Sutter Health
CPMC

California Pacific Medical Center

Community Health Needs Assessment 2016–2018

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I. About California Pacific Medical Center

California Pacific Medical Center (CPMC) is an affiliate of Sutter Health, a not-for-profit health care system. CPMC was created in 1991 by the merger of Children's Hospital and Pacific Presbyterian Medical Center. In 1996, CPMC became a Sutter Health affiliate. In 1998, the Ralph K. Davies Medical Center merged with CPMC. Nine years later, in 2007, St. Luke's Hospital became the fourth campus of CPMC. Today, CPMC consists of four acute care campuses in San Francisco:

- The Pacific Campus (Pacific Heights) is the center for acute care, including oncology, orthopedics, ophthalmology, cardiology, liver, kidney, and heart transplant services.
- The California Campus (Laurel Heights) is the center for prenatal, obstetrics, and pediatric services.
- The Davies Campus (Castro District) is the center for neurosciences, microsurgery, and acute rehabilitation.
- The St. Luke's Campus (Mission District) is a vital, full-service community hospital serving residents in the South-of-Market districts. St. Luke's Campus also has one of the busiest emergency departments in the city.

These four locations have a total of 1,059 licensed beds, and 817 active beds. In addition to the acute care hospitals, CPMC manages outpatient clinics located at its St. Luke's and California campuses.

II. Executive Summary

This Community Health Needs Assessment (CHNA) takes a broad view of health conditions and status in San Francisco. It reviews conditions where San Franciscans are born, grow, live, work and age, local risk and protective factors for health, as well as local disease and death rates.

This CHNA report has as its foundation the CHNA report that was collectively developed by the San Francisco Health Improvement Partnership (SFHIP) – *San Francisco Community Health Needs Assessment 2016*. The processes and findings described within this document refer to those of SFHIP's 2016 needs assessment. SFHIP's original 2016 CHNA document can be found at www.sfhip.org.

The CHNA process involved four steps:

- Community health status assessment
- Assessment of prior assessments
- Community engagement
- Health needs identification and prioritization

Overall, the CHNA found that health has improved in San Francisco:

- More than 97,000 residents gained health insurance under the Affordable Care Act in 2014. Insurance coverage in San Francisco was higher than coverage across the state or nation.
- Overall rates of smoking declined from 20.8 percent in 1996 to 12.3 percent in 2014 and are approaching the Healthy People 2020 goal of 12.0 percent.
- Since 2006, we have had steady declines in HIV diagnoses.
- Between 2007 and 2013, the rates of death due to cardiovascular disease (ischemic heart disease and hypertensive heart disease), cerebrovascular disease, lower respiratory infections, and poisonings and drugs decreased.
- Between 2008 and 2010, the incidence rate of invasive cancers decreased.
- Rates of tooth decay among school children decreased between 2007–2008 and 2013–2014.

The CHNA identified two foundational issues contributing to local health needs:

- Economic barriers to health
- Racial health inequities

The CHNA identified seven health needs that heavily impact disease and death in San Francisco:

- Psychosocial health
- Healthy eating
- Safety and violence prevention
- Access to coordinated, culturally and linguistically appropriate services across the continuum
- Housing stability/homelessness
- Substance abuse
- Physical activity

The CHNA further prioritized and consolidated these seven needs into three “priority health needs”:

- Access to care
- Healthy eating and physical activity
- Behavioral health

III. PURPOSE AND COLLABORATORS

This Community Health Needs Assessment (CHNA) takes a comprehensive look at the health of San Francisco residents by presenting data on demographics, socioeconomic characteristics, quality of life, behavioral factors, the built environment, morbidity and mortality, and other determinants of health status.

This report was written in order to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a CHNA at least once every three years. Internal Revenue Service guidance for conducting the CHNA is provided by 26 CFR Parts 1, 53, and 602; final regulations were effective on December 29, 2014, and published in the Federal Register on December 31, 2014. This written report is intended to satisfy each of the applicable requirements set forth in those regulations. The required written plan of Implementation Strategy will be set forth in a separate document.

Federal requirements: Federal requirements included in the Patient Protection and Affordable Care Act (ACA) of 2010 stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a CHNA every three years. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to: collect and take into account input from public health experts as well as community leaders and representatives of high-need populations – this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; identify and prioritize community health needs; document a separate CHNA for each individual hospital; and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy to address the identified community health needs and submit a copy of the Implementation Strategy along with the organization's annual Form 990.

SB 697 and California's history with past assessments: For many years, San Francisco's nonprofit hospitals have partnered to conduct needs assessments to guide allocation of community benefit resources. In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. As part of SB 697, hospitals are also required to annually submit a summary of their community benefit contributions, particularly those activities undertaken to address the community needs that arose during the CHNA.

San Francisco Health Improvement Partnership (SFHIP): As a member of SFHIP, CPMC participates in a collective needs assessment process to ensure that our community benefit investments are responsive to real community health needs. SFHIP's *San Francisco Community Health Needs Assessment 2016* serves as the foundation for CPMC's Community Health Needs Assessment 2016–2018 (this document). The processes and findings described within this document refer to those of SFHIP's 2016 needs assessment. The original 2016 CHNA document collectively developed by SFHIP and prepared by SFDPH can be found at www.sfhip.org.

SFHIP is a collaborative body whose mission is to embrace collective impact and to improve community health and wellness in San Francisco. Membership in SFHIP includes:

- San Francisco Department of Public Health
- African American Community Health Equity Council
- Asian and Pacific Islander Health Parity Coalition

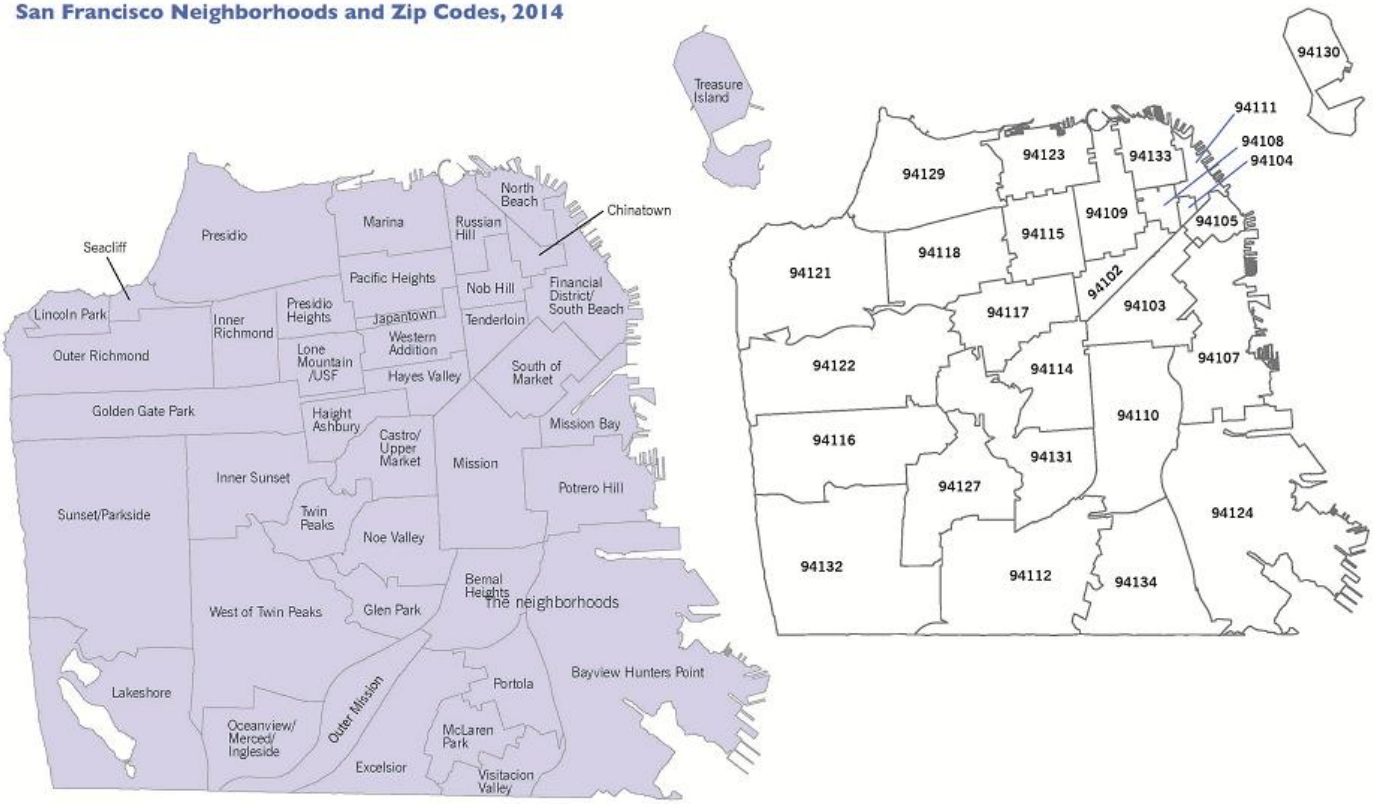
- Chicano/Latino/Indigena Health Equity Coalition
- Human Services Network
- Dignity Health Saint Francis Memorial Hospital
- Dignity Health St. Mary's Medical Center
- Sutter Health California Pacific Medical Center
- Kaiser Permanente
- Chinese Hospital
- San Francisco Community Clinic Consortium
- Metta Fund
- San Francisco Foundation FAITHS program
- San Francisco Unified School District
- San Francisco Mayor's Office
- UCSF Clinical and Translational Science Institute's Community Engagement and Health Policy Program

SFHIP completes a CHNA once every three years, which provides data enabling identification of priority issues affecting health and is the foundation for citywide health planning processes including the Community Health Improvement Plan, San Francisco's Health Care Services Master Plan, the San Francisco Department of Public Health's Population Health Division's Strategic Plan, and each San Francisco nonprofit hospital's Community Health Needs Assessment and Implementation Strategy.

IV. Service Area and Population

The hospital service area includes all populations residing in the City and County of San Francisco.

San Francisco Neighborhoods and Zip Codes, 2014



Population Growth

San Francisco is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. At roughly 47 square miles, it is the smallest county in the state, but is the most densely populated large city in California (with a population density of 18,187 residents per square mile) and the second most densely populated major city in the U.S., after New York City.[1]

Between 2010 and 2014, the population in San Francisco grew by 5 percent to 845,602, outpacing population growth in California (3.9 percent).[2,3] By 2030, San Francisco's population is expected to total nearly 970,000.[4]

An Aging Population

The proportion of San Francisco's population that is 65 years and older is expected to increase from 13.7 percent in 2010 to 19.9 percent in 2030.[4] The proportion of the population 75 years and older will increase from 6.9 percent to 9.8 percent. At the same time, it is estimated that the proportion of working age residents (25 to 64 years old) will decrease from 63.4 percent in 2010 to 57.7 percent in 2030. This shift could have implications for the provision of social services.

Population by age group as a percentage of the total population projections, San Francisco, 2010–2030[4]

Groups by age range in years	2010	2020	2030
Seniors (65+)	13.7%	17.1%	19.9%
Working age (25-64)	63.4%	61.6%	57.7%
College age (18-24)	9.6%	5.8%	6.7%
School age (5-17)	9.0%	10.4%	11.4%
Preschool age (0-4)	4.4%	5.1%	4.3%

Ethnic Shifts

In the past 50 years, the most notable ethnic shifts have been a steep increase in the Asian and Pacific Islander population and a decrease in the Black/African American population.[5,6] By 2030, growth is expected in the number of multi-ethnic and Latino residents, while the number of Black/African American residents will likely continue to drop.[4] The White population is expected to continue to increase in numbers, but will decrease as a percentage of the total population.

Ethnic composition by percentage of population, San Francisco, 2010 vs. 2030[4]

Ethnicity	2010	2030 Projected
White	42.1%	39.3%
Black/African American	5.8%	4.5%
Asian	33.3%	33.4%
Pacific Islander	0.4%	0.4%
Latino	15.1%	18.0%
Native American	0.2%	0.2%
Multi-ethnic	3.1%	4.1%

Currently, about one third of San Francisco's population is foreign born and 23 percent of residents speak a language other than English at home and speak English less than "very well."[1] The majority of the foreign-born population comes from Asia (64 percent), while 20 percent were born in Latin America, making Chinese (Mandarin, Cantonese, and other) (18 percent) and Spanish (12 percent) the most common non-English languages spoken in the city.

Families and Children

Although San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (36 percent), the number of school-aged children is projected to rise.[7]

As of 2013, San Francisco was home to 58,000 families with children, 29 percent of which were headed by single parents. There were approximately 114,000 children under the age of 18. Although the overall number of children under 18 decreased by 7 percent in the last 20 years, the number of school-aged children is projected to rise by 28 percent by 2020.[7]

The neighborhoods with the greatest proportion of households with children are: Seacliff, Bayview Hunters Point, Visitacion Valley, Outer Mission, Excelsior, Treasure Island, and Portola.

We present further details regarding San Francisco's population in Demographics Appendix A.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

The CHNA was guided by the principles of equity, alignment, promotion of community connections, increasing efficiency, catalyzing and prioritizing action, and understanding assets and alignment of solutions.

The CHNA was conducted from February to December 2015, and collected information on the health of San Franciscans using three methods: Community Health Status Assessment, Assessment of Prior Assessments, and Community Engagement. Through review of the comprehensive set of data provided by these sources, SFHIP identified and prioritized San Francisco's health needs.

Community Health Status Assessment

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[8] While biology, genetics, and access to medical services are largely understood to play an important role in health, social-economic and physical environmental conditions are now known to be major, if not primary, drivers of health.[8,9,10] These conditions are known as the *social determinants of health* and are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.[11]

Recognizing the essential role that social determinants of health play in the health of San Franciscans, the Community Health Status Assessment examined population-level health determinant and outcome variables. We used the San Francisco Framework for Assessing Population Health and Equity (see diagram in Appendix C), which is a modified version of the Public Health Framework for Reducing Health Inequities published by the Bay Area Regional Health Inequities Initiative to guide variable selection.[12] We ranked and selected available variables based on the Results-Based Accountability criteria for indicator selection – communication power (ability to communicate to broad and diverse audiences), proxy power (says something of central significance), and data power (available regularly and reliably), as well as the ability to examine health inequities and current use by stakeholders.[13] In all, 177 variables were analyzed.

We present a summary of the results from all data analyses in Appendix C's Community Health Data Summary.

Assessment of Prior Assessments

Over the years, a variety of valuable health needs assessments have been completed in San Francisco; therefore, we completed an assessment of assessments to ensure that this existing knowledge was integrated into the CHNA. We identified existing assessments by reaching out to community groups, city agencies and others, as well as through internet searches.

We included assessments in the analysis if:

1) they included primary data collection;
2) the primary data was available for San Francisco alone;
3) the primary data was collected in 2010 or later;
4) the data collection methods were identified; and
5) the assessment topic included social determinants of health or health outcomes.

Data extraction and analysis involved description of the populations assessed and the motivations for the assessments, as well as identification of health issues.

The Assessment of Prior Assessments included 21 existing health assessments that engaged community members representing a broad spectrum of San Francisco residents. These assessments identified the following community health needs: safety and violence; drugs and alcohol (including personal addiction and effects on community); access to healthy food; housing; poverty and employment; mental health; and services and resources (health care, food access programs, recreational activity opportunities, education).

Further details on methods used and findings are presented in the Assessment of Prior Assessments section of Appendix B.

Community Engagement

The goals of the community engagement component of the CHNA were to:

- Identify San Franciscans' health priorities, especially those of vulnerable populations;
- Obtain data on populations for which we have little quantitative data;
- Build relationships between the community and SFHIP;
- Meet the regulatory requirements including the IRS rules for charitable 501(c)(3) hospitals, Public Health Accreditation Board requirements for the San Francisco Health Department, and San Francisco's Planning Code requirements for a Health Care Services Master Plan.

We worked with community partners to co-host community meetings with target populations. Target populations were selected based on four factors:

1) the population has known health disparities;
2) little information describing the health of the population was available;
3) the population was not included in a recent health assessment; and
4) the population was reachable through an existing community group.

Where possible, we joined existing meetings in an effort to increase efficiency and facilitate participation by residents. Successful community engagement would not have been possible without the contributions of these community partners:

- Asian Americans Advancing Justice – Asian Law Caucus
- African American Art and Culture Complex
- Asociación Mayab
- CARECEN
- Filipino American Development Foundation
- Instituto Familiar de la Raza
- Larkin Street Youth Services
- SF LGBT Community Center
- Native American Health Center
- On Lok 30th Street Senior Center
- Swords to Plowshares
- Transitions Clinic

We facilitated all meetings using two Technology of Participation techniques – the Focused Conversation Method and the Consensus Workshop Method.[14] The main question we asked of participants was, *What actions can we take – including residents, community groups, and SFHIP – to improve health?* Participants were also asked about the assets and barriers which exist in their communities regarding health.

In total, 127 participants attended 11 meetings between July 1 and October 2, 2015. Participants came from a variety of backgrounds. The ethnic groups with the largest representation in the meetings were Latino (23 percent), Black/African American (15 percent), White (17 percent), and Asian (12 percent). Other self-reported ethnicities included Arab, Filipino, Jewish, Middle Eastern, and Native American. The majority of participants were female (59 percent).

At the meeting we identified these community health priorities: access to healthy foods and physical activity opportunities, safe and affordable housing, health education and empowerment, economic opportunities, clean and safe parks, restrooms, and other shared environments, and access to health care services that are culturally and linguistically appropriate.

Further details on the methods and findings are available in Appendix B's "2016 CHNA Community Engagement" section**.**

Health Needs Identification and Prioritization

To identify and prioritize the most significant health needs in San Francisco, SFHIP members met in October, November and December of 2015.

Participants identified health needs through a multistep process. First, participants reviewed data and information from the Community Health Status Assessment, the Assessment of Prior Assessments, and the Community Engagement, as well as the health priorities from the 2013 Community Health Needs Assessment. Then, using the Technology of Participation approach to consensus development, participants engaged in small-group, focused discussions about the data. Finally, participants developed consensus on the health needs by using the following steps:

1) Individually listing top health needs;
2) Small group discussions on the top health needs to identify similarities and differences;
3) Sharing all the health needs identified by the individuals;
4) Clustering the similar health needs into themes;
5) Determining a name for the theme, which is the health need;
6) Comparing and discussing new needs with those from the 2013 Community Health Needs Assessment.

Health needs were screened using the following pre-established criteria:

- The need is confirmed by more than one indicator and/or data source;
- The need performs poorly against defined, measurable benchmark(s).

Through this process, two foundational issues and seven health needs were identified. *Health needs* include health outcomes of morbidity and mortality as well as behavioral, environmental, clinical care, social and economic factors that impact health and well-being. *Foundational issues* shape the context from which health needs emerge, affect health at every level, and must be addressed to improve health in San Francisco.

The two foundational issues identified were:

- Economic barriers to health
- Racial health inequities

The seven health needs identified were:

- Psychosocial health
- Healthy eating
- Safety and violence prevention
- Access to coordinated, culturally and linguistically appropriate services across the continuum
- Housing stability/homelessness
- Substance abuse
- Physical activity

The following Findings/Needs Identified section of this report highlights aspects of the data describing each of the foundational issues and health needs listed above.

With the goal of prioritizing and consolidating these health needs, SFHIP Steering Committee members each scored them according to how they believe each need measures against the following criteria:

- Severity of need
- Disparity in community
- Priority of the community
- Feasibility of intervention/impact

Needs were further refined based on the following observations:

- Homelessness cuts across many needs and can be addressed as an equity issue rather than a need.
- We have made significant strides in providing access to care through health insurance coverage. The real need with regard to health care is the quality of the services being offered – specifically, that they be culturally and linguistically appropriate.
- Safety and violence prevention is important and cannot be ignored but may be best addressed as a strategy for improving health rather than a need. Similarly, housing stability was identified as a strategy.
- Equity will be addressed through the following:
    - In the process of health needs identification, the health needs were evaluated with consideration for equity.
    - SFHIP will develop and select objectives and strategies that directly address the most vulnerable and at-need populations.

The three resulting “priority health needs” are:

- Access to care
- Healthy eating and physical activity
- Behavioral health

VI. FINDINGS / NEEDS IDENTIFIED

FOUNDATIONAL ISSUES

Economic Barriers to Health

Income generally confers access to resources that promote health – like good schools, health care, healthy food, safe neighborhoods, and time for self-care – and the ability to avoid health hazards such as air pollution and poor-quality housing.

Low-income groups are at greater risk of a wide range of health conditions than higher income groups, and have a shorter life expectancy.[15]

People who live in communities with higher income disparity are more likely to die before the age of 75 than people in more equal communities.[16]

More than half of new jobs in San Francisco are expected to be low-wage (less than $54,000/year), service sector jobs.[17,18]

For a family of four, the federal poverty level is $24,250 (2015).[19]

- Almost 1 in 3 San Franciscans (211,000 people) live below 200 percent of the federal poverty level.[1]
- 14 percent of children live in poverty.[16]
- In San Francisco, there is significant inequality in household income between races: White household median income is over $100,000, while Black/African American household median income is $30,000.[20]

San Francisco shows significant disparities in unemployment rates between Whites and Black/African Americans.

- Less than 5 percent of White San Franciscans are unemployed, while almost 18 percent of Black/African Americans are unemployed.[21]
- Black/African Americans are less than half as likely as Whites to have at least a Bachelor's degree and 5 to 10 times more likely to have less than a high school education.[1]

San Francisco has the highest income inequality in California. Between 2007 and 2014, the widening income gap was driven primarily by increasing incomes among the highest earners while incomes among lower earners stagnated.[22]

- The wealthiest 5 percent of households in San Francisco earn 44 times more than the poorest 20 percent of households.[1]

Having a low household income impacts lifetime health, beginning with pregnancy and birth. Lower-income children in San Francisco experience higher rates of asthma, hospitalization, obesity, and dental caries.[23,24,25] Low birth weight is highest among low-income mothers.[26]

Racial Health Inequities

Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from unevenly distributed systematic social, economic, and environmental obstacles that impact risk, prevention, and treatment of health problems.[27,28] Health inequities are issues of social justice and human rights.[29]

All San Franciscans do not have equal opportunity for good health. Obstacles to health are unevenly distributed between racial/ethnic groups. While health inequities are felt by all racial and ethnic communities, Black/African Americans experience inequities to a greater degree. A persistent, consistent pattern emerges when examining San Francisco health data by race and ethnicity: Black/African American residents face the greatest social, economic, and environmental hardships and consequently have the highest rates of acute and chronic disease, injury, and disability, and ultimately lower life expectancy.

Below is a data sample focusing on disparities for Black/African Americans. (The needs assessment also looked at disparities for other ethnicities – see Appendix C's Community Health Data Summary.)

Unevenly distributed obstacles to health

Variable	White	B/AA
No prenatal care in first trimester[30]	5%	36%
Children 0-18 living in poverty*[7]	2%	48%
Not exclusively breastfed in first weeks[30]	9%	33%
Child neglect or abuse, age 0-18[31]	5/10,000	40/10,000
Not proficient on English language standardized test in 3rd grade[32]	19%	76%
Did not meet 5th grade fitness standards[33]	26%	48%
Did not graduate from high school[1]	16%	63%
Unemployed[21]	4%	18%
Arrests[34]	45%	40%
Homelessness[35]	39%	36%

*Poverty = household income <100% FPL

Health inequities

Variable	White	B/AA
Unintended pregnancy[30]	18%	69%
Born preterm[36]	7%	16%
Asthma hospitalizations at ages 0-4[23]	11/10,000	72/10,000
Experienced cavities by kindergarten[25]	17%	40%
Overweight or obese by 5th grade[24]	23%	50%
Overweight/obese as an adult[37]	33%	60%
Emergency room visits due to assault[38]	39/10,000	24/10,000
Diabetes hospitalization[23]	6/10,000	40/10,000
Disability[37]	26%	41%
Major depression hospitalization[23]	9/10,000	14/10,000
Have high blood pressure[37]	18%	47%
Invasive cancer[39]	451/100,000	571/100,000
Tuberculosis[40]	3/100,000	22/100,000
Years of life expectancy[41]	81	71

Whites and Black/African Americans make up similar percentages of arrested and homeless persons, but there are seven times more White than Black/African American residents in San Francisco.[34]

On average, Black/African American residents live 10 years less than Whites, 14 years less than Asians and Pacific Islanders, and 11 years less than Latinos(as).[41]

Black/African American residents disproportionately live in poverty; lack access to a healthy diet; experience and witness violence; fall behind in education; are unemployed; are homeless; and experience negative effects of substance abuse and mental illness. Frequent and/or prolonged challenges can result in toxic stress, which disrupts brain and organ development in young children and increases risks for serious cognitive and chronic health conditions over the lifetime.[42,43]

Hurdles to a healthy life start early in San Francisco.

- 36 percent of Black/African American mothers do not receive prenatal care in the first trimester. Only 5 percent of White mothers do not.[30]
- 48 percent of Black/African American children live in households earning less than 100 percent of the federal poverty level. Only 2 percent of White children do.[7]
- 76 percent of Black/African American 3rd graders score lower than proficient on English language standardized tests. Only 19 percent of White students do.[32]

Health inequities also start early in San Francisco.

- The rate of asthma hospitalizations among Black/African American children aged 0 to 4 years is 6.5 times higher than among White children.[23]
- 50 percent of Black/African American 5th graders are overweight or obese.
- Black/African American 5th graders are 2 times more likely to be overweight or obese than White 5th graders.[24]
- 2.4 times more Black/African American children have cavities by kindergarten than White children.[25]

There has been a Black/African American exodus from San Francisco.[44,45] Since a high of nearly 88,000 in 1970, out-migration has led to notable declines in the Black/African American population.

- Between 1990 and 2005 the Black/African American population decreased by 41 percent – from almost 79,000 to less than 47,000.

The out-migration was largely led by middle and upper-middle class Black/African Americans. Between 1990 and 2005, the proportion of very low-income households increased from 55 percent to 68 percent.

- In 2014, Black/African Americans accounted for less than 6 percent (45,000) of the total population in San Francisco.

HEALTH NEEDS

Psychosocial Health

Mental Health is part of community health. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to the community.[46,47]

Mental illness, by contrast, includes all diagnosable mental disorders or conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired

function. Mental disorders include depression, schizophrenia, anxiety, injuries to the brain, dementias, intellectual disabilities, developmental disorders, and substance abuse.[46]

Risk factors for mental health disorders include individual (e.g., genetics, stress, thinking patterns) and environmental (e.g., social, cultural, economic) factors.[46,48,49] Mental illness is elevated among certain vulnerable populations such as the homeless, the incarcerated, and those leaving the child welfare system.[50,51] Social disadvantage is also a prominent risk factor for mental disorder.[52,53]

Mental health is an important part of community health. Mental illnesses, including substance use disorders, are the leading causes of years lived with disability worldwide.[54] Presence of mental illness can adversely impact the ability to perform across various facets of life – work, home, social settings – and it also impacts the families, caregivers, and communities of those affected.[49] Depressed youth are more likely to engage in risk-taking behaviors including using drugs, practicing unsafe sex, attempting suicide, and running away from home and are less likely to succeed in school and, possibly, later life.

Adult psychological distress is reported more often among certain populations.

- Serious psychological distress is reported by 9 percent of adults, and some groups experience even greater frequency.[55]
- Lower income residents are 2.5 times more likely to experience distress than residents from wealthier households (10 percent compared to 4 percent).[56]
- 55 percent of chronically homeless individuals acknowledge having a psychological or emotional condition.[57]
- 23 percent of all city residents report needing emotional help and support although some groups less often reported the need.[55]
- Only 10 percent of Asian and Pacific Islander residents report needing help.[37]

Hospitalizations in San Francisco[23] to treat major depression among adults occurred 1,852 times during the three years between 2012 and 2014. The number of hospitalizations for major depression exceeded that of adult asthma or hypertension.

Hospitalization rates for adult major depression are highest in zip codes 94102 and 94103. These rates are elevated among Whites, Black/African Americans, and certain age groups:

Whites	90 hospitalizations/100,000 residents
Black/African Americans	140 hospitalizations/100,000
Adults 18–24 years	110 hospitalizations/100,000
Adults 45–64 years	110 hospitalizations/100,000

Asians and Pacific Islanders are the least likely to be hospitalized for major depression:
27 hospitalizations per 100,000 residents.

Suicide is the eighth leading cause of death in San Francisco.[58]

- 337 San Franciscans committed suicide in the four years between 2010 and 2013.
- Whites have the highest rates of suicide (19 per 100,000). Despite low hospitalization rates and low reporting of needing help, Asians and Pacific Islanders have the second highest rates of suicide (9 per 100,000).
- Suicide completion is most common among men (75 percent).
- 49 is the average age of death for those who complete suicide.

Depressive symptoms are common among San Francisco school-aged youth. Some groups express greater incidence of prolonged sadness that interferes with usual activities while other groups experience less.

- 53 percent of Gay or Lesbian students report prolonged sadness – twice the rate of heterosexual students (24 percent).[59]
- 35 percent of Filipino and 37 percent of Latino students report prolonged sadness.[59]
- 26 percent of San Francisco high school students report episodes of prolonged sadness.[59]
- 17 percent of Filipino, Latino, and White high school students consider suicide.[59]
- 13 percent of high schoolers and 15 percent of middle schoolers consider suicide.[59]

Addressing high rates of psychological distress requires a culturally sensitive approach. Ethnic groups show differences that are complex and may represent stigma, lack of availability of culturally competent services, or other barriers preventing access to needed preventative and treatment services.

- Asian and Pacific Islander residents report needing help less often and are less often hospitalized for depression, but have the second highest rate of suicide.[37]
- White residents have higher rates of accessing hospitalization services, but also higher rates of completing suicidal acts.[23,58]
- Black/African American residents have the highest rate of hospitalization for major depression.[23]

Healthy Eating

Good nutrition means getting the right amount of nutrients from healthy foods and drinks. Good nutrition is essential from infancy to old age.

The USDA's MyPlate.org recommends that fruits and vegetables make up at least half of our plate, or approximately five servings a day.[60]

Leading medical and health associations recommend drinking water instead of sugary drinks.[61] The Institute of Medicine recommends 13 cups of liquids per day for men and 9 cups for women who live in temperate climates.[62]

A healthy diet promotes health and reduces chronic disease risk. It is critical for growth, development, physical and cognitive function, reproduction, mental health, immunity, stamina, and long-term good health.[63]

- Many San Franciscans do not eat enough fruits and vegetables. 2 out of 3 youth and 4 out of 5 adults do not eat 5 or more servings of fruits or vegetables daily.[63,64]
- Many San Franciscans do not drink enough water. 1 out of 3 adults drinks less than 4 glasses of water per day.[37]
- Many do drink sugary drinks. 1 out of 3 adults consume at least one sugar-sweetened beverage a day.[37]

Many factors influence healthy eating, including cost and income, food availability, transportation, time, availability of facilities to store and cook foods, and food preferences. Factors vary across the city and result in neighborhood differences in consumption.

- Many cannot afford healthy foods. 44 percent of adults living below 200 percent of the federal poverty level are not able to afford enough food at some time during the year.[55]

- Not everyone has access to a kitchen. According to the American Community Survey, approximately 20,756 occupied housing units in San Francisco do not have complete kitchen facilities.[21]
- Healthy foods are not evenly distributed across the city. Some neighborhoods, including Chinatown, have a dense array of food options, while others, especially Oceanview/Merced/ Ingleside, Bayview Hunters Point, Visitation Valley, and Treasure Island, have less access to healthy food outlets.[65]
- Not cooking is the new normal. On average, San Francisco area households spend 48 percent of their food dollars on foods and nonalcoholic beverages prepared away from home, such as meals from restaurants and school or workplace cafeterias, or vending machines.[66]
- Unfamiliar fruits and vegetables are scary. Childcare providers participating in the Child and Adult Care Food Program who serve low-income children in San Francisco report that children are unwilling to eat unfamiliar fruits and vegetables.

Safety and Violence Prevention

Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. Witnessing violence is linked to lifelong negative physical, emotional and social consequences.[67,68,69,70]

Community violence decreases the real and perceived safety of a neighborhood, disrupting social networks by inhibiting social interactions, causing chronic stress among residents who are worried about their safety, and acting as a disincentive to engage in physical activity outdoors.[71,72,73,74]

Children are particularly vulnerable. Witnessing and experiencing violence disrupts early brain development and causes longer term behavioral, physical, and emotional problems, including perpetrating or being a victim of violence, depression, suicide attempts, smoking, obesity, high-risk sexual behaviors, school absenteeism, unintended pregnancy, eating disorders, and alcohol and drug abuse.[67,68,69,70]

Violence is rarely caused by a single risk factor but instead by the presence of multiple risk factors. Some risk factors for violence are: poverty, poor housing, illiteracy, alcohol and other drugs, mental illness, community deterioration, discrimination and oppression, and experiencing and witnessing violence.[75,76,77]

Violent crime is a concern in San Francisco. From 2007 to 2014, the rate of homicides decreased; however, violent crime rates are high and exceed California rates, and aggravated assaults are at a 10-year high.[78]

Men, people of color, and residents of the Eastern neighborhoods are most likely to be victims of violence. Violent crime rates and rates of emergency room visits due to assault are highest in the Eastern half of the city. Residents are less likely to feel safe in these neighborhoods.[79]

- 155 males died violent deaths between 2010 and 2013. Violence is the sixth leading cause of death among Black/African American men in the city.[41]
- Violence kills men in their prime years; 36 was the average age at death for men who died violently.[41]

Some data suggest an uptick in violence in the home.

- Since 2008, the rate of 911 calls reporting domestic violence has increased by 21 percent, to 953 calls per 100,000 residents in 2014. 36 percent of these calls reported injuries.[80]
- But, simultaneously, substantiated cases of child abuse have decreased by 50 percent, from 260 to 120 incidents per 100,000 children.[31]

Emergency room visits due to assault increased between 2006–2008 and 2012–2014.[38] The rate of emergency room visits due to assault is highest in the Eastern half of San Francisco.

- Emergency room visit rates are 1.2 times higher among Latinos and 5 times higher among Black/African Americans than other San Francisco residents.

Many San Franciscans do not feel safe in their neighborhoods.

- 18 percent of residents feel unsafe walking alone at night.[81]
- Women (27 percent) are 2 times more likely to feel unsafe at night than men (12 percent).[81]
- Asians (21 percent), Latinos (28 percent), and Black/African Americans (27 percent) are more likely to feel unsafe walking at night than Whites (13 percent).[81]
- Eastern neighborhood residents are less likely to feel safe.[81]

Access to Coordinated, Culturally and Linguistically Appropriate Services across the Continuum

Healthy People 2020 defines access to health care as "the timely use of personal health services to achieve the best possible health outcomes."[82]

Access is influenced by availability of providers, location, affordability, hours, and cultural and linguistic appropriateness of health care services. Accessible health care can prevent disease and disability, detect and treat illnesses, maintain quality of life, and extend life expectancy.[83]

From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations and can save public and private dollars.

While access to health care in San Francisco is better than many other places, significant disparities exist by race, age, and income.

San Francisco's population now numbers over 850,000 people. Many San Franciscans do not access health care:

- While over 97,000 San Franciscans gained health insurance in 2014 under the Affordable Care Act, an estimated 7.3 percent of residents, 60,877, still do not have health insurance.[84,20]
- 13 percent do not have a usual place to go for medical care.[85]
- 41 percent of adults have not had a routine check-up in the past year.[85]
- 42 percent have not had a flu shot in the past year.[85]
- 40 percent of women ages 18 to 44 have not received counseling or information about birth control from a doctor or medical provider in the past year.[85]
- 22 percent of women with public safety-net insurance do not receive timely prenatal care.[30]
- 35 percent of adults have not seen a dentist in the past year.[85]

- 60 percent of Denti-Cal eligible infants ages 0 to 3 years do not access dental care.[25]
- Young adults are at risk. Young adults 18 to 34 years of age and people of color are less likely to be covered by insurance.[20]

Residents covered by public safety-net insurance do not receive preventative prenatal care at the same rate as those with private insurance.

- In 2012, 95 percent of mothers with private insurance received prenatal care in the first trimester.[30]
- Only 78 percent of those with Medi-Cal received early prenatal care.[30]

Preventable hospitalizations and emergency room visits:

- While preventable hospitalizations for most causes have decreased over time, preventable hospitalizations for diabetes and hypertension have increased – potentially indicating that these conditions are not being well managed at the population level.[23]
- Preventable hospitalizations and ER visits are significantly higher among Black/African Americans compared to all other ethnicities in San Francisco.[38]
- Similarly preventable ER visits are much higher among adults 18 to 24.[38]

Language barriers and cultural competency of services are serious barriers to receiving quality care. Those with limited English proficiency are more likely to report problems understanding a medical situation, trouble understanding labels, and bad reactions to medications.[86]

Housing Stability/Homelessness

Shelter is a basic human need. Sub-standard housing quality, overcrowding, housing instability, and homelessness impact health by decreasing opportunity for self-care (sound sleep, home-cooked food, warmth, hygiene) and increasing risk exposure.[87]

Housing instability and homelessness compound health risks for vulnerable population groups (e.g., low income, seniors, disabled, mentally ill) in San Francisco.[87]

Those who pay more than 30 percent of their income on housing costs are at risk for foreclosure, eviction, or homelessness if they experience a dip in income.[88] Those paying over 50 percent are at extreme risk. Spending a high proportion of income on rent also means fewer resources are available for other needs including food, heating, transportation, health care, and childcare.[87]

From 2013–2015, 81 percent of the 186 homes inspected as part of the Supplemental Nutrition Program for Women Infants and Children (WIC) had environmental health hazards.[89]

Fifty-one thousand people in San Francisco live in crowded conditions.[1] Living in overcrowded conditions can increase risk for infectious disease, noise and fires.[87]

The number of all-cause evictions has steadily increased since 2010. In 2014–2015 there were 2,120 evictions.[90] Moving can result in the loss of employment, difficult school transition, increased transportation costs, and the loss of health-protective social networks.[87]

Over 7,500 people are homeless in San Francisco; 18 percent reported eviction, increased housing costs, or foreclosure as the primary reason for homelessness.[57] Among the many dangers homeless persons face – including those in temporary housing – safely storing medications, eating healthfully, and going to the doctor are difficult when trying to find a place to sleep each night.[91,92]

Housing affordability:

- Between 2000 and 2012, the median rent in San Francisco increased by 22 percent.[93]
- It takes 6 working adults earning minimum wage to afford a two-bedroom, market-rate apartment.[90]
- A typical San Franciscan spends 41 percent of their income on rent.[1]
- 22 percent of all renter households spend more than 50 percent on rent.[1]

Substance Abuse

Many factors affect the decision to start and continue using tobacco, alcohol and other drugs, including: substance abuse among friends and family, poor academic performance, unstable family and social relationships, exposure to abuse, availability, exposure to advertising, mental illness, and poverty.[94]

The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. The earlier a person begins to use drugs and alcohol, the more likely he or she is to develop serious problems. Harms associated with substance abuse include: unintended pregnancy and STD transmission, poor academic performance, cognitive functioning deficits, motor vehicle crashes, violence, mental and behavioral disorders (unipolar depressive disorders, epilepsy, and suicide), injury and death.[95,96,97,98,99,100,101] Unintentional poisoning is now the leading cause of injury death among adults nationwide, surpassing motor vehicle accidents.[101] In 2012, alcohol was associated with 31 percent of motor vehicle crashes.[100]

Binge drinking is defined as five or more drinks for men, four or more drinks for women, consumed on one occasion. Fifty percent of men and 25 percent of women binge drink.[99]

- 33 percent of Californians overall binge drink.[55]
- 39 percent – two out of five – of San Franciscans binge drink.[55]
- 15 percent of total food expenditures in the home are for alcohol.[102]

Substance abuse is a risk factor for seven of the top ten causes of death in the city: lung cancer, COPD, heart failure, stroke, hypertensive heart disease, Alzheimer's and organic dementias, and poisonings.[41]

The number of hospitalizations due to acute and chronic alcohol abuse is greater than for diabetes, hypertension, or COPD.[23]

- Between 2012 and 2014, 2,394 hospitalizations and 4,647 emergency room visits resulted from acute and chronic alcohol abuse. That is 798 hospitalizations and 1,549 emergency room visits per year.[23,38]
- Between 2012 and 2014, the Sobering Center received almost 13,000 emergency room diversions due to alcohol intoxication.[103]
- Neighborhoods with the highest density of off-sale alcohol outlets coincide with those with higher rates of hospitalizations and emergency room visits due to alcohol.[38,104]

Drug and alcohol abuse contribute to homelessness in San Francisco.

- 18 percent of homeless persons report drug and alcohol abuse as the primary cause of their homelessness.[57]
- 62 percent of chronically homeless persons have a drug or alcohol abuse condition.[57]

Significant gains against smoking have been made, but not everybody has benefited from tobacco control policies and education campaigns. Between 1996 and 2012, the smoking rate declined by 41 percent.[105] However, 11 percent of San Franciscans still smoke.[55] Young adults, people of color, low-income earners and LGBTQ residents are disproportionately affected by tobacco.

- Young adults 18 to 24 years are more likely to smoke than those 25 and older (16 percent vs. 10 percent).[99]
- Gay and Lesbian students are more likely to smoke than their heterosexual peers (11 percent vs. 9 percent).[106]
- Black women are over 12 times more likely to be smokers prior to pregnancy than are all other new mothers (12 percent vs. 1 percent).[26]
- Lower income earners are 45 percent more likely to smoke than those who earn more (14 percent vs. 9 percent).[99]

San Francisco spends nearly $400 million a year on tobacco-related costs, including medical expenses, loss of productivity, and secondhand smoke exposure.[107]

Districts in San Francisco with higher concentrations of smokers, ethnic minorities, and youths are associated with a higher density of tobacco retailers, despite the fact that all the districts have approximately the same number of residents.[108,109]

Secondhand smoke is a problem in densely populated San Francisco. In 2014, 40 percent of residents experienced at least some degree of drifting smoke into their home.[110]

Youth in San Francisco are at risk of substance abuse.

- 28 percent of SFUSD high school students smoke marijuana. SFUSD students are more likely to smoke marijuana than their national peers (23 percent).
- 14 percent of SFUSD high school students use methamphetamines, inhalants, ecstasy or cocaine.
- 11 percent of SFUSD high school students abuse prescription drugs.
- 10 percent of SFUSD high school students binge drink.[111]

There is growing concern that electronic cigarettes may cause addiction among non-smokers and reverse decades of anti-smoking efforts.

- Between 2011 and 2012, the percentage of youth using e-cigarettes nationally increased from 4.7 to 10 percent.[112]
- In San Francisco, 17 percent of high school students tried e-cigarettes while only 8 percent used cigarettes.[107]

Physical Activity

Regular exercise extends lives. The World Health Organization (WHO) recommends that children and adolescents (aged 5 to 17 years) should do at least one hour of moderate to vigorous physical activity daily, while adults (aged 18 years and above) should do at least 150 minutes of moderate-intensity physical activity, 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate and vigorous activity throughout the week.[113]

Just 2.5 hours of moderate-intensity aerobic physical activity each week is associated with a gain of approximately three years of life.[114]

Walking is a simple, affordable way for people to get around. A walkable city provides a free and easy way for people to incorporate physical activity into their daily lives as they walk to work, to school, to the market, to transit or other nearby services, or just for fun.[115]

Many San Franciscans don't spend the recommended amount of time doing physical activity.

- Scheduled daily physical activity at childcare centers varies from less than 45 minutes to more than 2 hours.[116]
- Fewer than 1 in 5 high school students is active for 60 minutes each day.[117]
- Only 25 percent of adults spend enough time physically active by walking for transport and 33 percent by walking for leisure.[118]

Many San Franciscans don't walk.

- 47 percent of kindergarten students live within a mile of school, but only 28 percent of kindergarten students walk or bike to school.[119]
- 42 percent of 5th graders live within a mile of school, but only 25 percent of 5th graders walk or bike to school.[119]

The six main barriers to walking in San Francisco are: lack of time, violence or criminal activity, unclean sidewalks, hills or steep streets, medical conditions, and speeding vehicles.[118]

- 1 out of 3 older adults reports a medical condition as a main barrier to walking.[118]
- 14 percent of adults report not walking because of fear of violence or crime.[118]

Neighborhood resources for physical activity:

- Consistent with less parking availability, less car ownership, better transit access, sense of safety, and closer goods and services, residents in the Northeast neighborhoods engage in more walking and biking each day than those in Southern neighborhoods.[119]
- The average adult in Northeast San Francisco spends 40 minutes per day walking or biking for daily errands, and meets his or her recommended minutes of physical activity with these trips alone.[120]
- In other parts of San Francisco, such as Bayview Hunters Point and Oceanview, the average adult spends as little as 15 minutes walking or biking for transportation.[120]

VII. Community Assets Available to Respond to the Identified Health Needs

See Appendix D for health care assets maps showing the locations of hospitals, primary care clinics, skilled nursing facilities, substance abuse disorder providers, and mental health providers, in relation to the neighborhoods where residents most in need of those services live.

In addition to San Francisco's acute not-for-profit community hospitals, a university hospital that serves as a tertiary care center, and the Department of Public Health, which operates an acute hospital/trauma center and a long-term hospital along with many community clinics, there are numerous community agencies that provide direct services, education and/or advocacy.

A unique asset for San Francisco is Healthy San Francisco, a universal health care program created by the City of San Francisco that makes health care services accessible and affordable for uninsured residents. The program offers a new way for San Francisco residents who do not have health insurance to have basic and ongoing medical care. It is available to all San Francisco residents regardless of immigration status, employment status, or pre-existing medical conditions. San Francisco residents with an income at or below 500 percent of the federal poverty level ($59,400 for one person; $121,500 for a family of four) are eligible to enroll in this one-of-a-kind access program.

Below is a list of the 2016 assessment's priorities with some available community assets and resources identified to respond to each need:

Priority 1: Access to Care
Some community assets and resources available to respond to this need:

- Health Reform as a driver toward primary care home as well as integration and coordination
- Healthy San Francisco
- Strong interagency and community collaboration – e.g., SFHIP, Children's Oral Health Collaborative, Tenderloin Health Improvement Partnership, SFDPH's Black/African American Health Initiative Project, API Health Parity Coalition, San Francisco Kindergarten Dental Screening Project
- Community-based organizations that focus on physical health and the social determinants of health
- San Francisco system of care (SFDPH, nonprofit hospitals, community clinics, private providers)

Priority 2: Healthy Eating and Physical Activity
Some community assets and resources available to respond to this need:

- Strong interagency and community collaboration to improve nutrition – e.g., SFHIP, Southeast Food Access Working Group, Tenderloin Healthy Corner Store Coalition, Healthy Retail SF, Food Security Task Force (San Francisco Board of Supervisors), San Francisco WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children)
- Strong interagency and community collaboration to improve opportunities for physical activity – e.g., Sunday Streets, WalkFirst, Bayview HEAL Zone, Safe Routes to School, Shape Up SF Coalition, Healthy Hearts SF, SFUSD Wellness Policy, Walk SF, Vision Zero Network
- Community-based organizations such as YMCA, CARECEN (Central American Resource Center)
- Strong network of existing and well-maintained parks
- Current assessment efforts: Communities of Excellence in Nutrition, Physical Activity, and Obesity Prevention (CX^3)

Priority 3: Behavioral Health
Some community assets and resources available to respond to this need:

- Strong interagency and community collaboration – e.g., SFHIP's Alcohol Policy Partnership Working Group, Our Children Our Families Council, San Francisco Tobacco-Free Project
- Community-based organizations such as Family Service Agency of San Francisco, Jewish Family and Children's Services, Project Homeless Connect, Mission Council on Alcohol Abuse for the Spanish Speaking, Asian American Recovery Services, 3rd Street Youth Center & Clinic, Larkin Street Youth Services, Phatt Chance Community Services, Bayview Hunters Point Foundation, Homeless Children's Network, Homeless Youth Alliance, Richmond Area Multi-Services, NAMI (National Alliance on Mental Illness), Jelani House, San Francisco Child Abuse Prevention Center, Conard House, Progress Foundation, Community Behavioral Health
- San Francisco system of care (SFDPH, nonprofit hospitals, community clinics, private providers)

VIII. Soliciting for Public Comments

CPMC is soliciting for public comments to help inform the development of its next Community Health Needs Assessment. You have the opportunity to review this CHNA and corresponding Implementation Strategy, and submit comments on either document to SHCommBene@sutterhealth.org. All comments received will be considered as part of the community input component in the development of CPMC's Community Health Needs Assessment 2019–2021.

CPMC requested written comments from the public on its 2013 Community Health Needs Assessment and corresponding Implementation Strategy through its website www.cpmc.org. At the time of the development of this CHNA report, CPMC had not received any written comments. However, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community we serve for the 2016 CHNA through the process documented in Section V of this report. CPMC will continue to use its website as a tool to solicit for public comments, and will ensure that these comments are considered community input in the development of future CHNAs.

IX. Evaluation of Impact of Actions Taken Since the Previous CHNA

An important component of this CHNA report is an evaluation of the impact of any actions that were taken since CPMC finished conducting its immediately preceding CHNA to address the significant health needs identified three years ago.

Appendix E uses the framework of the 2013 Implementation Strategy that described how CPMC planned to address each identified significant health need, and lists the impacts achieved for each of the programs where CPMC provided services and/or resources in 2014 and 2015.

X. Next Steps

Utilizing the City and County's Community Health Assessment, California Pacific Medical Center's Community Benefit Department will meet to review and discuss the hospital's existing community benefit activities and assets in regard to each priority, and identify opportunities for collaboration in order to enhance impact and avoid unnecessary duplication of services.

The next phase will include developing an implementation strategy for each health need identified, building on current assets and resources. The implementation plan will incorporate evidence-based strategies wherever possible and take into account Sutter Health goals and metrics.

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San Francisco Community Health Needs Assessment 2016

Appendices

PHOTOGRAPH: PHOTOEVERYWHERE / STOCKARCH.COM

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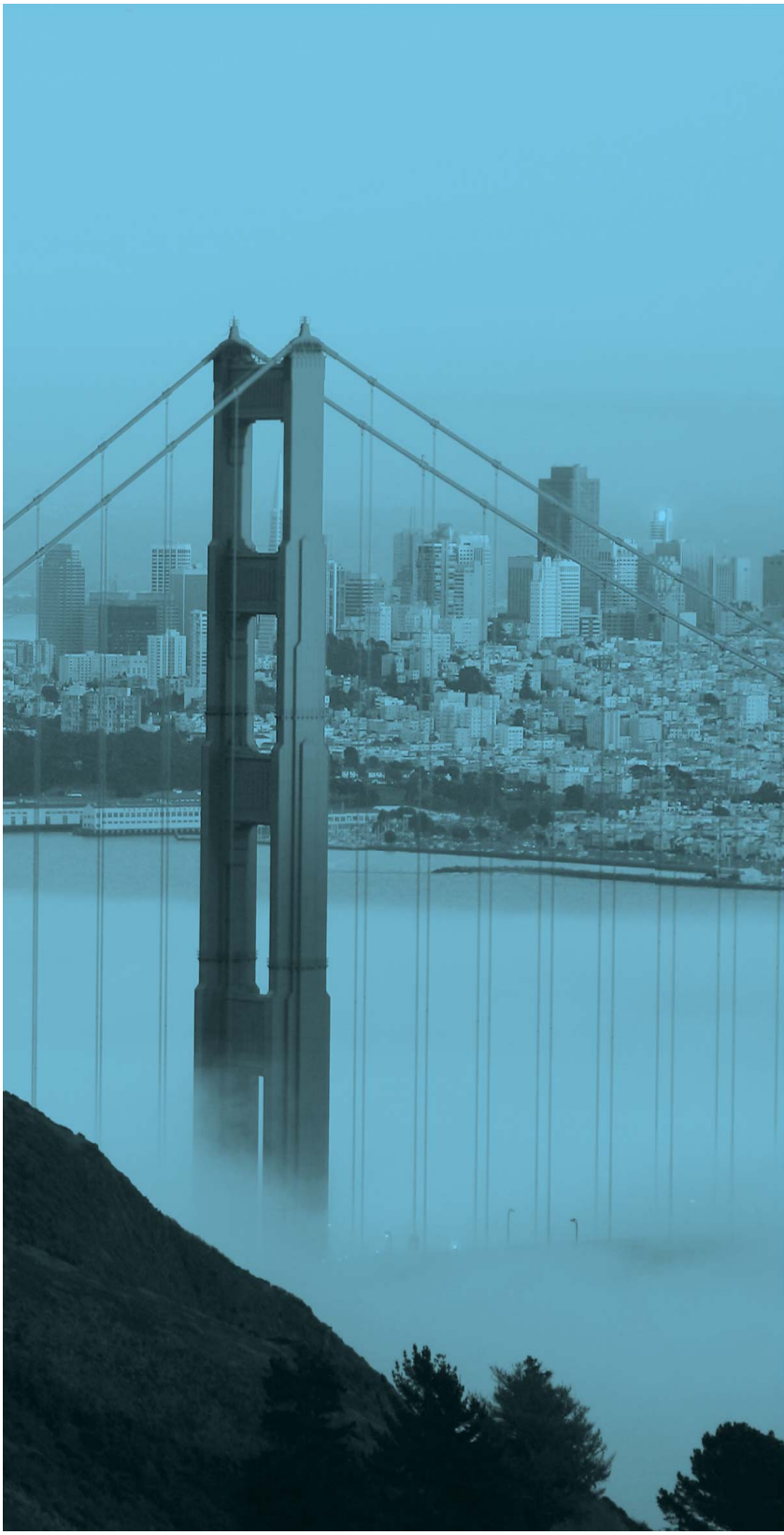
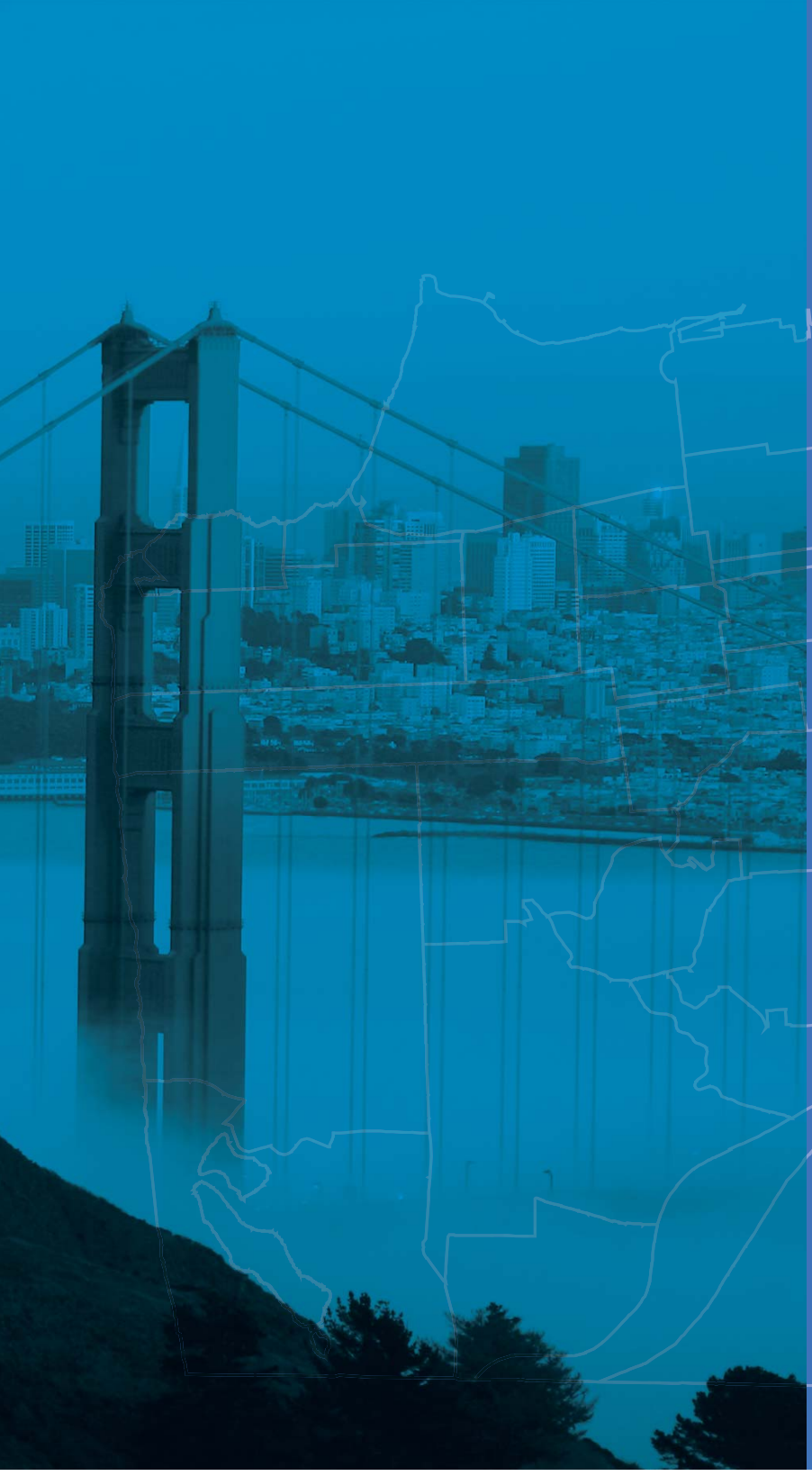
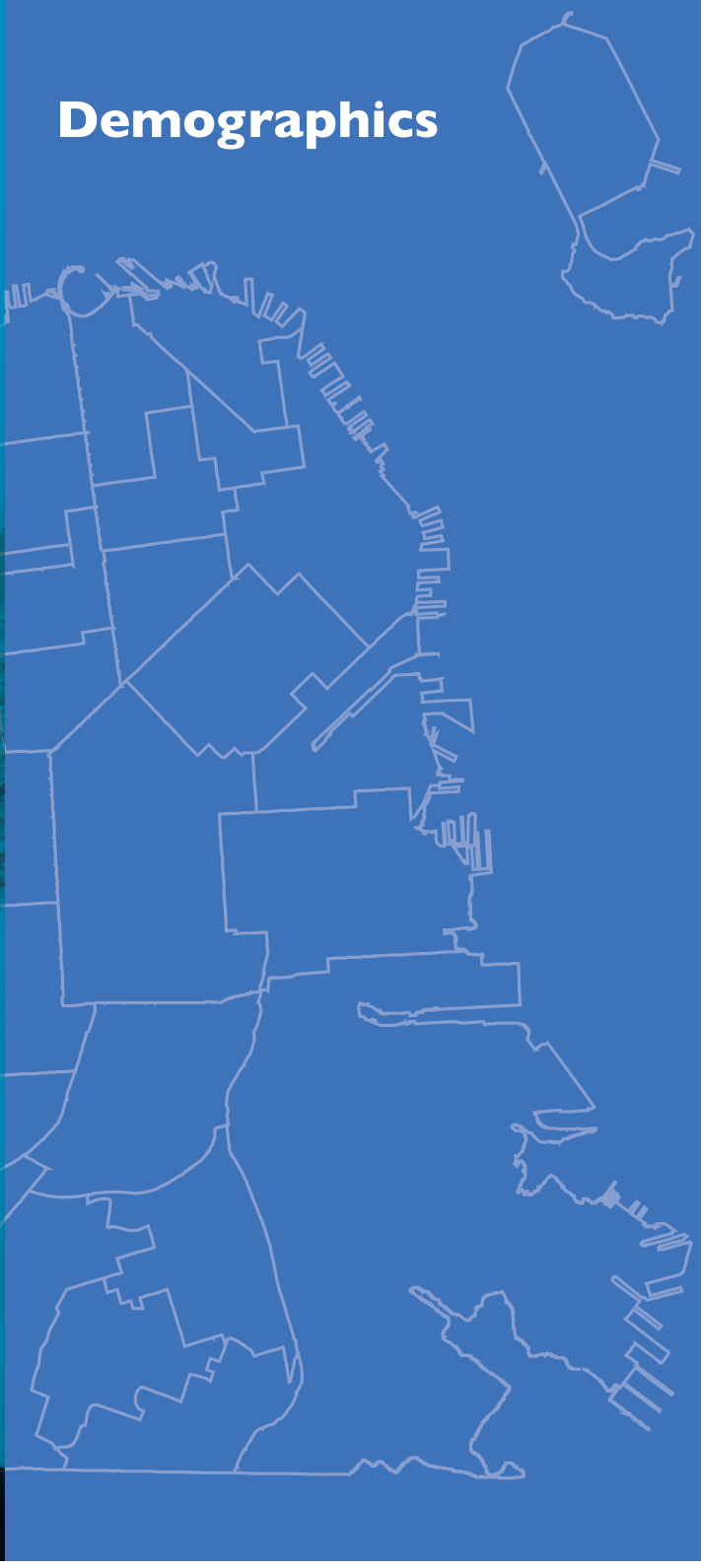


Demographics





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Demographics

Variables

- Population by age, sex, and race/ethnicity
- Population change
- Socioeconomics
- Immigration and Languages spoken
- Households with families

San Francisco by the numbers

Between 2010 and 2014 the population in San Francisco grew by 4.37 percent to 840,391, out pacing population growth in California (3.8 percent). By 2030, San Francisco's population is expected to total nearly 97,000 and by 2060, over 1.1 million.

Age and sex

The age structure of a population is important in planning for community needs. For example, a younger population may have greater demands for education and child care services, while an older population may have increasing healthcare needs as they age.

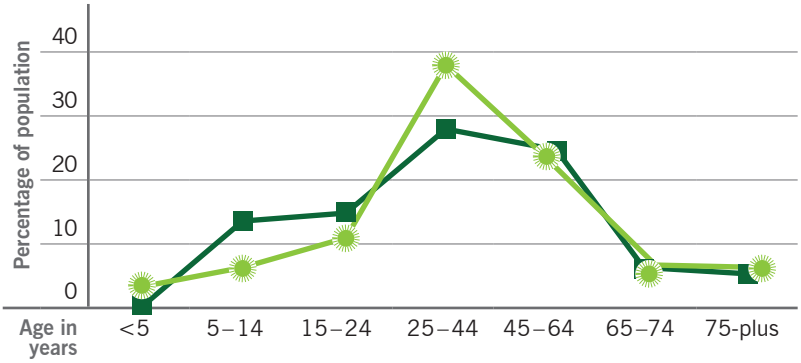
The population of San Francisco is slightly older than that of California. The median age in San Francisco is 38.5 years old, compared to 35.4 years in California. Sixty-four percent of San Franciscans are between the ages of 25 and 64 years (**Figure A**). Relative to California, San Francisco has a greater percentage of children five years of age or younger. However, the opposite is true for slightly older children, with children age five to 14 years making up only 6.8 percent of the population in San Francisco compared to 13.5 percent in California.

Overall, there are slightly more males (50.8 percent) than females (49.2 percent) in San Francisco. Among working-age adults, men (52 percent) outnumber women (48 percent). Among seniors age 70 and older, 58 percent are female (**Figure B**).

The greatest population growth in San Francisco is expected to be among the 65-plus age group (**Figure C**). The percentage of residents age 65-plus is expected to increase from 13.7 percent of the total population in 2010 to 19.9 percent in 2030 and 27.1 percent in 2060, with the majority of this increase among people age 75-plus. In comparison, the percentage of residents 65-plus in California is expected to increase from 11.5 percent to 23.6 percent by 2060.

At the same time, population projections suggest that the percentage of working-age residents will decrease from 63.4 percent of the total population in 2010 to 57.7% in 2030 and 49.8 percent in 2060. This has important implications for the San Francisco tax base and the provision of public services as the tax base shrinks.

Figure A: Percentage of population by age group: San Francisco vs. California, 2009–13



San Francisco, California. **Data source:** ACS, 2009–13.

Table 1: Race/ethnicity and population, SF, 2009–13

		Total population		Percentage of total city population	
		Number	Margin of error	Percentage	Margin of error
Race/ethnicity	B/AA	45,909	+/-703	5.6%	+/-0.1
	Native American	1,942	+/-374	0.2%	+/-0.1
	Asian	270,621	+/-1,270	33.1%	+/-0.2
	Latino	124,167	*	15.2%	*
	Pacific Islander	3,362	+/-148	0.4%	+/-0.1
	Multi-ethnic	26,653	+/-1,432	3.3%	+/-0.2
	Other	3,747	+/-789	0.5%	+/-0.1
	White	341,100	+/-471	41.7%	+/-0.1

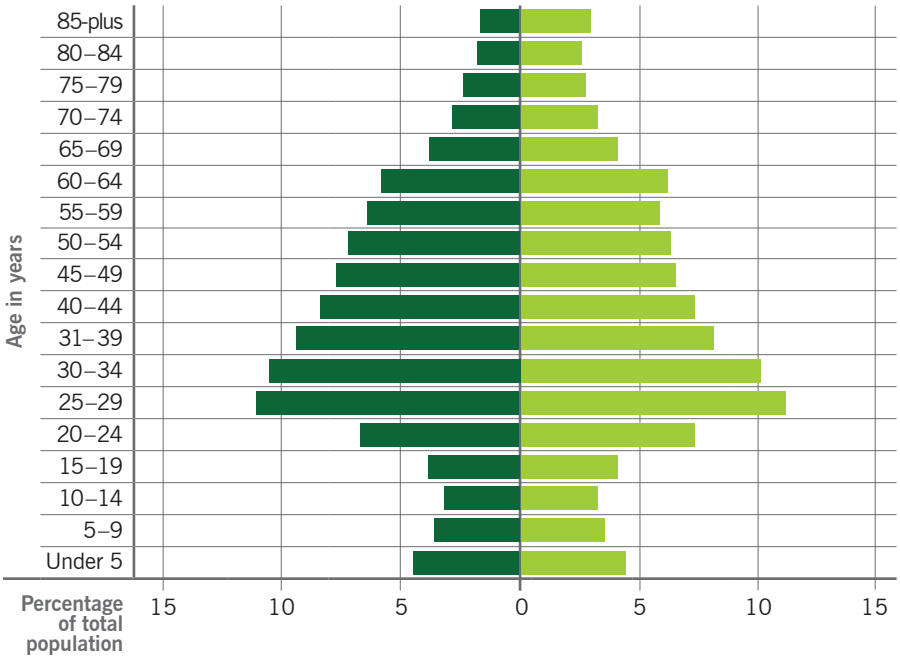
*Estimate is controlled. A statistical test for sampling variability is not appropriate in this case.
Data source: ACS 2009–13

Race and ethnicity

San Francisco is a majority minority city. People of color account for 58.3 percent of the city's total population, while Whites account for 41.7 percent. Asians represent the largest minority group (33.1 percent) followed by Latinos (15.2 percent) (**Table 1**).

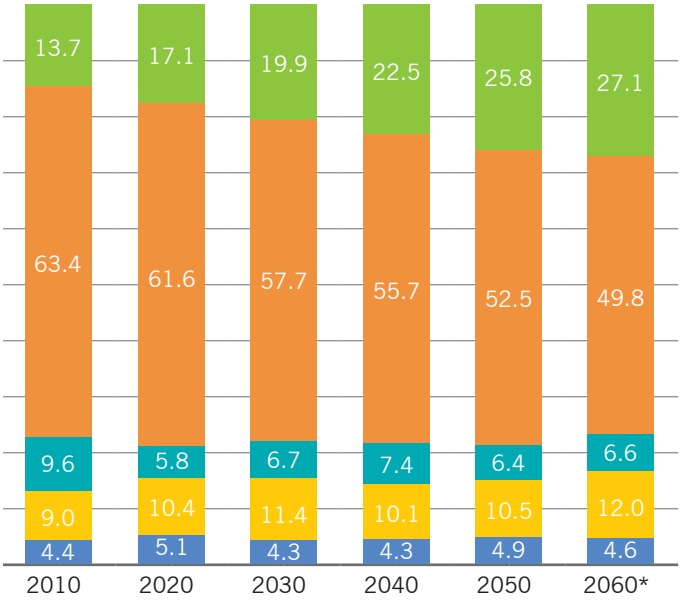
Communities which are majority Black/African American are in the southeastern quadrant. Large Asian communities are in the south, west, and to a smaller extent in the central part of the City (**Map 1**). Predominantly Latino communities are in the Mission and the southeastern quadrant. Segregation in San

Figure B: Age Pyramid, SF, 2009–13



Male, Female. **Data source:** ACS, 2009–13.

Figure C: Population by age group as a percentage of the total population projections, SF, 2010–60



Groups by age range in years: Seniors (65-plus), Working age (25–64), College age (18–24), School age (5–17), Preschool age (0–4). **Data source:** CaDOF1 2014.

Francisco is the result of a complex set of historical events and current day realities that reflect both positive and negative social and economic conditions. Minorities, especially Black/African Americans, are more likely to live in impoverished neighborhoods. (*See the economic section of this assessment for additional information.*)

The Black/African American community has experienced the greatest recent change in population. Between the years 2000 and 2014, the population shrank by 27 percent. The percentage of Whites also dropped during this time period, though by a much smaller percentage (6.3 percent). The largest growth was among Latinos, whose numbers grew by 12.7 percent during these years (**Figure E**).

As the total population grows, net changes within each racial and ethnic group will contribute to the changing demographics of the city. Significant growth in the number of multi-ethnic, and Latino, residents is expected between 2010 and 2030. Meanwhile, the number of Black/African American residents in San Francisco will continue to drop. The White population will continue to increase in numbers, but will drop as a proportion of the total population (**Figure D**). It should be noted that this trend among Whites is the opposite of that expected statewide, where there is a projected net decrease in the White population.

Socioeconomics

Federal Poverty Level (FPL) is a widely used measure to define poverty, and is often used to determine eligibility for public services. FPL is $24,250 for a family of four.[1] Thirteen percent of San Franciscans earn less than 100 percent of FPL; 29 percent earn less than 200 percent of FPL. Many social services are available only to those earning less than 180–200 percent of FPL.

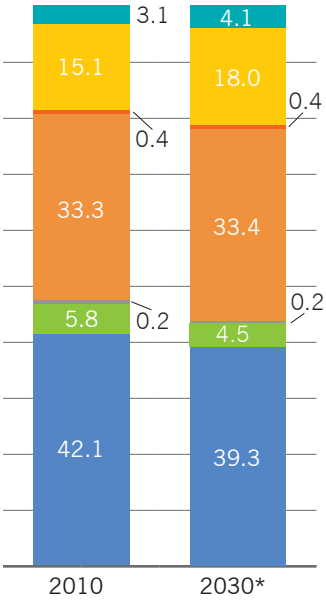
The high cost of living in San Francisco means that many who don't qualify for social services are in need. According to the Insight Center, a family of four requires an annual income of between $54,000 and $97,000, depending upon the ages of the children, to cover all necessary expenses—housing, food, childcare, healthcare, transportation, and taxes.[2] The annual median household income in 2013 was $77,487 (adjusted dollars).

Median income varies by race and ethnicity (**Figure F**). On average, Whites have a higher median income than any other group, and Black/African Americans have the lowest. (*See the Economic datasheets for more detail.*)

Poverty level by neighborhood is often used as an indicator of overall deprivation. Treasure Island, Tenderloin and Chinatown are the neighborhoods that experience the greatest burden of poverty by either measure. Additional high-poverty areas include South of Market, Visitacion Valley, Bayview Hunters Point, Lakeshore, and Western Addition (**Map 2**).

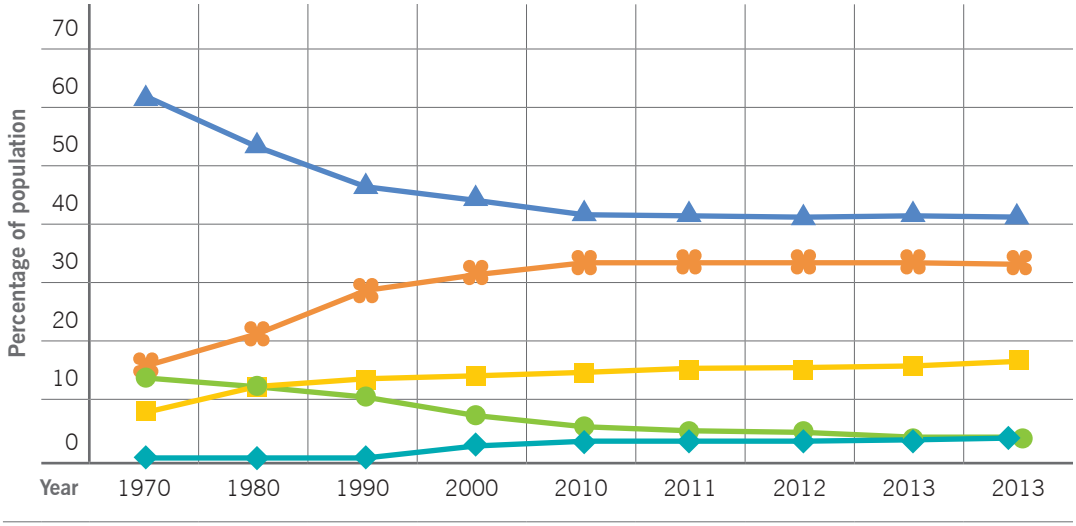
Affordability of housing in San Francisco is an important indicator of poverty. High housing costs relative to income reduces money available to

Figure D: Ethnic composition by percentage of population, SF, 2010 vs. 2030



Multi-ethnic, Latino, Pacific Islander, Asian, Native American, B/AA, White. *Projected population.

Figure E: Population change by race/ethnicity



API, B/AA, Latino, White, Other. **Data source:** CaDOF2–4.

meet other needs. It can result in living in overcrowded and/or substandard housing, moving from neighborhood to neighborhood, or becoming homeless. More than 25 percent of the population living in the Financial District, Downtown/Civic Center, Lakeshore, Excelsior, Oceanview, Bayview Hunters Point, and Visitacion Valley spends at least half of their income on rent (**Map 3**).

On average, the population density in San Francisco is 17,488 persons per square mile. The three neighborhoods with the highest population density are, in descending order, the Tenderloin, Chinatown, and Nob Hill (**Map 4**). Given the different socioeconomic profiles of these neighborhoods, it can be revealing to examine overcrowding as an indicator of health. The neighborhoods that have the fewest households living in uncrowded conditions are Chinatown, Visitacion Valley, Downtown/Civic Center, and Oceanview. (*For more information on crowding and other housing conditions see the Housing Section of this assessment.*)

Immigration and languages spoken

Roughly one-third (35.6 percent) of the population of San Francisco is foreign-born. Of these residents, 61.4 percent are naturalized U.S. citizens. The majority are from Asia (63.5 percent) with China being the largest country of origin. Twenty percent of foreign born residents are from Latin America with half originating from Mexico.

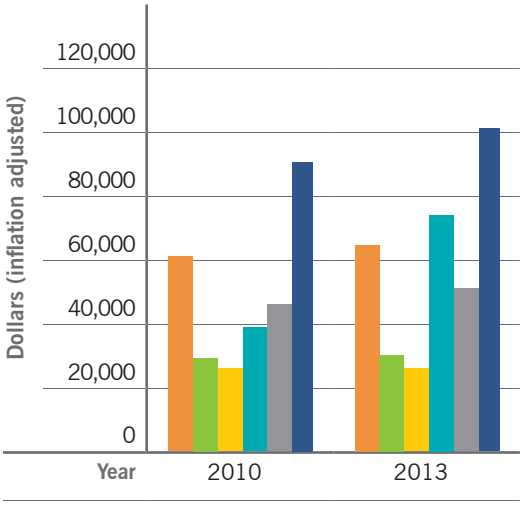
Fifty-five percent of San Francisco residents speak only English. A wide variety of other languages are also spoken. Chinese (Mandarin, Cantonese, and others) and Spanish are the most prevalent non-English languages, with 18.4 percent and 11.6 percent of the population, respectively, speaking these languages. Tagalog (3.2 percent), Russian (1.7 percent), and Vietnamese (1.3 percent) are the next most widely spoken languages. (*See* **Table 11** *for a more comprehensive list of languages spoken in San Francisco.*)

Twenty-three percent of San Francisco residents age five and older speak a language other than English at home and speak English less than very well. Geographically, this most common in Chinatown, where 67 percent of the population does not speak English very well. Other neighborhoods with a high percentage of people who speak a language other than English at home and speak English less than very well include Visitacion Valley, Excelsior, Portola, the Outer Mission, and Oceanview/Merced/Ingleside (**Map 5**). Across all non-English languages, this variation in English speaking ability is more prevalent among older generations, highlighting the need for translation services, particularly among this older population, so that they are able to access services that require English.

Households with Children

Overall, 19 percent of San Francisco households include youth under 18 years of age, and 29 percent of these households are headed by single parents. Neighborhoods with the highest proportion of households with youth under 18 years are Seacliff, Bayview Hunters Point, Visitacion Valley, Outer Mission, Excelsior, Treasure Island, and Portola. Neighborhoods with the highest proportion of single parent households with youth under 18 years are Treasure Island, Hayes Valley, Bayview Hunters Point, Lone Mountain/USF, Lakeshore, Western Addition, Tenderloin, and Visitacion Valley.

Figure F: Median household income in the last 12 months by race/ethnicity, 2009–13



Asian, B/AA, Latino, Multi-ethnic, Other, White. Note that some groups are not included in this chart because the data was not stable. **Data source:** CaDOF1 2014.

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CaDOF2 State of California, Department of Finance, "Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060. Sacramento, California, December 2014."

CaDOF3 State of California, Department of Finance, "Report E-3 Race/Ethnic Population Estimates: Components of Change for California Counties: 1970-1990."

CaDOF4 State of California, Department of Finance, "Report E-3 Race/Ethnic Population Estimates: Components of Change for California Counties: 1990-2000."

References:

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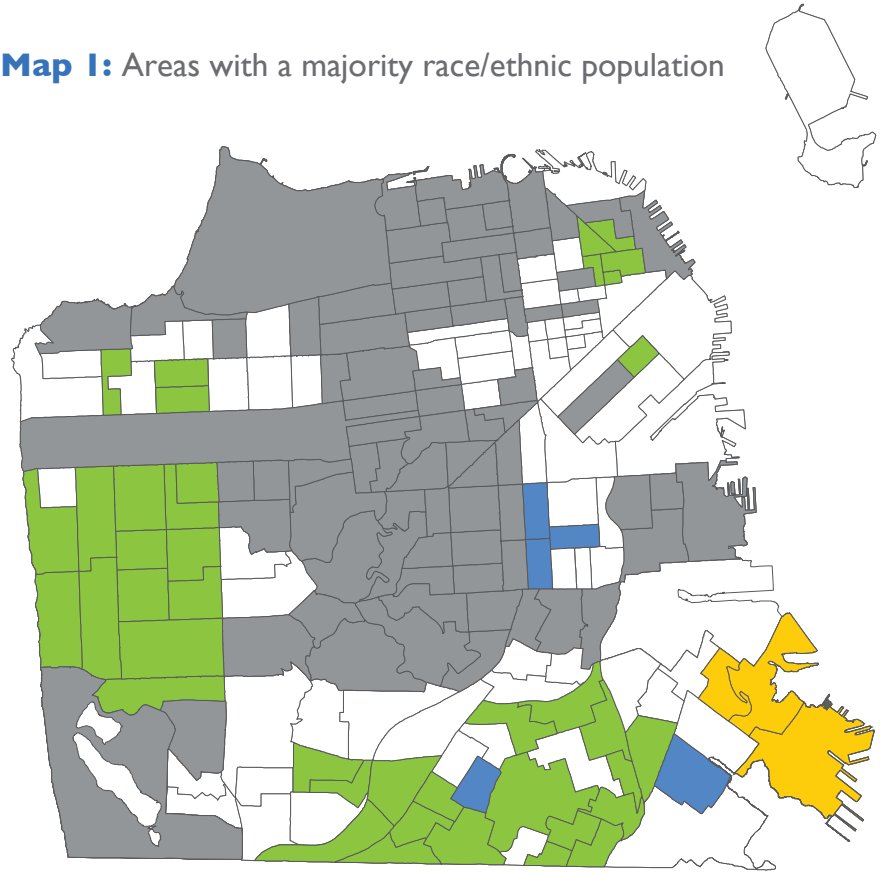
2. Insight Center for Community Economic Development. http://www.insightcced.org/

Table 2: Median household income in dollars, by race/ethnicity, SF

	2010	Margin of Error	2013	Margin of Error
White	91,064	+/-3,914	101,272	+/-2,110
B/AA	29,409	+/-4,712	30,368	+/-9,724
Asian	60,914	+/-4,152	64,859	+/-5,851
Other	46,245	+/-8,736	50,906	+/-7,758
Multi-ethnic	39,778	+/-19,584	74,804	+/-25,396
Latino	56,861	+/-4,564	53,670	+/-10,321
Native American	56,151	+/-35,080	48,251	+/-30,459
Pacific Islander	75,044	+/-26,365	22,843	+/-21,188

Data source: ACS 2010 and 2013.

Map 1: Areas with a majority race/ethnic population

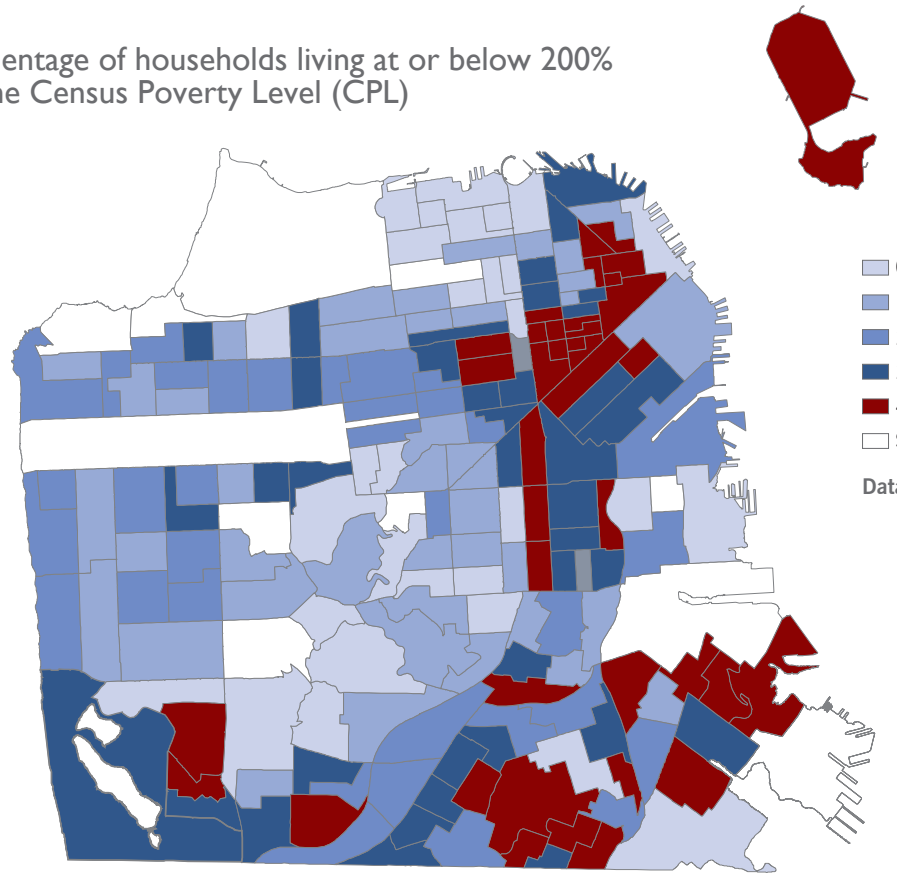


Data source: ACS 2009–13.

*San Francisco defines an area of *minority concentration* as any census tract with a non-White population that is 20 percent greater than that of the City's total Non-White percentage.

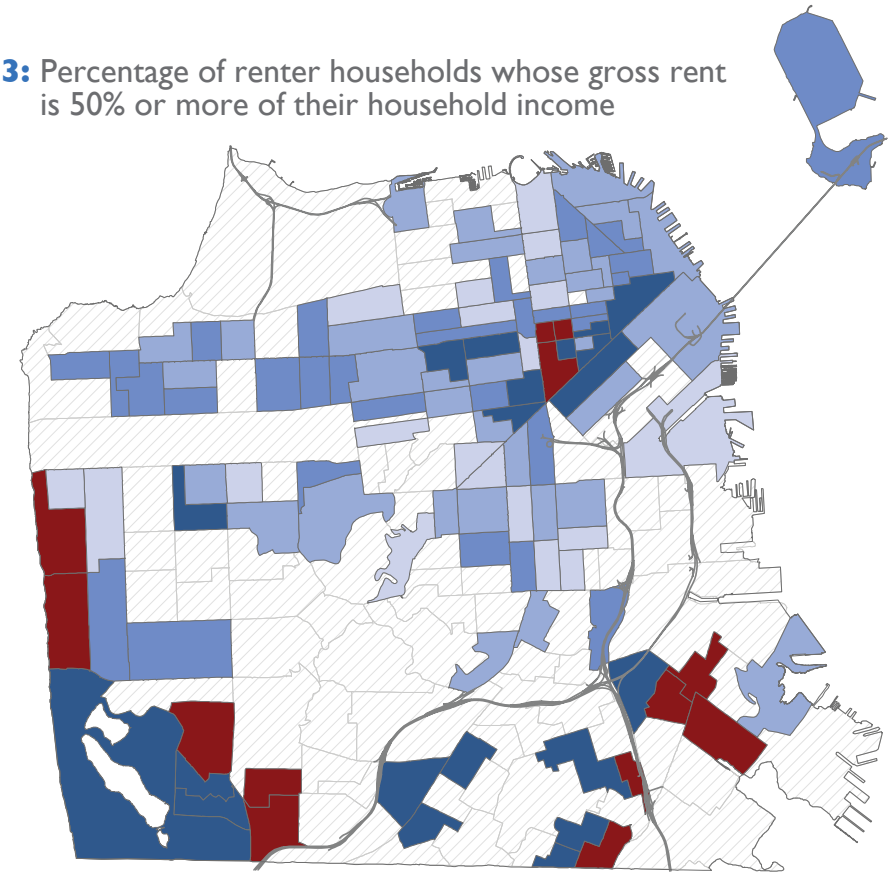
According to the 2009–13 ACS, 58.3 percent of the City's population identifies as being Non-White. Therefore any census tract in which 78.3% of the population is classified as minority would qualify as an area of minority concentration.

Map 2: Percentage of households living at or below 200% of the Census Poverty Level (CPL)



Data source: ACS 2009–13.

Map 3: Percentage of renter households whose gross rent is 50% or more of their household income



Map 4: Population density

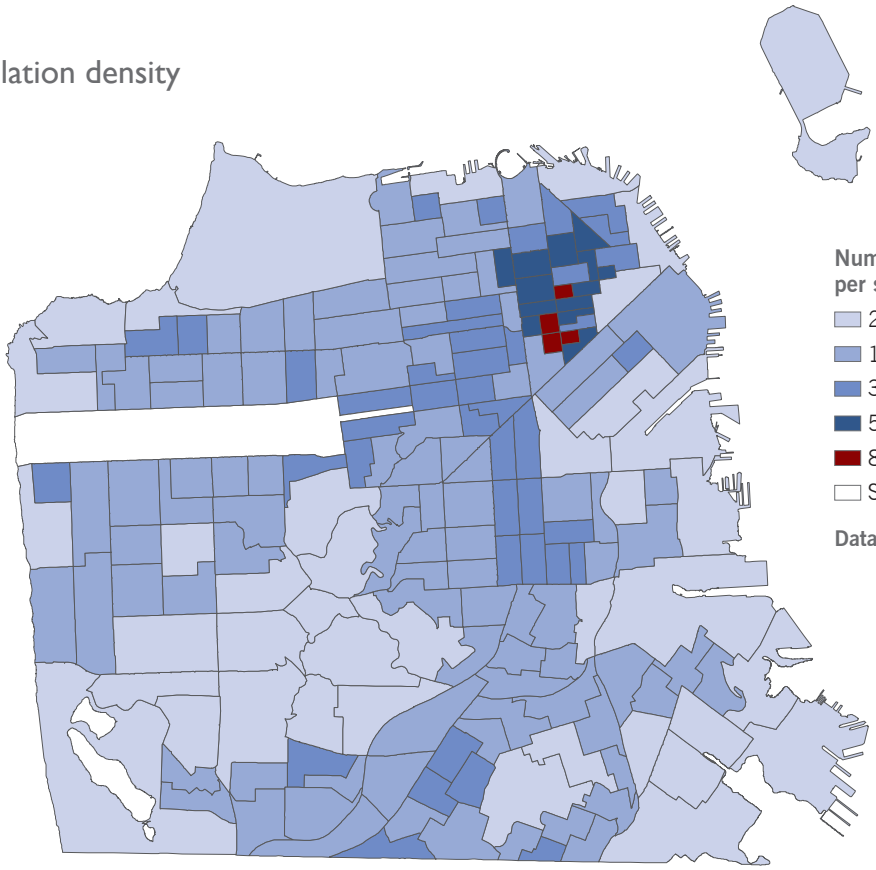


Table 3: Race/ethnicity and population, SF

	2009		2010		2011		2012	
Total	801,799		805,236		816,127		825,308	
	Total	%	Total	%	Total	%	Total	%
Native American	1,817	0.2	1,861	0.2	1,878	0.2	1,893	0.2
Asian	264,056	32.9	267,164	33.2	271,729	33.3	274,721	33.3
B/AA	48,363	6.0	47,121	5.9	46,887	5.7	46,728	5.7
Latino	121,205	15.1	121,774	15.1	124,506	15.3	127,304	15.4
Pacific Islander	3,232	0.4	3,178	0.4	3,239	0.4	3,288	0.4
White	339,453	42.3	339,492	42.2	342,243	41.9	344,946	41.8
Multi-ethnic	23,674	3.0	24,646	3.1	25,645	3.1	26,428	3.2

	2013		2014		2015	
Total	833,827		840,391		848,564	
	Total	%	Total	%	Total	%
Native American	1,906	0.2	1,912	0.2	1,922	0.2
Asian	277,556	33.3	279,660	33.3	282,322	33.3
B/AA	46,464	5.6	46,304	5.5	46,189	5.4
Latino	129,828	15.6	132,159	15.7	134,759	15.9
Pacific Islander	3,327	0.4	3,368	0.4	3,408	0.4
White	347,469	41.7	348,849	41.5	351,012	41.4
Multi-ethnic	27,277	3.3	28,139	3.3	28,952	3.4

Data source: CaDOF2

Table 4: Percentage of population by age and sex

		California		San Francisco		San Francisco males		San Francisco females	
		Total estimate	90% MOE*	Total estimate	90% MOE*	Total estimate	90% MOE*	Total estimate	90% MOE*
Age in years	Under 5 years	6.7	+/-0.1	4.5	+/-0.1	4.5	+/-0.1	4.5	+/-0.1
	5–9 years	6.7	+/-0.1	3.5	+/-0.1	3.6	+/-0.1	3.5	+/-0.2
	10–14 years	6.8	+/-0.1	3.3	+/-0.1	3.2	+/-0.1	3.3	+/-0.2
	15–19 years	7.3	+/-0.1	4.0	+/-0.1	3.9	+/-0.1	4.2	+/-0.1
	20–24 years	7.6	+/-0.1	7.0	+/-0.1	6.7	+/-0.1	7.3	+/-0.1
	25–29 years	7.4	+/-0.1	11.2	+/-0.1	11.1	+/-0.1	11.3	+/-0.1
	30–34 years	7.0	+/-0.1	10.3	+/-0.1	10.5	+/-0.1	10.1	+/-0.1
	35–39 years	6.8	+/-0.1	8.7	+/-0.2	9.3	+/-0.2	8.1	+/-0.2
	40–44 years	7.0	+/-0.1	7.9	+/-0.2	8.4	+/-0.2	7.3	+/-0.2
	45–49 years	7.0	+/-0.1	7.1	+/-0.1	7.7	+/-0.1	6.5	+/-0.1
	50–54 years	6.9	+/-0.1	6.7	+/-0.1	7.1	+/-0.1	6.3	+/-0.1
	55–59 years	6.0	+/-0.1	6.2	+/-0.1	6.4	+/-0.2	5.9	+/-0.2
	60–64 years	5.1	+/-0.1	6.0	+/-0.1	5.8	+/-0.2	6.1	+/-0.2
	65–69 years	3.7	+/-0.1	3.9	+/-0.1	3.7	+/-0.1	4.1	+/-0.2
	70–74 years	2.7	+/-0.1	3.1	+/-0.1	2.8	+/-0.1	3.3	+/-0.2
	75–79 years	2.1	+/-0.1	2.6	+/-0.1	2.4	+/-0.1	2.9	+/-0.2
	80–84 years	1.6	+/-0.1	2.0	+/-0.1	1.6	+/-0.1	2.5	+/-0.1
	85-plus years	1.7	+/-0.1	2.2	+/-0.1	1.5	+/-0.1	3.0	+/-0.1

*MOE: Margin of error. **Data source:** ACS 2009–13

Table 5: Median Age

	Total		Male		Female	
	Estimate	90% MOE*	Estimate	90% MOE*	Estimate	90% MOE*
San Francisco median age	38.5	+/-0.2	38.6	+/-0.2	38.5	+/-0.2
California median age	35.4	+/-0.1	34.2	+/-0.1	36.6	+/-0.1

*MOE: Margin of error. **Data source:** ACS 2009–13

Table 6: Neighborhood by percentage of race/ethnicity, SF, 2009–13

	White		Black/African American		Latino		API		Other	
	Percent	MOE*	Percent	MOE*	Percent	MOE*	Percent	MOE*	Percent	MOE*
San Francisco	42	0	6	0	15	0	34	0	4	0
Bayview Hunters Point	8	1	33	2	24	3	32	2	3	1
Bernal Heights	42	2	3	1	30	4	19	2	5	1
Castro/ Upper Market	75	2	3	1	10	2	9	1	4	1
Chinatown	12	2	**	**	**	**	82	3	**	**
Excelsior	14	1	2	1	33	3	48	2	3	1
Financial District/ South Beach	49	5	2	1	13	6	32	4	3	1
Glen Park	63	3	6	2	11	3	14	4	5	2
Golden Gate Park	**	**	**	**	**	**	**	**	**	**
Haight Ashbury	75	2	3	1	8	2	9	2	4	1
Hayes Valley	56	2	14	3	13	5	12	2	5	1
Inner Richmond	44	3	2	1	7	2	43	4	5	1
Inner Sunset	56	2	1	1	6	1	31	3	5	1
Japantown	47	6	**	**	**	**	30	4	**	**
Lakeshore	45	4	6	2	16	3	27	4	7	2
Lincoln Park	**	**	**	**	**	**	**	**	**	**
Lone Mountain/USF	58	3	5	2	10	2	22	3	4	1
Marina	78	2	**	**	7	1	12	2	3	1
McLaren Park	**	8	**	**	**	**	**	**	**	**
Mission	43	1	3	1	39	3	12	1	3	1
Mission Bay	43	5	**	**	10	3	42	6	**	**
Nob Hill	48	3	2	1	11	2	35	3	4	1
Noe Valley	68	2	3	1	14	3	13	2	3	1
North Beach	46	4	**	**	10	3	39	4	5	2
Oceanview/ Merced/Ingleside	13	2	13	2	21	4	49	3	5	1
Outer Mission	16	2	1	0	30	3	50	3	2	1
Outer Richmond	42	1	1	0	8	2	44	2	5	1
Pacific Heights	73	3	2	1	7	1	15	2	2	1

*MOE: Margin of error. **Statistically unstable data not shown. **Data source:** ACS 2009–13

Table continues on next page.

Table 6: Neighborhood by percentage of race/ethnicity, SF, 2009–13 (*continued*)

	White		Black/African American		Latino		API		Other	
	Percent	MOE*	Percent	MOE*	Percent	MOE*	Percent	MOE*	Percent	MOE*
Portola	18	3	5	2	18	4	57	4	**	**
Potrero Hill	57	2	5	2	15	3	16	3	7	3
Presidio	80	7	**	**	5	2	**	**	**	**
Presidio Heights	66	4	**	**	8	2	22	3	**	**
Russian Hill	60	3	**	**	7	2	31	3	2	1
Seacliff	69	5	0	0	**	**	18	5	**	**
South of Market	34	3	12	2	10	3	38	3	6	2
Sunset/Parkside	31	1	1	0	6	1	58	2	4	1
Tenderloin	32	2	10	2	18	4	33	3	6	2
Treasure Island	31	8	23	6	22	8	19	7	**	**
Twin Peaks	61	3	5	2	11	2	17	3	6	2
Visitacion Valley	5	1	16	3	18	2	58	4	3	1
West of Twin Peaks	49	2	3	1	10	1	33	2	5	1
Western Addition	41	2	20	3	10	2	25	3	5	1

*MOE: Margin of error. **Statistically unstable data not shown. **Data source:** ACS 2009–13

Table 7: Population density, SF, 2009–13

	Total population	90% MOE*	Square miles	Population per square mile
San Francisco	817,501	**	46.75	17488
Bayview Hunters Point	37,363	1,456.91	5.17	7223
Bernal Heights	26,052	1,106.67	1.08	24169
Castro/Upper Market	19,775	612.36	0.86	23070
Chinatown	14,905	708.23	0.22	66351
Excelsior	39,437	1,319.29	1.39	28328
Financial District/ South Beach	16,091	1,299.91	1.12	14321
Glen Park	7,895	468.00	0.67	11811
Golden Gate Park	39	24.00	1.72	23
Haight Ashbury	17,715	818.18	0.56	31820

*MOE: Margin of error. **Statistically unstable data not shown. **Data source:** ACS 2009–13

Table continues on next page.

Table 7: Population density, SF, 2009–13 (*continued*)

	Total population	90% MOE*	Square miles	Population per square mile
Hayes Valley	17,787	1,149.55	0.49	36271
Inner Richmond	21,861	1,131.00	0.74	29381
Inner Sunset	27,710	996.13	1.42	19464
Japantown	3,939	490.00	0.12	32638
Lakeshore	13,189	935.27	2.53	5214
Lincoln Park	324	104.00	0.39	821
Lone Mountain/USF	15,608	874.52	0.58	26945
Marina	23,793	928.59	1.01	23475
McLaren Park	662	196.00	0.62	1075
Mission	54,611	1,747.14	1.77	30831
Mission Bay	9,251	722.00	0.79	11770
Nob Hill	25,816	926.74	0.41	63455
Noe Valley	21,564	787.29	0.98	22091
North Beach	12,451	746.21	0.50	25142
Oceanview/ Merced/Ingleside	27,930	1,566.25	1.05	26517
Outer Mission	23,223	1,203.84	1.00	23127
Outer Richmond	44,910	1,370.34	1.79	25079
Pacific Heights	23,299	970.15	0.80	29299
Portola	14,861	867.71	0.83	17997
Potrero Hill	15,008	726.12	1.25	12014
Presidio	2,918	328.00	2.36	1235
Presidio Heights	10,251	578.22	0.50	20408
Russian Hill	18,949	814.60	0.49	38396
Seacliff	2,459	183.00	0.21	11551
South of Market	17,797	1,044.71	0.88	20110
Sunset/Parkside	78,132	1,909.69	4.23	18478
Tenderloin	26,085	1,216.18	0.39	66407
Treasure Island	2,654	432.00	0.89	2988
Twin Peaks	7,092	415.60	0.66	10702
Visitacion Valley	17,197	780.26	0.61	28109
West of Twin Peaks	36,377	1,015.15	3.06	11894
Western Addition	20,521	794.27	0.58	35174

*MOE: Margin of error. **Data source:** ACS 2009–13

Table 8: Net change in race/ethnicity, 1970–2014

	White		Black/African American		API		Latino		Other		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Percent
1970	443,032	62.1	97,070	13.6	111,454	15.6	58,686	8.2	2,944	0.4	713,186
1980	364,101	53.5	85,135	12.5	144,493	21.2	83,849	12.3	2,920	0.4	680,498
1990	337,094	46.6	75,979	10.5	206,743	28.6	100,645	13.9	2,726	0.4	723,187
2000	345,160	44.3	58,381	7.5	247,072	31.7	109,848	14.1	18,481	2.4	778,942
2010	338,874	42.0	46,758	5.8	271,165	33.6	122,869	15.2	26,587	3.3	806,254
2011	340,568	41.9	46,518	5.7	273,067	33.6	125,496	15.4	27,474	3.4	813,123
2012	341,929	41.7	46,154	5.6	275,537	33.6	128,501	15.7	28,228	3.4	820,349
2013	343,103	41.6	45,785	5.5	276,865	33.6	130,282	15.8	28,992	3.5	825,027
2014	344,706	41.5	45,419	5.5	278,263	33.5	131,976	15.9	29,756	3.6	830,120

Data source: CaDOF2–4

Table 9: Projected population by age group, 2010–60

		Total (all ages)	Preschool age (0 4 years)	School age (5–17 years)	College age (18 24 years)	Working age (25 64 years)	Young retirees (65–74 years)	Mature retirees (75 84 years)	Seniors (85-plus years)
2010	California	37,341,978	2,526,568	6,747,186	3,938,575	19,848,598	2,296,157	1,374,454	610,440
	San Francisco	808,850	35,740	72,401	77,334	512,712	54,747	38,122	17,794
2020	California	40,619,346	2,582,984	6,648,897	3,794,319	21,331,612	3,697,849	1,796,644	767,041
	San Francisco	891,493	45,444	92,843	51,850	548,754	88,588	42,651	21,363
2030	California	44,085,600	2,654,422	6,967,489	3,871,223	21,964,706	4,642,204	2,937,737	1,047,819
	San Francisco	967,405	41,783	110,646	64,613	557,884	98,090	69,880	24,509
2040	California	47,233,240	2,722,589	7,233,623	4,126,034	23,004,932	4,693,807	3,720,613	1,731,642
	San Francisco	1,027,004	44,092	103,958	75,791	571,659	113,098	77,945	40,461
2050	California	49,779,362	2,895,153	7,461,555	4,260,081	23,960,477	5,078,679	3,814,038	2,309,379
	San Francisco	1,081,540	52,540	113,112	69,561	567,407	138,929	91,017	48,974
2060	California	51,663,771	2,984,518	7,800,131	4,320,381	24,346,784	5,513,876	4,161,032	2,537,049
	San Francisco	1,103,174	50,849	132,433	72,331	549,025	125,671	113,214	59,651

Data source: CaDOF1

Table I0: Projected population change by race/ethnicity

		Total		White		B/AA		Native American		Asian	
		Number	%	Number	%	Number	%	Number	%	Number	%
2010 -2030	California	6,743,622	15	-241,095	-2	162,677	7	18,917	10	1,332,504	22
	San Francisco	158,555	16	39,909	11	-3,726	-9	125	6	54,064	17
2010 -2060	California	14,321,793	38	-1,988,944	-13	31,043	1	5,583	3	3,224,097	67
	San Francisco	294,324	36	49,609	15	-12,241	-26	-694	-37	94,447	35

		Pacific Islander		Latino		Multi-ethnic	
		Number	%	Number	%	Number	%
2010 -2030	California	37,528	22	4,901636	26	531,455	37
	San Francisco	673	17	52,255	30	15,255	38
2010 -2060	California	89,646	67	11,414,679	81	1,545,689	168
	San Francisco	1,305	41	119,338	98	42,560	171

Data source: CaDOF1

Table 11: Languages spoken

	Population		Percentage of population	
	Estimate	MOE*	Percentage	MOE*
San Francisco	780,888	81		
African languages	1,024	424	0.1	0.05
Arabic	2,930	524	0.4	0.07
Armenian	711	252	0.1	0.03
Chinese	143,872	3,222	18.4	0.41
French (incl. Patois, Cajun)	8,811	892	1.1	0.11
French Creole	117	136	0.0	0.02
German	4,639	531	0.6	0.07
Greek	1,390	386	0.2	0.05
Gujarati	1,263	510	0.2	0.07
Hebrew	1,229	271	0.2	0.03
Hindi	3,545	706	0.5	0.09
Hmong	158	109	0.0	0.01
Hungarian	265	161	0.0	0.02
Italian	3,700	533	0.5	0.07
Japanese	6,790	671	0.9	0.09
Korean	6,271	878	0.8	0.11
Laotian	309	163	0.0	0.02
Mon-Khmer, Cambodian	1,212	571	0.2	0.07
Navajo	19	28	0.0	0.00
Other and unspecified languages	473	233	0.1	0.03
Other Asian languages	3,593	690	0.5	0.09
Other Indic languages	2,322	624	0.3	0.08
Other Indo-European languages	1,235	355	0.2	0.05
Other Native North American languages	138	135	0.0	0.02
Other Pacific Island languages	4,957	788	0.6	0.10
Other Slavic languages	975	285	0.1	0.04
Other West Germanic languages	661	196	0.1	0.03

*MOE: Margin of error. **Data source:** ACS, 2009–13

Table continues on next page.

Table 11: Languages spoken (*continued*)

	Population		Percentage of population	
	Estimate	MOE*	Percentage	MOE*
Persian	2,459	628	0.3	0.08
Polish	749	254	0.1	0.03
Portuguese or Portuguese Creole	1,704	437	0.2	0.06
Russian	13,003	1,124	1.7	0.14
Scandinavian languages	960	304	0.1	0.04
Serbo-Croatian	1,045	346	0.1	0.04
Spanish or Spanish Creole	90,720	1,843	11.6	0.24
Tagalog	24,935	1,887	3.2	0.24
Thai	2,183	611	0.3	0.08
Urdu	877	444	0.1	0.06
Vietnamese	9,860	968	1.3	0.12
Yiddish	45	38	0.0	0.00

*MOE: Margin of error. **Data source:** ACS 2009–13

Table 12: Proportion of population age 5-plus that speaks a non-English language at home and speaks English less than very well

	Percentage	MOE*		Percentage	MOE*
San Francisco	23	0	Nob Hill	20	3
Bayview Hunters Point	30	2	Noe Valley	4	1
Bernal Heights	19	3	North Beach	27	4
Castro/Upper Market	3	1	Oceanview/Merced/ Ingleside	37	3
Chinatown	67	2	Outer Mission	38	3
Excelsior	42	2	Outer Richmond	27	2
Financial District/ South Beach	15	5	Pacific Heights	6	1
Glen Park	6	3	Portola	39	4
Golden Gate Park	**	**	Potrero Hill	8	2
Haight Ashbury	3	1	Presidio	**	**
Hayes Valley	9	5	Presidio Heights	9	2
Inner Richmond	23	4	Russian Hill	15	2
Inner Sunset	13	2	Seacliff	5	2
Japantown	23	8%	South of Market	26	3
Lakeshore	18	3%	Sunset/Parkside	30	2
Lincoln Park	**	**	Tenderloin	32	3
Lone Mountain/USF	9	2	Treasure Island	14	6
Marina	4	1	Twin Peaks	10	2
McLaren Park	38	11	Visitacion Valley	43	3
Mission	25	2	West of Twin Peaks	13	2
Mission Bay	22	5	Western Addition	18	2

*MOE: Margin of error. **Statistically unstable data not shown. **Data source:** ACS 2009–13

Table 13: Languages spoken in San Francisco, by age

	Total		Percentage of specified language speakers			
			Speak English "very well"		Speak English less than "very well"	
	Estimate	MOE*	Estimate	MOE*	Estimate	MOE*
Population 5-plus years	780,888	+/-81	77.4	+/-0.4	22.6	+/-0.4
Speak only English	55.0%	+/-0.4	**	**	**	**
Speak a language other than English	45.0%	+/-0.4	49.8	+/-0.7	50.2	+/-0.7
Spanish or Spanish Creole	90,720	+/-1,843	56.8	+/-1.6	43.2	+/-1.6
5–17 years	12,378	+/-601	81.4	+/-2.9	18.6	+/-2.9
18–64 years	69,550	+/-1,487	55.2	+/-1.9	44.8	+/-1.9
65-plus years	8,792	+/-339	34.4	+/-3.6	65.6	+/-3.6
Other Indo-European languages	50,211	+/-2,111	71.3	+/-2.0	28.7	+/-2.0
5–17 years	3,583	+/-454	86.7	+/-4.0	13.3	+/-4.0
18–64 years	35,983	+/-1,819	79.8	+/-2.0	20.2	+/-2.0
65-plus years	10,645	+/-690	37.4	+/-3.8	62.6	+/-3.8
Asian and Pacific Island languages	204,140	+/-2,540	40.8	+/-1.0	59.2	+/-1.0
5–17 years	20,316	+/-727	68.0	+/-2.4	32.0	+/-2.4
18–64 years	140,539	+/-2,182	43.6	+/-1.2	56.4	+/-1.2
65-plus years	43,285	+/-598	18.9	+/-1.4	81.1	+/-1.4
Other languages	6,078	+/-834	69.8	+/-4.5	30.2	+/-4.5
5–17 years	610	+/-177	80.5	+/-11.2	19.5	+/-11.2
18–64 years	4,779	+/-738	72.8	+/-5.5	27.2	+/-5.5
65-plus years	689	+/-202	39.3	+/-12.3	60.7	+/-12.3

*MOE: Margin of error. **Estimate not applicable or not available. **Data source:** ACS 2009–13

Table 14: Place of birth of foreign-born population, SF

	Estimate	MOE*
Total	290,752	+/-3,137
Europe	38,343	+/-1,519
Northern Europe	9,271	+/-641
Western Europe	8,955	+/-782
Southern Europe	3,941	+/-593
Eastern Europe	16,166	+/-1,126
Europe, n.e.c.	10	+/-15
Asia	184,527	+/-2,168
Eastern Asia	116,191	+/-2,462
China	104,109	+/-2,510
South Eastern Asia	53,041	+/-2,016
Western Asia	4,810	+/-753
Asia, n.e.c.	367	+/-221
Africa	3,094	+/-553
Eastern Africa	945	+/-226
Middle Africa	31	+/-48
Northern Africa	673	+/-271
Southern Africa	487	+/-174
Western Africa	633	+/-233
Africa, n.e.c.	325	+/-301
Oceania	2,812	+/-527
Australia and New Zealand sub-region	1,977	+/-456
Fiji	530	+/-244
Oceania, n.e.c.	305	+/-147
Americas	61,976	+/-1,819
Latin America	57,145	+/-1,823
Central America	46,651	+/-1,720
Mexico	23,349	+/-1,840
South America	8,978	+/-1,021
Northern America	4,831	+/-548

*MOE: Margin of error. **Data source:** ACS, 2009–13.

Table 15: Proportion of population living below 100% to 200% of the CPT*, 2009–13

	Percentage living below 100% CPT*	90% MOE** to 100% CPT*	Percentage living below 200% CPT*	90% MOE** to 200% CPT*
San Francisco overall	13	0	29	1
Bayview Hunters Point	21	3	42	4
Bernal Heights	11	2	27	4
Castro/Upper Market	8	1	17	2
Chinatown	30	4	66	6
Excelsior	10	2	33	4
Financial District/South Beach	11	4	20	5
Glen Park	9	3	16	4
Golden Gate Park	***	***	***	***
Haight Ashbury	10	2	19	3
Hayes Valley	17	3	30	3
Inner Richmond	14	3	26	4
Inner Sunset	11	2	20	3
Japantown	21	9	37	13
Lakeshore	29	5	42	5
Lincoln Park	***	***	***	***
Lone Mountain/USF	13	3	24	4
Marina	5	1	11	2
McLaren Park	***	***	***	***
Mission	16	2	35	3
Mission Bay	***	***	22	8
Nob Hill	17	3	33	4
Noe Valley	6	1	14	2
North Beach	14	4	33	5
Oceanview /Merced/Ingleside	16	2	36	5
Outer Mission	9	2	27	5
Outer Richmond	9	1	25	3
Pacific Heights	7	1	14	2
Portola	11	3	30	5
Potrero Hill	12	4	21	5

CPT: Census Poverty Threshold, *MOE: Margin of error, ***Estimates not available **Data source: ACS 2008–12

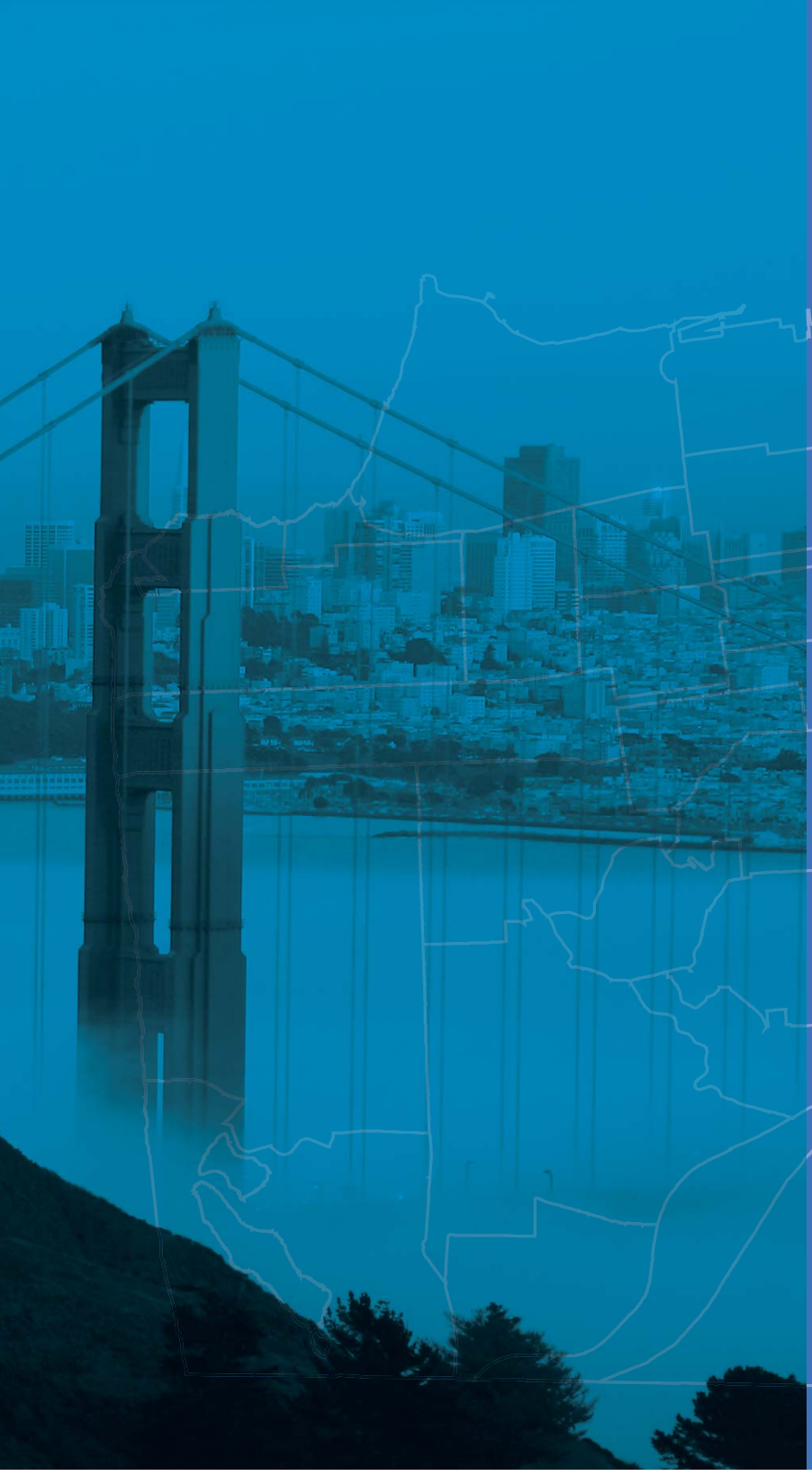
Table continues on next page.

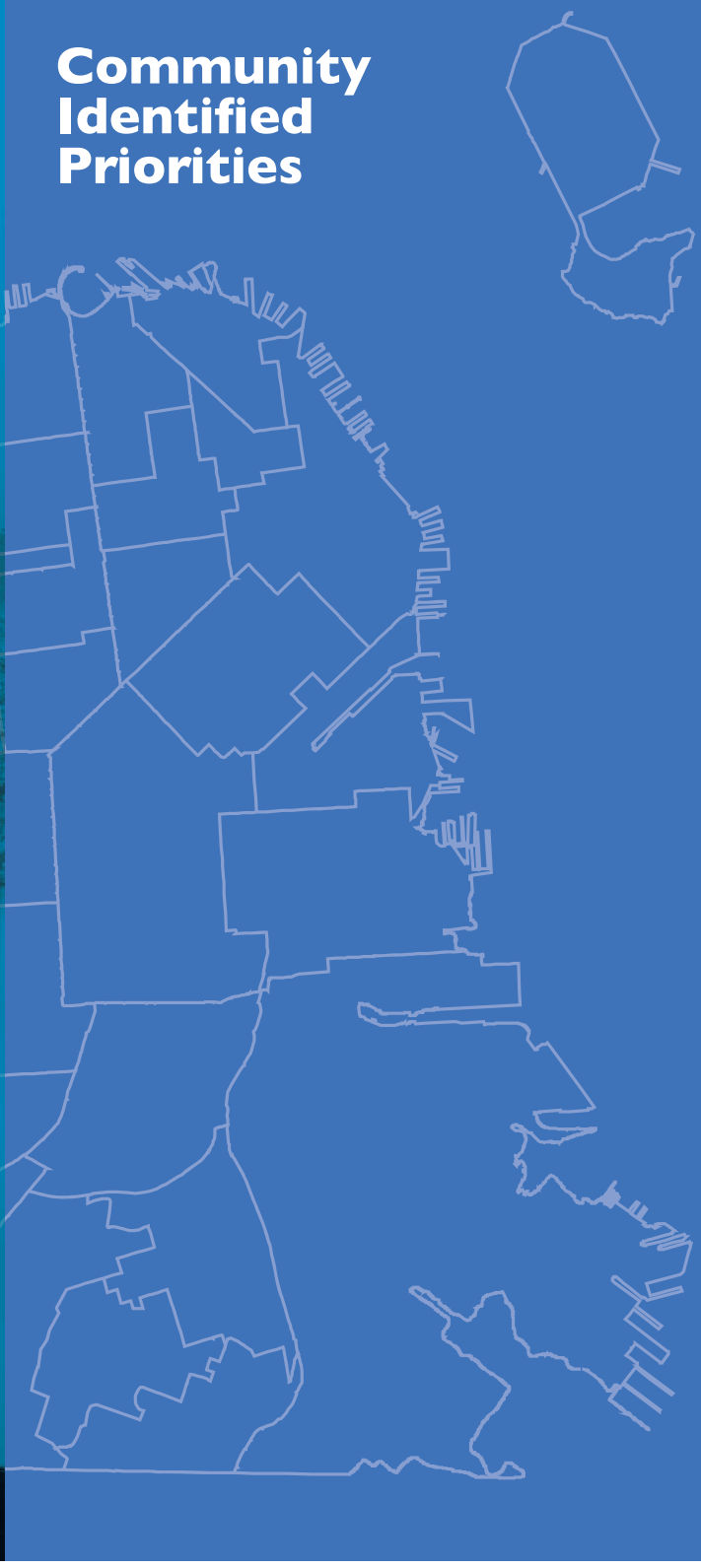
Table 15: Proportion of population living below 100% to 200% of the CPT*, 2009–13 (*continued*)

	Percentage living below 100% CPT*	90% MOE** to 100% CPT*	Percentage living below 200% CPT*	90% MOE** to 200% CPT*
Presidio	***	***	8	4
Presidio Heights	7	2	18	5
Russian Hill	11	3	23	4
Seacliff	***	***	***	***
South of Market	26	3	47	5
Sunset/Parkside	10	1	22	2
Tenderloin	34	3	64	5
Treasure Island	45	10	70	10
Twin Peaks	8	3	16	4
Visitacion Valley	17	3	42	5
West of Twin Peaks	6	2	13	2
Western Addition	20	4	40	5

*CPT: Census Poverty Threshold, **MOE: Margin of error, ***Estimates not available **Data source:** ACS 2008–12

Community Identified Priorities





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Assessment of Prior Assessments

Assessment of Prior Assessments

We completed an assessment of prior assessments to identify which communities in San Francisco were engaged in health needs assessment processes during the past five years, to identify the topics that had been questioned on, and to learn about known, existing health needs and priorities in San Francisco.

In March, 2015, we identified and collected 46 assessments for possible inclusion in the assessment of prior assessments. Twenty-one met our established inclusion criteria (**Table 1**). The 21 health assessments completed in the last five years focused on: safety and violence; drugs and alcohol; chronic diseases and their risk factors; education and extracurricular activities; childcare; housing; poverty and employment; mental health issues; available services and resources (**Table 3**).

The 21 included assessments, which included community members representing a broad spectrum of the population, identified the factors that in their experience had a major impact on community health. They cited the following: safety and violence; drugs and alcohol (including personal addiction and broader effects on the community); access to healthy food; housing; poverty and employment; mental health issues; and available services and resources such as health care, food access programs, recreational activity opportunities, and education and education (**Table 3**).

Table 1: Assessment inclusion criteria

Assessment includes primary data
Primary data can be viewed for San Francisco alone
Primary data was collected in 2010 or later
Methods for collecting primary data are identified
Assessment topic includes health determinant (social determinants of health) or health outcomes

Table 2: Assessment inclusion summary

46	Number of assessments identified
43	Number screened
24	Number meeting inclusion criteria
3	Number excluded due to quality and other issues found after screening
21	Included in Assessment of Assessment findings

Methods and limitations:

Collection: Assessments were identified by reaching out to community groups, city agencies, and others, as well as through internet searches. It is likely that not all eligible assessments have been included.

Screening and Review: Assessments were distributed among San Francisco Health Improvement Partnership (SFHIP) CHA subcommittee members. Assessment screening was done by the members or appointed staff and/or volunteers (**Table 2**).
A list of assessments included in the analysis are in **Appendix 1**. For each assessment which met the inclusion criteria a data extraction form was completed. See **Appendix 2** for an example of the form.

Analysis:
Population Assessed: The target population for each primary data collection activity in an assessment was identified and tagged by examining the following:

1) the reasons for the assessment,
2) reviewer identified target population,
3) primary data collection study methods,
4) participant recruitment methods, *and*
5) study limitations.

Assessment Topic: The health topics covered in each assessment were identified and tagged through reviewing the following:

1) the reasons for the assessment,
2) the reviewer identified list of health issues explored,
3) the health related prompts and questions which were asked, *and*
4) study limitations.

Health Needs: Health needs were identified and tagged by reviewing the following:

1) the health needs identified in the report, *and*
2) any health needs identified by the assessment reviewer.

Quality of each of the assessment has not been incorporated into the findings. Data potentially available to do so are the following:

1) type of study,
2) number of participants,
3) recruitment methods, *and*
4) inclusion of adequate data on study methods.

Limitations:

This assessment of assessment suffers from all the biases inherent in each of the included assessments as well as any introduced by study design and implementation for this assessment; care should be exercised in interpretation.

Assessments may have multiple topics, table subcategories do not add up to the topic headers. Topic headers only count each assessment one time (**Table 3**).

Because many assessments had multiple and sometimes overlapping target populations (for instance Mission and Latino, Southeast and HOPESF, Children/Youth and SFUSD, LGBTQ and seniors), results by target population should be reviewed only to get a sense of the breadth of concern a topic has.

The target population is not necessarily the same as those who actually participated. Sufficient data is not available from all assessments to determine how closely those who actually participated a given assessment resemble the target population of that assessment.

What is defined as mental health may vary from assessment to assessment and among participants.

The services and resources topic intermingles health care with other services (food access programs, recreational activity opportunities, education).

Table 3: Assessment topics and identified health needs by target population

A: Number of assessments finding health need. **B**: Number of assessments with topic as stated goal	All		Latinos		B/AAs		Asians		LGBTQ		Seniors		SROs and direct access housing		Mission		Tenderloin		Bayview/ Southeast		HopeSF		Children/ Youth		SFUSD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B
Safety and Violence	10	5																								
safety	9	4	1		1		1			1	1	1	1	1	1		1		3	2	2	1	2		1	
violence prevention	2																				1		1			
violence		1																								
police relations	2																		1		1					
Drugs and Alcohol	9	2		1		1		1								1		1		1						
youth and alcohol	1																		1							
drugs and alcohol	9	2					1		1		1				1		1		2		3	2	1			
loitering	1														1		1		1							
littering/nuisance	1														1		1		1							
outsiders/roh	1														1		1									
Chronic Disease and Risk Factors	13	14																								
chronic disease	1	2	1	1																				1		
diabetes	1																		1							
cancer	1																		1							
physcial activity	5	4		1																	1		1	1	3	1
smoking	2	1											1										1			
environmental contamination (air, noise, etc) and living conditions	4	3																	2		1	1	1	1		
access to healthy food	7	4	1	1	1		1			1	1		1	2	1	1	1	1	3		1		2			
Education, Childcare and Extracurricular Activities	3	1																								
education	2	1																	1		1	1				

Table continues on the next page.

Table 3: Assessment topics and identified health needs by target population (*continued*)

A: Number of assessments finding health need.
B: Number of assessments with topic as stated goal

	All		Latinos		B/AAs		Asians		LGBTQ		Seniors		SROs and direct access housing		Mission		Tenderloin		Bayview/ Southeast		HopeSF		Children/ Youth		SFUSD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B
childcare/early education	1																						1			
afterschool summer, and extracurricular programs	2																				1		1			
Housing, Poverty, Employment	14	1																								
unemployment/poverty	6		1				1		1		1										1			2		
housing/homelessness	6	1	1								1		1						2			2				
gangs/criminal involvement	2																				1		1			
Mental Health	9	12																								
social isolation/ social capital	3	8		1						1		1							1	3	2	1				
mental health	8	4					1	1	1		1								2		3	2	1	1		
Services and Resources	14	8	1				1		2		2			*					3		1		3			
services and resources	13	5								1		1								1		*		2		
access to medical care		3		1						1				2		1		1								
limited transportation	1																				1		1			
Miscellaneous																										
lack of data	1								1																	
health inequities/justice	2	1																	2					1		
oral health	1	1																					1	1		
cultural problems	1																						1			
health need prioritization		1																						1		
pregnancy and development		1																						1		
aging		1																								
transport to school		2																								2

This table shows the number of times a health topic or health need is identified in one of the 21 assessments. Data are shown by target population. Because each assessment may include multiple topics, identified health needs, and target populations, the values shown do not sum to the number of assessments. *Alcohol* includes problems affecting individuals as well as those created in the broader community. The definition of *mental health* may vary from assessment to assessment and among participants. Because many assessments had multiple and sometimes overlapping target populations (for example Mission and Latino, Southeast and HOPESF, Children/Youth and SFUSD, LGBTQ and seniors), assessments of the target population indicate the degree to which a community is concerned about the given topic. *Services and Resources*" intermingles health care with other services (food access programs, recreational activity opportunities, education).

Appendix 1: A list of assessments included in our analysis

Document title	Lead agency or entity
AB 636 Child Welfare Services: System Improvement Plan (SIP)	San Francisco Human Services Agency (SF-HSA)
Addressing the Needs of LGBT Older Adults in San Francisco: Recommendations for the Future	LGBT Aging Policy Task Force, San Francisco, CA
Addressing Violence Throughout the Lifespan	SF Department on the Status of Women
Alcohol Policy and Nutrition Policy Research Study	San Francisco Health Improvement Partnership
Assessing support, barriers, and access to social, physical and mental health services for survivors of non-sexual human trafficking in San Francisco	San Francisco State University Public Health and San Francisco Department of Public Health Newcomers Health Program
*Assessment of Food Security in San Francisco	San Francisco Food Security Task Force
Campaign for HOPE SF	Campaign for HOPE SF Health Task Force
Community Needs Assessment	SF Department of Children, Youth, and Their Families
DAAS Needs Assessment: Part 1 (Demographics)	SF Dept. of Aging & Adult Services
DAAS Nutrition Needs Assessment Findings	SF Dept. of Aging & Adult Services
Eat Drink Bayview	University of California Berkeley School of Public Health
Engaged Learning Zone Project: Phase 1	San Francisco State University Institute for Civic and Community Engagement
Exposure to Second-hand Smoke & Healthy Food Access for Tenants in Four Supportive Housing Sites in San Francisco: Healthy Lifestyles Survey 2013–14	SFDPH, Population Health Division, Community Health & Equity Promotion Branch
First 5 San Francisco Strategic Plan 2012–15	First 5
First Steps: A Data Report on the Status of San Francisco's Young Children	First 5 San Francisco Children and Families Commmission
Health and Social Impact of Free, Stop-in Group Physical Activity offered in San Francisco	Department of Public Health
HIV and Aging, A survey in three San Francisco area counties: San Francisco City and County, San Mateo County, and Marin County	San Francisco State University,
*Homeless point-in-time count and survey	The San Francisco Local Homeless Coordinating Board
*Homeless Prenatal Program Annual Report	Homeless Prenatal Program
Key Stakeholder Focus Groups	Maternal, Child, and Adolescent Health
Lesbian, Gay, Bisexual, and Transgender (LGBT) Seniors	San Francisco Human Services Agency Planning Unit
LGBT Aging at the Golden Gate: San Francisco Policy Issues & Recommendations	The San Francisco Department of Adult and Aging Services
MPN School Climate Survey	Mission Economic Development Agency
Our Children, Our City Stakeholder Engagement Process	Our Children, Our City Stakeholder Council
Our Journey to Improve Quality and the Health of Our Population	San Francisco Health Plan

*Assessments not reviewed as part of Assessment of Assessments

Titles continues on the next page.

Assessment of Prior Assessments

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Table contined from previous page.

Document title	Lead agency or entity
Peer Health Strategies	San Francisco State University, Department of Health Education & Health Equity Institute
Portrait of School Readiness 2009–2010: SFUSD Comprehensive Report	SFUSD
Public Education Enrichment Fund: Annual Report for FY 2012–2013	CCSF Office of the Controller-City Services Auditor
Resilient Bayview Program Guide	Empowered Communities Program
San Francisco Asian and Pacific Islander Communities and Mental Health	The Asian & Pacific Islander Health Parity Coalition
San Francisco Community Health Needs Assessment Appendices and Profile	San Francisco Department of Public Health
San Francisco Community Transformation Initiative: 2014 Community Health Professional Survey results	San Francisco Department of Public Health
San Francisco Early Care Education Needs Assessment	CPAC San Francisco Child Care Planning & Advisory Council
San Francisco Healthy Homes Community Action Plan	SF Dept. of the Environment
San Francisco Safe Routes to School 2013–2014 Grant Final Report	San Francisco Safe Routes to School Program
San Francisco Unified School District Student Commute Study Summary of Results 2010–2013	SFUSD
Seniors and Adults with Disabilities in SROs: Survey and Recommendations	Senior Action Network
Sexual Healthcare Preferences among Gay and Bisexual Men: A Qualitative Study in SF	Center for AIDS Prevention Studies, UCSF and SF AIDS Foundation
SF Children's Oral Health Strategic Plan	San Francisco Health Improvement Partnerships
SFUSD PE Study Final Report	Shape Up San Francisco
Survey of Community Stakeholders about Maternal, Child & Adolescent Health	City and County of San Francisco
The Health and Well-being of Youth Living in Hope SF Communities	San Francisco State University
The Mental Health of Children and Their Families Living in HOPE SF Communities	SF State University, Dept. of Health Education and Health Equity Institute
The San Francisco HIV Prevention Strategy, 2012–2016: An Integrated Citywide Approach	San Francisco Department of Public Health
The Story of the Mission Promise Neighborhood Community	Mission Economic Development Agency
*Health Care Focus Groups Report Back from San Francisco's Bayview, Sunnydale, and Western Addition Neighborhoods	Rafiki Coalition

*Assessments not reviewed as part of Assessment of Assessments

Assessment of Prior Assessments

Appendix 2: Sample data extraction form

Assessment title:

Lead agency/entity:

Year published:

Inclusion criteria		
1a) Assessment includes primary data (any new information gathered specifically for the assessment	Yes ☐	No ☐
1b) If assessment spans counties, primary data can be viewed for San Francisco alone	Yes ☐	No ☐
1c) Primary data was collected in 2010 or later	Yes ☐	No ☐
1d) The methods for collecting primary data are identified	Yes ☐	No ☐
2) The assessment topic includes health determinants (social determinants of health) or health outcomes	Yes ☐	No ☐

If answered "No" to questions 1 through 2 this assessment will be excluded. Addition data extraction is not necessary.

Assessment Identification

List partner agencies/entities:

Is this a routine assessment? Yes ☐ No ☐ Unknown ☐

If available, identify the funding source:

Contact for lead agency/entity:

Name:

Phone number: Email:

Appendix 2: Sample data extraction form (*continued*)

Assessment Topic

Describe the reasons for the assessment:

Describe the target population (check all that apply):

- ☐ Children (0–5 years)
- ☐ Youth (5–25 years)
- ☐ Adults
- ☐ Seniors
- ☐ Males
- ☐ Females
- ☐ Families
- ☐ Mothers
- ☐ Fathers
- ☐ Blacks
- ☐ Latinos
- ☐ Asians/API
- ☐ SF Hope Residents
- ☐ SRO residents
- ☐ Homeless
- ☐ People with HIV
- ☐ LGBTQ
- ☐ Other, describe:

List the health issues explored:

Primary Data Collection

Complete a table for each primary data activity included in the assessment. Primary data includes any information that was gathered as an activity specific to the assessment. Secondary data, or data collected for other uses, including but not limited to census data, California Health Interview Survey Results, American Community Survey Data, or other program administration data, does not need to be described in the following tables.

Space is provided for up to 3 primary data activities. If additional space is needed please continue onto another extraction form.

Appendix 2: Sample data extraction form (*continued*)

Primary Data Collection Activity 1	
Study methods (survey, focus group, stakeholder interviews, key informant interviews, community forum, etc.)	
Year data collected:	Number of participants:
Participants were community members? Yes ☐ No ☐	Participants were community representatives? Yes ☐ No ☐
If available, provide descriptive statistics for the community participants:	
Describe affiliations for community representatives (clinicians, community business organization leaders, etc.)	
Describe how participants were identified and recruited	
Describe any gifts or rewards given for participation	
List the health related prompts/ questions asked **If available, email the assessment tool with this completed form.**	

Appendix 2: Sample data extraction form (*continued*)

Primary Data Collection Activity 2	
Study methods (survey, focus group, stakeholder interviews, key informant interviews, community forum, etc.)	
Year data collected:	Number of participants:
Participants were community members? Yes ☐ No ☐	Participants were community representatives? Yes ☐ No ☐
If available, provide descriptive statistics for the community participants:	
Describe affiliations for community representatives (clinicians, community business organization leaders, etc.)	
Describe how participants were identified and recruited	
Describe any gifts or rewards given for participation	
List the health related prompts/ questions asked **If available, email the assessment tool with this completed form.**	

Appendix 2: Sample data extraction form (*continued*)

Primary Data Collection Activity 3	
Study methods (survey, focus group, stakeholder interviews, key informant interviews, community forum, etc.)	
Year data collected:	Number of participants:
Participants were community members? Yes ☐ No ☐	Participants were community representatives? Yes ☐ No ☐
If available, provide descriptive statistics for the community participants:	
Describe affiliations for community representatives (clinicians, community business organization leaders, etc.)	
Describe how participants were identified and recruited	
Describe any gifts or rewards given for participation	
List the health related prompts/ questions asked **If available, email the assessment tool with this completed form.**	

Appendix 2: Sample data extraction form (*continued*)

Secondary Data

Identify any secondary data sources referenced in the assessment (Check all that apply.)

☐ American Communities Survey ☐ Census ☐ California Health Interview Survey ☐ Other, specify

Findings

As summarized in the report, list the top health issues identified:

What methods were used to identify the top health issues by the report authors? ☐ Unknown

List any additional health findings noted by the reviewer :

Describe any study limitations:

List any data gaps identified in the assessment:

Appendix 2: Sample data extraction form (*continued*)

Recommendations & Assets

List identified solutions:

Name entities indicated as key players in the solutions:

List any assets available in the target community which can contribute to the solutions:

Assessment Reviewer

Name:

Phone number: Email:

Community Engagement

Figure A: Health needs as voiced by the community. Words mentioned more frequently by community members are larger.

Community engagement goals

The goals of the community engagement component of the CHA were:

- To identify San Francisco residents' health priorities, especially those of vulnerable populations.
- To obtain data on populations for which we have little quantitative data.
- To strengthen relations between the community and SFHIP.
- To meet regulatory requirements, including the IRS rules for charitable 501(c)(3) hospitals (CHNA), Public Health Accreditation Board requirements for the San Francisco Health Department (CHA/CHIP), and San Francisco's Planning Code requirements for a Health Care Service Master Plan (HCSMP)

Participant Demographics

In total, 127 participants attended 11 meetings between July 1st and October 2nd, 2015. Participants came from a variety of backgrounds. The ethnic groups with the largest representation in the meetings were Latino (23 percent) , Black/African American (15 percent), White (17 percent), and Asian (12 percent). Other self-reported ethnicities included Arab, Filipino, Jewish, Middle Eastern, and Native American. The majority of participants were female (59 percent). Thirty-two percent of participants were male and nine percent identified as trans-male, trans-female, or other. Sixty-five percent of participants were between 25 and 64 years of age. More than half of all participants earned less than $25,000 per year. Only seven percent earned more than $75,000 (**Table 1**).

Themes identified at meetings

Physical activity: Community members recognized that increased physical activity is associated with a better quality of life. They voiced an interest in programs to support physical activity. Ideas included walking clubs, dance and music events, tennis tournaments, swimming, nature walks, and church-sponsored activities. Impediments to physical activity included expense. Suggestions for increasing physical activity included motivation through contests, and having well known experts visit the community.

Healthy foods: Community members recognized the need for, and expressed a desire to eat, healthy food in appropriate portions. Some mentioned the need for education (cooking classes, recipes, demos).

The major barrier noted to eating healthy food was cost. Healthy foods were viewed as expensive and out of reach. Those who access food through food banks and/or retailers that accept EBT or WIC stated that they have limited access to healthy foods, especially foods low in sodium, fat, and sugar. For those living in residential hotels and other locations which have limited or no facilities for storing or preparing foods, access to healthy hot meals from vendors who accept EBT would improve their diets. Additionally, some felt that school lunches needed improvement. Newcomers mentioned difficulty developing a healthy diet due to limited food access and difficulty transitioning to a new culture.. Some felt that more farmer's markets and stronger food regulations could make more healthy foods available.

Housing: Housing was mentioned during at least five of the meetings. Low-income housing, housing for seniors, additional public shelters, and safe places to go and stay were cited as needs. The cost of housing was a major concern because it puts greater financial pressure on residents at the lower end of the economic spectrum. Some felt discriminated against (sex offenders, people with dependencies) in the housing market. While some community members had an opportunity to be relocated to public housing outside of the city, the location and availability of services and resources were a concern. Participants stressed the need to define and build communities, especially for the homeless and people in transitional housing. The older population was cited as being especially vulnerable.

Education and empowerment: Education was seen as necessary for good health, especially for children. Participants noted a need for youth programs in general, and for tutoring in life skills, to encourage community involvement. The need for additional resources, and the importance of publicizing existing resources, such as medical services available in schools, were mentioned.

Many wanted the opportunity to be more involved, and requested assistance with organizing and self-empowerment. They want community representation on political committees, and a voice in decision making, with a focus on what services are available. They felt that partnerships with other communities could be beneficial.

Economic opportunity: Economic barriers to health were noted throughout the community meetings. Participants expressed a need for jobs with higher wages, and reported working long hours that didn't allow time to pay more attention to health. A lack of resources, both personal and community-wide, was noted.

Clean and safe environments: Residents voiced a desire for a cleaner and safer city. They felt environmental problems were beyond their control. They also expressed lack of knowledge about environmental problems. Suggestions included more green spaces, community gardens, public parks, and clean public restrooms. Some did not feel safe to exercise in their neighborhood.

Health care: Community members voiced three main needs regarding health care:

1) access to quality medical care including mental health care,
2) cultural competency, and
3) knowledge of resources.

Access to comprehensive medical care, dental care, and mental health services was discussed. It was pointed out that health care in general should encompass physical health and mental health. Participants believed that mental health services could help ameliorate domestic abuse and suicide issues in their communities. Access to health care was restricted by the costs of insurance, services, and medications, physical accessibility (transportation), immigration status, and delays in obtaining care through Medi-Cal. Some proposed solutions to problems with medical care access included universal health care, improved health care laws, lobbying for those with serious medical needs, improved transportation in the city, providing health system navigators, bringing health workers (medical, social workers and others) to residents' homes, and providing childcare for those going to medical visits. Participants also cited the need for more opportunities to receive preventative services.

Participants noted that culturally and/or linguistically appropriate medical services are often not available. There is a deficiency of printed materials, medical professionals, and interpreters fluent in the correct language and/or dialect. When interpreters were available their time with the patient was too limited. Some participants noted the need for medical professionals who "look like" them and who understand their health needs more personally, so that a trusting provider/client relationship can be

established. Proposed solutions for enhancing cultural competency included identifying and engaging with appropriate professionals in the community to make the required skills more available. It was noted that some skills may already be present but are not visible to the community. It was suggested that language interpretation services are more effective when conducted in person rather than over the phone. Some medical professionals need specialized training in social issues such as substance addiction and cultural differences. Some participants felt discriminated against while getting services. Stigma associated with accessing mental health services needs to be acknowledged and addressed.

A lack of available information about services and how to negotiate complicated medical systems (including insurance) was repeatedly mentioned in meetings. Access can be enhanced by simplifying forms and processes, producing materials in appropriate languages, and by employing both new technology (including smartphone apps) and basic methods of communicating (providing telephone numbers for those with limited access to the internet). Better coordination of services could also ameliorate problems encountered in dealing with the complex healthcare system.

Outreach: At many of the meetings, community members expressed the view that information was hard to come by. They suggested that better outreach could keep them informed about available medical and non-medical services and programs. They proposed organizing volunteers to provide information to the community, most effectively through personal contact. Public service announcements regarding available community services could be distributed on buses, by mail, and in medical settings. This would especially benefit seniors. Participants were also seeking ways to make their needs known. Two groups felt that gathering the community for the CHA meetings was beneficial in organizing themselves. There was a suggestion for additional similar forums in future.

Table 1: Participant demographics

		Number of participants	Percentage
Race/ethnicity	Arab	1	0.79
	Asian	15	11.81
	B/AA	19	14.96
	Filipino	4	3.15
	Jewish	1	0.79
	Latino	29	22.83
	Middle Eastern	12	9.45
	Multi-ethnic	8	6.30
	Native American	11	8.66
	White	17	13.39
	Missing	10	7.87
Gender	Female	75	59.06
	Male	32	25.20
	All	1	0.79
	Non-binary trans	1	0.79
	Trans-female	7	5.51
	Trans-male	2	1.57
	Missing	9	7.09
Age in years	15–24	14	11.02
	25–44	44	34.65
	45–64	38	29.92
	65–74	17	13.39
	75-plus	5	3.94
	Missing	9	7.09
Income	Less than $25,000	65	51.18
	$25,001–$50,000	22	17.32
	$50,001–$75,000	14	11.02
	Over $75,000	9	7.09
	Missing	17	13.39
	Totals overall	127	100.00

Methods

We worked with community partners to co-host community meetings with target populations. Where possible we joined existing meetings. All meetings were facilitated using Technology of Participation® techniques.

The main question posed to participants was, *What actions can we—residents, community groups, and SFHIP—take to improve health?* Participants were also asked these questions: *What are the strengths, resources, and assets that exist in your community to help you stay healthy?* and *What are the barriers that keep you, your family and friends, and your community from being healthy?*

Target populations included the formerly incarcerated, Native Americans, seniors, people with disabilities, transitional aged youth, children in the Tenderloin, veterans, undocumented residents, LGBTQ women, Black/African Americans who live outside of Bayview Hunters Point and HOPE SF sites, residents from the Middle East, and Filipinos. Selection criteria included persons who are at-risk, members of a minority, and groups for whom we are lacking health data.

Meetings were held in English and Spanish. We were able to complete meetings with 11 of the 13 target populations. Timing constraints prevented us from working with children in the Tenderloin and disabled persons. We were unable to reach lesbian and bisexual women, possibly indicating a lack of social services for this population.

Stipends ($500) were provided to partner organizations to be used for food, incentives, and other costs associated with hosting the meetings.

Table 2: Consensus Workshop responses from the meeting co-hosted with Advancing Justice of the Asian Law Caucus.

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Accessibility to services	Community wellness programs accessible to diverse sub-groups	Increase information availability	Liaison between community experts and the health care system	Culturally and linguistically appropriate services	Quality language access	Community engagement and awareness programs	Mental health services
Easy access to clinics including transportation	Women only general clinic ex. health and mental	Knowledge-written brochures (healthcare) in Arabic/English	Go-to group of cultural innovators and health experts	Hire more Arab speaking providers	Quality Arabic interpretors	Go making a lecture talk about taking care and health situation	Culturally competent mental health services
Arab healthcare club	Walking group ex. for elderly	Specific website of how to keep international people healthy	A grant specially for Arabic speaking programs	Breaking the language barrier	Language accessibility at all points of care	Resources and healthcare workshops in schools, mosques, communities	
Easy access to clinics including transportation	Women gym with daycare	Information in Arabic on what services already available		Trainings for all providers		Community events to increase awareness	
	All inclusive wellness program ex. nutrition, fitness, etc.	Videos, CDs and pictures so people who don't understand English can see		Social workers		Health workshops	
		HIPAA compliant Arabic/English healthcare app		More vocational programs for young Arabs in SF		Afterschool programs for kids	
		More acceptable health insurances		Adopting ideas from other established health care services in other cities (Detroit)		Door-to-door engagement	
				Hiring Arabic speaking case managers		Local iman workshops to mobilize resources/link to agencies	

Table 3: Consensus Workshop responses from the meeting co-hosted with Swords to Plowshares

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Complete access to care	Camaraderie/togetherness	Updated information	Build accessible housing	Build housing for veterans in business and certified
Better understanding of addiction in the medical field	Stay active	To be heard	Housing programs, separate, medical, drug, alcohol	No coddling
Complete access to all health care	Eat healthy	Current updated information	Housing stability	
Easier access	Healthy lifestyle	More interaction between police and veterans	Housing/business/ certifications	
Individualize care more instead of one-size-fits-all		Better mental health access and understanding throughout medical field	Financial stability (claims)	
Know your health provider			Nationwide: voucher programs, residence, limitations	
			Easier outsourcing	

Table 4: Consensus Workshop responses from the meeting co-hosted with African American Art | and Cultural Center

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Boogy for health	Increase accessibility	Involve yourself	More health awareness	Attract community involvement
Church exercise events	Transportation	Motivation	Get the word out (church, etc)	Bring a well-known health guru to the community
Tennis tournament	Incentives	Community members making their health a priority	Engage youth (school, social media)	Have speakers to target youth to left them know not to fall for the advertised type of drinks and cigarettes and the dangers of unprotected sex partners
Walking clubs	Accessibility (time/location)	Have a water tracking contest	Contact managers for all local complexes to inform tenants	Add food
Dance/music events	Timing	Have meetings in saturated areas IE park by McDonalds	Advertise on all forms of media	Venues
	Safe space for events		More meetings like this one	Look for sponsors
	Childcare		State and local funding to transport people	
	Providers for children		Get word out about what's in the community	
	Venues		Look for sponsors	

Table 5: Consensus Workshop responses from the meeting co-hosted with Native American Health Center

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Clear comunication	Increase healthy living	Create a Native space	First access to resources	Improved accessibility for Natuve Americans	Empowering community voice	Data sovereignty
Speak good English to communicate without accent	Nature walk	Provide commnity with a decent building to provide services to community	We need more resources for the community	Improved access to dental care	Help us organize, empower us	To c outcome of resports
What community X	Swimming groups	Cultural center	More funding to continue UTSF for youth and familieis	Improve access to health medical care	Get on city board's monthly meeting, agenda	Community input/based (research)
	Cooking class	Educate others, be understood	Money	Childcare while being seen at the appointment	Protest	What do we get out of the this for the community
	Health and food pantry	Affordable housing now	Increased $$$$$	Increased access to counseling	Guaranteed place on all political committees	
	Recipes/book to take home		Communtiy resources	Changes in health care in community	More partnerships with other communities	
	Food demo		Designated time for staff wellness	People that can't work need healthcare	Community voice in decision making for services	
			Ear mark funds – to fill the need assessment of	Cultural (humility) competency training for service providers		
			the community			
			Invest in our youth (7th generation)			
			Job retention for Native staff @ NAHC			

Table 6: Consensus Workshop responses from the meeting co-hosted with Instituto Familiar de la Raza/ Asociacion Mayab

¿Qué acciones podemos tomar para mejorar la salud? — incluyendo, residentes grupos comunitarios, y SFHIP?

Informar a la comunidad	Cobertura médica para todos	Más recursos en la escuelas	Mejorar los servicios	Reforma inmigración
Enterarse en la comunidad	Tener médica completo	Más recursos a la escuela	Más ayuda en el hospital	Votar por un buen presidente para que apoye todos los recursos
Información	Cobertura fácil de salud	Información impresa enescuelas de servicios medicos	Más clinicas	
Concientizar a la comunidad sobre la salud	Tener más recursos des alud	Calles libres de fumadores	En emergencia que sean más rápidos	
Información derechos ala salud	Que el gobierno seinterese a la comunidad	Niños saludables	El acceso a nuestro idioma	
Información de los numeros de telefono	Mejorar las reglas de salud		Intérpretes que tengan por lo menos 20 a 25 minutos para ayudar	
			Físicamente, mentalmente	
			Estar bien físicamente y mentalmente	
			Luchar por un mundo nuevo y saludable	
			Comer saludable	

Table 7: Consensus Workshop responses from the meeting co-hosted with Filipino American Development Foundation

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Increase economic capacity for Filipinos	Promote and sustain environmental health	Simplify and make healthcare affordable	Sustaining and advocating access	Increase engagement in education, research and technology	Promote Outreach!
Higher wages	More green spaces	Affordable healthcare	Community access; food parks, activitices, health	Education; relevant to community needs	Outreach let the community know their resources
Affordable housing	Community garden	Health insurance —simple	Increase access to drop-in clinics	Finding tech for better health	Community outreach!
Make healthy food affordable to all	Improve quality for our environment	Universarl healthcare	More programs for kids/families	Research on health and safety and society for Filipinos	Promote access.
Universal healthcare	Safer and clean neighborhoods	Simplify the system of care; the entire thing.		Undestanding mental health needs and issues	Culturally approproiuate and linguistically relevant to the community
	Safe areas to exercise			Work to remove stigma about seeking healthcare.	Work to remove stigma about seeking healthcare.
				Simple living.	Simple living.

Table 8: Consensus Workshop responses from the meeting co-hosted with LGBT Center-Trans Job Club

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Better services	Provide effective mental health services	People accessing services determine what serves are	Improve wellness	Quality coordination of services	Equal housing opportunities	Disability care
City-wide prevention health events	Suicide prevention	Team support	Self care	Communication between providers	Supporting housing should not be a dictatorship	There should be no lumping of different disabilty cases
A transgender doctor	Accessibility to mental health professionals	Peer leader	Exercise and eat healthy	Needs to be monitors for people who are serious about them calling.	Housing	
For funding for SFDPH	Domestic violence	Focus groups	Community partnerships		Aging	
Give dental care	Equality		Establish brothel		Sober discrimination	
Better trained doctors	Suicide prevention hotline		Opportunity to make money			
Common sense in the systems	NO discriminiation					
More training						
Sensitivity training						
More training for health care professionals treating trans folks						
Supportive services						
Health professionals who mirror “me”						
Less or no police brutality						

Table 9: Consensus Workshop responses from the meeting co-hosted with On Lok 30th Street Senior Center

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Access to larger facilities	Access to health resources	Increase access to physical activity	Increase personal connection (with non-healthcare providers)	Expand advertisement for services	Implement provider participation
We need larger facilities	Healthcare	Know your body	Have volunteers to help the patient	Ads in SF buses	Medical insurance to inform patients
	Healthcare	Better quality of life	Be teachable	Ads in hospitals and clinics	Health care providers, seminars & programs
	Provide medicine free and at low price	Pool exercise and expense	Outreach (person-to-person contact, volunteers; neighborhood fairs)	Advertise	Doctors & healthcare professionals spread the word
	Provide free or cheap medicine		Outreach personal contact (home visits; outreach targeted to family; personal, not computer/phone)	Get the word out	Doctors’ conferences
	Provide help and love of the patient			Information senior center	Doctors inform patients
	Try to help their needs			Conduct direct mail campaigns	Social workers inform patients
	Increase access to facilities			More advertising	SFHIP
	Access to transportation			Education (computer, legally blind)	Pharmacy update and information

Table 10: Consensus Workshop responses from the meeting co-hosted with Larkin Street Youth

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Universal housing	Increasing Awareness (Awareness of resources means need for education)	Eating healthy	Access to quality healthcare*	Accessing safe and sanitized places	Empowering Youth	Guarantee qualified Jobs
Housing	Advertise resources	Access to healthier food	Efficiency of mental health	Free public transportation	Youth programs	Jobs
Housing	Education tutor	Healthy food not food bank food	Psych Therapy	More safe, free public restrooms	Program for minor	Jobs
Free Housing	Services provide tuor and help meet basic needs, clothes. etc.	More food service	Doctor	Sanitary	Respect	Respect
More public shelters and housing	Teacher/mentor educate in life/prog, health/jobs, etc	More free food	Mental Health	Cleaner city		
A safe place to go	Community empowerment involvement	Respect	More youth, elderly an ment.	Public parks		
Respect	Programs	More hot food EBT locations	Disabled resources	Respect		
	Destroy capitalism		EMTs			
	Respect		Nurses			
			Free Clinic			
			Obtain Medi-cal faster			
			Respect			

*Participants decided they often have access to healthcare (free clinics), but felt that it wasn't always quality healthcare so decided to denote this characrteristic in theme name.

Table 11: Consensus Workshop responses from the meeting co-hosted with Transitions

The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

More shelter and more housing	Enhance dignity and quality of life	More well-being	More funding	Increase availability and ease of access	Make it simple
Provide low-income housing	I love life	Family reunification	More healthcare providers	Modify the RTC application to provide for ease of transportation	Make forms and instructions easier/ simple
Advocate for affordable housing	I want to be treated with respect regardless of my past	Alerting people to available mental health programs	Health workers on site	Transportation	Simplify the process
Homeless	I want to remain free	Mental health	In-house care		Share new information
Someone supply me with low cost senior housing	I love my freedom		Lobby the city, state and federal governments for more funding for people with series medical problems		Better informed community/patients
Working with state parole to lower homelessness			I want low-cost fitness centers		Counseling
Less discrimination against ex-offenders in housing			Lower the cost of medicines		
Expand the "fair chance ordinance" to include ex-offenders			Hands-on approach		
			Better Funding		

Table 12: Consensus Workshop responses from the meeting co-hosted with CARECEN

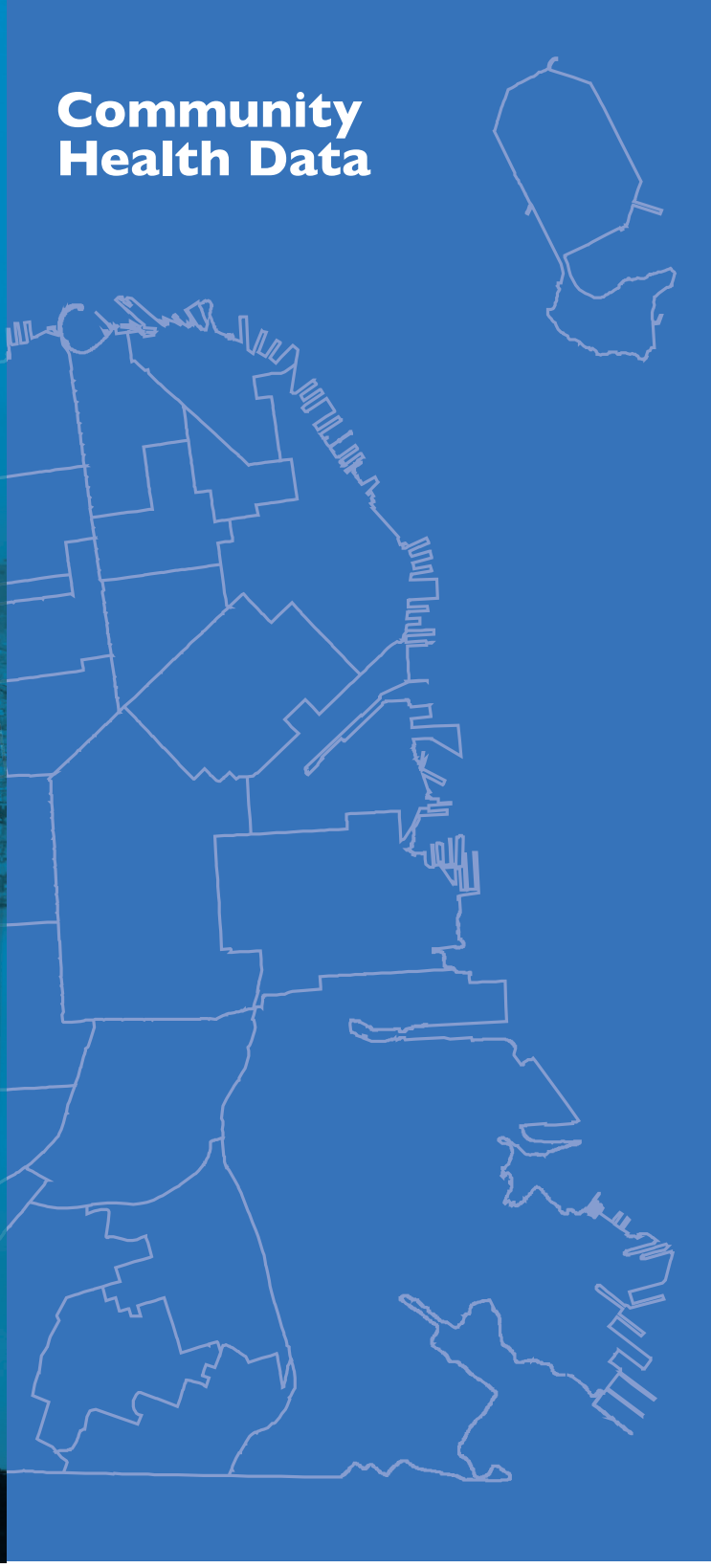
The actions we can take — including residents, community groups, and SFHIP — to improve health in the community are:

Access to health care for all	Promote healthy food	Pay attention to the food product regulation
Medical checkups, find support groups, workshops on health within the community	Re-orient products provided by WIC	Political will to make regulations on processed foods
That doctors are more reasonable in preventing and curing	Exercise and eating healthy	Provide funds to community agencies that focus on health
Health insurance at accessible cost	Do not drink a lot of soda or juice	Improve school meals
Become aware of the gravity of not taking care of one's health	Eating meals proportionately	Having a farmers market in this area
Access to low-cost dental care for adults	Reduce fatty foods and foods high in salt	Low prices for organic food
	Drink water and eat more fruit	
	Learn to eat healthier and be positive	

¿Qué acciones podemos tomar para mejorar la salud? — incluyendo, residentes grupos comunitarios, y SFHIP?

Acceso a cuidado de salud para todos	Promover la comida saludable	Poner atención a regulación al producto alimenticio
Chequeos médicos, buscar grupos de ayuda, buscar talleres de salud dentro de la comunidad	Reorientar los productos que prové el WIC	Voluntad política para hacer regulaciones, sobre los alimentos procesados
Que los médicos son mas r azonables en curar y prevenir	Ejercicios y comer saludable	Dar fondos a agencias comunitarias que se enfocan en salud
Precios accesible a seguro médico	No tomar mucha soda o jugo	Que mejoren las comidas en las escuelas
Tomar conciencia de la gravedad de no cuidar la salud	Comidas por porciones	Tener un mercado de agricultores en esta area
Acceso a dentistas a bajo costo para adultos	Disminuir la comida grasosa y con mucha sal	Bajos precios a la comida organica
	Tomar agua y comer mas frutas	
	Aprender a comer más saludable y estar positivo	

Community Health Data



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Framework

SAN FRANCISCO FRAMEWORK FOR ASSESSING POPULATION HEALTH AND EQUITY

UPSTREAM *Root Causes* ← → **DOWNSTREAM *Consequences***

Belief Systems
Cultural/ Societal Values
Discrimination/ Stigma

Institutional Policies & Practices
Public Policies
Organizational Practices

Living Conditions
PHYSICAL ENVIRONMENT
Land Use
Transportation
Housing
Natural Environment

SOCIAL ENVIRONMENT
Social Cohesion
Safety

ECONOMIC ENVIRONMENT
Educational Attainment
Employment
Income
Occupational Safety

SERVICE ENVIRONMENT
Health Care
Social Services
Education

Health Behaviors
Nutrition
Physical Activity
Tobacco Use
Alcohol and Other Drugs
Oral Health
Sexual Health
Preventive Care
Sleep

Psychosocial Factors
Stress
Lack of Control
Reactive Responding
Resilience

Health & Well-Being
QUALITY OF LIFE
FUNCTIONING
CLINICAL HEALTH
Communicable Disease
Chronic Disease
Injury
Mental Health

Death

INTERVENTIONS

- Strategic Partnerships, Advocacy
- Community Capacity Building, Community Organizing Civic Engagement
- Health Promotion & Prevention, Case Management
- Medical Care

EVIDENCE BASED POLICY MAKING

Terms and Definitions

Two Overall Factor Categories

Upstream	Upstream health factors are the root causes of health inequities. Public health interventions targeting upstream factors are important in eliminating inequitable social structure, providing access to resources, and removing impediments in and adding support for conditions that support health.
Downstream	Downstream factors are the consequences of health inequity. Public health interventions targeting downstream health factors are important to relieve the effects of health inequities.

Factors Affecting Health

Belief Systems	A set of mutually supportive beliefs (around ideology, religion, philosophy, or a combination) that shapes an individual's or society's knowledge, point of view, and interactions with the world.
Cultural and Societal Values	Commonly held standards of what is acceptable or unacceptable, important or unimportant, right or wrong, and so on, in a community or society. These values may not be static. The increase in support, from 1992 to 2007, for smoking bans in restaurants (from 45 percent to 64 percent), bars (24 percent to 44 percent), and sports arenas (67 percent to 79 percent) from 1992 to 2007 is an example of changing cultural values.
Discrimination and Stigma	Unjust or prejudicial attitudes toward or treatment of an individual or group of individuals based on their actual or perceived membership in a certain group or category.
Institutional Policies and Practices	Institutional policies are written guidelines or rules about howhow to reach a particular goal. A person or body invested with authority develops policies. A number of factors may affect policy development, including underlying values or assumptions, wider concerns, research, consultation processes, and current events. Institutional practice is the organized way in which associated individuals or groups carry out a particular activity. Guidelines or laws may frame practice, but ultimately it is the result of individual actions.
Organizational Practices and Policies	An organization's routine use of knowledge for conducting a particular function that has evolved over time under the influence of the organization's history, people, interests, and actions. Organizational practices and policies define the day-to-day experiences of community members, and shape the cultures in which they work and learn. The Ontario Association of Food Banks developed a program to salvage potentially wasted food. The food is made into soup by "chefs in training"—19 former street youth interested in developing cooking and job skills—make the food into soup. The organization freezes the soups and trucks them to food banks across Ontario. This is an example of organizational practices and policies in action.
Public Policy	An intentional course of action that a government institution or officials follow to resolve for resolving an issue of public concern. The institution must manifest such a course of action in laws, public statements, official regulations, or widely accepted and publicly visible patterns of behavior. Public policy is rooted in law and in the authority associated with law. Intentional courses of action include decisions made not to take a certain action. The Healthy Food Retailer Ordinance is an example of a public policy adopted in San Francisco. This 2013 ordinance established the Healthy Food Retailer Incentives Program to increase access to healthy food; reduce the availability of unhealthy options such as such as tobacco, alcohol, and processed foods high in salt, fat, and sugar in underserved parts of the city; and stimulate economic development and job creation by creating incentives for Healthy Food Retailers to open or expand in those underserved areas.
Living Conditions	The circumstances in which someone lives.

Terms and Definitions, *continued*

Economic Environment	Opportunities available to an individual to prepare for and obtain work, safe work environments, and income.
Educational Attainment	The highest degree of education an adult 25 years of age or over has completed.
Employment	The condition of having paid work.
Income	Money that a person earns from work, investments, business, and other sources.
Occupational Safety	Workplace conditions that affect the safety, health, and well-being of people engaged in work.
Physical Environment	The natural or artificial physical features of the world with which humans interact, with such as parks, housing, streets, buildings, air, products, art, and so forth.
Housing	Human shelter related issues include volume, quality, safety, and affordability of spaces for human shelter.
Land Use	The human use of land. Land use involves the management and modification of natural environment or wilderness into built environment.
Natural Environment	Environmental features such as natural land, water, air, and the atmosphere. Related issues include access to and preservation of the environment.
Transportation	The movement of people and goods. Related issues include accessibility, safety, and sustainability of systems that enable movement of people and goods.
Service Environment	The availability of and access to essential services such as medical care and education in a community.
Health Care (*Service Environment)*	Access to high-quality health care.
Education (*Service Environment)*	Access to high-quality educational opportunities.
Social Services	Government services provided for the benefit of the community such as subsidized food and housing.
Social Environment	The community in which one lives and/or identifies or interacts with.
Safety	The condition or perception of being safe from experiencing or causing physical or emotional violence. The ability to walk in one's neighborhood without the threat of violence is a characteristic of a safe environment.
Social Cohesion	A cohesive society works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward mobility. The components of social cohesion include, social capital, social isolation and social support.
Health Behaviors	Individual behaviors that affect health and well-being or help him or her prevent or detect disease.
Use of Alcohol and Other Drugs	Any chemical substance (legal or illegal), that changes a person's mental state when consumed, and that may have potentially harmful effects, such as poisoning, organ damage, dependence, or even death, in the event of improper short- or long-term use. Ethanol is an example of alcohol. Amphetamines, cocaine, heroin, and prescription drugs such as Vicodin are examples of drugs.
Nutrition	The intake of food and drink, considered in relation to the body's dietary needs. Good nutrition—an adequate, well-balanced diet—is a cornerstone of good health, along with regular physical activity.—*World Health Organization* (WHO)

Terms and Definitions, *continued*

Oral Health	A state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity.—WHO
Physical Activity	Any bodily movement produced by skeletal muscles that requires energy expenditure. Physical inactivity has been identified as the fourth leading risk factor for global mortality, causing an estimated 3.2 million deaths globally.—WHO
Preventive Care	A variety of health care services that prevent sickness and detect health problems before they become more serious.
Sexual Health	A state of physical, emotional, mental, and social well-being in relation to sexuality, not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. Attaining and maintaining sexual health requires respect, protection, and fulfillment of the sexual rights of all persons.—WHO
Sleep	Sleep is as important to our health as eating, drinking, and breathing. It allows our bodies to repair themselves and our brains to consolidate our memories and process information. Poor sleep is linked to physical problems, such as a weakened immune system, and mental health problems, such as anxiety and depression. While adults need 7–9 hours of sleep per night, one-year-olds need roughly 13 hours, school age children around 11, and teenagers a little over 9 hours.
Tobacco Use	Consumption of products made entirely or partly of leaf tobacco as raw material and intended to be smoked, sucked, chewed, or snuffed. All contain a highly addictive psychoactive ingredient, nicotine. Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases.—WHO Electronic cigarette (e-cig or e-cigarette), personal vaporizer, or electronic nicotine delivery system devices that simulate tobacco smoking by producing an aerosol, usually contain a mixture of chemicals that may include nicotine. There is growing concern that these devices may cause addiction among non-smokers and reverse decades of work to de-normalize smoking.

Gene Expression	Gene expression is the process by which genetic information gives rise to proteins that play a role in the functioning of our bodies. Gene expression is a result of both one's genetic makeup (genotype) and the mechanisms that are used to increase or decrease the gene products (proteins). Environmentally induced changes in the expression of one's genes can be both transient (for example, a response to an infectious disease), or permanent and heritable (epigenetics) such as a woman who is a BRCA1 gene carrier but does not develop breast cancer.

Psychosocial Factors	Pertaining to the influence of social factors on an individual's mind or behavior, and to the interrelation of behavioral and social factors.
Lack of Control or Perceived Control	A lack of power or authority to affect the circumstances under which one lives and works. A simple example of lack of control is when an employee is called in to work on her or his day off but cannot deny the request as he or he fears doing so will lead to dismissal.
Reactive Responding	Reactive responding is a type of response that occurs as a result of stress or emotional upset.
Resilience	The capacity to adapt successfully in the presence of risk and adversity, and to recover from or adjust to misfortune or change.

Terms and Definitions, *continued*

Stress	A process in which environmental demands strain a person's adaptive capacity, resulting in both psychological and biological changes that could place a person at risk of illness. The term *stress* describes the ways in which the body copes with or adapts to psychological, environmental, and physical challenges. Chronic or repeated stress may contribute to poor health. The coping or biologic mechanisms through which stress manifest is also referred to as *allostasis* and *allostatic load*.—*The MacArthur Foundation, Research Network on Socioeconomic Status and & Health* Stress may result from major life events such as the death of a loved one, the loss of a job, getting a divorce, moving, or going to court, or environmental stressors such as exposure to violence or trauma, noise pollution, and so on.
Health and Well-Being	Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.—WHO Well-being can be described as judging life positively and feeling good, as well as feeling healthy and full of energy. —*Center for Disease Control and Prevention*
Clinical Health	Health conditions that can be classified under the ICD-10 medical classification list.
Chronic Disease	A non-communicable diseases of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), and diabetes.—WHO Chronic diseases are the nation's leading causes of death and disability, and result in compromised quality of life and increased health care costs.
Communicable Disease	Disease that can be caught from another person or animal through direct or indirect contact. West Nile virus is an example of a communicable disease that can be caught indirectly through a mosquito vector. Tuberculosis is an example of a disease that can spread from person to person through the air.
Injury	Damage to a person's body. Injuries resulting from accidents, such as traffic collisions, drowning, poisoning, falls, or burns, together with injuries resulting from violence, such as assault, self-inflicted violence, or acts of war, kill more than 5 million people worldwide annually and cause harm to millions more.—WHO
Mental Health	Not just the absence of mental disorder but a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her or his community.—WHO
Functioning	An individual's ability to perform activities required in her or his daily life. Deficiencies in physical, cognitive, or emotional functioning can have interdependent negative consequences on health and well-being. Walking or mobility as well as activities of daily living, such as running errands or opening containers, are examples of physical functioning.
Quality of Life	An individual's perception of her or his position in life in the context of the culture and value systems in which she or he lives and in relation to her or his goals, expectations, standards, and concerns. It is a broad-ranging concept that interacts in a complex way with the person's physical health, psychological state, personal beliefs, social relationships, and relationship to her or his environment.—WHO
Death	Premature deaths are deaths that occur before a person reaches an expected age: for instance, age 75. Many of these deaths are considered to be preventable.

Terms and Definitions, *continued*

Intervention Strategies

Intervention	The act or a method of interfering with the outcome or course, especially of a condition or process. An example of an intervention is directly observed therapy (DOT) for tuberculosis. DOT assures that patients take medications correctly, therefore enhancing treatment for the patient and preventing spread to others.
Advocacy	A political process by which an individual or group aims to influence public policy and resource allocations decisions within political, economic, and social systems and institutions.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs.
Civic Engagement	Individual and collective actions designed to identify and address issues of public concern. Civic engagement can take many forms, from individual voluntarism to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others in a community to solve a problem, or interact with the institutions of representative democracy. Civic engagement encompasses a range of specific activities, such as working in a soup kitchen, serving on a neighborhood association, writing a letter to an elected official, or voting. An underlying principal of our approach is that an engaged citizen should have the ability, agency, and opportunity to move comfortably among these various types of civic acts.—*American Psychological Association* A resident practicing civic engagement is one who is working to make a difference in the civic life of her or his community while developing a combination of knowledge, skills, values, and motivation to make that difference. An individual can affect the quality of life in a community, through both political and nonpolitical processes. Neighborhood groups who petition to add crosswalks or stop signs or take other measures to make walking safe in their neighborhood are civically engaged.
Community Capacity Building	Activities, resources, and support that strengthen the skills and abilities of people and community groups to take effective action and leading roles in the development of their communities.
Community Organizing	A process by which people come together, engage with other community members in identifying shared problems and desired solutions, and form organizations that act in the shared self-interest of the group.
Coordinating Services and Resources	The alignment and promotion of social services and resources in order to better serve the population.
Health Promotion and Prevention	Activities intended to promote the adoption of healthy habits in order to prevent rather than treat illness.
Medical Care	Treatment and prevention of disease by trained and licensed professionals.
Strategic Partnerships	An arrangement between two companies or organizations to help each other or work together so that each can achieve the things they want to achieve.

Community Health Data Summary

Key[1]: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Asthma and COPD	Age-adjusted hospitalization rate due to pediatric asthma					
		Percentage of adults who have ever been told by a health care provider that they have asthma					
		Age-adjusted hospitalization rate due to adult asthma					
		Percentage of high school and middle school students that have been diagnosed with asthma					
		Age-adjusted hospitalization rate due to COPD					
	Cancer	Invasive cancer rates					
		Incidence of prostate					
		Incidence of colon and rectum (men)					
		Incidence of colon and rectum (women)					
		Incidence of lung and bronchus (women)					
		Incidence of lung and bronchus (men)					
		Incidence of breast (female invasive)					
		Incidence of melonoma of the skin (men)					
		Incidence of bladder (men)					
		Incidence of liver (men)					
		Incidence of oral cavity and pharynx (men)					
		Incidence of leukemia (lymphocytic, myeloid, monocytic, other) (men)					
		Incidence of myeloma (men)					
		Incidence of Non-Hodgkin Lymphoma (men)					
		Incidence of Hodgkin lymphoma (men)					
		Incidence of cervix (women)					
		Incidence of corpus uteri					
		Incidence of melnoma of the skin (women)					
		Incidence of bladder (women)					
		Incidence of liver (women)					
	Cancer, *continued*	Incidence of oral cavity and pharynx (women)					
		Incidence of leukemia (lymphocytic, myeloid, monocytic, other) (women)					
		Incidence of myeloma (women)					
		Incidence of Non-Hodgkin lymphoma (women)					
		Incidence of Hodgkin lymphoma (women)					
	Cardiovascular Disease and Stroke	Age-adjusted hospitalization rate due to heart failure					
		Percentage of adults who have been told they have high blood pressure					
		Age-adjusted hospitalization rate due to hypertension					
		Percentage of Medicare beneficiaries who were treated for stroke					
		Percentage of adults who have been told they have any kind of heart disease					
	Children's Oral Health	Percentage of kindergarteners who have experienced caries					
		Percentage of kindergarteners who have untreated caries					
		Percentage of Denti-Cal eligible children ages 0–3 years who received dental care					

Chart continues on next page.

COMMUNITY HEALTH DATA SUMMARY

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Key: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Chronic Hepatitis B and C	Newly reported, past or present hepatitis C Infection per 100,000					
		Age-adjusted hospitalization rates Due to hepatitis C among adults 18 and Over					
		Newly reported chronic hepatitis B Infection					
	Civic Engagement	Percentage of registered voters who voted					
		Percentage of eligible residents registered to vote					
		Percentage of eligible residents who voted					
		Percentage of teens who have done any volunteer work or community service					
		Percentage of adults who served as a volunteer on any local board, council, or organization that deals with community problems					
		Percentage of adults who met informally with others to deal with community problems					
	Diabetes	Age-adjusted rate of hospitalization due to diabetes among adults 18 and over					
		Age-adjusted rate of hospitalization due to uncontrolled diabetes among adults 18 and over					
		Percentage of adults who have ever been diagnosed with diabetes					
		Percentage of live births to women diagnosed with gestational diabetes					
	Economic Environment	Employment rate for age 16 years and over					
		Median household income					
		Households living in poverty (200% FPL)					
		Income inequality (Gini Co-efficient)					
		Cost of living					
		Highest education achieved among adults 25 and over (Bachelor's)					
	Education and Childcare	Child care slots per child (child care centers plus licensed family child care homes)					
		Cost of childcare relative to household income (median costs) (child care center/licensed family child care home)					
		Childcare subsidies					
		Children enrolled in preschool and kindergarten					
		Third grade students passing/scoring proficient on higher language arts					
		High school suspension and expulsion rates					
		Chronic absenteeism					
		High school graduation rate					
	Foodborne Disease	Incidence of salmonellosis					
	Health and Well-being	Self-reported general health status					
		Disability status due to physical, mental, or emotional condition					
		Physical/mental impairment preventing work					

Chart continues on next page.

Key: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Health Care Access and Quality	Preventable hospitalizations					
		Health insurance coverage and enrollment in San Francisco Health Coverage Programs					
		Persons who have a usual place to go when sick or need health advice					
		Residents who delayed or were unable to obtain needed medical care					
		Preventable emergency room visits (rates)					
	Housing	Rent affordability					
		Affordable housing inventory					
		Fraction of income spent on rent					
		Overcrowding					
		Number of no-fault evictions					
		Homeless population					
		Health and building code violations for housing and habitability					
		Percentage of land in 100-year flood plain					
		Percentage of land in liquefaction zones					
	Immunizations and Vaccine Preventable Diseases	Percentage of students entering licensed child care facilities or kindergarten with all required Immunizations					
		Measles incidence					
		Pertussis incidence					
		Percentage of infants immunized with the 4 DTaP, 3 Polio, 1 MMR (the 4:3:1 series) by 24 months of age					
	Influenza and Pneumonia	Percentage of adults who received the influenza vaccination in the past year					
		Age-adjusted hospitalization rate due to immunization-preventable pneumonia and influenza per 10,000 aged 65+					
		Age-adjusted emergency room rate due to bacterial pneumonia per 10,000 aged 18+					
	Mental Health	Needed help for emotional/mental health and or drug-alcohol issues (18+)					
		Serious psychological distress in the past year? (18-plus)					
		Hospitalization rates due to schizophrenia and other psychological disorders (per 10,000)					
		Prolonged sad/hopeless feelings in the past year (high school students)					
		Emergency room visits due to self inflicted injury (per 10,000)					
		Hospitalization rates due to mood disorders (per 10,000)					
		Death rates due to suicides					
		Death rates due to alzheimers disease, other dementias and CNS disorders.					
		Ever considered attempting suicide (high school students)					

Chart continues on next page.

COMMUNITY HEALTH DATA SUMMARY

sfhip

Key: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Mortality	Life expectancy					
		HIV age-adjusted death rate					
		Hypertensive heart disease—age-adjusted death rate					
		Prostate cancer (male)—age-adjusted death rate					
		Lung cancer—age-adjusted death rate					
		Lower respiratory infection—age-adjusted death rate					
		Violence					
		Breast cancer (female)—Age-adjusted death rate					
		Chronic obstructive pulmonary disease—age-adjusted death rate					
		Stroke (cerebrovascular disease)					
		Ishemic heart disease—age-adjusted death rate					
		Diabetes—age-adjusted death rate					
		Suicide					
		Drug poisoning					
		Infant mortality					
		Colon cancer—age-adjusted death rate					
		Liver cancer—age-adjusted death rate					
		Alzheimer's and organic dementias—age-adjusted death rate					
	Natural Environment	Solid waste disposal per capita					
		Greenhouse gas emissions per capita					
		Tree canopy					
		Impervious surface					
		Number of days with good air quality					
	Nutrition	Percentage of new mothers who exclusively breast fed					
		High school students consuming 5 or more fruit and vegetables per day					
		Fast food intake					
		Soda intake among high school students					
		Food security					
		Food retail variety					
	Physical Activity	Physically-fit children in 5th, 7th, and 9th grade					
		Adults doing 150-plus minutes of physical activity per week					
		High school students who engaged in physical activity 7 days per week					
		Recreation area score					
		Residents living within a half mile of a recreation facility					
		Land that is open space					
		Minutes spent per day walking and or biking for non-leisure, utilitarian trips					
	Pre-term Births	Percentage of live births born before 37 completed weeks of gestation					
		Percentage of live births born at less than 32 weeks of gestation					

Chart continues on next page.

COMMUNITY HEALTH DATA SUMMARY

sfhip

Key: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Safety	Violent crime rates					
		Emergency room visits due to assault					
		Emergency room visits due to domestic abuse					
		Substantiated child abuse					
		Students bullied at school or electronically					
		Dating violence					
		Dating sexual violence					
		Drug crime rate					
		Perceived safety at night					
		Domestic violence 911 calls					
	Sexual Health	Incidence of HIV infection					
		Prevalence of HIV					
		Incidence of chlamydia					
		Incidence of gonorrhea					
		Incidence of primary, secondary, and early latent, syphilis					
		Percentage of sexually active youth who used a condom the last time they had sexual intercourse					
		Percentage of youth who reported drinking alcohol or using drugs before they had sexual intercourse					
		Percentage of students reporting being forced to have sex when they did not want to					
		Percentage of students being hit by a girlfriend or boyfriend					
		Percentage of pregnancies that were unintended					
	Substance Abuse	Density of off-sale alcohol outlets					
		ER visits due to acute or chronic alcohol abuse					
		Hospitalizations due to acute or chronic alcohol abuse					
		Binge drinking among adults					
		Binge drinking among students					
		Drug use among students					
	Transportation	Vision Zero Network: Severe/fatal traffic injuries per 100 road miles					
		Traffic density					
		Proportion of trips by walking, biking or public transit					
		Bike Network: ratio of bike lanes and paths to road miles					
	Tobacco Use and Exposure	Percentage of adults who are current cigarette smokers					
		Percentage of high school students who smoked cigarettes in the past 30 days					
		Pregnant mothers who smoked before or during pregnancy					
		Density of tobacco permits					

Chart continues on next page.

Key: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

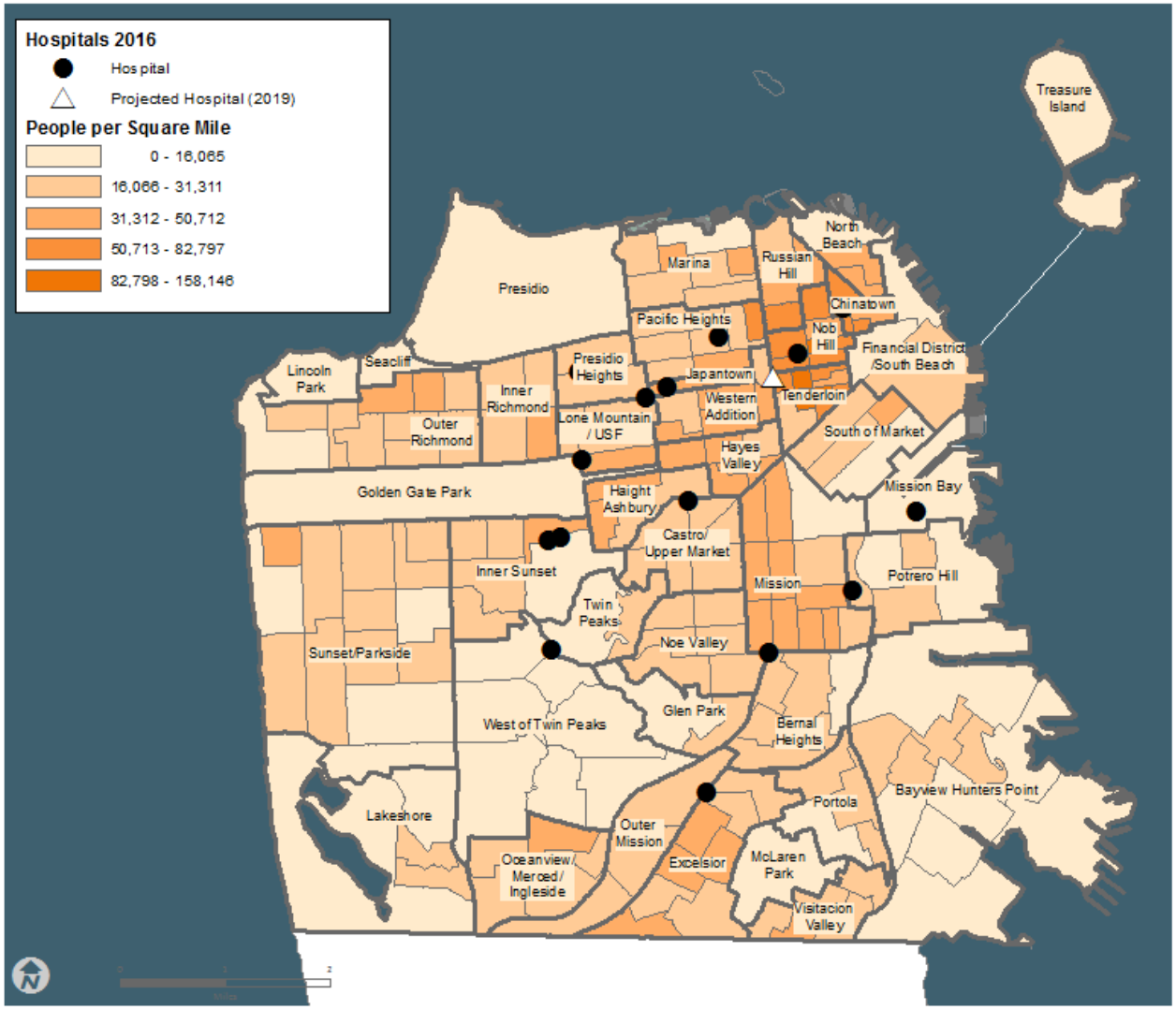
Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Tuberculosis	Tuberculosis incidence					
	Weight	Percentage of adults overweight or obese					
		Percentage of students in grades 5, 7, and 9 with a body composition outside the healthy range					
		Percentage of women who gain excess weight during pregnancy					
		Percentage of WIC participants ages 0 to 2 who are overweight or obese					
		Percentage of Headstart children ages 3 to 4 who are overweight or obese					

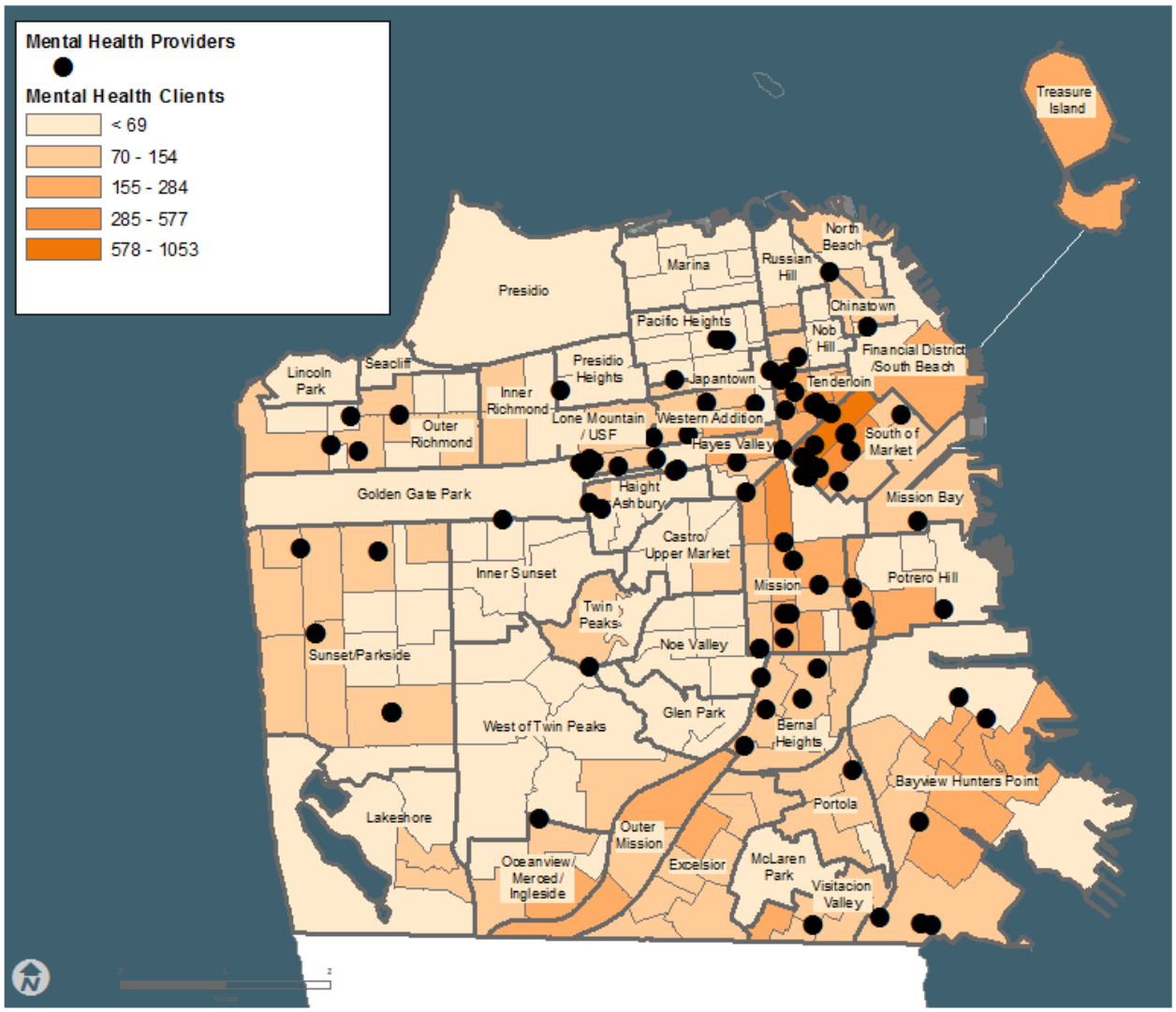
Methodology and Limitations

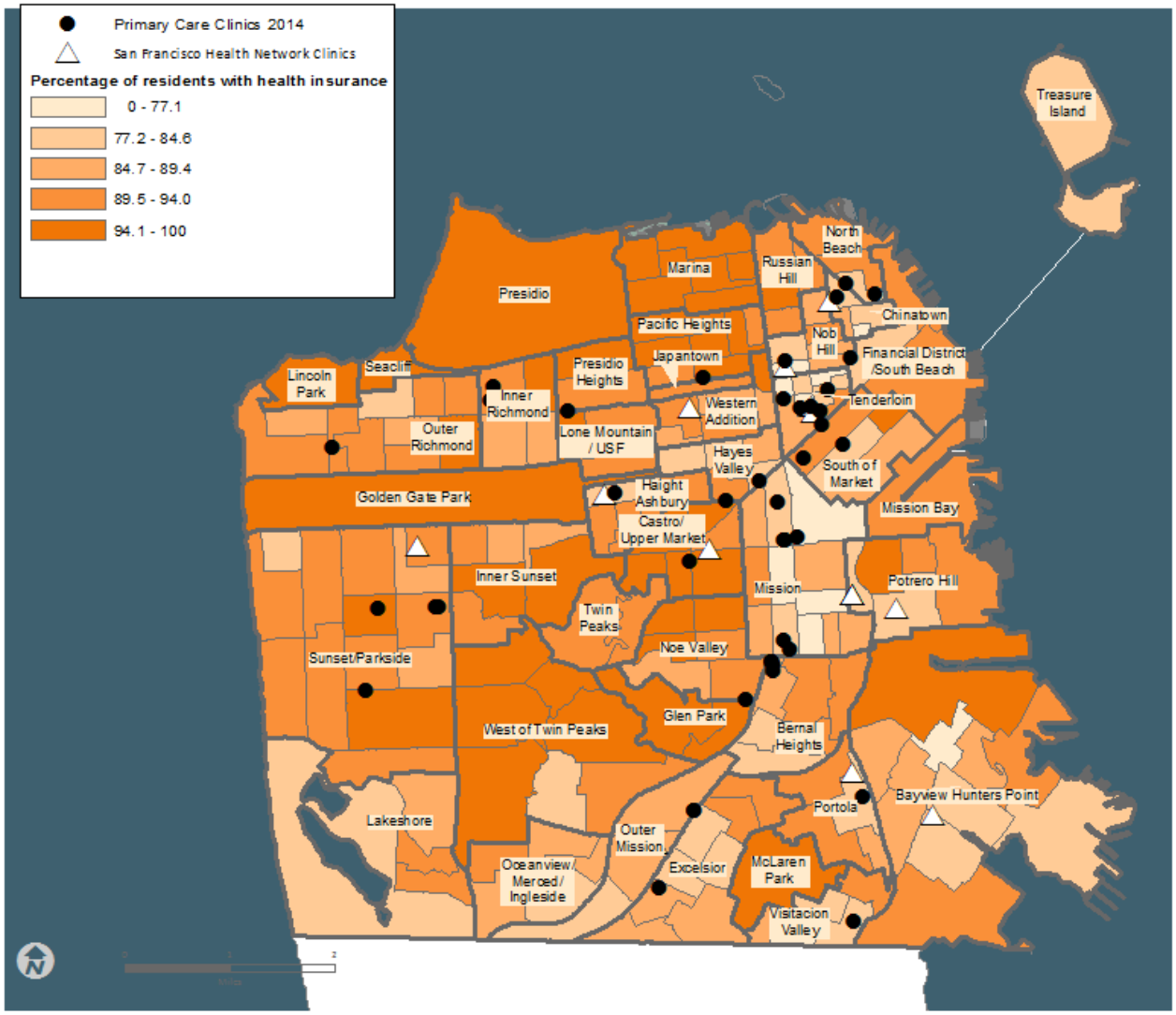
To identify issues for which San Francisco performs poorly on overall (first column), citywide estimates were compared against available external benchmarks—California estimates, HP2020 Targets, or national estimates. To identify disparities within the city (right most columns), subgroup estimates were compared against the citywide estimate.

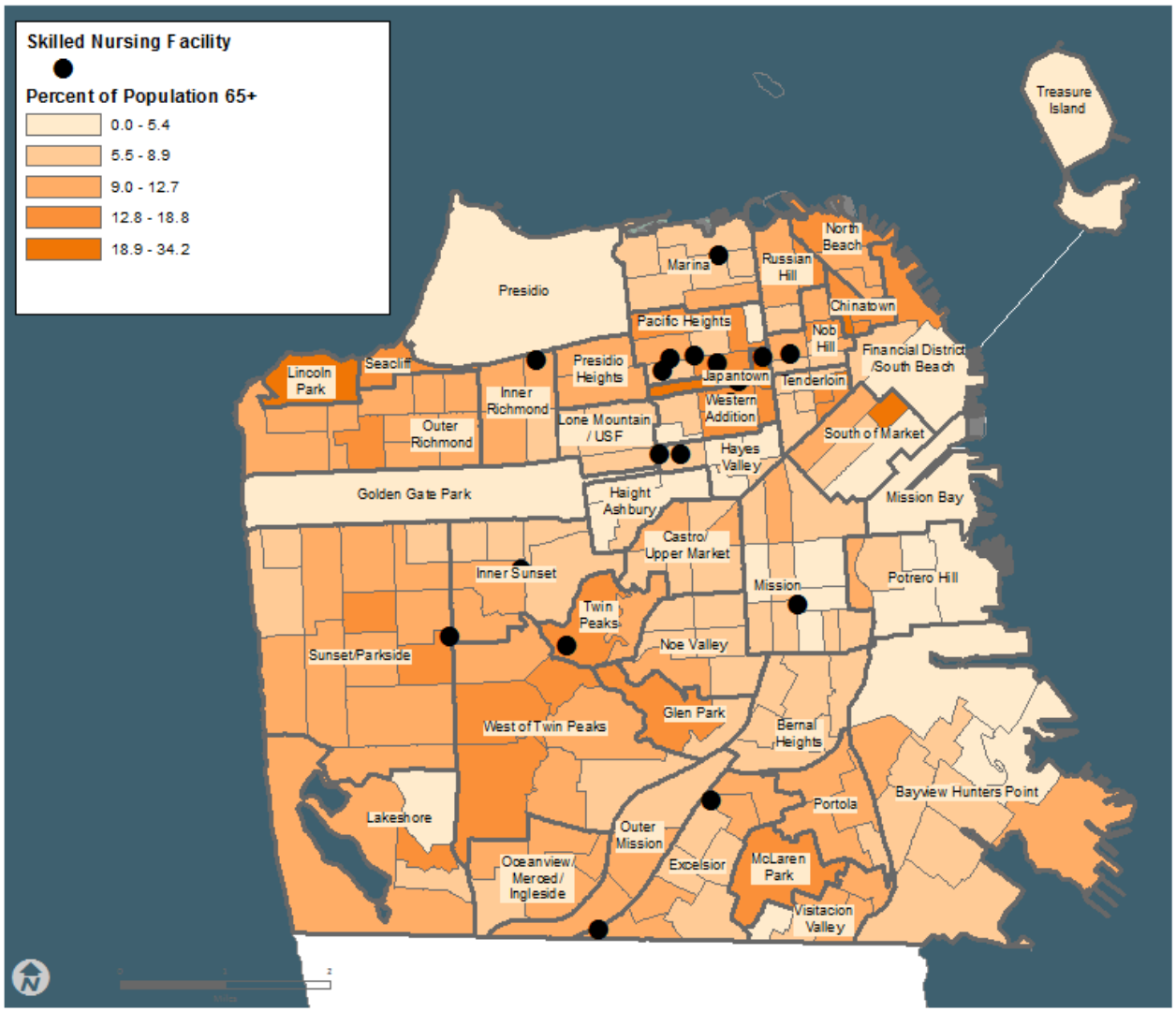
For both external and internal comparisons, "performs badly" was indicated if the estimates exceeded a target or if statistical tests found the estimate to vary from the non-target benchmark (California or national estimate). "Likely performs badly" was applied where insufficient data was available to perform a statistical comparison but a difference was seen consistently over time and or by magnitude. "Preforms equal to or better than the benchmark" was used in instances in which the city or subgroup performed better than a benchmark and or there data were insufficient to determine if a true difference existed. "Insufficient data/benchmark not available" was applied where an estimate or a benchmark was not available for performing comparisons.

APPENDIX D: COMMUNITY ASSETS MAPS




Mental Health Providers
Mental Health Clients
< 69
70 - 154
155 - 284
285 - 577
578 - 1053
Treasure Island
North Beach
Russian Hill
Marina
Presidio
Chinatown
Pacific Heights
Nob Hill
Financial District /South Beach
Lincoln Park
Seacliff
Presidio Heights
Japantown
Tenderloin
Inner Richmond
Lone Mountain / USF
Western Addition
Outer Richmond
Hayes Valley
South of Market
Golden Gate Park
Haight Ashbury
Mission Bay
Castro/ Upper Market
Inner Sunset
Mission
Potrero Hill
Twin Peaks
Noe Valley
Sunset/Parkside
Glen Park
West of Twin Peaks
Bernal Heights
Bayview Hunters Point
Portola
Lakeshore
Outer Mission
Excelsior
McLaren Park
Oceanview/ Merced/ Ingleside
Visitacion Valley


Primary Care Clinics 2014
San Francisco Health Network Clinics
Percentage of residents with health insurance
0 - 77.1
77.2 - 84.6
84.7 - 89.4
89.5 - 94.0
94.1 - 100
Treasure Island
North Beach
Russian Hill
Marina
Presidio
Pacific Heights
Chinatown
Nob Hill
Financial District /South Beach
Japantown
Presidio Heights
Seacliff
Lincoln Park
Inner Richmond
Western Addition
Tenderloin
Outer Richmond
Lone Mountain / USF
Hayes Valley
South of Market
Golden Gate Park
Haight Ashbury
Mission Bay
Castro/ Upper Market
Inner Sunset
Mission
Potrero Hill
Twin Peaks
Noe Valley
Sunset/Parkside
Glen Park
West of Twin Peaks
Bernal Heights
Bayview Hunters Point
Portola
Lakeshore
Outer Mission
Excelsior
McLaren Park
Oceanview/ Merced/ Ingleside
Visitacion Valley


Skilled Nursing Facility
Percent of Population 65+
0.0 - 5.4
5.5 - 8.9
9.0 - 12.7
12.8 - 18.8
18.9 - 34.2
Treasure Island
Presidio
Marina
North Beach
Russian Hill
Chinatown
Pacific Heights
Nob Hill
Financial District /South Beach
Lincoln Park
Seacliff
Presidio Heights
Japantown
Tenderloin
Inner Richmond
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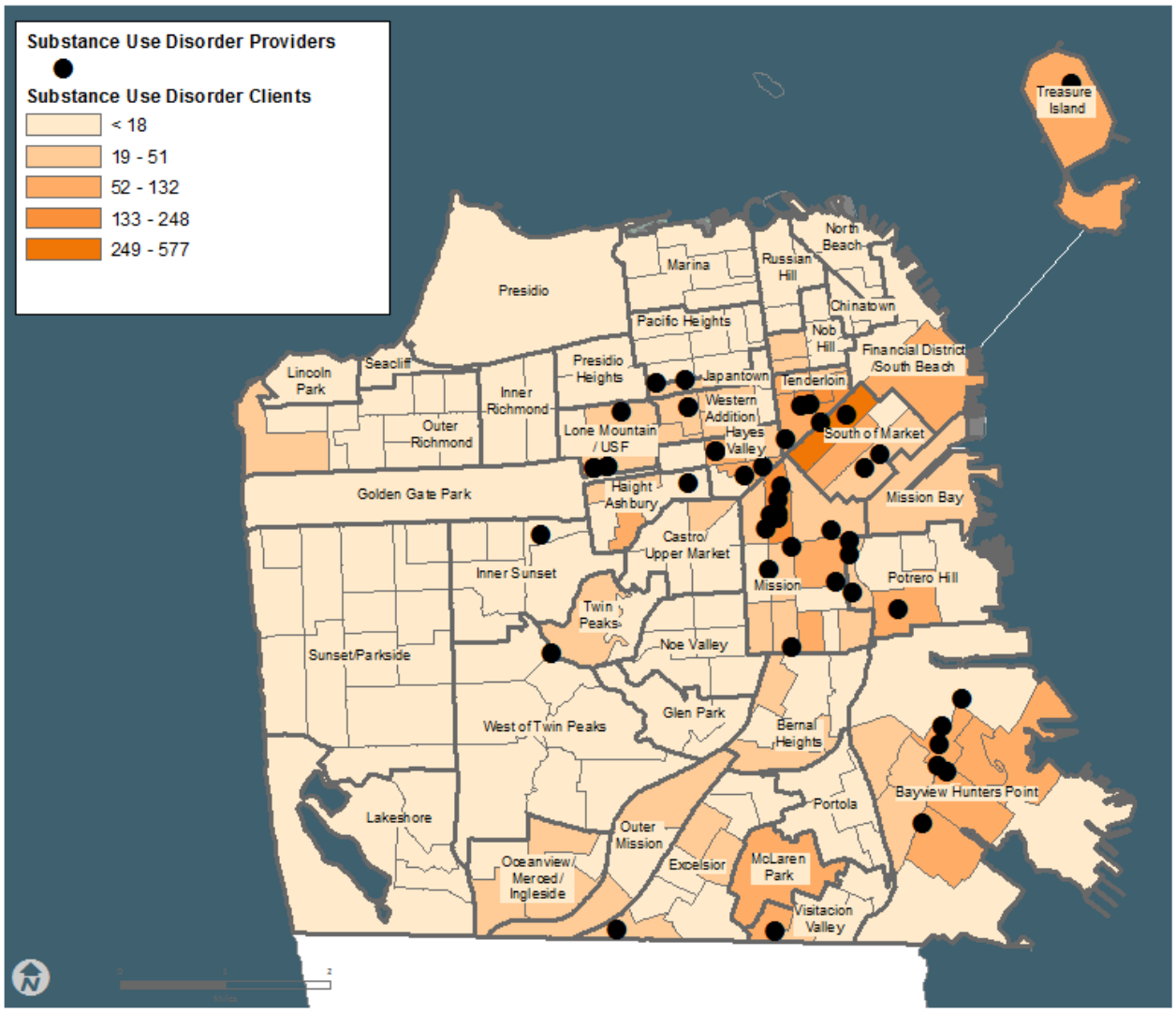
Excelsior
McLaren Park
Oceanview/ Merced/ Ingleside
Visitacion Valley


Substance Use Disorder Providers
Substance Use Disorder Clients
< 18
19 - 51
52 - 132
133 - 248
249 - 577
Treasure Island
North Beach
Russian Hill
Marina
Presidio
Chinatown
Pacific Heights
Nob Hill
Financial District /South Beach
Lincoln Park
Seacliff
Presidio Heights
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West of Twin Peaks
Bernal Heights
Bayview Hunters Point
Portola
Lakeshore
Outer Mission
Excelsior
McLaren Park
Oceanview/ Merced/ Ingleside
Visitacion Valley

APPENDIX E: CPMC'S EVALUATION OF IMPACT OF ACTIONS TAKEN SINCE THE PREVIOUS CHNA

This section is based on the 2013–2015 Implementation Strategy that described how CPMC planned to address significant health needs identified in its 2013 Community Health Needs Assessment. The strategy described actions the hospital intended to take, including programs and resources it planned to commit.

Listed here are the impacts achieved for each of the programs for which CPMC actually provided services and/or resources in 2014 and 2015.

Health Need: Increase Access to High-Quality Health Care and Services

Name of Program, Initiative or Activity: **St. Luke's Health Care Center (SLHCC)**

Description

CPMC's SLHCC provides a full range of obstetric and gynecological care at its Women's Center; well-baby care, well-child care, and care for ill or injured children at its Pediatric Clinic; and primary, acute and chronic care at its Adult Internal Medicine Clinic for teenagers and adults. SLHCC's clinicians and staff are bilingual in English and Spanish, ensuring culturally competent and sensitive care.

Anticipated Impact and Plan to Evaluate

SLHCC is anticipated to improve access to care for uninsured and underinsured patients residing in communities south of Market Street in San Francisco. CPMC will evaluate SLHCC's impact by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

2014 & 2015 Impact

St. Luke's Health Care Center:

2014	2015
12,000 unique patients served	12,800 unique patients served
44,000 patient visits	41,000 patient visits

HealthFirst, SLHCC's affiliated center for health education and disease prevention, serves patients in chronic disease management:

2014	2015
650 unique patients served	750 unique patients served
1,900 patient visits	2,300 patient visits

CPMC maintains SLHCC at its St. Luke's Campus in order to provide subsidized primary care and preventive services to underserved residents of the Mission, as well as Bayview, Downtown/Civic Center, Visitacion Valley and Excelsior – some of the San Francisco neighborhoods identified as having the highest disparities related to important socio-economic determinants of health. By providing services such as these, CPMC contributes to improved access to care as measured by a shift in the Needs Assessment indicator tracking the number of San Franciscans with a usual source of health care (from 86.8% in 2009 to 87.3% in 2014) (www.sfhip.org). By ensuring that services are culturally and linguistically appropriate, CPMC helps to bridge gaps in

	accessibility due to language and cultural barriers for non-native-English speakers, as measured by a shift in the Needs Assessment indicator measuring San Francisco's percentage of adults who speak a language other than English at home who have difficulty understanding their doctors (from 2.1% in 2009 to 1.7% in 2011-2012) (www.sfhip.org). These services also counter limited access that may be caused by primary care providers being less likely to serve Medi-Cal beneficiaries due to low government reimbursement rates.

Name of Program, Initiative or Activity:	**Kalmanovitz Child Development Center (KCDC)**
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/ Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. KCDC serves patients who otherwise may not have been able to receive child developmental services. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50 percent higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children by partnering with local schools and other community organizations, such as De Marillac Academy, Immaculate Conception Academy, and First 5 San Francisco. De Marillac Academy is a tuition-free independent Catholic school serving low-income 4th-to-8th-grade students in San Francisco's Tenderloin District, where the majority of students suffer from some form of post-traumatic stress disorder, impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech therapists, language therapists, educational therapists and psychological counselors from KCDC provide more intensive services as needed at the school.
Anticipated Impact and Plan to Evaluate	KCDC is anticipated to improve access to care for uninsured and underinsured patients residing in San Francisco. CPMC will evaluate KCDC's impact by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

2014 & 2015 Impact	Services provided at KCDC's clinics: 2014: 1,850 unique patients served; 19,600 patient visits 2015 (San Francisco clinics only): 1,450 unique patients served; 16,700 patient visits Outreach at De Marillac Academy: Although many De Marillac students arrive as 4th-graders already one to two grade levels behind their peers, 91 percent of the most recent 8th-grade class went on to graduate from high school in four years, and more than 70 percent of De Marillac's alumni go on to college after high school.

Name of Program, Initiative or Activity:	**Joint Venture Health (new in 2014)**
Description	Joint Venture Health (JVH) is a partnership between UC Berkeley School of Public Health, North East Medical Services (NEMS), and CPMC. CPMC's contribution supports the creation of a cost-effective, comprehensive developmental and behavioral health screening, treatment and referral program for the 10,000 children and their families who have NEMS as their medical home (one in 10 children in San Francisco). UC Berkeley School of Public Health's long-term vision for this program is to partner with community health centers, health systems, and health professional training programs to create high-performing primary care systems for kids and families from low-income communities. The first three-year pilot initiative at NEMS began services in August 2014 at the Stockton Clinic and seeks to build primary care teams to systematically detect, treat and support kids with developmental and behavioral health needs at the community clinics where they receive their medical care. Early identification and intervention is key to changing the course of developmental conditions and helping to minimize the life-impact of these conditions on children and the costs to society.
Anticipated Impact and Plan to Evaluate	Joint Venture Health is anticipated to improve access to care for uninsured and underinsured patients residing in San Francisco. CPMC will evaluate JVH's impact by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	Besides CPMC's annual cash contributions and program grants, in 2014, CPMC donated the labor time of a dedicated child development specialist stationed at NEMS. In this first year of the pilot program, more than 400 kids under age 11 were screened. In 2015, CPMC provided two dedicated child development specialists and a consulting psychologist, and nearly 3,000 kids under age 11 were screened. In both years, 14 percent were found to be at moderate or high risk for developmental and social/emotional delays. All were connected to appropriate resources for early intervention.

Name of Program, Initiative or Activity: **Bayview Child Health Center (BCHC)**

Description

BCHC offers routine preventative and urgent pediatric care in one of San Francisco's most vulnerable and medically underserved neighborhoods, and addresses prevalent community health issues such as weight control and asthma management. The center is particularly attuned to the impact of community violence and childhood trauma on children's mental and physical health. The clinic also offers psychological and case management services to families through a partnership with the Center for Youth Wellness. Dental services are provided on site through a partnership with the Native American Health Center.

The clinic opened in 2007 as a collaboration between CPMC, Sutter Pacific Medical Foundation, and CPMC Foundation. In 2014, clinic ownership was transferred to South of Market Health Center (SMHC), and we were jointly awarded a grant to transition BCHC to become a Federally Qualified Health Center. This transition ensures financial sustainability and high-quality health care for Bayview families for the long term. CPMC continues to provide financial support to BCHC to subsidize operational costs as well as construction costs connected to the clinic's modernization plan.

Anticipated Impact and Plan to Evaluate

BCHC is anticipated to improve access to care for uninsured and underinsured patients residing in the Bayview Hunters Point district of San Francisco. CPMC will evaluate BCHC's impact by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

2014 & 2015 Impact

2014	2015
1,000 unique patients served	700 unique patients served
2,500 patient visits	1,700 patient visits

Through services such as these, CPMC has contributed to improved access to care as measured by a shift in the Needs Assessment indicator tracking the number of San Franciscans with a usual source of health care (from 86.8% in 2009 to 87.3% in 2014) (www.sfhip.org). By ensuring that services are culturally and linguistically appropriate, CPMC helps to bridge gaps in accessibility due to language and cultural barriers for non-native-English speakers, as measured by a shift in the Needs Assessment indicator measuring San Francisco's percentage of adults who speak a language other than English at home who have difficulty understanding their doctors (from 2.1% in 2009 to 1.7% in 2011-2012) (www.sfhip.org). These services also counter limited access that may be caused by primary care providers being less likely to serve Medi-Cal beneficiaries due to low government reimbursement rates.

Name of Program, Initiative or Activity:	**African American Breast Health Program (AABH), Sister to Sister Breast Health Program, and St. Luke's Breast Health Partnerships**
Description	CPMC's AABH and Sister to Sister programs offer women mammography screening and all the subsequent breast health diagnostic testing and treatment they may need at no cost. Partnership organizations, such as Bayview Hunters Point Senior Center, HealthRIGHT 360, San Francisco Free Clinic, Clinic by the Bay, and the San Francisco Chapter of the National Coalition of 100 Black Women, refer uninsured, underinsured, disadvantaged and at-risk women for mammography services. CPMC's Breast Center at the St. Luke's Campus promotes breast health in underserved communities by partnering with neighborhood clinics and community agencies, including Southeast Health Center, Mission Neighborhood Health Center, and Latina Breast Cancer Agency.
Anticipated Impact and Plan to Evaluate	CPMC's breast health programs are anticipated to improve access to care for uninsured and underinsured patients residing in the community. CPMC will evaluate their impact by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	The African American and Sister to Sister breast health programs saw declines in services due to ongoing implementation of the Affordable Care Act, as many uninsured San Franciscans now have new coverage options through Medi-Cal expansion and Covered California: 2014: 229 screenings provided; 284 patient visits; 23 first-time mammograms 2015: 142 screenings provided; 175 patient visits; 11 first-time mammograms CPMC's grant to Latina Breast Cancer Agency provided assistance for low-income patients to receive 370 mammograms at CPMC's St. Luke's Campus in 2014, and 325 mammograms in 2015. In late 2014, CPMC implemented a new grant to Shanti Project's Margot Murphy Breast Cancer Program to address the need for Care Navigation services for Shanti patients receiving free breast cancer treatment, prioritizing women who faced particular challenges in completing treatment due to being low-income, uninsured/underinsured, with limited English proficiency, and/or from immigrant populations. Through this grant, care navigation services were provided to 417 Shanti patients receiving free breast cancer treatment; of these, over 200 had moderate to severe needs for intensive care navigation. Staff recruited and trained 68 volunteer caregivers, 38 of whom were matched with breast cancer program clients to provide emotional support and practical assistance three hours per week for at least six months. In addition, 65 wellness workshops empowered clients with self-management and health promotion resources.

Name of Program, Initiative or Activity: **Coming Home Hospice**	
Description	CPMC's Coming Home Hospice provides 24-hour care for terminally ill clients and their families in a caring, homelike setting. CPMC ensures that high-quality residential hospice care is accessible to terminally ill patients regardless of their ability to pay, by covering the difference between the full cost of providing these services and patient revenue.
Anticipated Impact and Plan to Evaluate	Coming Home Hospice is anticipated to improve access to care for uninsured and underinsured patients residing in San Francisco. CPMC will evaluate Coming Home Hospice's impact by annually tracking the number of people served, and by assessing access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	Coming Home Hospice helped to reduce disparities in access to quality hospice care by providing services to 209 terminally ill residents in 2014, and 201 in 2015.

Name of Program, Initiative or Activity: **Medi-Cal Managed Care Partnerships**	
Description	A key part of CPMC's Medi-Cal program is the Medi-Cal Managed Care partnership with North East Medical Services (NEMS) community clinic and San Francisco Health Plan (SFHP), a licensed community health plan that provides affordable health care coverage to over 130,000 low- and moderate-income San Francisco residents. Working together with NEMS, CPMC serves as the hospital partner for these Medi-Cal beneficiaries who select NEMS as their medical group through SFHP. CPMC also provides access to quality services at the St. Luke's Campus for patients who select Hill Physicians or Brown & Toland as their medical group through SFHP. Since 2014, CPMC has expanded these partnerships to accommodate patients newly insured through the Affordable Care Act, assuming responsibility for thousands of new Medi-Cal Managed Care beneficiaries.
Anticipated Impact and Plan to Evaluate	CPMC's Medi-Cal Managed Care partnerships are anticipated to improve access to care for uninsured and underinsured patients residing in San Francisco. CPMC will evaluate the impact of these partnerships by annually tracking the number of people served and utilization, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	In 2014, CPMC provided inpatient services, hospital-based specialty and ancillary services, and emergency care for over 31,000 Medi-Cal beneficiaries enrolled in this program at NEMS, as well as over 8,600 patients at Brown & Toland and Hill Physicians. In 2015, CPMC served nearly 33,000 Medi-Cal beneficiaries enrolled in this program at NEMS, as well as over 9,000 patients at Brown & Toland and Hill Physicians. This was 32 percent of SFHP's total membership, who otherwise may have faced difficulties in accessing a comprehensive, coordinated care network.

Name of Program, Initiative or Activity: **Healthy San Francisco**	
Description	CPMC participates in Healthy San Francisco (HSF), a citywide program that makes health care services accessible and affordable for uninsured San Francisco residents. Through partnerships with North East Medical Services (NEMS) community clinic and Brown & Toland Medical Group, CPMC provides free hospitalization and select specialty care to HSF participants who are enrolled with NEMS or Brown & Toland as their medical home.
Anticipated Impact and Plan to Evaluate	Healthy San Francisco is anticipated to improve access to care for uninsured patients residing in San Francisco. CPMC will evaluate the impact of HSF by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	In 2014, CPMC was the hospital partner for the 600 HSF participants who were enrolled with Brown & Toland as their medical home. In early 2015, enrollment in HSF as a whole was at 16,000, contributing to San Francisco's overall high rate of health coverage (96.8 percent in 2013). In 2015, Brown & Toland severed its relationship with Healthy San Francisco, and the 600 patients were transferred to coverage under the Affordable Care Act or other HSF providers. In 2014, CPMC took NEMS hospital referrals as needed. During that year, CPMC participated in a city-wide effort to enroll the uninsured, including HSF participants, in insurance programs, thus decreasing HSF program enrollment. The number of people enrolled in HSF further declined with ongoing implementation of the Affordable Care Act, as many uninsured San Franciscans now have new coverage options through Medi-Cal expansion and Covered California.

Name of Program, Initiative or Activity: **San Francisco General Hospital Partnership (new in 2015)**	
Description	CPMC provides echocardiograms and other diagnostics free of charge to low-income and uninsured patients referred by San Francisco General Hospital (SFGH), and pays physicians for associated professional fees.
Anticipated Impact and Plan to Evaluate	CPMC's diagnostic services provided to these patients are anticipated to improve access to care for uninsured and underinsured patients and decrease the wait times for these key diagnostic services. CPMC will evaluate their impact by annually tracking the services provided, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2015 Impact	Before CPMC's partnership with SFGH began in May 2015, there were 1,000 patients on a wait list for echocardiograms and 400 patients on a wait list for pulmonary function tests. CPMC provided these free diagnostic services to about 600 patients in 2015. SFGH echocardiogram wait times went from 48 days to less than 30 days.

	CPMC also made a one-time capital gift towards the completion of SFGH's new trauma medical center, which will serve the city of San Francisco with technological capabilities far beyond most public hospitals, as well as an expanded acute-care ward for the elderly.

Name of Program, Initiative or Activity:	**Lions Eye Foundation**
Description	Lions Eye Foundation and CPMC partner together to provide highly specialized eye care procedures free of charge to people without insurance or financial resources. CPMC also subsidizes eye clinic operational cost by maintaining staff, donating facility space, and providing medical residents who perform the procedures as part of their medical education and training.
Anticipated Impact and Plan to Evaluate	Lions Eye Foundation is anticipated to improve access to care for uninsured, low-income patients residing in San Francisco. CPMC will evaluate Lions Eye Foundation's impact by annually tracking the number of people served and services provided, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	2014 2,700 patient visits 215 general surgical procedures 142 laser surgeries 1,131 diagnostic tests 474 intravitreous injections for macular degeneration and eye complications due to diabetes 2015 2,544 patient visits 184 general surgical procedures 130 laser surgeries 1,750 diagnostic tests 520 intravitreous injections

Name of Program, Initiative or Activity:	**Operation Access**
Description	CPMC partners with Operation Access and the San Francisco Endoscopy Center to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. CPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. CPMC also provides a grant to support Operation Access's operating costs.
Anticipated Impact and Plan to Evaluate	Operation Access is anticipated to improve access to care for uninsured, low-income patients residing in San Francisco and the Bay Area. CPMC will evaluate the impact of its collaboration with Operation Access by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

2014 & 2015 Impact	CPMC staff provided procedures to Operation Access patients (see numbers below), addressing a significant community need for access to specialty care and helping to reduce health disparities. Operation Access's culturally competent case management and medical interpreters facilitated this donated care for underserved patients. 2014 81 patients served 98 procedures & evaluations 2015 122 patients served 183 procedures and evaluations

Name of Program, Initiative or Activity:	**Project Homeless Connect**
Description	CPMC annually sponsors a Project Homeless Connect event where CPMC staff and other volunteers help to provide medical and social services to San Francisco's homeless, including primary medical care, eye exams, wheelchair repair, dental treatment, substance abuse connections, and even acupuncture and massage. Besides donating hours of staff volunteer time to the event, CPMC also contributes a cash sponsorship to help cover event costs.
Anticipated Impact and Plan to Evaluate	Project Homeless Connect is anticipated to improve access to care for uninsured and underinsured patients in San Francisco. CPMC will evaluate the impact of its collaboration with Project Homeless Connect by annually tracking the number of people served, and by assessing the community's access to care needs in its next Community Health Needs Assessment.
2014 &2015 Impact	At the 2014 CPMC-sponsored event, 1,749 homeless individuals were connected to needed services, including 60 acupuncture treatments, 186 California State IDs, 42 dental procedures, 44 disability services, 140 employment visits, 154 eye exams, 60 foot washings, 19,955 lbs of groceries, 123 haircuts, 18 HIV and STI tests, 50 Homeward Bound services, 1,222 lunches, 57 massage therapy services, 117 medical appointments, 129 prescription glasses, 640 reading glasses, 274 shelter and housing information, 250 government assistance benefits (CAAP, SSI/Medi-Cal, CalFresh), 123 safer sex information and supplies, 350 Sprint phone calls, 15 TB tests, and 33 wheelchair and walker repairs. At the 2015 CPMC-sponsored event, 1,531 homeless individuals were connected to needed services, including 124 California State IDs, 29 dental procedures, 149 employment visits, 265 eye exams, 125 flu shots, 72 foot washings, 13,497 lbs of groceries, 99 haircuts, 24 HIV and STI tests, 17 Homeward Bound services, 83 legal services, 1,083 lunches, 46 massage therapy services, 107 medical appointments, 56 mental health services, 175 needle exchanges, 200 prescription glasses, 25 podiatry services, 475 reading glasses, 85 senior services, 259 shelter and housing information, 294 government assistance benefits (CAAP, SSI/Medi-Cal, CalFresh), 120 safer sex information and supplies, 13 TB tests, and 23 wheelchair and walker repairs.

Health Need: Increase Healthy Eating and Physical Activity

Name of Program, Initiative or Activity: HealthFirst

Description

HealthFirst is a center for health education and disease prevention affiliated with CPMC's St. Luke's Health Care Center. It concentrates on best practices in chronic disease management and particularly on integrating community health workers (CHWs) into the multidisciplinary health care team. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care. CHWs teach community workshops in healthy eating to parents of children at risk for obesity in the South of Market, Mission, and Bayview Hunters Point districts. They also teach classes on nutrition designed to manage chronic adult diabetes. CPMC subsidizes operational costs of the center.

Anticipated Impact and Plan to Evaluate

HealthFirst is anticipated to increase healthy eating towards the management of chronic disease among uninsured and underinsured patients residing in communities south of Market Street in San Francisco. CPMC will evaluate the impact of HealthFirst by annually tracking the number of people served, and by assessing the community's healthy eating and physical activity needs in its next Community Health Needs Assessment.

2014 & 2015 Impact

2014	2015
650 patients served	750 patients served
1,900 patient visits	2,300 patient visits

In 2014, clinical data recorded the following results: 64 percent of diabetic patients were under good control for hemoglobin HbA1c; 71 percent were under control for blood pressure; 70 percent were under control for LDL cholesterol; 100 percent of asthma patients had an action plan; 83 percent of asthma patients were considered well controlled.

In 2015, clinical data showed that 83 percent of diabetic patients were under good control for hemoglobin HbA1c; 100 percent of asthma patients had an action plan that is updated at least annually.

CPMC maintains the HealthFirst program in order to provide services to underserved residents of the Mission, as well as Bayview, Downtown/Civic Center, Visitacion Valley and Excelsior – some of the neighborhoods identified as having the highest disparities related to important socio-economic determinants of health. By providing services such as these, CPMC contributes to increased healthy eating and physical activity, as measured by a shift in the Needs Assessment indicator tracking the percentage of adults that report a BMI greater or equal to 30 (from 17.2 percent in 2009 to 12.1 percent in 2014; note that the rate is higher for specific populations served by HealthFirst, e.g., 22.3 percent for Latinos) (www.sfhip.org).

Name of Program, Initiative or Activity:	**Community-Based Services for Youth, including** • **Bayview Child Health Center's nutrition services** • **William McKinley Elementary School Noon Hour Wellness Program** • **De Marillac Academy Health Champions Program**
Description	• At Bayview Child Health Center, a nutritionist is available to help children learn to eat healthier through health education and weight management programs. • CPMC funds fitness consultants at William McKinley Elementary School to develop and implement a lunchtime recess wellness program that includes moderate to vigorous activities for students, emphasizing team building, sportsmanship skills, and conflict resolution as well as introducing healthy nutrition and fitness concepts. The fitness consultants provide training to interns, McKinley teachers, and lunchtime monitors to implement the program for sustainability. • CPMC's Health Champions Program has partnered with De Marillac Academy since 2004, creating a healthier school community for these children from underserved, low-income families in the Tenderloin and other at-risk communities in San Francisco. By combining nutrition education, food shopping and preparation with hands-on physical activities like mountain biking and rope climbing, the program establishes a culture of health consciousness among students, families, teachers, and staff.
Anticipated Impact and Plan to Evaluate	These community-based services for youth are anticipated to increase healthy eating and physical activity among uninsured and underinsured patients residing in San Francisco. CPMC will evaluate the impact of these services by annually tracking the number of people served, and by assessing the community's healthy eating and physical activity needs in its next Community Health Needs Assessment.
2014 & 2015 Impact	• Bayview Child Health Center: The 700 to 1,000 children who had BCHC as their medical home had access to the center's nutrition services. • William McKinley Elementary School Noon Hour Wellness Program: 360 school children participated in moderate to vigorous physical activity during their lunch period five days a week throughout each school year. Funded staff members helped to maintain the playground as a safe, inclusive, and fun environment where children were able to take full advantage of the available games and activities. Children's fitness levels were measured with various exercises as a way of challenging them to increase their physical activity. The school's principal and student advisor both reported a marked decrease in behavioral issues and office referrals during lunch recess as a direct result of the program. • De Marillac Academy's Health Champions Program: Each funded school year (2013–2014 and 2015–2016), 120 students were served by the program, with fifth and sixth graders receiving health and nutrition education classes, and seventh graders receiving physical education classes.

By making services such as these possible, CPMC contributes to increased healthy eating and physical activity as measured by shifts in the following Needs Assessment indicators: physically fit children in 5th grade within the SFUSD who score 6 of 6 on the CA Fitness-gram test (from 20.3 in 2010-2011 to 21.3 in 2013-2014); physically fit children in 7th grade within the SFUSD who score 6 of 6 on the CA Fitness-gram test (from 30.4 percent in 2010-2011 to 31.6 percent in 2013-2014) (www.sfhip.org).

Health Need: Ensure Safe and Healthy Living Environments

Name of Program, Initiative or Activity: **Community Health Grants and Sponsorships Program**

Description

CPMC's Community Health Grants and Sponsorships Program supports organizations that promote safe and health living environments. Some examples include:

- APA Family Support Services provides in-home support services to Asian/Pacific Islander children and families to prevent child abuse and domestic violence.
- The Center for Youth Wellness offers pediatric care that addresses the root causes of poor outcomes for children and youth in high-risk communities, based on emerging data on how exposure to poverty, domestic and community violence and other early life stressors affects the developing brains and bodies of children.
- Chinatown Community Development Center strives to build community and enhance quality of life by acting as neighborhood advocates, community organizers, planners, developers, and managers of affordable housing, serving Chinatown, North Beach, Tenderloin, the Northern Waterfront, the Western Addition, Japantown, Polk Gulch, the Richmond, Civic Center and the South of Market area.
- San Francisco Child Abuse Prevention Center and the Child Advocacy Center endeavor to prevent child abuse and reduce its devastating impact by providing supportive services to children and families; education for children, caregivers and service providers; and through advocacy for systems improvement and coordination.
- Kimochi provides culturally sensitive, Japanese language-based programs and services to 3,000 Bay Area seniors and their families each year, including transportation, referral and outreach, health and consumer education seminars, healthy aging and senior center activities, social services, congregate and home-delivered meals, in-home support services, adult social day care, and 24-hour residential and respite care.

Anticipated Impact and Plan to Evaluate

CPMC's various grants and sponsorships are anticipated to help ensure safe and healthy living environments for San Francisco residents. CPMC will evaluate the impact of these grants and sponsorships by annually tracking the number of people served by these organizations and/or any specific activities funded by the grant/sponsorship, and by assessing the community's safe and healthy living environments needs in its next Community Health Needs Assessment.

2014 & 2015 Impact

Here are some selected achievements:

- With CPMC's 2015 grant, APA Family Support Services served nearly 1,500 adults and children with parent education classes; in-home support to families in need of resources such as employment training, housing, child care, shelter and meal services; and postpartum depression support groups and linguistically appropriate counseling.

- With CPMC's grant, the Center for Youth Wellness provided case management, psychiatry and psychology services to nearly 100 Bayview Child Health Center patients in 2014, and to about 160 Bayview Child Health Center patients in 2015.
- With CPMC's grants, Chinatown Community Development Center provided services to 177 seniors in 2014, and 85 seniors in 2015, including evaluations for home safety and home health equipment, helping them live safely and independently for as long as possible.
- With CPMC's grant, in 2014 San Francisco Child Abuse Prevention Center continued to develop the city's first and only Children's Advocacy Center (CAC) as a best practice for treating and caring for victims of child abuse, co-located with Bayview Child Health Center for a "one-stop shop" with a full spectrum of wellness and intervention services. In 2014, CAC reached its 100-interview mark, and 70 percent of all the city's forensic interviews and medical exams for victims of child abuse now occur there. The Center continued to develop protocols and systems to improve information sharing and learning with partners, to expand client outreach, and build sustainability. Development continued in 2015, with the Center serving nearly 11,000 children, parents and caregivers that year; the CAC provided 245 child victims with forensic interviews and related services; over 6,000 school kids were taught how to stay safe; and over 7,000 counseling calls were fielded on crisis TALKLine. By the end of 2015, over 80 percent of families who have received services for six months or longer demonstrated improved protective factors shown to decrease abuse risk, such as knowledge of parenting and child development, social connections, access to basic needs, and children's social/emotional learning.
- Besides the organizations listed above, CPMC made grant and sponsorship cash contributions to other community organizations with a focus on ensuring safe and healthy living environments; these organizations together improved the lives of thousands of San Franciscans through their services. Organizations included:

3rd Street Youth Center and Clinic
Bayanihan Community Center & Filipino-American Development Foundation
Brothers for Change
Community Housing Partnership
Compass Family Services
Conard House
Curry Senior Center
Episcopal Charities
Episcopal Community Services
Gum Moon Women's Residence/ Asian Women's Resource Center
HealthRIGHT 360
Homeless Prenatal Program
Huckleberry Youth Programs
Institute on Aging
Jewish Family and Children's Services
Kimochi
Larkin Street Youth Services
Lava Mae
Mission Neighborhood Centers
NAACP San Francisco
On Lok Senior Services
Portola & Excelsior Family Connections
Project Homeless Connect
Richmond Area Multi-Services
San Francisco LGBT Community Center
San Francisco Parks Alliance
Self-Help for the Elderly
South of Market Health Center
Southeast Community Facility Commission
Tenderloin Health Services
Tenderloin Housing Clinic

Through its donations to organizations like these, CPMC contributes to ensuring safe and healthy living environments, for example, as measured by a shift in the Needs Assessment indicator tracking San Francisco playgrounds scoring an "A" or "B" for infrastructure quality, condition, and cleanliness (from 61.0 percent in 2012 to 65.0 percent in 2014) (www.sfhip.org).