2019 Community Health Needs Assessment

Kaiser Foundation Hospital: San Rafael

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

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KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit

CHNA Report for KFH-San Rafael

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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 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 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, https://www.kp.org/chna.

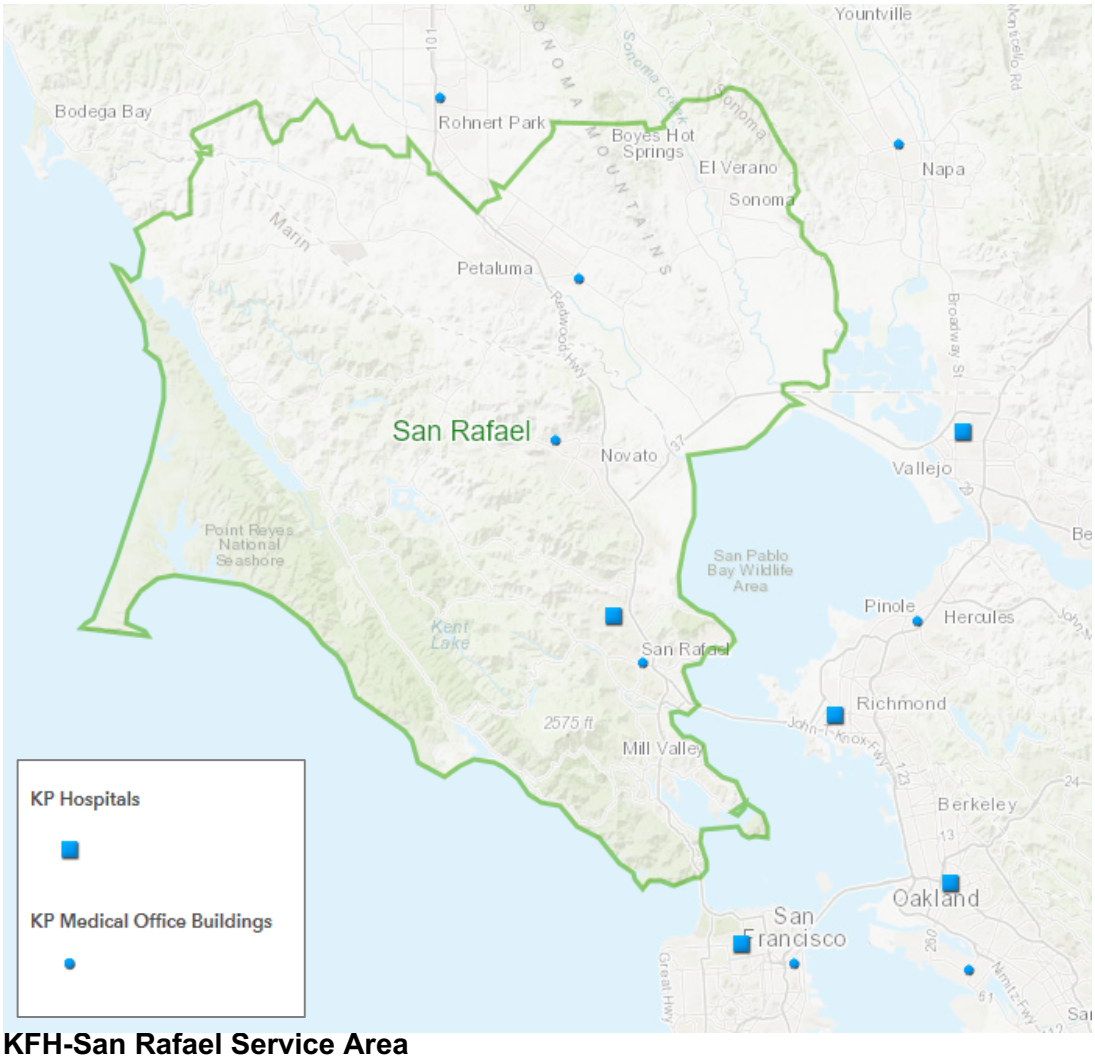
II. Community served

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 Rafael Service Area

ii. Geographic description of the community 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. The Kaiser Permanente data platform was the primary source of data for this report. However, Marin County data was used as a proxy for the service area when sub-county data was unavailable.

iii. Demographic profile of the community served

Demographic profile: KFH-San Rafael

Race/ethnicity		**Socioeconomic Data**	
Total Population	368,184	Living in poverty (<100% federal poverty level)	8.5%
Asian	4.9%	Children in poverty	10.6%
Black	1.9%	Unemployment	2.4%
Native American/Alaska Native	0.3%	Uninsured population	7.2%
Pacific Islander/Native Hawaiian	0.2%	Adults with no high school diploma	8.4%
Some other race	9.2%		
Multiple races	4.2%		
White	79.3%		
Hispanic/Latino	18.0%		

III. Who was involved in the assessment?

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

KFH-San Rafael collaborated with both hospital and other partner organizations with similar service areas in Marin County to support the CHNA. In Marin County, many of these partners were already engaged in a collaborative, the Healthy Marin Partnership (HMP), which was formed in 1995 as a result of working together on prior needs assessments. This group developed a coordinated approach to primary data collection, and then determined the list of significant health needs based on both primary and secondary data. KFH-San Rafael then organized with these partners to engage a broader group of community stakeholders to prioritize the identified health needs (described in Section VI-B).

Collaborative hospital partners:

1. Kaiser Foundation Hospital – San Rafael
2. Marin General Hospital
3. Sutter Health – Novato Community Hospital

Additional partners:

1. Marin County Health and Human Services
2. Healthy Marin Partnership
    a. Hospital Council of Northern and Central California
    b. Northbay Leadership Council
    c. Marin County Office of Education
    d. Marin Community Foundation
    e. San Rafael Chamber of Commerce

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

Harder+Company Community Research (Harder+Company) is a 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-responsive 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 offer 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 health care reform and the CHNA process in particular. Harder+Company is the consultant on several other CHNAs throughout the state, including the Kaiser Foundation Hospitals service areas in Roseville, Sacramento, San Bernardino, Santa Rosa, South Sacramento, Vacaville, and Vallejo.

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 Rafael used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources.

KFH-San Rafael also used additional data sources beyond those included in the CHNA Data Platform (e.g., California Healthy Kids Survey, Marin County Point in Time Homeless Count and Survey, and Commission on Aging: Housing Report).

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

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 Rafael also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners (e.g., county health departments, service providers, and other stakeholders) provided additional data (e.g., frequency tables, reports, etc.) to be included in the health need profiles (see Appendix A. Secondary data sources and dates for a list of additional data sources).

The Harder+Company team reviewed this additional data and included data points in the health need profiles that provided additional context or more up-to-date statistics to indicators already included in Kaiser's CHNA Data Platform. Each health need profile includes a reference section with a detailed list of all the secondary data sources used in that profile (see Appendix C. Health Need Profiles).

The Harder+Company team did not conduct any additional analysis on secondary data. The CHNA Data Platform provides information about health disparities and data benchmarks, and the additional secondary data that was shared by CHNA partners often disaggregated data by, for example, region and race/ethnicity.

B. Community input

i. Description of who was consulted

A broad range of community members provided input through key informant interviews, group interviews, and focus groups. We consulted individuals with knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, we gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., race/ethnic minorities and individuals experiencing homelessness). For a complete list of communities and organizations who provided input, see Appendix B. Community input tracking form.

ii. Methodology for collection and interpretation

In an effort to include a wide range of community voices from individuals with diverse perspectives and experiences and those who work with or represent underserved populations and geographic communities within the KFH-San Rafael service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries. For a complete list of participating organizations, see Appendix B. Community input tracking form.

The consulting team developed interview and focus group protocols, which the CHNA Collaborative reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. We also asked participants to describe any new or emerging health issues and to prioritize the top health concerns in their community. For more information about data collection protocols, see Appendix Z.

We conducted key informant interviews over the phone by a single interviewer, while provider group interviews and community focus groups were in person and completed by both a facilitator and notetaker. When respondents granted permission, we recorded and transcribed all interviews.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). 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 subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended healthcare solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, we finalized the codebook to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

In comparison to secondary (i.e., quantitative) data sources, primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

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 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 KP CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that fall below the state average flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

We also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, we made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, we conducted focus groups in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.

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

Extensive secondary quantitative data (from the Kaiser CHNA Data Portal and other publically available data), as well as primary qualitative data collected from key informant interviews, provider focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Portal groups approximately 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators).The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews, see Section IV B ii for details). Part of the analysis included grouping individual indicators into health need categories similar to those identified in the Kaiser CHNA Data Portal. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as **high need based on secondary data** from the Kaiser CHNA Data Portal if it met *any* of the following conditions:
    - *Overall severity:* indicator Z-score much worse or worse than benchmark.
    - *Disparities:* indicator Z-score much worse or worse than benchmark for any defined racial/ethnic group.
    - *External benchmark:* indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020) or represented a unique need of the region.
2. A health need category was classified as **high need based on primary data** if it was identified as a theme in a majority of key informant interviews, group interview, *and* focus groups.
3. Classification of primary and secondary data was combined into the final health need category using the following criteria:

- **Yes**: high need indicated in *both* secondary and across *all types* of primary data. Kaiser Permanente and CHNA partners then confirmed these high needs.
- **Maybe**: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with Kaiser Permanente and CHNA partners to determine final status.
    - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
    - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
- **No**: high need indicated in only one or fewer sources.

B. Process and criteria used for prioritization of health needs

For each identified community health need, Harder+Company developed a three- to four-page written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers, residents, and others) to prioritize the health needs. The community benefit manager from KFH-San Rafael attended the meeting to observe and help facilitate, but did not vote. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity:** Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.
- **Clear Disparities or Inequities:** Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
- **Impact:** The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

During the small-group discussions, meeting participants referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Harder+Company then tallied the votes after the prioritization meeting and shared the final ranked list with participants via email.

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

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to Appendix C. Health Need Profiles.

1. **Economic Security:** Economic security means having the financial resources, public supports, and career and educational opportunities that are necessary to live your fullest life. As such, this health need touches upon every other health-related issue in the KFH-San Rafael community, from mental health to housing. While Marin County ranks among the top in the country in terms of economic wealth and community resources, 50 percent of residents spend 30 percent or more of household income on rent.[1] Importantly, many residents expressed that the County's riches are unevenly distributed and not available to all. These divides are particularly stark along lines of race/ethnicity and citizenship status. For example, roughly, 60 percent of both the Black and Hispanic populations in Marin County are living below the 250 percent federal poverty line compared to 21 percent of the White population; in the state overall, the average is 35 percent.[2] Further, U.S. born residents in Marin County have an average annual wage of $75,493 compared to only $23,742 for undocumented immigrants.[3] Geographically, outcomes related to education, employment, and wage demonstrate a glaringly uneven distribution, with the Canal region and West Marin facing the greatest barriers to economic security. Relatedly, **t**he percentage of businesses owned by minorities is roughly 15 percent in Marin County compared to nearly 46 percent across the state of California.[4] In focus groups, participants connected economics and health by reporting how the economic necessity of working multiple jobs and the long commutes needed to get from where they can afford to live to where jobs are available, lead to mental and physical health issues.

2. **Education:** Educational attainment is a primary factor that influences individual health. It can both shape the economic opportunities that impact health outcomes, as indicated in

[1] American Community Survey. (2012-16).
[2] Ibid.
[3] USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
[4] Healthy People 2020; US Census Bureau – Economic Census 2012

the Economic Security section, above as well as inform people about how to live a healthy lifestyle. While some education outcomes are higher for Marin County than the rest of California, disparities—particularly among English language learners, African Americans, and Latino students—indicate that educational equality is a high concern in the county. Among White third graders, 76 percent demonstrate English and language arts proficiency compared to just 32 percent of Latino students and 27 percent of African Americans.[5] In mathematics, 73 percent of White third graders are proficient compared to 28 percent of Latino student and 31 percent of African Americans.[6] These disparities are present both among achievement (e.g., reading/math proficiency) outcomes and educational attainment (e.g., college attendance). For example, 85 percent of White 3- and 4-year olds attend preschool compared to only 35 percent of Latinos.[7] Among 16-24 year olds, college attendance among Whites is 80 percent compared to only 47 percent for Black/African Americans and 37 percent for Hispanic/Latinos.[8] These racial disparities also extend to a sense of belonging at school, with only 23 percent of African American 7th graders reporting a high level of school connectedness compared to 75 percent of Whites.[9] Many community members signaled educational equity and increased health awareness as strategies necessary to advancing health goals.

3. **Mental Health/Substance Use:** Marin County residents demonstrate high need in addressing mental health issues, indicated by rates of suicide, medication for mental health issues, and substance abuse treatment. In the KFH-San Rafael service area, 20 percent of adults report needing help with mental, emotional, or substance use issues compared to only 15 percent of adults in California.[10] Relatedly, 15 percent of Marin County adults take daily prescriptions for mental health issues, which is higher than the California rate of 11 percent.[11] In general as well as in Marin County specifically, mental health issues frequently coexist with substance abuse. In the KFH-San Rafael service area, 21 percent of adults report excessive drinking, higher than the California average of 18 percent.[12] The suicide rate is particularly high among non-Hispanic White and non-Hispanic Black residents, at 13 per 100,000 and 12 per 100,000 respectively; this is roughly twice the rate of suicide among Hispanic/Latinos in the region.[13] In focus groups, community members discussed the stigma around mental illness, a lack of access to mental health providers, and few treatment options for people who are homeless as major concerns.

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[5] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020

[6] Ibid.

[7] http://www.marinkids.org/wp-content/uploads/2015/02/Education-Data-20141.pdf

[8] American Community Survey. (2012-16).

[9] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020.

[10] Healthy People 2020. California Health Interview Survey. (2014-15).

[11] Ibid.

[12] Behavioral Risk Surveillance Task Force. (2017).

[13] CDPH. (2010-12). (Death Master Files, pulled from 2015 Pathways to Progress)

4. **Access to Care:** Access to health care includes insurance coverage, physician access, and availability and affordability of emergency and specialty health services. Access to quality health care is important to overall health, disease prevention, and reducing unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The KFH-San Rafael service area has nearly twice the rate of primary care providers (78/100,000) compared to the state (130/100,000)[14]. While Marin County scores better than the California state average on many indicators measuring health care access, the county has not yet met the Healthy People 2020 benchmark for insurance coverage. In particular, almost half of undocumented immigrants (48 percent) lack insurance coverage compared to just 6 percent without insurance among U.S. born citizens.[15] Group interview participants were aware of the disparity and reported that the county continues to work toward providing affordable and culturally competent care for all residents, especially community members who are undocumented. Racial minority groups and lower income individuals also face great challenges in obtaining affordable care. For example, in the KFH-San Rafael service area, roughly 20 percent of both Hispanic/Latino and non-Hispanic Pacific Islander populations are without health insurance.[16] There are also important disparities by income, with fewer women on Medi-Cal receiving prenatal care during their first trimester (89 percent) compared to 94 percent of all pregnant women in Marin.[17] Additionally, focus group participants expressed that, as Marin's population ages, innovative options for those who wish to age in place or who are unable to travel to receive health care services will be important. The elderly are less physically mobile, experience more frequent health issues, and often survive on fixed incomes.

5. **Housing/Homelessness:** Marin County's high cost of housing exacerbates issues related to health care access and affordability, which in turn has a negative impact on health outcomes in the area. More than half of renters pay 30 percent or more of their income on rent.[18] Focus group participants shared that, in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. These circumstances are exacerbated by racial inequities since only a quarter of Black or Latino residents in Marin own homes compared to two thirds of White residents.[19] Further, housing costs present unique challenges for older adults who wish to age in place but who often live on a fixed income and may require additional services and supports as their needs change. Additionally, homelessness exposes individuals to increased health risks, especially as 63 percent of Marin's homeless population is unsheltered,[20] and service providers have difficulty linking persons who are experiencing homelessness to supportive housing and health care services. Racial minorities are

[14] Area Health Resource File, 2010-16.
[15] USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
[16] American Community Survey. (2012-16).
[17] Family Health Outcomes Project, California Maternal Child and Adolescent Health 2012.
[18] American Community Survey. (2012-16).
[19] Ibid.
[20] Point in Time Homeless Count. (2015). Marin Homeless Census and Survey.

disproportionately represented among persons experiencing homelessness. For example, African Americans represent just 2% of the KFH-San Rafael population, but 20% of those experiencing homelessness.[21] Twenty-nine percent of those experiencing homelessness are between 18-24 years old, an increase from 6 percent in 2013.[22]

6. **Healthy Eating & Active Living (Inc. obesity, diabetes, CVD, and some cancers):** HEAL relates to Marin residents' ability to shape health outcomes through a focus on nutrition and physical activity. Rates of obesity and diabetes are lower in Marin County compared to California as a whole. However, there is a high prevalence of youth in the KFH-San Rafael service area who are overweight or obese, especially among Black (18 percent), Hispanic (20 percent), and Native American/Alaska Native populations (24 percent).[23] Disparities also exist in rates of cancer. For example, Whites have a rate 48% higher than Asian and Pacific Islanders.[24] Black Marin residents have a rate of cardiovascular disease 55% higher than Whites.[25] With respect to strokes, Blacks have more than double the rate of Whites.[26] Related to all of these disparities, healthy lifestyle choices greatly affect the rates of chronic conditions like cardiovascular disease, stroke, and cancer. For example, focus group participants bemoaned the lack of resources for education around diabetes management. They also expressed that access to healthy food is a top concern. This is particularly true in the "food deserts" of Lynwood, Hamilton, and the Canal area of San Rafael.[27]

7. **Maternal and Infant Health:** Maternal and infant health describes the health concerns of mothers and their newborn children, and many of the indicators in this category are predictive of health outcomes over the life course. The KFH-San Rafael service area has a lower infant mortality rate than California,[28] and the county has a lower maternal mortality rate, but still struggles with many issues relating to child health and development. For example, of the 750 children on Marin Childcare Council's waiting list, 288 are infants.[29] In interviews, service providers highlighted the racially concentrated nature of maternal and infant health concerns: only 83 percent of African American mothers and 88 percent of Latina mothers receive first trimester prenatal care compared to 94 percent of Whites.[30] Further, African Americans have higher rates of pregnancy-

[21] Ibid.
[22] Point in Time Homeless Count. (2015). Marin Homeless Census and Survey.
[23] FITNESSGRAM® Physical Fitness Testing (2016-17)
[24] CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress)
[25] Ibid.
[26] Ibid.
[27] Burd-Sharps, S. & Lewis, K. (2012). *A Portrait of Marin: Marin County Human Development Report 2012*
[28] Area Health Resource File (Health Resources & Services Administration)
[29] *Marin Independent Journal.* Retrieved from http://www.marinij.com/article/NO/20150617/NEWS/150619808
[30] Centers for Disease Control and Prevention, Birth Certificate Data 2008-17

related death and lower rates of pre-natal care than other ethnicities.[31] Additionally, the Marin Hispanic/Latino population has a teen birthrate 20 times higher than their White counterparts.[32] Relating this to the health need of Economic Security, described above, focus group participants expressed the need for improved childcare and better educational options.

8. **Violence/Injury Prevention:** Violence and Injury prevention is a broad category of health related indicators that captures things as distinct as physical abuse and accidental poisoning. These health-related events are concentrated among certain parts of the population, indicating they may have important social determinants. The KFH-San Rafael service area has nearly half the rate of violent crime (237/100,000) than California overall (403/100,000).[33] However, Marin does have several issues related to violence and injury that present distinct challenges. Due to heavy manual labor, many work-related injuries affect day laborers, particularly community members who are undocumented — 20 percent of day laborers report being injured on the job.[34] Crime rates are unevenly distributed, across racial groups and neighborhoods. For example, the rate of juvenile felony arrests for blacks is four times higher than Hispanic/Latinos, which itself is five times higher than for Whites.[35] Conditions that increase the likelihood of involvement with the juvenile justice system include family poverty, separation from family members including parental incarceration, a history of maltreatment, exposure to violence, and discrimination by law enforcement. Further, the city of San Rafael has a violent crime rate nearly twice as high as Novato.[36] Community residents expressed concern that crime reporting had decreased as a result of recent Immigration and Customs Enforcement (ICE) raids and that some youth in the Canal Area cities feel pressured to join gangs. Finally, older adults face unique challenges related to physical accidents, as falls are the leading cause of fatal injuries; 20 percent of seniors reporting a fall in the past year[37] and most homes are not designed for aging in place and universal accessibility.

9. **Oral Health:** Oral health is a key indicator of overall health; however, it is often treated as separate due to the professional separation of dentistry work from other medical fields. The impact of untreated oral health conditions disproportionally affects the most vulnerable populations and contributes to such conditions as cardiovascular disease, and poor pregnancy and birth outcomes. Although tooth decay and gum disease are preventable, inadequate access to dental insurance and dental providers, and underutilization of dental care, are affecting the oral health of Marin County residents.

[31] The California Pregnancy Associated Mortality Review. Retrieved from https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/PAMR/CA-PAMR-Report-1.pdf
[32] Family Health Outcomes Project, California Maternal Child and Adolescent Health
[33] FBI Uniform Crime Report 2017.
[34] *UCLA Newsroom,* http://newsroom.ucla.edu/releases/First-Nationwide-Study-of-Day-Laborers-6774.
[35] Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center. 2016.
[36] Data from Uniform Crime Reporting Statistics (2012), US Department of Justice.
[37] California Health Interview Survey (2011-12).

For example, 43 percent of adults in Marin County do not have dental insurance compared to the state average of 39 percent.[38] The incidence rate of oral cavity and pharynx cancer (14/100,000 persons) is 40% higher than the California average of (10/100,000).[39] Marin has not yet reached its Healthy People 2020 goal for children's dental health provision,[40] and Denti-Cal reimbursement rates are low, indicating an opportunity for improving access. Key informant and focus group participants report that dental insurance is difficult to obtain, and specialty care, like oral surgery, is not affordable.

10. **Social Connection:** Social connections can directly impact mental health and their influence on lifestyle have important consequences for physical health. The KFH-San Rafael service area boasts many social associations, and residents generally feel they know where to go for emotional and social support. Only 18 percent of residents feel they have insufficient social and emotional support compared to the California average of 25 percent.[41] However, economic inequality and the county's rapidly aging population increase the risk of social isolation. For example, 54 percent of individuals over 65 years of age reported eating alone, and 44 percent reported living alone.[42] Further, the lack of alternative forms of transportation in rural towns, and racial segregation in parts of Marin, create barriers to community cohesion. According to the residential segregation dissimilarity index, Whites and Hispanics in the San Rafael area in particular, experience a high degree of census tract separation.[43] Racial and ethnic minority students report bullying and a lack of connection to their schools; White 7th graders are three times more likely to feel connected to their schools than African Americans, and 50 percent more likely than Latinos.[44] Key informants reported that language barriers lead to further isolation among immigrant communities. Populations such as the LGBTQ community and people experiencing homelessness report a lack of safe and welcoming social spaces. Finally, at both ends of the age spectrum, youth and older adults desire social connection; youth want opportunities for positive mentorship and older adults desire more community events.

[38] California Health Interview Survey (2014-15).
[39] National Cancer Institute (2011-15).
[40] Healthy People 2020; California Oral Health Reporting 2008-10.
[41] Behavioral Risk Factor Surveillance System.
[42] American Community Survey. (2011-14).
[43] Brown University US2010 Project, 2010 data available from: http://www.s4.brown.edu/us2010/index.htm6. Centers for Disease Control and Prevention, Birth Certificate Data 2008-17.
[44] California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020

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

The service area for KFH-San Rafael 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.

Examples of community resources available to respond to each community-identified health need, as identified in qualitative data, are indicated in each health need brief found in Appendix C. Health Need Profiles. In addition, a list of community-based organizations and agencies that participated in the CHNA process can be found in Appendix B. Community input tracking form. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference https://www.211ca.org/ and enter the topic and/or city of interest.

VI. KFH-San Rafael 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-San Rafael'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 Rafael'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/chna). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-San Rafael in the 2016 Implementation Strategy Report.

1. Healthy Eating, Active Living
2. Access to Care and Coverage
3. Behavioral Health
4. Education

KFH-San Rafael 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 Rafael 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 Rafael 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 Rafael 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 Rafael awarded 269 grants amounting to a total of $5,566,348.25 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 the KFH-San Rafael service area. During 2017-2018, a portion of money managed by this foundation was used to award one grant totaling $4,761.90 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 Rafael 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 Rafael engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Examples of collaborations and partnerships are included in the section of the report below.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-San Rafael Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care	*During 2017 and 2018, KFH-San Rafael awarded 68 grants totaling $4,246,369.44 that address Access to Care in the KFH-San Rafael service area.*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 9,663 and 8,658 Medi-Cal members respectively totaling $17,618,584.93 worth of care. KP also provided a total of $13,053,392.70 of Medical Financial Assistance (MFA) to 4,935 individuals in 2017 and 2,252 individuals in 2018.
		Access to care programs: KFH San Rafael awarded $40,000 in grants to improve access to care for vulnerable populations: A. $20,000 was granted to RotaCare Clinic of San Rafael to provide free medical care for the relief of pain and suffering to those with the greatest need and the least access to health care resources. More than 600 patient visits were provided and a new electronic health record/ practice management system was rolled out during the first quarter of grant funding. B. $20,000 was awarded to La Luz Community Cares Program to provide wraparound support for Medi-Cal enrollment in Spanish and access to clinical services through a partnership with local community clinics. This funding supports enrollment of more than 100 community members in Covered CA or Medi-Cal and provides free health care resources to more than 1,000 people.
		PHASE: Over the course of three years (2017-2019), Redwood Community Health Coalition (RCHC) is the recipient of a $500K grant (evenly split between 3 KFH hospital service areas) to support the successful use of PHASE among member health center organizations. Strategies include developing a self-measured blood pressure monitoring program and facilitating peer sharing around quality improvement practices. RCHC is reaching over 25,000 patients through PHASE. 74% of their patients with diabetes and 68% of their patients with hypertension have their blood pressure controlled.
		Operation Access: Operation Access received a $350,000 grant (evenly split between 15 KFH hospital service areas) to coordinate donated medical care and expand access to care for low-income uninsured adults in the Bay Area through its volunteer and hospital network. 669 staff/physician volunteers provided 650 surgical and diagnostic services at 11 facilities, reaching 521 adults.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		211: In 2018, 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.
Healthy Eating Active Living	*During 2017 and 2018, KFH-San Rafael awarded 38 grants totaling $418,466.21 that address Healthy Eating Active Living in the KFH-San Rafael service area.*	Childhood Obesity: $50,000 in grant funding was provided to two local nonprofits addressing childhood obesity prevention: A. North Bay Children's Center received a $25,000 grant for its Garden of Eatin' obesity prevention program, which has reached 85 NBCC teachers and staff, and 329 children and parents using a garden to table curriculum at early learning centers. B. Marin Child Care Council received a $25,000 grant to recruit and coach 30+ HEAL champions in early childhood programs throughout Marin. The project will have a ripple effect, providing students, staff, and parents increased access to healthy high-quality foods, empowerment to make healthy choices, and an understanding that active living is an essential component of lifelong wellness.
		CalFresh: In 2018, Redwood Community Health Coalition (RCHC) received a $95,000 grant (evenly split between KFH-Rafael and KFH-Santa Rosa) to increase CalFresh participation by building health center capacity for outreach and in-reach. To date, outreach efforts have included staff presentations to service providers, tabling at health hubs, senior events and farmers markets. RCHC expects to assist 5,000 health center patients who are enrolled in Medi-Cal to enroll in CalFresh.
Mental Health and Wellness	*During 2017 and 2018, KFH-San Rafael awarded 29 grants totaling $349,516.50 that address Mental Health and Wellness in the KFH-San Rafael service area.*	Substance abuse prevention: Youth Leadership Institute (YGL) received $30,000 to address alcohol, tobacco, and other drug prevention in youth populations with a special focus on cannabis, parent norms, and vaping. This project reaches YGL coalition members, San Rafael parents and youth, decision makers and youth leaders from across Marin County through coalition work and peer-to-peer education.
		Substance abuse prevention: Huckleberry Youth Programs of Marin received $30,000 to support its Substance Misuse Prevention and Reduction Programming. By the end of the grant period, Huckleberry will have reached 1,125 Marin youth with vital prevention education and engaged 50 youth in brief intervention, outpatient treatment, and/or mental health services to reduce and/or eliminate use.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Stigma: In 2018, North Marin Community Services (NMCS) received a $90,000 grant to implement a Spanish language stigma-reduction media campaign and train community influencers to educate Latino men about the role of mental health in overall health. NMCS expects to train 50 Latino community influencers to provide education and referrals to low-income Latinos and plans to reach 15,000 Latinos through an online and print media campaign with the goal to reduce stigma and increase access to mental health services.
Education	*During 2017 and 2018, KFH-San Rafael awarded 71 grants totaling $321,246.45 that address Education in the KFH-San Rafael service area.*	Financial aid: 10,000 Degrees received $20,000 to support its College Access Program. The program has served approximately 60 high school seniors at San Rafael and Terra Linda high schools and more than 1,400 students and families in San Rafael School District have received financial aid workshops, including Free Application for Federal Student Aid (FAFSA) and Dream Act application completion workshops as well as college information workshops.
		Early childhood education: Community Action Marin received $38,610 to support the Early Childhood Education Community Workforce Project (ECECWP), an alliance to help incoming early childhood education teachers advance professionally and academically with a variety of supports. More than15 community members will complete the education required to be hired in this field.
		University prep: Canal Alliance received $20,000 for its University Prep (UP!) program. In Spring 2018, UP! celebrated the graduations of all nine of its high school seniors who will attend the following schools in the 2018-2019 school year: Biola University, Humboldt State University, Sacramento State University, San Francisco State University, Santa Rosa Junior College, and University of California Merced. UP! will continue its successful middle and high school programs, with 76 participating students, during the 2018-2019 school year.

VII. Appendices

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

ii. Additional sources

Appendix B. Community input tracking form

Appendix C. Health Need Profiles

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

	Source	Dates
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1.	American Association of Retired Persons	2012
2.	Area Agency on Aging Marin County Plan	2016-2020
3.	Behavioral Risk Surveillance Task Force	2017
4.	Brown University, Diversity and Disparities Project	2010
5.	California Department of Education, California Physical Fitness Report	2014-2015
6.	California Department of Education, School Level Data Files	2014-2015
7.	California Department of Public Health	2010-2012
8.	California Department of Public Health, Kindergarten Assessment Results	2013-15
9.	California Health Interview Survey	2014-2015
10.	California Healthy Kids Survey	2017-2018
11.	California Office of Traffic Safety (OTS)	2016
12.	California Oral Health Reporting	2008-2010
13.	Centers for Disease Control	2013
14.	Centers for Disease Control and Prevention	2008-2017
15.	Commission on Aging, Housing Report	2018
16.	County Business Patterns	2015
17.	Insight Center	2012
18.	Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center	2016
19.	Marin Community Clinic	2013-2015
20.	Marin County Human Development Report	2012
21.	Marin County Oral Health Report	2014
22.	Marin County Point in Time Homeless Count and Survey	2015
23.	Marin Independent Journal	2015
24.	MarinKids	2015
25.	Maternal and Infant Health Assessments, California Department of Public Health	2013-2015
26.	National Cancer Institute	2011-2015
27.	National Survey of Children’s Exposure to Violence	2015
28.	National Vital Statistics System	2016
29.	Same as above	
30.	The California Pregnancy-Associated Mortality Review, California Department of Public Health	2002-2007
31.	U.S. Census Bureau (Economic Census)	2012
32.	UCLA Newsroom	2006
33.	Uniform Crime Reporting Statistics, U.S. Department of Justice	2012
34.	USC Dornsife, Center for the Study Immigrant Integration	2016

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 Interview	Marin Food Policy Council (Program Manager)	1	a) health department representative b) minority c) medically underserved d) low income	Service provider	10/3/18
2	Key Informant Interview	Canal Alliance (Family Resource Manager)	1	b) minority c) medically underserved d) low income	Service provider	8/30/18
3	Key Informant Interview	City of San Rafael (Chief of Police)	1	b) minority c) medically underserved d) low income	Service provider	9/5/18
4	Key Informant Interview	Marin Transit (Director of Policy and Legislative Programs)	1	b) minority c) medically underserved d) low income	Service provider	9/18/18
5	Key Informant Interview	Marin County Dept. of Health & Human Services, Behavioral Health and Recovery Services (Director)	1	a) health department representative b) minority c) medically underserved d) low income	Service provider	8/28/18
6	Group Interview	Substance Use/Behavioral Health: RxSafe Marin (Coordinator), National Alliance of Mental Illness Marin (executive Director), North Marin Community Services (Director of Mental Health Programs)	3	a) health department representative, b) minority, c) medically underserved d) low income	Service providers	10/8/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
7	Group Interview	Healthcare Delivery/Access: Coastal Health Alliance (CEO), Marin City Health and Wellness Center (CEO), Marin Community Clinics (CEO), RotaCare Clinic of San Rafael (Medical Director)	4	a) health department representative, b) minority c) medically underserved d) low income	Service providers	10/11/18
8	Group Interview	Economic Development: Marin Economic Forum (Board member), San Rafael Chamber of Commerce (President and CEO), Novato Chamber of Commerce (CEO), Latino Council of Marin (Executive Director), North Bay Leadership Council (President and CEO)	5	a) health department representative, b) minority, d) low income	Service providers	10/15/19
9	Group Interview	Disabilities: Marin Center for Independent Living (Executive Director), Buckelew Programs (CEO), Whistlestop (Healthcare Market Strategist), Casa Allegra (Executive Director), Marin Ventures (Executive Director), Marin IHSS Public Authority (Executive Director)	6	a) health department representative b) minority c) medically underserved d) low income	Service providers	9/21/18
10	Group Interview	Housing/Safety Net: Ritter Center (Executive Director), Homeward Bound (Executive Director and	8	a) health department representative b) minority c) medically	Service providers	9/19/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
		Chief Provider of Homeless Services), St. Vincent de Paul Society (Executive Director), Marin Housing Authority (Executive Director), Whole Person Care Marin County (Director), Downtown Streets Team (Program Director)		underserved d) low income		
Community residents						
	Focus Group	Youth: Youth served by the Marin County Youth Court program located in San Rafael	6	b) minority d) low income	Community members	9/5/18
	Focus Group	LGBT: LGBT community members served by the Spahr Center located in San Rafael	7	d) low income	Community members	9/21/18
	Focus Group	ESL: Parent members of the District English Language Learners Advisory Council of San Rafael City Schools	9	b) minority c) medically underserved d) low income	Community members	10/2/18

*Focus Group and Group Interview participants completed an optional survey. These data were used to inform representation of the four target groups during data collection events.

Medically underserved
Focus Groups: One or more participant indicated they have “No Insurance”

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.

Low-income

Focus Groups: One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.

Minority

Focus Groups: One or more participant indicated their race/ethnicity as non-White.

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of the minority community.

Health department representative

Focus Groups: N/A

Group Interviews: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.

Appendix C. Health Need Profiles

Health need profiles include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics), and were developed prior to the prioritization meeting. The profiles do not reflect additional knowledge shared by individual stakeholders during that meeting. Additionally, statistics presented in the health need profiles were not analyzed for statistical significance and should be interpreted in conjunction with qualitative findings.

Kaiser Foundation Hospital - San Rafael: Community Health Needs Assessment

Access to Care

Access to quality health care is important to overall health, disease prevention, and reducing unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. While Marin County scores better than the California state average on many indicators measuring health care access, the county has not yet met the Healthy People 2020 benchmark for insurance coverage. Further, the county continues to work towards providing affordable and culturally competent care for all residents, especially community members who are undocumented. Racial minority groups and lower income individuals also face great challenges in obtaining affordable care. Additionally, as Marin's population ages, innovative options for those who wish to age in place or are unable to travel will be key.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adults with Health Insurance: 18-64 (89.8%) compared to Healthy People 2020 target (100%) [1]

Children with Health Insurance: 0-17 (99.2%) compared to Healthy People 2020 target (100%) [2]

Federally Qualified Health Centers (rate per 100,000) [3]

California | San Rafael service area

> They told me I don't qualify for Medi-Cal, that I earn too much … They don't understand that with every additional dollar you're earning, the rent goes up by that much, too. [Original in Spanish]
> *- Focus Group Participant*

> If you are a person who has economic insecurity, you have to think whether it's worth it for me to take the day off, or just muscle it back and say, 'It's not that severe anyway.'
> *- Key Informant*

Community Identified Barriers

Availability of Services

- Appointment wait times and distances traveled with few public transit options
- Food and shelter are prioritized when money is tight

System Navigation

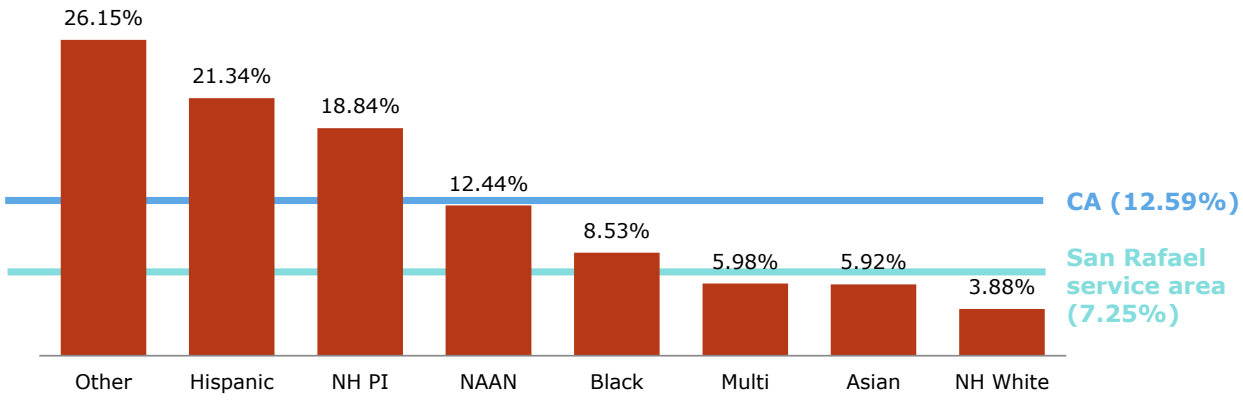
- Language/cultural barriers (e.g., fear of deportation for accessing services)
- Siloed organization making care coordination difficult

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Percentage of the population without health insurance[4]



88.5% of Marin kindergartners start school with all required immunizations

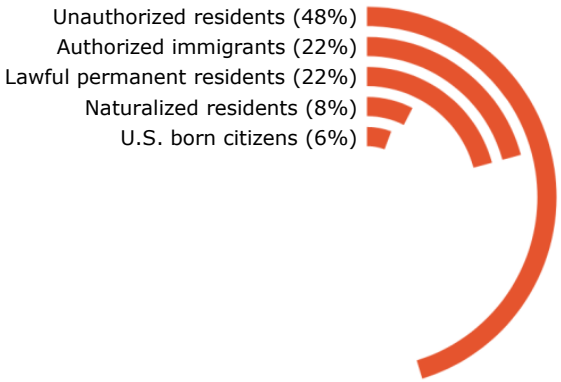
Compared to **92.8%** of kindergartners statewide *

93.6% of pregnant women in Marin initiated prenatal care during their first trimester in 2012

Compared to **88.5%** of women covered by Medi-Cal. [6]

**Marin rates were 80% in 2013-14 and 84% in 2014-15. Coverage varies widely (29%-100%) from school to school, creating communities more prone to outbreaks. Schools serving higher income communities have worse rates of immunization.* [5]

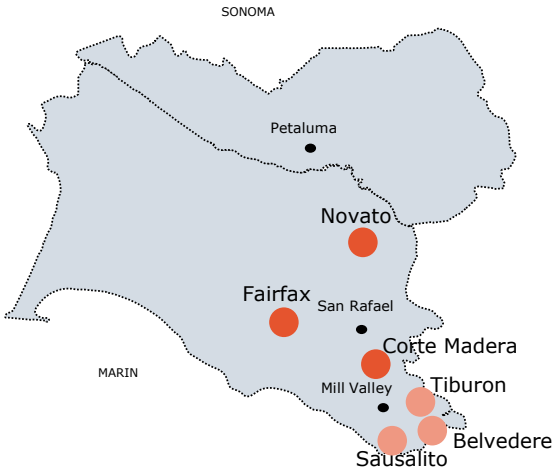
Percent uninsured by legal immigration status[7]



> We are in a difficult time here right now with some of our immigrant population not being comfortable signing up for healthcare or other things through a government agency because they're not sure of what will happen to them because of immigration or ICE.
> - *Key Informant*

Populations Disproportionately Affected

Geographic Areas with Demographic Change



Areas with the greatest change in elderly population by 2030:[8]

Highest
Fairfax (54% increase)
Corte Madera (53%)
Novato (41%)

Lowest
Belvedere (-12%)
Tiburon (16%)
Sausalito (21%)

Emerging Needs

For the "very old" (over 85) in California[9],

7.5%
Require full-time Nursing care

6.8%
Require full-time Assisted Living

11%
Receive Home Care

1.4%
Receive Adult Day Services

> For seniors, especially homeless seniors that don't have an adequate healthcare system that can really deal with issues like dementia, there just is no place for them to go.
> *- Key Informant*

> There's a long waiting list, and meanwhile you have somebody in crisis, who you have to say to: 'Hold onto that depression. Three months from now we'll be able to see you.'
> *- Key Informant*

Assets and Ideas

Examples of Existing Community Assets

Low cost or free community clinics

Public assistance programs (such as Medi-Cal)

Coordinated entry database/communications among social and medical service agencies

Community organizations, committees, and support groups

Ideas from Focus Groups and Interview Participants

- Increase number of bilingual and bicultural service providers
- Confront stigma around accessing mental health care services
- Increase place-based health delivery, such as mobile health clinics and home-based care
- Integrate currently fragmented channels of care (primary, dental, mental health, substance abuse, social services)

1. California Health Interview Survey (2014-2015)
2. Same as above.
3. Provider of Services File - Number of Federally Qualified Health Centers (FQHCs)
4. American Community Survey (2012-16)
5. California Dept. of Public Health, Immunization Branch, Kindergarten Assessment Results (2013-15)
6. Family Health Outcomes Project, California Maternal Child and Adolescent Health
7. USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
8. American Community Survey (2012-16)
9. CDC's "Long Term Care Services in the US: 2013."

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Economic Security

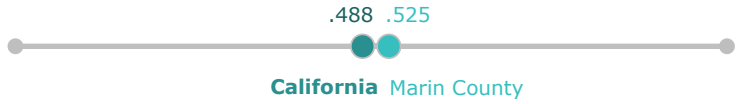
Economic security means having the financial resources, public supports, career and educational opportunities necessary to be able to live your fullest life. As such, this health need touches upon every other health-related issue in the Marin community from mental health to housing. While Marin County ranks among the top in the country in terms of economic wealth and community resources, many residents expressed that these riches are unevenly distributed and not available to all. These divides are particularly stark along lines of race/ethnicity and citizenship status. Geographically, education, employment, and wage outcomes demonstrate a starkly uneven distribution with the Canal region and West Marin facing the greatest barriers to economic security.

Key Data

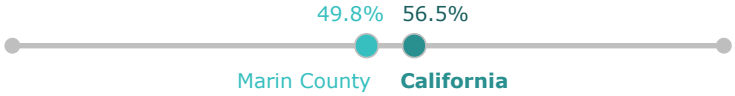
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

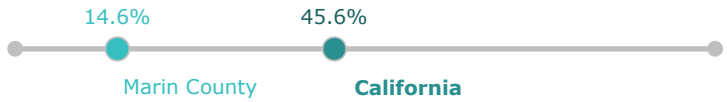
Income inequality (Gini Coefficient): Where 0 is full equality[1]



Renters spending 30% or more of household income on rent[2]



Firms owned by minorities[3]



> From an outsider's point of view, you could say Marin county is a very wealthy place. I know there's been some surveys that say it's one of the most healthy, but it does come down to the haves and the have-nots.
> *- Key Informant*

> There's affordable on the Federal level and there's affordable for Marin. They are not the same.
> *- Key Informant*

Community Identified Barriers

Income Inequality

- Community is split into "two different worlds" based on income disparity
- Worker exploitation / intimidation common among undocumented community members; people are forced into accepting lower wages

High Cost of Living

- Reduced budget for healthy food, enrichment opportunities for children, and medical treatment
- Economic necessity of working many jobs and long commutes lead to stressors on mental and physical health

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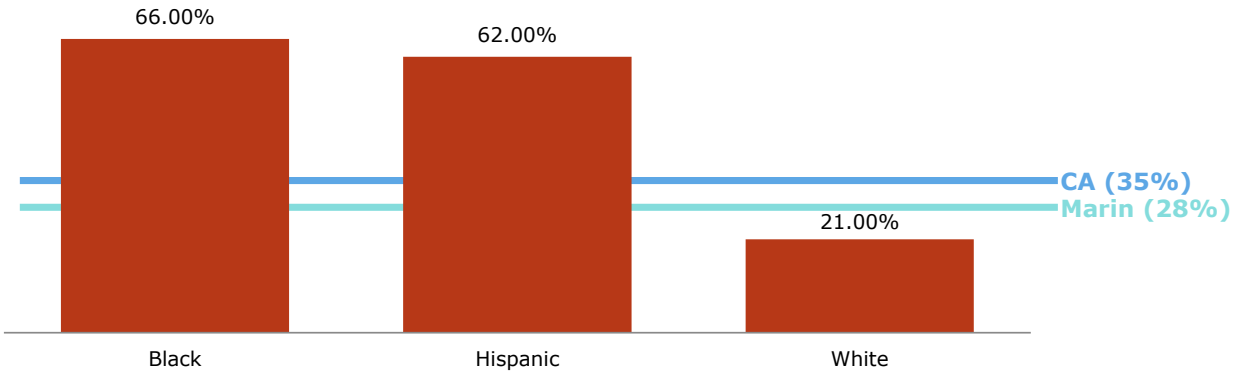
Populations with Greatest Risk

Individuals living below 250% of the federal poverty level (individual income)[4]



Unemployment rates across Marin County[5]

6% of 18-64 year olds in Marin County are unemployed

18% of Black 18-64 year olds in Marin County are unemployed

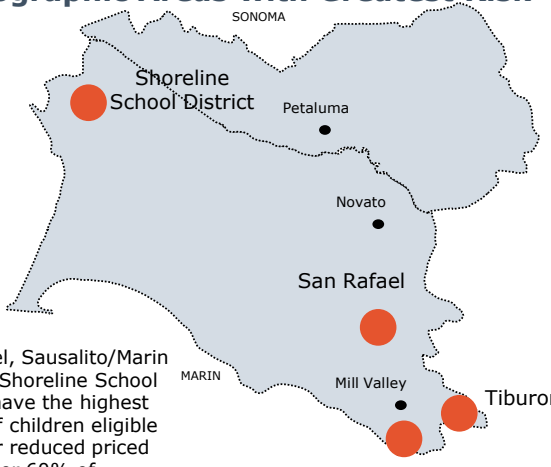
7% of Hispanic 18-64 year olds in Marin County are unemployed

5% of White 18-64 year olds in Marin County are unemployed

> In Marin County, we have the largest income gap between rich and poor—and White and people of color—in the entire state.
> - *Focus Group Participant*

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



San Rafael, Sausalito/Marin City, and Shoreline School Districts have the highest percent of children eligible for free or reduced priced meals (over 60% of children).

Average Income[6]

Downtown, Tiburon ($81,000)

5% Latino, 87% White

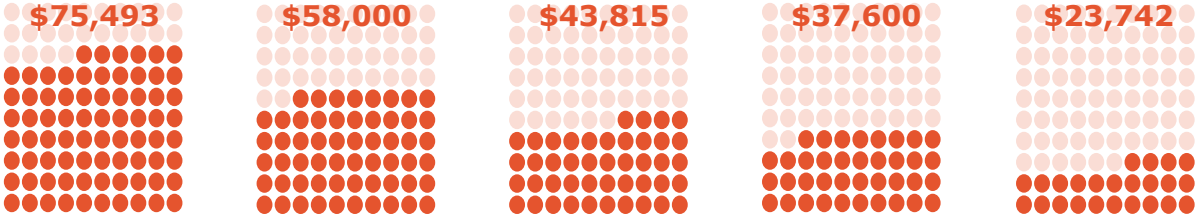
Canal Neighborhood, San Rafael ($21,000)

76% Latino, 13% White

There is a fourfold difference in income between Tiburon and San Rafael

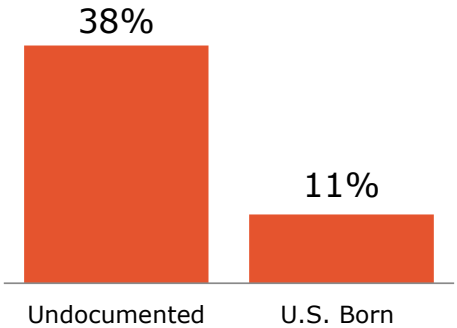
Emerging Needs

Median Annual Wages of Residents in Marin County[7]



U.S. born residents | Naturalized residents | Lawful permanent residents | Authorized immigrants | Un-authorized immigrants

Residents living below 100% Federal Poverty Level[8]



> Many people that live here, their children can't afford to live here, so even the natural supports that would typically be there … are missing in our community. That will feed the epidemic as people age.
> *- Key Informant*

Assets and Ideas

Examples of Existing Community Assets

Low cost or free community clinics

Public assistance programs (such as Medi-Cal)

Community organizations, committees, and support groups

Community food pantries

Ideas from Focus Groups and Interview Participants

- Reduce cost of transportation by making more of the community accessible for walking and biking
- Find ways for higher and lower income community members to relate to one another and create cohesive community
- Increase awareness of availability of in-home medical care
- Include community perspective in the development of strategic plans

1. Healthy People 2020 http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020; American Community Survey (2012-16)
2. Same as above
3. Healthy People 2020; US Census Bureau – Economic Census 2012
4. American Community Survey (2012-16)
5. Same as above
6. California Dept. of Education, School Level Data Files (2014-2015)
7. USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://dornsife.usc.edu/csii/publications/
8. Same as above

Kaiser Foundation Hospital - San Rafael: Community Health Needs Assessment

Education

Educational attainment is linked to health throughout the lifespan. While some education outcomes are higher for Marin County than the rest of California, disparities—particularly among English language learners, African Americans, and Latino students—indicate that educational equality is a high concern in the county. These disparities are present both among educational attainment (e.g., college attendance) and achievement (e.g., reading/math proficiency) outcomes. Many community members signaled educational equity and increased health awareness as important strategies to advance health goals.

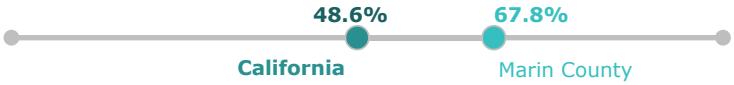
Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adults with some post-secondary education[1]

Preschool enrollment[2]



> It really starts with the younger kids where they started not having access to preschool, or to quality daycare. And then they kind of start at a lower level once they start school.
> *- Key Informant*

> Education level is one of the biggest social determinates of health… Because if they don't have that, they won't be able to get a decent job, or live in a decent place, or be probably civically engaged to keep the community strong.
> *- Key Informant*

81% of Marin households with less than a high school diploma live below the self-sufficiency standard

20% of Marin householders with a bachelor degree or higher live below the self-sufficiency standard[3]

Community Identified Barriers

Quality of preK-12 education and school environment

- Strive to provide universal access to preschool/early childcare
- Difficulty with retaining quality workforce due to high cost of living for educators

Access to community-level and higher education

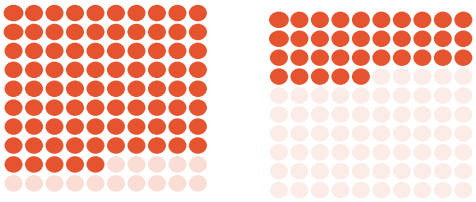
- Desire for greater education around preventive healthcare, such as nutrition, diabetes prevention, and identifying symptoms of poor mental health
- Foreign-born parents wish to improve their English, but lack time

Updated March 2019

Populations with Greatest Risk

High school dropout rates, 4-year cohort starting in 2013[4]

Preschool attendance in 3 and 4 year-olds[5]



85% of Whites

35% of Hispanic/Latinos

College attendance in 16-24 year-olds[6]

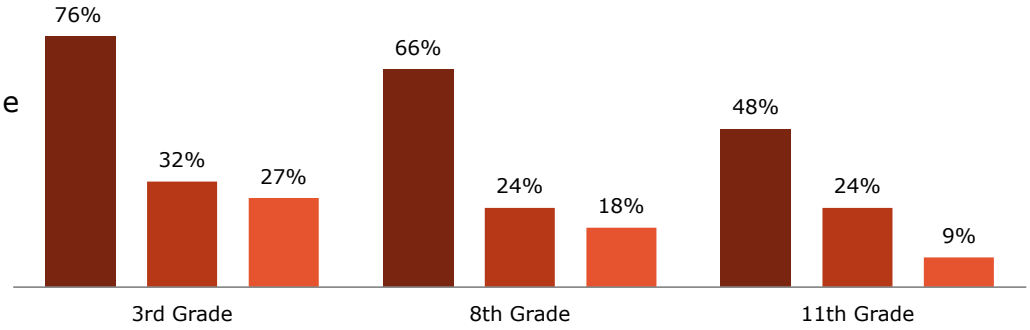
80% of Whites

47% of Black/African Americans

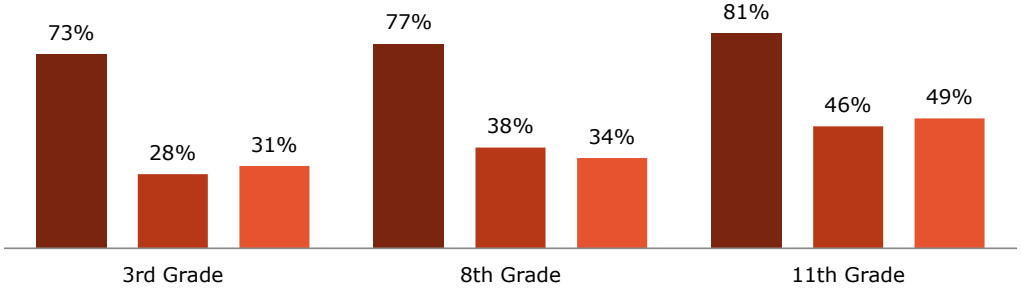
37% of Hispanic/ Latinos

Standardized testing proficiency
White, **Hispanic/Latino/a**, and **Black/African American** students[7]

English Language Arts/Literacy

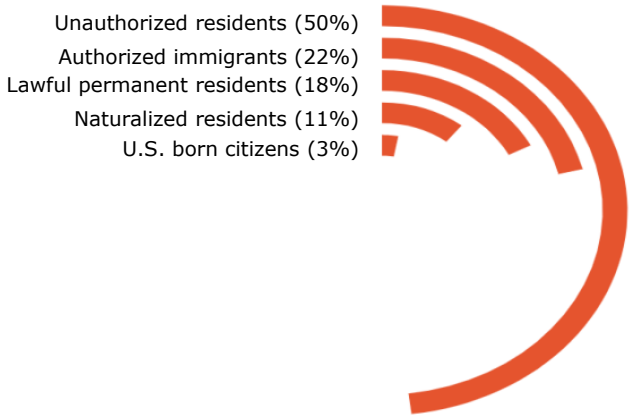


Mathematics



Emerging Needs

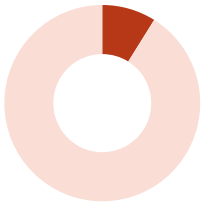
Percent who did not graduate from high school[8]



I have to improve my English. Why? Because if you see the school meetings, the first time, everyone comes. The second meeting no one comes anymore because they already know it will just be in English.

- Focus Group Participant

Non-English speakers by residency[9]

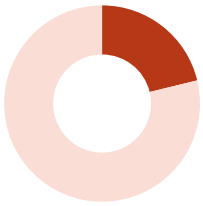


8%

1,704 Naturalized Residents

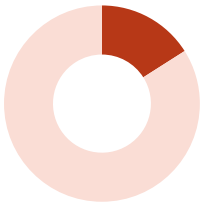
42%

5,530 [Undocumented] Immigrants



21%

594 Authorized Immigrants



16%

1,901 Lawful Permanent Residents

Assets and Ideas

Examples of Existing Community Assets

Community organizations and resources that support first generation college students

Multiple options for university attendance

High degree of parent involvement

Strong public school system

Ideas from Focus Groups and Interview Participants

- Increase community-based, culturally appropriate education initiatives around identifying and treating chronic diseases and mental health problems
- Advocate for alternatives to incarceration for youth in the criminal justice system
- Increase opportunities for professional development/training
- Increase support (i.e., counselors, therapists) in schools

1. American Community Survey (2012-16)
2. Same as above.
3. Insight Center. (2012). Table 21 Self Sufficiency Standard Tool [Table]. Retrieved from http://www.insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california/
4. California Department of Education. Retrieved from https://dq.cde.ca.gov/dataquest/
5. MarinKids.org
6. American Community Survey (2012-16)
7. California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020
8. USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. Retrieved from https://dornsife.usc.edu/csii/publications/
9. Same as above.

Healthy Eating, Active Living (HEAL)

OBESITY, DIABETES, CVD, STROKE, AND CANCER

Healthy Eating and Active Living (HEAL) relates to Marin residents' ability to shape health outcomes through a focus on nutrition and physical activity. While rates of obesity and diabetes are lower in Marin County compared to California as a whole, there is still a high prevalence of adults and youth in Marin County who are overweight or obese, especially among Black and Hispanic populations. Further, healthy lifestyle choices greatly impact the rates of chronic conditions like cardiovascular disease, stroke, and cancer. Access to healthy food is a top concern, particularly in specific geographically isolated areas of the county.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adults who are obese[1]

15.7 per 100,000 population in Marin County compared to

30.5 the Healthy People 2020 target

Age-adjusted death rate due cancer[2]

116 per 100,000 population in Marin County compared to

161.4 the Healthy People 2020 target

Age-adjusted death rate due to coronary heart disease[3]

52.1 per 100,000 population in Marin County compared to

103.4 the Healthy People 2020 target

> It's cheaper to go to McDonald's than it is to go to Whole Foods. And if you're working for 12 to 14 hours a day, how are you gonna go out and take an hour and a half walk?
> *- Key Informant*

> Someone recently said finding a diabetes doctor is like winning the lottery. That's a whole other thing because when I tried to find a diabetes doctor, two out of the three doctors had a nine month waiting list in Marin.
> *- Focus Group Participant*

Community Identified Barriers

Inequities in treatment and prevention of chronic disease

- Economic barriers and under-insurance impede preventative care
- Lack of educational resources for management and prevention of chronic disease

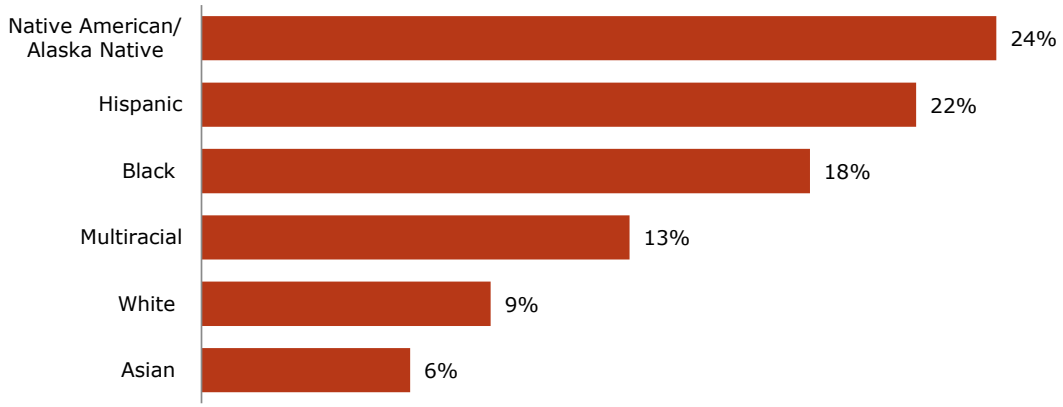
Barriers to physical activity/healthy food

- High concentration of fast food and liquor stores
- Childcare providers have limited policies and systems to support healthy eating an active living

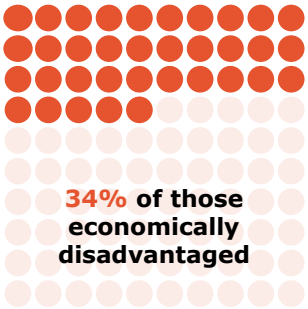
Updated March 2019

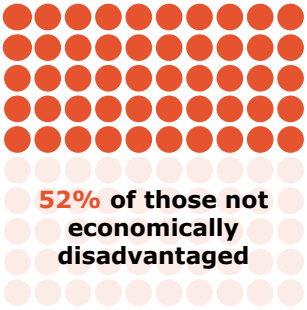
Populations with Greatest Risk

Obesity percentage among youth in the San Rafael service area[4]

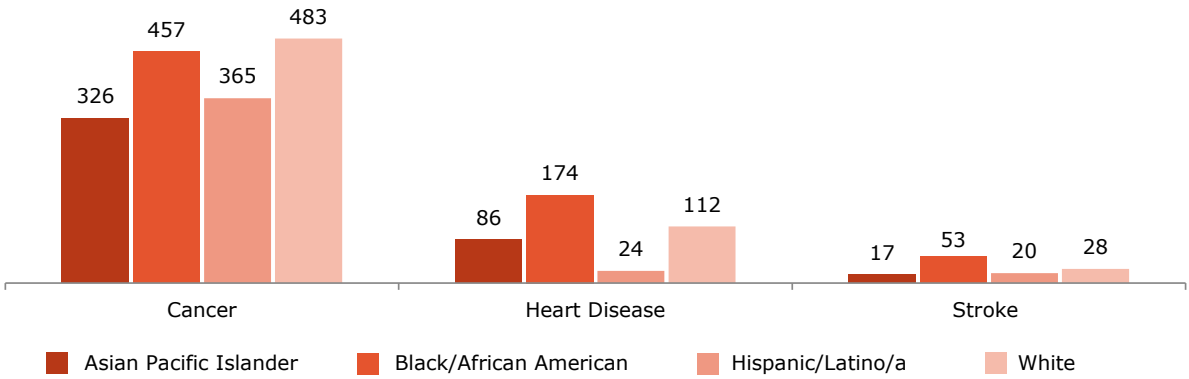


Percentage of 6th graders taking California Department of Education physical fitness test who meet fitness standards[5]





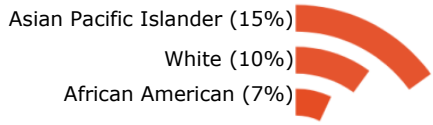
Incidence rates for **Cancer**, **Heart Disease**, and **Stroke** per 100,000 population by race/ethnicity from 2010-2012[6]



Populations Disproportionately Affected

Populations with Greatest Risk

Prevalence of diabetes among patients at the Marin Community Clinic[7]



Prevalence of food insecurity[8]

1 in 7 Caucasians

1 in 3 Asians and Pacific Islanders

1 in 2 African Americans and Latinos

> [The uninsured] are buying food, they're paying rent, instead of coming and utilizing the healthcare system. What does that result in? Inequities in cancer screenings, inequities in chronic disease control rates… We know that the life expectancy gap in Marin County, half of it's attributed to chronic disease, heart attack, strokes.
> *- Key Informant*

Geographic Areas with the Greatest Risk

Three of Marin's census tracts—Hamilton, the Canal area of San Rafael and the Lynwood section of Novato—have been deemed **"food deserts"** by the USDA. Food deserts are low-income neighborhoods without ready access to healthy and affordable food. [9]

> If you're familiar with the Canal, it's only like one street and then you have all these others shops, mechanics, and fumes, and all that stuff. There is a community center and a park here that is owned by the city, but the park really has minimal things for the kids.
> *- Key Informant*

Assets and Ideas

Examples of Existing Community Assets

Existing bike lanes and safe sidewalks (e.g., Safe Routes to School network)

Community centers with sports programs and social gatherings over healthy meals

Uptake of Food Pharmacies and Parks Prescription programs

Meals on Wheels; food pantries and "food trucks" that accept CalFresh

Ideas from Focus Groups and Interview Participants

- Increase peer to peer and group-oriented services for disease management to help people learn about nutrition and make healthy lifestyle changes
- Increase access to general preventative care resources, and education around chronic disease management
- Increase number of bilingual and bicultural service providers, across medical and social services
- Improve zoning regulations to separate commercial/industrial and residential areas

1. Healthy People 2020. Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020; California Department of Public Health 2014-16.
2. Same as above.
3. Same as above.
4. FITNESSGRAM® Physical Fitness Testing (2016-17)
5. California Department of Education. (2016). *2014-15 California Physical Fitness Report: Not Economically Disadvantages- Meeting Healthy Fitness Zone Summary of Results Marin County.* Note: Economic disadvantage means below 250% of the federal poverty line.
6. CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress)
7. Marin Community Clinic (2013-15).
8. American Community Survey. (2012-16).
9. Burd-Sharps, S. & Lewis, K. (2012). *A Portrait of Marin: Marin County Human Development Report 2012*

Housing and Homelessness

Marin County's high cost of living exacerbates issues related to healthcare access and affordability. More than half of renters pay 30 percent or more of their income on rent; and in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. Further, housing costs present unique challenges for older adults who wish to age in place but who may require additional services and supports as their needs change.

Additionally, homelessness exposes individuals to increased health risks. Service providers have difficulty linking persons who are experiencing homelessness to supportive housing and healthcare services. Racial minorities are disproportionately represented among persons experiencing homelessness and the portion of youth experiencing homelessness has increased in recent years.

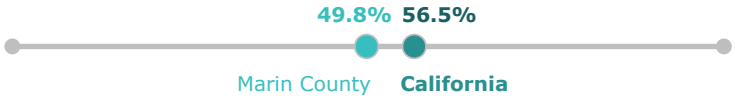
Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities[1]

Renters spending 30% or more of household income on rent[2]



Proportion of sheltered and unsheltered homeless individuals[3]

> There are no starter homes, there's no place for families to be re-formed on one income or just one spouse. One spouse income? Forget about it.
> *- Key Informant*

> The fact is that Marin as a whole, sees homelessness as a failing of the person experiencing homelessness and not a failing of the society that allowed them to become homeless. I think that really creates barriers.
> *- Key Informant*

Community Identified Barriers

Increasing population experiencing homelessness

- Different issues for those experiencing chronic versus temporary homelessness
- Housing is the first step in improving health for individuals experiencing homelessness

Unsustainably rising rent

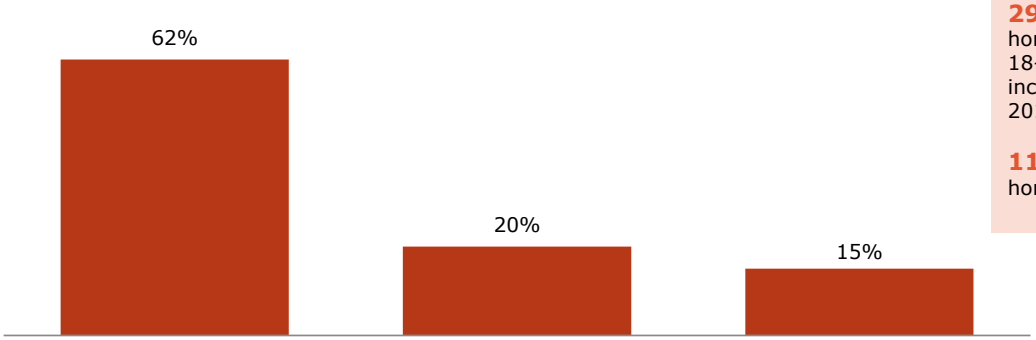
- Money spent on rent takes away from preventive and urgent medical care
- Service providers cannot afford to live in Marin; long commute times are unhealthy
- Precarious housing a reality for many; overcrowded, poor living conditions

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Race/ethnicity demographics of those experiencing homelessness[4]



29% of those homeless are between 18-24 years old, an increase from 6% in 2013.

11% of those homeless are under 18

Characteristics of those who are homeless[5]

44% Have psychiatric or emotional conditions

27% Have chronic health problems (2% have HIV/AIDS)

28% Have Post Traumatic Stress Disorder (PTSD)

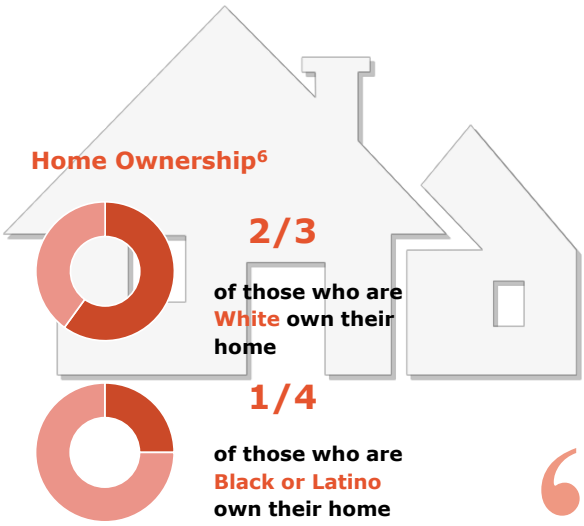
7% Have a traumatic brain injury

26% Have a physical disability

> Getting a 30-hour-a-week job at minimum wage somewhere is huge victory. Guess what? They're still homeless. That doesn't feel right.
> *- Key Informant*

Populations Disproportionately Affected

Population with Greatest Risk



Home Ownership[6]

2/3

of those who are White own their home

1/4

of those who are Black or Latino own their home

Overcrowding is experienced by... [7]

50% **of those undocumented**

11% **Authorized immigrants**

12% **Lawful permanent residents**

1% **U.S. born and naturalized citizens**

> The people we serve in the Canal have 8 to 10 people in a 2 bedroom apartment paying 200 bucks a month for 10x10 square feet on the floor to put their sleeping bag down with access to a bathroom and no access to the kitchen in place that is moldy with cockroaches.
> *- Key Informant*

Emerging Needs

Older Adults in Marin

The older adult population will increase **37%** by 2030 in Marin County[8]

90%

of older adults intend to stay in their own homes for the next 5-10 years[9]

70%

of older adult homeowners have **not** created a "second unit," to provide space for caregivers. [10]

> We have folks who have lived in the community for many years. They have a fall. They have a medical episode. They go into the hospital. And now the home that they lived in for 20-plus years is no longer accessible to them.
> *- Key Informant*

Assets and Ideas

Examples of Existing Community Assets

Coordinated entry database/communications among social and medical service agencies

Programs that connect residents in affordable housing to other social/medical services

Nonprofits and community organizations working to address housing crisis

Available shelters and affordable housing units

Ideas from Focus Groups and Interview Participants

- Fund service providers/increase services that help older adults age in place
- Increase cooperative/shared housing options, specifically for younger generations
- Build more affordable housing units at all income levels
- Multi-pronged approach that gives persons experiencing homelessness jobs/purpose while providing them housing

1. County Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation.
2. American Community Survey. (2012-16).
3. Point in Time Homeless Count. (2015). Marin Homeless Census and Survey.
4. Same as above.
5. Same as above.
6. American Community Survey. (2012-16).
7. Sanchez et al. USC Dornsife, Center for the Study Immigrant Integration. (2016). Retrieved from https://dornsife.usc.edu/csii/publications/.
8. "The United States of Aging". (2012). American Association of Retired Persons.
9. Commission on Aging – Housing Report. (2018).
9. Same as above.

Kaiser Foundation Hospital - San Rafael: Community Health Needs Assessment

Maternal and Infant Health

The San Rafael service area has a lower infant mortality rate than California, and the county has a lower maternal mortality rate, but still struggles with many issues relating to child health and development. Focus group participants expressed the need for childcare and improved educational options. Further, service providers highlighted the racially concentrated nature of maternal and infant health concerns: African Americans have higher rates of pregnancy-related death and lower rates of pre-natal care than other ethnicities. Hispanic/Latino populations have higher teen birthrates and lower pre-school attendance than White counterparts.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Infant mortality rate per 1,000 live births[1]

3.6	5.0
San Rafael service area	**California**

Percent of first trimester initiation of prenatal care[3]

There are currently **750** children on the Marin Childcare Council's waiting list for subsidized childcare, **288** of these are infants. [4]

> I think with the high cost of living, it also affects the lack of childcare, not having qualified people that can take care of your children while you work two jobs.
> *- Key Informant*

Community Identified Barriers

Lack of affordable options for young families with children

- Many families share houses with several other families
- Lack of childcare options within families' budgets

Youth focused issues

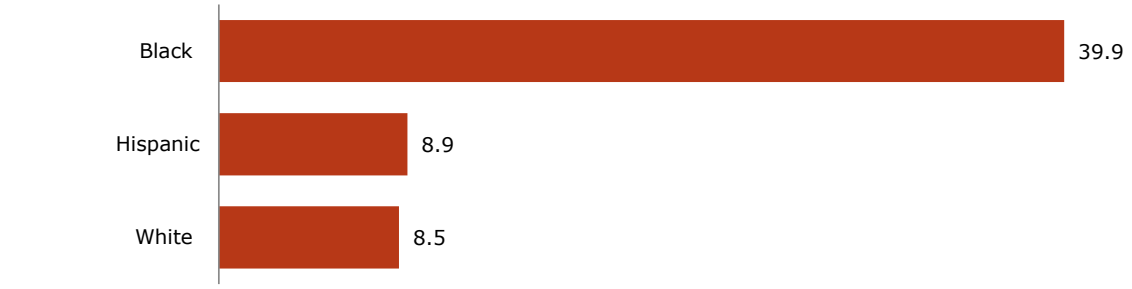
- Need for universal pre-k and early education
- Pressure on children from a young age to succeed socially and academically

Updated March 2019

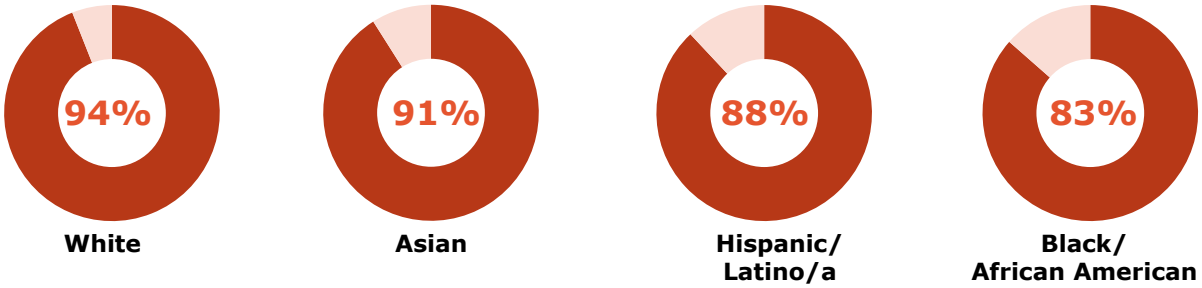
Populations Disproportionately Affected

Populations with Greatest Risk

Pregnancy-related mortality rates from 2002-2007 per 1,000 population[5]

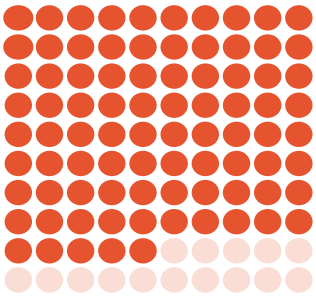


Percent receiving 1st trimester pre-natal care[6]

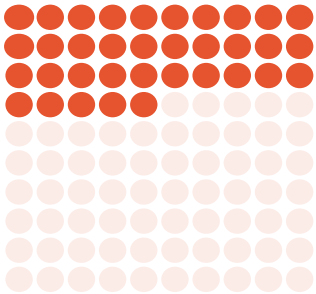


Emerging Needs

Pre-school attendance among 3 and 4 year-olds[7]



85% of Whites



35% of Hispanic/Latino/as

Latinas have a teen birth rate more than **20** times higher than their White counterparts. [8]

A lot of the cases that I hear, in talking with my staff, it's families who have immigrated here from Mexico, Central America, South America primarily, and the trauma that they've brought with them ... Even young children have experienced it.
- Key Informant

Assets and Ideas

Examples of Existing Community Assets

Parenting classes

Parks (i.e., places to play)

Services for mothers with post-partum depression

Ideas from Focus Groups and Interview Participants

- Increase support (i.e., counselors, therapists) in schools
- Implement universal pre-school program
- Improve access to midwives, doulas and alternative care

1. Area Health Resource File (Health Resources & Services Administration)
2. California Dept. of Public Health, Immunization Branch, Kindergarten Assessment Results
3. Maternal and Infant Health Assessments (2013-2015). Retrieved from https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-and-Reports.aspx?Name=SnapshotBy
4. *Marin Independent Journal.* Retrieved from http://www.marinij.com/article/NO/20150617/NEWS/150619808
5. The California Pregnancy Associated Mortality Review. Retrieved from https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/PAMR/CA-PAMR-Report-1.pdf
6. Centers for Disease Control and Prevention, Birth Certificate Data 2008-17
7. http://www.marinkids.org/wp-content/uploads/2015/02/Education-Data-20141.pdf
8. Family Health Outcomes Project, California Maternal Child and Adolescent Health

Mental Health & Substance Use

Marin County residents demonstrate high need in mental health issues, including suicide rate, medication for mental health issues or substance abuse treatment. Mental health issues frequently co-exist with substance abuse. The San Rafael service area ranks above the California averages for alcohol abuse and opioid deaths. The suicide rate is particularly high among non-Hispanic Whites. Access to mental health providers and treatment was also raised as a key concern by community members.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Percent of adults who report excessive drinking[1]

Adults needing help with mental, emotional, or substance use problems[2]

Percentage of adults taking daily prescriptions for mental health issues[3]

> Young people are so desperate to talk about their mental health needs - it's just a suicide conversation. We're not teaching them to talk about this from point A. It just becomes point C, "I'm suicidal."
> *- Key Informant*

> There is still the stigma of mental health and substance abuse. In many communities, the concept of mental health is so foreign or not even part of their culture.
> *- Key Informant*

Community Identified Barriers

Lack of culturally appropriate care and resources

- Language and cultural barriers prevent patients from feeling comfortable or understood by providers
- Feeling of isolation within LGBTQ community

Availability of mental health services

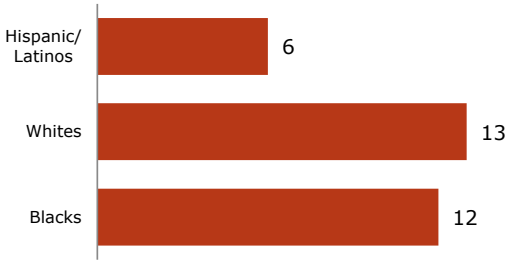
- Mental health care is inaccessible and unaffordable for many people
- Lack of specialized services for senior population with mental health needs

Updated March 2019

Populations Disproportionately Affected

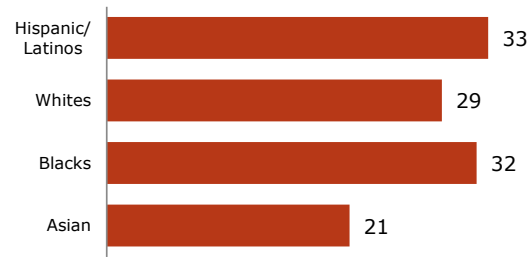
Populations with Greatest Risk

Suicide Rate per 100,000 population [4]



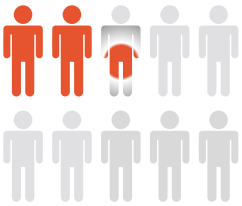
In 2010-2012, the **suicide rate** in Marin was lowest among Hispanic/Latinos (6/100,000) and highest among non-Hispanic Whites (13/100,000) and non-Hispanic Blacks (12/100,000).

Student-reported use of alcohol or any illegal drugs[5]

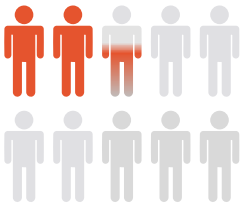


Among Marin County 7th, 9th and 11th graders between 2011-2013, nearly a third of Hispanic/Latino students and African American/Black students **reported using alcohol or any illegal drugs** in the past 30 days, with slightly lower figures for White students, and Asian students reporting lowest use.

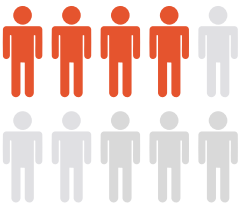
Percent of adults who reported there ever being a time in the past 12 months when they felt that they **might need to see a professional because of problems with their mental health**, emotions, nerves, or use of alcohol or drugs. [6]



22% of Whites



25% of Hispanic/Latinos



40% of Blacks

Emerging Needs

Late life depression is associated with increased risk of morbidity, suicide; decreased physical, cognitive, social functioning; and greater self-neglect (increases mortality).

25% of those with comorbidities suffer from clinically significant depression.

17% of Marin seniors reported binge drinking in the past year.[7]

Are you drinking at your kid's sporting event? Are you drinking in preparation for homecoming, while you're taking photos? Yeah, that's an issue.
- Key Informant

Assets and Ideas

Examples of Existing Community Assets

School-based therapists

Coordinated entry database/communications among social and medical service agencies

Community organizations, committees, and support groups; groups that raise awareness and educate general population

Services geared toward Medi-Cal patients

Ideas from Focus Groups and Interview Participants

- Implement "community health navigator" programs through faith-based, neighborhood, or community organizations
- Integrate currently fragmented channels of care (primary, dental, mental health, substance abuse, social services)
- Confront stigma around accessing mental health care services; educate community about the many manifestations of mental health
- Bring mental health services directly to hard-to-reach populations such as the homeless population

1. Behavioral Risk Surveillance Task Force. (2017). Excessive Drinking is the percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.
2. Healthy People 2020. California Health Interview Survey. (2014-15).
3. Same as above.
4. CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress).
5. California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020.
6. California Health Interview Survey (2014-15).
7. Same as above.

Kaiser Foundation Hospital - San Rafael: Community Health Needs Assessment

Oral Health

Oral health is a key indicator of overall health, however, it is often treated as separate. Oral health has been linked to cardiovascular disease, and poor pregnancy and birth outcomes. A lack of access to dental insurance and inadequate utilization of dental care are identified as important issues affecting oral health in Marin County. Key informant and focus group participants report that dental insurance is limited, and specialty care, like oral surgery, is not affordable. Marin has not yet reached its Healthy People 2020 goal for children's dental health provision, and Denti-Cal reimbursement rates are low, indicating an opportunity for improving dental care utilization.

Key Data

Indicators

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Adults (18+) without dental health insurance (self-reported)[1]

Ratio of the Population to the Total Number of Dentists Available[2]

943:1	1,291:1
Marin County	**California**

Between 2005 and 2012, a total of **4,183** people were **seen at emergency departments** in Marin County for ambulatory care-sensitive dental conditions (otherwise known as preventable dental conditions). [3]

> I know it's a long history of more than 100 years of why dental services are separate from medical health, so it's very political, but we need to see it as one thing. When people don't have good dental hygiene, it can affect their other health needs.
> *- Key Informant*

Community Identified Barriers

Limited access to oral health care

- High cost of care if underinsured, and/or undocumented
- Preventive services under-utilized, increasing need for emergency treatment
- Specialized dental care not accessible through low-cost/free clinics

Better integrate oral and general care

- Oral health tied to self-esteem, physical and mental health, and wellbeing

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Age-adjusted incidence rate for **oral cavity and pharynx cancer** (in cases per 100,000 population) [4]

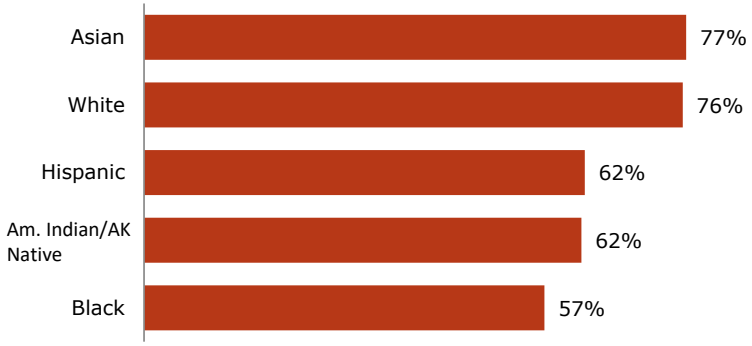
14.4 per 100,000 population in Marin County compared to

10.3 per 100,000 population in California

According to the American Cancer Society, individuals who both smoke and drink excessively are 30 times more likely to develop oral cancer than those who do not.

Oral surgery for low-income individuals, especially for impacted wisdom teeth, is a dental care gap in Marin. There is **1 private oral surgeon** who accepts Medi-Cal insurance. [5]

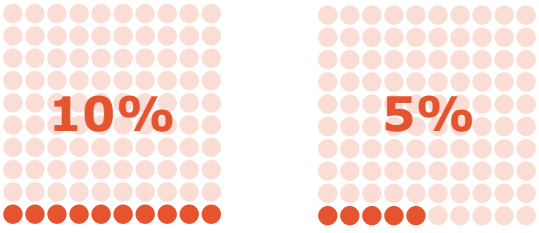
Reported dental cleanings in the past year [6]



Asians and Whites had the highest proportion of dental cleanings in 2008, followed by Hispanics and American Indians/Alaska Natives, while only about half of Blacks reported a dental cleaning in the past year.

> For people who don't have legal status here, they can't get full scope Medi-Cal, same for dental coverage. It's really expensive…most of the medical care that they have access to is only emergency medical.
> *- Key Informant*

The percent of children with untreated dental decay[7]



current percentage of children with dental decay

Healthy People 2020 target

2 school districts did not meet the Healthy People 2020 goal of no more than 25.9 percent of children aged 6 to 9 years with untreated tooth decay in at least one primary or permanent tooth. [8]

Assets and Ideas

Examples of Existing Community Assets

Community clinics with basic oral health services

Public Assistance Programs (e.g., Medi-Cal Dental)

System coordination among social and medical service providers

Ideas from Focus Groups and Interview Participants

- Integrate disparate channels of care (primary, oral/dental, mental/behavioral, substance use, social services)
- Make specialized care such as oral surgery available in low cost or free clinics

1. California Health Interview Survey (2014-15).
2. Area Health Resource File (Health Resources & Services Administration).
3. OSHPD Data analyzed by Marin County Department of Health and Human Services, Epidemiology Department
4. National Cancer Institute (2011-15).
5. Marin County Oral Health Report 2014 http://www.cda.org/news---events/state---budget---fails---to---address---low---denti---cal---rates.
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3866511/(Note: National study, trends consistent with Marin focus group reports).
7. Healthy People 2020; California Oral Health Reporting 2008-10.
8. Same as above.

Kaiser Foundation Hospital - San Rafael: Community Health Needs Assessment

Social Connection

The San Rafael service area boasts many social associations, and residents generally feel they know where to go for emotional and social support. However, economic inequality and the County's rapidly aging population increase the risk of social isolation. The high cost of living results in extended work hours and long commutes, leaving people with less time to spend engaging with their community. Further, the lack of alternative forms of transportation in rural towns, and racial segregation in parts of Marin, create barriers to community cohesion. Racial and ethnic minorities report bullying and a lack of connection to their schools; language barriers lead to further isolation among immigrant communities. Populations such as the LGBTQ community and people experiencing homelessness report a lack of safe and welcoming social spaces. Finally, at both ends of the age spectrum, youth and older adults desire social connection; youth want opportunities for positive mentorship and older adults desire more community events.

Key Data

Indicators

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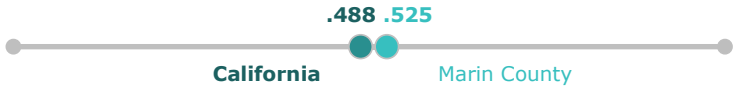
Insufficient Social & Emotional Support (%)[1]

Social Associations per 10,000 people (rate)[2]

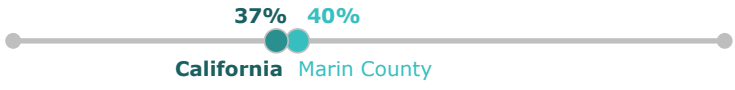
6.51 California

9.16 San Rafael service area

Income Inequality (Gini Coefficient): where 0 is full equality[3]



Long Commute – Driving Alone (%) [4]



> We tend to provide healthcare and housing, and those **fall short of a full life**. I hear a lot from clients, 'Can you help us organize an event? Can we go on a picnic together?'
> *- Key Informant*

> They're self-medicating because, in Marin County, there is an **epidemic of loneliness**. I know it's a huge problem in the senior community and I see it in our kids too.
> *- Key Informant*

Community Identified Barriers

Desire for social inclusion and connection

- Social isolation leads to substance use, and mental and physical health issues
- People struggle to change unhealthy behaviors without social support
- Economic inequality and a competitive social environment lead to loneliness, anxiety, and depression

Need for mentors and safe social spaces for youth

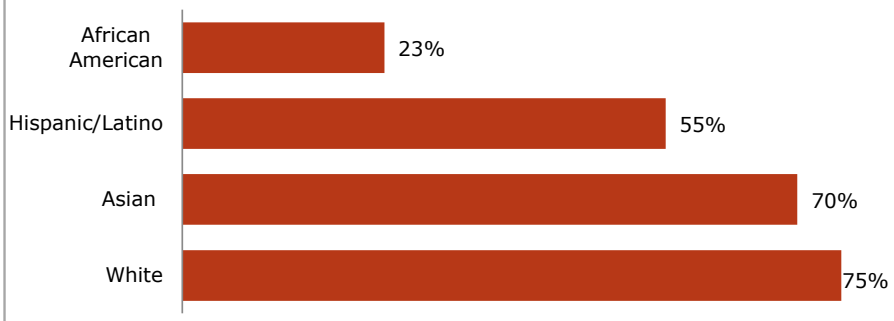
- Youth need positive alternatives to unhealthy behaviors and restorative, rather than punitive, discipline
- Youth do not always feel comfortable sharing personal concerns with their families

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Proportion of 7th graders who reported high levels of school connectedness, by race/ethnicity.[5]



31% reported being harassed or bullied at school for any bias related reason (i.e., gender, race/ethnicity, sexual orientation). [6]

We need access to mentors, please… Just not locking anyone up, definitely, a role model, and I don't know what else. Just a group of people you can talk to I guess. Just someone on your side.
- Youth Focus Group Participant

Geographic Areas of Interest

Residential segregation: The dissimilarity index measures whether one particular group resides across census tracts in the metropolitan area in the same way as another group. A high value indicates that the two groups tend to live in different tracts. A value of 60 or above is considered very high.[7]

San Rafael

Black-White/White-Black = **25**

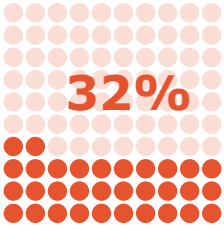
White-Hispanic/Hispanic-White = **52**

Novato

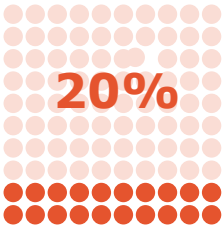
Black-White/White-Black = **26**

White-Hispanic/Hispanic-White = **20**

Emerging Needs



Proportion of undocumented [community members] who report they don't speak English well[8]



Proportion of Hispanic households that are linguistically isolated[9]

For people who don't speak English well, that's a challenge for them in terms of their social, cultural, and political participation.
- Key Informant

- **28,600 (44%)** individuals 65+ reported living alone.
- **35,100 (54%)** individuals 65+ reported eating alone.[10]
- **40%** of individuals 65+ reported feeling isolated and/or depressed as one of their top six health concerns.[11]

Assets and Ideas

Examples of Existing Community Assets

Community organizations, committees, and support groups

Collaborative partnerships between social agencies that connect individuals to the support they need and organize events

Financial and political capital that can be channeled to promote equity

Ideas from Focus Groups and Interview Participants

- Create safe spaces for diverse communities to interact, take part in meaningful activities, and learn from each other's experiences
- Address financial and transportation barriers to attending social events by subsidizing cost to participate
- Design community programs and events to be accessible by considering the location, time, language needs, and cultures of participants
- Offer more free, youth-centered extra-curricular community programming, whether social, recreational, or skills-based. Provide youth with opportunities to interact with positive role models
- Offer support groups through local clinics, hospitals, and community-based organizations to help individuals with chronic disease management, mental health, and physical health
- Promote programs and events using strategic messaging and channels, such as social media

1. Behavioral Risk Factor Surveillance System.
2. County Business Patterns, http://www.countyhealthrankings.org/app/california/2015/measure/factors/140/datasource.
3. Healthy People 2020; US Census Bureau – Economic Census 2012.
4. Same as above.
5. California Healthy Kids Survey, Marin County Elementary Main Report 2017-18. *Healthy People 2020.* Retrieved from http://www.healthymarin.org/indicators/index/dashboard?alias=hp2020.
6. Same as above.
7. Brown University US2010 Project, 2010 data available from: http://www.s4.brown.edu/us2010/index.htm6. Centers for Disease Control and Prevention, Birth Certificate Data 2008-17.
8. USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. Retrieved from https://dornsife.usc.edu/csii/publications/.
9. American Community Survey (2011-14).
10. Same as above.
11. Area Agency Marin County 2016-2020 Plan.

Violence and Injury Prevention

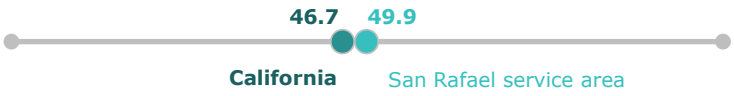
The San Rafael service area has a much lower rate of violent crime than California overall. However, Marin does have several issues related to violence and injury that present unique challenges. Due to heavy manual labor, many work-related injuries affect day laborers, particularly community members who are undocumented. Crime rates are unevenly distributed, both across racial groups and regions. Finally, older adults face unique challenges related to physical accidents, as falls are the leading cause of fatal injuries, and most homes are not designed for aging in place and universal accessibility.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Injury deaths (rate per 100,000)[1]



Alcohol impaired driving deaths (%) [2]

Violent crimes (rate per 100,000) [3]

> Suicide is happening across the county at significant levels, at higher rates here than in other counties in this state. For young people, and also across the age span as well.
> *- Key Informant*

> The biggest crime in Marin County is domestic violence. And VOWA, the Violence Against Women Act, they actually say that, if you could cure poverty, you could have many things cured, including things like domestic violence.
> *- Key Informant*

Community Identified Barriers

Police Relationships

- Need for law enforcement and health providers to coordinate services
- Police slow to respond to calls in Canal areas
- Decrease in crime reporting due to fear of ICE

Violence (Youth & Family)

- Domestic violence number one violent crime in Marin County
- Easy for youth to become involved with the wrong crowd and fall into gangs

Updated March 2019

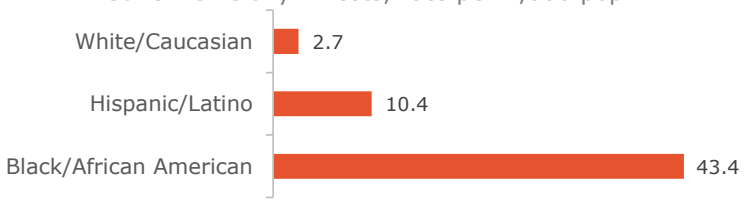
Populations Disproportionately Affected

Populations with Greatest Risk

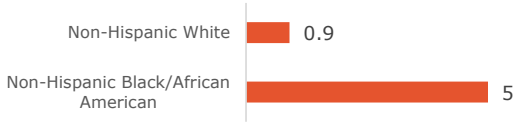
Youth who have contact with the juvenile justice system are at **increased risk** for a number of negative long-term outcomes, such as **injury, substance use** and dependency, **dropping out of school**, and **early pregnancy**.

Conditions that increase the likelihood of involvement with the juvenile justice system include **family poverty**, **separation from family members** including parental incarceration, a **history of maltreatment**, and **exposure to violence.**

Juvenile Felony Arrests, rate per 1,000 pop.[4]

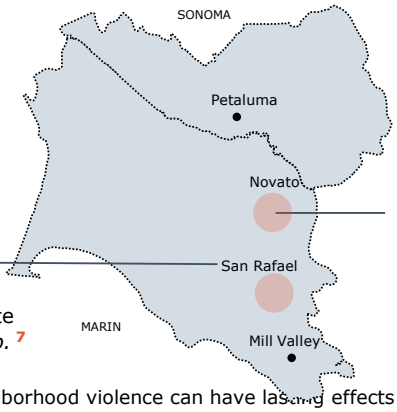


Homicides, rate per 100,000 pop.[5]



Out of 58 counties in California, Marin ranks **3rd worst** for vehicle collisions, and **2nd worst** for vehicle collisions with bicycles.[6]

Geographic Areas with Greatest Risk



San Rafael

Violent Crime Rate
325/100,000 pop.

Property Crime Rate
1,923/100,000 pop. [7]

Novato

Violent Crime Rate
181/100,000 pop.

Property Crime Rate
1,806/100,000 pop.

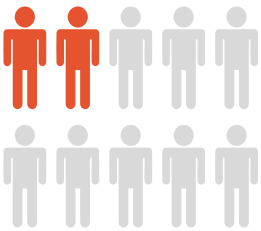
> Local law enforcement should work closely with behavioral health services because there's often a behavioral health issue there… What's the best service for this person to rehabilitate them and get the services they need so they can thrive?
> *- Key Informant*

Exposure to neighborhood violence can have lasting effects on health and well-being, especially among children. Whether a victim or witness, children who experience violence are more likely to suffer from a variety of physical, emotional, and behavioral health problems, as well as struggle academically.[8]

Emerging Needs

20% of day laborers were injured on the job. Among those, **2/3 missed work** as a result. Of those,

more than 50% did not receive the medical care they needed for the injury, either because the worker could not afford healthcare or the employer refused to cover the worker under the company's workers' compensation insurance.[9]



20% of seniors 65+ reported falling in the past year.[10]

Falls are a leading cause of fatal and nonfatal injuries in older adults.

- **1 out of 5** falls causes a serious injury.
- Falls cause **> 95%** of hip fractures.
- **Up to 33%** of older hip fracture patients die within 1 year.[11]

Assets and Ideas

Examples of Existing Community Assets

Community groups and initiatives against violence (e.g., legal advocacy resources)

Law enforcement; especially bilingual/bicultural officers

Community members who have experienced adversity and can teach others how to cope with feelings of suicide

Ideas from Focus Groups and Interview Participants

- Protections for manual laborers
- Alternative programs for incarceration
- Improve response time of police (especially in the Canal area)
- Increase bilingual/bicultural law enforcement officers

1. National Vital Statistics System (2016).
2. Healthy People 2020; County Health Rankings (2012-16).
3. FBI Uniform Crime Report 2017.
4. Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center. 2016.
5. California Department of Public Health, 2013 (retrieved from Healthymarin.org).
6. California Office of Traffic Safety, https://www.ots.ca.gov/Media_and_Research/Rankings/default.asp#what.
7. Data from Uniform Crime Reporting Statistics (2012), US Department of Justice.
8. Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the national survey of children's exposure to violence. *JAMA Pediatrics, 169*(8), 746-754.
9. *UCLA Newsroom,* http://newsroom.ucla.edu/releases/First-Nationwide-Study-of-Day-Laborers-6774.
10. California Health Interview Survey (2011-12).
11. Same as above.