations represented in SFHIP:
- APA Family Support Services
- Asian Pacific Islander Health Parity Coalition
- San Francisco Community Clinic Consortium
- Chicano/Latino/Indigena Health Equity Coalition
- Instituto Familiar de la Raza
- Bayview Hunter's Point Foundation for Community Improvement
- San Francisco Human Services Network
- San Francisco Unified School District
- San Francisco Mayor's Office
- African American Community Health Equity Coalition

- Rafiki Wellness
- CAL Insurance and Associates, Inc.
- Metta Fund
- The San Francisco Foundation
- Interfaith Coalition for Immigrants Rights
- San Francisco Interfaith Council
- San Francisco Department of Public Health
- University of California, San Francisco

Community Engagement Partners:

- Advancing Justice of the Asian Law Caucus
- African American Art and Cultural Center
- CARECEN
- Filipino American Development Foundation
- Instituto Familiar de la Raza/Asociación Mayab
- Larkin Street Youth
- LGBT Center
- Native American Health Center
- On Lok 30th Street Senior Center
- Swords to Plowshares
- Transitions

C. Identity and Qualifications of Consultants Used To Conduct the Assessment

Lynn Basket, MBA, attended the SFHIP CHNA meetings on behalf of Kaiser Permanente, compiled the CHNA Report and worked very closely with the San Francisco County Department of Public Health (SFDPH) staff that provided neighborhood-level data not otherwise available. The SFDPH team was led by Michelle Kirian, MPH, REHS, Epidemiologist, Population Health Division.

Ms. Baskett has worked with health and social service organizations to increase their impact on the communities they serve since fall of 2012. Clients include Kaiser Permanente, Marin General Hospital, California Tobacco Education and Research Oversight Committee, Hospital Council of Northern and Central California and Monument Impact. Recent projects include community health needs assessments; implementation strategies; master plan facilitation and writing; and project management.

In 2012-2013 she was the consultant for the Kaiser Foundation Hospital - San Rafael community health needs assessment and implementation strategy as well as the Kaiser Foundation Hospital - Fresno implementation strategy.

Previously, she was the VP/Executive Director of John Muir Health, Community Health Alliance. At John Muir Health Ms. Baskett coordinated the community needs assessments and reporting for California's SB 697 non profit hospital compliance from 2000-2012 as well as community health program implementation, community partnership facilitation, and government affairs. Prior to working at John Muir Health, Ms. Baskett was a regional vice president for Hospital Council of Northern and Central California, a hospital trade association.

Ms. Baskett received her MBA in health care administration from Cornell University, S.C Johnson Graduate School of Management.

Michelle Kirian, MPH, REHS, is the lead epidemiologist of the Community Health Assessment and Impact Unit of the San Francisco Department of Public Health (SFDPH), where she and her multi-disciplinary team provide support for population health policies, programs, and funding through health assessment, data access, and knowledge integration.

During more than 10 years with SFDPH, she has been a key contributor on many divergent projects from multi-county outbreak investigation to regulatory program design for onsite non-potable water re-use systems. Ms. Kirian is part of the Our Children, Our Families Council-Outcomes Framework Working Group, the Black/African American Health Initiative Think Tank, and the Healthy Hearts SF initiative.

Ms. Kirian received a Masters in Public Health from the University of California, Berkeley and a Bachelors of Science in Cellular and Molecular Biology from Tulane University. She is also a Registered Environmental Health Specialist.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary data

i. Sources and Dates of Secondary Data Used In the Assessment

The SFDPH drafted list of health variables derived by first creating a comprehensive list of variables and then grading using pre-established criteria. Variables on the comprehensive list were identified from a variety of sources including, but not limited to the previous SF Community Health Assessment (CHA), CHAs from other health departments, San Francisco strategic plan, SF Community Health Improvement Plan, SF Vital Signs and NAACHO. Grading criteria included: communication power, proxy power, data power, stakeholder needs, inequities assessment, appropriate life course indicators are included.

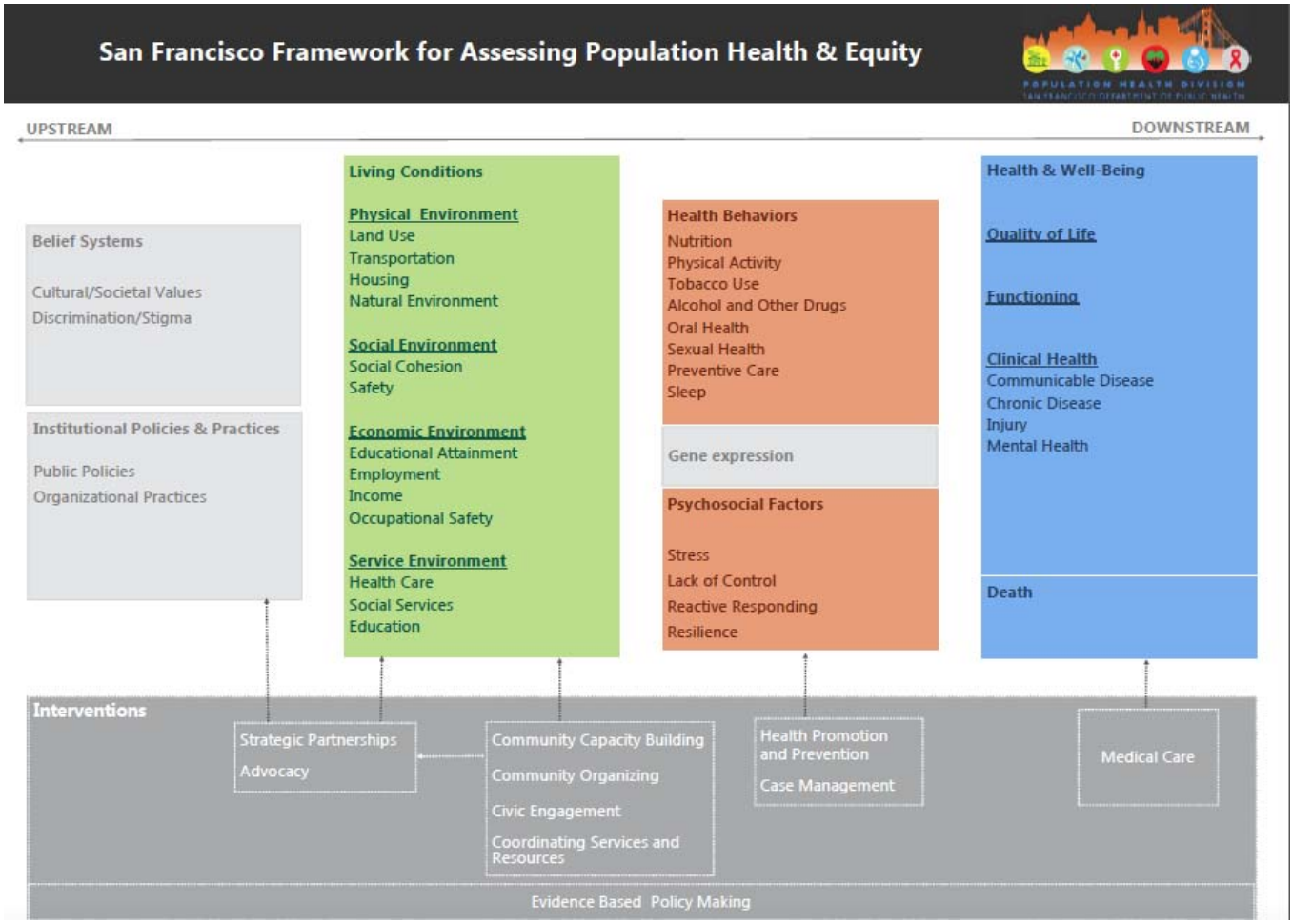
The KP CHNA Service Area Report was completed using the KP CHNA Data Platform. Indicators that performed poorly against the State benchmark by 2 percent or more for the Service Area as a whole or for one or more racial or ethnic groups were highlighted. These indicators were then compared to the SFHIP/CHA Sub-Committee list of indicators. Comparable indicators with data available at the local level are included in the SFDPH data set. For details on specific sources and dates of the data used, please see Appendix A.

II. Methodology for collection, interpretation and analysis of secondary data

San Francisco Department of Public Health (SFDPH) took the leadership for the secondary data identification and analysis with input from SFHIP members. The KFH-SF CHNA was completed using the KP CHNA Data Platform, data from SFHIP.org and other databases and local SFDPH data collection activities.

Because county-wide health status data for San Francisco reflects a generally healthy city, the neighborhood specific data available from the SFDPH was critical for making informed decisions about health inequities and health need priorities.

SFDPH organized the data based on the San Francisco Framework for Assessing Population Health and Equity.



The data themes map well to the KP CHNA Data Platform Potential Health Needs.

The San Francisco CHNA supports several organizational needs:

- Hospital reporting required under section 501 (r) of the Internal Revenue Code
- SFHIP's Community Health Improvement Plan
- SFDPH accreditation requirements
- San Francisco Health Care Services Master Plan

To meet the needs of all the partners, the secondary data were organized according to 29 Social Determinants of Health and Health Outcome categories:

Asthma and Chronic Obstructive Pulmonary Disease

Pulmonary disease

Cancer

Cardiovascular Disease and Stroke
Children's Oral Health
Civic Participation
Diabetes
Economic Environment
Education and Childcare
Foodborne Disease
Health and Wellbeing
Health Care Access and Quality
Hepatitis B and C
Housing
Influenza and Pneumonia
Mental Health
Mortality
Natural Environments
Nutrition
Physical Activity
Pre-term Births
Safety
Sexual Health
Substance Abuse
Tobacco
Transportation
Tuberculosis
Vaccine Preventable Disease
Weight

A report for each category was generated and any indicators that performed poorly against the State benchmark by 2 percent or more for the Service Area as a whole or for one or more racial or ethnic groups were flagged and used to inform the health need identification process.

B. Community input

i. Description of the Community Input Process

Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. SFHIP screened 43 published community health assessments completed between 2012 and 2015 to identify gaps in primary data available. Twenty-one of the assessments were included in the data analysis. This review informed the selection of community partners and target populations for community input. For a complete list of individuals and groups who provided input, see Appendix B.

ii. Methodology for collection and interpretation

The SFHIP identified target populations for which there was limited secondary data or limited data from other assessments as described above. The target populations are listed below. Community conversations with members of these groups included low-income, minority and medically underserved residents:

- Formerly incarcerated
- Transitional age youth
- Seniors
- Latinos
- Middle Eastern and Arab residents
- African American mothers

- Filipinos
- LGBT
- Native Americans
- Veterans

Using the SFHIP member relationships, community-based organizations representing or serving the target populations were asked to host a community conversation with residents about their health needs. SFDPH staff facilitated 11 community conversations using the Technology of Participation techniques for focused conversations and consensus development. SFDPH staff compiled the themes and identified health needs from the 11 community conversations for inclusion in the CHNA and in the 29 SFDPH Social Determinant of Health and Health Outcome reports. The Health Need Summaries in Appendix C include the community feedback about each health need. In addition to the input from public health experts who serve on SFHIP, two formal key informant interviews with SFDPH staff were conducted, including the County Population Health Branch Director. Key informants were asked about their highest health issue concerns for vulnerable San Franciscans, the top health needs in San Francisco and community assets to protect and enhance. Appendix B includes the list of interviews and community conversations as well as the target population of the community conversations.

C. Written Comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through *CHNA-communications@kp.org.* This website will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH San Francisco had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data Limitations and Information Gaps

The KP CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old. While SFDPH was able to collect neighborhood-level data for many indicators, there were limitations due to sample size and availability of race, ethnicity and other demographic indicators for some neighborhood data.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying Community Health Needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

SFHIP reviewed the 29 health need data reports produced by the SFDPH, which included both secondary and primary data. SFHIP met to identify the significant health needs for San Francisco. SFHIP has a tradition of focusing on upstream social determinants of health status when possible.

The criteria for selecting a health need included:

- Health condition or driver performs poorly against a defined benchmark
- Health need was confirmed by more than one indicator or data source
- Severity of need
- Disparities in health outcomes
- Community priority

The consensus development process included the following steps:

1. Using the criteria mentioned above, and based on the data in the data reports, members of SFHIP individually listed the significant health needs facing San Francisco.
2. SFHIP members then met in pairs to discuss their significant health needs to identify similarities and discuss differences.
3. The group came together to share all the health needs identified by the individual SFHIP members.
4. Similar health needs were clustered into seven themes.
5. The group determined a name for the theme, which then became the health needs for KFH San Francisco.

B. Process and Criteria Used For Prioritization of the Health Needs

SFHIP members used the following prioritization criteria, with prompts, to prioritize the identified health needs:

<u>What is the severity of the need?</u>

- The magnitude of the need is high, e.g. mortality rate, premature mortality rate, percent of population at risk, incidence rate, prevalence, or other measure of impact on the population.
- Need poses an imminent health threat
- Need is getting worse

<u>Are communities disproportionately affected by the need?</u>

- Degree of disparity between inter-county groups
- Addressing this issue will help address root causes that cut across multiple health issues

<u>Is the need a priority for the community?</u>

- Need is a concern among those affected
- Need supports or is related to a concern identified by the community
- Extent of public concern on the issue

<u>Are there feasible and effective interventions?</u>

- Addressing this issue will help address root causes that cut across multiple health issues
- Effective, cost-effective, culturally appropriate, “shovel-ready strategies or interventions exist
- Sufficient resources are available to address the issue in a meaningful

way/turn the curve

Each criterion was given a weight of 25 percent. The SFHIP members indicated their ranking, on a scale of 1-5, for each criterion for each identified health need. The total value of the rankings for each health need was tabulated.
The community-identified health needs were ranked as follows:

1. Psychosocial health
2. Healthy eating
3. Safety and crime prevention
4. Access To Coordinated, Culturally and Linguistically Appropriate Care Across the Continuum
5. Housing stability
6. Substance abuse
7. Physical activity

In addition, three foundational issues were identified: economic barriers to health, health equity (racial and ethnic health inequities) and community mobilization. These issues are SFHIP values and will be SFHIP and individual member decision-making criteria for program, partnership and policy initiatives.

SFHIP will use the Community Health Needs Assessment findings to further prioritize the seven identified health needs and develop goals, objectives and strategies for collaborative action to improve the health of San Francisco residents. The Community Health Improvement Plan (CHIP) will describe the continuing prioritization process and action plan.

As part of the Implementation Strategy development process, KP-San Francisco will review the CHIP to align its strategies with the CHIP as part of its commitment to the San Francisco collective impact approach to improving the health of San Franciscans.

C. Prioritized Description Of All The Community Health Needs Identified Through the CHNA

Psychosocial Health: Psychosocial or mental health and well-being is crucial to supporting, maintaining, and optimizing life quality.[103] A state of mental disorder or stress can adversely impact one's ability to perform across various facets of life: at work, at home, and socially, and also affect the families, caregivers, and communities of those afflicted.[102] Poorer mental health status is associated with greater participation in risky health behaviors (e.g., smoking, low physical activity, insufficient sleep, excessive drinking) that can in turn promote chronic disease.[26] During the community conversations, residents expressed concern about complete access to medical care, including dental, and especially mental health services. Participants believed that mental health services could help ameliorate domestic abuse and suicide issues in their communities. Some cultures feel stigma associated with accessing mental health services.

Healthy Eating: Good nutrition provides key building blocks for growth, repair and maintenance of our bodies. Breastfeeding protects against infant illness and death and is associated with improved life-long health outcomes. Good nutrition can alleviate stress, depression, pollution and lack of stamina and sexual vitality. It can prevent and help remedy obesity, acute illness, and the leading causes of preventable hospitalization and early death. Drinking water instead of caloric beverages, such as soda, is recommended as the best way to hydrate without consuming excess calories.[27] In San Francisco:

- 44% of low-income adults report food insecurity.

- 33% of adults report consuming at least one soda each day.
- 10% of high school students drink one or more sodas per day.
- 33% of middle and high school students are overweight or obese; 35% of male high school students and 59% of female high schools report trying to lose weight.

Safety and Violence Prevention: Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Safe communities prevent adverse childhood experiences. In San Francisco, youth intentional injuries, assault injuries, domestic violence reports and all violent crimes rates are higher than the California rate per 100,000 population. Females, African Americans, Latinos and Asian/API residents feel more unsafe walking alone in their neighborhoods at night than San Francisco as a whole.

Access To Coordinated, Culturally and Linguistically Appropriate Care Across the Continuum: Access to quality health care and services affects physical, social, and mental health status. Health care utilization prevents disease and disability, detects and treats health conditions, maintains quality of life, delays death, and extends life expectancy. Effective, inclusive access to health care and services will also reduce the economic barriers to care and cost to the entire delivery system. In the community conversations culturally and linguistically appropriate care and services; connection to health care services and a medical home; and integration and coordination of services across the continuum were brought up repeatedly. Community input clearly indicated residents were not uniformly benefiting from the services available through commercial, California Covered subsidized insurance or the Healthy San Francisco access program

Housing Stability: Lack of housing stability often results in homelessness and may occur due to poverty, low education levels which limit job and income opportunities, lack of access to health care and services and other health conditions such as mental health, substance abuse or disability. Homelessness results in high levels of stress which put individuals and families at greater risk of violence and injury, food insecurity, unhealthy food options, infectious disease and frequent moves which have been linked with negative childhood events such as abuse, neglect, household dysfunction and increased likelihood of smoking and suicide in children. In San Francisco, a typical San Franciscan spends 41% of their income on rent and 22% of all renter households spend more than 50% of their income on rent. Among those who are very low income, 59% spend more than 50% of their income on rent. Housing in San Francisco is out of reach for minimum wage earners. It takes 5.6 minimum wage jobs to afford an apartment with two bedrooms.

Substance Abuse: The effects of substance abuse include poor academic performance, cognitive functioning deficits, unintended pregnancy, HIV and other sexually transmitted diseases, motor vehicle crashes, violence, child abuse, crime, homicide, chronic diseases including liver disease and certain cancers (e.g. colon and rectal, liver, breast cancer, prostate cancer), and mental and behavioral disorders (unipolar depressive disorders, epilepsy, suicide).[96] Alcohol use is associated with 22% of all traffic related fatalities.[25] Cigarette smoking increases risk of heart disease; chronic obstructive pulmonary disease; acute respiratory illness; stroke; and cancers of the lung, larynx, oral cavity, pharynx, pancreas, breast, and cervix.[2,93,94] There is growing concern that electronic cigarettes may cause addiction among non-smokers and reverse decades of work to de-normalize smoking.[64,101] In San Francisco, more than 40% of white, black and Latino students have used marijuana. Binge drinking is highest among White and Latino high school students.

Twenty percent of San Francisco callers to the California Smoker's Helpline in 2014 were LGBTQ.[19]

Physical Activity: Regular physical activity helps improve overall health and fitness, and reduces risk for many chronic health conditions including obesity, cardiovascular disease, type 2 diabetes and metabolic syndrome and cancer (breast and colon). It also helps with strengthening bones and muscles and improving mental health, mobility and longevity.[28] In San Francisco public schools, one third of middle and high school students are overweight or obese. Latino and African American adults and youth are disproportionately overweight or obese and the youth are less active than other populations and the City as a whole.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

The following community resources are available in San Francisco to address the significant community health needs described in Section VI.C above:

- Hospital in- and outpatient services including charity care, financial assistance programs and participation in Medi-Cal and Healthy San Francisco coverage programs
- Hospital health education, screening and early intervention programs
- Hospital community benefit programs and grants
- Foundations who fund health programs such as the Metta Fund and the San Francisco Foundation
- Community Clinics such as Curry Senior Center, Glide Health Services, HealthRight 360, Lyon-Martin Health Services, Mission Neighborhood Health Center, Native American Health Center, North East Medical Services, Saint Anthony Free Medical Clinic, San Francisco Free Clinic, South of Market Health Center, Street Outreach Services, Veterinary Street Outreach Services and Women's Community Clinic
- San Francisco Department of Public Health programs
- San Francisco Departments of Human Services, Aging and Adult Services, Children Youth and Their Families, etc.
- San Francisco Health Improvement Partnership and the organizations its members represent as well as their organizational partners
- Health and social services community-based organizations such as the United Way of the Bay Area, Boys and Girls Clubs of San Francisco, YMCA of San Francisco, etc.
- Programs of the SFDPH such as Shape Up San Francisco, Healthy San Francisco and Women, Infants and Children program
- San Francisco Medical Society
- San Francisco Chamber of Commerce

VII. KFH SAN FRANCISCO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH San Francisco's 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH San Francisco's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies,

please visit www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH San Francisco in the 2013 Implementation Strategy Report.

1. Access to Quality Health Care and Services
2. Healthy Eating and Active Living
3. Safe and Healthy Living Environments

KFH San Francisco is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH San Francisco tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH San Francisco awarded 238 grants totaling $7,354,029 in service of 2013 health needs. Additionally, KFH in Northern California has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within San Francisco. During 2014-2015, a portion of money managed by this foundation was used to award 50 grants totaling $2,459,560 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH San Francisco donated several in-kind resources in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH San Francisco engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: ACCESS TO QUALITY HEALTH CARE AND SERVICES

Long Term Goal:

- Increase the number of low-income and uninsured San Franciscans who have access to appropriate health care services.

Intermediate Goal:

- Reduce barriers to enrollment and increase access to health care coverage.
- Improve access to culturally competent care and appropriate utilization of services.

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 6,819 Medi-Cal members* • *2015: 6,750 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $ 2,259,345* • *2014: 3,275 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $2,238,978* • *2015: 3,062 applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 464 members receiving CHC* • *2015: 408 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 78 active KFH grants totaling $4,786,165 addressing Access to Quality Health Care and Services in the KFH-San Francisco service area.[1] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 17 grants totaling $115,211 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Conard House, Inc.	$25,000 in 2015	Trained/certified peer health navigators joined Conard's health navigation teams to better serve the agency's supportive housing residents. Many residents in the Tenderloin, Mission, South of Market, and southern San Francisco neighborhoods are low-income, mentally ill, drug/alcohol compromised, and aging.	• 5 peer health navigators screened 658 residents at 10 Conard housing sites • 279 residents who lacked primary care connections were helped • by year end, 81% had verified coverage and a medical home, and 53% had a verified primary care provider

[1] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

Shanti Project	$70,000 over 2 years $40,000 in 2014 $30,000 in 2015	Shanti's breast cancer program augments hospital-based care and aims to reduce the barriers that low-income, uninsured, and underinsured women face accessing, maintaining, and completing treatment.	During 2014 and 2015, 392 women received care navigation services, including weekly case management and appointment accompaniment. 261 women with breast and gynecological cancers received culturally competent care, navigation, and weekly practical support, and 96% were able to adhere to treatment plans whether newly diagnosed, in remission or end-of-life.
Mission Neighborhood Health Center	$25,000 in 2014	Program provides integrated behavioral health services in a primary care setting for Latino men and women, using "warm hand-off" referrals from the primary care team to onsite behavioral health clinicians who provide brief psychotherapy and connections to community services.	A total of 263 adult patients were screened for depression, of these 23 were diagnosed with significant depression. Clinic medical providers referred to the Behavioral Health Clinician 295 patients for a total number of 1033 behavioral health visits.
San Francisco General Hospital (SFGH)/San Francisco Health Network Primary Care	$400,000 (over 2 years) $200,000 in 2014 & 2015	PHASE (Prevent Heart Attacks And Strokes Everyday) will improve the care provided to those at risk of cardiovascular disease. SFGH will focus on adults with uncontrolled diabetes or hypertension and expect a minimum 30% increase in the number of patients participating in PHASE. It will sustain and spread PHASE by expanding/optimizing proactive use of electronic tools, developing roles for nurses and pharmacists to support chronic disease management, and building on lifestyle interventions.	SFGH has 16,806 PHASE patients: outcomes included: • expanded PHASE to entire patient population by integrating PHASE clinical guidelines into a system-wide approach to population health management • increased effectiveness of care teams by expanding the role of pharmacists and nurses and developing related medication algorithm, workflows, protocols, and standing orders • increased staff's ability to identify heath disparities related to race/ethnicity in PHASE patients through improved data analytics • increased ability of clinic sites to sustain/ institutionalize PHASE by identifying variations in clinic implementation models, focusing on implementation of PHASE protocol, and maximizing team-based care
*Operation Access (OA)	$300,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California	Core support to organize OA's network of 41 medical centers and 1,400 medical professionals who donate surgical, specialty, and diagnostic services to 1,500 low-income, uninsured people residing in nine Bay Area counties.	With 1,274 staff/physician volunteers providing more than 700 services at 14 hospitals in 2015, Kaiser Permanente is the largest health system participant. A total of 116 procedures were performed on 37 low-income and uninsured patients at OA events at KFH San Francisco in

	Region.		2014 and 2015.
San Francisco Community Clinic Consortia (SFCCC)	$250,000 over 2 years $125,000 in 2014 & 2015	Core support for SFCCC's governance, clinical transformation, health policy, administration, and development activities, which form the foundation of the agency's operations. SFCCC reaches nine health center that serve 93,000 patients.	• improved testing for diabetes and hypertension control by convening monthly meetings on best practice strategies for 10 to 12 representatives • two SFCCC staff members became certified PCHH (patient-centered health home) coaches and are working with two centers to develop-implement PCHH plans to become accredited • new revenue cycle management program will increase health centers' ability to receive third party revenue • increased health centers' knowledge of web-based reporting; conducted board education session on value of web-based data reporting in four clinical areas and three operational measures, benchmarked against SFCCC network, HEIDIS, Healthy People 2020 and prior year base • advocated to expand Healthy San Francisco to uninsured adults over 65; policy change became effective 1/1/16
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**		**Results to Date**
San Francisco Health Improvement Partnership (SFHIP)	This coalition of hospitals, SFDPH, UCSF, SFUSD, foundations, businesses, and other stakeholders conducts the triennial community health needs assessment and encourages collective impact to improve community health in San Francisco.		KFH-San Francisco's CB manager is an active member of the SFHIP steering committee and CHNA group of hospital representatives that worked with SFDPH epidemiologists to collect and analyze primary and secondary health data, and identify the key community health needs. SFHIP's next step is to develop goals, objectives, and strategies for the community health improvement plan.
San Francisco Tech Council	This public-private partnership advances digital inclusion for vulnerable populations of older adults and people with disabilities so all can participate in the City's connected community.		KFH-San Francisco's CB manager is on the founding council of 22 representatives from business, nonprofits, and the City that secured funding from Microsoft and the City to support projects helping seniors use technology for better health, get help in an emergency, advocate for safer streets, and improve access to healthful food.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
UCSF Pediatrics	KFH-San Francisco's CB manager provided training on securing private funding for evidence-based projects addressing		

Department	child health needs for medical residents in UCSF's Pediatric Leadership For The Underserved Program.
Operation Access	KP San Francisco physicians and staff donated over 570 hours of time to treat patients at OA events at KFH San Francisco in 2014 and 2015.
Curry Senior Center Hospital Council of Northern and Central California	Kaiser Permanente Northern California Region's MultiMedia Communications staff provided professional video production assistance (in-kind donation valued at $46,000) to both organizations.Curry Senior Center is using its two new Kaiser Permanente-produced videos to engage new donors and volunteers. The Hospital Council uses its video to highlight the contributions of San Francisco's nonprofit hospitals.
San Francisco Department of Public Health (SFDPH)	All-day meeting at Kaiser Permanente's Garfield Center wherein six Kaiser Permanente National Facility Services leaders provided technical assistance on clinic design to the SFDPH director and managers of its network of community-based primary care clinics.
The Arc of San Francisco	The medical director and staff from KFH-San Francisco's Special Needs Program consulted with The Arc's Health Advocacy Program to improve its care navigation for developmentally disabled patients.
NICOS Chinese Health Coalition	Anne Tang, MD and other KFH-San Francisco Chinese Primary Care Module physicians and staff provided blood pressure screenings and physician consultations to 400 seniors and residents at the annual Chinatown Community Health Fair.
MedShare	For each of four Saturday sessions, TPMG's Physician Volunteer Champion Diane Sklar, MD organized 20 to 40 KFH-San Francisco volunteers who went to MedShare and sorted donated medical equipment that will benefit underserved populations both here and abroad.
All PHASE Grantees	To increase clinical expertise in the safety net, Quality and Operations Support (QOS), a Kaiser Permanente Northern California Region TPMG (The Permanente Medical Group) department, helped develop a PHASE data collection tool. QOS staff provided expert consultation on complex clinical data issues, such as reviewing national reporting standards, defining meaningful data, and understanding data collection methodology. This included: • conducting clinical training webinars • wireside/webinar on PHASE clinical guidelines • presentation at convening on Kaiser Permanente's approach to PHASE • presentation to various clinical peer groups through CHCN, SFCCC, etc. • individual consultation to staff at PHASE grantee organizations • individual consultation to Community Benefit Programs staff Kaiser Permanente Northern California Region's Regional Health Education (RHE) also provided assistance to PHASE grantees: • conducted two seven-hour Motivating Change trainings (24 participants each) to enable clinical staff who implement (or will) PHASE to increase their skills with regard to enhancing patients' internal motivations to make health behavior changes • provided access to patient education documents related to PHASE
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.

Impact of Regional Initiatives
PHASE: PHASE (Prevent Heart Attacks And Strokes Everyday) is a program developed by Kaiser Permanente to advance population-based, chronic care management. Using evidence-based clinical interventions and supporting lifestyle changes, PHASE enables health care providers to provide cost-effective treatment for people at greatest risk for developing coronary vascular disease. By implementing PHASE, Kaiser Permanente has reduced heart attacks and stroke-related hospital admissions among its own members by 60%. To reach more people with this life saving program, Kaiser Permanente began sharing PHASE with the safety net health care providers in 2006. KP provides grant support and technical assistance to advance the safety net's operations and systems required to implement, sustain and spread the PHASE program. By sharing PHASE with community health providers, KP supports development of a community-wide standard of care and advances the safety net's capacity to build robust population health management systems and to collectively reduce heart attacks and strokes across the community.

PRIORITY HEALTH NEED II: HEALTHY EATING AND ACTIVE LIVING

Long Term Goals:

- Reduce obesity and increase the number of residents who maintain a healthy weight

Intermediate Goals:

- Increase healthy eating.
- Increase physical activity.

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 77 active KFH grants totaling $1,735,524 addressing Healthy Eating and Active Living in the KFH-San Francisco service area.[2] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 12 grants totaling $2,072,970 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Children's Council of San Francisco	$20,000 in 2015	Healthy Apple+ is Children's Council's nutrition intervention program. It trains and rewards child care providers in low-income neighborhoods who adopt evidence-based nutrition and activity practices to improve the health of the children in their care. The goal was to reach 20 to 25 child care providers and the 300 children in their care.	• 24 child care programs in the Mission District participated • nine sites, serving 349 children 0 to 5, completed the Healthy Apple+ program • providers at the nine sites adopted an average of 6.3 best practices and showed significant gains in nutritious foods/beverages and physical activity provided daily.
Education Outside	$20,000 in 2014	Grounds for Healthy Kids, is a project that provides garden-based education to students at George Washington Carver Elementary School in Bayview to help them grow,	270 Carver Elementary students participated in 450 outdoor lessons that included weekly garden-based education, seed to table experiences, and physical activity.

[2] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

		harvest, prepare, and appreciate healthy foods.	
Transportation for a Livable City	$20,000 in 2014	Throughout the year, the Sunday Streets program is activated in 10 different San Francisco neighborhoods to create miles of car-free space where people can exercise and play safely, while connecting communities where open space and recreational opportunities are limited.	Transportation for a Livable City Hosted nine Sunday Streets events, produced in diverse San Francisco neighborhoods. Each event featured dozens of free fitness activities, including cycling, dance, yoga, Zumba, supervised kids play, and personal fitness programming.
Lemonade, a Yoga Program -- through SF Study Center	$10,000 in 2015	Yoga instructors increase opportunities for physical activity for boys at the Juvenile Detention Center during recreation hours that are currently spent in sedentary activities and teach them to do yoga on their own.	• 332 boys participated in biweekly yoga classes and gained an extra 60 minutes of physical activity per week • Handouts, simple poses, and referrals are used encourage the boys to practice yoga in their cells and after release to maintain the physical and emotional benefits
San Francisco Department of Public Health	$1,000,000 over 2 years $500,000 in 2015	HEAL Zone 3.0 grant to implement coordinated, high-reach and high-impact strategies focused on policy, systems, built environment, and program changes to support healthy eating and active living in the Bayview neighborhood.	Expected reach is 24,000 people and expected outcomes include: • passing at least two city-wide and eight organizational policies limiting access to and availability of sugar-sweetened beverages • establishing sustainable community gardening programs • increased healthy food options in the community, as a result of resident engagement in food justice training and advocacy efforts • improved neighborhood park as a result of resident advocacy
*San Francisco Foundation HOPE SF	$3,000,000 over 2 years $1,000,000 in 2015	HOPE SF is a large-scale public housing revitalization project. It includes a peer health leadership program to support residents to lead healthy lifestyles, improve resident mental health, and increase community safety.	Expected reach is 4,000 people; outcomes to date include: • trained more than 20 peer leaders, who have provided more than 700 residents with healthy eating, active living activities, including cooking and nutrition classes, food assistance, Zumba, walking clubs, health coverage enrollment, health training and awareness, gardening, and meditation

			• more than 100 community agencies are engaged in HOPE SF, bringing much needed services to the community • development of a strategy to embed mental health services into a range of job training, school, and other programs

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Bayview HEAL Zone	Kaiser Permanente funds this collaboration between SFDPH and several community organizations in the Bayview Hunters Point neighborhood. The goal is to improve access to nutrition and physical activity through policy, systems, and environmental changes.	KFH-San Francisco's CB manager is on the steering committee that oversees the work of the Food Guardians (healthy retail), urban agriculture projects, transportation, and park activation programs. Kaiser Permanente funding will end in 2017, so the HEAL Zone plans to merge with Southeast Food Access to sustain and expand HEAL Zone achievements with other funding sources.
Shape Up San Francisco (SUSF)	SUSF is a collaborative of advocacy groups and service providers that coordinates citywide efforts to increase awareness of and opportunities for improved nutrition and increased physical activity through primary prevention and systems change.	KFH-San Francisco's CB manager is on the steering committee, which oversees initiatives to improve food access, increase physical activity, and reduce consumption of sugar-sweetened beverages. SUSF helped SFUSD develop a wellness policy, completed a three-year strategic plan, launched the Open Truth Campaign about sugary sodas, and is planning a 10th anniversary symposium for 2016 entitled Transforming Communities through Chronic Disease Prevention.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
San Francisco-Marin Food Bank	KFH-San Francisco donated 36 cases of disaster meals for distribution to seniors and other vulnerable persons in the event of an emergency.
California Transplant Donor Network	KFH-San Francisco's African American Health Initiative supported the annual Citywide Revival Health Fair in the Bayview and Gina Gregory-Burns, MD participated in a featured talk about African American health disparities.
Bayview HEAL Zone	KFH-San Francisco supplied a wide array of cooking-related giveaway items for six Bayview HEAL Zone events in 2015, including the annual Healthy Heroes celebration, Day of Fun in the Sun, and a collard greens cook-off.
18 Reasons, APA Family Support Services, America Scores, Lemonade, Children's Council, Community Grows	KFH-San Francisco supplied the listed organizations, all of which are 2015 healthy eating/ active living grantees, with as many giveaway items as they requested for their use as incentives and prizes. Giveaways included Kaiser Permanente-branded grocery bags, citrus peelers, kitchen scrub brushes, apple slicers, measuring spoons, cutting boards, spatulas, jar openers, recipe booklets, water bottles, notepads, yoga mats, t-shirts, pens, and stress balls.

Impact of Regional Initiatives

HEAL Zones:

Kaiser Permanente's HEAL (Healthy Eating, Active Living) Zone initiative is a place-based approach that aims to lower the prevalence and risks of diseases associated with obesity in communities that have disproportionate rates of heart disease, type 2 diabetes, high blood pressure, stroke, depression, and some cancers. HEAL Zones focus on increasing access to fresh fruit, vegetables, and healthy beverages, as well as increasing safe places to be play and be physically active. HEAL Zones deploy robust coalitions of local public agencies, schools and school districts, community-based organizations, employers, local businesses, faith-based organizations, and health care providers, including Kaiser Permanente, to affect broad population-level behavior change that will ultimately lead to better health outcomes.

PRIORITY HEALTH NEED III: SAFE AND HEALTHY LIVING ENVIRONMENTS

Long Term Goals:

- Increase crime prevention.
- Create safe environments where people can live, play, and work.
- Reduce exposure to environmental hazards.

Intermediate Goals:

- Reduce events that result in violent injury to children and adults.
- Foster safe public spaces.
- Reduce exposure to second-hand smoke.

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 63 active KFH grants totaling $655,861 addressing Safe and Healthy Living Environments in the KFH-San Francisco service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $63,124 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
San Francisco Kidpower	$40,000 over 2 years $20,000 in 2014 $20,000 in 2015	Kidpower trainings in public elementary and middle schools and community programs teach practical skills to decrease behavioral risk factors and increase protective factors against bullying, abuse, and injury. The goal is to keep youth physically and emotionally safe, build healthy social relationships, and reduce aggressive, inappropriate, and ineffectual coping behaviors.	During 2014 and 2015, the project provided training and support to 951 schoolchildren at Flynn Elementary in the Mission, the Tenderloin's Boys & Girls Club, Rosa Parks Elementary, Our Kids First Program, and the International Studies Academy. 97% demonstrate increased skills related to abuse and violence prevention, and 99% of the children demonstrated an understanding and acquisition of new personal safety skills
Niroga Institute	$15,000 in 2015	Niroga's yoga program helps Mission High	• 334 students participated in twice-weekly

[3] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

		School students reduce youth violence and bullying through a multi-dimensional curriculum that teaches stress-resilience, self-awareness, self-regulation, and healthy relationship skills.	dynamic mindfulness sessions over 12 weeks in the Spring and Fall semesters • teachers reported marked improvement in school climate, reduced disciplinary referrals, and increased focus and reported well-being
Northeast Medical Services	$25,000 in 2015	Culturally-appropriate education, behavioral counseling, and group interventions supports low-income, Asian immigrants who want to successfully quit smoking.	• 3 staff became certified tobacco treatment specialists • 238 clinic patients received individual/group counseling, education, and phone check-ins • 13% of clients reduced their tobacco use • 11% quit smoking by the end of the year

Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Bay Area Health Funders Group	Northern California Grantmakers sponsors this health-focused group of private foundations and corporate social responsibility programs to encourage alignment of resources to improve community health and ensure safe and healthy living environments.	KFH-San Francisco's CB manager serves as co-chair of the group, which hosted sessions on the community health needs assessment, mapping health data and donations, health equity, and diversifying the health care workforce to engage other funders in collective impact investments to improve community health.
HOPE SF	Multi-year support for HOPE SF, a large-scale public housing revitalization project in the Bayview and Potrero Hill neighborhoods that aims to engage residents in creating healthy communities.	Funders and executive leaders from city departments engaged in this work come together to hear about transformative activities that address the social determinants of health and wellness, including community engagement, economic mobility, safety, and education in public housing sites.

In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Center for Youth Wellness, SF Child Abuse Prevention Center	KFH-San Francisco Pediatrics Department staff (14 physicians, six clinical leaders, and two mental health clinicians) provided technical assistance about identifying and addressing the consequences of adverse childhood experiences at an all-day conference in the Bayview.
San Francisco Unified School District	KP-San Francisco pediatrician consulted with staff designing a Wellness Center at a new high school in the Bayview. The pediatrician's recommendations about health care follow-up and safety measures to prevent bullying will be incorporated into the new center's policies and procedures.
John Muir Elementary School	Two to five KFH-San Francisco employees are engaged as mentor/tutors for children with behavioral and learning difficulties at this neighborhood Thriving School. In 2014 the Martin Luther King Day of Service drew 35 KP San Francisco volunteers who provided one-on-one tutoring and support for at-risk children.
La Casa de las Madres	Four KP- San Francisco OB-GYN medical residents led two days of women's health workshops.

	The physician-led workshops improved the ability of La Casa staff to serve the needs of domestic violence victims in the shelter and on the crisis line.

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE			
KFH Workforce Development Highlights			
Long Term Goal: • To address health care workforce shortages and cultural and linguistic disparities in the health care workforce			
Intermediate Goal: • Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care			
Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 20 Workforce Development grants totaling $176,479 that served the KFH-San Francisco service area.[4] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 13 grants totaling $176,913 that address this need. In addition, KFH San Francisco provided trainings and education for 271 residents in their Graduate Medical Education program and 282 residents in 2015, 61 nurse practitioners or other nursing beneficiaries in 2014 and 35 in 2015, and 65 other health (non-MD) beneficiaries as well as internships for 27 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.			
Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
*The Regents of the University of California	$75,000 in 2015 This grant impacts all KFH hospital service areas in Northern California Region	UC Berkeley's Health Careers Opportunity Program (HCOP) aims to diversify the health professions workforce by working directly with 600 students from underrepresented groups through direct student counseling at UC Berkeley, through visits and outreach to local community colleges, and through the Public Health and Primary Care, a UC Berkeley class taught by HCOP staff.	HCOP supported programs and workshops throughout Northern California that reached more than 600 underrepresented students through mentoring, classes on biostatistics and public health research analytical concepts, professional development on oral and written communication, and business professionalism, HCOP served nine Summer Scholars (underrepresented students) eight other students enrolled in and completed Kaplan's GRE preparation course
*Oakland Local - Center For Media Change	$95,000 in 2015 This grant impacts three KFH hospital service areas in Northern California	Project supports expansion of Hack the Hood (HTH) into five high-need communities in the Bay Area. HTH partners with business and community-based organizations to address the digital divide and skills gap for 21st century job training for low-income youth of	Reach will be 350 students and anticipated outcomes include: • develop, test, and iterate a train-the-trainer curriculum that includes new content in health care technology • develop partnerships with entities in four new

[4] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

	Region	color by providing hands-on job training, mentorship, and exposure to large tech companies (Google, Facebook) and small local businesses.	communities and reach 225 students • initiate partnerships with an additional four entities to prepare for expansion in 2016 • train three non-profit partners to deliver HTH in local communities • develop an evaluation framework to measure collective impact • organize HTH bootcamps in East Oakland, the Lake Merritt area, West Oakland, East Palo Alto, Richmond, and San Francisco • graduate 150 youth from HTH bootcamps
*U.C. San Francisco Office of Diversity and Outreach	$23,000 in 2015	The goal of UCSF Summer Science Camp is to excite, motivate, and inspire 5th graders from lower performing schools, who are underserved and underrepresented in the natural and health sciences, to pursue those sciences in college and as a career.	• program effectively recruited and served 60 students from underrepresented groups: 25% African American, 41% Latino, 23% Asian, 6% Mixed Race, and 5% White • 90% of participants were eligible for free and reduced lunch • based on survey responses, participants experienced greater confidence and belief in their own science ability • in the pre-survey, 45% answered “Yes” to the question “I enjoy Science;” 95% said “Yes” in the post-survey • “Yes” responses to “Science is difficult for me” decreased from 80% to 33% • the percentage who said they were “good” at science increased from 40% to 83%
*San Francisco State University (SFSU) Health Equity Initiative	$99,211 in 2015 This grant impacts 13 KFH hospital service areas in Northern California	SFSU’s Metro College Success, a school within a school, has increased graduation rates of low-income, underrepresented and/ or first-generation students by redesigning the first two years of college. Initiative will develop new health equity and career	Anticipated outcomes include: • design/implement new curricula for three core courses (health equity, social determinants of health, and history of health) for 350 Metro Health Academy students • develop/disseminate video modules to train

	Region	readiness content for the Metro Health Academy curriculum to diversify the health care workforce in the 10-county Bay region.	Metro faculty in the new curricula • develop a webpage to share curricula with faculty from other institutions in the region

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH			
KFH Research Highlights			
Long Term Goal: • To increase awareness of the changing health needs of diverse communities			
Intermediate Goal: • **I**ncrease access to, and the availability of, relevant public health and clinical care data and research			
Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
UCLA Center for Health Policy Research	$2,100,000 over 4 years 1,158,200 over 2014 & 2015 This grant impacts all KFH hospital service areas in Northern California Region.	Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.	CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews. In addition, funding has supported the AskCHIS NE tool which has allowed the Center to: • Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology. • Develop and deploy AskCHIS NE. • Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

In addition to the CHIS grants, two research programs in the Kaiser Permanente Northern California Region Community Benefit portfolio – the Division of Research (DOR) and Northern California Nursing Research (NCNR) – also conduct activities that benefit all Northern California KFH hospitals and the communities they serve.

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

DOR Projects	Project Information
Central Research Committee (CRC)	Information on recent CRC studies can be found at: **http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx**
Clinical Research Unit (CCRU)	CCRU offers consultation, direction, support, and operational oversight to Kaiser Permanente Northern California clinician researchers on planning for and conducting clinical trials and other types of clinical research; and provides administrative leadership, training, and operational support to more than 40 regional clinical research coordinators. CCRU statistics include more than 420 clinical trials and more than 370 FDA-regulated clinical trials. In 2015, the CCRU expanded access to clinical trials at all 21 KPNC medical centers.
Research Program on Genes, Environment and Health (RPGEH)	RPGEH is working to develop a research resource linking the EHRs, collected bio-specimens, and questionnaire data of participating KPNC members to enable large-scale research on genetic and environmental influences on health and disease; and to utilize the resource to conduct and publish research that contributes new knowledge with the potential to improve the health of our members and communities. By the end of 2014, RPGEH had enrolled and collected specimens from more than 200,000 adult KPNC members, had received completed health and behavior questionnaires from more than 430,000 members; and had genotyped DNA samples from more than 100,000 participants, linked the genetic data with EHRs and survey data, and made it available to more than 30 research projects

A complete list of DOR's 2015 research projects is at **http://www.dor.kaiser.org/external/dorexternal/research/studies.aspx**. Here are a few highlights:

Research Project Title	Alignment with CB Priorities
Risk of Cancer among Asian Americans (2014)	Research and Scholarly Activity
Racial and Ethnic Disparities in Breastfeeding and Child Overweight and Obesity (2014)	Healthy Eating, Active Living
Transition from Healthy Families to Medi-Cal: The Behavioral Health Carve-Out and Implications for Disparities in Care (2014)	Access to Care Mental/Behavioral Health
Health Impact of Matching Latino Patients with Spanish-Speaking Primary Care Providers (2014)	Access to Care
Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention – Susan Brown	Access to care

Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young – Steven Sidney	Access to care
Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes – Monique Hedderson	Access to care
Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs – Susan Brown	HEAL
The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization – Kelly Young-Wolff	HEAL
Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention – Cynthia Campbell	Mental/Behavioral Health
Integrating Addiction Research in Health Systems: The Addiction Research Network – Cynthia Campbell	Mental/Behavioral Health

RPGEH Project Title	Alignment with CB Priorities
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity
RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

The main audience for NCNR-supported research is Kaiser Permanente and non-Kaiser Permanente health care professionals (nurses, physicians, allied health professionals), community-based organizations, and the community-at-large. Findings are available at the Nursing Pathways NCNR website: https://nursingpathways.kp.org/ncal/research/index.html,

Alignment with CB Priorities	Project Title	Principal Investigator
Serve low-income, underrepresented, vulnerable populations located in the Northern California Region service area	**1.** *A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.* **2.** *Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.*	**1.** Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing **2.** Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University
Reduce health disparities.	**1.** *Making sense of dementia: exploring the use of the markers of assimilation of problematic experiences in dementia scale to understand how couples process a diagnosis of dementia.* **2.** *MIDAS data on elder abuse reporting in KP NCAL.* **3.** *Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.* **4.** *Transforming health care through improving care transitions: A duty to embrace.* **5.** *New trends in global childhood mortality rates.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA **3.** Tracy Trail-Mahan, et al., KFH-Santa Clara **4.** Michelle Camicia, KFH-Vallejo Rehabilitation Center **5.** Deborah McBride, KFH-Oakland
Promote equity in health care and the health professions.	**1.** *Family needs at the bedside.* **2.** *Grounded theory qualitative study to answer the question,*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center

	"What behaviors and environmental factors contribute to emergency department nurse job fatigue/burnout and how pervasive is it?" **3.** *A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.* **4.** *Electronic and social media: The legal and ethical issues for health care.* **5.** *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	**2.** Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED. **3.** Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL **4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. APPENDIX

A. **Secondary Data Sources and Dates**
B. **Community Input Tracking Form**
C. **Health Need Profiles**
    - **i.** Rationale
    - **ii.** Contributing factors influencing the health need
    - **iii.** Geographic impact/Communities disproportionately impacted
    - **iv.** Primary data/Community Input

APPENDIX A: Secondary Data Sources and Dates

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APPENDIX B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Number of participants**	**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1	Key Informant Interview	Director Population Health Division San Francisco County Public Health Department	1	Health department representative	Leader	10/12/15
2	Key Informant Interview	Epidemiologist, Division of Population Health San Francisco Department of Public Health	1	Health department representative	Member	10/14/15
3	Community conversation/focus group	Transitions	11	Formerly incarcerated, low income, minority, underserved	Members	8/13/15
4	Community conversation/focus group	Larkin Street Youth Center	10	Transitional age youth, minority, low income, underserved,	Members	8/5/15
5	Community conversation/focus group	Onlok 30th Street Health Center	15	Seniors, low income, minority	Members	8/31/15
6	Community conversation/focus group	CARECEN	19	Minority, low income, Latino	Members	9/9/15
7	Community conversation/focus group	Advancing Justice of the Asian Law Caucus	13	Minority, Middle Eastern, Arab, low income	Members	10/2/15
8	Community conversation/focus group	African American Art and Cultural Center	6	African American mothers, minority, low income	Members	10/10/5
9	Community conversation/focus group	Filipino American Development Foundation	11	Minority, low income, Filipino	Members	9/16/15
10	Community conversation/focus group	Instituto Familiar de la Raza/Asociacion Mayab	8	Minority, low income, Latino	Members	9/22/15
11	Community conversation/focus group	LGBT Center-Trans Job Club	13	LGBT, underserved, low income, minorities	Members	9/25/15
12	Community conversation/focus group	Native American Health Center	12	Native Americans, minority, low income	Members	9/24/15
13	Community conversation/focus group	Swords to Plowshares	8	Veterans, underserved, low income, minority	Members	9/30/15

APPENDIX C: Health Need Profiles

RDINATED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE ACROSS THE CONTINUUM HEALTH NEED SUMMARY		
y against the State benchmark by 2 percent or more for the Service Area as a whole or for one or more racial or ethnic groups ks in the Health Need Summaries below. Indicators that performed poorly against the State benchmark by 1 percent for the one or more racial or ethnic groups are highlighted with one asterisk in the Health Need Summaries below.		
IALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
are and services affects al health status. Health disease and disability, n conditions, maintains eath, and extends life lusive access to health o reduce the economic to the entire delivery rsations culturally and care and services; services and a medical coordination of services brought up repeatedly. cated residents were not the services available rnia Covered subsidized San Francisco access t reflect a broad health e population lacks e. In 2014, the number of eased: 41,000 with ia plans and 56,000	Insured Residents in San Francisco • Commercial and Medi-Cal 92.8% // CA 87.6% • Citywide access programs (Healthy SF, Healthy Kids 2.6% Uninsured Residents in San Francisco • SF 7.2%// CA 12.4%//US 11.7% • African American 9.4%**// SF 7.2% • Native American 23.25%**%//SF 7.2% • Latino 13.9%//SF 7.2% Persons who have usual place to go when need health services • SF 89.4%//CA 85.8% Age adjusted rate of preventable ED visits, adults 18+ • SF 189.91//CA 261.88 • AA 746.93**// SF 189.91 • Latino 211.05**// SF 189.91 • 18-24 yrs. 348.48**// SF 189.91 • 65-74 yrs. 213.08**// SF 189.91 • 75+ yrs. 369.71**// SF 189.91 Percent SFUSD kindergarteners with	• Availability of physicians and dentists who accept Medi-Cal and other government program beneficiaries • Proximity to clinics and physician offices • Culturally and linguistically appropriate care • Effective coordination of care and services • Unemployment

However, community input clearly indicated residents were not uniformly benefiting from the services available through commercial, Covered California subsidized insurance or the Healthy San Francisco access program Health disparities, clearly displayed in the neighborhood-specific data, can only be reduced if residents have health care coverage, a medical home and culturally and linguistically health care and services coordinated across the continuum when needed. For example: • Twenty percent of postpartum women reported not having a medical home before pregnancy. • Less than 10% of women San Francisco Health Plan members ages 18 44 years old access preventive health care. • One in 10 adults in San Francisco delayed or did not get needed medical care.[64] • Pregnant women do not consistently receive prenatal care in the first trimester	• White 14.1%//SF 32.1 • Asian 38.4%**//White 14.1% • Latino 36.1%**//White 14.1% • Black 30.0%**//White 14.1% Percent Mothers Receiving Prenatal Care in 1st Trimester • SF 88.6% • Younger than 19 64.9%**// SF 88.6% • Latino 80.2%**// SF 88.6% • African American 63.5%**// SF 88.6% • Pacific Islander 42.2%**// SF 88.6% • Mothers with Medi-Cal 78.4%**// Mothers with private insurance 95.8% • Mothers with other government programs 55.2%**// Mothers with private insurance 95.8%	
• **PRIMARY DATA:**	• Community members voiced three main needs regarding health care: a) access to quality medical care including mental health care, b) cultural competency, and c) knowledge of resources. • Complete access to medical care, including dental, and especially mental health services, was discussed. Participants believed that mental health services could help ameliorate domestic abuse and suicide issues in their communities. Access was inhibited by the costs of insurance, services and medications, physical accessibility (transportation), and delays in obtaining care through Medi-Cal. Some solutions to medical care access issues included universal health care, improved health care laws and lobbying for those with serious medical needs, improved transportation in the city, providing health navigators, bringing health workers (medical, social workers and others) to where the people are at (i.e. in-house) and by providing childcare for those going to medical visits. More opportunities to receive preventative services were mentioned. • Participants noted that too often culturally and/or linguistically appropriate medical	

	services are not available. The availability of printed materials, medical professionals and or interpreters fluent in the correct language/dialect were noted as deficient. When interpreters were available their time with the patient was too limited. Both international and national groups mentioned the need to have medical professionals who "look like" them and who understand their health needs more personally. Solutions that were suggested to enhance cultural competency included engagement with, or organization of, professionals in the community to make the appropriate skills available. It was noted that some skills may already be present but unknown and unorganized. Medical professions need specialized training in substance addiction, and cultural humility and competency. Some felt discriminated against while getting services. Some cultures feel stigma associated with accessing mental health services. • A lack of knowledge of services or how to maneuver the complicated medical systems (including insurance) was repeatedly mentioned in meetings. Access can be enhanced by simplifying forms and processes, producing materials in appropriate languages, and by employing both technology (apps) and basic methods of communicating (providing telephone numbers for those with limited access to the internet). Better coordination of services could also ameliorate problems maneuvering through the system. • At many of the meetings, community members felt that information was hard to come by and suggested better outreach in regards both the available medical services but also non-medical services and programs. They suggested organizing volunteers to get the word out and thought that personal contact would be helpful. Advertisements could be distributed on buses, by mail, and in medical settings for community services. Two groups felt that gathering the community for meetings to talk about their health needs was beneficial in organizing themselves.
GEOGRAPHIC IMPACT:	• Highest enrollment in citywide access programs, which includes those without commercial or Medi-Cal coverage, is in Bayview, Visitacion Valley, South of Market (SOMA) and Tenderloin. • Mothers who are Latina, Black of Pacific Islander are less likely to receive early prenatal care than White and Asian mothers. • Zip codes where kindergarteners experience caries at a rate more than 5 percent higher than the overall San Francisco rate of 32.1 percent include: 94102,Tenderloin; 94108,Chinatown; 94109, Polk, Russian Hill, Nob Hill; 94112, Crocker Amazon, Ingleside, Oceanview, Excelsior; 94124, Bayview Hunters Point; 94130, Treasure Island; 94133, North Beach, Chinatown; 94134, Sunnydale, Visitacion Valley.

HEALTHY EATING HEALTH NEED SUMMARY		
Indicators that performed poorly against the State benchmark by 2 percent or more for the Service Area as a whole or for one or more racial or ethnic groups are highlighted with two asterisks in the Health Need Summaries below. Indicators that performed poorly against the State benchmark by 1 percent for the Service Area as a whole or for one or more racial or ethnic groups are highlighted with one asterisk in the Health Need Summaries below.		
RATIONALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
Good nutrition provides key building blocks for growth, repair and maintenance of our bodies. Breastfeeding protects against infant illness and death and is associated with improved life-long health outcomes. Good nutrition can alleviate stress, depression, pollution and lack of stamina and sexual vitality. It can prevent and help remedy obesity, acute illness, and the leading causes of preventable hospitalization and early death. Drinking water instead of caloric beverages, such as soda, is recommended as the best way to hydrate without consuming excess calories.[27] **In San Francisco:** In San Francisco, 44% of low-income adults report food insecurity. In 2014, an estimated 14.0 percent of American households lacked access to enough food for an active, healthy life for all household members.[85] 33% of adults report consuming at least one soda each day. 10% of high school students drink one or more sodas per day. 37% of residents earning less than 100% of the Federal Poverty Level (FPL) consume soda daily compared to 30% of residents earning over 300% FPL. Latinos (50%) are significantly more likely to drink soda daily compared to whites (29%) and Asians (29%). Among San Francisco WIC participants, 15% of infants are above the 98th percentile for weight for length at age 1 year.[60] By age 3 to 4, one third of low-income children are overweight or obese.	Overweight (adults, 18+ years old) • SF 32.5% // CA 35.4% • Latino 48.5%** // SF 32.5% • African American 27.4% // SF 32.5% Obesity (adults) • SF 11.1% // CA 25.3% • African American 32.7%** //SF 11.1% • Latino 19.5%**// SF 11.1% Obesity (youth 10-17 years old) • SF 13.95% //CA 18.99% • African American 22.65%** //SF 13.95% • Latino 25.79%**// SF 13.95% Fast food intake at least once in the last week • 20-45 year olds 45%// 80 year olds 23% • Latino 69%**// White 35% • <200% FPL 55%**// >200% FPL 37% Prevalence of overweight and obesity by age	• Breastfeeding (any) ** • Breastfeeding (exclusive** • Food security • Food retail variety • Consumption of fruits, vegetables, water and soda

In San Francisco public schools, one third of middle and high school students are overweight or obese; 35% of male and 59% of female high school students report trying to lose weight.	• 20-24 year olds 31%// SF 43.6% • 35-49 year olds 48%**// SF 43.6% • 50-64 year olds 51%**// SF 43.6% • 65-79 year olds 56%**// SF 43.6%	
PRIMARY DATA:	**Eating Healthy Foods:** Like physical activity, community members recognized the need and expressed desire to eat healthier. Some mentioned the need to learn to eat healthier (cooking classes, recipes, demos) and to consume appropriate proportions. Access to healthy food (low sodium, low fat, non-soda) was noted as a problem particularly though food banks and retailers that accept EBT. A need to review foods available with WIC benefits was also noted. Healthy foods were viewed as expensive and out of reach for some. Increasing availability of healthy food through the development of additional farmer's markets and hot food retailers who accept EBT was suggested. Some felt that school lunches needed improvement. It was also suggested that food regulations should be considered to make available foods healthier.	
GEOGRAPHIC IMPACT:	**Nutrition:** In San Francisco, food retail options and quality of these options vary by neighborhood. The most food retail options are found Downtown, in Civic Center, Chinatown, the Financial District, Castro, Mission, Haight, on Upper Market, Nob Hill and Russian Hill. Treasure Island, Visitacion Valley, Lakeshore, Presidio, Seacliff, Bayview and Visitation Valley have the least food retail options. Neighborhoods vary dramatically with respect to fruit or vegetable markets. While Chinatown has 44.8 fruit and vegetable markets per square mile, over one third of San Francisco neighborhoods have zero fruit and vegetable markets. San Francisco has an estimated 801 food retail establishments, of which, only 214 are considered "Healthy" retailers. Healthy retailers include super markets, produce stores, and farmer's markets. Healthy retailers are unevenly distributed across the city and only half of the healthy retailers (56%) accept WIC or EBT. **Adult Obesity:** Consistent with national obesity disparities, local risk of overweight and obesity varies by income, race-ethnicity, and zip code. Latino adults and African American are more likely to be overweight or obese than White or Asian adults (69%, 60% vs. 42%, 33%). Obesity is concentrated in parts of Bayview, Tenderloin, Western Addition, Hayes Valley, Visitacion Valley, and McLauren Park, coinciding with concentrations of those at higher risk.	

HOUSING STABILITY HEALTH NEED SUMMARY		
Indicators that performed poorly against the State benchmark by 2 percent or more for the Service Area as a whole or for one or more racial or ethnic groups are highlighted with two asterisks in the Health Need Summaries below. Indicators that performed poorly against the State benchmark by 1 percent for the Service Area as a whole or for one or more racial or ethnic groups are highlighted with one asterisk in the Health Need Summaries below.		
RATIONALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
Housing stability means that households have a choice over when and under what circumstances to move. They do not live in perpetual uncertainty about their housing needs. Households are able to afford monthly housing payments without it taking up a significant portion of their budget. Lack of housing stability often results in homelessness and may occur due to poverty, low education levels which limit job and income opportunities, lack of access to health care and services and other health conditions such as mental health, substance abuse or disability. Homelessness results in high levels of stress which put individuals and families at greater risk of violence and injury, food insecurity, unhealthy food options, infectious disease and frequent moves which have been linked with negative childhood events such as abuse, neglect, household dysfunction and increased likelihood of smoking and suicide in children. Frequent family relocation is associated with children repeating grades, school suspensions and emotional and behavioral problems, as well as teen pregnancy and higher rates of illicit drug use. Childhood residential instability has also been found to predict lifetime risk of depression. Those who pay more than 30% of their income in	Homeless population 7,539 • 9% families with children • 6% <18 years old • 20% 18-24 years old • 58% unsheltered • 24% of those sheltered were in residential programs, hospitals or jail. Assisted housing units per 10,000 housing units • SF 696.46**//US 1468.19 • SF 696.46**//CA 1399.04 San Francisco residents living at or below 100% of the Federal Poverty Level • SF 13.45 %//CA 15.94 • Black 30.02%** // SF 13.45% • Native Americans 21.08%**// SF 13.45% • Pacific Islander 23.4%**// SF 13.45% • Latino 16.66%**// SF 13.45% San Francisco children living at or below 100% of the Federal Poverty Level • Black 44.93%**// SF 3.42 • Native American 14.52%**// SF 3.42 • Pacific Islander 28%**// SF 3.42 • Latino 30.32%**// SF 3.42	Reasons for being homeless: 13% Eviction 3% Increase in rent 2% foreclosure Obstacles to permanent housing: • Lack of housing availability • Lack of income • Difficulty with housing process • Criminal record • Eviction Record • Medical illness Lack of access to mental health services (See Psychosocial Health Need Summary) Lack of health insurance and access to health care services Lack of sufficient education to obtain and maintain stable employment and income.

housing costs are at risk for foreclosure, eviction, or homelessness if they experience a significant dip in income and are therefore not able to keep up with housing costs For patients who are homeless, properly storing medication, maintaining a healthy diet and consistently going to the doctor are difficult to do when they are spending a good deal of time trying to find a place to sleep every night.[3,48] In San Francisco, • A typical San Franciscan spends 41% of their income on rent and 22% of all renter households spend more than 50% of their income on rent. Among those who are very low income, 59% spend more than 50% of their income on rent. • Housing in San Francisco is out of reach for minimum wage earners. 5.6 minimum wage jobs are required to afford an apartment with two bedrooms.		
PRIMARY DATA:	Housing was mentioned during at least five of the 11 community meetings. Low-income housing, housing for seniors, additional public shelters, and, safe places to go were needed. Some felt discriminated against (sex offenders, people with dependencies) in the housing market. While some had the opportunity to be relocated to public housing outside of the city, the location and availability of other services and resources were noted as impediments to using the vouchers.	
GEOGRAPHIC IMPACT:	Neighborhoods with the largest homeless populations: Supervisory Districts 10 and 6; South of Market, Rincon Hill, Civic Center, Potrero Hill, Bayview Hunter's Point, Visitation Valley. African Americans make up 6% of the general population but represent 36% of the homeless population. Latinos make up 14% of the general population in San Francisco and 19% of the homeless population.	

HOUSING STABILITY HEALTH NEED SUMMARY		
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RATIONALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
Housing stability means that households have a choice over when and under what circumstances to move. They do not live in perpetual uncertainty about their housing needs. Households are able to afford monthly housing payments without it taking up a significant portion of their budget. Lack of housing stability often results in homelessness and may occur due to poverty, low education levels which limit job and income opportunities, lack of access to health care and services and other health conditions such as mental health, substance abuse or disability. Homelessness results in high levels of stress which put individuals and families at greater risk of violence and injury, food insecurity, unhealthy food options, infectious disease and frequent moves which have been linked with negative childhood events such as abuse, neglect, household dysfunction and increased likelihood of smoking and suicide in children. Frequent family relocation is associated with children repeating grades, school suspensions and emotional and behavioral problems, as well as teen pregnancy and higher rates of illicit drug use. Childhood residential instability has also been found to predict lifetime risk of depression. Those who pay more than 30% of their income in	Homeless population 7,539 • 9% families with children • 6% <18 years old • 20% 18-24 years old • 58% unsheltered • 24% of those sheltered were in residential programs, hospitals or jail. Assisted housing units per 10,000 housing units • SF 696.46**//US 1468.19 • SF 696.46**//CA 1399.04 San Francisco residents living at or below 100% of the Federal Poverty Level • SF 13.45 %//CA 15.94 • Black 30.02%** // SF 13.45% • Native Americans 21.08%**// SF 13.45% • Pacific Islander 23.4%**// SF 13.45% • Latino 16.66%**// SF 13.45% San Francisco children living at or below 100% of the Federal Poverty Level • Black 44.93%**// SF 3.42 • Native American 14.52%**// SF 3.42 • Pacific Islander 28%**// SF 3.42 • Latino 30.32%**// SF 3.42	Reasons for being homeless: 13% Eviction 3% Increase in rent 2% foreclosure Obstacles to permanent housing: • Lack of housing availability • Lack of income • Difficulty with housing process • Criminal record • Eviction Record • Medical illness Lack of access to mental health services (See Psychosocial Health Need Summary) Lack of health insurance and access to health care services Lack of sufficient education to obtain and maintain stable employment and income.

housing costs are at risk for foreclosure, eviction, or homelessness if they experience a significant dip in income and are therefore not able to keep up with housing costs For patients who are homeless, properly storing medication, maintaining a healthy diet and consistently going to the doctor are difficult to do when they are spending a good deal of time trying to find a place to sleep every night.[3,48] In San Francisco, • A typical San Franciscan spends 41% of their income on rent and 22% of all renter households spend more than 50% of their income on rent. Among those who are very low income, 59% spend more than 50% of their income on rent. • Housing in San Francisco is out of reach for minimum wage earners. 5.6 minimum wage jobs are required to afford an apartment with two bedrooms.		
PRIMARY DATA:	Housing was mentioned during at least five of the 11 community meetings. Low-income housing, housing for seniors, additional public shelters, and, safe places to go were needed. Some felt discriminated against (sex offenders, people with dependencies) in the housing market. While some had the opportunity to be relocated to public housing outside of the city, the location and availability of other services and resources were noted as impediments to using the vouchers.	
GEOGRAPHIC IMPACT:	Neighborhoods with the largest homeless populations: Supervisory Districts 10 and 6; South of Market, Rincon Hill, Civic Center, Potrero Hill, Bayview Hunter's Point, Visitation Valley. African Americans make up 6% of the general population but represent 36% of the homeless population. Latinos make up 14% of the general population in San Francisco and 19% of the homeless population.	

PSYCHOSOCIAL HEALTH HEALTH NEED SUMMARY		
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RATIONALE	**HEALTH OUTCOMES INDICATORS (REPORT AREA// BENCHMARK)**	**CONTRIBUTING FACTORS**
Psychosocial or mental health and well-being is crucial to supporting, maintaining, and optimizing life quality.[103] A state of mental disorder or stress can adversely impact one's ability to perform across various facets of life: at work, at home, and socially, and also affect the families, caregivers, and communities of those afflicted.[102] Poorer mental health status is associated with greater participation in risky health behaviors (e.g., smoking, low physical activity, insufficient sleep, excessive drinking) that can in turn promote chronic disease.[26] Mental health has also been observed to positively correlate with physical health outcomes. There is evidence of lowered incidence, successful treatment and slowed progression of chronic diseases such as cancer, heart disease, diabetes, asthma, and obesity with better mental health. Without support, intervention, or treatment, mental health disorders can readily worsen over time, leading to impaired quality of life, disability, hospitalization, institutionalization, incarceration, suicide and self-injury, and/or death.[102]	Needing mental health care • SF 23.2%**//CA 16.6% • White 29.9%**//SF 23.2% • African American 35.0%**// SF 23.2% • Latino 27.0%**// SF 23.2% • <300% FPL 23.6%// SF 23.2% • >300% FPL 22.3%// SF 23.2% Suicide per 100,000 population, age adjusted • SF 8.47// CA 9.8 • White 11.6**//SF 8.47 • Asian 14.7**//SF 8.47 Hospitalization due to self-inflicted injury • SF 9.85%// CA 10.19% • African American 26.04%**// SF 9.85% • White 12.88%**// SF 9.85% • 18-24 year olds 26.37%**// SF 9.85% • 45-64 year olds 11.9%** // SF 9.85% Adults experiencing serious psychological distress	• Poverty o SF 13.45 %//CA 15.94 o Black 30.02%** // SF 13.45% o Native Americans 28.59%**// SF 13.45% o Pacific Islander 23.4%**// SF 13.45% o Latino 16.66%**// SF 13.45% • Lack of health insurance and access to health care services • Lack of sufficient education to obtain and maintain stable employment and income. • Insufficient community support resources available • Lack of community cohesion

	• SF 9%*//CA 8% Rate of hospitalizations for schizophrenia and other psychotic disorders/10,000 population • SF 19.29//CA 22.54 • African Americans 91.14**// SF 19.29 • 18-24 year olds 30.48**// SF 19.29 • 45-64 year olds 30.33**// SF 19.29 • 65-74 year olds 21.18**// SF 19.29 • Males 23.71**// SF 19.29 Rate of hospitalizations due to mood disorders /10,000 population • SF 18.2// CA 22.54 • African American 43.16**// SF 18.2 • White 24.48**// SF 18.218-24 year olds 30.58**// SF 18.2 • 45-64 year olds 28.09**// SF 18.2	
PRIMARY DATA:	The community expressed concern about complete access to medical care, including dental, and especially mental health services. Participants believed that mental health services could help ameliorate domestic abuse and suicide issues in their communities. Some cultures feel stigma associated with accessing mental health services.	
GEOGRAPHIC IMPACT:	Age adjusted mental health hospitalizations for both mood disorders and schizophrenia and other psychotic disorders with higher rates than San Francisco as a whole include: 94102, Tenderloin; 94103, Central City; 94105, Embarcadero, South of Market (SOMA); 94109, Polk, Russian Hill, Nob Hill; 94110, Mission; 94111, Embarcadero, Barbary Coast; 94115, Western Addition; and 94124, Bayview Hunters Point.	

SAFETY AND VIOLENCE PREVENTION HEALTH NEED SUMMARY		
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RATIONALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
Safe communities contribute to overall health and well being. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Safe communities prevent adverse childhood experiences. Witnessing and experiencing violence disrupts early brain development and causes longer term behavioral, physical, and emotional problems in children and youth including perpetrating or being a victim of violence, depression, suicide ideation and attempts, smoking, obesity, high-risk sexual behaviors, school absenteeism, unintended pregnancy, eating disorders, and alcohol and drug misuse.[1, 50, 56, 57] Community violence decreases the real and perceived safety of a neighborhood, inhibiting social interactions and adversely affecting social cohesion.[47 ,58]	Mortality-Homicide per 100,000 population • SF 6.08//CA 5.15 • African American 48.3**//SF 6.08 • Pacific Islander 17.89**//SF 6.08 Mortality-motor vehicle accident per 100,000 population • SF 1.93//CA 5.18 • African American 6.4**//SF 1.93 Mortality-pedestrian accident per 100,000 population • SF 1.29//CA 1.97 • African American3.3**//SF 1.29 Suicide per 100,000 population age adjusted • SF 8.47// CA 9.8 • White 11.6**//SF 8.47 • Asian 14.7**//SF 8.47 Youth (13-20 years old) intentional injury per 100,000 population • SF 804.7**//CA 738.7 Assault (injury) per 100,000 population • SF 494.9**//CA 290.3	Liquor store Access per 100,000 population • SF 13.41** // CA 10.02 Alcohol consumption per 100,000 population • SF 21.6%** //CA 17.2% Alcohol expenditures, % of total food at home expenditures • SF 15.42%** // CA 12.93%

	Domestic violence injuries per 100,000 population • SF 27.1**//CA 9.5 Substantiated child abuse/1,000 children • African American 4.1**//SF 1.2 • Latino 2.7*//SF 1.2 All violent Crimes per 100,000 population • SF 702.6**//CA 425 Resident who feel unsafe walking alone in their neighborhoods during the day • Female 6%*//SF 5% • African American 8%**//SF 5% • Asian/API 7%*//SF 5% • Latino 7%*//SF 5% Resident who feel unsafe walking alone in their neighborhoods at night • Female 27%**//SF 18% • African American 27%**//SF 18% • Asian/API 21%**//SF 18% • Latino 28%**//SF 18%	
PRIMARY DATA:	**Community Cohesion:** Many wanted to have the opportunity to be more involved and requested assistance with organizing and self-empowerment. They wanted community representation on political committees and a voice in decision-making including determining what services are available. They felt that partnerships with other communities could be beneficial. **Safe environments:** Residents voiced a desire for a cleaner and safer city. Some did not feel safe to exercise in their neighborhood.	
GEOGRAPHIC IMPACT:	• Violent crime rates and rates of emergency room visits due to assaults are highest in the eastern half of San Francisco, including Bayview, Financial District, and Mission Neighborhoods. High drug crime areas coincide with violent crimes. Minorities, especially those living in high crime areas, suffer disproportionately; the rate of emergency room visits due to assault are more than five times higher among Blacks and 1.25 times higher among Latinos than San Francisco overall. • Since 2008, the rate of domestic violence calls has increased by 21% (2014). Similar to other crimes in San Francisco, more calls per 1,000 people were initiated from the	

	Tenderloin and Bayview police districts. The rate of emergency room visits due to domestic violence in 2012-2014 was lower in San Francisco than California; however, rates among Blacks were almost 6 times higher than the San Francisco rate. • Despite a city-wide decrease in substantiated cases of child sexual, physical or emotional abuse, a 10-fold racial-ethnic disparity in child abuse persists between Black and White and Asian/PI children.

SUBSTANCE ABUSE HEALTH NEED SUMMARY		
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RATIONALE	**HEALTH OUTCOME INDICATORS [REPORT AREA // BENCHMARK]**	**CONTRIBUTING FACTORS**
Drug and alcohol abuse has significant direct and indirect impacts on health. Unintentional poisoning is now the leading cause of injury death among American adults, surpassing motor vehicle accidents. Tobacco is the number one preventable cause of death. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include poor academic performance, cognitive functioning deficits, unintended pregnancy, HIV and other sexually transmitted diseases, motor vehicle crashes, violence, child abuse, crime, homicide, chronic diseases including liver disease and certain cancers (e.g. colon and rectal, liver, breast cancer, prostate cancer), and mental and behavioral disorders (unipolar depressive disorders, epilepsy, suicide).[96] Alcohol use is associated with 22% of all traffic related fatalities.[25] The earlier a person begins to use drugs and alcohol, the more likely he or she is to develop serious problems. Cigarette smoking increases risk of heart disease; chronic obstructive pulmonary disease; acute respiratory illness; stroke; and cancers of the lung, larynx, oral cavity, pharynx, pancreas, breast, and cervix.[2,93,94] There is growing concern that electronic cigarettes may cause addiction among non-smokers and reverse decades of work to de-normalize smoking.[64,101] Data from National Youth Tobacco Survey (NYTS) found a significant increase in ever (4.7% to 10.0%) and past 30-day (1.5% to 2.8%), e-cigarette use between 2011 and 2012.[39]	Alcohol consumption per 100,000 population • SF 21.6%** //CA 17.2% Alcohol expenditures, % of total food at home expenditures • SF 15.42%** // CA 12.93% Binge drinking (5 or more drinks or 4 or more drinks on an occasion for men and women, respectively) in the past year on at least one occasion, adults 18+ years old • SF 39%** //CA 32.6% • Male 49.3%**// SF 39% • Latino 50.7%**// SF 39% • White 43.8%**// SF 39% • 18-24 year olds 64.8%**// SF 39% • 25-44 year olds 50.4%**// SF 39% Marijuana use in high school • SF 28.2%**//US 23.4% • Black 54.7** //SF 28.2% • Filipino 30.4**//SF 28.2% • White 47.9%**//SF 28.2% • Latino 51.2%**//SF 28.2% • 11th grade 33.2%**//SF 28.2%	• Density of alcohol outlets • Density of tobacco sales permits • Needing mental health care • Liquor store Access per 100,000 population o SF 13.41** // CA 10.02

In San Francisco: Overall, ED and admission rates due to alcohol abuse in San Francisco exceed California rates. City areas with the highest density of Off-Sale Alcohol Outlets have higher emergency department and admission rates. The number of students reporting drug and alcohol use steadily increases with age and varies by ethnicity. High school seniors are 3 times more likely to binge drink than 9th graders. More than 40% of white, black and Latino students have used marijuana. Binge drinking is highest among White and Latino High school students. Chinese students are the least likely to use any drug. Youth, low income, ethnic minorities, and LGBTQ are disproportionately affected by tobacco use. Twenty percent of San Francisco callers to the California Smoker's Helpline in 2014 were LGBTQ.[19] A survey conducted by the San Francisco Unified School District showed that 10% of middle school and 17% of high school students have tried e-cigarettes while only 7.5% of high school students have used cigarettes in the last 30 days.[14,63]	• 12th grade 37%**//SF 28.2% • Gay, Lesbian 30.9%**// SF 28.2% Age-adjusted emergency department visit rates/10,000 due to acute and chronic alcohol abuse • SF 16.04**//CA 8.84 • Men 23.11** // SF 16.04 • White 23.26** // SF 16.04 • African American 24.04**// SF 16.04 • Latino 24.01**// SF 16.04 • 45-64 year olds 37.48**// SF 16.04 Percentage of adults who are current smokers • SF 14%// CA 13.6% • 18-24 year olds 25.6%**// SF 14% • Below 300% FPL 19.4%**// Above 300% FPL 10.4% High school students smoking 1+ cigarettes in the last 30 days • African American 13.8%**// SF 9.1% • White 19.5%** // SF 9.1% • Latino 12.6%** // SF 9.1% • 12th grade 12.8%**// SF 9.1% • Gay, Lesbian 11.4**// SF 9.1% • Bisexual 24.4**// SF 9.1%	
PRIMARY DATA:	Substance abuse was not specifically mentioned in the community conversations. However, other health needs impacted by substance abuse were of concern to residents, including domestic violence, homelessness, and psychosocial health.	

GEOGRAPHIC IMPACT:	• There is currently a moratorium on new off-sale alcohol outlet licenses in San Francisco. Citywide there are 1.2 outlets per 1,250 residents therefor exceeding the state threshold of 1 outlet per 1,250 residents. A number of neighborhoods however, have license densities that are far higher, including: the Financial District, North Beach, Japantown, Castro/Upper Market, Chinatown, South of Market, and the Tenderloin, which have between 2-4 licenses per 1,250 residents. The physical density of permits however, is by far the highest in the Tenderloin, where there are 125 licenses per square mile, compared to 17 per square mile for the city as a whole. • Districts in San Francisco with higher concentrations of smokers, ethnic minorities, and youths are associated with a higher density of tobacco retailers despite all districts having the same number of residents. These Districts include historically ethnic neighborhoods such as the Mission, Tenderloin, Western Addition, Bayview, Excelsior, and Chinatown. Districts 3 (Chinatown), 6 (Tenderloin), and 9 (Bayview) all exceed 100 tobacco retailers compared with District 7 (Inner Sunset), which only has 33 tobacco retailers. Research has shown that areas with higher density of tobacco retailers are associated with an increased prevalence of smoking.[41] It should be noted that these districts with higher numbers of tobacco retailers are also districts with lower socioeconomic status.