2019 Community Health Needs Assessment

Kaiser Foundation Hospital: San Francisco

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Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

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KAISER PERMANENTE®

Kaiser Permanente San Francisco Region Community Benefit

CHNA Report for KFH San Francisco

Contents

I. 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 12 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 Health

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. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. 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. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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 https://www.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 120 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 constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

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

II. Community served

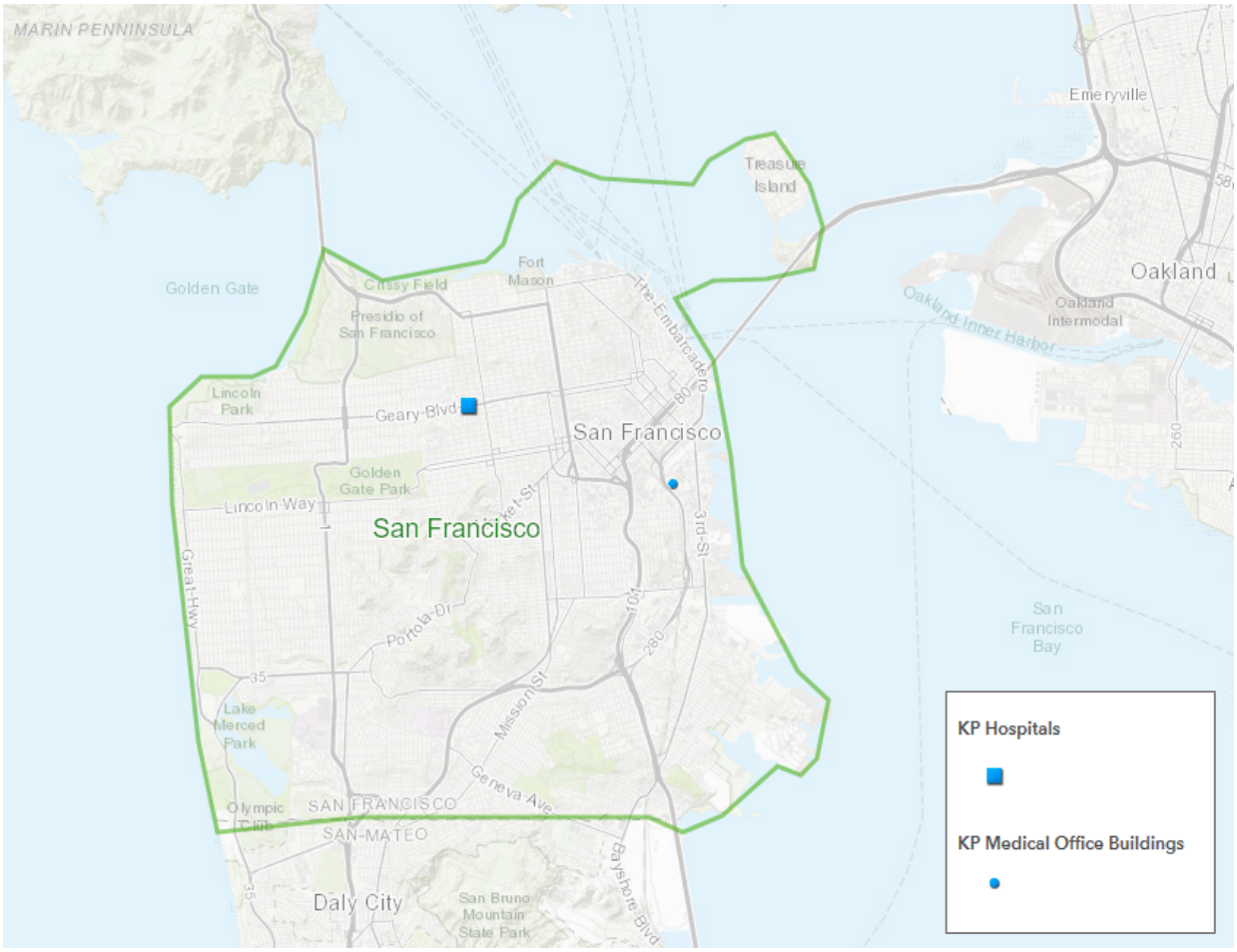
A. Kaiser Permanente's definition of community served

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and description of community served

i. Map

KFH San Francisco Service Area



ii. Geographic description of the community served

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

iii. Demographic profile of the community served

Demographic profile: KFH San Francisco

Race/ethnicity		**Socioeconomic Data**	
Total Population	850,282	Living in poverty (<100% federal poverty level)	12.5%
Asian	33.8%	Children in poverty	11.5%
Black	5.3%	Unemployment	2.3%
Native American/Alaska Native	0.4%	Uninsured population	6.9%
Pacific Islander/Native Hawaiian	0.3%	Adults with no high school diploma	12.6%
Some other race	7.0%		
Multiple races	4.9%		
White	48.2%		
Hispanic/Latino	15.3%		

Data from the San Francisco Health Improvement Partnership (SFHIP) 2019 Community Health Needs Assessment show that San Francisco has a relatively small proportion of households with children (19%) as compared to the state overall (34%). Meanwhile, the proportion of San Francisco's population that is 65 years and older is expected to increase from 17% in 2018 to 21% in 2030. The proportion of working age residents (25 to 64 years old) is estimated to decrease from 61% in 2018 to 56% in 2030. In 2018, the age demographic profile of San Francisco was as follows: 17% ages 65 and older; 61% ages 25 to 64; 7% ages 18 to 25; 10% ages 5 to 17; and 5% ages birth to 4 years.

III. Who was involved in the assessment?

Since 1995, KFH San Francisco has collaborated with the other nonprofit hospitals in the county to produce a triennial CHNA. KFH San Francisco was a founding member of this collective effort, which has grown over time as other partners joined. The project became known as the Building a Healthy San Francisco collaborative then, in 2012, the San Francisco Health Improvement Partnership (SFHIP). SFHIP's membership includes representatives from a range of organizations concerned about the health of the community. This collaborative is sustained through the backbone support of the Hospital Council of Northern & Central California, the San Francisco Department of Public Health, and the University of California, San Francisco. SFHIP conducts the triennial CHNA to meet the requirements of the nonprofit hospitals, the San Francisco Health Care Services Master Plan, and the San Francisco Department of Health accreditation process, then develops the Community Health Improvement Plan (CHIP) to guide the strategies to address the identified health needs. Jim Illig, Community Health Manager, KFH San Francisco has represented KFH San Francisco for six years at this collaborative and is currently co-chair of SFHIP. More information on the SFHIP process for the 2019 CHNA, which was complementary to KFH San Francisco's CHNA process, can be found in Appendix E.

The KFH San Francisco Community Benefit Advisory Committee examined the primary and secondary data at their meeting on September 19, 2018 (see Appendix F for full list of KFH San Francisco Community Benefit Advisory Committee members. They then reviewed SFHIP's identified health needs at their meeting on November 14, 2018, and produced a prioritized list of those health needs for the KFH San Francisco Community Health Needs Assessment. More information on this process can be found in Appendix E.

A. Identity of hospitals and other partner organizations that collaborated on the assessment

i. Hospitals:

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

ii. Partner organizations represented in SFHIP

- African American Community Health Equity Council
- APA Family Support Services
- Asian Pacific Islander Health Parity Coalition
- Chicano/Latino/Indigena Health Equity Coalition
- Bayview Hunter's Point Foundation for Community Improvement
- Instituto Familiar de la Raza
- Rafiki Wellness
- Metta Fund
- San Francisco Community Clinic Consortium
- San Francisco Human Services Network
- San Francisco Interfaith Council
- San Francisco Department of Public Health
- San Francisco Mayor's Office
- San Francisco Unified School District
- University of California, San Francisco

B. Identity and qualifications of consultants used to conduct the assessment

Engage R+D is a consulting firm dedicated to helping foundations, nonprofits, and public agencies achieve their greatest possible impact. The firm's founding was inspired by the belief that creating social change requires bringing together good data, stakeholder voice, and field insights in creative ways to inform strategy and drive results. Engage R+D approaches its work with an organizational development lens, recognizing that people and relationships are central to this work.

Engage R+D's staff bring experience conducting CHNAs in multiple California communities, as well as needs assessments with vulnerable populations (e.g., homeless youth, rural farmworkers, and low-income families). Some of their key qualifications and relevant project experience include:

- **Expertise in public health**. Engage R+D's work is rooted in public health and social change with a solid commitment to equity. Their staff has expertise in supporting a range of public health efforts.
- **Gathering data from vulnerable populations**. Engage R+D has conducted focus groups and interviews with youth and adults from a diverse range of demographics and experiences. They also have experience conducting focus groups in Spanish and other languages and working with community partners to coordinate focus group logistics.
- **Presenting secondary data in compelling ways**. When synthesizing data for clients, Engage R+D strives to present it in ways that are visually compelling, user-friendly, and engaging to a variety of audiences and stakeholders.

IV. Process and methods used to conduct the CHNA

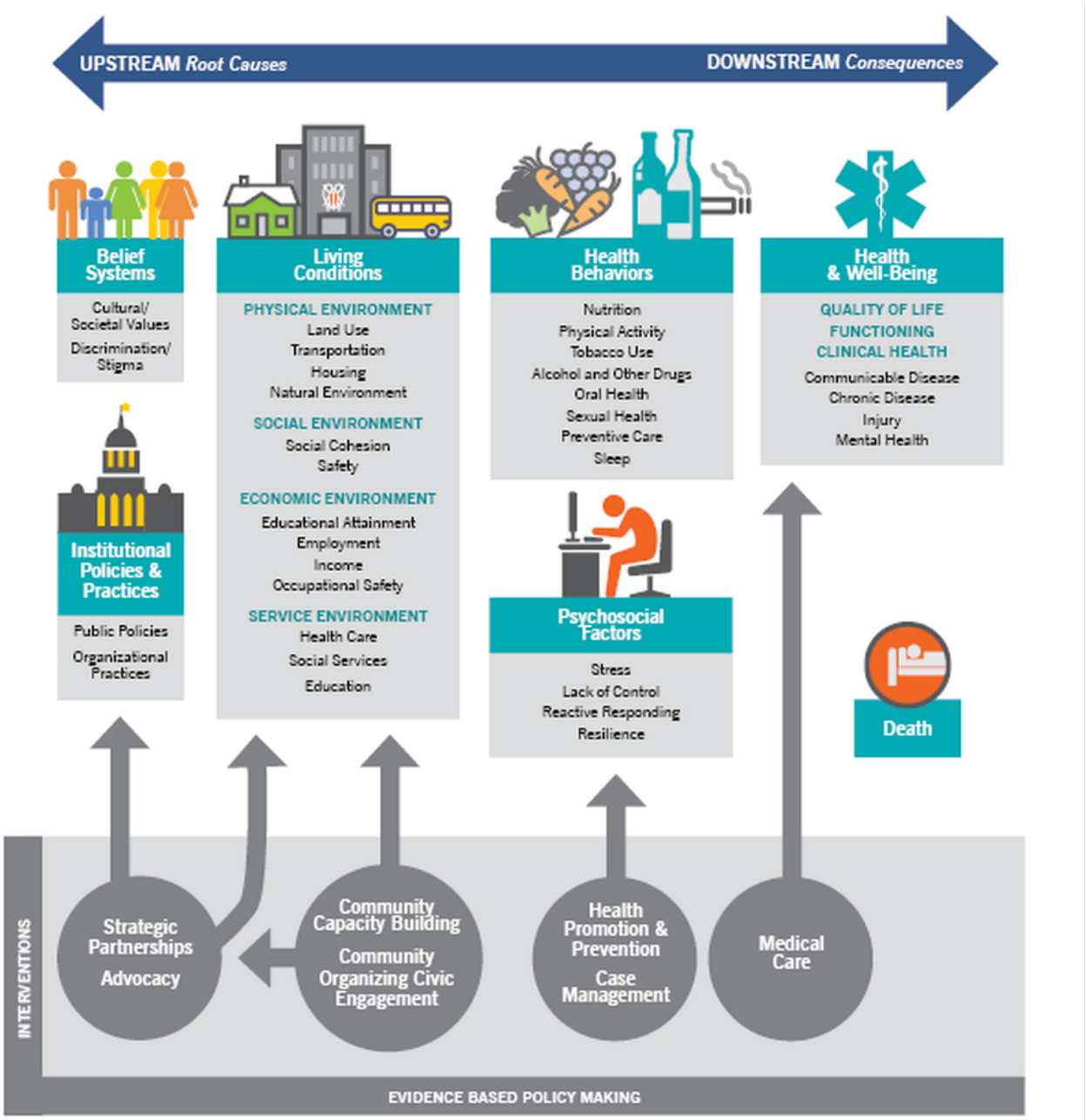
A. Secondary data

i. Sources and dates of secondary data used in the assessment
KFH San Francisco used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review over 120 indicators from publicly available data sources. KFH San Francisco also used additional data sources beyond those included in the CHNA Data Platform.

For details on specific sources and dates of the data used, please see Appendix A.

ii. Methodology for collection, interpretation, and analysis of secondary data
Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KFH San Francisco also leveraged additional data sources beyond those included in the CHNA Data Platform. The San Francisco Department of Public Health created a web-based resource to support SFHIP's community health needs assessment process. The platform includes a focused set of population health indicators for San Francisco. It allows users to understand health as it aligns with the San Francisco Framework for Assessing Population Health and Equity. The Framework examines both upstream root drivers of health as well as downstream consequences (see below). In some cases, the indicators were also disaggregated by sub-populations. The Framework aligns well with the community health indicator categories used in Kaiser's CHNA Data Platform. We thus used the San Francisco Department of Public Health data to supplement the secondary data from the Kaiser CHNA Data Platform when possible.



Source: http://www.sfhip.org/framework.html

B. Community input

i. Description of who was consulted

Community input was provided by a broad range of community members using key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives leaders, representatives and members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local

health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

ii. Methodology for collection and interpretation

Based on the analysis of secondary data, KFH San Francisco designed focus groups to broadly survey health needs, as well as collect more in-depth information on select topics. For each of the focus groups described below, KFH San Francisco convened in-person meetings to ask respondents questions from a scripted protocol regarding health needs and other in-depth topics. The responses were audio recorded with permission from participants and transcribed with the exception of the youth focus groups, where respondents requested that they not be recorded and a note-taker was used instead. The focus group transcripts and notes were coded using Dedoose qualitative analysis software. The transcripts and notes were coded for key themes and information related to health needs and drivers of health needs. Cross-cutting themes were then identified across focus groups.

Community input from both stakeholders and residents influenced the CHNA report by contextualizing and reinforcing the severity of previously identified health needs from the secondary data. Community input also offered additional detail to help us better understand the specific barriers, populations, and neighborhoods most impacted. The Health Need Summaries in Appendix C include the community feedback about each health need.

Focus group participants included the following:

Community stakeholders: To broadly understand the range of health needs affecting San Franciscans, KFH San Francisco conducted two focus groups with service providers working on a variety of health issues. One focus group was conducted with organizational leadership (n=9) and one with program staff (n=9), each lasting about an hour. In addition to these focus groups, SFHIP hosted a key informant focus group session with its members (n=15) and conducted three focus groups with the health equity coalitions, including the Asian Pacific Islander Health Parity Coalition (n=9), the African American Health Equity Coalition (n=16), and the Chicano/Latino/Indigena Health Equity Coalition (n=15). For a complete list of individuals who provided input, see Appendix B.

Community residents: Based on the analysis of secondary data in the Kaiser Permanente CHNA Data Platform, KFH San Francisco also designed two targeted focus groups with community members to better understand specific health needs in select topics or within hard-to-reach populations who may not have been previously interviewed for the CHNA. Drawing on existing partnerships, community-based organizations representing or serving the target populations were asked to host a focus group with residents about their health needs. One focus group was conducted with Spanish-speaking parents (n=2) concerning their children's healthy eating and active living habits to better understand youth obesity in the Hispanic community, an indicator that performed poorly in San Francisco compared to the state benchmark. The second focus group was conducted with homeless and/or HIV positive youth (n= 10) concerning sexual health, two more indicators that performed poorly against the state benchmark. In addition to these focus groups, SFHIP conducted four focus groups with food insecure pregnant women, including one for Chinese-speakers (n=11), African Americans

(n=11), other English speakers (n=7), and Spanish-speakers (n=12). For a complete list of those who provided input, see Appendix B.

C. Written comments

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

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

D. Data limitations and information gaps

The KP CHNA data platform includes approximately 120 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Where possible, data from the San Francisco Public Health Department provided additional detail. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

i. Definition of "health need"

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

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

To identify the community health needs, KFH San Francisco consultants analyzed over 120 indicators provided in Kaiser Permanente's CHNA Data Platform. The platform groups these indicators into health categories designed to understand the health profile of a community. Health categories were considered an identified community health need if:

- The health category contained at least one indicator that was statistically significantly worse than the state benchmark.
- The health category was also identified as a key theme from the focus groups, meaning it was mentioned in two or more of the community stakeholder focus groups, by at least one participant in each of the groups.

B. Process and criteria used for prioritization of health needs

Required criteria:

Before beginning the prioritization process, KFH San Francisco chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

a) **Fits the Kaiser definition of a health need**: A “health need” is defined as a health outcome and/or the related conditions that contribute to a defined health need (as described in V.A.i.).
b) **Health need performs poorly against a defined benchmark**: At least one indicator in the health need is statistically significantly worse than the state of California as a whole.
c) **Health need was confirmed by more than one indicator or data source**: In addition to performing poorly against a defined benchmark, the health need appears as a theme in the focus groups or key informant interviews.
d) **Clear disparities in health outcomes**: This refers to differences in health outcomes by subgroups. This analysis primarily focused on disparities by race/ethnicity, although information on geography, economic status, gender, and age were examined where available. Where possible, data was used from the Kaiser CHNA Data Platform
e) **When data were not available**, the information was supplemented with information from the San Francisco Department of Public Health CHNA Data Platform.
f) **Community prioritizes the issue over other issues**: The community prioritizes the issue over other issues on which it has expressed concern during the CHNA primary data collection process. This was determined in consultation with SFHIP and is described below.

Process:
KFH San Francisco used the above criteria to score each of the health needs identified in Section V-A of this report. The results of this process can be seen in the health needs matrix, Appendix D. While some of the scoring can be determined objectively, such as criteria a. through d. above, the scoring for community prioritization was determined through a joint process with the San Francisco Health Improvement Partnership (SFHIP), whose membership includes local public health experts, community leaders, and representatives from a range of organizations concerned about the health of the community.

SFHIP members, including representatives of KFH San Francisco, met on October 18, 2018 to prioritize the health needs through a multistep process. First, participants reviewed data and information collected during the CHNA process to date. This includes the secondary data and community input described in Section IV of this report. Then, using the Technology of Participation approach to consensus development – a structured facilitation method to help groups think, talk and work together – participants engaged in a focused discussion about the data. As a result, participants developed consensus on the prioritized health needs for San Francisco. A detailed description of this process can be found in Appendix E. Items that were prioritized by SFHIP were ranked as higher priority needs in the health needs prioritization list described in the next section.

The KFH San Francisco Community Benefit Advisory Committee also reviewed and approved the final results of this process.

C. Prioritized description of all the community needs identified through the CHNA

In the process of identifying and prioritizing community health needs, SFHIP and KFH San Francisco identified two foundational issues that contribute to local health needs: health inequities and poverty. Health inequities are avoidable differences in health outcomes between population groups and can result from both the actions of individuals (e.g.., health behaviors, biased treatment by health professionals) and from the structural and institutional behaviors that confer health opportunities or burdens based on status. For example, the uneven distribution of wealth and resources determines the level of health those getting the least of these resources can achieve. These same forces work to decrease the health of many minority populations, both locally and nationally. Additionally, income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self-care— and the ability to avoid health hazards —like air pollution and poor quality housing conditions. These issues are recognized by SFHIP and KFH San Francisco as overarching foundational issues to the following health needs:

Higher priority needs: The following health needs performed poorly against the California benchmark, were confirmed by more than one data source, showed clear disparities in health outcomes, and were prioritized over other issues through the SFHIP process.

- **Access to Care:** This health need draws upon data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health. Access to care represents more than the hours and availability of services to include location, affordability, cultural and linguistic appropriateness, and coordination of health care and non-medical social services. A review of the secondary data shows San Franciscans were significantly less likely than residents in the entire state of California to have had a recent primary care visit. This was especially true for African Americans. Focus group themes surfaced the need for a more flexible and adaptable health care system that could provide equitable and inclusive services that expand access to care. This included the need for more culturally appropriate care and coordinated approach. SFHIP also identified “access to coordinated, culturally and linguistically appropriate care and services” as a community priority.
- **Housing and Homelessness/Economic Security**: This health need draws upon data related to economic wellbeing, the cost of housing, and drivers of poverty including educational attainment. A review of the secondary data shows Hispanics, African Americans, Native Americans/Alaskan Natives, and Native Hawaiians/Pacific Islanders were significantly more likely than residents of California as a whole to have incomes below the federal poverty level, use SNAP benefits, and report a low median income. In focus groups, participants also connected economic security and homelessness as key drivers of other issues affecting the city such as mental health, substance abuse, HIV/AIDS, food insecurity, and access to care. SFHIP also identified “housing security and an end to homelessness” as a community priority.
- **Mental Health:** This health need draws upon data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes. A review of the secondary data shows residents of San Francisco were significantly more likely to have seriously considered suicide than residents of California as a whole.

Furthermore, certain racial/ethnic groups — White, Hispanic, and African American — were at higher risk for mental health services and distress. Focus group themes surfaced a need for addressing mental health issues relating to trauma, especially amongst veterans, youth, and the homeless. SFHIP also identified "social, emotional, and behavioral health" as a community priority.

- **Obesity/Healthy Eating-Active Living/Diabetes:** This health need draws upon data related to healthy eating and food access, physical fitness and active living, overweight and obesity prevalence, and downstream health outcomes including diabetes. A review of the secondary data shows Hispanics, African Americans, and Native Hawaiians/Pacific Islanders were significantly more likely than white residents of San Francisco and residents of California as a whole to experience indicators of youth obesity such as physical inactivity. Focus group themes elevated the affordability of food as the number one concern cited by both providers and community members related to health eating and active living. SFHIP also identified "food security, healthy eating, and active living" as a community priority.
- **Substance Abuse/Tobacco**: This health need draws upon data related to forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs. A review of the secondary data shows San Francisco residents were significantly more likely to engage in excessive drinking, while sales of beer, wine, and liquor were significantly higher in the city than in the rest of the state. Although the age-adjusted mortality rate due to substance use disorder has decreased in San Francisco since 2015, African Americans were 5 times more likely to experience a substance use disorder than other ethnicities. Focus group themes identified substance abuse as an exacerbating factor to other health needs. SFHIP also identified "social, emotional, and behavioral health," which they related to substance abuse/tobacco, as a community priority.

Lower priority needs: The following health needs performed poorly against the California benchmark, and may or may not have been confirmed by more than one data source, showed clear disparities in health outcomes, and/or prioritized over other issues through the SFHIP process.

- **HIV/AIDS/STDs:** This health need draws upon data related to known drivers of sexually transmitted infections including HIV and related STD and AIDS outcomes. A review of the secondary data shows the incidence of HIV was significantly higher in San Francisco, though the rate of new infection was comparatively low and continuing to decrease. In general, focus group participants reported that San Francisco has done a good job of responding to the HIV/AIDS epidemic over the last 30 years, though they noted that equity issues still exist in the treatment and care of those living with HIV, including knowledge of prevention options in communities of color and services for the homeless, including homeless youth. SFHIP addressed this issue under access to care.
- **Violence/Injury Prevention:** This health need draws upon data related to intended and unintended injury such as violent crime, motor vehicle accidents, and domestic violence. A review of the secondary data shows violent crime rates, hospitalizations for domestic violence, and pedestrian accident deaths were significantly higher in San Francisco than

the state as a whole. SFHIP also identified “freedom from violence and trauma” as a community priority.

Additional details can be found in Appendix C: Health Need Profiles and Appendix D: Health Needs Criteria Matrix.

D. Community resources potentially available to respond to the identified health needs

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

Resource provider name	Summary description
Nonprofit community hospitals: Chinese Hospital, Dignity Health’s St. Mary’s and St. Francis, Sutter Health CPMC	• In- and out-patient services for low-income vulnerable populations including charity care, financial assistance programs and participation in Medi-Cal and Healthy San Francisco coverage programs, • Hospital health education, screening and early intervention programs • Hospital community benefit programs and grants
San Francisco Dept. of Public Health	• San Francisco General Hospital and Trauma Center • Laguna Honda - skilled nursing and rehabilitation center • Public Health Clinics - neighborhood primary care centers • Behavioral Health and other services contracted with community-based nonprofit organizations • Population Health & Prevention activities such as Shape Up San Francisco, Food Security Task Force, etc.
Other San Francisco government social service departments	• San Francisco Health Plan – administers MediCal and Healthy San Francisco • Dept. of Human Services – enrolls for benefits, child welfare, etc. • Dept. of Aging & Adult Service – community services for seniors and disabled adults • Dept. of Homelessness and Supportive Housing – outreach, shelters, housing • Dept. of Children, Youth and Their Families
San Francisco Community Clinic Consortium	Nonprofit neighborhood health centers providing primary and specialized care, such as Curry Senior Center, Glide Health Services, HealthRight 360, Lyon-Martin Health Services, Mission Neighborhood Health Center, Native American Health Center, North East Medical Services, Saint Anthony Free Medical Clinic, San Francisco Free Clinic, South of Market Health Center, Street Outreach Services, and Women's Community Clinic
Nonprofit social service organizations	Community-based nonprofit organizations providing a range of social services and working in collaboratives such as the Human Service Network, Coalition of Agencies Serving the Elderly, HIV/AIDS Provider Network, Mental Health Service Providers Association, SFHIP, Tenderloin Health Improvement Partnership, etc.
Community Foundations	Foundations with a local health focus such as the San Francisco Foundation, Metta Fund, Walter & Elise Haas Foundation, Levi Strauss Foundation, Salesforce Foundation, etc.

VI. KFH San Francisco 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH San Francisco's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH San Francisco's Implementation Strategy Report, including the health needs identified in the facility's 2016 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/kp). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH San Francisco in the 2016 Implementation Strategy Report.

1. Behavioral Health
2. Access to Care: Access to coordinated, culturally and linguistically appropriate care across the continuum
3. Healthy eating/active living

KFH San Francisco is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH San Francisco tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH San Francisco had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH San Francisco will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 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 2017 and 2018, 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 2017-2018, 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 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 2017-2018, KFH San Francisco awarded 428 grants amounting to a total of $8,660,019.23 in service of 2016 health needs. Additionally, KFH Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within San Francisco. During 2017-2018, a portion of money managed by this foundation was used to award 4 grants totaling $278,185.53 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to

health in our communities. From 2017-2018, KFH San Francisco leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report 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 2017-2018, KFH San Francisco engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including:

- Hospital Council of Northern & Central California
- San Francisco Health Improvement Partnership (SFHIP)
- Tenderloin Health Improvement Partnership (TLHIP)
- Shape Up San Francisco
- Bay Area Health Funders of Northern California Grantmakers
- San Francisco Tech Council

C. 2016 Implementation Strategy evaluation of impact by health need

KFH San Francisco Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care	*During 2017 and 2018, KFH awarded 130 grants totaling $5,534,916.83 that address Access to Care in the KFH-San Francisco service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 8,653 Medi-Cal members each year totaling $26,802,776.04 worth of care. KP also provided a total of $13,851,129.30 of Medical Financial Assistance (MFA) to 4,576 individuals in 2017 and 3,805 individuals in 2018.
		PHASE: Over the course of three years (2017-2019), San Francisco Community Clinic Consortium (SFCCC) is the recipient of a $500K grant to support the successful use of PHASE among member health center organizations. SFCCC is creating a robust data analytic infrastructure to support its health centers with using data on a regular basis. SFCCC is reaching almost 15,000 patients through PHASE. 78% of their patients with diabetes and 76% of those with hypertension have their blood pressure controlled.
		211: United Way of the Bay Area received a $95,000 grant (evenly split between 8 KFH hospital service areas) to support 211's services that provide health and human services resources and information for people who call, text, or visit the website. In the six Bay Area counties, it is expected that the 211 program will answer 50,000 calls and texts and 60,000 users will visit the 211 Bay Area website.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Electronic health record: San Francisco General Hospital Foundation received $5,000,000 to support implementation of the Epic electronic health record system to improve patient coordination, safety, and access to data for research that will promote better health outcomes for more than 100,000 people who seek care at San Francisco General Hospital each year.
		Social non-medical services: Swords to Plowshares received $25,000 to assist 700 homeless and at-risk veterans through individualized case management and connection to social non-medical services, which included housing stability and permanent placement for 300 veterans.
Healthy Eating / Active Living	*During 2017 and 2018, KFH awarded 51 grants totaling $860,043.36 that address Healthy Eating Active Living in the KFH-San Francisco service area*	CalFresh: San Francisco Marin Food Bank received a $95,000 grant (evenly split between KFH-San Francisco and KFH-San Rafael) to increase staff capacity to provide CalFresh outreach and increase collaboration with new partner agencies that largely serve immigrant communities. To date, the Food Bank has screened 2,326 individuals for food insecurity, submitted 382 applications and received 200 approved applications. The Food Bank held trainings for 20 agencies and added two new application assistance agency partners.
		Parks: San Francisco Parks Alliance received a $75,000 grant to renovate the Merced Heights playground. The renovation will include installing new playground equipment, providing residents with a welcoming, accessible place to gather and play. Detailed designs of the playground were completed and construction is expected to begin in April 2019, with completion expected in late 2019. The playground is projected to serve 2,236 children and youth in the surrounding neighborhood.
		Partnership: KFH-San Francisco was one of the founders of Shape Up San Francisco more than 10 years ago and continues as an active collaborator in this group of Department of Public Health experts and service providers dedicated to chronic disease management through preventive behavioral change. In 2018, Shape Up SF provided expertise to the Sugary Drinks Distributor Tax Advisory Committee to decide how to spend $10 million from this groundbreaking initiative.
Behavioral Health	*During 2017 and 2018, KFH awarded 87 grants totaling $1,429,321.73 that address Behavioral Health in the KFH-San Francisco service area*	Resilience: Huckleberry Youth Programs, Inc. received a $98,000 grant to improve the trauma-informed school culture and provide mental health services to students at Martin Luther King Middle School and Willie L. Brown Jr. Middle School. It is expected that a minimum of 30 students impacted by trauma will receive academic and social emotional support and all 830 students will receive information about how to access mental health services.
		Stigma: A total of $120,000 in grants was awarded to three organizations to address mental health stigma in African American, Latino and Asian Pacific Islander communities. Through education, outreach and a media campaign, it is expected that people will increase their understanding that mental health is a part of overall health and be more likely to access services.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Street-based services: KFH-San Francisco provided $50,000 to Downtown Streets Team to enhance outreach efforts to 1,500 individuals and to engage 90 homeless and marginally housed persons in intensive street-based services, including employment, training, and connections to housing and social supports.
		Mobile services: Project Homeless Connect received $50,000 to deliver services and support through a mobile van to homeless individuals unable or unwilling to access fixed-site service providers. There were 6,500 encounters and 4,700 individuals were served.
		Support services: San Francisco AIDS Foundation was awarded $35,000 for its “Todos Somos Familia” (We Are Family) program to train 15 bilingual Latinx individuals with lived experience of homelessness and substance abuse to conduct outreach, reach 360 persons, and engage 90 individuals in a network of culturally appropriate support.

VII. Appendix

A. Secondary data sources and dates
   i. KP CHNA Data Platform secondary data sources
   ii. San Francisco Department of Public Health CHNA Data Platform secondary data sources
B. Community Input Tracking Form
C. Health Need Profiles
D. Health Needs Criteria Matrix
E. Description of SFHIP Process
F. KFH San Francisco Community Benefit Advisory Committee members

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Secondary sources from the San Francisco Department of Public Health CHNA Data Platform

	Source	Dates
1.	American Communities Survey	2012-2016
2.	California Department of Education, FitnessGram® physical fitness test	2016-2017
3.	California Department of Health Care Services, Medi-Cal Management Information System/Decision Support System.	2012
4.	California Department of Public Health, Birth Statistical Master File.	2017
5.	California Department of Public Health, California Cancer Registry	2006-2010
6.	California Department of Public Health, Childcare and kindergarten immunizations	2017-2018
7.	California Department of Public Health, Children's Dental Referral Directory	2017-2018
8.	California Department of Public Health, Maternal and Infant Health Assessment	2013-2015
9.	California Department of Public Health, Newborn Screening Program	2017
10.	California Department of Public Health, VRBIS Death Statistical Master File Plus	2005-2017
11.	California Health Interview Survey	2017
12.	California Health Interview Survey: Neighborhood Edition	2017
13.	California Opioid Overdose Surveillance Dashboard	2017
14.	Centers of Disease Control and Prevention, Youth Risk Behavioral Surveillance System	2017
15.	Child Care Planning & Advisory Council, Early Care & Education Community Needs Assessment	2016-17
16.	Head Start, Program Information Report	2008-2016
17.	Insight Center for Community Development, Self-Sufficiency Standard Tool for California	2014
18.	Lets Get Healthy California	2016
19.	Medicare Chronic Conditions Dashboard	2015
20.	National Center for Health Statistics	2016
21.	Neilsen Percent of Food-At-Home Expenditures	2008-2012
22.	Office of Statewide Health Planning and Development	2018
23.	Our Children, Our Families Council	2017
24.	San Francisco Controller's Office	2017
25.	San Francisco County Transportation Authority	2014
26.	San Francisco Department of Elections	2017
27.	San Francisco Department of Homelessness and Supportive Housing	2017
28.	San Francisco Department of Public Health, Air Quality Enforcement Program	2017
29.	San Francisco Department of Public Health, Child Care Health Program	2017
30.	San Francisco Department of Public Health, Climate and Health Program	2017
31.	San Francisco Department of Public Health, Communicable Disease Control & Prevention	2017
32.	San Francisco Department of Public Health, Environmental Health Protection, Equity, and Sustainability Branch	2017
33.	San Francisco Department of Public Health, Expanded Kindergarten Retrospective Survey	2015

	Source	Dates
34.	San Francisco Department of Public Health, HIV and STD Surveillance	2017
35.	San Francisco Department of Public Health, San Francisco Denti-Cal Clinic Capacity Survey	2018
36.	San Francisco Department of Public Health, WIC Program	2017
37.	San Francisco Food Security Task Force Presentations	2018
38.	San Francisco Health Network, Fluoride Varnish Applications for Children Age 0-5 Years	2014-2018
39.	San Francisco Indicator Project	2017
40.	San Francisco Juvenile Probation Department	2017
41.	San Francisco Metropolitan Transportation Agency	2017
42.	San Francisco Planning Department	2017
43.	San Francisco Police Department	2003-2018
44.	San Francisco Recreation and Parks Department	2018
45.	San Francisco Rent Board	2018
46.	San Francisco Unified School District-San Francisco Department of Public Health, Dental Services	2018
47.	Trends in Health	2017
48.	Trust for Public Land	2017
49.	United States Department of Agriculture, Economic Research Service	2017
50.	United States Environmental Protection Agency, Air Quality Index Report	2017
51.	University of California, Berkeley, California Child Welfare Indicators Project	2017
52.	WIC Program Eat SF participant survey	2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Key Informant Focus Groups	• Executive Director, APA Family Support Services, API Health Parity Coalition • Executive, Chinese Hospital • Manager, CMPC • Manager, CPMC • Policy and Communications Director, Instituto Familiar de la Raza, Chicano, Latina, Indígena Health Equity Coalition • Community Health Manager, Kaiser Permanente • Director of Programs, Metta Fund • Executive Director, Rafiki Wellness, African American Community Health Equity Council • Vice President, SF Community Clinic Consortium • Director of Population Health Division, SFDPH • MCAH Medical Director, SFDPH • Reverend, SF Interfaith Council • Director, St. Francis Memorial Hospital Manager of Community Health, St. Mary's Medical Center • Director CTSI, USCF Center for Community Engagement	15	Health department representatives and those representing minority, medically-underserved, and low-income community members	Community leaders, experts	9/20/18
2	Key Informant Interview	Tomás J. Aragón, MD, DrPH, SFDPH	1	Health department representative	Community leader, expert	10/31/18
3	Focus group	*Organizational leadership* from social service organizations addressing homelessness, trauma, poor nutrition, women's issues, and mental health, and serving special populations such as youth, families, and the religious community.	9	Service providers and those representing minority, medically-underserved, and low-income community members	Community leaders, service providers	9/19/18
4	Focus group	*Program staff* from social service organizations addressing homelessness, trauma, poor nutrition, women's issues, and mental health, and serving special populations such as youth, families, and the religious community.	9	Service providers and those representing minority, medically-underserved, and low-income community members	Community leaders, service providers	9/19/18
5	Focus group	Asian Pacific Islander Health Parity Coalition	9	Those representing minority community members	Community leaders	9/27/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
6	Focus group	African American Health Equity Coalition Group	18	Those representing minority community members	Community leaders	10/6/18
7	Focus group	Chicano/Latino/Indigena Health Equity Coalition	15	Those representing minority community members	Community leaders	10/10/18
Community residents						
8	Focus group	Spanish-speaking parents	2	Minority, low-income	Representative community members	9/17/18
9	Focus group	Homeless and/or HIV-positive youth	10	Medically underserved, low-income	Representative community members	9/24/18
10	Focus group	Chinese-speaking mothers	11	Minority, low-income	Representative community members	10/17/18
11	Focus group	African American mothers	11	Minority, low-income	Representative community members	10/5/18
12	Focus group	English-speaking mothers	7	Low-income	Representative community members	10/11/18
13	Focus group	Spanish-speaking mothers	12	Minority, low-income	Representative community members	9/20/18

Appendix C. Health Need Profiles

See Appendix D for a comparison of the health needs in a criteria matrix and explanation of ranking.

HIGHER PRIORITY HEALTH NEEDS

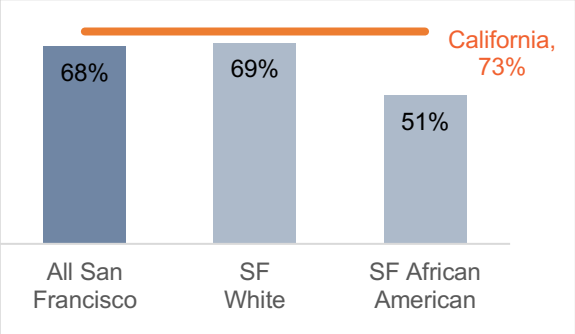
Health Need: **Access to Care**

This health need draws upon data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health. Access to care represents more than the hours and availability of services to include location, affordability, cultural and linguistic appropriateness, and coordination of health care and non-medical social services.

RELEVANT DATA:

A review of the secondary data shows San Franciscans were significantly less likely than residents in the entire state of California to have had a recent primary care visit. This was especially true for African Americans. While 97% of the population was insured in 2016, certain groups such as African Americans, Latinos, Native Americans/Alaskan Natives, those earning less than $50k a year, and young women were more likely to not have health insurance than other San Francisco residents.

Recent primary care visits:



QUOTES:

Focus group themes surfaced the need for a more flexible and adaptable health care system that could provide equitable and inclusive services that expand access to care. This included the need for more culturally appropriate care and coordinated approach.

“We have this term, ‘service resistant.’ But that just means that your services don't fit the needs of the person. Nobody does not want to be served.” —Service Provider

“There are issues of provider equity and inclusion. We're really aware of the fact that there's differences in how people are diagnosed and treated and assessed based on what they look like and who they are.” —Service Provider

"The location of the clinic or the hospitals [is challenging]. Where I used to live, there was no hospital around the area, and there were hills, so it was hard to get to the hospitals that were closest.” — Community Member

“The constant bureaucracy and red tape is in the way of getting to the solutions. People are very clear of what the solutions are that they need, be it housing or some kind of medical attention or be it whatever else. And there's just constant ... Well first you have to fill out this form. And then you have to go and talk to this person and then afterwards they're going to send you this person who's going to make you fill out another form, which is going to be the same information on the first form that you filled out.” —Service Provider

SFHIP PRIORITIZATION:

SFHIP identified this issue as “Access to coordinated, culturally- and linguistically-appropriate care and services.”

Health Need: **Housing and Homelessness/Economic Security**

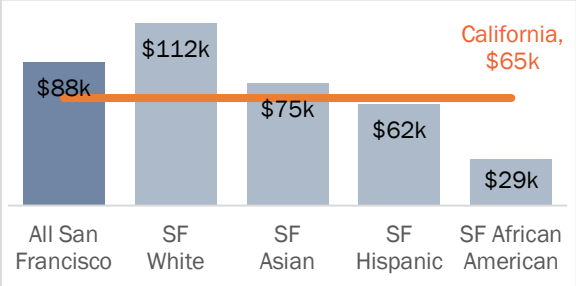
This health need draws upon data related to economic wellbeing, the cost of housing, and drivers of poverty including educational attainment.

RELEVANT DATA:

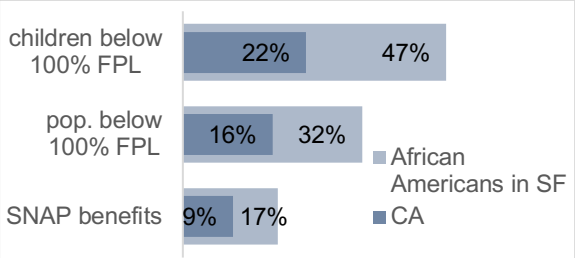
A review of the secondary data shows Hispanics, African Americans, Native Americans/Alaskan Natives, and Native Hawaiians/Pacific Islanders were significantly more likely than residents of California as a whole to report a low median income, have incomes below the federal poverty level, and use SNAP benefits.

- 72% of San Francisco residents graduate on time from high school, compared to 83% of California residents
- Hispanic adults (24%) and Native Americans (25%) were much less likely to have a high school diploma than San Francisco residents (13%) and Californians as a whole (18%)
- African Americans (32%) and Native Hawaiians (23%) were much more likely to live below the federal poverty level than San Francisco residents (12%) and Californians as a whole (16%)

Median Household Income:



African American Economic Indicators:



QUOTES:

In focus groups, participants connected economic security and homelessness as key drivers of other issues affecting the city such as mental health, substance abuse, HIV/AIDS, food insecurity, and access to care. SFHIP also identified "housing security and an end to homelessness" as a community priority.

"People feel like they don't belong in their own neighborhoods. You don't have the money anyway and then you're starting to feel like you don't belong in your own neighborhood anymore. They've lived there for generations and people are stepping over them wondering why they're still here. There's a psychological effect of that displacement that affects people's health." —Service Provider

"All I see are two people [in San Francisco] who are different. One is the rich and one is the poor." —Homeless youth

"We hear constantly from people that they just need more money for food, or more money for healthy food. That goes back to the misconception that poor people don't want to eat healthy. People do want to eat healthy, they do want to feed their family healthy food, it's just not affordable." —Service Provider

"In the last six months we're starting to look at a lot of young people that use sex as employment, are sex workers, or are commercially exploited. There are huge health implications to that." —Service Provider

"Sometimes if they don't have housing, it causes people to have sex for money. It causes people to be outside and do a lot more to get inside. —Homeless youth

SFHIP PRIORITIZATION:

SFHIP identified this issue as "Housing security and an end to homelessness."

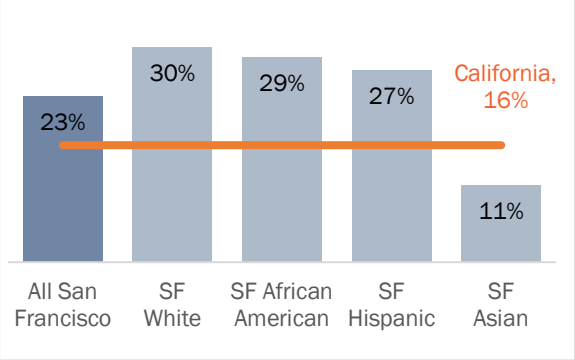
Health Need: **Mental Health**

This health need draws upon data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes.

RELEVANT DATA:

A review of the secondary data shows residents of San Francisco were significantly more likely to have seriously considered suicide than residents of California as a whole. Furthermore, certain racial/ethnic groups — White, Hispanic, and African American — were at higher risk for mental health services and distress. Mental health issues were also more common among women than men, people ages 18-24 and 45-54 years old than other age groups, people living with incomes below 200 percent of the Federal Poverty Limit than people with higher income, and people identifying as bisexual, gay or lesbian.

Needed Help with Mental Health or Alcohol/Drug Abuse in the Past 12 Months:



QUOTES:

Focus group themes surfaced a need for addressing mental health issues relating to trauma, especially amongst veterans, youth, and the homeless.

"One experience, like a homelessness experience, creates so many other health issues. The anxiety it creates can create drug usage or alcoholic abuse, and unhealthy eating. Everything just trickles down." —Service Provider

"The daily trauma and fear is huge and it affects everything and it affects your whole mental health." —Service Provider

"I believe the most important part of the children's health is psychological health. We need to provide a safe space for children." —Community member

"The wrap around services that we're providing students in our public school systems have to work with their families, and there's less and less funding, and less and less social workers every year. So not only are kids suffering trauma, they're not getting the socio-emotional support to learn how to talk about it, learn how to manage it." —Service Provider

"Twenty plus years ago, when my program started, it was the idea that you're just going to take care of your grandma. But grandma's very different these days and people are living a lot longer and they have many more health issues and there's a lot more mental illness and dementia than we used to see. So it's more complicated." —Service Provider

"We serve a mixture of folks who are experiencing homelessness and other folks who are at risk. There is a lot of isolation and depression for folks who are at risk of homelessness. They have been homeless for so long and out on the streets and then when they get housed they get stuck in this really small walled space." —Service Provider

SFHIP PRIORITIZATION:

SFHIP identified this issue as "Social, emotional, and behavioral health."

Health Need: **Obesity/Healthy Eating-Active Living/Diabetes**

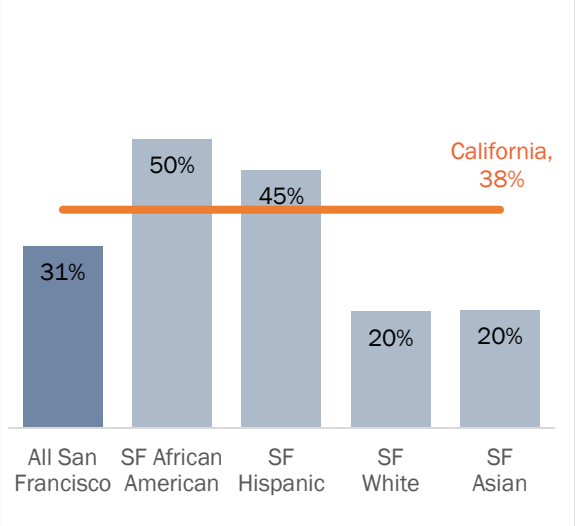
This health need draws upon data related to healthy eating and food access, physical fitness and active living, overweight and obesity prevalence, and downstream health outcomes including diabetes.

RELEVANT DATA:

A review of the secondary data shows Hispanics, African Americans, and Native Hawaiians/Pacific Islanders were significantly more likely than white residents of San Francisco and residents in California as a whole to experience indicators of youth obesity such as youth physical inactivity.

- Available data suggest that the diets of many San Franciscans do not meet minimum recommendations for vitamins and water and exceed maximum recommendations for salt, fat, and added sugar.
- Two thirds of children and teens in San Francisco report less than 5 servings of vegetables and fruit daily.
- The affordability of food was the number one concern in this category cited both by providers and community members.

Youth Inactivity:



QUOTES:

Focus group themes elevated the affordability of food as the number one concern cited by both providers and community members related to health eating and active living.

"You see all that extremely inexpensive junk food compared to the pricey healthy products. Organic foods are a great example: organic milk and all that stuff is too expensive. So you finally resort to what's the cheapest." —Spanish-speaking Hispanic parent

"Those folks that are living, particularly on the streets and trying to go through the transition process can be particularly challenging for them. And just around nutrition and understanding nutrition and food insecurity for a lot of our folks. Even if they're in permanent supportive housing, having access to healthy foods and being able to make healthy foods is a challenge." —Service Provider

"It's an economically rational decision to eat bad food when you don't have money and it's practically for free. And when Burger King accepts your EBT card, then that's what happens." —Service Provider

"We serve a wide population, so we work with a lot of seniors living in SRO's and individuals living in supportive housing and SRO's, all the way to a lot of families in supportive housing, pregnant moms coming through WIC, and the rates of chronic disease that we consistently see across populations is 80-something percent, whether it be diabetes, pre-diabetes, hypertension, kind of like a multitude of chronic diseases." —Service Provider

SFHIP PRIORITIZATION:

SFHIP identified this issue as "Food security, healthy eating, and active living."

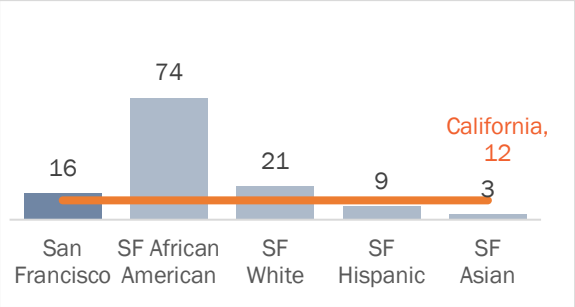
Health Need: **Substance Abuse/Tobacco**

This health need draws upon data related to forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs.

RELEVANT DATA:

A review of the secondary data shows San Francisco residents were significantly more likely to engage in excessive drinking, while sales of beer, wine, and liquor were significantly higher in the city than in the rest of the state. Although the age-adjusted mortality rate due to substance use disorder has decreased in San Francisco since 2015, African Americans were 5 times more likely to experience a substance use disorder than other ethnicities.

Mortality Rates due to Drug Use Disorders per 100,000:



QUOTES:

Focus group themes identified substance abuse as an exacerbating factor to other health needs.

"There's a constellation of challenges around homelessness and substance use and mental health. It's hard to unpack any one need because they are all stuck together." —Service Provider

"I was walking with my children a few days ago and saw some empty drug injections scattered over the street as we were passing, and later saw them injecting themselves. I acknowledge there are a lot of drugs here, but I'm going to focus on my children. If they see these people I'll tell them it's wrong, that we should talk about it, that that decision is going to bring them terrible consequences. Naturally, it's hard to walk knowing the children are looking at that." —Community member

"It is an exacerbating factor that we don't often talk about. If there is a substance use issue at hand, people are hustling for that next fix. It adds an element of urgency to a daily life that is already stressful on the street. We see people who are hustling for that next hit and they're stressed out." —Service Provider

"If there were safe consumption sites, there would be medical staff onsite and social workers and all the other services that somebody could get connected to that they're not otherwise doing." —Service Provider

SFHIP PRIORITIZATION:

SFHIP identified "social, emotional, and behavioral health" as a community priority, which they related to substance abuse/tobacco.

LOWER PRIORITY HEALTH NEEDS

Health Need: **HIV/AIDS/STDs**

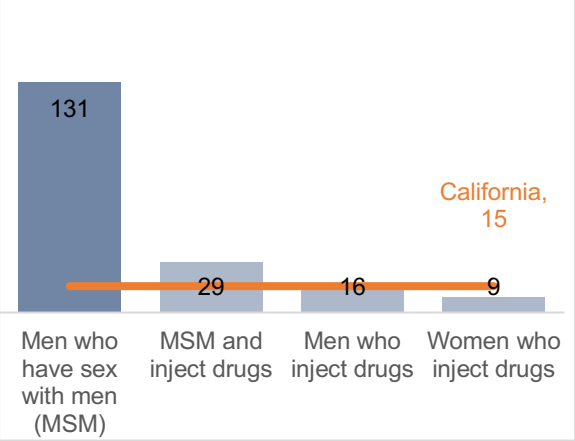
This health need draws upon data related to known drivers of sexually transmitted infections including HIV and related STD and AIDS outcomes.

RELEVANT DATA:

A review of the secondary data shows the incidence of HIV was significantly worse in San Francisco, though the rate of new infection was comparatively low and continuing to decrease.

- The estimated rate of new HIV infection in San Francisco has decreased from 56 per 100,000 in 2012 to 40 per 100,000 in 2014.
- Incidence rates for HIV and each STD are higher among men; men contract chlamydia and gonorrhea up to 9 times more often than woman.
- Between 2013 and 2016, incidence rates for chlamydia, gonorrhea, and early syphilis increased by 60 percent, 107 percent, and 13 percent, respectively.

Mortality Rates due to Drug Use Disorders per 100,000:



QUOTES:

In general, focus group participants reported that San Francisco has done a good job of responding to the HIV/AIDS epidemic over the last 30 years, though they noted that equity issues still exist in the treatment and care of those living with HIV, including knowledge of prevention options in communities of color, and services for the homeless, including homeless youth.

"Say we have 16,000 with HIV, we're only getting 200 new cases of HIV a year. That's enormously successful. San Francisco is the leader." —Service Provider

"Our HIV model is super successful. We brought in community-based organizations and the Department of Public Health. We went to the places where people were at risk, whether that was bath houses, clubs, bars, you know, we're just testing at events, like folks from a street fair. We saturated every opportunity for people to engage in health." —Service Provider

"Transmission is primarily sexual. We have a really robust syringe access network. Only about 10 people a year get HIV from syringes versus the 200 who are men who have sex with men." —Service Provider

"We see the same sort of constellational challenges around homelessness, substance use, mental health and recent rising rates of HIV and Hep C in our population. So it's hard to unpack any sort of one need because they are all stuck together." —Service Provider

"Make it mandatory that all medical coverage includes these things regardless of who you are, because humans have sex. And even if they don't, there's a chance they could get molested and coverage is not given." —Youth

SFHIP PRIORITIZATION:

SFHIP addressed this issue under "Access to care."

Health Need: **Violence/Injury Prevention**

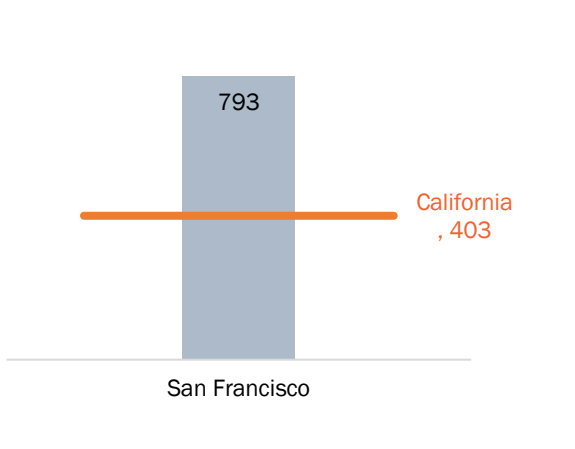
This health need draws upon data related to intended and unintended injury such as violent crime, motor vehicle accidents, and domestic violence.

RELEVANT DATA:

A review of the secondary data shows violent crime rates, hospitalizations for domestic violence, and pedestrian accident deaths were significantly higher in San Francisco than the state as a whole.

- There was an increase in all crime types, except for drug crime, between 2013-2015.
- Asian, Black, and Hispanic residents have significantly lower perceptions of safety during the day and night compared to White residents.
- Gay, lesbian, and bisexual identified middle and high school students experienced at least twice the rate of dating violence than their heterosexual peers.

Violent Crime Rates per 100,000:



QUOTES:

In the focus groups, participants noted the mental and physical health effects on people who witness or experience violence in their neighborhoods, and the effects of trauma on health. They also noted the importance of institutional violence as well as physical violence.

"There's a lot of stuff around trauma. People are living in neighborhoods where they witness violence and living through the effects of racism on their population." —Service Provider

"When I walk I feel safe as I can always see policemen around. In fact, there is a police station near my house. I believe it is a city that is always there for you in so many ways." —Spanish-speaking Hispanic parent

"I'm really curious about the safety and violence prevention aspect, like what exactly that means. Quite frankly, there are people who are scared of homeless people. But I'm thinking about a whole other level of violence. The population that I work with is extremely marginalized folks. For them, violence is institutional. I'm talking about racist violence. Unless you undo the systemic violence of marginalized populations, you're not going to create a level playing field where people can feel safe. So when we talk about violence, we really need to think about people who have been re-traumatized on the daily by the harshness of the enforcement." —Service Provider

SFHIP PRIORITIZATION:

SFHIP identified "freedom from violence and trauma" as a community priority.

Appendix D. Health Need Criteria Matrix

Below is an abbreviated comparison of the health needs using KFH San Francisco's criteria for health need identification. Needs were categorized as higher priority if they met these criteria and aligned with SFHIP's needs identification process. See Appendix C for a more detailed description of each prioritized health need.

	Meets the definition of a health need	Confirmed by multiple data sources		Performed poorly against benchmark	Disparities (stan dev below the benchmark)	Community importance (SFHIP Priority)
		qualitative theme	*quantitative data*			
HIGHER PRIORITY HEALTH NEEDS Met multiple criteria for inclusion and were prioritized by the community through SFHIP						
Access to Care	Meets criterion	Need for more culturally appropriate care and a trauma-informed approach	Recent primary care visit **SF:** 67.7% **CA:** 72.9%	SF was statistically significantly worse than CA for recent primary care visits	Recent primary care visits (African American): -3SD Uninsured population (Nat. American): -2.7SD	Access to coordinated, culturally- & linguistically-appropriate care and services *AND* Freedom from violence and trauma
Housing and Homeless/ Economic Security	Meets criterion	Economic security and homelessness are key drivers of other issues affecting residents	On-time HS graduation **SF:** 72.2% **CA:** 82.9%	SF was statistically significantly worse than CA for on-time high school graduation	Below federal poverty (African American): -3SD Median household income (African American): -2.5SD	Housing security and an end to homelessness
Mental Health	Meets criterion	Need for addressing mental health relating to trauma, especially amongst veterans, youth, and the homeless	Seriously considered suicide **SF:** 13.4% **CA:** 10.0%	SF was statistically significantly worse than CA for those who had considered suicide	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Social, emotional, and behavioral health
Obesity/ Healthy Eating-Active Living/Diabetes	Meets criterion	Affordability of food was the number one concern for both providers and community members	Food insecurity **SF:** 16.0% **CA:** 13.4%	SF was statistically significantly worse than CA for food insecurity	SNAP benefits (African Americans, Native Americans & PI) Youth inactivity (Hispanics, African Americans & PI)	Food security, healthy eating, and active living
Substance Abuse/ Tobacco	Meets criterion	Identified substance abuse as an exacerbating factor to other health needs	Excessive drinking **SF:** 23.0% **CA:** 18.3%	SF was statistically significantly worse than CA for excessive drinking	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Social, emotional, and behavioral health

	Meets the definition of a health need	Confirmed by multiple data sources: *qualitative theme*	Confirmed by multiple data sources: *quantitative data*	Performed poorly against benchmark	Disparities (stan dev below the benchmark)	Community importance (SFHIP Priority)
LOWER PRIORITY HEALTH NEEDS Met multiple criteria but were not prioritized by the community through SFHIP or the priority was accounted for elsewhere						
HIV/AIDS/ STDs	Meets criterion	While SF has done a good job responding to the HIV/AIDS epidemic, disparities remain	HIV/AIDS prevalence **SF:** 1,990/ 100,000 **CA:** 375/ 100,000 **SF:** 67.9 **CA:** 36.8	SF was statistically significantly worse than CA for HIV/AIDS prevalence	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Not prioritized
Violence/ Injury Prevention	Meets criterion	Respondents were more concerned about systemic violence and trauma than physical violence	Violent crimes **SF:** 793/ 100,000 **CA:** 402.6/ 100,000	SF was statistically significantly worse than CA for violent crimes	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Freedom from violence and trauma
NOT PRIORITIZED AS HEALTH NEEDS The following were evaluated using the Kaiser CHNA Platform but did not meet multiple criteria for inclusion as health needs						
Asthma	Meets criterion	None	Respiratory hazard index **SF:** 3.23 **CA:** 2.15	SF was statistically significantly worse than CA for the respiratory hazard index	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Not prioritized
Cancer	Meets criterion	None	Does not rank worse than CA in any of the key driver indicators	None	Cancer deaths (African American): -3SD	Not prioritized
Cardiovascular Disease/ Stroke	Meets criterion	None	Does not rank worse than CA in any of the key driver indicators	None	Stroke deaths (African American): -3SD	Not prioritized
Climate and Health	Meets criterion	None	Does not rank worse than CA in any of the key driver indicators	None	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Not prioritized
Maternal and Infant Health	Meets criterion	None	Does not rank worse than CA in any of the key driver indicators	None	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Not prioritized
Oral Health	Meets criterion	None	Does not rank worse than CA in any of the key driver indicators	None	*No Kaiser CHNA Platform data available. See Appendix C for more details.*	Not prioritized

Appendix E. Description of SFHIP Process

In San Francisco, the San Francisco Health Improvement Partnership (SFHIP) guides the collective CHNA process for the city's non-profit hospitals (including KFH San Francisco), the San Francisco Department of Public Health, and its partners. As summarized in SFHIP's 2019 Community Health Needs Assessment, this process included:

SFHIP members, including representatives of KFH San Francisco, met on October 18, 2018 to prioritize the health needs through a multistep process. First, participants reviewed data and information collected during the CHNA process to date. This included the secondary data and community input described in Section IV of this report. Then, using the Technology of Participation approach to consensus development – a structured facilitation method to help groups think, talk and work together – participants engaged in a focused discussion about the data. The consensus development steps included:

- Individual listing of top health needs
- Small group discussions on the top health needs to identify similarities and differences
- Sharing all the health needs identified by the individuals
- Clustering the similar health needs into themes
- Determining a name for the theme, which is the health need
- Comparing and discussing new needs with those from 2012 Community Health Improvement Plan

Through this process two foundational issues and five health needs were identified. Foundational issues are needs which affect health at every level and must be addressed to improve health in San Francisco.

The two foundational issues identified were:

- Poverty
- Racial health inequities

The five needs identified at the meeting were:

- Access to Coordinated, Culturally and Linguistically Appropriate Care and Services
- Social, Emotional, and Behavioral Health
- Freedom from Violence and Trauma
- Food Security, Healthy Eating, and Active Living
- Housing Security and an End to Homelessness

Appendix F. KFH San Francisco Community Benefit Advisory Committee members

TITLE	DEPARTMENT
Chief of Diversity; Spanish Module MD	Medicine
Community Health Manager	Public Affairs
Contributions Operations Specialist	Public Affairs
Medical Social Worker	Continuum
Psychologist - Pain Management	Chronic Pain
Pediatrician	Pediatrics
Health Educator, Cancer Center	Surgery, Oncology
Area Compliance Officer	Compliance Ethics & Integrity
Sr. Consultant	TPMG Administration
Hospice Site Director	Continuum
Physician	Internal Medicine
Gynecological Surgeon	OB/GYN
Consulting Associate	TPMG Administration
Manager	Specialty Services Call Center
Director	Allergy & Asthma, Chronic Pain, Head & Neck Departments
Project Manager	Employee Wellness
Area Quality Leader	KFH Administration
KFH Social Worker	Palliative Care
Communications Manager	Public Affairs
Associate Public Affairs Rep.	Public Affairs
Community & Govt. Relations Manager	Public Affairs
Chief, Addiction Medicine	CDRP
Chief, Allergy & Asthma	Allery & Asthma
Chief, Oncology	Medicine
Assistant Medical Group Administrator	TPMG Administration
Medical Social Worker	Continuum