2019 Community Health Needs Assessment

Kaiser Foundation Hospital: South San Francisco

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Approved by Kaiser Foundation Hospital Board of Directors' Community Health Committee

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KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit

CHNA Report for KFH-South San Francisco

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

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

B. About Kaiser Permanente Community Health

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

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

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

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

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

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

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

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

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

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 130 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-South San Francisco will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, https://www.kp.org/chna.

II. Community served

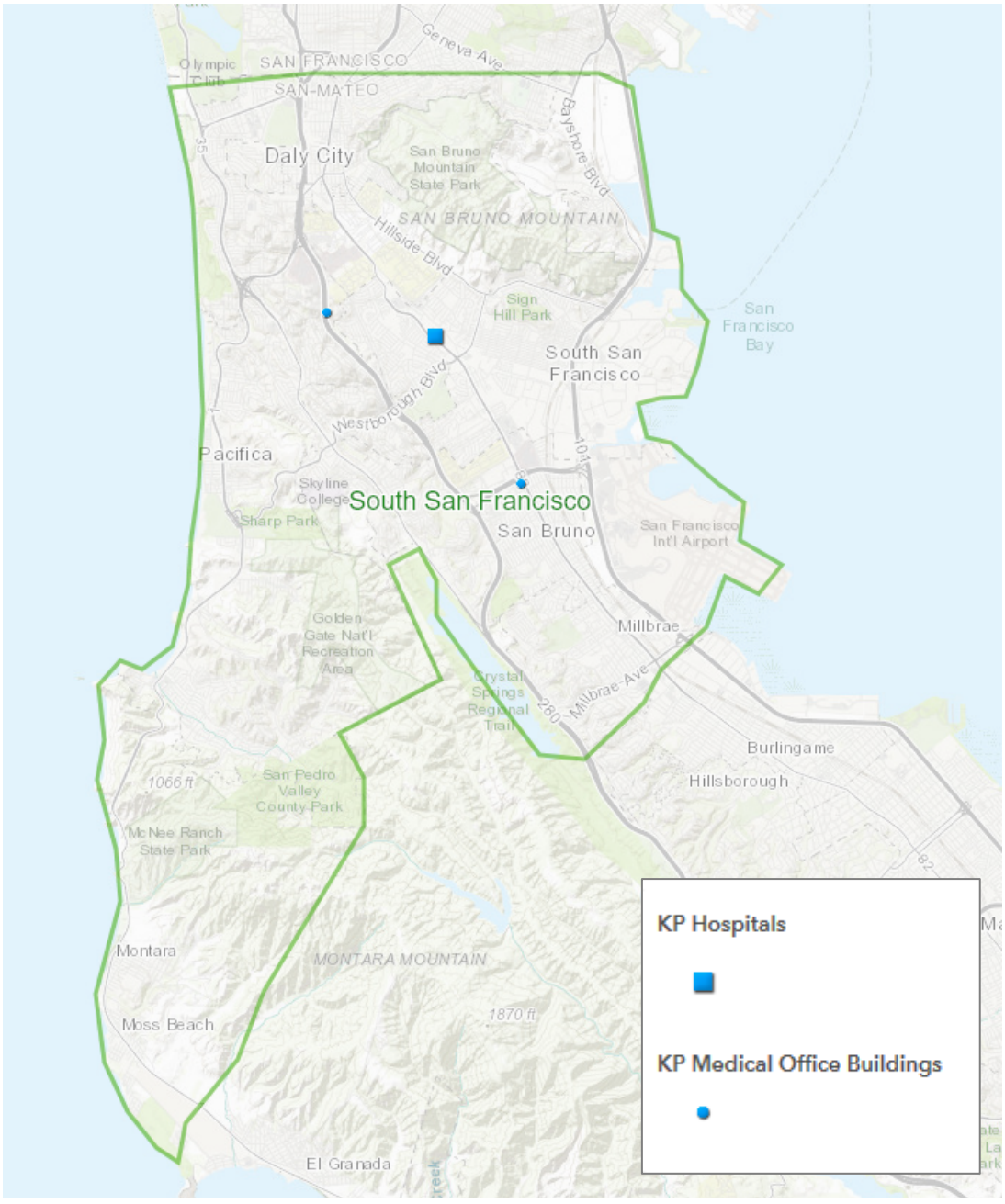
A. Kaiser Permanente's definition of community served

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

B. Map and description of community served

i. Map

KFH-South San Francisco Service Area



ii. Geographic description of the community served

The KFH-South San Francisco service area includes portions of northern San Mateo County, including the cities of Brisbane, Daly City, Montara, Moss Beach, Pacifica, San Bruno, and South San Francisco.

iii. Demographic profile of the community served

The KFH-South San Francisco service area is diverse, with over 40% of the population identifying as Asian, 25% identifying as Hispanic or Latinx, and multiple other ethnicities represented (see table below). Across the larger county, over a third (35%) of residents are foreign-born.[1]

Demographic profile: KFH-South San Francisco

Race/ethnicity		**Socioeconomic Data**	
Total Population	296,007	Living in poverty (<100% federal poverty level)	7.3%
Asian	41.5%	Children in poverty	8.8%
Black	2.3%	Unemployment	2.1%
Native American/Alaska Native	0.3%	Uninsured population	7.6%
Pacific Islander/Native Hawaiian	1.4%	Adults with no high school diploma	12.1%
Some other race	10.8%		
Multiple races	5.1%		
White	38.6%		
Hispanic/Latinx	25.0%		

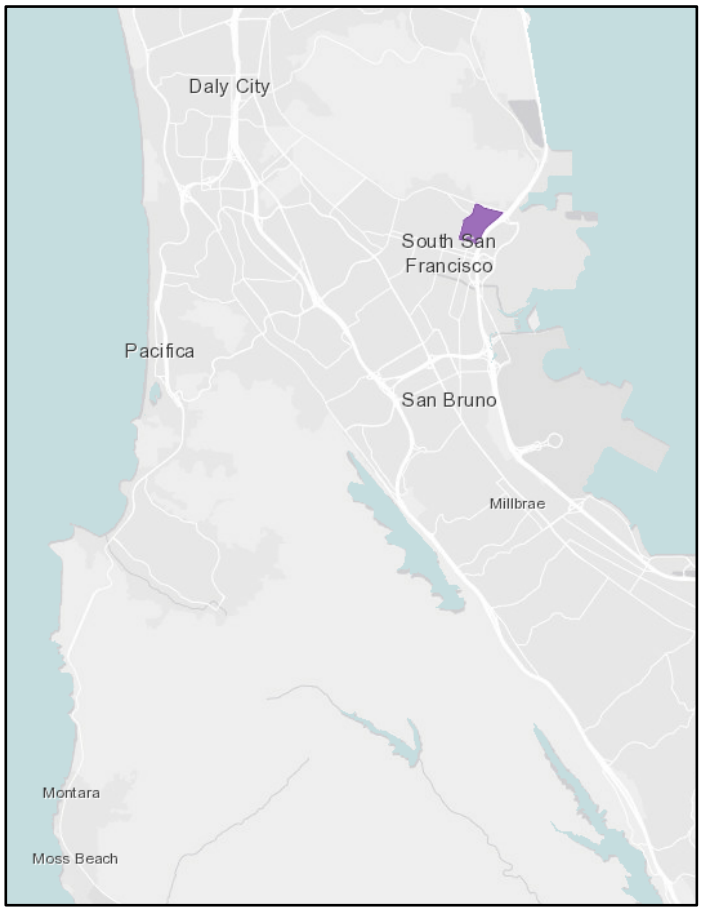
The map that follows identifies where high concentrations of the population living in poverty and populations living without a high school diploma overlap. The orange shading shows where the percentage of the population living at or below 100% of the Federal Poverty Level exceeds 25%. The purple shading shows where the percentage of the population with no high school diploma exceeds 25%. Educational attainment is determined for all non-institutionalized persons aged 25 and older. Dark red areas indicate where the census tract is above these thresholds (worse) for both educational attainment and poverty.

[1] U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012-16.

Vulnerability Footprint: KFH-South San Francisco Service Area

Legend

- 25% or more of the population lives at or below 100% of FPL
- 25% or more of the population age 25+ does not have a high school diploma
- 25% or more of the population both lacks a high school diploma and lives at or below 100% of FPL
- Mean income for the highest fifth of earners is double the county mean income



Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012-16.

III. Who was involved in the assessment?

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

The Health Community Collaborative (HCC) consists of representatives from nonprofit hospitals, County Health Department and Human Services, and public agencies. The collaborative was created to identify and address the shared health needs of the community. Since its formation in 1995, the HCC has conducted prior community health assessments for San Mateo County (1995, 1998, 2001, 2004, 2008, 2011, 2013, and 2016). The 2019 report marks the ninth such assessment and builds upon those earlier assessments. The following organizations are members of the HCC and collaborated on the 2019 CHNA:

- Dignity Health Sequoia Hospital
- San Mateo County Health

- Hospital Consortium of San Mateo County
- County of San Mateo Human Services Agency
- Kaiser Permanente, San Mateo Area
- Lucile Packard Children's Hospital Stanford
- Peninsula Health Care District
- Seton Medical Center and Seton Coastside, part of Verity Health System
- Stanford Health Care
- Sutter Health Menlo Park Surgical Hospital and Sutter Health Mills Peninsula Medical Center

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

Actionable Insights, LLC (AI), an independent, local research firm, was contracted by both the HCC and KFH-South San Francisco to conduct and write the CHNA report. For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

AI helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for over 25 hospitals during 2018-19 CHNA cycle.

IV. Process and methods used to conduct the CHNA

KFH-South San Francisco and its partners worked collaboratively on the primary and secondary data requirements of the 2019 CHNA. The CHNA data collection process took place over seven months and culminated in a report written for the hospital in the first half of 2019.

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KFH-South San Francisco used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review over 130 indicators from publicly available data sources. For details on specific sources and dates of the data used, please see Appendix A.

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

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform

provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

The secondary data that were gathered were compared to state benchmarks. When trend data, data by race/ethnicity, and/or data by age were available, they were reviewed to enhance understanding of the issue(s).

B. Community input

i. Description of who was consulted

Community input was provided by a broad range of community members using key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from county public health departments as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

ii. Methodology for collection and interpretation

Hospital community benefit managers in the HCC planned qualitative data collection to better understand health needs and the drivers of health needs. The HCC identified topics and populations which are less well understood than others (including emerging needs) and then identified experts on those topics/populations or groups of residents or stakeholders who could be convened to discuss them. Importantly, San Mateo is one of the healthiest and wealthiest counties in the state, but there are pockets of poverty and disparities that are not represented in the secondary data. Therefore, it was critical to gather data directly from primary sources to understand those disparities. The consultants used best practices to determine whether resident group feedback could be gathered in a sensitive and culturally appropriate way. Also, the HCC sought out the input of sectors that had not been included in previous CHNAs.

Interviews with professionals knowledgeable about health issues and/or drivers of health were conducted in person or by telephone, lasting approximately one hour. Focus groups were conducted in person and lasted 60-90 minutes. Nonprofit hosts, such as Peninsula Conflict Resolution Center, recruited participants for the groups. The focus group discussions and interviews centered around five topics, which the consultants modified appropriately for each audience:

- What are the most important health needs that you see in your community?
- What drivers or barriers are impacting the top health needs?
- To what extent is health care access a need in the community?
- To what extent is mental health a need in the community?
- What policies or resources are needed to address the top health needs?

Each interview and focus group was recorded as a stand-alone piece of data. Recordings were transcribed, and then the team used qualitative research software tools to analyze the transcripts for common themes. The consultants also tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. KFH-South San Francisco and its hospital partners used this tabulation to help

assess community health priorities. Note that community resident input was treated the same way and given the same standing as the input from of community leaders, service providers, and public health experts.

In the KFH-South San Francisco service area, community input surfaced health issues that cannot be understood with extant data. Often feedback related to inequities in health outcomes and health care access based on social determinants of health and immigration status.

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-South San Francisco had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

The KP CHNA data platform includes approximately 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 consultants and hospital partners together noted additional data limitations/information gaps around substance use, mental health, data for different groups (e.g. Asian sub-groups and undocumented immigrants), specific conditions (e.g., hepatitis C and Alzheimer's disease), and community infrastructure.

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

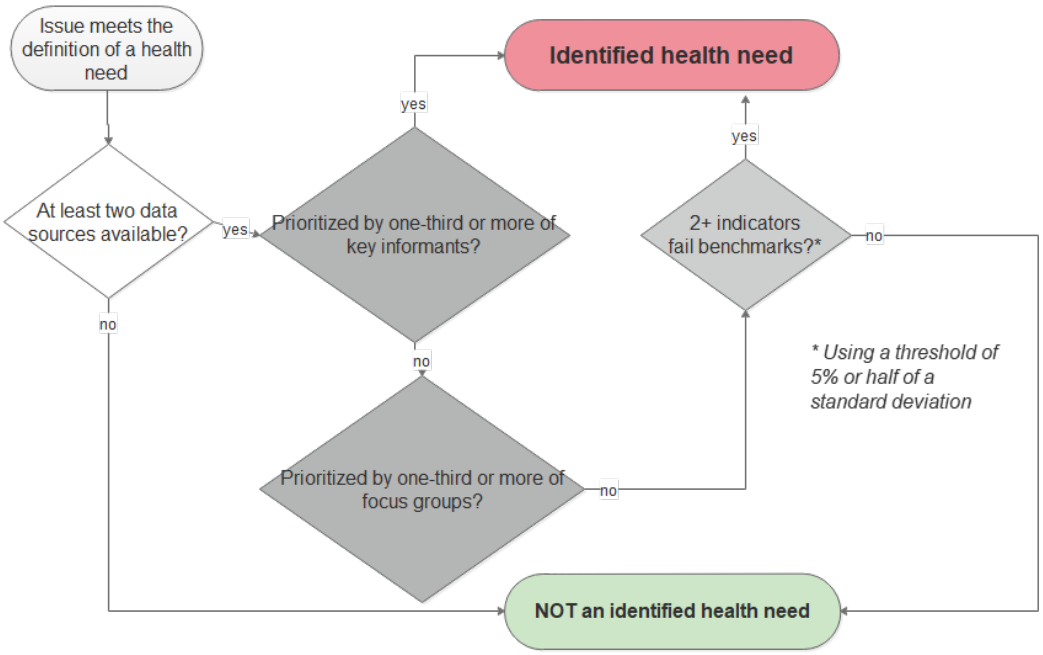
The consultants began with the set of health needs that were identified in the community in 2016. It also took into consideration the health need categories provided by Kaiser

Permanente's data platform,[2] and the social determinants of health categories provided by Healthy People 2020.[3]

In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria (depicted in the diagram below).

- A "data source" is either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from the interviews and focus groups that were conducted for the hospitals.
- A "benchmark" is either the California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

What goes on the list?
Health needs list decision tree



Criteria details:

1. Meets the definition of a "health need."
2. At least two data sources were consulted.
3. a. Prioritized by at least half of key informants or focus groups.
   b. If not (a), three or more direct indicators fail the benchmark by ≥5% or ≥0.5 standard deviations.
   c. If not (b), four or more indicators must show ethnic disparities of ≥5% or ≥ 0.5 standard deviations.

[2] http://www.chna.org/kp
[3] https://www.healthypeople.gov

In 2014, final IRS regulations clarified the definition of a health need, which includes social determinants of health. Social determinants of health affect entire families and communities; they explain, in part, why some individuals thrive and experience good health, while other individuals are not as healthy as they could be. In addition to health behaviors such as eating nutritious foods and avoiding health risks such as smoking, our health is determined in large part by: our economic opportunities; whether we receive a quality education; the availability of resources and support in our homes, neighborhoods, and communities; our workplaces; environmental factors such as access to clean water, healthy food, and air; community safety; and the nature of our social interactions and relationships. In 2019, given this broader definition, the KFH-South San Francisco identified seven health needs that fit all criteria.

B. Process and criteria used for prioritization of health needs

The IRS CHNA requirements state that hospital facilities must identify and prioritize significant health needs of the community. As described previously, the KFH-South San Francisco consultants analyzed the secondary data and solicited qualitative input from focus group and interview participants about which needs they thought were the highest priority (most pressing). The hospital used this input as well as additional input described below to identify the significant health needs listed in this report.

Hospital prioritization process and results

The hospital's Community Benefit Advisory Committee (CBAC) met on October 4, 2018 to learn about the health needs identified during the CHNA and participate in the prioritization process. The positions of the members of the CBAC who participated are listed below.

- Area Director of Revenue Cycle
- Area Pharmacy Director
- Assistant Medical Group Administrator
- Assistant Physician in Chief
- Community & Government Relations Manager
- Community Health Manager
- Director of Health Education
- Licensed Clinical Social Worker, Psychiatry
- Physician, Occupational Medicine
- Physician, Pediatrics
- Registered Nurse, Case Manager, Continuum

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

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

- **Community priority:** This refers to the extent to which the community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. This criterion was ranked based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.

Members used a modified version of the multi-voting process to identify top priorities. Each member identified which needs they felt were higher priorities based on the criteria described. Members could identify as higher priority any number of needs on the list. Needs that received 50% or more of members' votes were ranked as "Highest priority." Needs that received between 25% and 50% of members' votes were ranked as "Medium priority." Needs that received less than 25% of members' votes were ranked as "Lower priority." Summary descriptions of each health need appear in the following pages.

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

HIGHEST PRIORITY:

MENTAL HEALTH AND WELL-BEING

KFH-South San Francisco residents and representatives of various vulnerable groups (e.g., LGBTQI, Pacific Islanders) expressed a greater need for behavioral health care. Economic insecurity (including housing instability) was discussed as a driver of poor mental health and substance use. Statistical data suggest that there are significantly[4] fewer social associations (e.g., civic organizations, recreational clubs, and the like) per capita in the service area (4.5 per 10,000 people) compared to the state average (6.5); social associations contribute to personal well-being.[5]

A common theme in community input was the co-occurrence of poor mental health and substance use. Community members frequently identified stigma as a barrier to behavioral health care, both in acknowledging the need for care and in seeking and receiving care. The community cited a lack of providers and services, both for mental health care and for alcohol and drug treatment, as a major concern, and identified the need for co-location of physical and behavioral health services. Behavioral health professionals also discussed the issue of burnout due to vicarious trauma experienced by staff and the concern that physical health clinicians may not have the knowledge or resources to address mental health.

ECONOMIC SECURITY (INCLUDING HOUSING & HOMELESSNESS)

Economic security, as well as housing and homelessness, were of chief concern to the KFH-South San Francisco community. The community emphasized the relative lack of affordable housing and the poor quality of the affordable housing that is available in the county. Community members also described stress about the high costs of housing and lack of

[4] "Significantly" worse = at least 5% or 0.5 standard deviations worse.
[5] Putnam, R. (2000.) *Bowling Alone.*

affordable rent as another major priority; the community linked housing instability with mental health. Moreover, the community shared how economic instability and stress were increasing for those with middle incomes; community members described the growing call for help with basic needs among those with middle incomes for whom services are lacking as they do not qualify for most assistance programs.

The statistical data indicate significant ethnic disparities in income, which is a key factor driving economic instability. Data for the KFH-South San Francisco service area show that the proportion of the Black population living in poverty (13%) is more than twice that of their White peers (6%). Black residents in the service area are also much more likely to be receiving SNAP (i.e., food stamps) than residents of other ethnicities. Another indicator of economic instability is low educational attainment; the highest proportions of adults in the service area without a high school diploma exist among the Latinx population (26%) and those of "Other" ethnicities (29%).[6]

HEALTHY EATING/ACTIVE LIVING

Healthy eating, together with active living, is a need in the KFH-South San Francisco service area that was prioritized by the community. This need includes concerns about diabetes, obesity, fitness, diet, and nutrition, and access to food and recreation. The KFH-South San Francisco community expressed concern about the rising number of children and youth being diagnosed with diabetes. They also identified diabetes as an issue disproportionately affecting individuals experiencing homelessness. Diabetes management among the service area's Medicare patients (79%) is significantly worse than the state (82%). The community was also concerned about obesity among youth and young adults, emphasizing that healthy habits of diet and activity begin in childhood. While physical activity statistics among adults and youth in the KFH-South San Francisco service area are better than the state averages, there are differences by ethnicity. Physical inactivity significantly exceeds the benchmark (38%) for Latinx (46%) and Pacific Islander (40%) youth.

Further community input about this need included notions regarding cultural differences in diet and formal exercise, lack of time (or, in some cases, space) for cooking or recreation, and issues of access to healthy food in schools, senior centers, and other institutions. The community also discussed related factors that contribute to physical inactivity and poor diet/nutrition, such as the built environment, stress, and poverty.

HEALTH CARE ACCESS AND DELIVERY

Health care access and delivery were prioritized by the KFH-South San Francisco community. As reflected in statistical and qualitative data, barriers to receiving quality care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. While the service area has high rates of available primary care, dental, and mental health providers overall, community input suggests that health care is often unaffordable.

[6] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

Latinxs and those of “Other” ethnicities have the lowest rates of health insurance in the service area (12% and 15% uninsured, respectively). This can result in inequitable health outcomes such as uncontrolled diabetes and premature death. Community input also included concerns about how few primary and specialty care providers accept Medi-Cal, which participants connected both to longer wait times for appointments and to lower levels of attention exhibited by providers during appointments, possibly due to overwork.

The community indicated that undocumented immigrants are accessing health care less often in recent years due to the political climate that has resulted in a fear of being identified and deported. Professionals specifically cited a drop in patient visits.

Lack of frequent, convenient, and affordable transportation can also affect health care access. Community input described public transit access as poor all across the county, especially for Coastside residents, for individuals – particularly older adults – whose homes are not near transit lines, and for commuters (students and workers) who must travel long distances.

MEDIUM PRIORITY:

ORAL/DENTAL HEALTH

Oral/dental health was a priority for the KFH-South San Francisco service area community. Community members perceived there to be a lack of access to high-quality dental services and a lack of dental insurance in the service area. Perhaps due to the former, the community noted long wait times for appointments. Further, community members said that insurance that covers routine care as well as dental surgery (e.g., root canals) is expensive.

Community members were also concerned that there are few providers who accept Denti-Cal. Experts described low reimbursement rates and complicated billing procedures, which have driven many oral health providers away from accepting Denti-Cal. They explained that Federally Qualified Health Centers (FQHCs) are the only organizations that receive a higher reimbursement rate for dental services. However, statistics show that the ratio of FQHCs to residents is significantly worse in the service area (0.7 per 100,000 people) than the state (2.5).

Finally, a driver of poor oral health is drinking water violations; contaminated water can be associated with a rise in sugar-sweetened beverage consumption. Drinking water violations were flagged as an issue in the KFH-South San Francisco service area.

LOWER PRIORITY:

CANCER

Statistical data on cancer incidence rates in the KFH-South San Francisco service area suggest that cancer is a health need. High-quality screening can serve to reduce cancer mortality rates; however, a variety of complex factors contribute to disparities in cancer incidence and death among different ethnic, socioeconomic, and otherwise vulnerable groups. When discussing

factors contributing to cancer risk, the community expressed concern regarding unhealthy behaviors that increase such risk, like lack of regular physical activity.

Incidence rates for breast cancer (136.6 per 100,000 people) and prostate cancers (119.1 per 100,000) are worse in the service area than in the state (120.7 and 109.2, respectively). A significant ethnic disparity in cancer mortality is seen for the Black population (161.9 per 100,000 people) in the service area compared to the benchmark (147.3).

ENVIRONMENT

Statistical data indicate that drinking water violations in the KFH-South San Francisco service area's community water systems were flagged as an issue. Lack of access to clean drinking water affects physical health in a variety of ways, including the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay. In addition to water contamination, the percentage of housing units that are vulnerable to flooding is higher in the service area (6%) than the state average (4%). Community members expressed concerns about how such natural disasters and climate change could impact health outcomes.

The KFH-South San Francisco community also discussed the built environment and its impacts on health. The community described long commutes with congested traffic as the norm. Increased traffic has been shown to exacerbate air pollution, which has negative impacts on respiratory conditions, such as asthma.[7] Long commutes were sometimes identified as being due to workers having been priced out of the local housing market and living farther away. Community members connected long commutes to increased stress and poor health outcomes.

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

The service area for KFH-South San Francisco contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations that are engaged in addressing many of the health needs identified by this assessment. Hospitals and clinics are listed below. Additional key resources available to respond to the identified health needs of the local community are listed in Appendix C.

Existing Health Care Facilities

Resource name	Summary description	Website
Kaiser Foundation Hospital (South San Francisco)	Hospital serving Kaiser-Permanente members in Daly City, San Bruno and South San Francisco	www.kp.org/southsanfrancisco

[7] Community Commons. https://www.communitycommons.org/chna

Resource name	Summary description	Website
Lucile Packard Children's Hospital, Stanford	Hospital providing comprehensive pediatric and obstetric clinical services	www.stanfordchildrens.org
Mills-Peninsula Medical Center (Burlingame)	Hospital in Burlingame	www.sutterhealth.org/mills
Peninsula Health Care District	Identifies and addresses gaps in needed health services through education, prevention and access	www.peninsulahealthcaredistrict.org
Seton Medical Center/Seton Coastside (Daly City/Moss Beach)	Medical Centers serving the Coastside communities	www.verity.org/SMCC/index.php
Stanford Health Care, Palo Alto	Network of 60+ clinics across the Bay Area	www.stanfordhealthcare.org

Existing Clinics & Health Centers

Resource name	Summary description	Website
Belle Air School Student Health Clinic (San Bruno Park School District)	Promotes higher levels of student attendance by engaging parents and students in identifying and addressing school, family, medical, and community issues that contribute to chronic absence	http://sbpsd.k12.ca.us/health-center/index.htm
Clinic by the Bay	Free health care for the working uninsured in San Francisco and San Mateo counties	www.clinicbythebay.org
Daly City Youth Health Center	Mental health programming, Mental Health Stigma Reduction Initiative	www.dalycityyouth.org
Rotacare Clinic (Coastside)	Provides care to the growing population of working and unemployed residents who are unable to pay for primary health care	www.rotacarebayarea.org/coastside

Resource name	Summary description	Website
Rotacare Clinic (Daly City)	Provides care to the growing population of working and unemployed residents who are unable to pay for primary health care	www.rotacarebayarea.org/nopeninsula
San Mateo Medical Center Clinics	Comprehensive primary and specialty care for infants, children, teens, adults and seniors in clinics throughout San Mateo County	www.smchealth.org/smmc-guide-clinics

VI. KFH-South San Francisco 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-South San Francisco's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-South San Francisco's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit: https://www.kp.org/chna. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-South San Francisco in the 2016 Implementation Strategy Report.

1. Healthy Eating/Active Living
2. Health Care Access & Delivery
3. Behavioral Health

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

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

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

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-South San Francisco awarded 281 number of grants amounting to a total of $5,693,447.26 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-South San Francisco service area. During 2017-2018, a portion of money managed by this foundation was used to award 3 grants totaling $259,449.40 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-South San Francisco leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report below.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-South San Francisco engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including the San Mateo County Healthy Communities Collaborative. 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-South San Francisco Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Healthy Eating / Active Living	*During 2017 and 2018, KFH-South San Francisco awarded 40 grants totaling $378,346.36 that address Healthy Eating Active Living in the KFH-South San Francisco service area*	Senior meals: KFH-South San Francisco provided $15,000 to Peninsula Volunteers to deliver meals to 300 homebound seniors who are unable to shop and cook for themselves in Daly City and Millbrae.
		Garden education: KFH-South San Francisco awarded $30,000 to Education Outside to provide 1,793 K thru 5 students at five Daly City public elementary schools with garden-based education and healthy food experiences throughout the school year.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		After school physical activity program: Girls on the Run of the Bay Area received $25,000 to provide 138 girls from low-income communities of color with a 10-week after-school program at three Daly City and six South San Francisco elementary and middle schools to increase their physical activity, improve their self-image, and build healthy habits.
Access to Care	*During 2017 and 2018, KFH-South San Francisco awarded 71 grants totaling $4,302,795.13 that address Access to Care in the KFH-South San Francisco service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 4,053 and 4,037 Medi-Cal members respectively totaling $12,992,878.30 worth of care. KP also provided a total of $7,878,655.75 of Medical Financial Assistance (MFA) to 4,998 individuals in 2017 and 2,556 individuals in 2018.
		PHASE: Over the course of three years (2017-2019), Community Health Partners (CHP) is the recipient of a $500K grant (evenly split between 4 KFH hospital service areas)to support the successful use of PHASE among member health center organizations, such as by helping develop QI infrastructure within the health centers and supporting them to address social needs in order to reach higher levels of blood pressure control. CHP is reaching over 15,000 patients through PHASE. 70% of patients with diabetes and 68% of those 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.
		Connection to resources: Pacifica Resource Center received $15,000 to connect 300 homeless and marginally-housed adults and seniors with food, housing assistance, and income supports to increase their stability and health.
Behavioral Health	*During 2017 and 2018, KFH-South San Francisco awarded 44 grants totaling $490,032.60 that address Behavioral Health in the KFH-South San Francisco service area*	Stigma: StarVista received a $90,000 grant (evenly split between KFH-Redwood City and KFH-South San Francisco) to reduce mental health stigma within the LGBTQ+ community through education, trainings, media, outreach, peer support and social events. StarVista expects to reach 1,100 providers, teachers, staff and students. Expected outcomes include an increase in understanding about stigma and increase in access to services.
		Behavioral health screening: KFH-South San Francisco awarded LifeMoves $20,000 to screen 100 clients at Crossroads Family Shelter in Daly City for behavioral health issues, and connect those needing services to onsite individual, group, and milieu therapy.
		Resilience: Niroga Institute was awarded $20,000 to provide an evidence-based, trauma-informed, stress resilience intervention throughout the school year for 448 students at Jefferson and Thornton Continuation high schools in Daly City.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
		Connection to services: KFH-South San Francisco provided $20,000 to Urban Services YMCA to provide outreach, screening, linkages, and direct mental health services to 550 uninsured low-income community members in South San Francisco.

VII. Appendix

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
    ii. Other secondary data sources
B. Community Input Tracking Form
C. Community resources
D. 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

Appendix B. Community Input Tracking Form

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities, and the medically underserved. The participants included leaders from the San Mateo County Health System, nonprofit hospital representatives, local government employees, and nonprofit organizations. For a description of members of the community who participated in focus groups, please see Section IVB, “Community Input.”

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Interview	Director, San Mateo County Behavioral Health and Recovery Services	1	Medically underserved	Leader	4/16/18
2	Interview	Vice President of Programs & Services, Second Harvest Food Bank of Santa Clara and San Mateo Counties	1	Low-income	Leader	4/16/18
3	Interview	Executive Director, Boys & Girls Club of the Coastside	1	Low-income, minority	Leader	4/16/18
4	Interview	Executive Director, Adolescent Counseling Services	1	Medically underserved	Leader	4/18/18
5	Interview	Chair, San Mateo County Oral Health Coalition	1	Medically underserved	Leader	4/18/18
6	Interview	Co-Founder and Member, African American Community Health Advisory Committee	1	Medically underserved, Minority	Leader, Representative	4/26/18
7	Interview	Chief Executive Officer, Health Plan of San Mateo	1	Medically underserved	Leader	4/27/18
8	Interview	Medical Director at Family Health Services Division, San Mateo County Health System	1	Health department representative, Medically underserved	Leader	4/27/18
9	Interview	Executive Director, First 5 San Mateo County	1	Low-income	Leader	5/8/18
10	Interview	Supervising Physician, Daly City Youth Health Center	1	Medically underserved	Leader	5/8/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
11	Interview	Vice President of Resident Services, MidPen Housing	1	Low-income	Leader	5/14/18
12	Interview	Endowed Professor in Child Health, Professor of Pediatrics and of Medicine and, by courtesy, of Health Research and Policy, and Director of the Center for Healthy Weight, Stanford University and Lucile Packard Children's Hospital Stanford	1	Medically underserved	Leader	5/15/18
13	Interview	Physician, North East Medical Services	1	Medically underserved	Leader	5/21/18
14	Interview	Associate Superintendent, San Mateo County Office of Education	1	Medically underserved	Leader	5/31/18
15	Interview	Deputy Chief, San Mateo County Health System	1	Health department representative	Leader	6/11/18
16	Focus group	**Host:** San Mateo County Human Services Agency; attendees were service providers who address social determinants of health	18	Low-income, Medically underserved	Leaders	4/27/18
17	Focus group	**Host:** Before Our Very Eyes/Bay Area Anti-Trafficking Coalition; attendees were service providers and law enforcement personnel who address community and family safety and human trafficking	9	Low-income, Medically underserved	Leaders	5/8/18
18	Focus group	**Host:** Sequoia Wellness Center; attendees were professionals who serve older adults	11	Low-income	Leaders	5/10/18
19	Focus group	**Host:** LifeMoves; attendees were service providers who work with individuals experiencing homelessness	7	Low-income, Medically underserved	Leaders	5/24/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
20	Focus group	**Host:** KFH-South San Francisco; attendees were leaders of local nonprofit organizations	14	Low-income, Medically underserved	Leaders	9/11/18
Community residents						
21	Focus group	**Host:** The Villages of San Mateo County; attendees were older adults on fixed incomes whose original socioeconomic status was middle-class	8	Low-income	Members	4/18/18
22	Focus group	**Host:** Peninsula Family Services Agency, North Fair Oaks Senior Center; attendees were low-income, Spanish-speaking older adults	12	Low-income, Medically underserved, Minority	Members	5/16/18
23	Focus group	**Host:** Pride Center; attendees were members of the LGBTQ population	10	Medically underserved, Minority	Members	5/17/18
24	Focus group	**Host:** Cañada College; attendees were young adults who were community college students	5	Low-income	Members	5/9/18
25	Focus group	**Host:** Peninsula Conflict Resolution Center; attendees were Pacific Islanders (Tongans)	10	Minority	Members	6/12/18

Appendix C. Community resources

Health Care Facilities and Agencies

In addition to assets and resources available to address specific health needs, the following health care facilities are available in the county. Many hospitals provide charity care and cover Medi-Cal shortfalls.

Hospitals

Resource name	Summary description	Website
Kaiser Foundation Hospital (South San Francisco)	Hospital serving Kaiser-Permanente members in Daly City, San Bruno and South San Francisco	www.kp.org/southsanfrancisco
Lucile Packard Children's Hospital, Stanford (Palo Alto)	Hospital providing comprehensive pediatric and obstetric clinical services	www.stanfordchildrens.org
Mills-Peninsula Medical Center (Burlingame)	Hospital in Burlingame	www.sutterhealth.org/mills
Peninsula Healthcare District	Identifies and addresses gaps in needed health services through education, prevention and access	www.peninsulahealthcaredistrict.org
Seton Medical Center/Seton Coastside (Daly City/Moss Beach)	Medical Centers serving the Coastside communities	www.verity.org/SMCC/index.php
Stanford Health Care, Palo Alto	Network of 60+ clinics across the Bay Area	www.stanfordhealthcare.org

Clinics

Resource name	Summary description	Website
Belle Air School Student Health Clinic (San Bruno Park School District)	Promotes higher levels of student attendance by engaging parents and students in identifying and addressing school, family, medical, and community issues that contribute to chronic absence	http://sbpsd.k12.ca.us/health-center/index.htm
Clinic by the Bay	Free healthcare for the working uninsured in San Francisco and San Mateo counties	www.clinicbythebay.org
Daly City Youth Health Center	Mental health programming, Mental Health Stigma Reduction Initiative	www.dalycityyouth.org
Rotacare Clinic (Daly City)	Provides care to the growing population of working and unemployed residents who are unable to pay for primary healthcare	www.rotacarebayarea.org/nopeninsula
San Mateo Medical Center Clinics	Comprehensive primary and specialty care for infants, children, teens, adults and seniors in clinics throughout San Mateo County	www.smchealth.org/smmc-guide-clinics

Community Resources Related to Specific Health Needs

Cancer

Resource name	Summary description	Website
“Look Good, Feel Better”	Free support program that helps people with cancer deal with the appearance side effects of cancer treatment	www.lookgoodfeelbetter.org/programs

Resource name	Summary description	Website
American Cancer Society	Provides information, research, prevention, support and referrals for cancer patients	www.cancer.org
Bay Area Cancer Connections	Supports anyone with breast or ovarian cancer with personalized services	www.bayareacancer.org
Breast Cancer Connections, Gabriela Pastor Program	Provides free medical information/ education and emotional support to persons with breast cancer and their families and friends.	https://www.smc-connect.org/locations/breast-cancer-connections-bcc
Colon Cancer Community Awareness campaign	Promotes colon cancer awareness through education and free screening for the low-income, uninsured and the under-insured in the community	https://www.stridesforlife.org
Relay For Life	Relay team track walking event to raise funds for the American Cancer Society	https://secure.acsevents.org/site/SPageServer/?pagename=relay
Samaritan House	Primary and specialty medical, dental and vision care to low income and uninsured individuals (including free mammograms)	www.samaritanhousesanmateo.org/what-we-do/freeheathcareclinics

Community & Family Safety

Crime/Intentional Injuries

Resource name	Summary description	Website
ALLICE (Alliance for Community Empowerment)	Filipino American organization promoting domestic violence prevention education	www.allicekumares.com
Asian American Recovery Services	Prevention/early intervention for adolescents in the Asian American, Pacific Islander and other ethnically diverse communities	www.healthright360.org/agency/asian-american-recovery-services

Resource name	Summary description	Website
Community Overcoming Relationship Abuse (CORA)	Family Centered Mental Health program	www.corasupport.org
Edgewood Center for Children & Families	Kinship Program – support for family members who step up when crises, abuse, illness, incarceration, or violence separates children from their parents	www.edgewood.org/kinship-support
Elder Abuse Prevention Task Force	Prevention of abuse (financial, physical, sexual or emotional), neglect, isolation, or abandonment of elders	www.smchealth.org/elderabuse
Kaiser Permanente	KP Educational Theatre “PEACE SIGNS” program	https://etnortherncalifornia.kaiserpermanente.org/peace-signs-2
Lucile Packard Children’s Hospital Stanford	Community Health Education Programs which address drivers of violence, including lack of coping skills, developmental delays, and mental health issues	www.stanfordchildrens.org
Peace Development Fund	Provides grants, training, and other resources to community-based organizations focused on human rights and social justice	www.peacedevelopmentfund.org
Peninsula Conflict Resolution Center	Offers dispute resolution services for individuals, businesses, schools, nonprofits, government agencies and community groups	www.pcrcweb.org
Peninsula Kidpower, Teenpower, Fullpower	Social-Emotional Health & Safety Program	www.kidpower.org/california
Rape Trauma Services	Sexual Assault Intervention Services	www.rapetraumaservices.org
SafeKids Coalition:	SafeKids works to prevent unintentional injury (including shaken baby syndrome), the leading cause of death of children ages 1-14	www.safekids.org/safe-kids-coalitions-united-states

Resource name	Summary description	Website
San Mateo County Human Trafficking Initiative	Assessment and recommendations regarding efforts to identify and work against human trafficking in San Mateo County	https://csw.smcgov.org/human-trafficking

Unintentional Injuries

Resource name	Summary description	Website
Brainbook and ImPACT	Concussion education and intervention for student athletes	www.dignityhealthfoundation.org/news-and-events/news-brainbook-concussion-education
CPR classes	Classes on cardiopulmonary resuscitation available to the community free of charge.	www.cprcpr.com/home/free-cpr-classes-in-the-bay-area
San Mateo County Fall Prevention Coalition	Fall prevention health education programs across the county, including: - Stepping On - Farewell to Falls - Matter of Balance - Fall-Proof falls prevention classes - Seniors in Motion classes	www.smcfallprevention.org

Economic Security (including Housing & Homelessness)

Resource name	Summary description	Website
California Department of Rehabilitation	Assists individuals with disabilities with information and referrals for education, vocational training, career opportunities, independent living and the use of assistive technology to improve their lives.	https://dor.ca.gov

Resource name	Summary description	Website
Coastside Hope	Entry to the Coordinated Entry System for Homeless Services, Core Services Agency - Emergency Safety Net Services (Information and Referral Services, Emergency Food, Homeless prevention)	www.coastsidehope.org
Community Gardens	Promote healthy eating and lower food costs by encouraging the public to grow their own food	Various
County of San Mateo Employment Services	Free employment assistance services and referrals.	https://hsa.smcgov.org/employment-services
Daly City Community Services Center	Entry to the Coordinated Entry System for Homeless Services. Core Service Agency - Emergency Safety Net Services (Information and Referral Services, Emergency Food, Homeless prevention)	www.dalycity.org/residents/community_service_center.htm
Edgewood Center for Children & Families	Food Bank - a weekly community gathering for individuals and families to receive grocery boxes of fresh fruit, vegetables, legumes, and other foods	www.edgewood.org/food-bank
Family Service Agency of San Mateo County: Senior Employment Services	Provides training and job placement to eligible people age 55 or over who meet certain income qualifications.	www.peninsulafamilyservice.org
Goodwill Industries of San Mateo County	Community-based vocational rehabilitation program that provides services to disabled and disadvantaged adults including veterans.	https://sfgoodwill.org
HIP Housing	Home sharing, Self-Sufficiency Program	www.hiphousing.org
Home & Hope	Shelter and services for homeless population	www.homeandhope.net

Resource name	Summary description	Website
JobTrain (formerly OICW)	Job training to low-income, unemployed or underemployed adults and independent youth.	www.jobtrainworks.org
LifeMoves	Emergency shelter	www.lifemoves.org
Mid-Pen Housing	Low-income housing	www.midpen-housing.org
North Peninsula Food Pantry & Dining Center of Daly City	Food pantry, dining center hot meal program	www.fooddc.org
Nova Job Center	Services for jobseekers, including workshops, training, and referrals. Offices in Daly City and San Mateo.	https://novaworks.org
Pacifica Resource Center	Entry to the Coordinated Entry System for Homeless Services. Economic Security & Income Supports Program	www.pacresourcecenter.org
Project WeHOPE	Emergency homeless shelter and transitional/ supportive housing program	www.projectwehope.org
Rebuilding Together Peninsula	Home repairs for low income homeowners	www.rebuildingtogetherpeninsula.org
Samaritan House	Entry to the Coordinated Entry System for Homeless Services. Core Service Agency - Emergency Safety Net Services (Information and Referral Services, Emergency Food, Homeless prevention)	www.samaritanhousesanmateo.org
San Mateo County NAACP	Focuses on eliminating race-based discrimination, and on ensuring the political, educational, social, and economic equality of rights of all persons	www.sanmateonaacp.com

Resource name	Summary description	Website
Second Harvest Food Bank	Food bank providing food to people in need throughout San Mateo County; also provide information about federal nutrition programs and other food resources	www.shfb.org
Summer lunch programs	Help meet the needs of low-income children and their families who face hunger in the summer by providing them with nutritious meals and snacks when school is not in session	Various; see https://www.feedingamerica.org/our-work/hunger-relief-programs/summer-food-service-program
YMCA	Entry to the Coordinated Entry System for Homeless Services. Community Resource Center: Core Service Agency - Emergency Safety Net Services (Information and Referral Services, Emergency Food, Homeless prevention)	www.ymcasf.org/community-resource-center-ymca

Environment

Resource name	Summary description	Website
County of San Mateo Office of Sustainability	An initiative to bring together non-profit and community-based organizations, local government, businesses, and other key partners to make San Mateo County climate ready.	https://www.smcsustainability.org/climate-ready
The Watershed Project	The mission of The Watershed Project is to inspire Bay Area communities to understand, appreciate, and restore their local watersheds.	http://thewatershed project.org/

Health Care Access & Delivery

Resource name	Summary description	Website
Children's Health Initiative - Healthy Kids insurance program	Locally funded program for low-income children who do not qualify for Medi-Cal or other health insurance	www.hpsm.org/about-us/programs
City of San Mateo Get Around Senior Transportation Program	Discounted ride cards for seniors 60+ for taxi rides originating or ending in the City of San Mateo	www.cityofsanmateo.org/3795/Get-Around-Senior-Transportation-Program
Community Gatepath	Support services to individuals with special needs and developmental disabilities	www.gatepath.org
Daly City Partnership Social Services	Collaborative connecting the community to resources that promote well-being	www.dcpartnership.org
Daly City Peninsula Partnership Collaborative, Healthy Aging Response Team	Healthy Aging Response Team (HART) provides a peer-based volunteer telephone response system for Daly City residents age 50 or older and adults with disabilities who would like assistance in locating county services	www.dcpartnership.org/programs/healthy-aging-response-team
Edgewood Center for Children and Families	Programs for abused, neglected and traumatized children	www.edgewood.org
Family Caregiver Alliance (FCA)	Services, education programs and resources addressing the needs of families and friends providing long-term care for loved ones at home	www.caregiver.org/bay-area-caregiver-resource-center
Get Healthy San Mateo County	Collaborative of community-based organizations, County agencies, cities, schools, and hospitals working to advance policy change to prevent diseases and ensure everyone has equitable opportunities to live a long and healthy life	www.gethealthysmc.org

Resource name	Summary description	Website
Get Up & Go Senior Transportation	Provides a way for those who don't drive to be more independent through transportation services	www.pjcc.org/programs/senior-transportation/
Health Benefits Resource Center	A centrally located information and referral service that links families to government-sponsored health benefits and social services	Not found
Kognito	Evidence-based health simulations for health practitioners and educators to improve talking about health and well-being	www.kognito.com
Lucile Packard Children's Hospital Stanford	Mobile Adolescent Health Services: primary treatment and preventative care to homeless and uninsured teens	www.stanfordchildrens.org
Mental Health Association of San Mateo County	Provides housing and support services, particularly for those affected by mental illness and/or HIV/AIDS	www.mhasmc.org
Mills-Peninsula Health Services	Referrals for the uninsured and under-insured	www.sutterhealth.org/mills
Mission Hospice & Home Care	Provides a continuum of care designed to serve patients – and their families – at every stage of a life-limiting illness	www.missionhospice.org
Northeast Medical Services (NEMS) Behavioral Health services (Daly City clinic)	Community health center targeting the medically underserved Asian population in north San Mateo county	www.nems.org
Ombudsman Services of San Mateo County	Ombudsman advocacy for residents of long-term care facilities	www.ossmc.org
Pacifica Collaborative	A group of social service agencies joined with city and school district personnel to share ideas about how to best serve the community	Not found

Resource name	Summary description	Website
Pathways Health	Home health, hospice and palliative care; bereavement support; veterans services	www.pathwayshealth.org
Redi-Wheels program	Curb-to-curb transportation service meeting the needs of the mobility impaired in San Mateo County	www.smc-connect.org/locations/san-mateo-county-transit-district-samtrans/redi-wheels-and-redicoast
San Mateo County Access to Care for Everyone Program Supports	Health care program for low-income adults who do not qualify for other health insurance	www.hpsm.org/member/ace
San Mateo County Paratransit Coordinating Council	Focuses on improving the quality and availability of door-to-door public transportation for people with disabilities	www.sanmateopcc.org
San Mateo Medical Association Community Service Foundation	Improving quality of life through the promotion and development of programs that encourage healthier personal and professional lifestyles	www.smcma.org/advocacy/get-involved/community-service-foundation.aspx
SCAN Foundation	Advances a coordinated system of services for older adults	www.thescanfoundation.org
Social Justice Collaborative	Community advocacy and legal representation in immigration and criminal courts to immigrants and their families	www.socialjusticecollaborative.org
Stanford Health Care	Free access to medical librarian for research/information on stroke, CVD, etc.	http://healthlibrary.stanford.edu
The Latino Commission	Substance abuse and addiction recovery through counseling, medical services, and a residential program	www.thelatinocommission.org

Healthy Eating/Active Living

Resource name	Summary description	Website
70 Strong	A free referral service for people 60 years old and older to stay active and connected	www.70strong.org
American Board for Child Diabetics	Diabetic supplies and enriched life experiences for families of children and young adults living with diabetes, who lack adequate financial resources	www.abcdiabetics.org
Bay Area Community Health Advisory Council (formerly African American Community Health Advisory Committee)	Blood glucose screenings, annual heart health screening, Fitness is my Witness physical fitness program, Soul Stroll for Health Walk, and Resource Fair	www.aachac.org
Community/Senior Centers	Monthly blood glucose and blood pressure screenings, and counseling	Various
Diabetes Weight Management Program	Weight management resources for people at risk for diabetes, or who have pre-diabetes or diabetes	www.sutterhealth.org/services/diabetes/diabetes-weight-management
Local Parks and Recreation Departments	Facilities and programs for indoor and outdoor recreation in local communities	Various
Lucile Packard Children's Hospital Stanford	Community education on nutrition and obesity, prevention Pediatric Weight Control Program (accessible for low-income families)	www.stanfordchildrens.org
Overeaters Anonymous	12-step support groups for compulsive overeating and other food-related compulsions	www.oa.org
Pacific Stroke Association	Free services for people who have suffered stroke, their families and friends, and individuals interested in learning more about stroke	www.pacificstrokeassociation.org

Resource name	Summary description	Website
Peninsula Conflict Resolution Center	Senior Peers and Senior Fitness	www.pcrcweb.org
Police Activities League	Youth programs focusing on life skills, enrichment opportunities and intervention programs	www.californiapal.org/home/membership/pal-chapters/
Prenatal-to-Three Program	A collaboration of agencies and individuals working to provide information, support, and care for families of pregnant women and children to age five who receive Medi-Cal services in San Mateo County	www.smchealth.org/pre3
SafeKids Coalition of Santa Clara and San Mateo Counties	Programs to help parents and caregivers prevent childhood injuries	www.safekids.org/coalition/safe-kids-santa-clarasan-mateo
Samaritan House	Food pharmacy for diabetes patients	www.samaritanhousesanmateo.org
Stanford Health Care	Strong for Life group exercise program for older adults	https://stanfordhealthcare.org/medical-clinics/aging-adult-services/strong-for-life.html
Via Heart Project	Peninsula Heart Safe Program	www.viaheartproject.org/programs
YMCA	Enhance Fitness with YMCA	www.ymca.net/enhancefitness

Mental Health & Wellbeing

Resource name	Summary description	Website
70 Strong	A free referral service for people 60 years old and older to stay active and connected	www.70strong.org

Resource name	Summary description	Website
Acknowledge Alliance (formerly Cleo Eulau Center)	Builds school connectedness and positive relationships between students and educators	www.acknowledgealliance.org
Al-Anon	Support group for the family members and friends of people who have a drinking problem	www.al-anon.org
Alateen	Support group for younger family members and friends of people who have a drinking problem	www.al-anon.org/for-members/group-resources/alateen
Alcoholics Anonymous	12-step recovery program for people who have a drinking problem	www.aa.org
Asian American Recovery Services	Behavioral Health services for Asian American, Pacific Islander and other ethnically diverse communities	www.healthright360.org/agency/asian-american-recovery-services
Boys & Girls Clubs of North San Mateo County	Mental Health Stigma Reduction Initiative: targeting mental health stigma among vulnerable teens and young adults while promoting improved mental health and wellness for them and their families	www.theclubs.org
Caminar	Bridges to Wellness program (integrated primary and behavioral health care services), and other programs	www.caminar.org/resources/2015/2/18/medication-clinic
Catholic Charities	Service areas: aging support, children & youth, homelessness and housing, immigration	www.catholiccharitiessf.org
Coastside Adult Day Health Center	Adult Day Care, including health care, memory care, activities, support groups and transportation	www.coastsideadultdayhealth.org
Community Overcoming Relationship Abuse (CORA)	Family Centered Mental Health program	www.corasupport.org

Resource name	Summary description	Website
Daly City Peninsula Partnership Collaborative	Mental health services for families	www.smc-connect.org/locations/daly-city-peninsula-partnership-collaborative
Daly City Youth Health Center	Mental health programming, Mental Health Stigma Reduction Initiative	www.dalycityyouth.org
Edgewood Center for Children & Families	Kinship Program – support for family members who step up when crises, abuse, illness, incarceration, or violence separates children from their parents	https://edgewood.org/kinship-support
El Centro de Libertad	Substance Use Intervention Program for adults and at-risk youth/probation youth	www.elcentrodelibertad.org
Freedom House	Provides a safe home and long-term aftercare for survivors of human trafficking	www.freedomhousesf.org
Friends for Youth	Whole Health for Youth Counseling Services, group and 1-to-1 mentoring for at-risk youth	www.friendsforyouth.org
Health Right 360 San Mateo	Provides a diverse array of programs and services in San Mateo County	www.healthright360.org/location/san-mateo-county
Healthy Schools Initiative and ATOD education programs in schools	Programs aimed at improving the physical and emotional health of students and families	Various; see http://sanmateo.networkofcare.org/mh/services/subcategory.aspx?tax=PH-2360.8000
LifeMoves	Family & Children's Support Project at shelters	www.lifemoves.org
Lucile Packard Children's Hospital Stanford: Mental Health Dissemination and Innovation Initiative	Mental Health Dissemination and Innovation Initiative to combat the effects of early childhood trauma in San Mateo County communities with high violence rates (East Palo Alto and East Menlo Park)	www.stanfordchildrens.org

Resource name	Summary description	Website
Lucile Packard Children's Hospital Stanford: Health Initiative to Improve the Social and Emotional Health of Youth	Health Initiative to Improve the Social and Emotional Health of Youth Pediatric Resident Advocacy mini - grant to determine causes of drug abuse and re - incarceration in incarcerated youth in San Mateo County	www.stanfordchildrens.org
Lucile Packard Children's Hospital Stanford: Community Health Education	Community Health Education classes offered on mindfulness and wellbeing (either free of charge or with scholarships available to low income community members)	www.stanfordchildrens.org
Mental Health Association of San Mateo County	Provides housing and support services, particularly for those affected by mental illness and/or HIV/AIDS	www.mhasmc.org
Mills-Peninsula	Anti-Bullying Campaign with middle and high school teens	www.sutterhealth.org/mills
National Alliance on Mental Illness/San Mateo County	Education, advocacy and support for people with mental illness, and their families	www.namisanmateo.org
Niroga Institute	Dynamic Mindfulness program at DC high schools	www.niroga.org/training/dm
Peninsula Family Services	Senior Peer Counseling Program - weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief	www.peninsulafamilyservice.org/our-programs/older-adult-services/seniorpeercounseling
Project Safety Net/Heard Alliance	Funding collaborative focused on suicide prevention and the social and emotional health of youth in Palo Alto	www.psnpaloalto.com/ www.heardalliance.org/about-affiliation
Rape Trauma Services	Counseling, advocacy and education to facilitate healing and the prevention of violence, sexual assault and abuse	www.rapetraumaservices.org

Resource name	Summary description	Website
Samaritan House	Behavioral health services at Safe Harbor Shelter in SSF	www.samaritanhousesanmateo.org
San Mateo County Health Department	Youth Mental Health First Aid Training	www.smchealth.org/general-information/youth-mental-health-first-aid
San Mateo County Health Office of Diversity & Equity	Advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo County	www.smchealth.org/office-diversity-equity
School counseling services	Provide school-based mental health services	Various
Sitike Counseling Center	Community based counseling and education focused on alcohol and/or drug addiction, anger management and domestic violence	www.sitike.org
StarVista	Insights Program offering outpatient substance abuse and mental health treatment services for youth	www.internal.star-vista.org/whatwedo_services/counseling/youth/insights.html
The Latino Commission	Entre Familia Program	www.thelatinocommission.org
Women's Recovery Association	Offers residential and outpatient treatment programs for women and their children who are having problems with alcohol or drugs and/or mental health issues	www.womensrecovery.org
YMCA	Project Cornerstone training on youth developmental assets	www.ymcasv.org/projectcornerstone

Oral Health

Resource name	Summary description	Website
Delta Dental provided through Healthy Kids HMO	Program for low-income children who do not qualify for Medi-Cal or other health insurance	www.hpsm.org/member/healthy-kids
Ravenswood Family Health Center	Children's dental services	www.ravenswoodfhc.org/index.php/services/family_dentistry
Samaritan House Free Clinic	Primary and specialty medical, dental and vision care to low income and uninsured individuals	www.samaritanhousesanmateo.org/what-we-do/freeheathcareclinics
San Mateo County Oral Health Coalition	Focuses on improving the oral health status of San Mateo County's traditionally underserved and vulnerable populations	www.smchealth.org/oralcoalition
Sonrisas Dental Health	Dental clinic specializing in increasing access for older adults and disabled individuals	www.sonrisasdental.org

Appendix D. Health Need Profiles

COMMUNITY HEALTH NEED

Health Care Access & Delivery

What's the issue?

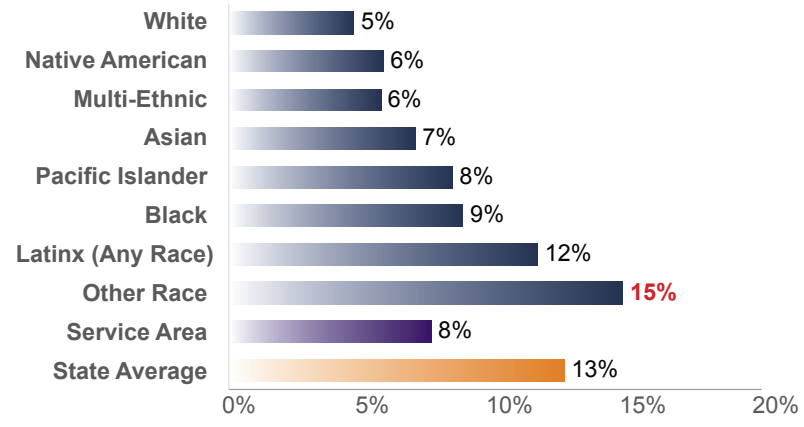
Access to health care is important for everyone's well-being and quality of life.[1] "Access" generally means a patient has a sufficient number of health care providers available locally, reliable transportation to medical appointments, and adequate insurance (or can otherwise afford services and medications). "Delivery" refers to the timeliness, standards, transparency, and appropriateness with which providers render services. Too often, common medical conditions that could be controlled through preventive care and proper management, such as Type 2 diabetes, are instead exacerbated by barriers to access and/or delivery. This can lead to premature death.

What does the data show?

There are significant disparities in insurance coverage across ethnic groups in the KFH-South San Francisco service area. For example, the proportion of Latinx service area residents without insurance is nearly two and a half times the rate of uninsured White service area residents. Service area residents of "Other" ethnicities are the most likely to be uninsured, compared with other ethnic groups.[2]

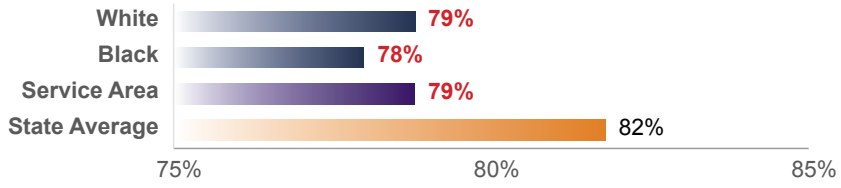
continued >>

Ethnic Disparities: Uninsured Populations



Percentage of the total population without health insurance coverage. / SOURCE: Dartmouth Atlas of Health Care, 2014.

Ethnic Disparities: Diabetes Management



SOURCE: U.S. Census Bureau American Community Survey, 2012–2016.

KEY DISCOVERY

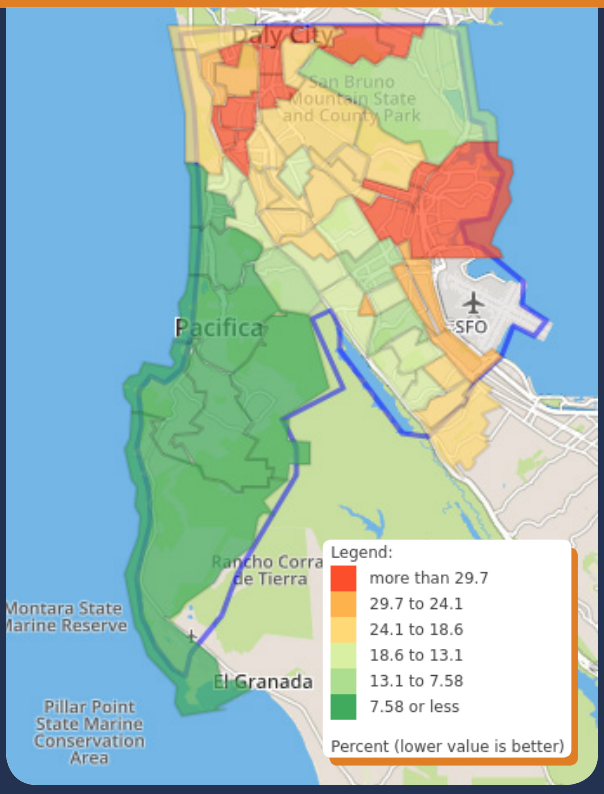
21%

of Medicare patients in the KFH-South San Francisco service do not manage their diabetes well, which suggests access and delivery issues with respect to preventive care.[6]

In the KFH-South San Francisco service area, the rate of Federally Qualified Health Centers, community organizations that provide health care to vulnerable populations, is 0.7 per 100,000, which is 72% lower than the state average of 2.5 per 100,000.[3] Perhaps related to this, only 71% of residents in the service area made a recent primary care visit, below average compared to the state.[4]

There are certain neighborhoods in the KFH-South San Francisco service area where high proportions of residents have limited English proficiency. Speaking limited English can interfere with a patient's ability to communicate effectively with health care providers. Orange and red areas in the map below highlight communities where the percentages of linguistically isolated households are higher than average.[5]

Limited English Proficiency



SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

What does the community say?

Residents and local health experts in San Mateo County (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified health care access and delivery—particularly affordability—as a chief concern. Lower-income residents who do not receive health insurance subsidies may lack the means to pay for medical care, even though the county's Affordable Care for Everyone (ACE) program is available to all. Community members voiced a need for health care providers to spend more time listening to and empathizing with patients. They suggested that greater provider diversity and training, as well as one-on-one partnerships with patients, would help better serve vulnerable populations. Specific shortcomings called out by the community: support in languages other than English, culturally appropriate services, and whole-person care.

"In terms of timely access for mental health ... that is in dire straits. ... Teachers and families say, 'I'm concerned. The young person is showing definite signs of anxiety and depression, and they can't get in ... with a psychiatrist or a therapist.'"

—LOCAL HEALTH EXPERT

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2015). http://www.healthypeople.gov
[2]"Other" is a U.S. Census category for ethnicities not specifically called out in data sets.
[3]U.S. Centers for Medicare and Medicaid Services. (2016).
[4]UCLA Center for Health Policy Research, California Health Interview Survey. (2015–2016).
[5]Limited English Proficiency indicates the percentage of the population age 5 and older that is linguistically isolated (speaks a language other than English at home and speaks English less than "very well"). On average, statewide, nearly 22% of the population is linguistically isolated.
[6]Dartmouth Atlas of Healthcare. (2014).

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COMMUNITY HEALTH NEED

Behavioral Health

What's the issue?

Emotional and psychological well-being are important to every person's capacity to maintain healthy relationships and function in society.[1] "Well-being" generally means having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing satisfaction and fulfillment in life. Roughly one in five adults in the U.S. is coping with a mental illness.[2] Common disorders such as depression and anxiety can affect self-care. Likewise, chronic diseases can negatively impact mental health.[3] So too can substance use. Substance use can lead or contribute to other social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, car accidents, and HIV/AIDS.[4]

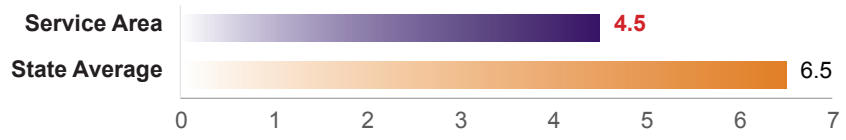
What does the data show?

Socializing can promote personal well-being.[5] Statistics suggest that access to social groups—recreational clubs, business or professional associations, civic organizations—is lower in the KFH-South San Francisco service area than the state average, which may negatively affect residents' mental health.

Statistics indicate that the KFH-South San Francisco service area is generally faring better than average when it comes to substance use and related health conditions. One exception: More than one in three service area residents self-report binge drinking, a ratio which is slightly above the California average. The percentage of smokers in the service area is 46% lower than the state average. However, ethnic disparities exist: Black service area residents are far more likely to die of heart disease, a chronic condition associated with long-term substance use (including tobacco and alcohol use), than service area residents of other ethnic groups.

continued >>

Social Associations



Rate per 10,000 people. / SOURCE: U.S. Census Bureau, County Business Patterns (2015).

Smoking and Drinking

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Current or Former Smokers	14%	7%
Binge Drinkers	33%	34%

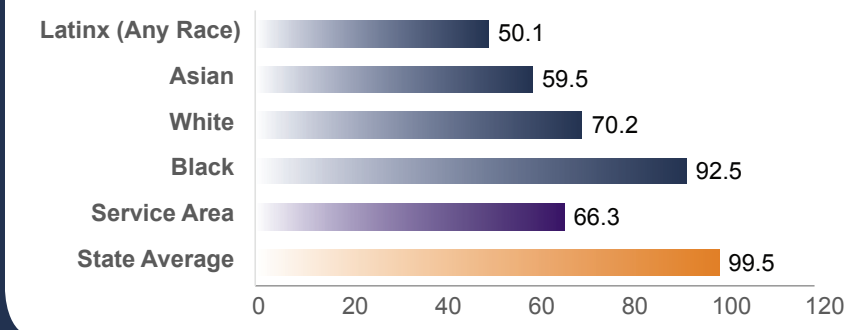
SOURCE: UCLA Center for Health Policy Research, California Health Interview Survey: Smoking, 2014; Drinking, 2015–2016.

KEY DISCOVERY

11 per 100,000

Approximate suicide rate of White residents, which is notably higher in KFH-South San Francisco, where average suicide deaths in the service area are 7.6 overall.[6]

Ethnic Disparities: Heart Disease Mortality



Age-adjusted rates per 100,000 people. / SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, 2011–2015.

What does the community say?

Residents and local health experts in the KFH-South San Francisco service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified behavioral health as a priority. Depression and stress were the most common issues raised. Focus group participants and key informants discussed the co-occurrence of poor mental health and substance use. Economic insecurity, including housing instability, surfaced as a driver of both issues.

"If emotional regulation is challenged by chronic stress and trauma, that shows up as a high risk factor for dropping out of school, which then leads to homelessness, substance abuse, juvenile incarceration, and more."

—SERVICE PROVIDER

The community cited a lack of providers/services for mental health and for alcohol and drug treatment as a major concern, and identified the need for co-location of general and behavioral health services. Community members frequently pointed to stigma as a barrier to mental health care and substance use treatment, both in acknowledging the need for care (facing cultural taboos, either internalized or imposed by loved ones) and in seeking and receiving care (feeling shamed by providers delivering care). Service providers talked about burnout due to the vicarious trauma experienced by staff as well as concerns that general health clinicians may not have the knowledge or resources to address mental health.

SOURCES

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[2] Centers for Disease Control and Prevention. (2018). *Learn About Mental Health.*
[3]Lando, J. & Williams, S. (2006). A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion. *Preventing Chronic Disease*, *3*(2): A61.
[4]World Health Organization. (2018). *Management of Substance Abuse.*
[5]Putnam, R. (2000). *Bowling Alone.*
[6]Centers for Disease Control and Prevention, National Vital Statistics System. (2011–2015).

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Cancer

What's the issue?

Cancer, in all of its forms, is the second-leading cause of death in the U.S.[1] High-quality screening can reduce cancer rates. Yet health disparities related to cancer contribute to higher death rates for low-income residents and ethnic minorities than other people. Delivery issues in cancer screening and follow-up care exacerbate the problem. Poverty and the lack of health insurance and screening are strongly related.[2] Although personal, behavioral, and environmental factors are significant (for example, a smoker is exposed to known carcinogens), the most important risk factors for cancer are not having health insurance and being of low socioeconomic status.[3]

What does the data show?

The incidence rates of breast and prostate cancer in the KFH-South San Francisco service area are 13% and 9% higher, respectively, than average in California. Yet two of the biggest risk factors, the use of cigarettes and the excessive use of alcohol, do not significantly exceed state averages.[4, 5] This suggests that other factors may contribute to cancer incidence here, such as an aging population; cancer risk increases with age, and the median age in San Mateo County has been rising over the past decade.[6, 7]

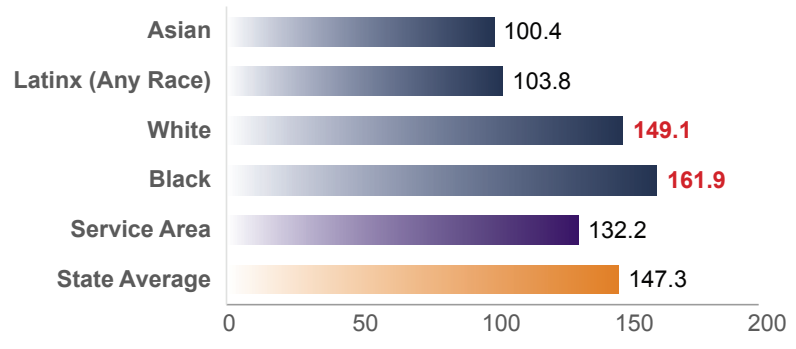
continued >>

Cancer Incidence Rates

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Breast Cancer Incidence (females only)	120.7	**136.6**
Prostate Cancer Incidence (males only)	109.2	**119.1**

Age-adjusted rates per 100,000 people. / SOURCE: State Cancer Profiles, 2010–2014.

Ethnic Disparities: Cancer Mortality



Age-adjusted rates per 100,000 people. / SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, 2011–2015.

KEY DISCOVERY

+22%

The cancer mortality rate differential for Black residents over the KFH-South San Francisco service area's average of 132.2 per 100,000 people.[8]

KFH-South San Francisco service area residents who are Black are far more likely to die from cancer than those who are White, Asian, Latinx, or Native American. Perhaps contributing to the higher death rate, Black women are less likely to get a breast cancer screening (i.e., mammogram) than their White peers.[9]

What does the community say?

Despite the statistical evidence of higher incidence rates and ethnic disparities in cancer mortality, which makes cancer an issue in the KFH-South San Francisco service area, residents and local experts (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) did not identify cancer as a health need. This may be because screening measures like mammograms take place more widely here than elsewhere in California,[9] and the cancer mortality rate in the service area is 10% lower than the state average, perhaps the result of prevention initiatives. Community members emphasized the importance of healthy habits, such as exercising regularly and eating a nutritious diet, in reducing cancer risk.

"Cancer health disparities are further compounded by greater delays in diagnostic evaluation among minority patients ... and by suboptimal treatment among poor and minority patients diagnosed with cancer."[2]

—RESEARCHERS FISCELLA, ET AL.

SOURCES

[1]Centers for Disease Control and Prevention. (2017). *Leading Causes of Death.*
[2]Fiscella, K., et al. (2011). Eliminating Disparities in Cancer Screening and Follow-Up of Abnormal Results: What Will It Take? *Journal of Health Care for the Poor and Underserved*, *22*(1): 83–100.
[3]National Cancer Institute. (2018). *Cancer Disparities.*
[4]UCLA Center for Health Policy Research, California Health Interview Survey. (2014).
[5]UCLA Center for Health Policy Research, California Health Interview Survey. (2015–2016).
[6]National Institutes of Health. (2014). *NIH Study Offers Insight Into Why Cancer Incidence Increases With Age.* See also: Xu, Z. and Taylor, J.A. (2014). Genome-Wide Age-Related DNA Methylation Changes in Blood and Other Tissues Relate to Histone Modification, Expression, and Cancer, *Carcinogenesis*, *35*(2): 356–64.
[7]U.S. Census Bureau, American Community Survey. (2005–2009 through 2013–2017).
[8]Centers for Disease Control and Prevention, National Vital Statistics System. (2011–2015).
[9]Dartmouth Atlas of Healthcare. (2014).

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COMMUNITY HEALTH NEEDS

Economic Security and Housing & Homelessness

What's the issue?

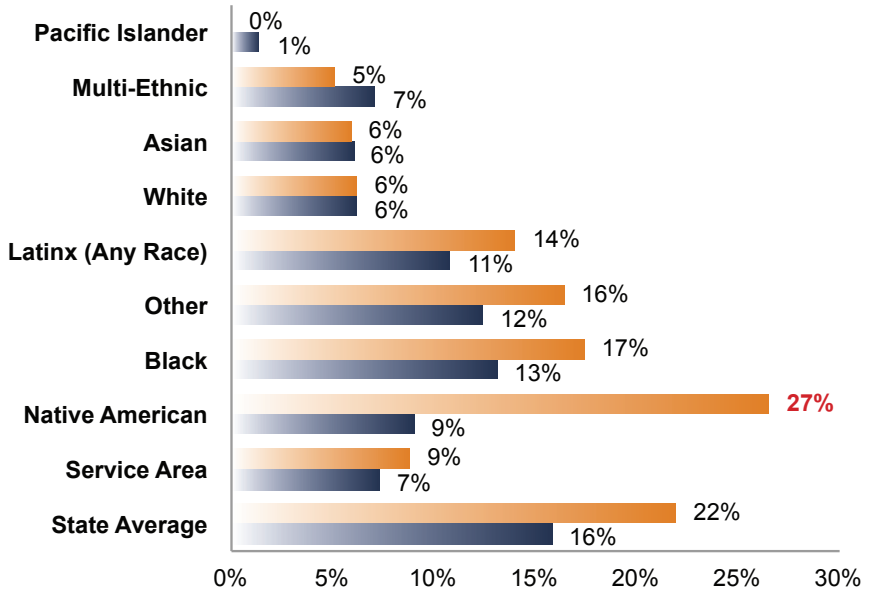
The context of people's lives determines their health, the World Health Organization notes. A secure social support system—families, friends, communities—plays a significant role in healthier populations.[1] Higher income and social status have each been linked to greater health. Research shows that access to economic security programs (such as the Supplemental Nutrition Assistance Program) results in better long-term health outcomes.[2] Childhood poverty has lasting effects: Even when economic and social conditions later improve, childhood poverty still results in poorer health outcomes over time.[3] Housing is a factor in this. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the well-being, educational achievement, and economic success of those who live inside it.[4] Poor health can lead to homelessness, and homelessness can lead to poor health.[5] People experiencing homelessness suffer from preventable illnesses at a greater rate, require longer hospital stays, and have a greater risk of premature death than their peers with housing security.[6]

What does the data show?

Economic insecurity and homelessness have a negative effect on mental and physical health. Lower-than-average incomes earned by many non-White residents in the KFH-South San Francisco service area make certain racial groups especially

continued >>

Ethnic Disparities: Poverty



Percentage of the general population (red) and the child population (blue) that live in households with incomes below the Federal Poverty Level. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

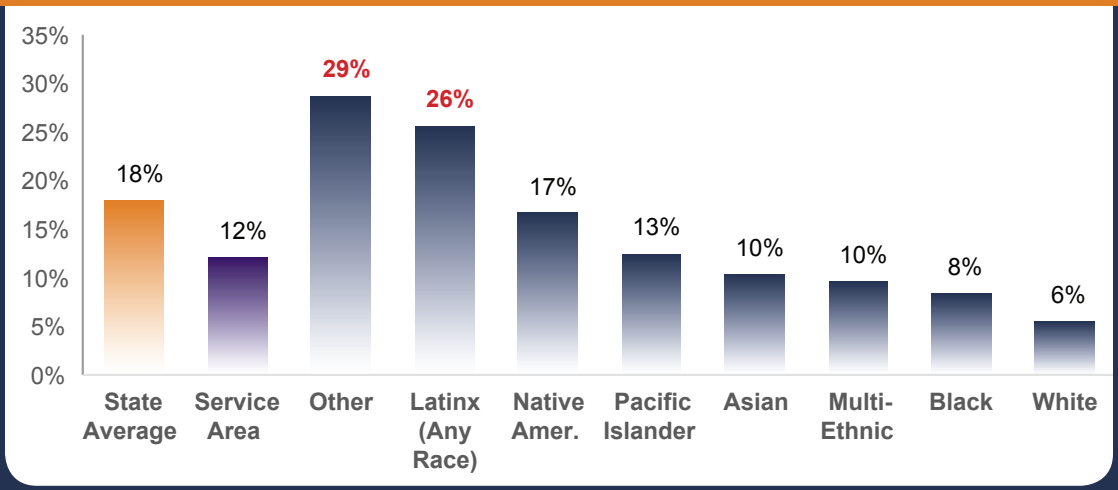
KEY DISCOVERY

$54,964

The median annual household income of Black residents in the KFH-South San Francisco service area is less than half that of their White counterparts.[7]

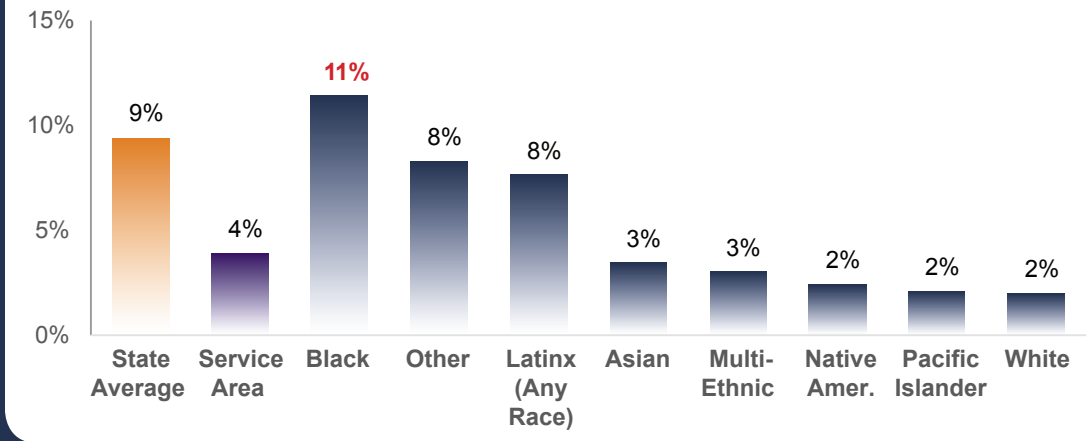
vulnerable.[7] In the service area, Black residents are twice as likely as White residents to live in poverty.[7] Income and educational attainment are strongly associated.[8] Communities where educational attainment is lower tend to face economic challenges. One in four Latinx adults in the service area does not have a high school diploma.

Ethnic Disparities: Adults 25+ With No High School Diploma



Percentage of all residents in service area. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

Ethnic Disparities: SNAP Participation



Estimated percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits. / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

Low-income households that are eligible for federal entitlement programs may receive benefits from the Supplemental Nutrition Assistance Program (SNAP, formerly called food stamps).[9] Undocumented individuals age 18 and over are ineligible for SNAP. Access to SNAP for mixed-immigration-status households is problematic because of the fear of family separation and potential deportation that undocumented individuals may have.

In the KFH-South San Francisco service area, housing concerns are prevalent (see community section, next page). Most statistical data on housing appear to meet benchmarks, but geographic data suggest that certain neighborhoods and communities disproportionately experience housing challenges.

continued >>

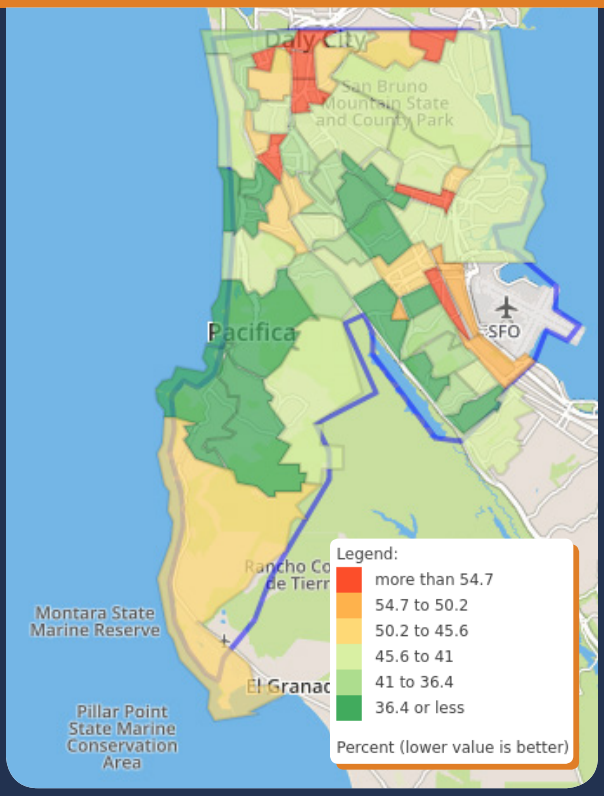
What does the community say?

Residents and local health experts in the KFH-South San Francisco service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified housing and homelessness as a chief concern. They frequently discussed the relative lack of affordable housing—and the poor quality of what is available—in San Mateo County.

> *"Families and individuals feel forced to stay in unsafe, unhealthy living conditions ... because they don't have another option. This is the cheapest that they can find. If they complain ... the landlords evict them."*
>
> —FOCUS GROUP PARTICIPANT

The community described stress about high rents and housing costs as another big concern; in the majority of focus groups and interviews, housing was mentioned in conjunction with mental health. Further, community feedback surfaced the growing call for help with basic needs among those with middle incomes who do not qualify for most assistance programs.

Households With Housing Problems



Housing problems include at least one of the following: Housing unit lacks complete kitchen facilities; housing unit lacks complete plumbing facilities; housing unit is overcrowded (>1 person per room); or household is cost burdened (all housing costs represent over >30% of monthly income). / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

SOURCES

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COMMUNITY HEALTH NEED

Environment

What's the issue?

A healthy environment is critical to everyone's physical health and quality of life. Nearly 25% of all deaths and diseases worldwide can be attributed to environmental issues such as air, water, food, and soil contamination, the U.S. Office of Disease Prevention and Health Promotion reports.[1, 2] Exposure to a poor environment can compound the problems of people whose health is already compromised.[2] Therefore, any effort to improve overall health must consider environmental factors that may increase the likelihood of illness and disease. This includes climate change, which is projected to have an increasing impact on air quality, the spread of infectious diseases, and the severity of fires, floods, droughts, and other natural disasters.[3]

What does the data show?

In the KFH-South San Francisco service area, several environmental hazards are cause for concern. Drinking water violations in the service area's community water systems were flagged as an issue.[4] Road density (miles of streets per square mile of land), a contributor to air pollution, is more than five times greater in the KFH-South San Francisco service area than the state average. Additionally, a much higher proportion of housing units in the service area than statewide are at risk of flooding. Homelessness that may occur as a result of natural disasters, like floods, can significantly impact health.[5]

Some neighborhoods are more vulnerable to floods than others. In the KFH-South San Francisco service area, the parts of South San Francisco and the Daly City/Colma border that are most prone to flooding are also some of the places with the lowest median income in the service area.[6] Research shows that low-income residents are more likely than middle-income residents to live in high flood-hazard zones, probably because housing is more affordable in those areas.[7] Low-income residents are also more likely to rent than own their homes, and experience greater financial burden as the result of flood-related losses than middle- or high-income residents.[7, 8]

Pollution and Environmental Hazards

HEALTH NEED INDICATOR	STATE AVERAGE	SERVICE AREA
Flood Vulnerability Index	3.7	5.7
Road Network Density (road miles per square mile)	2.0	12.6

SOURCES: Flood vulnerability, Federal Emergency Management Agency, National Flood Hazard Layer, 2011; Road density, Environmental Protection Agency, Smart Location Database, 2011.

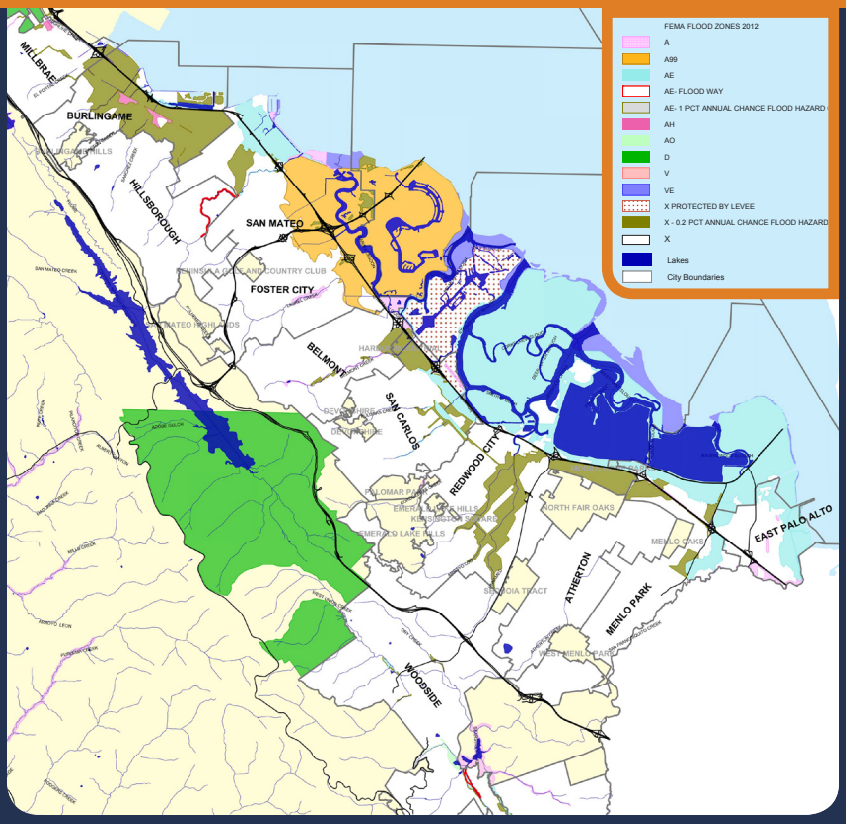
continued >>

KEY DISCOVERY

54%

more housing units are at risk of flooding in the service area than the state average.

Flood Vulnerability With Zone Definitions[9]



SOURCE: County of San Mateo, Planning and Building Department, 2012.

What does the community say?

Residents and local health experts in the KFH-South San Francisco service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified long commutes and traffic congestion, perhaps due to the fact that many people have been priced out of the local housing market and live farther away from their jobs.* CHNA participants connected the long commutes with increased stress and poor health outcomes. Some community members were also concerned by climate change.

* As noted, road congestion is related to poor air quality.

SOURCES

[1]Office of Disease Prevention and Health Promotion. (2018). *Environmental Health.*
[2]Morris, G. & Saunders, P. (2017). The Environment in Health and Well-Being, *Oxford Research Encyclopedias.*
[3]U.S. Global Change Research Program. (2018). *Fourth National Climate Assessment.*
[4]University of Wisconsin's County Health Rankings, using data from the Environmental Protection Agency's Safe Drinking Water Information System. (2015).
[5]National Health Care for the Homeless Council. (2011). *Care for the Homeless: Comprehensive Services to Meet Complex Needs.*
[6]U.S. Census, American Community Survey. (2012–2016).
[7]Sarmiento, C., & Miller, T. E. (2006). Inequities in Flood Management Protection Outcomes. University of Minnesota Paper No. 379-2016-21673, American Agricultural Economic Association Meetings, 2006. High-income individuals are also more likely than middle-income individuals to live in flood zones, likely due to the "esthetic attributes of living next to water;" however, Sarmiento and Miller point out that they are also much more likely to be able to afford flood insurance.
[8]U.S. Department of Housing and Urban Development, Office of Policy Development and Research. (2005). *Homeownership Gaps Among Low-Income and Minority Households.*
[9]Federal Emergency Management Agency. (1998). Managing Floodplain Development Through the NFIP, Appendix D. Zone definitions:
Zones V (salmon) and VE (light purple): Special Flood Hazard Area subject to coastal high hazard flooding
Zones A–AO (light pink, dark pink, aqua blue, light green, white with red border) and A99 (orange): Special Flood Hazard Area with base flood elevations provided and/or sheet flow, ponding, or shallow flooding
Zone AE (gray): 1% annual chance flood hazard contained in channel
Zone X (olive green): 0.2% annual chance flood hazard
Zone X (white, white with red dots): Minimal to moderate flood hazard
Zone D (bright green): Undetermined but possible flood hazard

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COMMUNITY HEALTH NEED

Healthy Eating & Active Living

What's the issue?

Nearly two in five adults and one in five children in the U.S. are obese.[1] Being obese or overweight raises the risk for diabetes, hypertension, stroke, and cardiovascular disease—some of the leading causes of preventable death.[2] Obesity also can contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation.[1,3] Risk factors of obesity include an unhealthy diet, a sedentary lifestyle, underlying medical issues, family models, and social and economic factors.[3] Obesity often co-exists with food insecurity (a lack of available financial resources for food at the household level)[4,5] because "both are consequences of economic and social disadvantage."[6]

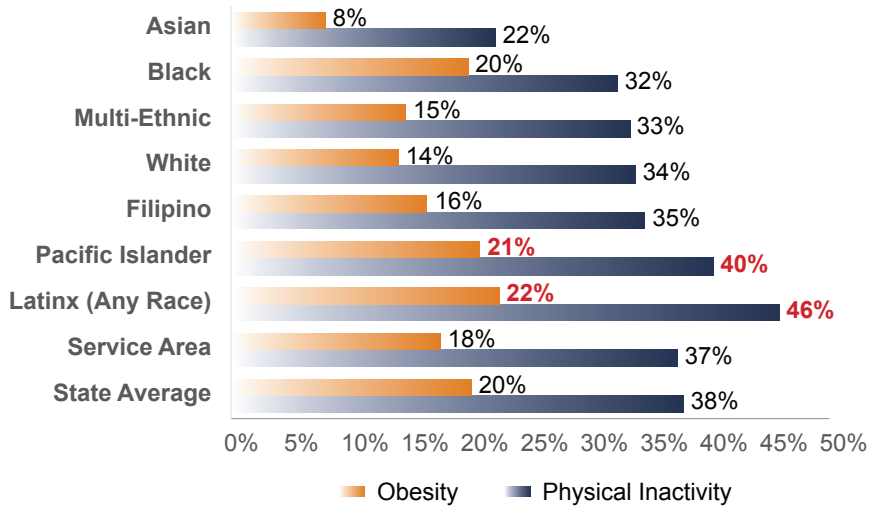
Getting regular exercise can help reduce the risk of obesity and Type 2 diabetes, as well as cardiovascular disease, some cancers, and other physical issues. It also can help strengthen bones and muscles, prevent falls for older adults, and promote a longer life.[7,8] Similarly, maintaining a healthy diet can help prevent high cholesterol and high blood pressure and lower the risks of obesity, osteoporosis, and dental cavities.[9] For children and adolescents, a nutritious diet contributes to growth, bone development, and cognitive function.[10] Yet most people do not follow the recommended food and exercise guidelines.

What does the data show?

Concerns in the KFH-South San Francisco service area focused on disparities in food security, obesity, and diabetes. The rates of obesity among Black and Latinx adults[11] and Latinx and Pacific Islander youth in the KFH-South San Francisco service area are higher than average. Earning a low income is correlated with eating a poor diet,

continued >>

Ethnic Disparities: Youth Fitness and Obesity



Percentage of youth ages 10–17. / SOURCES: California Department of Education, FitnessGram Physical Fitness Testing, 2016–2017.

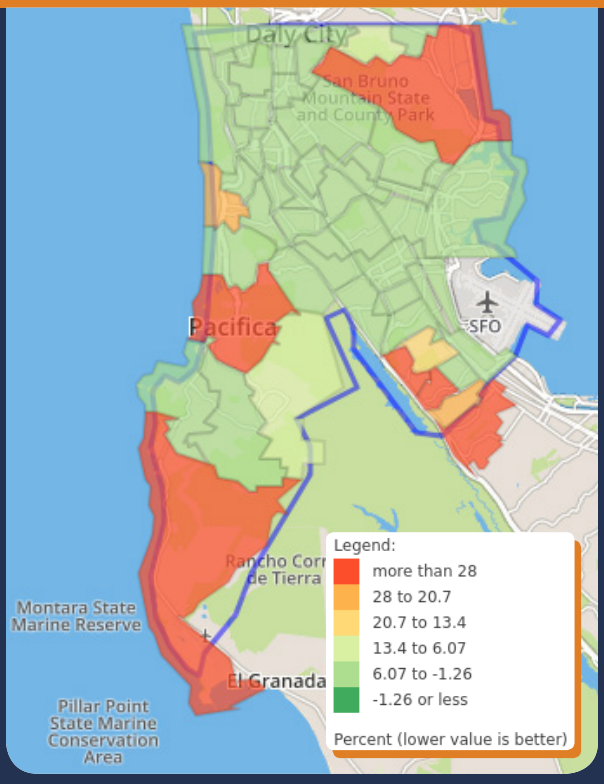
KEY DISCOVERY

33%

The percentage of Black adults in the KFH-South San Francisco service area who are obese significantly exceeds the percentage of White adults (20%).

and people living in poverty are much less likely than people in higher-income families to eat a nutritious, well-balanced diet.[12] Communities experiencing food insecurity often also have less access to healthy food. The map shows how census tracts in the KFH-South San Francisco service area compare with the state average of 13.4% low access (i.e., high relative distance) to supermarkets and large grocery stores. Coastal residents are especially affected.

Low Access to Healthy Food Stores



SOURCE: U.S. Department of Agriculture, Food Access Research Atlas, 2014.

What does the community say?

Residents and local health experts in the service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) prioritized healthy eating and active living. Concerns were raised about obesity among youth and young adults, noting low levels of physical activity and fruit and vegetable consumption in the community. Experts underscored the rising numbers of children being diagnosed with diabetes and diabetes among people experiencing homelessness. Residents emphasized that diet and exercise habits are strongly affected by family models, access to recreation, and the food environment. They cited many barriers to eating well and being physically active, including stress, poverty, access to public transit (particularly for coastal residents and seniors), lack of time and space for cooking and recreation, and unhealthy food being served in schools, homeless shelters, senior centers, and other institutions.

"It's a vicious circle in the sense that not being able to address those significant [housing] cost needs, then they very often cut on food, and by cutting the food, they're putting their health at risk, and if the circle comes back, health risks are actually increasing their cost situation."

—COMMUNITY EXPERT

SOURCES

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[6]Food Research and Action Center. (2015). *Food Insecurity and Obesity.*
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[10]World Health Organization. (2018). *Early Child Development–Nutrition and the Early Years.*
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[13]Undocumented adults are ineligible for Supplemental Nutrition Assistance Program (SNAP). Access to SNAP for individuals in mixed-immigration-status households is problematized by the fear of family separation and potential deportation that undocumented family members may have.

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COMMUNITY HEALTH NEED

Oral/Dental Health

What's the issue?

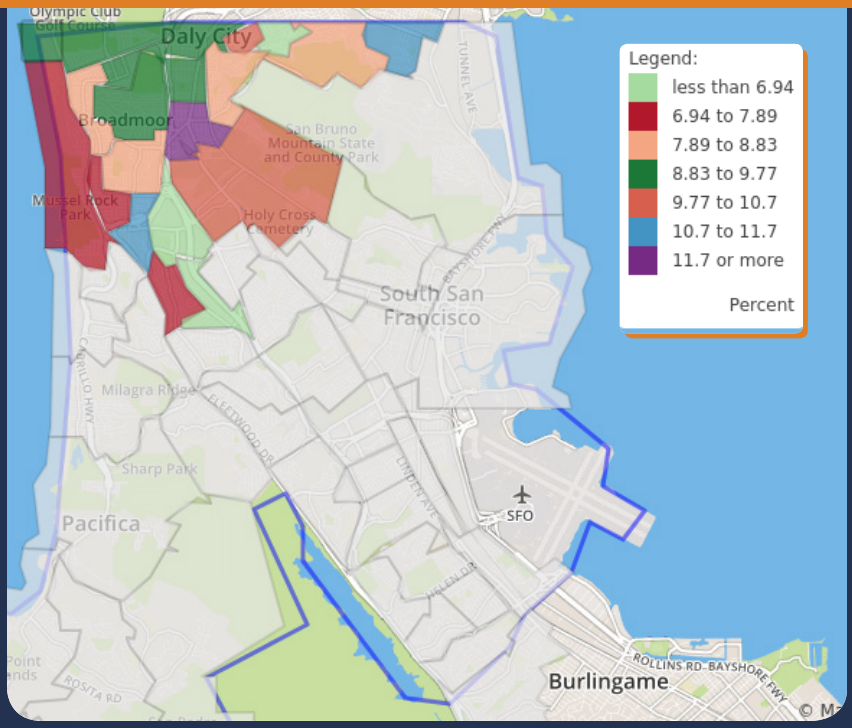
A healthy smile can indicate more than a good mood. Oral/dental health promotes overall well-being by allowing a person to taste, chew, swallow, and speak, as well as to express feelings and emotions through facial expressions.[1] Maintaining oral/dental health depends on routine self-care, such as brushing teeth with a fluoride-based toothpaste, flossing, and receiving professional dental treatment.[2] Unhealthy behaviors, such as poor dietary choices, substance use (nicotine, methamphetamines, other drugs), and inconsistent hygiene, can result in conditions from cavities to cancer.[3]

What does the data show?

In the KFH-South San Francisco service area, the ratio of Federally Qualified Health Centers, community assets that provide health care to vulnerable populations, to residents is 0.7 per 100,000, less than a third of the state's ratio of 2.5 per 100,000.[4] The map shows the percentage of adults with poor dental health by census tract in the KFH-South San Francisco service area. The service area average is 8.7%.

continued >>

Poor Dental Health



Percentage of adults self-reporting the removal of all of their permanent teeth due to tooth decay, gum disease, or infection. / SOURCE: Centers for Disease Control and Prevention, Behavioral Health Risk Factor Surveillance System, 500 Cities: Local Data for Better Health Project, 2014.

KEY DISCOVERY

1 in 4

The number of people in the KFH-South San Francisco service area who lack dental insurance isn't ideal—but it beats the statewide average of six in 10.[5]

Drinking water violations, which were flagged as an issue in the KFH-South San Francisco service area, are a driver of poor oral health.[6] Contaminated water can be associated with a rise in sugar-sweetened beverage consumption.

What does the community say?

Residents and local health experts in the KFH-South San Francisco service area (who recently participated in a community health needs assessment sponsored by Kaiser Permanente) identified oral/dental health as a major need. A frequently cited concern was the inability to access high-quality dental services, whether due to a lack of dental insurance or a shortage of providers. Although 74% of service area residents have dental insurance,[5] even those with coverage struggle to find a dentist who accepts their policy. Despite offering nearly 100 dentists per 100,000 people,[7] the KFH-South San Francisco service area has only one Federally Qualified Health Center (FQHC), one private dental practice, and four individual dentists that currently accept new Denti-Cal patients.[8] Local experts attributed this to Denti-Cal's low reimbursement rates and complicated billing procedures. They noted that only FQHCs receive a higher reimbursement rate for dental services, but the ratio of FQHCs to residents in the service area is significantly worse than the state's.

The KFH-South San Francisco service area has 23% more dentists than the statewide average of 80.3 per 100,000 people,[7] but the community feels they aren't accessible to the patients who need them the most.

SOURCES

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[2]Mayo Clinic. (2016). *Oral Health: Brush Up on Dental Care Basics.*
[3]Office of Disease Prevention and Health Promotion. (2018). *Oral Health.*
[4]Centers for Medicare and Medicaid Services, Providers of Service data file (2016), and U.S. Census Bureau Decennial Census population estimates (2010).
[5]UCLA Center for Health Policy Research, California Health Interview Survey. (2015–2016)
[6]University of Wisconsin's County Health Rankings, using data from the Environmental Protection Agency's Safe Drinking Water Information System. (2015).
[7]U.S. Department of Health and Human Services, Area Health Resource File (2015–2016).
[8]State of California, Medi-Cal Dental Program. (2018). Dentists Accepting New Patients by Specialty, and *San Mateo County Federally Qualified Health Centers, Rural Health Centers, and Tribal Health Centers*.

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