2016 Community Health Needs Assessment

Kaiser Foundation Hospital—San Rafael
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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
Many individuals and organizations participated in the success of this Community Health Needs Assessment.

Healthy Marin Partnership (HMP) was established in 1995 to complete a triennial community health needs assessment (CHNA) required of all not-for-profit hospitals by the California Office of Statewide Health Planning and Development. HMP is chaired by Patricia Kendall, RN, Medical Group Administrator, Kaiser Permanente San Rafael Medical Center, and includes all acute-care hospitals in Marin County as well as Marin County Health & Human Services, Marin Community Foundation, Marin County Office of Education, and representatives of the business community. HMP has been coordinating the completion of each triennial CHNA since 1995. The participation of HMP members, community leaders, and residents in the community convening enhanced the accuracy and usefulness of the CHNA for the organizations that will use it to create even healthier communities in Marin County.

Partner hospitals have worked closely together throughout the CHNA process to ensure the CHNA complied with the requirements of the Affordable Care Act and included data on which to build effective implementation strategies. Members of the Marin County Community Health Needs Assessment Collaborative include:

- Healthy Marin Partnership
  - Teri Rockas, Project Manager
    Health Education & Promotion, Member Outreach, Kaiser Permanente
- Marin General Hospital
  - Jamie Maites, Director of Communications
- Kaiser Foundation Hospital—San Rafael
  - Carl Campbell, Public Affairs Director
  - Jeannie Dulberg, Community Benefit Manager
  - Molly Bergstrom, Community Benefit Manager
- Novato Community Hospital
  - Mary Strebig APR, Manager, Communications & Community Benefit
- Sutter West Bay Region Employer Marketing
- Marin County Health & Human Services
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  - Kathy Koblick, MPH, Public Health Division Director
- Consultants
  - Harder+Company Community Research was instrumental in supporting the community health need prioritization process by presenting extensive data in a useful way and facilitating a meaningful conversation that resulted in establishment of community priorities on which future decisions can be based.

Several other organizations were also instrumental to the CHNA process, including:

- Marin County Health & Human Services, which has provided invaluable support with data, technical assistance, and participation in the Marin County CHNA Collaborative.
- The CHNA data collection subgroup, which included members of Marin County CHNA Collaborative as well as representatives from Marin Community Foundation and Marin County Aging & Adult Services, informed the sampling plan for key informant interviews and focus groups as well as interview questions, and assisted in ensuring alignment between concurrent assessments.
- Multiple social service and nonprofit organizations who helped coordinate and recruit participants for focus groups, participated in key informant interviews, and attended the prioritization session.
- Community members who participated in focus groups and provided instrumental insight into the needs of their community.

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I. EXECUTIVE SUMMARY

The 2016 Community Health Needs Assessment (CHNA) offers a comprehensive community health profile that encompasses the conditions that impact health in our county. Conducting a triennial CHNA is a requirement for not-for-profit hospitals as part of the Patient Protection and Affordable Care Act (ACA).

A. Community Health Needs Assessment (CHNA) Background

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.

B. Summary of Prioritized Needs

Kaiser Foundation Hospital (KFH) San Rafael collaborated on its CHNA with Healthy Marin Partnership since the KFH San Rafael service area is made up mostly of Marin County. Marin County is a healthy and affluent county, especially compared to California as a whole. However, Marin is also an aging county with substantial disparities in socioeconomic status. These issues present challenges for the health of Marin County residents.

Consideration of the eight health needs that emerged as top concerns in Marin County highlights the significance of social determinants of health in building a healthier and stronger community. These results align closely with county priorities and previous findings from the 2013 Pathways to Progress CHNA report. In its entirety, this list of health needs supports the work of Healthy Marin Partnership (HMP) to foster collaboration and action among community partners, including key hospital partners, to identify cross-cutting strategies that address multiple health needs. In descending priority order, the following health needs were identified in Marin County; additional information about each health need can be found in Appendix A.

1) **Obesity and Diabetes:** Though rates of obesity and diabetes are lower in Marin County compared to California as a whole, this health need emerged as the top priority for stakeholders. There is still a high prevalence of adults and youth in Marin County who are overweight or obese, and data indicate that Marin County residents have a higher risk of heart disease compared to California residents on average. Residents and stakeholders pointed to access to healthy food as a top concern, particularly in some specific areas of the county. Interviewees and focus group participants noted that older adults are disproportionately impacted by this health issue. Access to healthy food and the ability to maintain a healthy lifestyle are more limited for older adults, particularly those living on a fixed or lower income.

2) **Education:** While some education outcomes, such as high school graduation rate, are higher for Marin County than the rest of California, disparities, particularly among English Language Learners, African American, and Latino students, indicate that education is a high concern in the county. English Language Learners are less likely to pass the high school exit exam in Math and English Language Arts compared to their peers in Marin County and compared to English Language Learners on average in California. Community members and key stakeholders highlighted education as an important health need and recommended strategies to improve county-wide

access and to decrease disparities, such as increasing investment in early childhood education.

3) **Economic and Housing Insecurity:** Marin County's high cost of living exacerbates issues related to economic security and affordable housing. More than half of renters pay 30% or more of their income on rent, and in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. Additionally, 1,309 individuals are homeless, 835 of which are unsheltered. Low-income residents, youth, and single mothers face particular challenges affording quality housing in Marin County, especially in Canal and West Marin.

4) **Access to Health Care:** With the implementation of the ACA, many adults in Marin County are able to obtain insurance coverage and access regular healthcare. While Marin County scores better than the California state average on many indicators measuring healthcare access, the county continues to work towards providing affordable and culturally competent care for all residents. Lower-income residents face the greatest challenges; many providers that see low-income patients are at capacity, and public insurance is not accepted by many physicians in the county. In addition to barriers in obtaining affordable care, Marin residents have notably low utilization rates for childhood vaccinations compared to California as a whole.

5) **Mental Health:** Marin County residents demonstrate high need in mental health issues, including suicide rate, taking medicine for an emotional/mental health issue, and reporting needing mental health or substance abuse treatment among adults. Mental health was also raised as a key concern among community members and other key stakeholders, who discussed barriers to accessing treatment among other key themes. Mental health issues frequently co-occur with substance abuse and homelessness. Racial disparities in Marin County are evident, and the Latino population was highlighted in primary data as a population of concern. Youth, older adults, and incarcerated individuals were also noted as particularly high-risk populations for mental health concerns.

6) **Substance Use:** Substance abuse was identified as a health need of concern in multiple existing data sources, as well as in interviews and focus groups. In particular, use and abuse of prescription drugs is recognized as a health need of concern. Nearly half (48.1%) of adults responding to one survey reported it would be easy to obtain prescription drugs from a doctor in their community. Among youth, percentages of students reporting binge drinking and being "high" from drug use are higher for Marin County than for California overall. Interview and focus group participants identified Fairfax, West Marin, and Canal as areas of high risk for drug abuse.

7) **Oral Health:** A lack of access to dental insurance or inadequate utilization of dental care is an important issue affecting oral health in Marin County. Nearly half of adults in the county (43.3%) do not have dental insurance, and adults older than 65 are even more likely not to have dental insurance. Some key informants shared that oral health access may have increased slightly in West Marin with the Coastal Health Alliance's new full-time Dental Clinic, but it is still not enough, particularly for underserved populations. Additionally, key informants and focus group participants report that dental insurance is limited and specialty care is not affordable.

8) **Violence and Unintentional Injury:** In Marin County, this area was identified as a health need because of data related to domestic violence, as well as key drivers of violence such as alcohol abuse. Additionally, racial disparities in intimate partner violence and homicide exist. Marin County also experiences high rates of unintentional injury mortality and drunk driving among youth. Violence and injury also arose as a health need through key themes in interviews and focus groups. Community residents and other key stakeholders identified mental health and substance abuse as drivers of unintentional injury and injury due to violence.

C. Summary of Needs Assessment Methodology and Process

The CHNA process used a mixed-methods approach to collect and compile data to provide a robust assessment of health in Marin County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. Data sources included:

- Analysis of over 150 health indicators from publicly available data sources such as the California Health Interview Survey, American Community Survey, and the California Healthy Kids Survey. Secondary data were organized by a framework developed from Kaiser Permanente's list of potential health needs, and expanded to include a broad list of needs relevant to Marin County.
- Interviews with 20 key informants from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted.
- Eight focus groups were conducted in English and Spanish, reaching 90 residents, representing different populations that the Marin County CHNA Collaborative identified as high-risk, including youth, adults in recovery from substance abuse, individuals experiencing homelessness, and residents of Marin City, Novato, San Geronimo, Canal, and West Marin.

Data were used to score each health need. Potential health needs were included in the prioritization process if:

a. At least two distinct indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, the California state average).
b. Health issue was identified as a key theme in at least 10 out of 20 interviews OR in at least four out of eight focus groups.

The Marin County CHNA Collaborative convened key stakeholders on December 1, 2015, to review the health needs identified, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the County. The group utilized the Criteria Weighting Method, which enabled consideration of each health area using four criteria: severity, disparities, impact, and prevention.

The CHNA is an important first step towards taking action to effect positive changes in the health and well-being of county residents. The results will be used to drive development of hospital-specific implementation strategies for the priority health needs each hospital will address. These strategies will build on their assets and resources, as well as evidence-based strategies, wherever possible. The CHNA and the hospital-specific implementation strategies will provide the impetus for concerted action in a strategic, innovative, and equitable way.

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 include 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.

The CHNA process provides a deep exploration of health in Marin County, updating and building upon work done in prior years to identify current priority health needs. The 2013 CHNA identified eight health needs: mental health; substance abuse; access to health care/medical homes/health care coverage; socioeconomic status; healthy eating and active living; social supports; cancer; and heart disease.

While the leading causes of death in California remain chronic diseases, evidence indicates that addressing and improving social and environmental conditions will have a positive impact on trends in morbidity and mortality, and diminish disparities in health. Many chronic diseases and conditions are caused in part by preventable factors such as poor diet and physical inactivity, and there is growing awareness of the important link between how communities are structured and the opportunities for people to lead safe, active, and healthy lifestyles. Previous assessments have focused community discussion on upstream health impacts, tracking a set of four lifestyle issues that underlie the leading causes of death in Marin: high-risk alcohol use, tobacco use, diet, and physical inactivity. Guided by the understanding that health encompasses more than disease or illness, the 2016 CHNA process continues to utilize a comprehensive framework for understanding health that looks at ways a variety of social, environmental, and economic factors – also referred to as “social determinants” – impact health. Thus, the CHNA process identifies top health needs (including social determinants of health) in the community, and analyzes a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing drivers – or contributing factors – of each health need.

In addition to considering a broad definition of county-wide health, this assessment explored the particular impact of identified health issues among vulnerable populations which may bear disproportionate risk across multiple health needs. These populations may be residents of particular geographic areas, or may represent particular races, ethnicities, or age groups. In striving towards health equity, the Marin County CHNA Collaborative placed strong emphasis on the needs of high-risk populations in the process of identifying health needs and as a criterion for prioritization.

With the passage of the ACA, completion of a CHNA has been codified into the Internal Revenue Code and required to assure the nation’s not-for-profit hospitals maintain their 501(c)(3) status. The Code requires the CHNA to include:

- Data Research & Prioritization of Identified Health Needs
- Report on Findings
- Implementation Plan

Through HMP, Marin’s hospitals (Marin General Hospital, Novato Community, and Kaiser Permanente-San Rafael) and Marin County Health & Human Services work together to meet these requirements of the ACA.

In conjunction with this report, KFH—San Rafael 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

In order to determine the health needs of the Marin County CHNA Collaborative member hospital service areas, it is first important to understand the communities of interest. The following section describes the service area community by geography, demographics, and socioeconomic indicators, as well as by indicators of overall health, and climate and the physical environment.

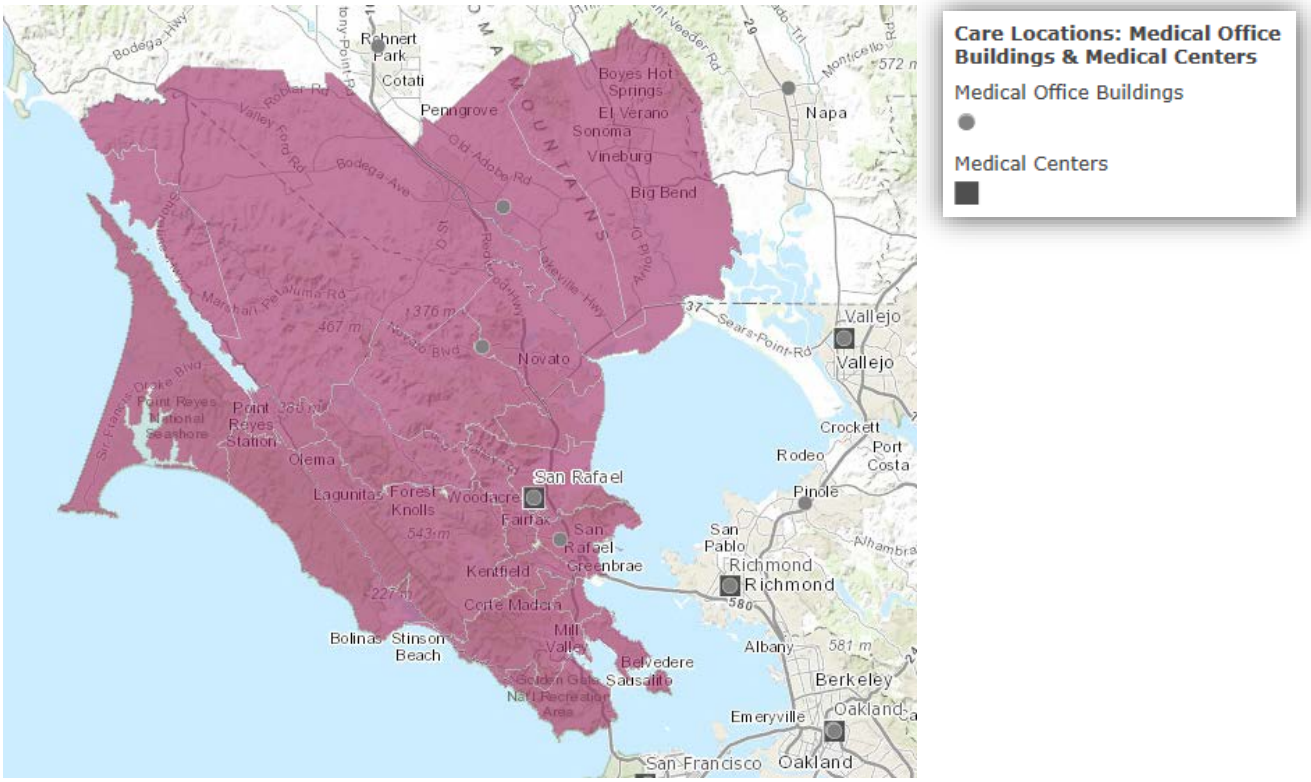
A. Kaiser Permanente's Definition of Community Served

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

The map below depicts the service area of KFH—San Rafael.



ii. Geographic Description of the Communities Served

The KFH—San Rafael service area comprises Marin County and the southern portion of Sonoma County, including the cities of Petaluma and Sonoma. Cities in Marin County include Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, and Tiburon, and the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales. Using the Kaiser Permanente data platform, a comparison was done between Marin County and this service area. No notable differences in health status exist, so for the purpose of this assessment, all hospitals in the Marin County CHNA Collaborative consider the service area to be

Marin County. Sonoma County resident health is assessed by the Sonoma County Community Health Needs Assessment.

iii. Demographic Profile

The following data provide an overall picture of the Marin County population. Demographic and socioeconomic data present a general profile of residents, while overall health indicators present an assessment of the health of the county. Key drivers of health (e.g., health care insurance, education, and poverty) illuminate important upstream conditions that affect the health of Marin County today and into the future. Finally, climate and physical environment indicators complement these socioeconomic indicators to provide a comprehensive understanding of the determinants of health in Marin County. All indicators include California comparison data as a benchmark to determine disparities between Marin County and the state. Healthy People 2020 benchmarks are also included when available.

Demographic Data	
Total Population	362,600
White	80.65%
Black	1.73%
Asian	5.12%
Native American/ Alaskan Native	0.4%
Pacific Islander/ Native Hawaiian	0.22%
Some Other Race	8.34%
Multiple Races	3.54%
Hispanic/Latino	18.5%

Socio-economic Data	
Living in Poverty (<200% FPL)	21.57%
Children in Poverty[1] (<100% FPL)	12.34%
Unemployed[2]	5.2%
Uninsured	9.68%
No High School Diploma[3]	8.8%

[1] US Census Bureau, 2014 American Community Survey 1-Year Estimate.
[2] US Department of Labor, Bureau of Labor Statistics, June 2015.
[3] US Census Bureau, 2010-2014 American Community Survey 5-Year Estimate.

Marin County and California Health Profile Data[4]			
Indicator	**Marin County**	**California**	**HP 2020 Benchmark[5]**
Overall Health			
Diabetes Prevalence (Age Adjusted)[6]	5.5%	8.1%	--
Adult Asthma Prevalence[7]	13.8%	14.2%	--
Adult Heart Disease Prevalence[8]	7.6%	6.1%	--
Poor Mental Health[9]	4.5%	17.4%	--
Adults with Self-reported Poor or Fair Health (Age Adjusted)[10]	9.7%	18.4%	--
Adult Obesity Prevalence (BMI > 30)[11]	17.5%	22.3%	≤ 30.5%
Child Obesity Prevalence (Grades 5, 7, 9) (BMI>30)[12]	8.9%	19.0%	≤ 16.1%
Adults with a Disability[13]	23.9%	28.5%	--
Infant Mortality Rate (per 1,000 births)[14]	3.3	5.0	≤ 6.0
Cancer Mortality Rate (Age Adjusted) (per 100,000 pop.)[15]	146.7	157.1	≤ 160.6
Climate and Physical Environment			
Days Exceeding Particulate Matter 2.5 (Pop. Adjusted)[16]	5.2%	4.2%	--
Days Exceeding Ozone Standards (Pop. Adjusted)[17]	0.0%	2.5%	--
Weeks in Drought[18]	89.1%	92.8%	--
Total Road Network Density (Road Miles per Acre)[19]	2.1	4.3	--
Pounds of Pesticides Applied[20]	84,836	193,597,806	--
Population within Half Mile of Public Transit[21]	5.6%	15.5%	--

IV. WHO WAS INVOLVED IN THE ASSESSMENT

The Marin County CHNA was a collaborative effort that included not only Marin County's hospitals but also partner organizations and individuals throughout the community who worked alongside consultants to collect and analyze data and ultimately produce this report.

A. Identity of Hospitals that Collaborated on the Assessment

As has been done in Marin since 1996, Marin County's hospitals (Marin General, Novato Community Hospital, and KFH—San Rafael) worked in collaboration to complete a county-wide CHNA. Representatives from these institutions, joined by representatives from Marin County Health and Human Services and HMP, formed the 2016 Marin County CHNA Collaborative.

[4] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2009-2013 American Community Survey 5-Year Estimate.
[5] Whenever available, Healthy People 2020 Benchmarks are provided. Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
[6] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional analysis by CARES, 2011-12.
[8] California Health Interview Survey, 2013-14.
[9] California Health Interview Survey, 2014.
[10] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[11] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[12] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[13] California Health Interview Survey, 2014.
[14] Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2006-10.
[15] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data, 2010-12.
[16] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008.
[17] Ibid.
[18] US Drought Monitor, 2012-2014.
[19] Environmental Protection Agency, EPA Smart Location Database, 2011.
[20] California Department of Pesticide Regulation (CDPR), 2013.
[21] Environmental Protection Agency, EPA Smart Location Database, 2011.

B. Other Partner Organizations that Collaborated on the Assessment

- Healthy Marin Partnership
- Marin County Health and Human Services

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

Harder+Company Community Research: Harder+Company Community Research (Harder+Company) is a comprehensive social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-based evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts – including conducting needs assessments; developing and operationalizing strategic plans; engaging and gathering meaningful input from community members; and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation which is essential to both healthcare reform and the CHNA process in particular. Harder+Company is also the consultant on several other CHNAs throughout the state including in Napa, San Joaquin, and Sonoma Counties.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

The Marin County CHNA Collaborative used a mixed-methods approach to collect and compile data to provide a robust assessment of health in Marin County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. The following section outlines the data collection and analysis methods used to conduct the CHNA.

A. Secondary Data

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

With the Marin County CHNA Collaborative, KFH—San Rafael used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Additional secondary data were compiled and reviewed from existing sources including California Health Interview Survey, American Community Survey, and California Healthy Kids Survey, among other sources. Where more recent data were readily available and current estimates were critical to assessing changing landscapes such as health insurance status, Kaiser Permanente CHNA Data Platform information was replaced with new data as it was publically released, to reflect more recent data. In addition to statewide and national survey data, previous CHNAs and other relevant external reports were reviewed to identify additional existing data on additional indicators at the county level. For details on the specific sources and years for each indicator reported, please see Appendix B.

ii. Methodology for Collection, Interpretation and Analysis of Secondary Data

Secondary data were organized by a framework of potential health needs, a comprehensive list of health need areas explored during this assessment process. This framework was developed from Kaiser Permanente's list of potential health needs, which was based on the most commonly identified health needs from the 2013 CHNA cycle, and expanded to include a broad list of needs relevant to Marin County. The consulting team and Marin County CHNA Collaborative finalized this framework in advance of analysis.

Where available, Marin County data were considered alongside relevant benchmarks including the California state average, Healthy People 2020, and the United States average. Each indicator was compared to a relevant benchmark, most often the California state average. If no appropriate

benchmark was available, the indicator could not be considered in criteria to identify health needs, but is presented in the final data book (Appendix B) and was used to provide supplementary information about identified health needs. In areas of particular health concern, data were also collected at smaller geographies, where available, to allow for more in-depth analysis and identification of community health issues. Data on gender and race/ethnicity breakdowns were analyzed for key indicators within each broad health need where subpopulation estimates were available.

B. Community Input

i. Description of the Community Input Process

Community input was provided by a broad range of community members and leaders through key informant interviews and focus groups.

Individuals identified by the Marin County CHNA Collaborative as having valuable knowledge, information, and expertise relevant to the health needs of the community were interviewed. Interviewees included representatives from the local public health department as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Other individuals from various sectors with expertise of local health needs were also consulted. A total of 20 key informant interviews were conducted during this needs assessment. For a complete list of individuals who provided input, see Appendix C.

Additionally, eight focus groups were conducted throughout Marin County. These groups were intentionally sampled to reach specific subpopulations of the county that were identified as high-risk populations by the Marin County CHNA Collaborative. These subpopulations included youth, adults in recovery from substance abuse, individuals experiencing homelessness, and residents in Marin City, Novato, San Geronimo, Canal, and West Marin. Focus groups were monolingual, conducted in either English or Spanish.

Community partners provided invaluable assistance in recruiting and enrolling focus group participants. Many individuals who participated in focus groups identified as leaders, representatives, or members of medically underserved, low-income, chronically diseased, and minority populations. For more information about specific populations reached in focus groups, see Appendix C.

ii. Methodology for Collection and Interpretation of Primary Data

Interview and focus group protocols were developed by the consulting team and reviewed by the Marin County CHNA Collaborative, and were designed to inquire about top health needs in the community, as well as about a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing drivers of each health need. For more information about data collection protocols, see Appendix D.

All qualitative data were coded and analyzed using ATLAS.ti software. A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to specific drivers of health needs, subpopulations or geographic regions disproportionately affected, existing assets or resources, and community recommendations for change. At the onset of analysis, one interview transcript and one focus group transcript were coded by the entire analysis team to ensure inter-coder reliability and minimize bias.

Transcripts were analyzed to examine the health needs identified by the interviewee or group participants. Health need identification in qualitative data was based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions of that particular health need within each transcript.

C. Written Comments

Kaiser Permanente 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 Rafael 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 Kaiser Permanente CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. While changes to the platform are ongoing, the data presented in this report reflect estimates presented on the Kaiser Permanente CHNA data platform on December 2, 2015. Supplementary secondary data were obtained from reliable data platforms including U.S. Census Bureau American FactFinder, AskCHIS, and others. However, as with any secondary data estimates, there are some limitations with regard to this information. With attention to these limitations, the process of identifying health needs was based on triangulating primary data and multiple indicators of secondary data estimates. The following considerations may result in unavoidable bias in the analysis:

- Some relevant drivers of health needs could not be explored in secondary data because information was not available—for example, only limited information was available about the rising cost of housing and increasing pressures of gentrification.
- Many data were available only 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, limiting the ability to examine disparities of health within the community.
- In all cases where secondary data estimates by race/ethnicity are reported, the categories presented reflect those collected by the original data source, which yields inconsistencies in racial labels within this report.
- For some county level indicators, data are available but reported estimates are statistically unstable; in this case estimates are reported but instability is noted.
- Secondary data collection was subject to differences in rounding from different data sources; i.e., Kaiser Permanente CHNA data platform indicators are rounded to the nearest hundredth, whereas other data sources report only to the nearest tenth or whole number.
- Data are not always collected on a yearly basis, meaning that some data estimates are several years old and may not reflect the current health status of the population. In particular, data reported from prior to 2013 should be treated cautiously in planning and decision-making.
- California state averages and, where available, United States national averages are provided for context. No analysis of statistical significance was done to compare county data to a benchmark; thus, these benchmarks are intended to provide contextual guidance and do not intend to imply a statistically significant difference between county and benchmark data.

Primary data collection and the prioritization process are also subject to information gaps and limitations. The following limitations should be considered in assessing validity of the primary data.

- Themes identified during interviews and focus groups were likely subject to the experience of individuals selected to provide input; the Marin County CHNA Collaborative sought to receive input from a robust and diverse group of stakeholders to minimize this bias.
- The final prioritized list of health needs is also subject to the affiliation and experience of the individuals who attended the Prioritization Day event, and to how those individuals voted on that particular day. The closeness in priority scores suggests that all identified health needs are of importance to stakeholders in Marin County. While a priority order has been established during

this needs assessment process, narrow difference in the results highlight the importance of directing attention and resources to each identified resource to the extent possible.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying Community Health Needs

i. Definition of a "Health Need"

For the purposes of the CHNA, the Marin County CHNA Collaborative defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. In this context, potential health needs are intended to identify a condition or related set of conditions, rather than a specific population of high need. Within each health need, populations of high risk are explored. For this reason, information about needs of specific at-risk subpopulations such as older adults is included within the context of the health needs that specifically impact this population. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

A total of 19 potential health needs were examined, as outlined in the table below.

Health Need	Definition
Access to Care	Data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health
Access to Housing	Data related to cost, quality, availability, and access to housing
Asthma and COPD	Known drivers of asthma and other respiratory diseases, and health outcomes related to these conditions
Cancers	Known drivers of cancers, and health outcomes related to cancers
Early Child Development	Data related to development of mental and emotional health in young children, particularly age 0-5
Climate and Health	Data related to climate and environment, and related health outcomes
CVD/Stroke	Known drivers of heart disease and stroke, and related cardiovascular health outcomes
Economic Security	Data related to economic well-being, food insecurity, and drivers of poverty including educational attainment
Education	Data related to educational attainment and academic success, from preschool through post-secondary education
HIV/AIDS/STD	Known drivers of sexually transmitted infections including HIV, and related STD and AIDS outcomes
Mental Health	Data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes
Obesity and Diabetes	Data related to healthy eating and food access, physical fitness and active living, overweight/obesity prevalence, and downstream health outcomes including diabetes
Oral Health	Data related to access to oral health care, utilization of oral health preventative services, and oral health disease prevalence
Overall Health	Data related to overall community health including self-rated health and all-cause mortality
Pregnancy and Birth Outcomes	Data related to behaviors, care, and outcomes occurring during gestation, birth, and infancy; includes health status of both mother and infant
Substance Abuse/Tobacco	Data related to all forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs

Vaccine-preventable Infectious Disease	Data related to vaccination rates and prevalence of vaccine-preventable disease
Violence and Injury	Data related to intended and unintended injury such as violent crime, motor vehicle accidents, domestic violence, and child abuse
Youth Growth and Development	Data related to supports and outcomes affecting youth ability to develop to their full potential as adults, particularly focused on adolescent youth

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

To identify the list of community health needs for the Health Marin Partnership hospitals, all secondary data for Marin County were scored against a benchmark, in most cases the California-wide estimate, and a score was applied to each potential health need based on the aggregate score of the indicators assigned to that health need. Additionally, content analysis was used to analyze key themes in both the Key Leader Interviews and Focus Groups. Section V contains more information on quantitative and qualitative data analysis.

Potential health needs were identified as a health need for the Health Marin Partnership hospitals if:

a. At least two distinct indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, the California state average).
b. Health issue was identified as a key theme in at least 10 out of 20 interviews OR in at least four out of eight focus groups.

If a health need was mentioned overwhelmingly in primary data but did not meet the criteria above for secondary data, the analysis team conducted an additional search of secondary data to confirm that all valid and reliable data concurred with the initial secondary data and to examine whether indicators within the health need disproportionately impact specific geographic, age, or racial/ethnic subpopulations. However, no potential health need was identified as a health need in Marin County unless it was confirmed by both secondary and primary data.

Harder+Company summarized the results of the analysis in a matrix, which was then reviewed and discussed by the Marin County CHNA Collaborative.

Ten health needs were identified which met the first criteria of having multiple secondary data indicators that performed >1% worse than comparison benchmarks. Only seven of these health needs met the additional criteria of being identified as a theme in key leader interviews or focus groups. One health need, Access to Housing, did not have a high secondary data score but was a salient theme in the majority of interviews and focus groups. Therefore, the Marin County CHNA Collaborative decided to include data about Access to Housing with Economic Insecurity, as access to safe and affordable housing and economic security are very closely linked. Violence and Injury did not meet the criteria for inclusion in primary data, but was on the cusp and was identified by key informants across sectors. With this information and the need demonstrated in secondary data, the Marin County CHNA Collaborative decided to include Violence and Injury as an identified health need.

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

The Criteria Weighting Method, a mathematical process whereby participants establish a relevant set of criteria and assign a priority ranking to issues based on how they measure against the criteria, was used to prioritize the eight health needs. This method was selected as it enabled consideration of each health need from different facets, and allowed the Marin County CHNA Collaborative to weight certain criteria to use a multiplier effect in the final score.

To determine the scoring criteria, Marin County CHNA Collaborative members reviewed a list of potential criteria and selected a total of four criteria:

Criteria	Definition
Severity	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Disparities	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
Prevention	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.
Leverage	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.

In order to develop a weighted formula to use in prioritization, each member of the Marin County CHNA Collaborative assigned a weight to each criterion between 1 and 5. A weight of 1 indicated the criterion is not that important in prioritizing health issues whereas a weight of 5 indicated the criterion is extremely important in prioritizing health issues. The average of weights assigned by members of the Marin County CHNA Collaborative for each criterion were used to develop the formula below to provide a final formula for use in scoring health needs for prioritization.

Overall Score= (1.5*Severity) + (1*Disparities) + (1.5*Prevention) + (1*Leverage)

In order to review and prioritize identified health needs, a half-day prioritization session was held on December 1, 2015, at the Four Points by Sheraton in San Rafael. A total of 50 stakeholders representing diverse sectors including health, early childhood, education, and government attended. The goals of the meeting were to: review health needs identified in Marin County; discuss key findings from the CHNA; and prioritize health needs in Marin County.

After each health need was reviewed and discussed, participants voted on each health need using the four criteria discussed above. To review the matrix used to score each health need, see Appendix E. The table below outlines the average score of the voting on each health need.

Health Needs in Priority Order					
Final Results		**Unweighted Scores by Criteria**			
Health Need	**Weighted Score**	**Severity**	**Disparities**	**Prevention**	**Leverage**
1. Obesity and Diabetes	29.60	5.75	5.68	6.13	6.11
2. Education	29.45	5.44	6.39	5.78	6.23
3. Economic and Housing Insecurity	29.27	6.11	6.44	5.04	6.11
4. Access to Health Care	28.91	5.35	6.15	5.79	6.07
5. Mental Health	28.76	6.07	5.21	5.56	6.10
6. Substance Use	28.28	6.13	4.71	5.72	5.80
7. Oral Health	27.81	4.98	6.01	6.20	5.04
8. Violence and Injury	25.55	5.52	4.74	5.04	4.98

C. Prioritized Description of the Community Health Needs Identified Through the CHNA

In descending priority order, established per the vote at the end of the three-hour community convening, the following health needs have been identified in Marin County:

1. **Obesity and Diabetes:** Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese.[22] Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes.

[22] http://www.cdc.gov/obesity/adult/defining.html

In Marin County, an estimated 17.5% of adults are obese (compared to 22.3% of adults in California),[23] and 30.8% are overweight (compared to 35.9% in California overall).[24] Among youth, 8.7% are obese (compared to 19.0% in California overall) and 16.3% are overweight (compared to 19.3 in California overall).[25] Access to healthy food was identified as a concern, particularly in specific areas of the county. Since economic disadvantage is strongly linked to barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as youth and older adults, are disproportionately affected by this health need. Interviewees and focus group participants noted that older adults are disproportionately impacted by this health issue. Access to healthy food and the ability to maintain a healthy lifestyle are more limited for older adults, particularly those living on a fixed and low income.

2. **Education:** Educational attainment is strongly correlated with health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.

   In Marin County, English Language Learners are a population of particularly high concern with respect to educational attainment. Only 26.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts (compared to 89% among all students in Marin County); only 37% passed in Mathematics (compared to 90% among all students in Marin County).[26] For all students in the county, pressure to succeed academically and bullying in schools were also raised as issues of high concern.

3. **Economic and Housing Insecurity:** Economic resources such as jobs paying a livable wage, stable and affordable housing, as well as access to healthy food, medical care, and safe environments can impact access to opportunities to be healthy.

   The high cost of living in Marin exacerbates issues related to economic security and stable housing. Among renters, 56.0% spend 30% or more of household income on rent (this is compared to 57.2% in California overall).[27] In many neighborhoods, residents face fear of displacement due to rising housing costs and gentrification. An estimated 1,309 individuals are homeless in Marin County; 835 of these individuals are unsheltered.[28]

   Interviewees and focus group participants emphasized that those least able to afford quality housing are the low-income, aging, and youth populations, and single mother families in Marin County, and particularly in Canal and West Marin.

4. **Access to Health Care:** Ability to utilize and pay for comprehensive, affordable, quality physical and mental health care is essential in order to maximize the prevention, early intervention, and treatment of health conditions.

   With the implementation of the ACA, a majority of adults in Marin County have access to insurance coverage and regular healthcare. However, disparities persist. Specifically, lower income residents have difficulty accessing specialty care services and mental health services, particularly outpatient services, and public insurance is not accepted by many physicians in the county. Additionally, many providers who see low-income patients are at capacity. In addition to barriers in obtaining affordable care, Marin residents have notably low utilization rates for childhood vaccinations. Only 84.2% of kindergarteners in the county enter school with all required immunizations (compared to 90.4% in California overall).[29]

[23] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[24] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[25] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[26] California Department of Education, 2013-14.
[27] US Census Bureau, American Community Survey, 2010-14.
[28] Marin County Homeless Point-in-Time Census and Survey, 2015.
[29] California Department of Public Health Immunization Branch, Immunization Branch, Kindergarten Assessment Results, 2014-15.

5. **Mental Health:** Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression, or Post-traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.

   Mental health was raised as a high concern for all residents, especially youth and older adults. Most notably, Marin residents have a high risk of suicide. 12.8 per 100,000 county residents die by committing suicide (compared to 9.8 per 100,000 in California overall),[30] and 18.0% of eleventh grade students report having seriously considered suicide in the past month.[31] Residents and stakeholders noted challenges in obtaining mental health care, including that the spectrum of services is limited and that stigma may prevent individuals from seeking professional treatment.

6. **Substance Use**: Use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences.

   In Marin County, substance abuse was identified as a concern, particularly with respect to misuse of prescription drugs. Among RxSafe Marin Survey respondents, 48.1% report that they feel it would be very or somewhat easy to obtain prescription pain, sleep, or calming medication from a doctor in their community.[32] Among eleventh grade students, 48.7% self-report ever having been "high" from drug use (compared to 38.3% in California overall), and 16.0% report having used prescription painkillers for non-medical reasons (compared to 19% in California overall).[33]

7. **Oral Health:** Tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.

   In Marin County, oral health is impacted by a lack of access to dental insurance coverage. Among adults, 43.3% do not have dental insurance coverage and may find it difficult to afford dental care.[34] Among adults older than 65 years, 46.6% do not have dental insurance coverage.[35] Oral health care access also arose as a key theme in primary data; some key informants shared that oral health access may have increased slightly in West Marin with the Coastal Health Alliance's new full-time Dental Clinic, but it is still not enough, particularly for underserved populations. Additionally, key informants and focus group participants report that dental insurance is limited and specialty care is not affordable.

8. **Violence and Unintentional Injury:** Violence and injury is a broad topic that covers many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others.

   In Marin County, the data show that the core issues within this health need are related to injuries due to domestic violence, and key drivers of violence such as alcohol abuse. Among adults, 15.4% self-report having experienced sexual or physical violence by an intimate partner during adulthood (compared to 14.8% in California overall).[36] The injury rate due to domestic violence is 15.3 per 100,000 females age 10 and older (compared to 9.5 per 100,000 in California overall).[37]

The eight health needs that emerged as top concerns in Marin County highlight the importance that Marin County stakeholders give to addressing the social determinants of health in order to build a healthier and stronger community. Access to quality education, safe and affordable housing, and economic stability rose to the top of the list of prioritized health needs. This list of health needs

[30] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[31] California Healthy Kids Survey, 2013-2014.
[32] RxSafe Marin County Survey, 2015.
[33] California Healthy Kids Survey, 2011-13.
[34] California Health Interview Survey, 2009.
[35] California Health Interview Survey, 2013-14.
[36] California Health Interview Survey, 2009.
[37] 3-year averages for 2011-2013 generated using the California EpiCenter data platform for Overall Injury Surveillance, 2011-13.

underscores the importance of multi-sector collaboration and cross-cutting strategies that address multiple health needs simultaneously.

In addition to the supporting data presented for each identified health need, several cross-cutting themes emerged in primary data that speak to a broader consideration of community structure and cohesion. In working towards equal opportunities for people to lead safe, active, and healthy lifestyles, Marin residents and key stakeholders cited challenges of social cohesion and racism that impact specific populations within the county and the community as a whole. Themes emerged from conversations with residents and stakeholders about distrust in law enforcement in some communities, as well as social isolation and a lack of support for many residents.

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

Marin County has a rich network of community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of community resources available to respond to each community identified health need, as identified in qualitative data, are indicated in each health need profile in Appendix A. For a more comprehensive list of community assets and resources, please call 2-1-1 or reference http://211bayarea.org/marin/.

VII. KFH—SAN RAFAEL 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH—San Rafael'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 Rafael 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 Rafael in the 2013 Implementation Strategy Report.

1. Mental health
2. Substance abuse
3. Access to health care/medical homes/health care coverage
4. Socioeconomic status (income, employment, education level)
5. Healthy eating and active living (nutrition/healthy food/food access/physical activity)
6. Social supports (family and community support systems and services; connectedness)
7. Cancer
8. Heart disease

KFH—San Rafael 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 Rafael 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 Rafael had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH—San Rafael 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 Rafael awarded 137 grants totaling $1,216,640 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 the KFH San Rafael service area. During 2014-2015, a portion of money managed by this foundation was used to award 35 grants totaling $242,765 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 Rafael 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 Rafael

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 CARE

Long Term Goal:

- Increase the number of individuals who have access to and receive appropriate health care services in the KFH-San Rafael service area.

Intermediate Goal:

- Increase the number of low-income people who enroll in or maintain health care coverage.
- Increase access (insurance coverage, a medical home, and regular preventive appointments) to culturally competent, high-quality health care services for low-income, uninsured individuals.

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: 7,005 Medi-Cal members* • *2015: 6,492 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 - $1,810,021* • *2014: 1,974 Applications approved* • *2015: KFH - Dollars Awarded By Hospital - $1,692,191* • *2015: 1,947 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: 1,662 members receiving CHC* • *2015: 1,784 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 49 active KFH grants totaling $633,028 addressing Access to Care in the KFH-San Rafael service area.[38] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 15 grants totaling $102,211 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Rotacare - Bay Area	$10,000 in 2015	RotaCare Clinic of San Rafael provides episodic care, diagnoses, and referrals for continuing care. For patients with chronic conditions, RotaCare is a portal to other medical clinics, including Marin Community Clinic. The clinic of San Rafael currently operates out of the KFH-San Rafael medical office building Mondays and Thursdays, 5:30pm-8:30pm. It has an all-volunteer staff	From July 1 to November 30, 499 patients (of an anticipated 1,500 for the year) were served for a total of 800 visits; 494 were seen for an acute diagnosis (755 visits), nine for a chronic condition, and two for other reasons.

[38] 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.

		of 177 that includes doctors, nurses, pharmacists, interpreters, and other medical professionals.	
Redwood Community Health Coalition (RCHC)	$400,000 (over two years; $190,498.85 in 2015) This grant impacts five KFH hospital service areas in Northern California Region.	This grant will strengthen core infrastructure to increase access to high-quality care for underserved patients and communities served by health centers; support health centers to continually improve operational capabilities, coordination of care, and workforce development; and support the Triple Aim infrastructure and management of the health center Accountable Care Organization (ACO).	RCHC has 6,685 PHASE patients and outcomes include: • increased health coaching skills among consortia/clinic staff using a comprehensive training/coaching program; 40 people were trained and three trained as trainers • participated in a county-wide committee with leaders from the county's major health care delivery systems to develop an approach to reduce heart attacks and strokes; all leaders agreed to base the county-wide strategy on the PHASE clinical guidelines • worked with other delivery systems to create data sharing agreements and identify which data sets can be shared across systems • improved parts of a learning community to share promising practices with clinics; added PHASE resources to program website
*Operation Access (OA)	$300,000 This grant impacts 14 KFH hospital service areas in Northern California Region.	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 341 procedures were performed on 159 low-income and uninsured patients at OA events at KFH San Rafael in 2014 and 2015.
Redwood Community Health Coalition (RCHC)	$250,000 This grant impacts two KFH hospital service areas in Northern California Region.	RCHC is a network of 18 community health centers (CHCs) serving 242,000 patients. Grant will strengthen core infrastructure to increase access to high-quality care for underserved patients served by CHCs; support CHCs to continually improve operational capabilities, coordination of care, and workforce development; support Triple Aim infrastructure; and support management of the local Accountable Care Organization (ACO), Redwood Community Care Organization (RCCO).	RCHC achieved the following outcomes: • enrolled 3,660 clients in health coverage programs, exceeding target for Covered California enrollments • developed a health information exchange (HIE) that its CHCs populated with more than 120,000 records • will connect local HIE to a regional HIE where continuity of care records will be exchanged to facilitate treatment In addition, RCCO successfully reported all clinical quality indicators to CMS in 2015 for the

			Medicare Shared Savings Affordable Care Organization's 2014 performance year. Highlights include: • scored above 90th percentile for How Well Your Doctors Communicate, Patients' Rating of Doctor, and Health Promotion and Education • scored above 90th percentile for Risk Standardized All Condition Readmissions • new quality measure for all CHCs, screening patients over 65 for risk of future falls • developing a multi-county project to integrate behavioral health into primary care and to increase care management across systems
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**	
Healthy Marin Partnership (HMP)	HMP's vision: "For Marin County to be a community of communities that creates and supports a culture of health; with social norms that make it possible for individuals to make healthy choices; where the incidence of killer diseases are less than state and national averages."	*US News and World Report* named Marin County as the healthiest county for children in America (June 2013). HMP is at the core of public health-related work in the county. From January 2015 to the present, HMP has been the core organizing agent for conducting Marin County's CHNA. KFH-San Rafael provides staff support and volunteers who serve on HMP steering and sub committees.	
HMP Community Health Needs Assessment (CHNA) Hospital Group	CHNAs let HMP study community conditions that foster ill-health. With a focus on upstream policies and practices that link social equity, community conditions, and access to resources as key determinants of health, HMP believes all Marin citizens regardless of education, income, address, or ethnic background should live long, healthy lives.	KFH-San Rafael CB Manager served on the Hospital Subgroup and worked with other area hospitals to complete the CHNA. This subgroup is working on common grant application processes; collective funding opportunities; and clear, directed practices to maximize community impact.	
Marin Health Funders	Collaborative includes Kaiser Permanente, Marin Community Foundation, First 5, County of Marin, and Peter Haas Jr. Family Foundation. On a quarterly basis, it convenes public and private entities that fund health programs and strategies in Marin County to network, exchange information, and coordinate grant making activities.	Marin Health Funders works to coordinate and to leverage funding opportunities to achieve more impactful outcomes in Marin County. Key activities include: • Participating in strategic planning efforts • Strategizing on issues of common concern • Coordinating funding to organizations of mutual interest Marin Community Foundation provides administrative and in kind staff support to the group.	
In-Kind Resources Highlights			

Recipient	Description of Contribution and Purpose/Goals
American Heart Association (AHA)	Marin-Sonoma Area Senior VP & Area Manager is an AHA-North Bay Division board member; a National Emergency Cardiovascular Care Committee member; and a Western States Affiliates board member. Former CB Manager was on the Sonoma/Marin County Heart Walk Executive Leadership Team. Both provided leadership/volunteer support for the Go Red For Women luncheon and the AHA Heart Walks in Marin and Sonoma counties. More than 4,000 Northern California Kaiser Permanente employees participated in 2015 AHA Heart Walks, helping raise $280,400 to fight against heart disease and stroke. More than 300 KFH-San Rafael and KFH-Santa Rosa employees, friends, and family members joined the North Bay Heart Walks in 2015, which raised close to $17,000.
Operation Access	KP physicians and staff volunteered 519 hours of time serving low-income and uninsured patients at OA events at KFH San Rafael in 2014 and 2015.
Community Benefit grantees from Kaiser Permanente, Sutter, St. Joseph Health System, County of Marin, and County of Sonoma	In October and December 2015, Kaiser Permanente Community Benefit partnered with health care organizations and county public health departments in Marin and Sonoma counties to help local nonprofit organizations plan, conduct, and evaluate federally mandated CHNAs. Aiming to "de-mystify" the new CHNA requirement and help strengthen local nonprofit programs, Kaiser Permanente collaborated with Sutter Health Novato and Marin General Hospital to host a Community Benefit Grantee Development Day at Marin County Office of Education in October. More than 30 participants (representing Community Benefit grantees from local hospitals) attended the half-day workshop. The facilitator, from evaluation consulting firm Harder + Company, presented key components for using CHNA as a valuable decision-making and strategic planning tool. Among participants, 100% agreed that the workshop was valuable to their work and 80% strongly agreed that "As a result of the training," they were "better prepared to participate in impact evaluation."
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 Goal:

- Increase healthy eating and physical activity among youth in the Canal area of San Rafael, Marin City, southern Novato, and low-income communities of Petaluma and Sonoma Valley.

Intermediate Goal:

- Increase healthy eating among youth in the Canal area of San Rafael, Marin City, southern Novato, and low-income communities of Petaluma and Sonoma Valley.
- Increase youth physical activity in community and institutional settings (e.g., safe walking and biking routes, parks and hiking trails, joint use of school recreational facilities).

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 44 active KFH grants totaling $286,502 addressing Healthy Eating and Active Living in the KFH-San Rafael service area.[39] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 10 grants totaling $67,470 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Old Adobe Unified School District	$25,000 in 2015 (even split with KFH Santa Rosa)	Free daily lunches, snacks, and physical activities, including soccer, tennis, and SPARK (Sports, Play, and Active Recreation for Kids) during the district's Summer Scholars program.	As of Dec. 1, 2015: • 4,124 students received free meals during summer camp (an increase from 1,279 the previous year) and 1,886 received free snacks • 150 youth 6 to 12 attended soccer camp • 85 played tennis during the school year • 170 took part in daily Spark activities

[39] 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.

Agricultural Institute of Marin	$15,000 in 2015	Supports the campaign (specifically, critical pre-development and planning tasks) for the Market Hall & Canopy, a permanent marketplace for Marin Farmers Market, which serves all Marin residents, including low-income community members, children and youth, and seniors.	The market serves a weekly average of 400 farmers and small business owners, 10,000 to 15,000 shoppers, 900 low-income residents through the Market Match program, and 1,000 students with educational tours. When the Canopy is completed, it's anticipated that these numbers will increase by at least one-third due to the additional market day.
*Playworks	$95,000 in 2015 This grant impacts eight KFH hospital service areas in Northern California Region.	Supports Junior Coach Leadership Program in 70 low-income elementary schools in 10 Northern California school districts. Fourth and fifth grade students will be trained to support active play at recess, proactively encourage participation by all students, and identify and help resolve conflicts. The goal is an overall decrease in bullying and an increase in cooperation and physical activity among elementary students.	Expected reach is 1,050 individuals; expected outcomes include: • improved social and emotional learning competencies of participating junior coaches • increased physical activity and problem-solving skills among participants increased physical activity at recess leads to decreased physical and verbal conflicts among students
*Golden Gate National Parks Conservancy	$300,000 (over two years) $150,000 in 2015 This grant impacts 14 KFH hospital service areas in Northern California Region	Golden Gate National Parks Conservancy and Institute at the Golden Gate will coordinate the Healthy Parks Healthy People (HPHP) Bay Area program, a collaborative of park and health agencies designed to increase the accessibility and use of parks for activities that promote health.	Expected reach is 10,000 people and expected outcomes include: • HPHP program leaders trained to run effective park programs that engage target populations, including low-income, ethnic minorities, high-risk youth, seniors, and those referred by health care and social service providers • to ensure long-term sustainability, at least one person at each park agency is trained as an HPHP programming trainer • all nine Bay Area public health departments/ health systems actively prescribe HPHP for at-risk youth, seniors, ethnic minorities, and low-income community residents • an HPHP blueprint model/toolkit based on lessons learned in the Bay Area is created for other parts of California and the U.S.

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
HEAL Marin	A countywide initiative bringing residents and community partners together to create a	KFH-San Rafael staff served on and provided guidance/support to the steering committee and active living team. The collaborative

	roadmap to improve healthy eating and active living wherever Marin residents live, learn, work, and play.	developed and distributed *Strategic Framework*, a HEAL initiative road map for improving community health in the county.
Health Funders of Marin/HEAL Funders	Collaborative includes Kaiser Permanente, Marin Community Foundation, First 5, County of Marin, and Peter Haas Jr. Family Foundation. On a quarterly basis, it convenes public and private entities that fund health programs and strategies in Marin County to network, exchange information, and coordinate grant making activities.	Marin Health Funders works to coordinate and to leverage funding opportunities to achieve more impactful outcomes in Marin County. Key activities include: • Participating in strategic planning efforts • Strategizing on issues of common concern • Coordinating funding to organizations of mutual interest Marin Community Foundation provides administrative and in kind staff support to the group. A HEAL funders meeting is planned for Jan. 2015.
In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Marin County Office of Education (MCOE); Marin County elementary schools	County of Marin Health and Human Services, Haas Foundation, MCOE, and KFH-San Rafael teamed up to design and develop an effective Thriving Schools program in Marin County. Results included implementing healthy nutrition and physical activity programs at five Marin County schools, and hiring a Wellness Coordinator at MCOE.	
Kaiser Permanente Educational Theater	In 2015, KPET held 10 events and 22 performances in Marin County schools. There were a total of 563 adult attendees and 7,970 students involved at 15 schools.	
Impact of Regional Initiatives		
Parks Initiative: The physical and mental health benefits of experiencing nature and outdoor physical activity are well-documented. Kaiser Permanente's investments in parks focus on increasing access to and use of safe parks and open spaces by low-income, underserved populations that have historically faced significant obstacles in accessing parks. By connecting people to parks, creating infrastructure enhancements in parks, and supporting policies to advance sustainability and improve culturally available services within park departments, we also aim to increase the competencies of local, regional, state, and national parks to effectively engage diverse communities. In addition to our monetary contributions, we are expanding volunteer opportunities in parks for Kaiser Permanente physicians and employees.		

PRIORITY HEALTH NEED III: MENTAL HEALTH
Long Term Goal: • Improve mental health outcomes among high-risk populations in the KFH-San Rafael service area.
Intermediate Goals: • Improve management of mental health symptoms among high-risk populations. • Decrease risks for mental, emotional, and behavioral disorders among high-risk populations • Improve integration of primary care and behavioral health for high-risk populations.

Grant Highlights			
Summary of Impact: During 2014 and 2015, there were 23 active KFH grants totaling $202,574 addressing Mental Health in the KFH-San Rafael service area.[40] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 2 grants totaling $13,095 that address this need. These grants are denoted by asterisks (*) in the table below.			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Canal Alliance	$40,000 over 2 years $20,000 in 2014 & 2015	This program provides free, community-based, culturally and linguistically competent behavioral health services for at-risk, low-income, Spanish-speaking Latino residents in Marin who are ineligible for other behavioral health services.	The program reached a total of 1,226 low income Latino immigrants, including 846 through Promotora Community education and Outreach. 171 received strength-based, client-centered case management and mental and behavioral health support.
Novato Youth Center	$20,000 in 2015	The Center's Behavioral Health Promotion program aims to increase access to culturally competent, early intervention substance abuse services and ongoing mental health treatment services for low-income and/or at-risk youth by partnering with Marin Community Clinics to provide integrated, coordinated care during a weekly Teen Clinic. The program also works with eight peer health promoters (PHPs) from two high schools.	Goal was to reach 738 clients. By December, 274 youth received services at Teen Clinic or at school; 80 were screened and 72 received at least one session of brief intervention counseling. In a first time partnership with Novato High School, the program served Spanish-speaking "newcomer" students. Six sessions held for groups of boys and a group of girls. Teen Clinic provided reproductive health or counseling services. Among youth who participated in at least three brief intervention sessions, 81% reported increased wellbeing. Trainings were delivered on reproductive health topics, the role of PHPs, public speaking, coping with stress, and dating violence and sexual assault prevention.
Jewish Family and Children's Services (JFCS)	$15,000 in 2014	JFCS' BOOST (Behavioral Options Optimize Senior Transitions) program provides in-home assessment, outreach, and early intervention and service linkages for Marin County seniors at risk for mental health decline.	286 individuals received education regarding identifying and referring seniors at risk, as well as tools to manage depression. Those trained included caregivers, seniors and firefighters. 168 older adults were screened for depression, and of those 41 individuals received short term treatment services through BOOST.
Center for Domestic Peace (C4DP)	$10,000 in 2014	Help protect domestic violence (DV) victims who call C4DP's 24/7 hotlines by providing them safety planning, compassionate support, DV information and referrals, and links to C4DP's emergency shelter.	4,140 hotline callers received support and resources to help increase their safety. 111 women and 126 children gained entrance to C4DP's emergency shelter and had their needs met through C4DP's emergency shelter and

[40] 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.

			other supportive services (food, clothing, transportation, etc.). Of those who exited the shelter, 41% of adult shelter residents found permanent housing within six months of program entry. An additional 24% exited to transitional housing, where they would receive further assistance stabilizing their lives and securing permanent housing. 79% either maintained or increased their income from shelter entry to exit.
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**	
Community Health Initiative of the Petaluma Area (CHIPA)	CHIPA is an advisory committee of Petaluma Health Care District's board of directors and the local Health Action chapter. Through collaboration, partnership, and alignment with Health Action, CHIPA provides leadership in identifying local community health priorities and taking action to engage in policy, system, and environmental change to improve local health outcomes.	KFH-San Rafael's Director of Diversity, Linguistics, and ADA Services and Community and Government Relations Manager serve on the CHIPA steering committee and mental health subcommittee.	
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
Kaiser Permanente Educational Theater	In 2015, KPET held 10 events and 22 performances in Marin County schools. There were a total of 563 adult attendees and 7,970 students involved at 15 schools.		

PRIORITY HEALTH NEED IV: SUBSTANCE ABUSE
Long Term Goals: • Decrease number of youth who use tobacco or abuse alcohol and drugs.
Intermediate Goals: • Increase access to culturally competent substance abuse prevention and treatment services for low-income, at-risk youth. • Increase access to resiliency programs for low-income youth at-risk for alcohol and substance abuse or DUIs. • Increase policies, and their enforcement, to decrease use of tobacco, alcohol, and other drugs (ATOD) among youth.
Grant Highlights
Summary of Impact: During 2014 and 2015, there were 9 active KFH grants totaling $64,050 addressing Substance Abuse in the KFH-San

Rafael service area.[41]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Huckleberry Youth Programs	$40,000 over 2 years $20,000 in 2014 & 2015	Project aims to increase access to culturally competent substance abuse prevention and treatment for 300 low-income, at-risk Marin County youth 12 to 21.	Within the 2 year grant period, 513 low income youth and young adults were served, including 359 youth screened at Huckleberry's Teen Tuesday clinic; 133 engaged in brief intervention counseling (individual and/or group); 131 participated in outpatient treatment, 52 received case management services; and 100% were linked for additional resources.
San Geronimo Valley Community Center	$8,500	West Marin Healthy Kids provides services and resources to reduce the number of youth in rural West Marin communities who use tobacco, drugs, and alcohol. It offers increased access to substance abuse prevention and treatment services, healthy alternatives and recreational activities, job development, leadership opportunities, and various in-school and afterschool programs for middle and high school youth.	From July 1 to November 30, 200 youth were reached. Students in grades 6 to 8 are enrolled in Emotional Literacy classes supervised by a clinical MFT (marriage and family therapist). Afterschool programs include youth internships, individual case management and referrals, and engagement with Youth Leadership Institute. A family advocate (MFT intern) and MFT provide support and referrals to youth and families whose lives are affected by substance abuse.
Novato Youth Center	$20,000 in 2014	Project will train and support promotores to engage in community mobilization, environmental prevention strategies, and policy change to reduce youth alcohol and other drug (AOD) use in conjunction with Novato Blue Ribbon Coalition for Youth.	949 Youth, particularly those challenged by language and/or cultural barriers, poverty, or limited or no insurance were reached through outreach, screening and brief behavioral health counseling. Promotores and staff attended refresher training on best practices related to Social Health Ordinance, participated in two Coalition meetings attended by Novato Police Department, participated in four live radio broadcast in Spanish, discussed underage drinking and mental health issues related to alcohol and other drug use.
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**	
Rx Safe Marin	RxSafe Marin is a grassroots community initiative working to address and decrease prescription drug misuse and abuse through measurable strategies and 12-month action	• community-wide survey of knowledge, attitudes and beliefs • social media campaign and RxSafe website established • community coalition forums, town halls, city councils, school groups	

[41] 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.

	plans that address factors across the continuum.	• CURES data analyses of prescribing practices countywide • development of "report card" with data from multiple sectors to describe and provide a benchmark for tracking progress • countywide prescriber survey for practice norms and knowledge gaps • countywide ordinance for a Pharma-funded system for safe disposal of unwanted medications • letters from District Attorney to prescribers identified as prescribing to people arrested for prescription drug violations • prescription drug abuse awareness presentations to sheriff's department and police chiefs • countywide standards to support safe pain medication prescribing in emergency rooms and primary care clinics • registration drive for prescribers to enroll into CURES; pilot to distribute lock boxes for safe home storage of medications • CME training for prescribers countywide • pilot to track naloxone distribution, use, and results among high-risk clients at Marin Treatment Center • increase rehabilitation and outpatient detox services • community-wide convening drew 120 attendees who identified additional partners and strategies • California Health Care Foundation identified RxSafe Marin as a mentor county to work with other California counties struggling with developing local strategies to address this issue
In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Rx Safe Marin	RxSafe Marin is a grassroots community initiative working to address and decrease prescription drug misuse and abuse through measurable strategies and 12-month action plans that address factors across the continuum. KP has donated both staff time and funding to support the group's efforts.	

PRIORITY HEALTH NEED V: 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 12 Workforce Development grants totaling $30,486 that served the KFH-San Rafael service area.[42] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $28,647 that address this need. In addition, KFH San Rafael provided trainings and education for 7 residents in their Graduate Medical Education program in 2014 and 7 residents in 2015, 10 nurse practitioners or other nursing beneficiaries in 2014 and 10 in 2015, and 18 other health (non-MD) beneficiaries as well as internships for 20 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.			
Grant Highlights			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
*Vision Y Compromiso	$98,093 This grant impacts 16 KFH hospital service areas in Northern California Region	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities • increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks
*Stiles Hall	$75,000 This grant impacts all KFH hospital service areas in Northern California Region	Stiles' Experience Berkeley Program aims to promote admission of low-income, first-generation students of color, specifically Black, Latino, and Native American high school students, to University of California Berkeley (UCB) through mentorship by UCB students and admissions officers, academic counseling, and active recruitment of underrepresented high school and community college students.	Anticipated outcomes for the 260 mentored Experience Berkeley students include: • 100% of mentees apply for admission to UCB • 52% UCB admission rate for high school program participants • 87% UCB admission rate for community college program participants • 65% of those admitted from high school will attend UCB • 95% of those admitted from community college will attend UCB • 3.3 average GPA and maintained by program participants (vs. 2.9 GPA for underrepresented minority students not in program)
*San Francisco State University (SFSU) Health Equity Initiative	$99,211 This grant impacts 13 KFH hospital	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	Anticipated outcomes include: • design/implement new curricula for three core courses (health equity, social determinants of

[42] 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.

	service areas in Northern California Region	the first two years of college. Initiative will develop new health equity and career readiness content for the Metro Health Academy curriculum to diversify the health care workforce in the 10-county Bay region.	health, and history of health) for 350 Metro Health Academy students • develop/disseminate video modules to train Metro faculty in the new curricula • develop a webpage to share curricula with faculty from other institutions in the region
*Students Rising Above (SRA)	$50,000 This grant impacts 15 KFH hospital service areas in Northern California Region	SRA's College2Careers program enables low-income, first-generation college students from the greater Bay Area to attain college degrees and enter careers in science, technology engineering and math (STEM) and health care through college preparation, college and financial aid application support, tutoring, health care, tuition assistance, career development, mentoring, internships, and college-to-workforce transition support.	Anticipated outcomes include • through College2Careers' tutoring workshops and webinars, 182 youth in SRA's College and Workforce Success Program gain the job readiness skills and knowledge needed for STEM and health care careers • via online webinars and informational interview videos with professionals from underserved socio-economic communities, more than 200 users of the web-based resource College2CareersHub are encouraged to consider majoring in STEM/health care fields

PRIORITY HEALTH NEED V: 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	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	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

	Northern California Region.	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.	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, "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.*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center **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. APPENDICES

- **A. Health Need Profiles**
- **B. Secondary Data, Sources, and Years**
- **C. Community Input Tracking Form**
- **D. Primary Data Collection Protocols**
- **E. Prioritization Scoring Matrix**

Marin County Community Health Needs Assessment

Obesity and Diabetes

Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent some of the leading causes of death nationwide.[1] Although some indicators demonstrate better health In Marin County than California State on average, there is still a high prevalence of adults and youth in Marin County who are overweight or obese. Data also indicate that Marin County residents have a higher risk of heart disease compared to California residents on average, and that they experience limited access to affordable healthy food. Primary data corroborates lack of healthy and affordable food as a need, and issues related to healthy eating and active living arose as key themes in focus groups and interviews. Low-income residents, older adults, and youth are also disproportionately face barriers to healthy eating and active living.

Key Data

Indicators

Percent of Adults Obese (BMI > 30.0)[2]

Marin: 17.5 California: 22.3

Percent of Youth (Grades 5, 7, 9) Obese (BMI > 30.0)[3]

HP 2020 Goal: ≤ 16.1%

Marin: 8.9 California: 19.0

Diabetes Prevalence[4]

Age-adjusted; Adult

Marin: 5.5 California: 8.1

> **"We are seeing more awareness when we are talking about healthy eating and exercise."**
>
> **– Interviewee**

> **"In Marin County, overall the county is very healthy, but there are pockets of poverty where the outcomes are not as good. When you drill down in those communities, like Marin City or the Canal, there are issues of access to grocery stores, and they have corner stores, liquor stores, or fast food places where unhealthy food is advertised."**
>
> **– Interviewee**

Key Themes from Qualitative Data

Economic Disparities Drive Health Disparities

- Few affordable grocery stores
- Healthy food options are more expensive than calorie dense, less nutritious options
- Stigma associated with accessing healthy eating resources such as food banks

Link Between Stress/Mental Health and Obesity

- Pace of life and reliance on technology as drivers of poor eating habits and exercise habits
- Healthy eating and active living as drivers of positive mental health outcomes

† Body composition is determined by skinfold measurements or bioelectrical impedance analysis for the calculation of percent body fat and/or Body Mass Index (BMI) calculation. The percent body fat "high risk" threshold is 27.0%-35.1% for boys and 28.4%-38.6% for girls, depending on age. The BMI "high risk" threshold is 17.5-25.2 for boys and 17.3-27.2 for girls, depending on age. These measures are based on the CDC's BMI-for-age growth charts, which define an individual as obese when his or her weight is "equal to or greater than the 95th percentile".

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Marin County Community Health Needs Assessment

Obesity and Diabetes (continued)

Supporting Data and Key Drivers

Supporting Data: Related Health Outcomes

Diabetes Mortality, Adult
Age-adjusted mortality rate per 100,000 population[5]

8.9 (Marin) | 20.8 (California)

Diabetes Prevalence, Older Adult
% of Medicare fee-for-service population with diabetes[6]

15.2 (Marin) | 26.6 (California)

Diabetes Hospitalizations
Rate of diabetes-related discharge per 10,000 discharges[7]

5.1 (Marin) | 10.4 (California)

Overweight, Adult
% of adults with BMI between 25.0 and 30.0[8]

30.8 (Marin) | 35.9 (California)

Overweight Youth
% of 5,7,9 grade with "Needs Improvement" for body composition[9]

16.3 (Marin) | 19.3 (California)

Stroke Mortality, Adult
Age-adjusted mortality rate per 100,000 pop.[10]

27.6 (Marin) | 37.4 (California)

Ischaemic Heart Disease Prevalence, Older Adult
% of Medicare fee-for-service population[11]

23.6 (Marin) | 37.4 (California)

Heart Disease Prevalence, Adult
% of adults with any kind of heart disease[12, *]

7.6 (Marin) | 6.1 (California)

Driver: Healthy Eating

Fruits and Vegetables, Adults
% adults consuming <5 servings of fruit and vegetables[13]

64.3 (Marin) |

WIC Authorized Food Stores
% of food stores authorized to accept WIC program benefits per 100,000 pop vegetables[14]

Low Food Access
% of population with low food access[15]

17.1 (Marin) |

71.5
Marin California

9.0 | 15.8
Marin California

14.3
Marin California

Fruits and Vegetables-Youth
% youth age 2-13 consuming <5 servings of fruit and vegetables [16]

50.1 |
47.4 Marin
California

*Unstable county estimate; findings should be interpreted with caution.

Marin County Community Health Needs Assessment

Obesity and Diabetes (continued)

Driver: Physical Activity

Adult Activity
% adults with no leisure time activity [17]

10.3 | 16.6
Marin California

Youth Activity
% of youth in Marin County who exercised vigorously for at least 20 minutes during 4 or more of the past 7 days [18]

75.0
% of 7th graders

67.0
% of 9th graders

54.0
% of 11th graders

Physical Environment
% population living ½ mile from a park [19]

68.0 | 58.6
Marin California

Youth Fitness
% youth in grades 5,7,9 with "high risk" or "needs improvement" aerobic capacity [20]

23.7 | 35.9
Marin California

"Having resources to eat right, to exercise— all the preventive things are luxuries for lower income folks."
– Interviewee

Driver: Clinical Care

Diabetes Management
% diabetic Medicare patients with HbA1c test [21]

84.1 | 81.5
Marin California

Driver: Social and Economic Risks

Food Insecurity
% population experiencing food insecurity[22]

11.5	16.2
Marin	California

Poverty and Food Access
% of low-income pop. with low food access[23]

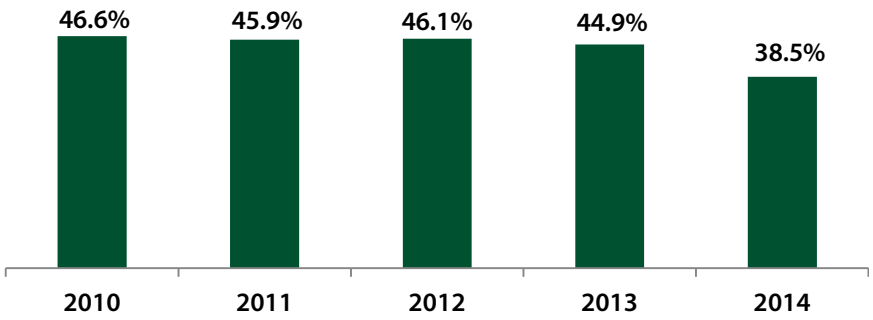
2.0	3.4
Marin	California

Marin County Community Health Needs Assessment

Obesity and Diabetes (continued)

Trends and Disparities

Percent of Adults Overweight or Obese in Marin County[24]



The percent of adults who are overweight or obese has been slowly decreasing over time since 2010. Monitoring this trend in future years is important to identify if the decline continues.

Populations with Greatest Risk in Marin County

Age disparities

Interviewees and focus group participants noted that older adults are disproportionately impacted by this health issue. Access to healthy food and the ability to maintain a healthy lifestyle are more limited for older adults, particularly those living on a fixed and low income.

Overall, trends in youth obesity in Marin County remain constant. While youth in focus groups emphasized that Marin County provides a supportive environment to make healthy dietary and lifestyle choices, interviewees noted that children and adolescents are a particularly vulnerable population because developing healthy habits during youth sets the foundation for healthy eating and active living during adulthood. One interviewee said, "I'm focusing more on adolescents, [with] a broader look at nutrition – where are they eating and how are they eating. I see more kids grabbing food whenever they can, even if it's healthy. They eat on the run a lot and then not at all. Eating habits, and when they eat as well, are important."

Targeted initiatives in specific school districts seek to reduce disparities in youth obesity. Evaluations of these programs may provide additional information about how youth weight status is changing over time.

Marin County Community Health Needs Assessment

Obesity and Diabetes (continued)

Examples of Existing Community Assets†

Clinics and Schools	Farmers Markets / Community Garden	Parks and Recreations
		

Community Recommendations for Change†

Changes in clinical care

- Increase linguistically and culturally appropriate services
- Increase nutritionist services in community clinics
- Change payment structure so that healthcare workers are not dis-incentivized to talk about upstream HEAL factors

Changes in built environment

- Increase education about HEAL for the whole family
- Increase safe places to exercise in low income communities
- Create more affordable exercise/gym facilities

† Assets and recommendations excerpted from qualitative data. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

[1] "Obesity Health Risks," Harvard School of Public Health, Obesity Prevention Source, accessed November 2015, http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/.
[2] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[3] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.

[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[5] California Department of Public Health, County Health Profile Marin County, 2011-13.
[6] Centers for Medicare and Medicaid Services, 2012.
[7] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011.
[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[9] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[10] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[11] Centers for Medicare and Medicaid Services, 2012.
[12] California Health Interview Survey, 2013-14.
[13] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2005-09.
[14] US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
[15] US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2010.
[16] California Health Interview Survey, 2011-12.
[17] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[18] California Healthy Kids Survey, 2013-14.
[19] US Census Bureau, Decennial Census. ESRI Map Gallery, 2010.
[20] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[21] Dartmouth College Institute for Health Policy and Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[22] Feeding America. Child Food Insecurity Data, 2012.
[23] US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2010.
[24] California Health Interview Survey, 2010-14.

Marin County Community Health Needs Assessment

Education

Educational attainment is linked to health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthier behaviors, experience better health outcomes, and raise healthier children.[1] While some education outcomes, such as high school graduation rate, are higher for Marin County than the rest of California, disparities, particularly among English Language Learners, African American, and Latino students, indicate that education is a high concern in the county. In secondary data, English Language Learners are less likely to pass the high school exit exam in Math and English Language Arts compared to their peers in Marin County and compared to English Language Learners on average in California. In primary data, community members and key stakeholders highlighted education as an important health need and recommended strategies to improve county-wide access and decrease disparities such as increasing investment in early childhood education.

Key Data

Indicators

Percent of Children (age 3-4) Enrolled in School[2]

California: 47.8 Marin: 66.2

Percent of Third Grade Children in Public Schools Scoring at or Above the "Proficient" Level on English Language Arts California Standards Test[3]

California: 45.0 Marin: 66.0

Percent of Cohort Graduating from High School[4]

HP 2020 Goal: ≥ 82.4

California: 80.4 Marin: 91.4

"We're making strides in expanding early childhood education [ECE] in Marin City because high school graduation rates can be linked to ECE so we have to move upstream, starting from parents ability to care for their children and institutional partners that can provide excellent services for young folks so they're fully developed."

– Interviewee

Key Themes from Qualitative Data

- **The educational gap is wide for immigrants and English-language learners.**
- **There is a need for more awareness around bullying in schools.**
- **Students feel a great deal of pressure to succeed academically.**
- **College courses are expensive and unattainable for many, particularly undocumented immigrants.**

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Education (continued)

Supporting Data

Early Childhood Education

Head Start programs rate
% of children enrolled in Head Start, per 10,000 children under age 5.[5]

Marin	California
6.5	6.3

English Language Learners

English Language Performance (Grade 10)
% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts[6]

Marin: All	Marin: ELL	California: ELL
89.0	26.0	38.0

Math Performance (Grade 10)
% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in Math[7]

Marin: All	Marin: ELL	California: ELL
90.0	37.0	54.0

Retention/Discipline

Expulsion
Rate of expulsion per 100 enrolled K-12 public school students[8]

Marin	California
0.01	0.05

Suspension
Rate of suspension per 100 enrolled K-12 public school students[9]

Marin	California
2.1	4.0

Bullying

Bullying
Percent of 11th grade students reporting harassment or bullying on school property within the past 12 months for any reason.[10]

Marin	California
24.7	27.6

Post-Secondary Education

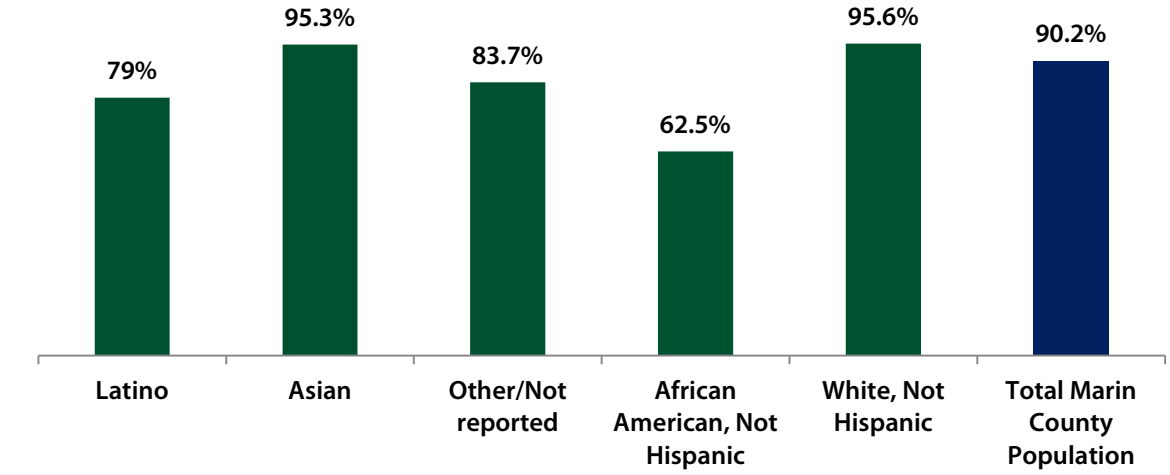
Population Educational Attainment
% of population age 25+ with Associates Degree or higher[11]

Marin	California
60.9	38.4

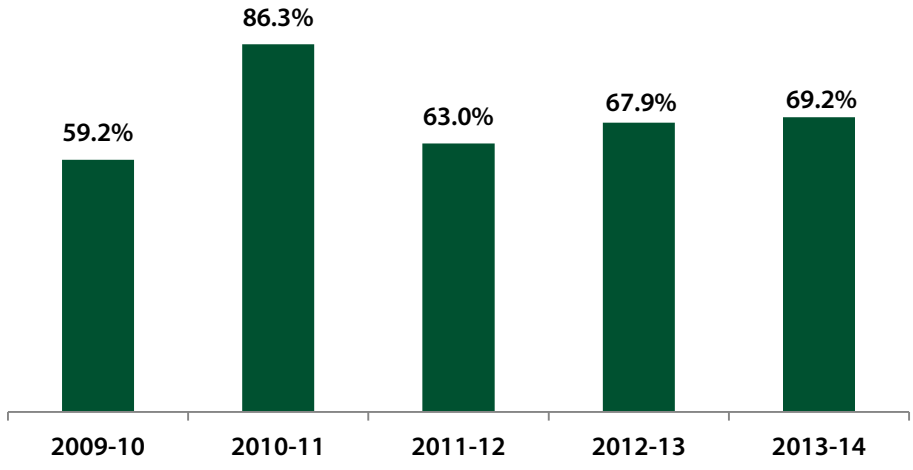
Education (continued)

Populations Disproportionately Affected

Cohort High School Graduation by Race/Ethnicity in Marin County (2011-12)[12]



Percent of Cohort Graduating High School Among English Language Learner Students in Marin County[13]



Disparities in education attainment persist in Marin County. In particular, African American and Latino students have are less likely to graduate high school with their cohort. English Language Learners are also less likely to graduate in four years; this trend is increasing overall since 2009-10.

"Student achievement for low-income students and students of color in Marin falls far below the achievement of more advantaged students in the County. The gap in achievement begins at an early age and increases over time."[14]

Marin County Community Health Needs Assessment

Education (continued)

Assets and Recommendations

Examples of Existing Community Assets†

School Districts

First 5 Commission

Community Organizations/Collaboratives

Community Recommendations for Change†

- Take a cross-sectorial approach and collaboration to close gaps in educational attainment (e.g., public sector, schools, philanthropy, nonprofit, business communities, etc.)
- Change approaches to addressing needs from a single-issue perspective to a holistic perspective—recognizing that housing, economic security, access to health insurance, and education are inter-related and impact health.
- Support and target resources for universal preschool—early childhood education is essential for future educational success.

† Assets and recommendations excerpted from qualitative data. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

[1] "Exploring the Social Determinants of Health: Education and Health," Robert Wood Johnson Foundation, Accessed October 19, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447.
[2] US Census Bureau, American Community Survey, 2014.
[3] California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013.
[4] California Department of Education, 2013.
[5] US Department of Health & Human Services ,Administration for Children and Families. 2014.
[6] California Department of Education, 2013-14.
[7] Ibid.
[8] California Department of Education, 2013.
[9] Ibid.

[10] California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd), 2011-13.
[11] US Census Bureau, American Community Survey, 2009-13.
[12] California Department of Education, 2011-13.
[13] California Longitudinal Pupil Achievement Data System (CALPADS), 2009-2014.
[14] Marin Community Foundation, School Readiness in Marin County, 2014.

Economic & Housing Insecurity

Economic security is very strongly linked to health; having limited economic resources can impact access to opportunities to be healthy, including access to healthy food, medical care, and safe environments.[1] In addition to good paying jobs, access to stable and affordable housing is also an essential foundation for good health. Substandard housing and homelessness tends to exacerbate other physical and mental health issues. High cost of living contributes to both economic and housing issues. In Marin County, the cost of living is higher in the county than California average, as is the Gini Coefficient of Income Inequality, revealing blind spots in traditional poverty measures. Additionally, 1,309 individuals are homeless, 835 of which are unsheltered.[2] Lack of affordable housing was a key issue raised by community residents and stakeholders. Furthermore, reports indicate that the low-income Canal neighborhood of San Rafael and the African American population in Marin City face risk of displacement due to gentrification.[3,4]

Key Data

Indicators

Percent of Renters Spending 30% or More of Household Income on Rent[5]

Marin: 56.0 California: 57.2

Percent of Population Living Below 200% Federal Poverty Level[6]

Marin: 19.4 California: 35.9

HUD-Assisted Units (per 10,000 housing units)[7,†]

Marin: 351.0 California: 368.3

> "Marin tied for the most expensive housing - as San Francisco and New York City. What that means is that people who are most vulnerable get squeezed out. They are already in the worst housing, and as rent goes up with no rent control, [and stifled development], more people are getting squeezed out. People come from San Francisco, but people who were living in Marin, the working poor, they are pushed out."
>
> – Interviewee

> "It's the combination of pay, no housing, and the limits on development. More and more people have housing insecurities. Then they can't address other health issues or take care of basic needs like buying medication."
>
> – Interviewee

Key Themes from Qualitative Data

Lack of affordable housing

- Increase in cost of housing
- Overcrowded housing
- Increase in homelessness
- Housing affordability tied to income inequality

Employment Opportunities

- Strong economy in Marin, though jobs are limited and service jobs pay minimum wage
- Lack of transportation to jobs

† Reports counts of all housing units receiving assistance through the US Department of Housing and Urban Development (HUD). Assistance programs include Section 8 housing choice vouchers, Section 8 Moderate Rehabilitation and New Construction, public housing projects, and other multifamily assistance projects. Units receiving Low Income Housing Tax Credit assistance are excluded from this summary. This measure does not indicate the need for HUD-Assisted Units, which may be lower in Marin County than other parts of the state.

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Marin County Community Health Needs Assessment

Economic & Housing Insecurity (continued)

Supporting Data and Key Drivers

Supporting Data: Housing Quality

Vacant Housing Units

% of housing units that are vacant[8, †]

Marin	California
7.6	8.6

Overcrowded Rental Environments

% of renter occupied households with more than one person per room[9]

Marin	California
7.4	13.3

"Housing is not affordable, so there are families living with other families and multiple children sharing bedrooms. People cannot afford their own home to live here. This is a difficult situation, mentally and emotionally and leads to [poor] health outcomes as well."
– Interviewee

Supporting Data: Poverty and Unemployment

Gini Coefficient of Income Inequality is **0.5164** in Marin County, compared to 0.4782 in California State. This indicates a *more uneven distribution of income* among households in Marin County compared to across the state.[10]

Children in Poverty

% of children (age <18) living below 100% of Federal Poverty Level[11,††]

Marin	California
8.9	22.2

Older Adults in Poverty

% of adults (age 65+) living below 100% of Federal Poverty Level[12,††]

Marin	California
5.5	9.9

Unemployment Rate

% of civilian non-institutionalized population age 16 and older that is unemployed[13]

Marin	California
4.2	7.4

Driver: Education

Population with Less than High School Education

% population age 25+ with no high school diploma[14]

Marin	California
7.6	18.8

3rd Grade Reading Proficiency

% of all public school students tested in 3rd grade who scored proficient or advanced on the English Language Arts California Standards Test [15]

Marin	California
66.0	46.0

Driver: Cost of Living

Median Household Income[16]

$91k | **$61K**

Marin California

Living Wage

Annual income required to support one adult and one child[17]

$61k | **$53k**

Marin California

"If we address some of the housing and economic issues for people in poverty, their health outcomes change dramatically. It's not just talking about healthy eating. How do we change the economics?"

– Interviewee

† Vacant housing reported as an indicator of blight across the city. Research demonstrates links between foreclosed, vacant, and abandoned properties with reduced property values, increased crime, increased risk to public health and welfare, and increased costs for municipal governments. (U.S. Department of Housing and Urban Development, Evidence Matters, Winter 2014).

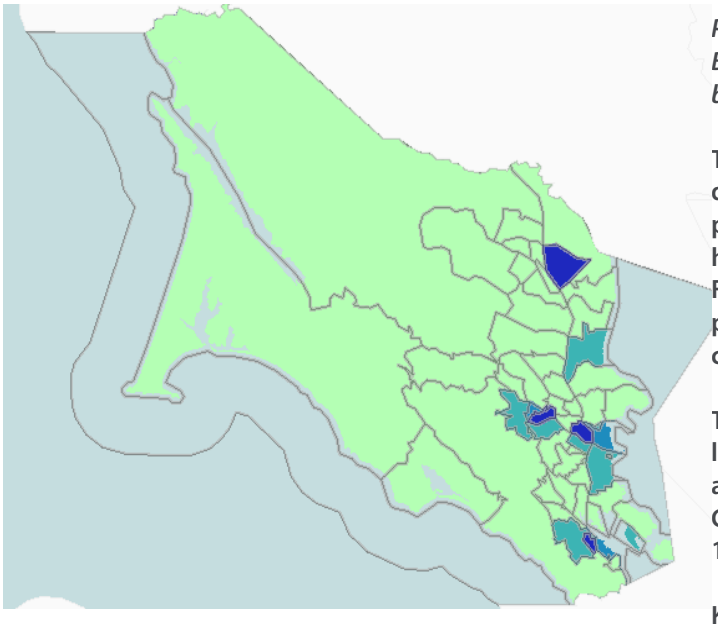
†† Due to high cost of living, income <100% of FPL indicates severe poverty in Marin County.

Marin County Community Health Needs Assessment

Economic & Housing Insecurity (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk in Marin County



Population of Children (Age 0-17) Living Below 50% of Federal Poverty Level, Percent by Tract[18]

The map displays extreme geographic disparities of children living in extreme poverty across Marin County. Given the high cost of living in the county, <50% of Federal Poverty Level indicates severe poverty that can have profound consequences on a child and their family.

The census tracks with >13% of children living below 50% of Federal Poverty Level are 1012 (Novato), 1121 (San Rafael: California Park), 1170 (San Anselmo), and 1290 (Marin City).

Key

- Over 13.0%
- 9.1 - 13.0%
- 5.1 - 9.0%
- Under 5.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed

Populations with Greatest Risk in Marin County

Interviewees and focus group participants emphasized those least able to afford quality housing are the low-income, aging, and youth populations and single mother families in Marin County, and particularly in Canal and West Marin.

Aging Population

- Older adults in Marin County are the "hidden poor," with limited, fixed incomes, but not eligible for federal support
- Caregivers can't afford to live in Marin County
- Increasing population of older adults who are homeless because they are priced out of the rental market

Youth

- Unsafe and overcrowded living environment places young people at risk for abuse
- Homeless youth need rehabilitation and residential substance treatment programs
- Abusive home environments lead to homelessness

Marin County Community Health Needs Assessment

Economic & Housing Insecurity (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Renaissance Center Marin (Job Development)

Wealth of Marin County

Marin City Community Development

Community Recommendations for Change†

Workforce development

- Support workforce development programs
- Develop employment options for older adults and people with disabilities
- Improve transportation support to jobs

Address rising costs of housing and living

- Political leadership (e.g., County and Health and Human Services) to direct resources towards innovative solutions to addressing affordable housing need (e.g., high-density housing with mixed-incomes and interdependent communities)
- Increase access to affordable child care

Strengthen educational opportunities

- Focus on early childhood education
- Work in collaboration with other sectors (e.g., schools) to break silos and address needs

† Assets and recommendations excerpted from qualitative data. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

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[1] **"Health & Poverty," Institute for Research on Poverty, Accessed October 19, 2015, http://www.irp.wisc.edu/research/health.htm.**
[2] **Marin County Homeless Point-in-Time Census and Survey, 2015.**
[3] **Marin Grassroots and Center for Community Innovation, UC Berkeley, "Canal: An Immigrant Gateway in San Rafael at Risk," 2015.**
[4] **Marin Grassroots and Center for Community Innovation, UC Berkeley, "Marin City: Historic African-American Enclave at Risk," 2015.**
[5] **US Census Bureau, American Community Survey, 2010-14.**
[6] **US Census Bureau, American Community Survey, 2009-13.**
[7] **US Department of Housing and Urban Development, 2013.**
[8] **US Census Bureau, American Community Survey, 2009-13.**
[9] **Ibid.**
[10] **Ibid.**
[11] **Ibid.**
[12] **Ibid.**
[13] **Ibid.**
[14] **Ibid.**
[15] **California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013.**
[16] **US Census Bureau, American Community Survey, 2009-13.**
[17] **Calculated from *livingwage.mit.edu*; 2015.**
[18] **US Census Bureau, American Community Survey, 2009-13.**

Marin County Community Health Needs Assessment

Access to Health Care

Access to comprehensive, affordable, quality physical and mental health care is critical to the prevention, early intervention, and treatment of health conditions. While Marin County scores better than the California state average with respect to many indicators measuring healthcare access, the county continues to work towards providing affordable and culturally competent care for all residents. This area was identified as a health need because indicators measuring the percent of insured population receiving Medi-Cal and the percent of kindergarteners with all required immunizations scored worse than state benchmarks, and because barriers to access including limited physicians accepting public insurance and limited access to specialty care were key themes in focus groups and interviews. With the implementation of the Affordable Care Act (ACA), a majority of adults in Marin County are able to access insurance coverage and access regular healthcare. However, disparities persist. Specifically, lower income residents have difficulty accessing specialty services and mental health services. Additionally, older adults in Marin County – specifically, the "hidden poor" – face challenges in accessing care.

Key Data

Indicators

Percent of Kindergarteners with All Required Immunizations[1]

HP 2020 Goal: ≥ 95%

Marin: 84.2 California: 90.4

Access to Primary Care Physicians[2]
Rate Per 100,000 Population

California: 77.3 Marin: 142.9

Access to Mental Health Providers[3]
Rate Per 100,000 Population

California: 157.0 Marin: 405.1

"Many physicians in Marin County are at capacity. They are more likely to fill their schedule with patients that are commercially insured because the payment rates are better."
–Interviewee"

I think mental health services still remain a real challenge and that's probably because of the lack of adequate compensation for medical services and the lack of service providers who are willing to see patients in our vulnerable communities who carry public insurance."
– Interviewee

Key Themes from Qualitative Data

- As a result of the Affordable Care Act, more Marin residents have health care coverage.
- Low-income residents lack access to mental health services, particularly outpatient services.
- It is more difficult for Medi-Cal patients to access specialty care services.
- There are limitations to dental coverage, it often does not cover prevention services.
- Providers who see low-income patients are at capacity.

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Marin County Community Health Needs Assessment

Access to Health Care (continued)

Supporting Data and Key Drivers

Supporting Data

Federally Qualified Health Centers
Rate per 100,000 population[4]

Marin	California
3.96	1.97

Lack of Primary Care Professionals
% of population living in a primary care health professional shortage area[5,†]

Marin	California
0	25.2

16,774
Number of approved Covered California applications in Marin County during first and second ACA enrollment periods (January 2014 - February 2015)[6]

Driver: Insurance

Uninsured Population, Adult
% of population without health insurance (age 18-64) [7]

Marin	California
9.7	17.3

Uninsured Population, Children
% of child population (<age 19) without health insurance[8]

Marin	California
2.7	5.4

Insured Population Receiving Medi-Cal
% of insured population receiving Medi-Cal[9]

Marin	California
19.5	14.0

Supporting Data: Indicators of Health Care Access and/or Utilization

Breast Cancer Screening
% of female Medicare enrollees with mammogram in past 2 years[10]

Marin	California
65.0	59.3

Pap Test
% of females age 18+ with regular pap test (age-adjusted) [11]

Marin	California
79.0	78.3

Colon Cancer Screening
% of adults age 50+ who self-report ever having had a sigmoidoscopy or colonoscopy (age-adjusted) [12]

Marin	California
70.0	57.9

Vaccinated Older Adults
% of adults age 65+ who have ever received a pneumonia vaccination[13]

Marin	California
64.3	63.4

Preventable Hospital Events
Preventable hospitalization rate among Medicare enrollees, per 1,000 population[14,††]

Marin	California
30.2	45.3

† Primary Care Health Professional Shortage Area (HPSA) is defined as an area with 3,500 or more people per primary care physician (U.S. Department of Health and Human Services, http://www.hrsa.gov/shortage/). As a note, there is no generally accepted ratio of physician to population ratio. Care needs of an individual community will vary due to a myriad of factors. Additionally, this indicator does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area.

†† This indicator reports the patient discharge rate for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients.

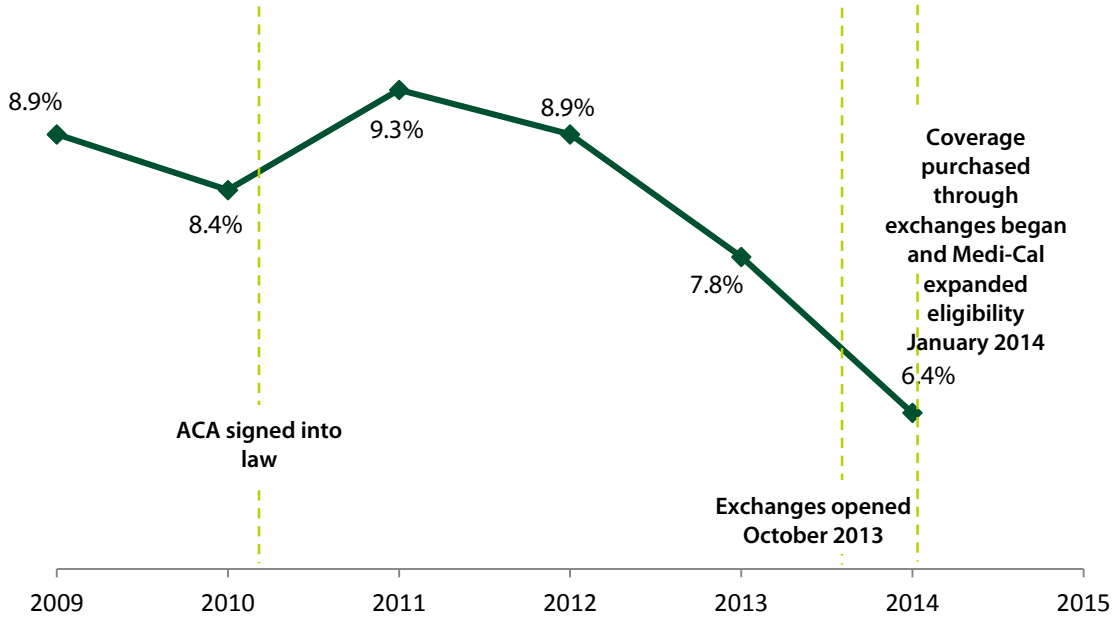
Marin County Community Health Needs Assessment

Access to Health Care (continued)

Trends and Disparities

Insurance Status Over Time in Marin County

Percent of Population Uninsured in Marin County [15]



This graph demonstrates yearly estimates of the percent of the total population in Marin County that was uninsured over the previous five years. Since the Covered California Insurance Exchange Marketplace opened in 2013 and coverage through Covered California plans began in 2014, the percent of the population that is uninsured has decreased to 6.4%.

While a greater percentage of the population is insured following health care reform implementation, focus group participants noted challenges to accessing care such as health centers that seem unable to meet high demands and a lack of transportation to health care.

"I think another challenge in Marin, is to go from San Rafael to Novato feels like you're going to New York. People in San Rafael don't know Novato is part of Marin County, and Sausalito and the west side, Point Reyes, is way over the hill. It's broken into pockets, which makes access difficult."
-Interviewee

Populations with Greatest Risk in Marin County

Age disparities

Older adults in Marin County, particularly the "hidden poor" have less access to health services as a result of isolation, lack of financial resources, and transportation issues.

Other disparities

Lower income residents have difficulty accessing care, particularly specialty care.

Marin County Community Health Needs Assessment

Access to Health Care (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Community Organizations (e.g., Whistlestop)

Community Clinics and Mobile Clinics

Community Recommendations for Change†

- Provide more specialist services
- Provide more mental health services, particularly outpatient services for lower income residents
- Develop models to encourage physicians to see patients with less profitable insurance
- Continue funding and support for adolescent health services
- Enhance transportation opportunities, particularly for older adults

† Assets and recommendations excerpted from qualitative data and Marin County CHNA Collaborative Input. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

[1] California Department of Public Health Immunization Branch, Immunization Branch, Kindergarten Assessment Results, 2014-15.
[2] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2012.
[3] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[4] US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2014.
[5] US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration, 2015.
[6] Marin County Department of Health and Human Services, 2015.
[7] US Census Bureau, American Community Survey, 2014.
[8] Ibid.
[9] Ibid.
[10] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[11] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[12] Ibid.
[13] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-12.
[14] Dartmouth Atlas of Healthcare, 2012.
[15] US Census Bureau, American Community Survey, 2009-2014..

Marin County Community Health Needs Assessment

Mental Health

Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.[1,2] Secondary data identified specific areas in which Marin County residents demonstrate higher need than California residents on average, including suicide rate, taking medicine for an emotional/mental health issue, and reporting needing mental health or substance abuse treatment among adults. Mental health was also raised as a key concern among community members and other key stakeholders, who discussed barriers to accessing treatment among other key themes. Mental health issues frequently co-occur with substance abuse and homelessness. Racial disparities in Marin County are evident, and the Latino population was highlighted in primary data as a population of concern. Youth, older adults and incarcerated individuals were also noted as particularly high-risk populations for mental health concerns.

Key Data

Indicators

Suicide Rate[3]

Age-adjusted; Per 100,000 Population

HP 2020 Goal: ≤ 10.2

California: 9.8 Marin: 12.8

Percent Taken Medicine for an Emotional/Mental Health Issue in the Past Year[4]

Taken for at least two weeks

California: 10.1 Marin: 15.6

> "The number one driver of health issues in Marin is a lack of access to mental health services. It is those services that are short of inpatient psychiatric care. Meaning, whether it's outpatient psychiatry or a group home or a halfway house or some type of not-locked inpatient unit, more than just seeing someone one hour a week—there's a spectrum of services that are needed and because we don't have them either at all or in a quantity that is even approaching adequate, problems are allowed to get worse and then what happens is people end up deteriorating. Then they need a locked inpatient psych unit."
>
> – Interviewee

> "There's a huge need for mental health support here."
>
> – Interviewee

Key Themes from Qualitative Data

Barriers to treatment

- Limited outpatient services
- Limited services along the spectrum of care
- Associated stigma, particularly among older adults and immigrants
- Non-acute needs are not met

Awareness

- Placed lower on hierarchy of needs or not grouped with primary care needs

Co-morbidity

- Co-occurrence with prescription drug use or alcoholism

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Marin County Community Health Needs Assessment

Mental Health (continued)

Supporting Data and Key Drivers

Supporting Data: Mental Health Among Older Adults

Depression, Older Adults

% of Medicare beneficiaries with depression[5]

Marin	California
11.2	13.4

Mental or Physical Disability

% of older adults living with a mental, physical, or emotional disability[6]

Marin	California
57.7	51.0

Supporting Data: Mental Health Among Youth

Depression, Youth

% of 11th grade students who felt sad or hopeless almost every day for 2 weeks or more[7]

Marin	California
26.7	32.5

Suicidal Thoughts, Youth

18.0%

of 11th graders in Marin County have seriously considered suicide in the past 12 months.[8]

Bullying, Youth

% of 11th grade students who report harassment or bullying on school property within the past 12 months for any reason [9]

Marin	California
24.7	27.6

"My daughter was bullied a lot, which is what started everything. No matter how much we complained to the school, it just seemed like there was never any assistance. They made it seem like it was her."

– Focus group participant

Driver: Access to Mental Health Care

Adults Needing Treatment

% of adults reporting need for treatment for mental health, or use of alcohol /drug[10, *]

Marin	California
19.5	15.9

Mental Health Providers

Rate of mental health providers per 100,000 population[11]

Marin	California
405.1	157.0

"The number one issue is access to care... It's not an evenly distributed problem. It is especially true when it comes to mental health services. We have more psychiatrists per capita than any other county but for indigent populations it is almost impossible to find a psychiatrist who will see you on an outpatient basis."

– Interviewee

Driver: Substance Abuse and Homelessness

Drug-Poisoning Deaths

39

Total number of deaths in Marin County due to drug-poisoning in 2011.[12]

Homelessness

1,309

Total number of homeless individuals in Marin County.[13]

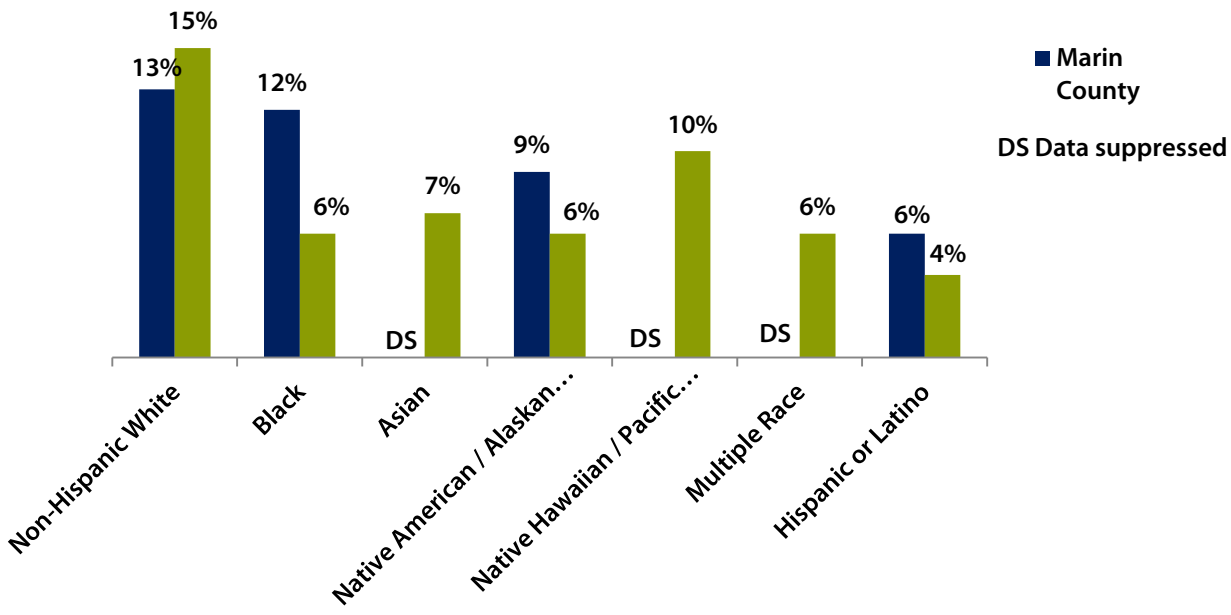
*Unstable county estimate; findings should be interpreted with caution.

Mental Health (continued)

Populations Disproportionately Affected

Populations with Greatest Risk in Marin County

Suicide Mortality by Race/Ethnicity in Marin County[14]



Other Vulnerable Populations Identified in Qualitative Data

Disparities by age:

- Children 0-5 years old are particularly vulnerable to stress and adversity.
- Older adults have less awareness or face greater stigmatization around mental health.
- Older adults living alone may have less social support.

Disparities by geography:

- Geographically isolated communities struggle to access resources.
- Residents of Canal were noted as a particular community at risk.

Disparities by race/ethnicity:

- Latino residents were noted as a population of particularly high risk in interviews and focus groups.

Other notable disparities:

- **Single parents are less likely to have time to access mental health services, and are more likely to experience high levels of stress.**
- **Immigrants suffer disproportionately from stigma in accessing services.**
- **Incarcerated individuals may not receive adequate mental health care.**

Mental Health (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Nonprofits

Support Groups

FQHCs / Safety Net Clinics / Wellness Clinics

Community Recommendations for Change†

Increase awareness:

- **Increase education about mental health to decrease stigma**
- **Increase funding for mental health outreach and education (not just direct services)**

Increase access to services:

- **Increase free or low cost mental health services**
- **Increase trauma-informed care**
- **Increase coordinated care**
- **Bring mental health services closer to Latino communities**
- **Staff bilingual mental health providers**

Work across sectors:

- **Address basic needs, including access to affordable housing**
- **Involve faith-based communities in social service outreach around mental health**
- **Integrate mental health services into community life**
- **Link Marin City Jail to social services for mental illness, substance abuse, alcoholism**

† Assets and recommendations excerpted from qualitative data. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

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[1] **Chapman DP, Perry GS, Strine TW. "The Vital Link Between Chronic Disease and Depressive Disorders," Preventing Chronic Disease, 2005; 2(1):A14.**

[2] **Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: the Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine ,1998; 14:245–258.**

[3] **University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.**

[4] **California Health Interview Survey, 2014.**

[5] **Centers for Medicare and Medicaid Services, 2012.**

[6] **California Health Interview Survey, 2014.**

[7] **California Healthy Kids Survey, 2013-14.**

[8] **Ibid.**

[9] **California Healthy Kids Survey, 2011-13.**

[10] **California Health Interview Survey, 2014.**

[11] **University of Wisconsin Population Health Institute, County Health Rankings, 2014.**

[12] **RxSafe Marin Report Card; California Department of Public Health Vital Statistics, 2011.**

[13] **Marin County Homeless Point-in-Time Census and Survey, 2015.**

[14] **University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.**

Marin County Community Health Needs Assessment

Substance Abuse

Substance abuse, including use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences. Substance abuse was identified as a health need of concern in multiple existing data sources, as well as in interviews and focus groups. In particular, use and abuse of prescription drugs is recognized as a health need of concern. Among youth, percentages of students reporting binge drinking and being "high" from drug use are higher for Marin County than California overall. Interview and focus group participants identified Fairfax, West Marin, and Canal as areas of high risk for drug abuse.

Key Data

Indicators

Percent of Teens Reporting Binge Drinking[1]

At least once in month prior

HP 2020 Goal: ≤ 8.6

California: 5.8 Marin: 16.2*

Percent of 11th Grade Students Reporting Being "High" From Drug Use[2]

California: 38.3 Marin: 48.7

Percent of 11th Grade Students Reporting Non-Medical use of Rx Painkillers[3]

Marin: 16.0 California: 19.0

"[Substance abuse] is a lot more prevalent than people are willing to admit."

– Interviewee

"We've seen a pretty big increase locally in terms of number of patients showing up in our department with substance abuse issues…particularly methamphetamine abuse and use is something we are starting to see a whole lot more of."

– Interviewee

"If it was cancer everyone would be talking about it.
But with drugs, everyone is zipped shut because of the stigma and shame."

– Interviewee

Key Themes from Qualitative Data

- **Prescription drugs are readily available**
- **Perceptions that drug use among youth is treated more casually in Marin than elsewhere**
- **Youth abuse of Adderall or Ritalin, particularly among middle and upper-class youth**
- **Methamphetamine use**
- **Stigma as a deterrent to seeking help for substance abuse problems**
- **Substance abuse issues co-occur with homelessness and mental health issues**
- **Substance abuse, particularly opioid abuse, used to "self-medicate"**

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

*Unstable estimate; findings should be interpreted with caution.

Marin County Community Health Needs Assessment

Substance Abuse (continued)

Supporting Data and Key Drivers

Supporting Data: Substance Abuse Among Youth

Tobacco Use, Youth

% of 11th grade students using cigarettes any time within last 30 days[4]

Marin	California
12.1	10.2

Driving Under Influence, Youth

% of 11th grade students reporting driving after drinking (respondent or by friend) [5]

Marin	California
24.2	23.0

Marijuana Use, Youth

% of 11th grade students reporting marijuana use within the last 30 days [6]

Marin	California
32.8	22.0

Supporting Data: Tobacco and Alcohol Use

Tobacco Use

% of population smoking cigarettes (age adjusted)[7]

Marin	California
11.0	12.8

Alcohol-related Arrests

Rate of arrests for alcohol related offenses (per 100,000) [8]

Marin	California
1,501.0	1,203.0

Alcohol Access

Liquor store rate (per 100,000)[9]

Marin	California
8.7	10.0

Supporting Data: Drug Use

Total Deaths

Drug poisoning deaths (total)[10]

Marin 2013	Marin 2011
39	21

Unintentional Deaths

Drug poisoning deaths (unintentional)[11]

Marin 2013	Marin 2011
27	13

Leftover Prescription Drugs[12]

45.4

% of RxSafe Marin Survey respondents had pills leftover from last pain medication prescription

61.7

% of those with pills leftover kept, sold, or gave away the leftover pills

25.0

% of RxSafe Marin Survey respondents reported having expired, unused or leftover prescription medication in their home currently

Narcotic Drug Use

Median number of pills per narcotic prescription[13]

Marin 2013	Marin 2011
56	45

Access to Prescription Drugs

48.1

% of RxSafe Marin Survey respondents think it would be very or somewhat easy to obtain prescription pain, sleep, or calming medication from a doctor in their community[14]

Key Themes About Drivers

- Social isolation and a lack of activities are drivers of substance abuse
- Untreated mental health problems are drivers of substance abuse
- Substance abuse problems are drivers of poor health outcomes
- Lower income individuals have fewer resources for recovery

"Substance abuse is a huge issue but I put it in a bucket with mental health issues, because frequently […] there's a connection there […]."
-Interviewee

Marin County Community Health Needs Assessment

Substance Abuse (continued)

Populations Disproportionately Affected, Assets, and Recommendations

Geographic Areas with Greatest Risk in Marin County

Interviewees and focus group attendees indicated that Fairfax, West Marin, and Canal are areas of high concern for substance abuse issues.

Populations with Greatest Risk in Marin County

Residents who do not have the financial resources to obtain expensive rehabilitation treatment, but whose income is too high to qualify for public programs and low-income treatment options, were identified as a population of high concern.

Examples of Existing Community Assets†

Non-Medical Detoxification Programs
(e.g., Vine Detoxification Program)

Outpatient and Residential Treatment Centers
(e.g., Marin Treatment Center, Center Point)

Community Recommendations for Change†

"There's the whole issue of harm reduction versus recovery. Sometimes you have to make sacrifices. I used to go to the needle exchange. Some people would say they're facilitating my using, but it helped me from catching Hepatitis C and A."
– Focus Group Participant

- Look to other county models of addressing substance abuse, particularly those that embrace partnerships among community organizations including schools
- Increase in activities for youth, particularly at night
- Parent education and outreach related to youth substance abuse
- There is a need for recovery programs for women

"'[We] should be looking at models where agencies are partnering with preschool, schools, health care centers, wellness centers, where they are physically on site."
-Interviewee

- **Need for medically assisted detox facility**

† Assets and recommendations excerpted from qualitative data and Marin County CHNA Collaborative. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

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[1] **California Health Interview Survey, 2014.**
[2] **California Healthy Kids Survey, 2011-13.**
[3] **Ibid.**
[4] **Ibid.**
[5] **Ibid.**
[6] **Ibid.**
[7] **Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.**
[8] **California Community Prevention Initiative (CPI), 2008.**
[9] **US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.**
[10] **California Department of Public Health (CDPH) Vital Statistics. Accessed via RxSafe Marin Report Card, 2011, 2013.**
[11] **Ibid.**
[12] **RxSafe Marin County Survey, 2015.**
[13] **RxSafe Marin; Controlled Substance Utilization Review and Evaluation System (CURES), California Prescription Drug Monitoring Program (PDMP), 2013.**
[14] **RxSafe Marin County Survey, 2015.**

Marin County Community Health Needs Assessment

Oral Health

Tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.[1] Oral health was identified as a health need because secondary data indicate that many adults, particularly adults older than 65, do not have dental insurance coverage and many find it difficult to afford dental care. Oral health care access also arose as a key theme in primary data; some key informants shared that oral health access may have increased slightly in West Marin with the Coastal Health Alliance's new full-time Dental Clinic, but it is still not enough, particularly for underserved populations. Additionally, key informants and focus group participants report that dental insurance is limited and specialty care is not affordable.

Key Data

Indicators

Percent of Adults with Poor Dental Health[2]

Marin: 6.2 California: 11.3

Percent of Adults without Dental Exam in the last 12 months[3]

Marin: 18.4 California: 30.5

Percent of Youth Age 2-11 without Dental Exam in the Past 12 Months[4]

Marin: 7.8* California: 9.9

"Oral health was not really included in the expansion of the ACA. People will have real barriers to oral health and prevention, for sure."

– Interviewee

"Dental [is a need]—each cleaning is 300 to 500 dollars. The problem is that I have no access to and no longer have dental [insurance]…there is much information on doctors or clinics. In the dental part, there is no information."

– Focus Group Participant

Key Themes from Qualitative Data

- Specialty dental care is not affordable. There is coverage to extract a tooth but not specialty care to prevent extractions or other issues related to poor oral health.
- Community Clinic and other providers are not able to meet the demand for affordable care.

Populations at Greatest Risk in Marin County

Data regarding oral health is not available at the sub-county level to identify whether specific communities are more impacted than others. However, key informants shared that oral health care is particularly challenging for underserved populations, particularly those without dental insurance coverage.

*Unstable estimate; findings should be interpreted with caution.

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Oral Health (continued)

Supporting Data and Key Drivers

Supporting Data: Access to Care

Access to Providers
Dentists, Rate per 100,000 population[5]

Marin	California
106.1	77.5

Lack of Oral Health Professionals
% of population living in Health Professional Shortage Area (HPSA)- Dental[6]

Marin	California
0.0	4.9

Dental Care Affordability, Youth
% of population age 5-17 unable to afford dental care[7,*]

Marin	California
4.7	6.3

Supporting Data: Dental Insurance Coverage

Dental Insurance, Older Adult
% of adults age 65+ with dental insurance[8]

Marin	California
46.6	52.7

Dental Insurance, Adult
% adults with dental insurance[9]

Marin	California
56.7	59.1

Driver: Health Behaviors

Children with Inadequate Nutrition
% population age 2-13 with inadequate fruit/ vegetable consumption[10]

Marin	California
50.1	47.4

Adults with Inadequate Nutrition
% adults with inadequate fruit/ vegetable consumption[11]

Marin	California
64.3	71.5

Driver: Social and Economic Risks

Children in Poverty
% of children under age 18 living below 200% of Federal Poverty Level[12]
*Unstable estimate; findings should be interpreted with caution.

Marin	California
17.8	47.3

Population in Poverty
% of population living below 200% of Federal Poverty Level[13]

Marin	California
19.4	35.9

Oral Health (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Marin Dental Clinics

Oral Health Prevention and Education Efforts

Community Recommendations for Change†

- Co-locate dental care within community health centers
- Support a dental mobile van or mobile clinic

† Assets and recommendations excerpted from qualitative data and Marin County CHNA Collaborative. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

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[1] "Healthy Smile, Healthy You: The Importance of Oral Health," Delta Dental Insurance, accessed October 28, 2015, https://www.deltadentalins.com/oral_health/dentalhealth.html
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2006-10.
[3] California Health Interview Survey, 2013-14.
[4] Ibid.
[5] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2013.
[6] US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas, March 2015.
[7] California Health Interview Survey, 2009.
[8] California Health Interview Survey, 2007.
[9] California Health Interview Survey, 2013-14.
[10] Ibid.
[11] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2005-09.
[12] US Census Bureau, American Community Survey, 2009-13.
[13] Ibid.

Marin County Community Health Needs Assessment

Violence and Unintentional Injury

Violence and injury prevention are broad topics that cover many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others. In Marin County, this area was identified as a health need because of data related to domestic violence, as well as key drivers of violence such as alcohol abuse. Additionally, racial disparities in intimate partner violence and homicide exist. Marin County also experiences high rates of unintentional injury mortality and drunk driving among youth. Violence and injury also arose as a health need through key themes in interviews and focus groups as well. Community residents and other key stakeholders identified mental health and substance abuse as drivers of unintentional injury and injury due to violence.

Key Data

Indicators

Unintentional Injury Mortality Rate[1]
Age-adjusted, per 100,000 residents

HP 2020 Goal: ≤ 36.4

California: 27.9 Marin: 29.1

Percent of Adults Reporting Experiencing Sexual or Physical Violence by an Intimate Partner Since Age 18[2]

California: 14.8 Marin: 15.4

Suicide Rate[3]
Age-adjusted, per 100,000 residents

HP 2020 Goal: ≤10.2

California: 9.8 Marin: 12.8

> "Women who are going through that endure it because what happens in the family stays here, all families have that stress. And if there is a problem no one knows about it, and the problem continues to grow."
> – Focus Group Participant

> "Safety in the family is a huge issue. People come from a culture that may be more male dominant, and it's easier here for women to find work than men. They turn to alcohol and sometimes to being abusive."
> – Interviewee

Key Themes from Qualitative Data

Family Violence

- Domestic violence prevalent in the county
- Violent homes can be difficult to escape; women face stigma in telling others about violence at home

Community Violence

- Gang violence was a theme among specific geographic regions, including in Canal
- Drunk driving is an issue among youth
- In some communities, distrust of law enforcement perpetuates violence

Note: California state average estimates are included for reference. Differences between Marin County and California state estimates are not necessarily statistically significant.

Marin County Community Health Needs Assessment

Violence and Unintentional Injury (continued)

Supporting Data and Key Drivers

Supporting Data: Family Violence

Rate of Calls for Assistance
Domestic violence calls per 1,000 population[4]

Marin	California
4.1	5.1

Domestic Violence Injuries Rate
Rate among females age 10+ per 100,000[5,†]

Marin	California
15.3	9.5

Child Abuse
Rate of substantiated claims of child maltreatment per 1,000 children age 0-17[6]

HP 2020 Goal: ≤8.5

Marin	California
4.0	8.7

Driver: Alcohol Abuse

Excessive Drinking, Adult
% of adults estimated to be drinking excessively, age-adjusted[7]

Marin	California
19.5	17.2

"When you look at alcohol consumption, our biggest issue is the amount people drink, not just children but adults. Fortunately we have clogged freeways so we don't see traffic accidents [due to drunk driving] that other areas see but we do have violence and alcohol [issues], even suicide is extremely important."
– Interviewee

Supporting Data: Community Violence

Homicide
Age-adjusted mortality rate per 100,000 residents[8]

HP 2020 Goal: ≤5.5

Marin	California
1.3	5.2

Violent Crime
Rate per 100,000 population[9]

Marin	California
202.7	425.0

"We have an issue with the police in Marin City- an issue with harassment. …[My daughter] was stopped the other day because the police could not read the [car] tag. It brought up a lot of anxiety, PTSD (post-traumatic stress), for her and her children. [Perception is] the police's job is to train people how to hand cuff people."
– Focus Group Participant

Supporting Data: Injury and Violence Among Youth

Drunk Driving, Youth
% of 11th grade students reporting driving after drinking (respondent or by friend)[10]

Marin	California
24.2	23.0

Gang Activity, Youth
% of 11th grade students reporting current gang involvement[11]

Marin	California
6.3	7.5

Marin California

Marin
California

† This indicator reports the rate of non-fatal emergency department visits coded as "batter by spouse/partner" (ICD-9 classification E-9673). These rates are likely underestimates (e.g., because not all crimes are reported, and not everyone goes to the hospital for domestic violence injuries for a variety of reason.

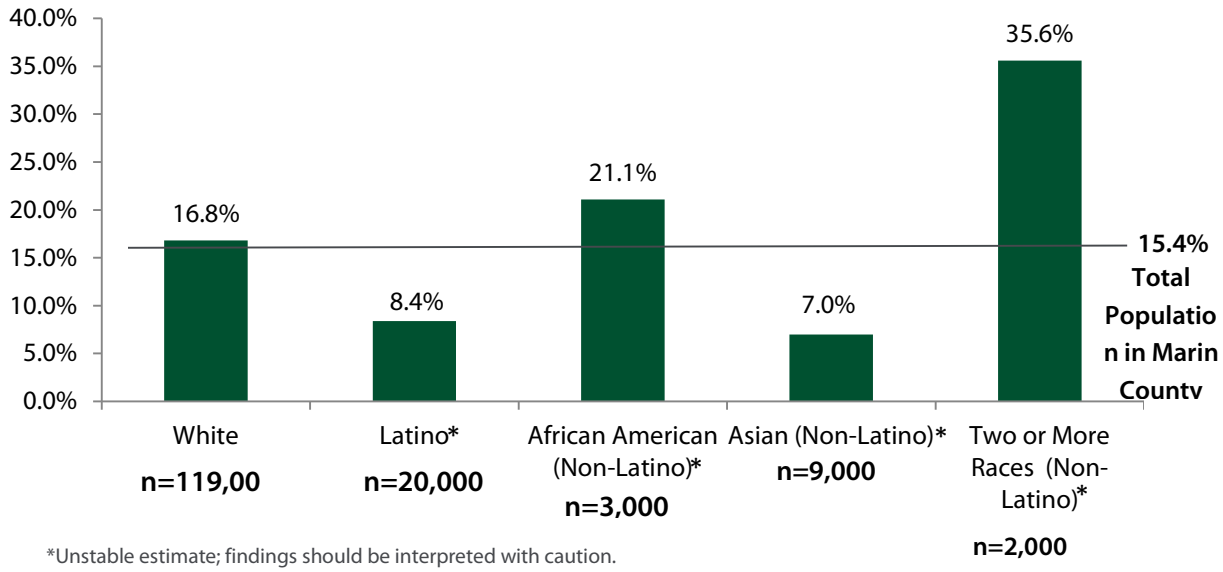
Marin County Community Health Needs Assessment

Violence and Unintentional Injury (continued)

Populations Disproportionately Affected

Disparities in Family Violence in Marin County by Race/Ethnicity

% of Adults Reporting Ever Having Experienced Physical or Sexual Violence by an Intimate Partner Since Age 18[12]



*Unstable estimate; findings should be interpreted with caution.

Disparities in Community Violence in Marin County

While local data on homicide mortality is not available for all racial and ethnic subgroups due to small sample size, Non-Hispanic Blacks in Marin County suffer a disproportionately high homicide mortality rate (4.9 per 100,000 residents) compared to the average across racial/ethnic subpopulations (1.5 per 100,000 residents).[13] This trend mirrors the disparity in homicide rates demonstrated across California.[14]

Geographic disparities may also exist in the impact of community violence across Marin County. Residents in Marin City in particular noted police harassment as a significant concern in their community. Canal was mentioned as a region with particularly high gang violence; San Rafael High School was also noted as having a reputation for youth in gangs.

Violence and Unintentional Injury (continued)

Assets

Examples of Existing Community Assets†

Law enforcement agencies, victim assistance through the District Attorney's Office, and Domestic Violence and Sexual Assault Crisis Providers	Coalition of Schools / Department of Education	Coordinated Community Resources Network (community based agencies, law enforcement, and other government agencies who work together to strengthen response systems)

† Assets excerpted from qualitative data and Marin County CHNA Collaborative. For a comprehensive list of county assets and resources, reference http://211bayarea.org/marin/.

[1] Centers for Disease Control and Prevention, National Vital Statistics System, 2011-13.
[2] California Health Interview Survey, 2009.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
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Health Indicators								Benchmark					Needs Score			Data Details						
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statisticall y unstable	County data statistically unstable
Access to Care	Core	Dentists, Rate per 100,000 Pop.	Access to Dentists	Clinical Care	Rate	258,365	n/a			77.5	63.2	State	Above benchmark	106.1	28.6	US Department of Health & Human			2013	2013	2013		
		Primary Care Physicians, Rate per 100,000 Pop.	Access to Primary Care	Clinical Care	Rate	256,069	n/a			77.3	74.5	State	Above benchmark	142.9	65.68	US Department of Health & Human			2012	2012	2012		
		Num ber of approved MediCal applications during first and second ACA enrollment periods (Jan 2014 - April	n/a	Clinical Care	Number					no data	no data	n/a	n/a	14277	n/a	Marin County Department of Health					2014-15		
		Num ber of approved Covered California applications during first and second ACA enrollment periods (Jan	n/a	Clinical Care	Number					no data	no data	n/a	n/a	16774	n/a	Marin County Department of Health					2014-15		
		Percentage of new managed MediCal members who enrolled between July 2014 and March 2015 who were	n/a	Clinical Care	Percentage					no data	no data	n/a	n/a	45.5%	n/a	Partnership Healthplan of					2014-15		
		Mental Health Care Provider Rate (Per 100,000 Population)	Access to Mental Health	Clinical Care	Rate	264,639	n/a			157.0	134.1	State	Above benchmark	405.1	248.08	University of Wisconsin Population			2014	2014	2014		
	Related	Percent of child population without health insurance (<age 18)	n/a	Social and Economic Factors	Percentage	53,783				5.4%	6.0%	State	Below benchmark	2.7%	-2.70%	US Census Bureau, American Community			2014	2014	2014		
		Percent of adults age 65+ with dental insurance for all or part of past year	n/a	Clinical Care	Percentage	37,000				52.7%	no data	State	Above benchmark	46.6%	-6.10%	California Health Interview Survey			2007		2007		
		Percent of adult population without health insurance (age 18-64)	n/a	Social and Economic Factors	Percentage	153,255				17.3%	16.3%	State	Below benchmark	9.7%	-7.60%	US Census Bureau, American Community			2014	2014	2014		
		Percent of population without health insurance	n/a	Social and Economic Factors	Percentage	248,491				17.8%	14.9%	State	Below benchmark	8.9%	-8.90%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of population receiving MediCal/Medicaid	n/a	Social and Economic Factors	Percentage					14.0%	no data	State	Below benchmark	19.5%	5.50%	US Census Bureau, American Community			2014		2014		
		Percent of kindergarteners with all required immunizations	n/a	Clinical Care	Percentage		>=95.0			90.4%	no data	State	Above benchmark	84.2%	-6.20%	CDPH Immunization Branch (data accessed			2015		2009-14		
		Percentage of adults age 65+ who have ever received a pneumonia vaccination	n/a	Clinical Care	Percentage					63.4%	67.5%	State	Above benchmark	64.3%	0.90%	Centers for Disease Control and			2006-12	2006-12			
		Percent Uninsured Population	Insurance - Uninsured	Social & Economic Factors	Percentage	248,491	n/a			17.8%	14.9%	State	Below benchmark	8.9%	-8.87%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Federally Qualified Health Centers, Rate per 100,000 Population	Federally Qualified Health	Clinical Care	Rate	252,409	n/a			2.0	1.9	State	Above benchmark	4.0	1.99	US Department of Health & Human			2014	2014	2014		
		Percentage of Population Living in a HPSA	Profession/al	Clinical Care	Percentage	252,409	n/a			25.2%	34.1%	State	Below benchmark	0.0%	-25.18%	US Department of Health & Human			2015	2015	2015		
		Preventable Hospital Events Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Preventable Hospital Events	Clinical Care	Rate	no data	n/a			83.2	no data	State	Below benchmark	44.8	-38.42	California Office of Statewide Health			2011		2011		
		Preventable hospitalization rate among Medicare enrollees / preventable hospital events per 1,000	n/a	Clinical Care	Rate					45.3	59.3	State	Below benchmark	30.2	-15.1	Dartmouth Atlas of Health Care			2012	2012	2012		
		Percent of Insured Population Receiving Medicaid	Insurance - Population Health	Social & Economic Factors	Percentage	248,491	n/a			23.4%	20.2%	State	Below benchmark	10.4%	-12.98%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage of Population Living in a HPSA	Profession/al	Clinical Care	Percentage	252,409	n/a			4.9%	32.0%	State	Below benchmark	0.0%	-4.93%	US Department of Health & Human			2015	2015	2015		
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Cancer Screening -	Clinical Care	Percentage	2,189	n/a			59.3%	63.0%	State	Above benchmark	65.0%	5.71%	Dartmouth College Institute for Health			2012	2012	2012		
		Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	Cancer Screening - Pap	Clinical Care	Percentage	162,215	n/a			78.3%	78.5%	State	Above benchmark	79.0%	0.70%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Percent Adults Screened for Colon Cancer (Age-Adjusted)	Cancer Screening -	Clinical Care	Percentage	80,384	n/a			57.9%	61.3%	State	Above benchmark	70.0%	12.10%	Centers for Disease Control and			2006-12	2006-12	2006-12		
Access to Housing	Core	Vacant Housing Units, Percent	Housing - Vacant Housing	Physical Environment	Percentage	111,351	n/a			8.6%	12.5%	State	Below benchmark	7.6%	-1.05%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of owner-occupied housing units where costs exceed 30% of household income	Housing - Cost Burdened	Social and Economic Factors	Percentage	64,596	n/a			39.3%	28.5%	State	Below benchmark	38.3%	-1.01%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of renter-occupied housing units where rent/utilities exceeds 30% of household income	n/a	Social and Economic Factors	Percentage	38,316	n/a			57.2%	52.3%	State	Below benchmark	56.0%	-1.20%	US Census Bureau, American Community			2010-14	2010-14	2010-14		
		Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard	Physical Environment	Percentage	102,912	n/a			48.4%	36.1%	State	Below benchmark	44.1%	-4.25%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		HUD-Assisted Units, Rate per 10,000 Housing Units	Housing - Assisted	Physical Environment	Rate	204,572	n/a			368.3	384.3	State	Below benchmark	351.0	-17.35	US Department of Housing and Urban			2013	2013	2013		
	Related	Total number of homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	1309	n/a	Marin County Homeless Point-in-					2015		
		Total number of unsheltered homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	835	n/a	Marin County Homeless Point-in-					2015		
		Percent of renter-occupied housing units where rent/utilities exceeds 30% of household income	n/a	Social and Economic Factors	Percentage					54.1%	48.3%	State	Below benchmark	53.2%	-0.90%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of renters spending 30% or more of household income on rent	n/a	Social and Economic Factors	Percentage					56.9%	52.3%	State	Below benchmark	55.3%	-1.58%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of renter occupied households living in overcrowded environments (>1 persons/room)	n/a	Physical Environment	Percentage					13.3%	6.2%	State	Below benchmark	7.4%	-5.90%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
	Core	Percent Adults with Asthma	Asthma - Prevalence	Health Outcomes	Percentage	187,509	n/a			14.2%	13.4%	State	Below benchmark	13.8%	-0.41%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Percent of childre age 2- 18 ever diagnosed with asthma	n/a	Health Outcomes	Percentage	52,000				15.7%	no data	State	Below benchmark	9.8%	-5.90%	California Health Interview Survey			2014		2014		x
		Tuberculosis incidence per 100,000 population	n/a	Health Outcomes	Rate		<=1.0			5.9	no data	State	Below benchmark	5.2	-0.7	California Department of Public Health /			2013		2013		
		Asthma Hospitalization Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Asthma - Hospitalizations	Health Outcomes	Rate	no data	n/a			8.9	no data	State	Below benchmark	2.9	-6.01	California Office of Statewide Health			2011		2011		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
Asthma and COPD	Related	Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard	Physical Environment	Percentage	102,912	n/a			48.4%	36.1%	State	Below benchmark	44.1%	-4.25%	US Census Bureau, American Community			2011-12	2011-12	2011-12		
		Chronic lower respiratory disease morality rate (age-adjusted), per 100,000 population	n/a	Health Outcomes	Rate					35.5	42.1	State	Below benchmark	21.6	-13.9	California Department of Public Health;			2011-13	2011-13	2011-13		
		Percentage of Days Exceeding Ozone Standards, Pop. Adjusted Average	Air Quality - Ozone (O3)	Physical Environment	Percentage	252,409	n/a			2.5%	0.5%	State	Below benchmark	0.0%	-2.47%	Centers for Disease Control and			2008	2008	2008		
		Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	198,881	n/a			12.8%	18.1%	State	Below benchmark	11.0%	-1.80%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a			1.0%	1.6%	State	Below benchmark	suppressed	n/a	Nielsen SiteReports			2014	2014	2014		
		Percentage of Days Exceeding Particulate Matter Standards, Pop. Adjusted Average	Air Quality - Particulate	Physical Environment	Percentage	252,409	n/a			4.2%	1.2%	State	Below benchmark	5.2%	1.05%	Centers for Disease Control and			2008	2008	2008		
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	197,845	n/a			22.3%	27.1%	State	Below benchmark	17.5%	-4.82%	Centers for Disease Control and			2012	2012	2012		
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	181,818	n/a			35.9%	35.8%	State	Below benchmark	30.8%	-5.01%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Percent Obese Among Children (grades 5, 7, 9)	Obesity (Youth)	Health Outcomes	Percentage	7,276	n/a			19.0%	no data	State	Below benchmark	8.9%	-10.11%	California Department of Education,			2013-14		2013-14		
		Percent Overweight Among Children (grades 5, 7, 9)	Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a			19.3%	no data	State	Below benchmark	16.3%	-2.98%	California Department of Education,			2013-14		2013-14		
Cancers	Core	Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	Cancer Incidence -	Health Outcomes	Rate	127,211	<= 40.9			122.4	122.7	State	Below benchmark	143.7	21.3	National Institutes of Health, National			2007-11	2007-11	2007-11		
		Colorectal cancer mortality rate (age-adjusted)	n/a	Health Outcomes	Rate					13.9	no data	State	Below benchmark	10.3	-3.6	California Department of Public Health			2011-13		2011-13		
		Breast cancer mortality rate (age-adjusted)	n/a	Health Outcomes	Rate					20.7	no data	State	Below benchmark	18.2	-2.5	California Department of Public Health			2011-13		2011-13		
		Lung cancer mortality rate (age-adjusted)	n/a	Health Outcomes	Rate					33.6	no data	State	Below benchmark	28.6	-5	California Department of Public Health			2011-13		2011-13		
		Prostate cancer mortality rate (age-adjusted)	n/a	Health Outcomes	Rate					20.2	no data	State	Below benchmark	16.2	-4	California Department of Public Health			2011-13		2011-13		
		Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Cancer	Health Outcomes	Rate	252,409	<= 160.6			157.1	no data	State	Below benchmark	146.7	-10.42	University of Missouri,Center for			2010-12		2010-12		
		Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	Cancer Incidence -	Health Outcomes	Rate	127,211	<= 7.1			7.8	7.8	State	Below benchmark	5	-2.8	National Institutes of Health,National			2007-11	2007-11	2007-11		
		Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	Cancer Incidence -	Health Outcomes	Rate	250,666	<= 38.7			41.5	43.3	State	Below benchmark	40.4	-1.1	National Institutes of Health,National			2007-11	2007-11	2007-11		
		Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	Cancer Incidence -	Health Outcomes	Rate	123,455	n/a			136.4	142.3	State	Below benchmark	174.2	37.8	National Institutes of Health,National			2007-11	2007-11	2007-11		
		Annual Invasive Melanoma Indicence Rate Among Males (Per 100,000 Pop.; age-adjusted)		Health Outcomes	Rate		n/a			186.6	no data	State	Below benchmark	351.9	165.3	Melanoma incidence in Marin County,			2011		2011		
		Annual Invasive Melanoma Indicence Rate Among Females (Per 100,000 Pop.; age-adjusted)		Health Outcomes	Rate		n/a			65.6	no data	State	Below benchmark	152.4	86.8	Melanoma incidence in Marin County,			2011		2011		
		Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	Cancer Incidence - Lung	Health Outcomes	Rate	250,666	n/a			49.5	64.9	State	Below benchmark	44.8	-4.7	National Institutes of Health,National			2007-11	2007-11	2007-11		
	Related	Estimated Adults Drinking Excessively Age-Adjusted Percentage)	Alcohol - Excessive	Health Behaviors	Percentage	198,881	n/a			17.2%	16.9%	State	Below benchmark	19.5%	2.30%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a			12.9%	14.3%	State	Below benchmark	suppressed	n/a	Nielsen Site Reports			2014	2014	2014		
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	252,409	n/a			1002.0%	1035.0%	State	Below benchmark	872.0%	-1.3	US Census Bureau,County			2012	2012	2012		
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	181,818	n/a			35.9%	35.8%	State	Below benchmark	30.8%	-5.01%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	197,845	n/a			22.3%	27.1%	State	Below benchmark	17.5%	-4.82%	Centers for Disease Control and			2012	2012	2012		
		Percent of women age 55+ with mammogram in past 2 years	n/a	Clinical Care	Percentage	51,000				83.9%	81.2%	State	Above benchmark	88.2%	4.30%	California Health Interview Survey			2012	2007	2012		x
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Cancer Screening -	Clinical Care	Percentage	2,189	n/a			59.3%	63.0%	State	Above benchmark	65.0%	5.71%	Dartmouth College Institute for Health			2012	2012	2012		
		Percent Adults with Inadequate Fruit / Vegetable Consumption	Low Fruit/Vegetable	Health Behaviors	Percentage	196,267	n/a			71.5%	75.7%	State	Below benchmark	64.3%	-7.20%	Centers for Disease Control and			2005-09	2005-09	2005-09		
		Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Fruit/Vegetable Expenditures	Health Behaviors	Percentage	no data	n/a			14.1%	12.7%	State	Above benchmark	suppressed	n/a	Nielsen Site Reports			2014	2014	2014		
		Percent Population with Low Food Access	Food Security - Food Desert	Social & Economic Factors	Percentage	252,409	n/a			14.3%	23.6%	State	Below benchmark	17.1%	2.74%	US Department of Agriculture,Economic			2010	2010	2010		
		Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	198,881	n/a			12.8%	18.1%	State	Below benchmark	11.0%	-1.80%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Percent of adults currently or formerly using tobacco	n/a	Health Behaviors	Percentage					no data	37.0%	National	Below benchmark	44.2%	7.20%	Centers for Disease Control and				2011-12	2008		
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a			1.0%	1.6%	State	Below benchmark	suppressed	n/a	Nielsen Site Reports			2014	2014	2014		
		Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	Cancer Screening - Pap	Clinical Care	Percentage	162,215	n/a			78.3%	78.5%	State	Above benchmark	79.0%	0.70%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Percent Population with no Leisure Time Physical Activity	Physical In/activity	Health Behaviors	Percentage	198,426	n/a			16.6%	22.6%	State	Below benchmark	10.3%	-6.29%	Centers for Disease Control and			2012	2012	2012		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
		Percent Adults Screened for Colon Cancer (Age-Adjusted)	Cancer Screening -	Clinical Care	Percentage	80,384	n/a			57.9%	61.3%	State	Above benchmark	70.0%	12.10%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Rank of pesticides use among California counties	n/a	Physical Environment	Rank					n/a	n/a	State	n/a	45.00	n/a	California Department of Pesticide					2013		
		Pounds of pesticides applied and rank among California counties	n/a	Physical Environment	Number					193,597,806	n/a	n/a	n/a	84,836	n/a	California Department of Pesticide			2013		2013		
		Percentage of Days Exceeding Particulate Matter Standards, Pop. Adjusted Average	Air Quality - Particulate	Physical Environment	Percentage	252,409	n/a			4.2%	1.2%	State	n/a	5.2%	1.05%	Centers for Disease Control and			2008	2008	2008		
Child Mental and Emotional Development	Core	Percent of children age 3-4 enrolled in school (includes Head Start, licensed child care, nurseries, Pre-K,	n/a	Social and Economic Factors	Percentage	no data				47.8%	47.1%	State	Above benchmark	66.2%	18.40%	US Census Bureau, American Community			2014	2014	2014		
		Head Start Programs Rate (Per 10,000 Children Under Age 5)	n/a	Social and Economic Factors	Rate	13932				6.34	7.62	State	Above benchmark	6.46	0.12	US Department of Health & Human			2014	2014	2014		
		3rd grade reading proficiency (Percentage of all public school students tested in 3rd grade who scored	n/a	Social and Economic Factors	Percentage					45.0%	no data	State	Above benchmark	66.0%	21.00%	Standardized Testing and Reporting (STAR)			2012-13		2012-13		
		Percent increase in DDS autism cases from 1990 to 2015	n/a	Health Outcomes	Percent Change			1554%		no data	no data	Greater Bay Area	Below benchmark	281.0%	-1273.00%	Autism Society, San Francisco Bay Area;	1990-2015				1990-2015		
		Percentage of public school children in grades K-12 receiving special education services whose primary	n/a	Health Outcomes	Percentage					12.0%	no data	State	Below benchmark	8.1%	-3.90%	Special Tabulation by the California Dept. of			2013-14		2013-14		
		Percent of children in foster care system for more than 8 days but less than 12 months with 2 or less	n/a	Social and Economic Factors	Percentage					86.6%	no data	State	Above benchmark	81.8%	-4.80%	California Child Welfare Indicators			2014		2014		
	Related	Percent of children age 0-12 considered in excellent or very good health	n/a	Health Outcomes	Percentage	36,000				78.7%	no data	State	Above benchmark	93.3%	14.62%	California Health Interview Survey			2014		2014		x
		Percent of children 4 months-5 years at moderate or high risk of developmental delay	Percent of children 4	Health Outcomes	Percentage	no data	n/a			23.1%	26.2%	State	Below benchmark	no data	n/a	National Survey of Children's Health			2011-12	2011-12			
		Percent of children no longer in foster care system after 12 months	n/a	Social and Economic Factors	Percentage	no data	n/a			38.3%	no data	State	Above benchmark	suppressed	n/a	California Child Welfare Indicators			2013		2013		
		Pounds of pesticides applied and rank among California counties	n/a	Physical Environment	Number					193,597,806	n/a	State	n/a	84,836	n/a	California Department of Pesticide			2013		2013		
Climate and Health	Core	Percentage of Days Exceeding Particulate Matter Standards, Pop. Adjusted Average	Air Quality - Particulate	Physical Environment	Percentage	252,409	n/a			4.2%	1.2%	State	Below benchmark	5.2%	1.05%	Centers for Disease Control and			2008	2008	2008		
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	257,059	n/a			2.7%	10.3%	State	Below benchmark	0.6%	-2.06%	University of Wisconsin Population			2012-13	2012-13	2012-13		
		Percentage of Days Exceeding Ozone Standards, Pop. Adjusted Average	Air Quality - Ozone (O3)	Physical Environment	Percentage	252,409	n/a			2.5%	0.5%	State	Below benchmark	0.0%	-2.47%	Centers for Disease Control and			2008	2008	2008		
		Percentage of Weather Observations with High Heat Index Values:%	Climate & Health - Heat	Physical Environment	Percentage	3,285	n/a			0.6%	4.7%	State	Below benchmark	0.0%	-0.63%	National Oceanic and Atmospheric			2014	2014	2014		
		Percentage of Weeks in Drought (Any)	Climate & Health - Drought	Physical Environment	Percentage	no data	n/a			92.8%	45.9%	State	Below benchmark	89.1%	-3.69%	US Drought Monitor			2012-14	2012-14	2012-14		
		Heat-related Emergency Department Visits, Rate per 100,000 Population	Climate & Health - Heat	Physical Environment	Rate	125	n/a			11.1	no data	State	Below benchmark	6.2	-4.88	California Department of Public Health,			2005-12		2005-12		
		Asthma Hospitalization Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Asthma - Hospitalizations	Health Outcomes	Rate	no data	n/a			8.9	no data	State	Below benchmark	2.9	-6.01	California Office of Statewide Health			2011		2011		
		Percent Adults with Asthma	Asthma - Prevalence	Health Outcomes	Percentage	187,509	n/a			14.2%	13.4%	State	Below benchmark	13.8%	-0.41%	Centers for Disease Control and			2011-12	2011-12	2011-12		
	Related	Percent Low Birth Weight Births	Low Birth Weight	Health Outcomes	Percentage	252,409	n/a			6.8%	no data	State	Below benchmark	6.2%	-0.63%	California Department of Public Health,			2011		2011		
		Total Road Network Density (Road Miles per Acre)	Transit - Road Network Density	Physical Environment	Rate	828	n/a			4.3	2.0	State	Below benchmark	2.1	-2.15	Environmental Protection Agency,			2011	2011	2011		
		Percentage of Population within Half Mile of Public Transit	Transit - Public Transit within	Physical Environment	Percentage	247,686	n/a			15.5%	8.1%	State	Above benchmark	5.6%	-9.90%	Environmental Protection Agency,			2011	2011	2011		
		Population Weighted Percentage of Report Area Covered by Tree Canopy	Climate & Health - Canopy	Physical Environment	Percentage	252,409	n/a			0.15	0.25	State	Above benchmark	0.32	16.42%	Multi-Resolution Land Characteristics			2011	2011	2011		
		Percentage of Housing Units with No Air Conditioning	Climate & Health - No	Physical Environment	Percentage	111,214	n/a			33.8%	11.4%	State	Below benchmark	no data		US Census Bureau, American Housing			2011, 2013		2011, 2013		
		Pounds of pesticides applied and rank among California counties	n/a	Physical Environment	Number					193,597,806	n/a	State	n/a	84,836	n/a	California Department of Pesticide			2013		2013		
		Diabetes Hospitalization Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a			10.4	no data	State	Below benchmark	5.11	-5.29	California Office of Statewide Health			2011		2011		
		Average Number of Mentally Unhealthy Days per Month	Mental Health - Poor Mental	Health Outcomes	Rate	198,881	n/a			3.6	3.47	State	Below benchmark	3.0	-0.6	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Ischaemic Heart	Health Outcomes	Rate	252,409	<= 100.8			163.2	no data	State	Below benchmark	107.9	-55.25	University of Missouri, Center for			2010-12		2010-12		
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	197,845	n/a			22.3%	27.1%	State	Below benchmark	17.5%	-4.82%	Centers for Disease Control and			2012	2012	2012		
		Percent Obese Among Children (grades 5, 7, 9)	Obesity (Youth)	Health Outcomes	Percentage	7,276	n/a			19.0%	no data	State	Below benchmark	8.9%	-10.11%	California Department of Education,			2013-14		2013-14		
	Core	Percent Adults with Heart Disease	Heart Disease Prevalence	Health Outcomes	Percentage	198,000	n/a			6.1%	no data	State	Below benchmark	7.6%	1.50%	California Health Interview Survey			2013-14		2013-14		x
		Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Ischaemic Heart	Health Outcomes	Rate	252,409	<= 100.8			163.2	no data	State	Below benchmark	107.9	-55.25	University of Missouri,Center for			2010-12		2010-12		
		Percent of Medicare fee-for-service population with ischaemic heart disease	n/a	Health Outcomes	Percentage					37.4%	28.6%	State	Below benchmark	23.6%	-13.78%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Stroke	Health Outcomes	Rate	252,409	n/a			37.4	no data	State	Below benchmark	27.6	-9.83	University of Missouri, Center for			2010-12		2010-12		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
CVD/Stroke	Related	Percent Population with no Leisure Time Physical Activity	Physical In/activity	Health Behaviors	Percentage	198,426	n/a			16.6%	22.6%	State	Below benchmark	10.3%	-6.29%	Centers for Disease Control and			2012	2012	2012		
		Percent Physically Inactive	Physical In/activity	Health Behaviors	Percentage	7,276	n/a			35.9%	no data	State	Below benchmark	23.7%	-12.20%	California Department of Education,			2013-14		2013-14		
		Percent Population Within 1/2 Mile of a Park	Park Access	Physical Environment	Percentage	252,409	n/a			58.6%	no data	State	Above benchmark	68.0%	9.38%	US Census Bureau,Decennial			2010		2010		
		Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Recreation and Fitness Facility	Physical Environment	Rate	252,409	n/a			8.7	9.4	State	Above benchmark	24.2	15.52	US Census Bureau,County			2012	2012	2012		
		Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	198,881	n/a			12.8%	18.1%	State	Below benchmark	11.0%	-1.80%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a			1.0%	1.6%	State	Below benchmark	suppressed	n/a	Nielsen Site Reports			2014	2014	2014		
		Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Alcohol - Excessive	Health Behaviors	Percentage	198,881	n/a			17.2%	16.9%	State	Below benchmark	19.5%	2.30%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a			12.9%	14.3%	State	Below benchmark	suppressed	n/a	Nielsen Site Reports			2014	2014	2014		
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	252,409	n/a			10.0	10.4	State	Below benchmark	8.7	-1.3	US Census Bureau,County			2012	2012	2012		
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	181,818	n/a			35.9%	35.8%	State	Below benchmark	30.8%	-5.01%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	197,845	n/a			22.3%	27.1%	State	Below benchmark	17.5%	-4.82%	Centers for Disease Control and			2012	2012	2012		
		Percent Overweight Among Children (grades 5, 7, 9)	Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a			19.3%	no data	State	Below benchmark	16.3%	-2.98%	California Department of Education,			2013-14		2013-14		
		Percent Obese Among Children (grades 5, 7, 9)	Obesity (Youth)	Health Outcomes	Percentage	7,276	n/a			19.0%	no data	State	Below benchmark	8.9%	-10.11%	California Department of Education,			2013-14		2013-14		
		Percent of adults (age 18+) who have ever been diagnosed with high blood pressure	n/a	Health Outcomes	Percentage					26.1%	28.2%	State	Below benchmark	18.8%	-7.30%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Percent of Medicare fee-for-service population diagnosed with high blood pressure	n/a	Health Outcomes	Percentage					51.5%	55.5%	State	Below benchmark	41.5%	-10.00%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Percent of Medicare fee-for-service population diagnosed with high cholesterol	n/a	Health Outcomes	Percentage					42.1%	44.8%	State	Below benchmark	39.7%	-2.40%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Percent Adults with Diagnosed Diabetes (Age-Adjusted)	Diabetes Prevalence	Health Outcomes	Percentage	197,942	n/a			8.1%	9.1%	State	Below benchmark	5.5%	-2.55%	Centers for Disease Control and			2012	2012	2012		
		Diabetes Hospitalization Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a			10.4	no data	State	Below benchmark	5.1	-5.29	California Office of Statewide Health			2011		2011		
		Total Population	n/a	Demographics	Number					37,659,181	n/a	n/a	n/a	254,643	n/a	US Census Bureau, American Community			2009-13		2009-13		
		Families with Children (% of total households)	n/a	Demographics	Percentage					32.7%	29.6%	n/a	n/a	29.4%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Male Population	n/a	Demographics	Percentage					49.7%	49.2%	n/a	n/a	49.1%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Female Population	n/a	Demographics	Percentage					50.3%	50.8%	n/a	n/a	50.9%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Population under Age 18	n/a	Demographics	Percentage					24.5%	23.7%	n/a	n/a	20.6%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 0-4	n/a	Demographics	Percentage					6.7%	6.4%	n/a	n/a	5.3%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 5-17	n/a	Demographics	Percentage					17.8%	17.3%	n/a	n/a	15.3%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 18-24	n/a	Demographics	Percentage					10.5%	10.0%	n/a	n/a	5.9%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 25-34	n/a	Demographics	Percentage					14.4%	13.4%	n/a	n/a	9.6%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 35-44	n/a	Demographics	Percentage					13.7%	13.1%	n/a	n/a	14.0%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 45-54	n/a	Demographics	Percentage					13.9%	14.3%	n/a	n/a	16.4%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 55-64	n/a	Demographics	Percentage					11.1%	12.1%	n/a	n/a	15.8%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 65+	n/a	Demographics	Percentage					11.8%	13.4%	n/a	n/a	17.6%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of Population 75y+	n/a	Demographics	Percentage					5.4%	6.0%	n/a	n/a	7.7%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Median Age in Years	n/a	Demographics	Age					35.4	37.3	n/a	n/a	44.8	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Veteran Population (% of total population)	n/a	Demographics	Percentage					6.7%	9.0%	n/a	n/a	7.6%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Rural	n/a	Demographics	Percentage					5.0%	19.1%	n/a	n/a	6.5%	n/a	U.S. Census Bureau			2010	2010	2010		
		Percent Population Urban	n/a	Demographics	Percentage					95.0%	80.9%	n/a	n/a	93.5%	n/a	U.S. Census Bureau			2010	2010	2010		
		Percent Population Hispanic	n/a	Demographics	Percentage					37.9%	16.6%	n/a	n/a	15.5%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		

Health Indicators								Benchmark					Needs Score			Data Details						
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
		Percent Population Foreign-Born	n/a	Demographics	Percentage					27.0%	13.0%	n/a	n/a	19.0%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population not a U.S. Citizen	n/a	Demographics	Percentage					14.3%	7.1%	n/a	n/a	10.6%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Population Geographic Mobility	n/a	Demographics	Percentage					4.9%	6.0%	n/a	n/a	7.4%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of the population that speak English less than "very well"	n/a	Demographics	Percentage					19.4%	8.6%	n/a	n/a	9.3%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of linguistically isolated households	n/a	Demographics	Percentage					10.3%	4.7%	n/a	n/a	4.8%	n/a	US Census Bureau, American Community			2007-11	2007-11	2007-11		
		Percent Population Age 5+ with Limited English Proficiency	n/a	Demographics	Percentage					19.4%	8.6%	n/a	n/a	9.3%	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Median household income	n/a	Social and Economic Factors	Dollars					$61,094	$53,046	n/a	Above benchmark	$90,839	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Living Wage - Annual income required to support household with two adults*	n/a	Social and Economic Factors	Dollars					$39,988	n/a	n/a	n/a	$46,991	n/a	calculated from livingwage.mit.edu			2015		2015		
		Living wage - Annual income required to support one adult and one child*	n/a	Social and Economic Factors	Dollars					$52,544	n/a	n/a	n/a	$61,096	n/a	calculated from livingwage.mit.edu			2015		2015		
		Median year housing units builts	n/a	Physical Environment	Year					1974	1976	n/a	n/a	1966	n/a	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of children under age 18 living below 200% of Federal Poverty Level	n/a	Social and Economic Factors	Percentage					47.3%	44.6%	State	Below benchmark	17.8%	-29.50%	US Census Bureau, American Community			2013	2013	2013		
		Percent Population in Poverty	Poverty - Population	Social & Economic Factors	Percentage	247,026	n/a			15.9%	15.4%	State	Below benchmark	7.7%	-8.20%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population with Income at or Below 200% FPL	Poverty - Population	Social & Economic Factors	Percentage	247,026	n/a			35.9%	34.2%	State	Below benchmark	19.4%	-16.50%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Under Age 18 in Poverty	Poverty - Children Below	Social & Economic Factors	Percentage	247,026	n/a			22.2%	21.6%	State	Below benchmark	8.9%	-13.21%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of people living below 50% of Federal Poverty Line	n/a	Social and Economic Factors	Percentage					6.9%	6.8%	State	Below benchmark	3.6%	-3.30%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent People 65 years or Older In Poverty	n/a	Social and Economic Factors	Percentage					9.9%	9.4%	State	Below benchmark	5.5%	-4.40%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Single Female Headed Households living below 100% of Federal Poverty Line	n/a	Social and Economic Factors	Percentage					29.9%	33.3%	State	Below benchmark	15.2%	-14.70%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of Families Earning over $75,000/year	n/a	Social and Economic Factors	Percentage					46.8%	42.8%	State	Above benchmark	68.9%	22.10%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
	Core	Median household income	n/a	Social and Economic Factors	Dollars					$61,094	$53,046	State	Above benchmark	$90,839	29745	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Per capita income	n/a	Social and Economic Factors	Dollars					$29,527	$28,154	State	Above benchmark	$56,791	27264	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Living wage - Annual income required to support one adult and one child*	n/a	Social and Economic Factors	Dollars					$52,544	n/a	State	n/a	$61,096	n/a	calculated from livingwage.mit.edu			2015		2015		
		Living Wage - Annual income required to support household with two adults*	n/a	Social and Economic Factors	Dollars					$39,988	n/a	n/a	n/a	$46,991	n/a	calculated from livingwage.mit.edu			2015		2015		
		Gini coefficient of income inequality	n/a	Social and Economic Factors	Proporotion					0.4782	0.4735	State	Below benchmark	0.5164	0.0382	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Population receiving MediCal/Medicaid	n/a	Social and Economic Factors	Percentage					14.0%	no data	State	Below benchmark	19.5%	5.50%	US Census Bureau, American Community			2014		2014		
		Percent of households with public assistance income	n/a	Social and Economic Factors	Percentage					4.0%	2.8%	State	Below benchmark	1.8%	-2.20%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Unemployment Rate	Economic Security -	Social & Economic Factors	Percentage	140,102	n/a			7.4%	6.3%	State	Below benchmark	4.2%	-3.20%	US Department of Labor, Bureau of			2015	2015			
		Percentage of civilian non-institutionalized population age 16 or older unemployed	n/a	Social and Economic Factors	Percentage					7.3%	6.2%	State	Below benchmark	4.8%	-2.50%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
Economic Security		Cohort Graduation Rate	Education - High School	Social & Economic Factors	Percentage	2,226	>= 82.4%			80.4%	no data	State	Above benchmark	91.4%	10.98%	California Department of Education			2013		2013		
		High school graduation rate	n/a	Social and Economic Factors	Percentage					80.8%	no data	State	Above benchmark	90.8%	10.00%	California Dept. of Education, California			2014		2014		
		3rd grade reading proficiency (Percentage of all public school students tested in 3rd grade who scored	n/a	Social and Economic Factors	Percentage					45.0%	no data	State	Above benchmark	66.0%	21.00%	Standardized Testing and Reporting (STAR)			2012-13		2012-13		
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	252,409	n/a			10.0	10.4	State	Below benchmark	8.7	-1.3	US Census Bureau,County			2012	2012	2012		
		Percent Students Eligible for Free or Reduced Price Lunch	Children Eligible for	Social & Economic Factors	Percentage	31,693	n/a			56.3%	51.7%	State	Below benchmark	25.6%	-30.70%	National Center for Education Statistics,			2012-13	2012-13	2012-13		
		Percent Population Receiving SNAP Benefits	Food Security - Population	Social & Economic Factors	Percentage	247,458	n/a			10.6%	15.2%	State	Below benchmark	3.7%	-6.92%	US Census Bureau, Small Area Income &			2011	2011	2011		
		Dignity Community Health Index	Dignity Community	Social and Economic Factors	Number					n/a	n/a	n/a	Below benchmark	2.5		Dignity Health Community Need							
		Percent of Insured Population Receiving Medicaid	Insurance - Population	Social & Economic Factors	Percentage	248,491	n/a			23.4%	20.2%	State	Below benchmark	10.4%	-12.98%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
	Related	Percent Uninsured Population	Insurance - Uninsured	Social & Economic Factors	Percentage	248,491	n/a			17.8%	14.9%	State	Below benchmark	8.9%	-8.87%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Average Daily School Breakfast Program Participation Rate	Food Security - School Breakfast	Social & Economic Factors	Percentage	no data	n/a			3.9%	4.2%	State	Below benchmark	no data		US Department of Agriculture,Food and			2013	2013			

Health Indicators								Benchmark					Needs Score			Data Details						
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
		Percentage of the Population with Food Insecurity	Food Security - Food Insecurity	Social & Economic Factors	Percentage	252,759	n/a			16.2%	15.9%	State	Below benchmark	11.5%	-4.72%	Feeding America			2012	2012	2012		
		Vacant Housing Units, Percent	Housing - Vacant Housing	Physical Environment	Percentage	111,351	n/a			8.6%	12.5%	State	Below benchmark	7.6%	-1.05%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage of Households where Housing Costs Exceed 30% of Income	Housing - Cost Burdened	Physical Environment	Percentage	102,912	n/a			45.9%	35.5%	State	Below benchmark	43.8%	-2.05%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Occupied Housing Units with One or More Substandard Conditions	Housing - Substandard	Physical Environment	Percentage	102,912	n/a			48.4%	36.1%	State	Below benchmark	44.1%	-4.25%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		HUD-Assisted Units, Rate per 10,000 Housing Units	Housing - Assisted	Physical Environment	Rate	111,214	n/a			1399.0	1468.2	State	Below benchmark	351.0	-1048.09	US Department of Housing and Urban			2013	2013	2013		
		Proportion of renter occupied households living in overcrowded environments (>1 persons/room)	n/a	Physical Environment	Percentage					13.3%	6.2%	State	Below benchmark	7.4%	-5.90%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage of Workers Commuting More than 60 Minutes	Economic Security - Economic	Social & Economic Factors	Percentage	108,758	n/a			10.1%	8.1%	State	Below benchmark	11.5%	1.35%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage of Households with No Motor Vehicle	Economic Security - Economic	Social & Economic Factors	Percentage	102,912	n/a			7.8%	9.1%	State	Below benchmark	5.0%	-2.81%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent Population Age 25+ with No High School Diploma	Education - Less than High	Social & Economic Factors	Percentage	187,029	n/a			18.8%	14.0%	State	Below benchmark	7.6%	-11.14%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of population age 25+ with Associate's degree or higher	n/a	Social and Economic Factors	Percentage					38.4%	36.7%	State	Above benchmark	60.9%	22.50%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in English	n/a	Social and Economic Factors	Percentage					38.0%	n/a	State	Above benchmark	26.0%	-12.00%	California Department of Education			2013-14		2013-14		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	n/a	Social and Economic Factors	Percentage					54.0%	n/a	State	Above benchmark	37.0%	-17.00%	California Department of Education			2013-14		2013-14		
Education	Core	Percent of children age 3-4 enrolled in school (includes Head Start, licensed child care, nurseries, Pre-K,	n/a	Social and Economic Factors	Percentage	no data				47.8%	47.1%	State	Above benchmark	66.2%	18.40%	US Census Bureau, American Community			2014	2014	2014		
		Percentage of Grade 4 ELA Test Score Not Proficient	Education - Reading Below	Social & Economic Factors	Percentage	2492	<= 36.3%			36.0%	n/a	State	Below benchmark	19.0%	-17.00%	California Department of Education			2012-13		2012-13		
		Percentage of Population Age 3-4 Enrolled in School	Education - School	Social & Economic Factors	Percentage	no data	n/a			47.8%	47.1%	State	Above benchmark	66.2%	18.41%	US Census Bureau, American Community			2014	2014	2014		
		Cohort Graduation Rate	Education - High School	Social & Economic Factors	Percentage	2,226	>= 82.4			80.4%	no data	State	Above benchmark	91.4%	10.98%	California Department of Education			2013		2013		
		3rd grade reading proficiency (Percentage of all public school students tested in 3rd grade who scored	n/a	Social and Economic Factors	Percentage					45.0%	no data	State	Above benchmark	66.0%	21.00%	Standardized Testing and Reporting (STAR)			2012-13		2012-13		
		Head Start Programs Rate (Per 10,000 Children Under Age 5)	Education - Head Start	Social & Economic Factors	Rate	13932	n/a			6.3	7.6	State	Above benchmark	6.5	12.00%	US Department of Health & Human			2014	2014	2014		
		Chlamydia Infection Rate (Per 100,000 Pop.)	STD - Chlamydia	Health Outcomes	Rate	255,031	n/a			444.9	456.7	State	Below benchmark	190.6	-254.31	US Department of Health & Human			2012	2012	2012		
		Gonorrhea Incidence (rate of gonorrhea cases per 100,000 population)	n/a	Health Outcomes	Rate					88.3	106.7	State	Below benchmark	32.4	-55.9	U.S. Department of Health & Human			2012	2012	2012		
	Core	AIDS Incidence (newly *diagnosed* cases) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					8.1	n/a	State	Below benchmark	3.4	-4.7	California Department of Public Health,			2011-13		2011-13		
HIV/AIDS/STDs		Population with HIV / AIDS, Rate (Per 100,000 Pop.)	STD - HIV Prevalence	Health Outcomes	Rate	250,259	n/a			310.1	289.0	State	Below benchmark	221.4	-88.69	Marin data source: County of Marin,			2012	2012	2012		
		HIV Hospital Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	STD - HIV Hospitalizations	Health Outcomes	Rate	no data	n/a			2.0	no data	State	Below benchmark	1.7	-0.27	California Office of Statewide Health			2011		2011		
	Related	HIV hospitalizations as percentage of total discharges	n/a	Clinical Care	Percentage	no data	n/a			0.2%	no data	State	Below benchmark	0.1%	-0.06%	California Office of Statewide Health			2011		2011		
		Percent Adults Never Screened for HIV / AIDS	STD - No HIV Screening	Clinical Care	Percentage	170,311	n/a			60.8%	62.8%	State	Below benchmark	58.0%	-2.79%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Suicide	Health Outcomes	Rate	252,409	<= 10.2			9.8	no data	State	Below benchmark	12.8	3.03	University of Missouri,Center for			2010-12		2010-12		
		Poor mental health (likely has serious psychological distress during past year)	n/a	Health Outcomes	Percentage	198,000				7.7%	8.5%	State	Below benchmark	4.5%	-3.20%	California Health Interview Survey			2014	2007	2014		x
		Percentage of Medicare Beneficiaries with Depression	Mental Health - Depression	Health Outcomes	Percentage	28,460	n/a			13.4%	15.5%	State	Below benchmark	11.2%	-2.18%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Mental Health Care Provider Rate (Per 100,000 Population)	Access to Mental Health	Clinical Care	Rate	264,639	n/a			157.0	134.1	State	Above benchmark	405.1	248.08	University of Wisconsin Population			2014	2014	2014		
		Percent reporting taken prescription medicine for emotional/mental health issue in past year (taken for	n/a	Clinical Care	Percentage	198,000	n/a			10.1%	no data	State	Below benchmark	15.6%	5.50%	California Health Interview Survey			2014		2014		
	Core	Percent of adults with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	198,000				28.5%	29.9%	State	Below benchmark	23.9%	-4.60%	California Health Interview Survey			2014	2011-12	2014		
		Percent of adults age 65+ with a physical, mental or emotional disability	n/a	Health Outcomes	Percentage	43,000				51.0%	51.9%	State	Below benchmark	57.7%	6.70%	California Health Interview Survey			2014	2011-12	2014		
		Percent of 11th grade students who seriously considered committing suicide in the past 12 months	n/a	Health Outcomes	Percentage	no date	n/a			17.0%	no data	n/a	Below benchmark	18.0%	1.00%	California Healthy Kids Survey			2011-13		2013-14		
Mental Health		Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that	n/a	Health Outcomes	Percentage					32.5%	no data	State	Below benchmark	26.7%	-5.80%	California Healthy Kids Survey			2011-13		2011-13		
		Youth suicide attempt rate (emergency room or hospitalization) (Per 100,000 residents ages 12-24)	n/a	Health Outcomes	Rate					235.0	no data	State	Below benchmark	158.0	-77	California Department of Public Health,			2000-11		2000-11		
		Drug poisoning deaths (total)	n/a	Health Outcomes	Number			21.00	n/a	no data		Marin County 2011	Below benchmark	39.00	18.00	RxSafe Marin Report Card; California	2011				2013		
		Percent of adults who report needing to see a professional	Mental Health - Needing Mental	Health Outcomes	Percentage	198,000	n/a			15.9%	no data	State	Below benchmark	19.5%	3.60%	California Health Interview Survey			2013-14		2013-14		x

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
		Total number of homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	1309	n/a	Marin County Homeless Point-in-					2015		
		Total number of unsheltered homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	835	n/a	Marin County Homeless Point-in-					2015		
	Related	Substantiated allegations of child maltreatment (abuse and neglect) per 1,000 children ages 0-17	n/a	Violence/Injury Prevention	Rate		<=8.5			8.7	no data	State	Below benchmark	4.0	-4.7	California Child Welfare Indicators			2014		2014		
		Percent of 11th grade students who report they've been victims of cyber bullying in the past 12 months	n/a	Health Outcomes	Percentage					23.2%	no data	State	Below benchmark	23.8%	0.60%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	n/a	Health Outcomes	Percentage					7.6%	no data	State	Below benchmark	6.6%	-1.00%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students reporting harassment or bullying on school property within the past 12	n/a	Health Outcomes	Percentage					27.6%	no data	State	Below benchmark	24.7%	-2.90%	California Healthy Kids Survey			2011-13		2011-13		
		Percent Adults Overweight	Overweight (Adult)	Health Outcomes	Percentage	181818	n/a			35.9%	35.8%	State	Below benchmark	30.8%	-5.01%	Centers for Disease Control and			2011-12	2011-12	2011-12		
		Percent Adults with BMI > 30.0 (Obese)	Obesity (Adult)	Health Outcomes	Percentage	197,845	<=30.5%			22.3%	27.1%	State	Below benchmark	17.5%	-4.82%	Centers for Disease Control and			2012	2012	2012		
		Percent Overweight Among Children (grades 5, 7, 9)	Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a			19.3%	no data	State	Below benchmark	16.3%	-2.98%	California Department of Education,			2013-14		2013-14		
	Core	Percent Obese Among Children (grades 5, 7, 9)	Obesity (Youth)	Health Outcomes	Percentage	7,276	<=16.1%			19.0%	no data	State	Below benchmark	8.9%	-10.11%	California Department of Education,			2013-14		2013-14		
		Percent of low income (<200% FPL) preschool children (age 2-4) who are obese	n/a	Health Outcomes	Percentage					17.2%	no data	State	Below benchmark	13.0%	-4.20%	CDPH (Pediatric Nutrition Surveillance			2010		2010		
		Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Diabetes Prevalence	Health Outcomes	Percentage	197,942	n/a			8.1%	9.1%	State	Below benchmark	5.5%	-2.55%	Centers for Disease Control and			2012	2012	2012		
		Percent of Medicare fee-for-service population with diabetes	n/a	Health Outcomes	Percentage					26.6%	27.0%	State	Below benchmark	15.2%	-11.40%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Diabetes mortality rate (age-adjusted) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					20.8%	no data	State	Below benchmark	8.9%	-11.90%	California Department of Public Health,			2011-13		2011-13		
		Diabetes Hospitalization Discharge Rate (Per 10,000 Pop.; Age-Adjusted)	Diabetes Hospitalizations	Health Outcomes	Rate	no data	n/a			10.4	no data	State	Below benchmark	5.1	-5.29	California Office of Statewide Health			2011		2011		
		Percent Adults with Heart Disease	Heart Disease Prevalence	Health Outcomes	Percentage	198,000	n/a			6.1%	no data	State	Below benchmark	7.6%	1.50%	California Health Interview Survey			2013-14		2013-14		x
		Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Ischaemic Heart	Health Outcomes	Rate	252,409	<= 100.8			163.2	no data	State	Below benchmark	107.9	-55.25	University of Missouri,Center for			2010-12		2010-12		
		Percent of Medicare fee-for-service population with ischaemic heart disease	n/a	Health Outcomes	Percentage					37.4%	28.6%	State	Below benchmark	23.6%	-13.78%	Centers for Medicare and Medicaid Services			2012	2012	2012		
		Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	Mortality - Stroke	Health Outcomes	Rate	252,409	n/a			37.4	no data	State	Below benchmark	27.6	-9.83	University of Missouri, Center for			2010-12		2010-12		
		Percent Adults with Inadequate Fruit / Vegetable Consumption	Low Fruit/Vegetable	Health Behaviors	Percentage	196,267	n/a			71.5%	75.7%	State	Below benchmark	64.3%	-7.20%	Centers for Disease Control and			2005-09	2005-09	2005-09		
		Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	Low Fruit/Vegetable	Health Behaviors	Percentage	31,000	n/a			47.4%	no data	State	Below benchmark	50.1%	2.70%	California Health Interview Survey			2012		2012		
		Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Fruit/Vegetable Expenditures	Health Behaviors	Percentage	no data	n/a			14.1%	12.7%	State	Above benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
		Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Soft Drink Expenditures	Health Behaviors	Percentage	no data	n/a			3.6%	4.0%	State	Below benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
		Percent Population with Low Food Access	Food Security - Food Desert	Social & Economic Factors	Percentage	252,409	n/a			14.3%	23.6%	State	Below benchmark	17.1%	2.74%	US Department of Agriculture, Economic			2010	2010	2010		
		Percent of low-income population with low food access	n/a	Physical Environment	Percentage					3.4%	6.3%	State	Below benchmark	2.0%	-1.42%	U.S. Department of Agriculture, Economic			2010	2010	2010		
		SNAP-authorized retailers (Per 1,000 Population)	n/a	Physical Environment	Rate					63.9	78.4	State	Above benchmark	0.4	-63.51045656	U.S. Department of Agriculture, Food and			2014	2014	2012		
		Fast Food Restaurants, Rate (Per 100,000 Population)	Food Environment - Food	Physical Environment	Rate	252,409	n/a			74.5	72.0	State	Below benchmark	76.1	1.56	US Census Bureau, County Business			2011	2011	2011		
Obesity/HEAL/ Diabetes		Grocery Stores, Rate (Per 100,000 Population)	Food Environment - Food	Physical Environment	Rate	252,409	n/a			21.5	21.1	State	Above benchmark	26.5	5.03	US Census Bureau,County			2011	2011	2011		
		WIC-Authorized Food Stores, Rate (Per 100,000 Population)	Food Environment - Food	Physical Environment	Rate	255,031	n/a			15.8	15.6	State	Above benchmark	9.0	-6.78	US Department of Agriculture,Economic			2011	2011	2011		
		Percent Population with no Leisure Time Physical Activity (Adult)	Physical Inactivity (Adult)	Health Behaviors	Percentage	198,426	n/a			16.6%	22.6%	State	Below benchmark	10.3%	-6.29%	Centers for Disease Control and			2012	2012	2012		
		Percent Physically Inactive (Youth)	Physical Inactivity	Health Behaviors	Percentage	7,276	n/a			35.9%	no data	State	Below benchmark	23.7%	-12.20%	California Department of Education,			2013-14		2013-14		
	Related	Percent of 7th graders who engaged in vigorous exercised for at least 20 minutes during 4 or more of	n/a	Health Behaviors	Percentage					no data	no data	n/a	Above benchmark	75.0%		California Healthy Kids Survey					2013-14		
		Percent of 9th graders who engaged in vigorous exercised for at least 20 minutes during 4 or more of	n/a	Health Behaviors	Percentage					no data	no data	n/a	Above benchmark	67.0%		California Healthy Kids Survey					2013-14		
		Percent of 11th graders who engaged in vigorous exercised for at least 20 minutes during 4 or more of	n/a	Health Behaviors	Percentage					no data	no data	n/a	Above benchmark	54.0%		California Healthy Kids Survey					2013-14		
		Percent of children age 2-11 drinking two or more sugar sweetened beverages (other than soda) on	n/a	Health Behaviors	Percentage	32,000				18.8%	no data	State	Below benchmark	20%	1.20%	California Health Interview Survey			2014		2014		x
		Percent of children under 18 consuming fast food at least once in past week	n/a	Health Behaviors	Percentage	52,000				72.3%	70.9%	State	Below benchmark	60.9%	-11.40%	California Health Interview Survey			2014	2011-12	2014		
		Percent of 11th grade students who report eating breakfast on day of survey	n/a	Health Behaviors	Percentage					60.6%	no data	State	Above benchmark	66.6%	6.00%	California Healthy Kids Survey			2011-13		2011-13		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
		Percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test administered by a health	n/a	Clinical Care	Percentage					81.5%	84.6%	State	Above benchmark	84.1%	2.60%	Dartmouth College Institute for Health			2012	2012	2012		
		Percent Population Within 1/2 Mile of a Park	Park Access	Physical Environment	Percentage	252,409	n/a			58.6%	no data	State	Above benchmark	68.0%	9.38%	US Census Bureau,Decennial			2010		2010		
		Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Recreation and Fitness Facility	Physical Environment	Rate	252,409	n/a			8.7	9.4	State	Above benchmark	24.2	15.52	US Census Bureau,County			2012	2012	2012		
		Percentage of Mothers Breastfeeding (Any)	Breastfeeding (Any)	Health Behaviors	Percentage	2,033	n/a			93.0%	no data	State	Above benchmark	98.5%	5.53%	California Department of Public Health,CDPH			2012		2012		
		Percentage of Mothers Breastfeeding (Exclusively)	Breastfeeding (Exclusive)	Health Behaviors	Percentage	2,033	n/a			64.8%	no data	State	Above benchmark	88.5%	23.72%	California Department of Public Health,CDPH			2012		2012		
		Average Daily School Breakfast Program Participation Rate	Food Security - School Breakfast	Social & Economic Factors	Percentage	no data	n/a			3.9	4.2	State	Below benchmark	no data		US Department of Agriculture,Food and			2013	2013			
		Percentage of Workers Commuting More than 60 Minutes	Economic Security - Food Security -	Social & Economic Factors	Percentage	108,758	n/a			10.1%	8.1%	State	Below benchmark	11.5%	1.35%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage of the Population with Food Insecurity	Food Insecurity	Social & Economic Factors	Percentage	252,759	n/a			16.2%	15.9%	State	Below benchmark	11.5%	-4.72%	Feeding America			2012	2012	2012		
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	257,059	n/a			2.7%	10.3%	State	Below benchmark	0.6%	-2.06%	University of Wisconsin Population			2012-13	2012-13	2012-13		
		Percent decrease in pedestrian volume during average weekday afternoon peak hour from 2012 to 2013	n/a	Health Behaviors	Percentage					no data	no data	n/a	Above benchmark	19.0%		County of Marin, Department of Public					2013-14		
		Percent decrease in bicyclist volume during average weekday afternoon peak hour from 2012 to 2013	n/a	Health Behaviors	Percentage					no data	no data	n/a	Above benchmark	3.0%		County of Marin, Department of Public					2013-14		
		Percentage Walking or Biking to Work	Commute to Work - Walking/Biking/	Health Behaviors	Percentage	121,269	n/a			3.8%	3.4%	State	Above benchmark	4.9%	1.04%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percentage Walking/Skating/Biking to School	Skating to	Health Behaviors	Percentage	41,558	n/a			43.0%	no data	State	Above benchmark	38.5%	-4.50%	California Health Interview Survey			2012		2012		
Oral Health	Core	Percent Adults with Poor Dental Health	Poor Dental Health	Health Outcomes	Percentage	197,152	n/a			11.3%	15.7%	State	Below benchmark	6.2%	-5.12%	Centers for Disease Control and			2006-10	2006-10	2006-10		
		Percent of adults who self-report they have not visited a dentist, dental hygienist, or dental clinic within past	Dental Care - No Recent Exam	Clinical Care	Percentage	197,152	n/a			30.5%	no data	State	Below benchmark	18.4%	-12.10%	Centers for Disease Control and			2013-14	2006-10	2013-14		
		Percent of children age 2-11 who self-report they have not visited a dentist, dental hygienist, or dental clinic	Dental Care - No Recent Exam	Clinical Care	Percentage	32,000	n/a			9.90%	no data	State	Below benchmark	7.8%	-2.10%	California Health Interview Survey			2014		2014		x
		Percent Adults Without Dental Insurance	Absence of Dental	Clinical Care	Percentage	189,000	n/a			40.9%	no data	State	Below benchmark	43.3%	2.40%	California Health Interview Survey			2009		2009		
		Percent of children and teens who could not afford needed dental care / dental care affordability	n/a	Clinical Care	Percentage	50,000	n/a			6.3%	no data	State	Below benchmark	4.7%	-1.60%	California Health Interview Survey			2009		2009		
		Dentists, Rate per 100,000 Pop.	Access to Dentists	Clinical Care	Rate	258,365	n/a			77.5	63.2	State	Above benchmark	106.1	0	US Department of Health & Human			2013	2013	2013		
		Percentage of Population Living in a Dental HPSA	Health Professional	Clinical Care	Percentage	252,409	n/a			4.9%	32.0%	State	Below benchmark	0.0%	-4.93%	US Department of Health & Human			2015	2015	2015		
	Related	Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Soft Drink Expenditures	Health Behaviors	Percentage	no data	n/a			3.6%	4.0%	State	Below benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
		Percent of adults with dental insurance for all or part of past year	n/a	Clinical Care	Percentage	189,000				66.3%	no data	State	Above benchmark	64.0%	-2.26%	California Health Interview Survey			2007		2007		
		Percent of adults age 65+ with dental insurance for all or part of past year	n/a	Clinical Care	Percentage	37,000				52.7%	no data	State	Above benchmark	46.6%	-6.13%	California Health Interview Survey			2007		2007		
		Percentage of Population Potentially Exposed to Unsafe Drinking Water	Drinking Water Safety	Physical Environment	Percentage	257,059	n/a			2.7%	10.3%	State	Below benchmark	0.6%	-2.06%	University of Wisconsin Population			2012-13	2012-13	2012-13		
		Percent Population Age 5-17 Unable to Afford Dental Care	Dental Care - Lack of	Clinical Care	Percentage	50,000	n/a			6.3%	no data	State	Below benchmark	4.7%	-1.60%	California Health Interview Survey			2009		2009		X
Overall Health	Core	Percent Adults with Poor or Fair Health (Age-Adjusted)	Poor General Health	Health Outcomes	Percentage	198,881	n/a			18.4%	15.7%	State	Below benchmark	9.7%	-8.70%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Percent of adults with a physical, mental or emotional disability	n/a	Mental Health	Percentage	198,000	n/a			28.5%	no data	State	Below benchmark	23.9%	-4.60%	California Health Interview Survey			2014		2014		
		Percent of adults age 65+ with a physical, mental or emotional disability	n/a	Mental Health	Percentage	43,000				51.0%	no data	State	Below benchmark	57.7%	6.70%	California Health Interview Survey			2014		2014		
		Percent Low Birth Weight Births	Low Birth Weight	Health Outcomes	Percentage	252,409	n/a			6.8%	no data	State	Below benchmark	6.2%	-0.63%	California Department of Public Health,CDPH			2011		2011		
		Percent Population with a Disability	Population with Any Disability	Demographics	Percentage	248,491	n/a			10.1%	12.1%	State	Below benchmark	9.0%	-1.18%	US Census Bureau, American Community			2009-13	2009-13	2009-13		
		Percent of children age 0-12 considered in excellent or very good health	n/a	Health Outcomes	Percentage	36,000				78.7%	no data	State	Above benchmark	93.3%	14.62%	California Health Interview Survey			2014		2014		x
		Age adjusted death rate, all causes (per 100,000 Pop.)	n/a	Health Outcomes	Rate					641.1	no data	State	Below benchmark	524.9	-116.18	Centers for Disease Control and			2011-13		2011-13		
		Child mortality, 1-4 years (per 100,000)	n/a	Health Outcomes	Rate	no data	<=25.7			20.4	26.0	State	Below benchmark	suppressed		US Census Bureau, American Community			2011-13	2011-13	2011-13		
		Child mortality, 5-14 years (per 100,000)	n/a	Health Outcomes	Rate	no data	n/a			10.4	12.9	State	Below benchmark	suppressed		California Department of Public Health / US			2011-13	2011-13	2011-13		
		Premature death/ Years of Potential Life Lost before age 75 (Per 100,000 Pop.)	Mortality - Premature	Health Outcomes	Rate					5,275	6,605	State	Below benchmark	3621.6	-1653.00	NVSS-M (CDC/NCHS)			2011-13	2011-13	2011-13		
		Alzheimer's disease mortality rate (age-adjusted) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					30.8	no data	State	Below benchmark	38.5	7.70	California Department of Public Health			2011-13		2011-13		
		Percent Low Birth Weight Births	Low Birth Weight	Health Outcomes	Percentage	252,409	n/a			6.8%	no data	n/a	Below benchmark	6.2%	-0.63%	California Department of Public Health,CDPH			2011		2011		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statistically unstable	County data statistically unstable
Pregnancy and Birth Outcomes	Core	Infant Mortality Rate (Per 1,000 Births)	Infant Mortality	Health Outcomes	Rate	12,775	<= 6.0			5.0	6.5	n/a	Below benchmark	3.3	-1.70	Centers for Disease Control and			2006-10	2006-10	2006-10		
		Percent Mothers with Late or No Prenatal Care	Lack of Pren/atal Care	Clinical Care	Percentage	252,409	n/a			3.1%	no data	State	Below benchmark	no data		California Department of Public Health,CDPH			2011				
		Percent of pre-term births (< 37 weeks gestation)	n/a	Health Outcomes	Percentage					8.8%	11.4%	State	Below benchmark	8.8%	0.00%	California Department of Public Health/			2013	2013	2013		
		Percent of newborns with low birth weight	n/a	Health Outcomes	Percentage					6.8%	8.0%	State	Below benchmark	6.9%	0.10%	Centers for Disease Control and			2013	2013	2013		
		Percent of newborns with very low birth rates	n/a	Health Outcomes	Percentage					1.2%	1.4%	State	Below benchmark	0.9%	-0.30%	California Department of Public Health /			2013	2013	2013		
		Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	Teen Births (Under Age 20)	Social & Economic Factors	Rate	27,504	n/a			8.5	no data	State	Below benchmark	2.7	-5.81	California Department of Public Health,CDPH			2011		2011		
	Related	Pounds of pesticides applied and rank among California counties	n/a	Physical Environment	Number					193,597,806	n/a	n/a	n/a	84,836	n/a	California Department of Pesticide			2013				
		Percent of births by C-section to low risk women giving birth for the first time	n/a	Health Outcomes	Percentage		<=23.9%			26.3%	26.5%	State	Below benchmark	22.2%	-4.10%	California Department of Public Health/			2011	2011	2011		
		Percentage of Mothers Breastfeeding (Any)	Breastfeeding (Any)	Health Behaviors	percentage	2,033	n/a			93.0%	no data	State	Above benchmark	98.5%	5.53%	California Department of Public Health,CDPH			2012		2012		
		Percentage of Mothers Breastfeeding (Exclusively)	Breastfeeding (Exclusive)	Health Behaviors	Percentage	2,033	n/a			64.8%	no data	State	Above benchmark	88.5%	23.72%	California Department of Public Health,CDPH			2012		2012		
		Head Start Programs Rate (Per 10,000 Children Under Age 5)	Education - Head Start	Social & Economic Factors	Rate	13,932	n/a			6.3	7.6	State	Above benchmark	6.5	0.12	US Department of Health & Human			2014	2014	2014		
		Percentage of Population Age 3-4 Enrolled in School	Education - School	Social & Economic Factors	Percentage	no data	n/a			47.8%	47.1%	State	Above benchmark	66.2%	18.40%	US Census Bureau, American Community			2014	2014	2014		
		Percentage of the Population with Food Insecurity	Food Security - Food Insecurity	Social & Economic Factors	Percentage	252,759	n/a			16.2%	15.9%	State	Below benchmark	11.5%	-4.72%	Feeding America			2012	2012	2012		
Substance Abuse/Tobacco	Core	Percent Population Smoking Cigarettes(Age-Adjusted)	Tobacco Usage	Health Behaviors	Percentage	198,881	n/a			12.8%	18.1%	State	Below benchmark	11.0%	-1.80%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Cigarette Expenditures, Percentage of Total Household Expenditures	Tobacco Expenditures	Health Behaviors	Percentage	no data	n/a			1.0%	1.6%	State	Below benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
		Percent of 12-17 year olds binge drinking at least once in month prior	n/a	Substance Abuse/Tobacco	Percentage		<=8.6%			5.8%	9.5%	State	Below benchmark	16.2%	10.40%	California Health Interview Survey			2014	2008	2014		x
		Percent of 11th grade students reporting driving after drinking (respondent or by friend)	n/a	Health Behaviors	Percentage					23.0%	no data	State	Below benchmark	24.2%	1.20%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students using cigarettes any time within last 30 days	n/a	Health Behaviors	Percentage					10.2%	no data	State	Below benchmark	12.1%	1.90%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th graders reporting non-medical use of Rx painkillers	n/a	Health Behaviors	Percentage					19.0%	no data	n/a	Below benchmark	16.0%	-3.00%	California Healthy Kids Survey			2011-13		2011-13		
		Number of naloxone doses administered by Emergency Medical Services	n/a	Health Behaviors	Number			198		n/a	no data	Marin County 2011	Below benchmark	131	-67.00	RxSafe Marin; Marin County Emergency	2011				2013		
		Median number of pills per narcotic prescription	n/a	Health Behaviors	Number			45		n/a	no data	Marin County 2011	Below benchmark	56	11.00	Controlled Substance Utilization Review and	2011				2013		
		Number of controlled substance prescriptions	n/a	Health Behaviors	Number			403,561		n/a	no data	Marin County 2011	Below benchmark	412,356	8795.00	Controlled Substance Utilization Review and	2011				2013		
		Percent of 11th grade students reporting marijuana use within the last 30 days	n/a	Health Behaviors	Percentage					22.0%	no data	State	Below benchmark	32.8%	10.80%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students who report they've been "high" from using drugs	n/a	Health Behaviors	Percentage					38.3%	no data	State	Below benchmark	48.7%	10.40%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of survey respondents who think it would be very or somewhat easy to obtain prescription pain,	n/a	Health Outcomes	Percentage					no data	no data	n/a	Below benchmark	48.1%		RxSafe Marin County Survey					2015		
		Drug poisoning deaths (total)	n/a	Health Outcomes	Number			21		n/a	no data	Marin County 2011	Below benchmark	39	18.00	California Department of Public Health	2011				2013		
		Drug poisoning deaths (unintentional)	n/a	Health Outcomes	Number			13		n/a	no data	Marin County 2011	Below benchmark	27	14.00	California Department of Public Health	2011				2013		
		Percent of survey respondents with pills leftover from last pain medication prescription	n/a	Clinical Care	Percentage					no data	no data	n/a	Below benchmark	45.4		RxSafe Marin County Survey					2015		
		Percent of survey respondents with pills leftover from last pain medication prescription who kept, sold, or	n/a	Clinical Care	Percentage					no data	no data	n/a	Below benchmark	61.7		RxSafe Marin County Survey					2015		
		Percent of survey respondents with expired, unsused, or "leftover" prescription medication in their home	n/a	Clinical Care	Percentage					no data	no data	n/a	Below benchmark	25		RxSafe Marin County Survey					2015		
		Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	Alcohol - Excessive	Health Behaviors	Percentage	198,881	n/a			17.2%	16.9%	State	Below benchmark	19.5%	2.30%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a			12.9%	14.3%	State	Below benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
	Related	Rate of arrests for alcohol related offenses (felony and misdemeanor) among persons age 10 to 69 years (Per	n/a	Social and Economic Factors	Rate					1203.0	no data	State	Below benchmark	1501.0	298.00	CA-Community Prevention Initiative			2008		2008		
		Percent of adult smokers who attempted to quit for at least one day in the past year	n/a	Health Behaviors	Percentage					60.7%	no data	State	Above benchmark	43.4%	-17.30%	California Health Interview Survey			2014		2014		
		Chronic liver disease and cirrhosis mortality rate (Per 100,000 Pop.)	n/a	Health Outcomes	Rate		<= 8.2			11.7	no data	State	Below benchmark	6.0	-5.70	California Department of Public Health, Marin County			2011-13		2011-13		
		Total number of homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	1309		Homeless Point-in-Marin County					2015		
		Total number of unsheltered homeless individuals	n/a	Social and Economic Factors	Number					no data	no data	n/a	n/a	835		Homeless Point-in-					2015		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statisticall y unstable	County data statistically unstable
		Liquor Stores, Rate (Per 100,000 Population)	Liquor Store Access	Physical Environment	Rate	252,409	n/a			10.0	10.4	State	Below benchmark	8.7	-1.30	US Census Bureau,County			2012	2012	2012		
Vaccine Preventable Infectious Disease	Core	Percent of kindergarteners with all required immunizations	n/a	Clinical Care	Percentage		>= 95.0			90.4%	no data	State	Above benchmark	84.2%	-6.20%	California Department of Public Health,			2015		2015		
		Percentage of adults age 65+ who have ever received a pneumonia vaccination	n/a	Clinical Care	Percentage					63.4%	67.5%	State	Above benchmark	64.3%	0.90%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Pertussis rate (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					6.3	no data	State	Below benchmark	71.8	65.50	California Department of Public Health,			2013		2013		
		Influenza and pneumonia mortality (age-adjusted) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					16.3	no data	State	Below benchmark	10.8	-5.50	California Department of Public Health			2011-13		2011-13		
Violence/Injury Prevention	Core	Homicide, Age-Adjusted Mortality Rate (Per 100,000 Pop.)	Mortality - Homicide	Health Outcomes	Rate	252,409	<= 5.5			5.2	no data	State	Below benchmark	1.3	-3.87	University of Missouri,Center for			2010-12		2010-12		
		Suicide, Age-Adjusted Mortality Rate (Per 100,000 Pop.)	Mortality - Suicide	Health Outcomes	Rate	252,409	<= 10.2			9.8	no data	State	Below benchmark	12.8	3.03	University of Missouri,Center for			2010-12		2010-12		
		Motor Vehicle Accident, Age-Adjusted Mortality Rate (Per 100,000 Pop.)	Mortality - Motor Vehicle	Health Outcomes	Rate	252,409	<= 12.4			5.2	no data	State	Below benchmark	0.7	-4.52	University of Missouri,Center for			2010-12		2010-12		
		Motor vehicle crash death rate (age-adjusted) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate					8.0	no data	State	Below benchmark	3.9	-4.10	Centers for Disease Control and			2011-13		2011-13		
		Pedestrian motor vehicle death rate (Per 100,000 Pop.)	n/a	Health Outcomes	Rate		<=1.3			2.0	no data	State	Below benchmark	no data		U.S. Department of Transportation,			2011-2013				
		Pedestrian Accident, Age-Adjusted Mortality Rate (Per 100,000 Pop.)	Mortality - Pedestrian	Health Outcomes	Rate	252,409	<= 1.3			2.0	no data	State	Below benchmark	0.3	-1.68	University of Missouri,Center for			2010-12		2010-12		
		Youth Intentional Injuries Rate (Per 100,000) (Youth Age 13 - 20)	Violence - Youth Intention/al	Social & Economic Factors	Rate	22,733	n/a			738.7	no data	State	Below benchmark	654.0	-84.75	3-year averages for 2011-2013 generated			2011-13		2011-13		
		Unintentional injury mortality rate (age-adjusted) (Per 100,000 Pop.)	n/a	Health Outcomes	Rate		<=36.0			27.9	no data	State	Below benchmark	29.1	1.20	Centers for Disease Control and			2011-13		2011-13		
		Assault Injuries Rate (Per 100,000 Pop.)	Violence - Assault (Injury)	Social & Economic Factors	Rate	254,673	n/a			290.3	no data	State	Below benchmark	190.2	-100.12	3-year averages for 2011-2013 generated			2011-13		2011-13		
		Domestic Violence Injuries Rate among Females Age 10+ (Per 100,000 Pop.)	Violence - Domestic	Social & Economic Factors	Rate	115,861	n/a			9.5	no data	State	Below benchmark	15.3	5.75	3-year averages for 2011-2013 generated			2011-13		2011-13		
		Assault Rate (Per 100,000 Pop.)	Violence - Assault (Crime)	Social & Economic Factors	Rate	255,060	n/a			249.4	246.9	State	Below benchmark	128.1	-121.33	Federal Bureau of Investigation,FBI			2010-12	2010-12	2010-12		
		Substantiated allegations of child maltreatment (abuse and neglect) per 1,000 children ages 0-17	n/a	Health Outcomes	Rate		<=8.5			8.7	no data	State	Below benchmark	4.0	-4.70	California Child Welfare Indicators			2014		2014		
		Non-fatal emergency department visits for intentional injuries among youth age 13-20	n/a	Health Outcomes	Rate					738.7	no data	State	Below benchmark	no data		California Office of Statewide Health			2011-13				
		Rate of non-fatal emergency department visits for assault (Per 100,000 Pop.)	n/a	Social and Economic Factors	Rate					290.3	no data	State	Below benchmark	no data		California Department of Public Health			2011-13				
		Percent of adults reporting experiencing physical or sexual violence by an intimate partner in past year	n/a	Social and Economic Factors	Percentage	154,000				3.5%	no data	State	Below benchmark	1.7%	-1.80%	California Health Interview Survey			2009		2009		
		Percent of adults reporting ever experiencing physical or sexual violence by an intimate partner since age 18	n/a	Social and Economic Factors	Percentage	154,000				14.8%	no data	State	Below benchmark	15.4%	0.60%	California Health Interview Survey			2009		2009		
		Robbery Rate (Per 100,000 Pop.)	Violence - Robbery (Crime)	Social & Economic Factors	Rate	255,060	n/a			149.5	116.4	State	Below benchmark	57.5	-92.00	Federal Bureau of Investigation,FBI			2010-12	2010-12	2010-12		
	Related	Rate of domestic violence calls for assistance (Per 1,000 Pop.)	n/a	Social & Economic Factors	Rate					5.1	no data	State	Below benchmark	4.1	-1.00	California Department of Justice, Criminal			2013		2013		
		Violent Crime Rate (Per 100,000 Pop.)	Violence - All Violent Crimes	Social & Economic Factors	Rate	255,060	n/a			425.0	395.5	State	Below benchmark	202.7	-222.30	Federal Bureau of Investigation,FBI			2010-12	2010-12	2010-12		
		Percentage of 11th grade students reporting current gang involvement	n/a	Social and Economic Factors	Percentage					7.5%	no data	State	Below benchmark	6.3%	-1.20%	California Healthy Kids Survey			2011-13		2011-13		
		Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	Alcohol - Excessive	Health Behaviors	Percentage	198,881	n/a			17.2%	16.9%	State	Below benchmark	19.5%	2.30%	Centers for Disease Control and			2006-12	2006-12	2006-12		
		Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Alcohol - Expenditures	Health Behaviors	Percentage	no data	n/a			12.9%	14.3%	State	Below benchmark	suppressed		Nielsen Site Reports			2014	2014	2014		
		Percent of 11th grade students reporting driving after drinking (respondent or by friend)	n/a	Health Behaviors	Percentage					23.0%	no data	State	Below benchmark	24.2%	1.20%	California Healthy Kids Survey			2011-13		2011-13		
		Liquor Stores, Rate (Per 100,000 Pop.)	Liquor Store Access	Physical Environment	Rate	252,409	n/a			10.0	10.4	State	Below benchmark	8.7	-1.30	US Census Bureau,County			2012	2012	2012		
		Rape Rate (Per 100,000 Pop.)	Violence - Rape (Crime)	Social & Economic Factors	Rate	255,060	n/a			21.0	27.3	State	Below benchmark	16.3	-4.66	Federal Bureau of Investigation,FBI			2010-12	2010-12	2010-12		
		Suspension Rate (Per 100 enrolled students)	Violence - School	Social & Economic Factors	Rate	65,437	n/a			4.0	no data	State	Below benchmark	2.1	-1.94	California Department of Education			2013-14		2013-14		
		Expulsion Rate (per 100 enrolled students)	Violence - School	Social & Economic Factors	Rate	65,437	n/a			0.1	no data	State	Below benchmark	0.0	-0.04	California Department of Education			2013-14		2013-14		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in English	n/a	Social and Economic Factors	Percentage					38.0%	n/a	State	Above benchmark	26.0%	-12.00%	California Department of Education			2013-14		2014		
		Percent of English language learners (grade 10) who passed the California High School Exit Exam in Math	n/a	Social and Economic Factors	Pecentage					54.0%	n/a	State	Above benchmark	37.0%	-17.00%	California Department of Education			2013-14		2014		
		Suspension Rate (per 100 enrolled students)	Violence - School	Social & Economic Factors	Rate	65,437	n/a			4.0	no data	State	Below benchmark	2.1	-1.94	California Department of Education			2013-14		2013-14		
		Expulsion Rate (per 100 enrolled students)	Violence - School	Social & Economic Factors	Rate	65,437	n/a			0.1	no data	State	Below benchmark	0.0	-0.04	California Department of Education			2013-14		2013-14		
		Cohort Graduation Rate (Percent of students graduating in 4 years)	Education - High School	Social & Economic Factors	Rate	2,226	>= 82.4			80.4	no data	State	Above benchmark	91.4	10.98	California Department of Education			2013		2013		

Health Indicators								Benchmark					Needs Score			Data Details							
Potential Health Needs	Core/ Related	Indicator	Kaiser Indicator Name	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Marin county previous time point	Greater Bay Area	State Benchmark	National Benchmark	Benchmark used to score	Desired Direction	Value for Marin County	Difference from the Benchmark Value	Data Source	Marin previous data year	Greater Bay Area data year	State data year	National data year	Marin County data year	State data statisticall y unstable	County data statistically unstable
Youth Development	Core	Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	Teen Births (Under Age 20)	Social & Economic Factors	Rate	27,504	n/a			8.5	no data	State	Below benchmark	2.7	-5.81	California Department of Public Health,			2011		2011		
		Percent of 11th grade students who report they've been victims of cyber bullying in the past 12 months	n/a	Health Outcomes	Percentage					23.2%	no data	State	Below benchmark	23.8%	0.60%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	n/a	Health Outcomes	Percentage					7.6%	no data	State	Below benchmark	6.6%	-1.00%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of 11th grade students reporting harassment or bullying on school property within the past 12	n/a	Health Outcomes	Percentage					27.6%	no data	State	Below benchmark	24.7%	-2.90%	California Healthy Kids Survey			2011-13		2011-13		
		Percentage of 11th grade students reporting current gang involvement	n/a	Social and Economic Factors	Percentage					7.5%	no data	State	Below benchmark	6.3%	-1.20%	California Healthy Kids Survey			2011-13		2011-13		
		Percent of children in foster care system for more than 8 days but less than 12 months with 2 or less	n/a	Social and Economic Factors	Percentage					86.6%	no data	State	Above benchmark	81.8%	-4.80%	California Child Welfare Indicators			2014		2014		
		Percent of children no longer in foster care system after 12 months	n/a	Social and Economic Factors	Percentage	no data	n/a			38.3%	no data	State	Above benchmark	suppressed		California Child Welfare Indicators			2013		2013		

Marin County, CA

Health Indicators							Benchmark	Race/Ethnic Group Data														
Potential Health Needs	Core/Related	Indicators	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	Report Area Benchmark	Desired Direction	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Native America/ Alaskan Native	Non-Hispanic Asian	Non-Hispanic Native Hawiian/ Pacific Islander	Non-Hispanic Other	Non-Hispanic Multiple Race	White Alone	Black Alone	Native American/ Alaskan Native Alone	Asian Alone	Native Hawiian/ Pacific Islander Alone	Some Other Race Alone	Multiple Race	Hispanic/ Latino (Any Race)	Not Hispanic/ Latino (Any Race)
Obesity/HEAL/ Diabetes	Core	Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a	16.32%	Below benchmark	13.45%								17.12%					19.41%	22.33%	
	Related	Low Fruit/Vegetable Consumption (Youth)	Health Behaviors	Percentage	31,000	n/a	50.10%	Below benchmark	65.70%					25.70%									27.60%	
		Physical Inactivity (Youth)	Health Behaviors	Percentage	7,276	n/a	23.72%	Below benchmark	18.08%	37.86%		19.07%			25.97%								41.41%	
		Breastfeeding (Any)	Health Behaviors	percentage	2,033	n/a	98.52%	Above benchmark	98.42%	100.00%		100.00%		100.00%	98.99%								98.18%	
		Breastfeeding (Exclusive)	Health Behaviors	Percentage	2,033	n/a	88.49%	Above benchmark	90.42%	84.09%		82.61%			81.82%								87.59%	
		Walking/Biking/Skating to School	Health Behaviors	Percentage	41,558	n/a	0.385	Above benchmark	0.376	0.929				0.287									0.42	
Mental Health	Core	Mortality - Suicide	Health Outcomes	Rate	252,409	<= 10.2	12.83	Below benchmark	13.311539								12.462001		9.24451			0	6.209172	
		Mental Health - Needing Mental Health Care	Health Outcomes	Percentage	245,000	n/a	11.60%	Below benchmark	22.20%	40.30%				11.80%									24.90%	
Access to Care	Related	Insurance - Uninsured Population	Social & Economic Factors	Percentage	248,491	n/a	8.91%	Below benchmark	5.18%								15.67%	27.09%		7.47%	33.07%	10.98%	26.57%	5.72%
Asthma	Related	Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a	16.32%	Below benchmark	13.45%								17.12%					19.41%	22.33%	
Oral Health	Core	Absence of Dental Insurance Coverage	Clinical Care	Percentage	189,000	n/a	43.30%	Below benchmark	34.44%															
CVD/Stroke	Core	Heart Disease Prevalence	Health Outcomes	Percentage	194,000	n/a	7.30%	Below benchmark	9.10%														3.80%	
		Mortality - Ischaemic Heart Disease	Health Outcomes	Rate	252,409	<= 100.8	107.93	Below benchmark	112.748139								174.54478		86.237659			49.343922	24.431514	
		Mortality - Stroke	Health Outcomes	Rate	252,409	n/a	27.55	Below benchmark	27.627009								53.038065		16.952954			3.989346	20.313126	
	Related	Physical Inactivity (Youth)	Health Behaviors	Percentage	7,276	n/a	23.72%	Below benchmark	18.08%	37.86%		19.07%			25.97%								41.41%	
		Overweight (Youth)	Health Outcomes	Percentage	7,276	n/a	16.32%	Below benchmark	13.45%								17.12%					19.41%	22.33%	
Violence/Injury Prevention	Core	Mortality - Homicide	Health Outcomes	Rate	252,409	<= 5.5	1.28	Below benchmark	0.897483								4.895692		0			0	0.7278	
		Mortality - Suicide	Health Outcomes	Rate	252,409	<= 10.2	12.83	Below benchmark	13.311539								12.462001		9.24451			0	6.209172	
		Mortality - Motor Vehicle Accident	Health Outcomes	Rate	252,409	<= 12.4	0.66	Below benchmark	0.325882								0		1.517075			2.757478	0.7278	
		Mortality - Pedestrian Accident	Health Outcomes	Rate	252,409	<= 1.3	0.29	Below benchmark	0.106556								0		1.517075			0	0	
Cancers	Core	Cancer Incidence - Breast	Health Outcomes	Rate	127,211	<= 40.9	143.7	Below benchmark								151.8							122.5	
		Mortality - Cancer	Health Outcomes	Rate	252,409	<= 160.6	146.68	Below benchmark	150.160192								187.18963		122.33169			81.032266	60.946421	
		Cancer Incidence - Cervical	Health Outcomes	Rate	127,211	<= 7.1	5	Below benchmark								5.9								
		Cancer Incidence - Colon and Rectum	Health Outcomes	Rate	250,666	<= 38.7	40.4	Below benchmark								40.1							43.5	
		Cancer Incidence - Prostate	Health Outcomes	Rate	123,455	n/a	174.2	Below benchmark								184.5	244.2						171	
		Cancer Incidence - Lung	Health Outcomes	Rate	250,666	n/a	44.8	Below benchmark								45.8	54.5						37.3	
HIV/AIDS/STDs	Core	STD - HIV Prevalence	Health Outcomes	Rate	215,041	n/a	426.8	Below benchmark	319.11	3484.32													520.53	
Maternal and Infant Health	Core	Infant Mortality	Health Outcomes	Rate	12,775	<= 6.0	3.3	Below benchmark	2.6	-9999													-9999	
	Related	Breastfeeding (Any)	Health Behaviors	percentage	2,033	n/a	98.52%	Above benchmark	98.42%	100.00%		100.00%		100.00%	98.99%								98.18%	
		Breastfeeding (Exclusive)	Health Behaviors	Percentage	2,033	n/a	88.49%	Above benchmark	90.42%	84.09%		82.61%			81.82%								87.59%	
Economic Security	Core	Poverty - Population Below 100% FPL	Social & Economic Factors	Percentage	247,026	n/a	7.74%	Below benchmark								6.25%	24.69%	34.11%		9.39%	16.26%	8.98%	17.53%	5.98%
		Poverty - Children Below 100% FPL	Social & Economic Factors	Percentage	247,026	n/a	8.94%	Below benchmark	4.19%								26.75%	61.49%		0.00%	19.77%	7.20%	20.74%	5.51%
	Related	Education - High School Graduation Rate	Social & Economic Factors	Rate	2,226	>= 82.4	91.42	Above benchmark	94.86	80.26		95.31		91.8									83.02	
		Education - Reading Below Proficiency	Social & Economic Factors	Percentage	2,492	<= 36.3%	19.00%	Below benchmark	0.98%	8.33%	0.00%	1.61%											10.03%	
		Education - Less than High School Diploma (or Equivalent)	Social & Economic Factors	Percentage	187,029	n/a	7.62%	Below benchmark								3.94%	22.17%	27.57%		19.38%	43.68%	13.82%	34.46%	3.82%
		Insurance - Uninsured Population	Social & Economic Factors	Percentage	248,491	n/a	8.91%	Below benchmark	5.18%								15.67%	27.09%		7.47%	33.07%	10.98%	26.57%	5.72%
Climate and Health	Related	Mortality - Ischaemic Heart Disease	Health Outcomes	Rate	252,409	<= 100.8	107.93	Below benchmark	112.748139								174.54478		86.237659			49.343922	24.431514	
Overall Health	Core	Population with Any Disability	Demographics	Percentage	248,491	n/a	8.95%	Below benchmark								9.36%	14.86%	19.79%		6.70%	3.45%	7.55%	4.94%	9.67%

Marin County
Community Health Needs Assessment
Appendix C. Community Input Tracking Form

Data Collection Method	Title/Name	Number	Target Group(s) Represented (interviewee or at least one participant in the focus group self-identified as a leader, member, or representative of the following populations)*					Date Input Was Gathered
Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and name or focus group population**	**Number of participants**	**Health Department representative**	**Chronic Condition**	**Minority**	**Medically underserved**	**Low-income**	**Date of data collection**
Interview	Executive Director, Apple Family Works	1		X	X		X	10/9/15
Interview	Executive Director, Canal Alliance	1						9/22/15
Interview	Executive Director, Coastal Health Alliance	1				X	X	9/22/15
Interview	Founder & Chairman, ExtraFood.org	1						10/21/15
Interview	Deputy Executive, Homeward Bound	1					X	9/23/15
Interview	Executive Director, Huckleberry Youth Program	1			X	X	X	10/2/15
Interview	Medical Group Administrator, Kaiser Permanente Medical Center	1						10/13/15
Interview	Executive Director, Marin Center for Independent Living	1		X	X	X	X	10/1/15

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Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Chief Executive Officer, Marin Community Clinics	1		X	X	X	X	9/24/15
Interview	President, Marin County Board of Supervisors	1						9/28/15
Interview	Public Health Officer, Marin County Health & Human Services	1	X					10/21/15
Interview	County Superintendent of Schools, Marin County Office of Education	1		X	X	X	X	10/2/15
Interview	Chief Administrative Officer, Marin General Hospital	1						10/2/15
Interview	Chief Administrative Officer, Novato Community Hospital	1		X	X	X	X	9/25/15
Interview	Medical Director, RotaCare Clinic of San Rafael	1		X	X	X	X	9/22/15
Interview	Chief Executive Officer, Whistlestop	1		X	X	X	X	9/22/15
Interview	Executive Director, Marin YMCA	1		X			X	9/24/15
Interview	General Manager, Marin City Community Services District	1			X	X	X	10/2/15
Interview	Police Chief, San Rafael	1		X	X	X	X	10/21/15
Interview	Director of Special Education, Novato Unified School District	1			X			10/27/15

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Appendix C. Community Input Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Focus Group	Marin County; Youth (English)	4		X	X		X	10/5/15
Focus Group	Marin City; Adults (English)	17		X	X	X	X	10/5/15
Focus Group	Marin County; Residents in recovery from substance abuse (English)	8		X	X	X	X	10/8/15
Focus Group	Novato; Adults (Spanish)	13		X	X	X	X	10/8/15
Focus Group	San Geronimo; Adults (English)	11		X			X	10/14/15
Focus Group	Canal; Adults (Spanish)	13		X	X	X	X	10/14/15
Focus Group	Novato; Residents experiencing homelessness (English)	14		X	X	X	X	10/13/15
Focus Group	West Marin; Adults (Spanish)	10		X	X	X	X	10/22/15

* Indicates self-identification of interviewees or focus group participants as a leader, member, or representative of each specified population. In some cases, individuals did not self-identify as a representative of any of the listed groups.

Marin County
Community Health Needs Assessment
Appendix D. Primary Data Collection Tools
Key Informant Interview Protocol

Date: _____

Interviewee ID: _____ **Interviewee Name:** _____

Position: _____ **Organization:** _____

Interviewer: _____

Introduction

Hello, my name is _____ and I work for Harder+Company Community Research. We are working with Healthy Marin Partnership and several non-profit hospitals in Marin on a comprehensive Community Health Needs Assessment (CHNA).

You have been identified as an individual with extensive and important knowledge of the *[Marin County Community / Specific subpopulation of Marin County]* that can help us with the CHNA -- to help ensure that we get a clear picture of health-related issues that impact our Marin County residents. We are very interested in having you share thoughts and ideas that go beyond access to medical care, taking into consideration social, economic, and environmental factors that impact health. Your input will inform the development of the CHNA as well as a community health implementation plan for all of Marin County

This interview will take about 30-45 minutes. Our discussion today will be incorporated into the Community Health Needs Assessment for Marin County. Everything we talk about today is confidential. That means that when I write up a report of what was said, I won't use your name or any other information to identify who you are. However, there is always a chance that someone is able to identify what you said.

Do you have any questions so far?

Before we start talking about the specifics, I want to make sure you know that, during this interview:
There is no right or wrong answer, just your ideas.
It's ok if you don't have an answer or opinion about a particular question. It is just as important for us to know that too. "I don't know" is an ok thing to say. And finally,
If at any time while we are talking you are not sure what I mean or have questions, do not hesitate to ask questions and let me know.

I would like to take notes and record during the interview so that I make sure that I get your statements exactly how you stated them.
Is it ok for me to take notes? Great! Just as a reminder, since I will be typing notes, there might be some short delays to make sure I am able to capture everything you say.
Is it ok for me to record our conversation?
Before we begin, do you have any questions?

Questions

1. a) Would you give me a brief description of your organization, and your role there?

   b) Within Marin County, what geographic area do you primarily serve?

2. a) What are the ***most important health needs*** that have the greatest impact on overall health in Marin County?

   b) What are the specific populations that are most adversely affected by the health problems you just mentioned? *(e.g., Latinos, postpartum women, seniors)*

   c) The following were identified as priority health issues during the previous CHNA process in 2013:

      i. Significant Health Issues:
         1. **Poor mental health**
         2. **Substance abuse**
         3. **Health Care Access**
         4. **Poverty/Income inequality**
         5. **Healthy eating / Active living**

      Can you tell me how aware you are of these health issues? How do they impact overall health in Marin County?

   d) What existing community assets and resources could be used to address these health issues and inequities [and the health issues you think are most important]?

3. a) What health behaviors do you think have the biggest influence on the issues we just discussed in your community?

   b) The following were identified as significant health behaviors during the previous CHNA process in 2013:

      i. Significant information about health behaviors from 2013 CHNA:
         1. 21.5% of adults reported that they needed help for emotional/mental health problem or use of alcohol/drugs
         2. 55% of 11th graders reported using alcohol or drugs, not including tobacco
         3. 10.4% of people were lacking a consistent source of primary care
         4. 8.2% of adults did not graduate high school; 63.1% of adults in Canal area of San Rafael did not graduate high school
         5. 70.6% of adults were getting moderate exercise

      Can you tell me how aware you are of these health behaviors? How do they impact overall health in Marin County?

   c) What existing community assets and resources could be used to address these health issues and inequities [i.e. the health issues we just mentioned or those you identified earlier]?

4. a) Are you aware of social factors that influence on the issues we've discussed for your clients/your community? If so, what social issues have the largest influence on these health issues?

b) Are you aware of economic factors that influence the issues we've discussed for your clients/your community? If so, what economic issues have the largest influence on these health issues?

c) The following were identified as socioeconomic conditions in Marin during the previous CHNA process in 2013:

   i. Significant information about socioeconomic conditions:
      1. 45.6% of adults were paying higher than 30% of total household income for housing.
      2. 17.2% of residents had incomes below 200% of Federal Poverty Line
      3. 6.7% were unemployed
      4. Median household income was $89,268
      5. 2,094 unmet subsidized child care slots existed in Marin

   Can you tell me how aware you are of these socioeconomic conditions? How do they impact overall health in Marin County?

d) What existing community resources could be used to address these health issues and inequities?

5. a) Are you aware of environmental factors that influence the issues we've discussed for your clients/your community? If so, which factors have the biggest influence on overall health in your community?

b) The following were identified as environmental conditions in Marin during the previous CHNA process in 2013:

   i. Significant information about environmental issues:
      1. 2.5% of housing units were overcrowded
      2. San Rafael had 113.9 liquor stores per every 100,000 people
      3. 3.8% of housing units in Marin were categorized as affordable housing
      4. 2.5% of housing units were overcrowded
      5. 24.2 recreation and fitness facility establishments were available in Marin per 100,000 residents

   Can you tell me how aware you are of these environmental factors? How do they impact overall health in Marin County?

c) What existing community resources could be used to address these health issues and inequities?

6. What are the **challenges** Marin County faces in addressing the health needs you mentioned previously?

a) Are there any current trends that may have an important impact on the health of Marin County residents?

b) Are there any challenges that may impact economic opportunities in the community? Access to health care services? Community engagement? Public safety?

7. a) Do you have suggestions for **systems-level collaborations or changes** that could help to address the inequities we just talked about?

b) Looking across all sectors, who are some **current or potential community partners** that we have not yet engaged who could help to impact these issues?

We have a brief demographics question we would like to ask. These are strictly for tracking purposes and you do not have to answer these questions if you don't want to.

8. Do you identify as a leader, representative, or member of any of the following communities? Please select all that apply.

☐ Individuals with chronic conditions
☐ Minorities
☐ Medically underserved
☐ Low-income

Those are all the questions I have for you today. Do you have anything else you would like to add?

Thank you for taking the time to have this conversation! The information that you provided will be very helpful not only for the needs assessment but also in crafting actions to address those needs.

Focus Group Protocol

Hi everyone. My name is _____ and I will be facilitating today's group. This is _____ and he/she will be taking notes and may jump in with any additional questions throughout the group.

First, we want to thank you for agreeing to be a part of this discussion, which will last about 1-2 hours. Marin County healthcare workers really want to improve the health of your community, and many of those people are sitting at the table together to think about the best ways to do this. The information we gather today will be used as part of a collaborative needs assessment that will help Kaiser Permanente, Sutter Health, Marin General Hospital, Health and Human Services, and Healthy Marin Partnership to work together to determine what they can do to improve health in Marin County. Additionally, as a part of the Affordable Care Act, the federal government requires nonprofit hospitals to conduct community health needs assessments every three years, and to use the results of these assessments to implement plans to improve community health. This assessment will also fulfill this requirement for the hospitals.

In this health needs assessment, we want to be sure to bring in voices that are not always represented. One of the reasons we are having this focus group is because we are really interested in the needs of [XX group] across the county. Please keep this lens in mind as we talk about your experience in your community.
Before we begin, I'd like to talk about a few guidelines for our discussion.

- **There are no right or wrong answers**.
- **Every opinion counts**. We will respect other's opinions. It is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.
- **Everyone should have an equal chance to speak**. Please speak one at a time and do not interrupt anyone else.
- **Do not hesitate to ask questions** if you are not sure what we mean by something.
- Because we have a limited amount of time and a lot to discuss, I may need to interrupt you to give everyone a chance to speak, or to get to all the questions.
- **What's said here, stays here. Everything we discuss today is completely confidential.** We will summarize what the group had to say, but will not tell anyone who said what. Your names will never be mentioned. We also ask that you not repeat what is said here outside this room.
- **We'd also like to record our conversation.** Our note taker will be taking notes so that we remember what people had to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

How do these guidelines sound to everyone? Do you have any questions before we begin?

Introductions/Background

1) Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

Quality of life in community

2) Briefly, please describe what it is like to live in your community.

3) From your perspective, what are the biggest health issues among [subpopulation]?

3a. Of the health issues you've mentioned, which would you say are the most important or urgent to address? Why?

4) What do you think are some of the biggest reasons why these health issues occur in your community?

4b) What things keep you and your family from being as healthy as they could be?

5) From your perspective, what health services are lacking for you and the people you know in your community?

5b) From your perspective, what health services are difficult to access for you and the people you know in your community?

- Follow up: What other challenges keep individuals from seeking help?

6) Has the Affordable Care Act [may also be known as Covered California, Obamacare] had any impact on you or the people you know in your community?

Community Assets, Barriers, and Gaps

7) Outside of healthcare, what resources exist in your community to help you and the people you know to live healthy lives?

7a) What are the barriers to accessing these resources?

7b) What resources are missing?

What is needed to improve health?

8) What do you think is [or who is] needed to improve your health or the health of the people you know in your community?

9) Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?

Please make sure to fill out the quick survey before you leave!
Thank you so much for your time!

Focus Group Demographic Survey

Thank you for participating in today's discussion group. We would like to ask you a few questions to understand who attended our groups. This survey is VOLUNTARY which means that do not have to participate. It is anonymous- your answers will not be tied to your name or any other personal information and we will report answers of the group as a whole.

1. What race/ethnicity do you identify as? (Please select all that apply.)

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Asian (if checked, please select a choice below):
  - o Cambodian
  - o Hmong
  - o Vietnamese
  - o Filipino
  - o Other: _____
  - o Chinese
  - o Pakistani
  - o Japanese
  - o Thai
  - o Korean
  - o Laotian
  - o East Indian
  - o Native Hawaiian or Pacific Islander

2. What is your current gender identity? (Check one that best describes your current gender identity.)

- ☐ Male
- ☐ Trans man
- ☐ Declined to answer
- ☐ Female
- ☐ Trans woman
- ☐ Genderqueer / Gender non-conforming
- ☐ Another gender identity (Fill in the blank.) _____

3. Do you identify as a leader, representative, or member of any of the following communities? (Please select all that apply.)

- ☐ Individuals with chronic conditions
- ☐ Minorities
- ☐ Medically underserved
- ☐ Low-income

4. What is your age group?

- ☐ 14-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 54-60
- ☐ 60+

5. What is the zip code where you live?

_____ _____ _____ _____ _____

6. What would you estimate your yealy household income is?

- ☐ $0 to $4,999
- ☐ $5,000 to $9,999
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $44,999
- ☐ $45,000 to $54,999
- ☐ $55,000 to $64,999
- ☐ $65,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 and Over

7. How many people, including you, live in your house (this includes everyone related to each other by blood, marriage or a marriage-like relationship including partners and foster children)?

___ __

Thank you for completing this survey!

FOR ADMINISTRATIVE PURPOSES ONLY

Group Location: _____ **Survey ID:** _____ **Today's Date:** _____ / ___ / ___

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Appendix E. Prioritization Scoring Matrix

Instructions: For each health need, write down a score between 1 to 7 for each criterion (1 being the lowest and 7 being the highest score possible). For example, if an issue is nearly impossible to prevent, it could be assigned a 1 in "Prevention" but may receive a score of 6 in "Severity". You will then use the clickers to indicate your score for each health need and criterion. Once everyone scores each health need, the scores will be averaged and multiplied by the weighting value to determine an overall score for each health need.

Health Need	Severity	Disparities	Prevention	Leverage
	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes.	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.
Weighting	**1.5**	**1**	**1.5**	**1**
Access to Health Care				
Economic and Housing Insecurity				
Education				
Violence and Unintentional Injury				
Mental Health				
Substance Abuse				
Obesity and Diabetes				
Oral Health				