Chinese Hospital
Community Health Needs Assessment
2019
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Section 1

Executive Summary

Chinese Hospital is part of the San Francisco Health Improvement Partnership (SFHIP), which is a collaborative body whose mission is to embrace collective impact and to improve community health and wellness in San Francisco. SFHIP includes the San Francisco Department of Public Health, San Francisco’s non-profit hospitals, the Clinical and Translational Science Institute’s Community Engagement and Health Policy Program at UCSF, the San Francisco Unified School District, the Office of the Mayor, community representatives from the Asian and Pacific Islander Health Parity Coalition, Human Services Network, Chicano/Latino/Indigena Health Equity Coalition, and African American Community Health Council, Community Clinic Consortium, Faith-based and other philanthropic partners. SFHIP completes a CHNA once every three years.

The citywide CHNA conducted by the SFHIP is the foundation for each non-profit Hospital’s community health needs assessment in San Francisco. Since Chinese Hospital primarily serves the Chinese community, we have decided to conduct a supplemental community health needs assessment in addition to the citywide CHNA to specifically look at the subpopulation Chinese Hospital serves. Therefore, the 2019 Chinese Hospital Community Health Needs Assessment includes two reports: 1). San Francisco Community Health Needs Assessment 2019; 2). Chinese Hospital Supplemental Community Health Needs Assessment (CHSCHNA) 2019.

SFHIP Community Health Needs Assessment (CHNA) Findings

Overall, SFHIP CHNA finds that health has improved in San Francisco since the last assessment three years ago:

- More San Franciscans have insurance.
- The estimated rate of new HIV infection in San Francisco continues to decrease.
- Life expectancy increased for all San Francisco with the biggest gains seen by Black/African Americans.
- Mortality rates due to lung, colon, and breast cancers and influenzas and pneumonia continue to decline.
- The availability of tobacco products has decreased. At 11%, rates of smoking are lower than the HP2020 goal of 12%.
- 2017 had the lowest number of traffic-related fatalities since record keeping began in 1915.

The SFHIP CHNA identifies two foundational issues contributing to local health needs:

- **Racial health inequities**
  Health inequities result from both the actions of individuals (health behaviors, biased treatment by health professionals) and from the structural and institutional behaviors that confer health opportunities or burdens based on status.

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

The SFHIP CHNA identifies five health needs that heavily impact disease and death in San Francisco:

- **Access to coordinated, culturally and linguistically appropriate care and services**
  An estimated 3.6% of the population (31,480 residents) still do not have health insurance. Access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services.

- **Food security, healthy eating and active living**
  Inadequate nutrition and lack of physical activity contribute to 9 of the leading 15 causes of death in San Francisco including heart failure, stroke, hypertension, diabetes, prostate cancer, colon cancer, Alzheimer’s, breast cancer, and lung cancer. Just 2.5 hours of moderate intensity physical activity a week is associated with a gain of approximately 3 years of life.

- **Housing security and an end to homelessness**
  Housing stability, quality, safety, and affordability all have very direct and significant impacts on individual and community health. An estimated 24,000 people in San Francisco live in crowded conditions and about 7,500 homeless persons were counted in San Francisco.

- **Safety from violence and trauma**
  Violence not only leads to serious mental, physical, and emotional injuries, and potentially, death for the victim, but it also negatively impacts the family and friends of the victim and their community. Persons of color are more likely to live in neighborhoods not perceived to be safe and to be victims of violence and inequitable treatment through the criminal justice system.

- **Social, emotional, and behavioral health**
  Presence of mental illness can adversely impact the ability to perform across various facets of life. In San Francisco, the number of hospitalizations among adults due to major depression exceed that of asthma of hypertension.
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PHOTOGRAPH: PHOTEVERYWHERE / STOCKARCH.COM
We would like to thank the many individuals including community residents, community-based organizations, and health care partners that contributed to this assessment. A special thank you goes out to the Community Health Needs Assessment and Impact Unit of the San Francisco Department of Public Health for their work on the data analysis and overall project management, and to the Backbone of SFHIP, staffed by the Department of Public Health, the Hospital Council, and the University of California at San Francisco, for their support for the project.

This Community Health Needs Assessment (CHNA) is part of an ongoing community health improvement process. The CHNA provides data enabling identification of priority issues affecting health and is the foundation for citywide health planning processes including the Community Health Improvement Plan, the 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 non-profit hospital’s Community Health Needs Assessment and Implementation Strategy.

A Community Health Improvement Plan (CHIP) is being developed as a companion to this document and will detail goals, objectives and action plans for each of the focus areas identified.

Many health needs were identified through this assessment including: access to coordinated, culturally and linguistically appropriate care and services; food security, healthy eating and active living; housing security and an end to homelessness; safety from violence and trauma; and social, emotional, and behavioral health. Additionally, poverty and racial health inequities were identified as structural and overarching issues which must be addressed to ensure a healthy San Francisco for all.

SFHIP recognizes that all San Franciscans do not have equal opportunity for good health, and we are committed to eliminating health disparities and inequities by working together across sectors to achieve health equity for all. We hope you find this assessment useful and we welcome any suggestions you may have for assisting us in improving the health of San Francisco.

SFHIP Co-Chairs
Jim Illig,
Kaiser Permanente San Francisco
Amor Santiago,
Asian and Pacific Islander Health Parity Coalition
In the following pages you will find a very informative, data-rich roadmap for the continued improvement of the health of San Francisco.

The assessment takes a comprehensive look at the health of San Franciscans, through a combination of studying the social determinants of health, as well as specific health outcomes of individuals, neighborhoods and populations.

The CHNA is completed once every three years and is an important tool for informing the community about San Franciscans' health, identifying key priorities for the city and county, and gaining a better understanding of health inequities. This year, we expanded our work to provide more insights regarding homelessness, trauma and violence.

The report paints a compelling and broad picture of health and the challenges to health in San Francisco – from life expectancy, to differences in health status by neighborhoods, and racial and ethnic groups, to the renewed threat of nicotine addiction presented by e-cigarettes. Just to name a few.

The CHNA is also a key part of DPH achieving and maintaining national Public Health Accreditation, which we earned in 2017. Accreditation means that the department is meeting national standards for ensuring essential public health services and improving and protecting the health of the community.

With the CHNA, we demonstrate our ongoing collaboration with the San Francisco Health Improvement Partnership (SFHIP) that includes San Francisco hospitals, San Francisco Unified School District, University of California, San Francisco, Asian and Pacific Islander Health Parity Coalition, Chicano/Latino/Indigena Health Equity Coalition, African American Community Health Equity Council and other community members.

I commend the DPH team for this outstanding report, and extend my gratitude to the numerous community members and SFHIP partners who also contributed. Our enduring efforts are essential to fulfill our mission to protect and promote the health and well-being for all in San Francisco.

Best regards,

Grant Colfax, MD
Director of Health
San Francisco Department of Public Health
City and County of San Francisco
### San Francisco Health Improvement Partnership Steering Committee

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Welcome to the **Community Health Needs Assessment** (CHNA). The CHNA takes a broad view of health conditions and status in San Francisco. In addition to providing local disease and death rates, this CHNA also provides data and information on social determinants of health—social structures and economic systems which include the social environment, physical environment, health services, and structural and societal factors.

The CHNA involves four steps:

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

The CHNA is the foundation for each San Francisco non-profit hospital’s Community Health Needs Assessment and is one of the requirements for Public Health Accreditation. While the CHNA informs large-scale city planning processes such as San Francisco’s Health Care Services Master Plan, the intent of this document is to inform the work of all organizations, teams and projects that impact the people of San Francisco. Gaining an understanding of why health outcomes exist here in San Francisco can help gear our efforts towards addressing root causes and developing better interventions, policies and infrastructure. SFDPH’s mission is to protect and promote the health of all San Franciscans, and we all have a contribution to achieving this goal, no matter the scale or scope of our work.

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

- More San Franciscans have access to health care.
- The estimated rate of new HIV infection in San Francisco continues to decrease.
- Life expectancy increased for all San Franciscans with the biggest gains seen by Black/African Americans.
- Mortality rates due to lung, colon, and breast cancers and influenza and pneumonia continue to decline.
- The availability of tobacco products has decreased. At 11%, rates of smoking are lower than the Healthy People 2020 goal of 12%.
- 2017 had the lowest number of traffic-related fatalities since record keeping began in 1915.

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

- Racial health inequities
- Poverty

The CHNA identifies five health needs that heavily impact disease and death in San Francisco:

- Access to coordinated, culturally and linguistically appropriate care and services
- Food security, healthy eating and active living
- Housing security and an end to homelessness
- Safety from violence and trauma
- Social, emotional, and behavioral health

### Foundational Issues

#### Racial Health Inequities

Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from both the actions of individuals (health behaviors, biased treatment by health professionals), and from the structural and institutional behaviors that confer health opportunities or burdens based on status. For example, the uneven distribution of wealth and resources determines the level of health those getting the least of these resources can achieve. Pages 17–19 include data on a few improvements to health and determinants of health and point to where more work needs to be done to address the structural and institutional racism in San Francisco. Additional data on health inequities are found throughout the Community Health Data pages.
Poverty
Enough income generally confers access to resources that promote health — like good schools, health care, healthy food, safe neighborhoods, and time for self-care — and the ability to avoid health hazards — like air pollution and poor quality housing conditions. Page 16 focuses on the economic barriers to health that many San Franciscans face. Find additional data on economics and health in the Economic Environment data page.

Health Needs

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services
San Francisco continued to see gains in access to health care with 10,000 fewer residents uninsured in 2017 than in 2015. Of the estimated 31,500 uninsured residents, 15,373 have health care access through Healthy San Francisco or Healthy Kids. Approximately 2% of residents remain without access. Having insurance or an access program is only the first step; however, as true access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services. Page 20 presents San Francisco statistics on health care use, barriers to use, and consequences of not having access to quality care. Additional information on health care quality and access is located in the Health Care Access and Quality data page.

Food Security, Healthy Eating and Active Living
Inadequate nutrition and a lack of physical activity contribute to 9 of the leading 15 causes of premature death in San Francisco — heart failure, stroke, hypertension, diabetes, prostate cancer, colon cancer, Alzheimer’s, breast cancer, and lung cancer. Studies have shown that just 2.5 hours of moderate intensity physical activity each week is associated with a gain of approximately three years of life. Data on physical activity and healthy eating and barriers to each are presented on pages 21–23. Additional data are available in the Physical Activity, Transportation, Crime and Safety, Overweight and Obesity, and Nutrition data pages.

Housing Security and an End to Homelessness
Housing is a key social determinant of health. Housing stability, quality, safety, and affordability all have very direct and significant impacts on individual and community health. Much of California, and especially the Bay Area, is currently experiencing an acute shortage in housing, leading to unaffordable housing costs, overcrowding, homelessness and other associated negative health impacts. Between 2011 and 2015, the Bay Area added 501,000 new jobs — but only 65,000 new homes. An estimated 24,000 people in San Francisco live in crowded conditions and about 7,500 homeless persons were counted in San Francisco. Pages 24 – 25 provide an overview of the housing stressors in San Francisco. Additional information on housing and health is found in the Housing data page.

Safety from Violence and Trauma
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. Persons of color are more likely to be victims of violence, to live in neighborhoods not perceived to be safe and to receive inequitable treatment through the criminal justice system. Pages 26 – 29 focus on violence and trauma, their determinants and health impacts in San Francisco. Additional data on violence and trauma in the City are presented in the Crime and Safety data page.

Social, Emotional, and Behavioral Health
Mental health is an important part of community health. In San Francisco the number of hospitalizations among adults due to major depression exceed that of asthma or hypertension. Presence of mental illness can adversely impact the ability to perform across various facets of life — work, home, social settings. It also impacts the families, caregivers, and communities of those affected. Substance abuse including drugs, alcohol and tobacco, contributes to 14 of the top causes of premature death in the City — lung cancer, Chronic Obstructive Pulmonary Disease, HIV, drug overdose, assault, suicide, breast cancer, heart failure, stroke, hypertensive heart disease, colon cancer, liver cancer, prostate cancer, and Alzheimer’s. Pages 30 – 34 focus on psychological distress, major depression, and substance abuse in San Francisco. Find additional data on social, emotional and behavioral health in the City in the Mental Health, Substance Abuse, and Tobacco Use and Exposure pages.
The 2019 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.

The CHNA is the foundation for each of San Francisco’s non-profit hospitals’ Community Health Needs Assessments and is one of the requirements for Public Health Accreditation, which includes: a CHNA, a community health improvement plan, and a strategic plan for population health. The CHNA also informs city planning processes such as San Francisco’s Health Care Services Master Plan.

While the CHNA informs large-scale city planning processes, the intent of this document is to inform the work of all organizations, teams and projects that impact the people of San Francisco. Gaining an understanding of why health outcomes exist here in San Francisco can help gear our efforts towards addressing root causes and developing better interventions, policies and infrastructure.

The San Francisco Health Improvement Partnership (SFHIP) guided CHNA development. 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 the San Francisco Department of Public Health, San Francisco’s non-profit hospitals, the Clinical and Translational Science Institute’s Community Engagement and Health Policy Program at UCSF, the San Francisco Unified School District, The Office of the Mayor, community representatives from the Asian and Pacific Islander Health Parity Coalition, Human Service Network, Chicano/Latino/Indigena Health Equity Coalition, and African American Community Health Council, Community Clinic Consortium, Faith based and philanthropic partners. SFHIP completes a CHNA once every three years.
The Community Health Needs Assessment takes a life course approach when exploring and presenting the health needs of San Franciscans.

A life course approach considers one’s lived experience and health throughout the lifespan, within the context of their history, environment, family, community, society, and culture. Certain events and exposures (i.e. trauma, racism, poverty, environmental factors, etc.) during sensitive time periods in early life can have long-term impacts on development and health.

In addition to impacting one’s own future health status, early life experiences can have intergenerational health outcomes. One’s wellness during the prenatal or pregnancy periods impacts the health of one’s children. Investing in pregnancy, early childhood, and family wellbeing through policies, interventions and systems can support our society and address the root causes of health inequities.

Data Collection

The CHNA collected information on the health of San Franciscans via three methods:

- Community Health Status Assessment
- Assessment of Prior Assessments, and
- Community Engagement.

Through review of the information provided by these sources, SFHIP identified San Francisco’s health needs. Additionally, following the health needs assessment a Community Asset Assessment was completed.

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. 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. 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.
Recognizing the essential role 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, 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.\(^3\) 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. Furthermore, we hosted meetings throughout 2017 to gather feedback on indicators from experts and community representatives. In all, 171 variables were analyzed. We present the results from all analyses in 30 Community Health Data pages.

To reveal health disparities, the Community Health Status Assessment analyzed data by age, race/ethnicity, poverty, place, and more. However, available data do not permit analyses for all groups which are known to experience health inequities including Native Americans, people who identify as LGBTQ, transgender persons and persons with disabilities.

**Assessment of Prior Assessments**

San Francisco's community-based organizations, healthcare service providers, public agencies and task forces conduct health needs assessments and publish reports of their activities for planning and evaluation purposes and to be accountable to those they serve. Our aim in conducting an assessment of these assessments and reports is to augment what we know from routinely collected secondary health data and primary data collection through CHNA community engagement activities. We hope thereby to gain a better understanding of which communities/populations in San Francisco have been engaged in health needs assessment activities; what topics are of concern and interest to these communities/populations; and learn about promising and effective approaches to eliciting and addressing these concerns. We included both needs assessments and service reports in our definition of "assessments" for this assessment.

Beginning in January 2017, CHNA administrative leads from the SF Department of Public Health and UCSF and a small Working Group consisting of members of San Francisco’s three health equity/parity coalitions, UCSF health professions students, and UCSF Clinical and Translational Research staff began conducting online searches for published assessment reports for the 2019 CHNA.

For this assessment, the San Francisco Framework for Assessing Population Health and Equity was used to define “Root Causes” that reflect social determinants. Additionally, the Working Group decided to add incarceration, experience with law enforcement, and community development/investment to the framework.

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

**Community Engagement**

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

- Identify San Franciscan's health priorities, especially those of vulnerable populations
- Obtain data on populations and issues for which we have little quantitative data
- Build relationships between the community and SFHIP
- Meet the regulatory requirements including the IRS rules for Charitable 501c3 Charitable Hospitals, Public Health Accreditation Board requirements for the San Francisco Health Department, and the San Francisco’s Planning Code requirements for a Health Care Service Master Plan

The 2019 CHNA includes 4 categories of focus groups:

**SFHIP key informant group interview, Equity Coalition focus groups, food insecure pregnant women focus groups, and Kaiser focus groups.**

**SFHIP Key Informant Group Interview**

One focus group was comprised of SFHIP members who are all subject matter experts. Two series of questions were asked, “What are the healthiest characteristics of this community? What supports people to live healthier lives?” and “What are the biggest health issues and/or conditions your community struggles with? What do you think creates those issues?”.

**Equity Coalition focus groups**

Three focus groups were conducted with each of the three health equity coalitions in San Francisco: The Chicano / Latino / Indigena Health Equity Coalition, The Asian Pacific Islander Healthy Parity Coalition, and The African American Health Equity Coalition. Using the Technology of Participation (ToP) Consensus Method, the question posed to each focus group was, “What actions can we take to improve health?”

**Food Insecure Pregnant Women focus groups**

The Homeless Prenatal Program held four focus groups with women who experienced food insecurity while pregnant. Each focus group focused on a different group of women: Spanish, Chinese, multi-ethnic English speakers, and African American. The question to respond to was, “What actions can we take to improve your food needs?”

**Kaiser led focus groups**

Kaiser conducted four focus groups, one each with Kaiser Permanente leadership, Kaiser Permanente staff, Spanish-speaking parents on youth healthy eating and active living, and homeless and/or HIV positive youth.

Further details on the methods and findings are available in the Community Engagement page.
Health Need Identification

To identify the most significant health needs in San Francisco the SFHIP steering committee met on October 18th, 2018. 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 2016 Community Health Improvement Plan. Then, using the Technology of Participation approach to consensus development, participants engaged in a focused discussion about the data. Finally, participants developed consensus on the health needs. (Figure A) Throughout the process needs were screened using pre-established criteria (Figure B). This process yielded two foundational issues and five health needs.

Foundational issues are needs which affect health at every level and must be addressed to improve health in San Francisco.

The two foundational issues identified were:
- Poverty
- Racial health inequities

The five health needs identified were:
- Access to coordinated, culturally and linguistically appropriate care and services
- Food security, healthy eating, and active living
- Housing security and an end to homelessness
- Safety from violence and trauma
- Social, emotional, and behavioral health

Data describing part of each of the foundational issues and health needs are located in the Major Findings pages and in the various Community Health Data pages.

Community Assets Assessment

To identify the community’s resources available to address identified health needs, the San Francisco Department of Public Health reviewed data collected during the Community Engagement activities described above.

Questions asked of the participants relevant to the Community Asset Assessment included, “What are the strengths, resources, and assets of your community?”, “What are the barriers that contribute to health issues for your community?”, “What are the strengths and resources you and your family have to support your food needs?”, and “What makes it hard to address you and your family’s food needs?”

Further details on the methods and findings are available in the Community Assets Assessment and Community Engagement pages.
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 17,352 residents per square mile) and the second most densely populated major city in the US, after New York City.1 Between 2011 and 2018 the population in San Francisco grew by almost 8 percent to 888,817 outpacing population growth in California (6 percent).2 By 2030, San Francisco’s population is expected to total more than 980,000.

An Aging Population
The proportion of San Francisco’s population that is 65 years and older is expected to increase from 17 percent in 2018 to 21% in 2030; persons 75 and over will make up about 11% of the population.2 At the same time, it is estimated that the proportion of working age residents (25 to 64 years old) will decrease from 61 percent in 2018 to 56 percent in 2030. This shift could have implications for the provision of social services.

Ethnic Shifts
Population growth is expected for all races and ethnicities except for Black/African Americans who are projected to drop from 4.9 percent of the population in 2018 to 4 percent in 2030.3 Asians and Whites will remain the most populous groups and will grow as a percentage of the overall population. Population growth is expected to be lower for Latinx and Pacific Islanders and Latinx are expected to drop from 15.1 to 14.8 percent of the population.

Currently, 35 percent of San Francisco’s population is foreign born and 20 percent of residents speak a language other than English at home and speak English less than “very well.”1,4 The majority of the foreign born population comes from Asia (65 percent), while 18 percent were born in Latin America, making Chinese (Mandarin, Cantonese, and other) (43 percent) and Spanish (26 percent) the most common non-English languages spoken in the City.4

Families and Children
Although San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent), the number of school-aged children is projected to rise.2,4 As of 2017, San Francisco is home to 67,740 families with children, 26 percent of which are headed by single parents.5 There are approximately 132,330 children under the age of 18.2 The number of school-aged children is projected to rise by 24 percent by 2030.2 The neighborhoods with the greatest proportion of households with children are: Seacliff, Bayview Hunters Point, Visitacion Valley, Outer Mission, Excelsior, Treasure Island, and Portola (all over 30%).1
Major Findings

The 2019 Community Health Needs Assessment identified two foundational issues and five health needs.

The following infographics highlight aspects of each issue and need.

**Foundational Issues**
- Poverty ............................................. 16
- Racial Health Inequities ...................... 17

**Health Needs**
- Access to Coordinated, Culturally, and Linguistically Appropriate Care and Services.......................... 20
- Food Security, Healthy Eating, and Active Living .......... 21
- Housing Security and an End to Homelessness ............ 24
- Safety from Violence and Trauma.......................... 26
- Social, Emotional, and Behavioral Health .................. 30
Income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self care—and the ability to avoid health hazards—like air pollution and poor quality housing.

Low income groups are at greater risk of a wide range of health conditions than higher income groups, and have a shorter life expectancy.\(^1\)

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.\(^2\)

For a family of four, 200% of the Federal Poverty Level is $50,200.\(^4\) A family of four in San Francisco, requires an income of greater than $120,000 to meet all of their needs.\(^5\) 40% of new jobs in San Francisco are expected to be low wage ($<54,000/year) jobs.\(^6,7\) 18% of children under 6 years of age in San Francisco live in poverty (<200% FPL).\(^8\)

Almost 1 in 4 (22%) San Franciscans live below 200% of the federal poverty level.\(^3\)

San Francisco has the highest income inequality in California.\(^9\)

The wealthiest 5% of households in SF earn 16 times more than the poorest 20% of households.\(^9\)

Low 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.\(^10-12\)

Low-birth weight is highest among low-income mothers.\(^13\)

More than half of new jobs in San Francisco are expected to be low wage ($<54,000/year), service sector jobs.\(^3-4\)

96% of White San Franciscans are employed. Only 83% of Black/African Americans are employed; Black/African American males have the lowest employment rate in San Francisco (81%).

Black/African Americans are a third as likely as Whites to have a Bachelor’s degree or higher and 5 times more likely to have less than a high school education.\(^3\)

In San Francisco, there is significant inequality in household income between races.\(^3\)

White household median income is over $111k

Black/African American household median income is $28k
Two types of racialized social interaction, interpersonal and structural racism, play a role the racial health disparities seen in San Francisco.

Racial discrimination in interpersonal behavior, often called everyday racism or bias, sets the kind of experiences that make up the social lives of people of color. The accumulation of those experiences has been associated with increased hypertension, preterm birth and other conditions mediated by stress.

Long-standing social and institutional rules, both historic and current, determine which spaces and resources are available to marginalized groups. The disparate treatment of children based on race in schools and courts is an example of these forces. So are the historic differences in family wealth that stem from government housing policy and private banking rules. These forces are often intertwined and reinforcing as they occur over the life-course.

Racial inequities are not just a matter of unfortunate history, but of on-going, correctable injustice.

Improvements

For Black/African Americans improvements are seen in some social determinants and some health conditions. However, the improvements do not always impact the inequity as other groups may experience greater gains.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Who Better for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen Birth</td>
<td>Between 2007 and 2016 the teen birth rate for first time moms decreased from 34% to 10% among Black/African American women in San Francisco. In that same time, the proportion of mothers who had a college education when they delivered their first baby increased by 16 percentage points.</td>
</tr>
<tr>
<td>Mortality</td>
<td>Mortality rates decreased for all in San Francisco. However, rates decreased the most for Black/African Americans (15%) (vs. 11% for Pacific Islanders, 12% for Whites, 14% for Asians and Latinx). Decreased rates among Black/African Americans were primarily due to decreases in ischemic heart disease, lung cancer, assault, and HIV. Life expectancy also grew for all San Francisco with the largest gains seen by Black/African Americans. ( +3 years between 2005–2007 and 2015–2017 vs +2 years for others).</td>
</tr>
<tr>
<td>High School Graduation</td>
<td>Graduation rates increased for all between 2012 and 2017. The biggest gains were seen among Black/African Americans (8%), and Pacific Islanders (12%) while rates for Latinx (4%), Whites (3%) and Asians (4%) were more modest.</td>
</tr>
<tr>
<td>Childhood Caries</td>
<td>Between 2007–2012 and 2012–2017, rates of untreated tooth decay among kindergarteners decreased the most for Black/African Americans (26% to 19%).</td>
</tr>
</tbody>
</table>

Population Loss

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

Between 1990 and 2005, the proportion of very low income households increased from 55% to 68%. The strong association between poverty and health would suggest that the poorer remaining Black/African American population is more likely to have poor health than the previous more mixed-income population.
Hurdles to a healthy life start early in San Francisco

**Food insecurity among pregnant women in San Francisco**
- **26.5%** among Latinx women
- **19.5%** among Black/African American women
- **6.6%** among Asian and Pacific Islander women

Almost no White women in San Francisco report food insecurity during pregnancy.

**Nutrition**
Black/African American and Latinx SFUSD students are 2–3 times more likely to consume fast food (64%, 73%), or soda (44%, 36%) at least weekly, as compared to White students (fast food (35%) and soda (17%). 5

**5th Grade Obesity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>0%</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>22</td>
<td>23</td>
<td>52</td>
<td>52</td>
<td>65</td>
</tr>
<tr>
<td>Filipino</td>
<td>22</td>
<td>23</td>
<td>52</td>
<td>52</td>
<td>66</td>
</tr>
<tr>
<td>Latinx</td>
<td>22</td>
<td>23</td>
<td>52</td>
<td>52</td>
<td>66</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>22</td>
<td>23</td>
<td>52</td>
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<tr>
<td>White</td>
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<tr>
<td>Asian</td>
<td>22</td>
<td>23</td>
<td>52</td>
<td>52</td>
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</tbody>
</table>

**Student Proficiency**
- **Black/African American Students**
  13% are proficient or above in mathematics, 19% in English language arts.
- **Latinx students**
  22% are proficient in mathematics, 28% in English language arts.
- **Pacific Islander Students**
  19% are proficient in mathematics, 25% in English language arts.
- **White Students**
  70% are proficient in mathematics, 77% in English language arts.

**Full-Term Birth**
Full-term birth more likely for Whites (93%) than Black/African Americans (86%). 2
Median Household Income
The median income in San Francisco varies greatly by race/ethnicity. Typically, Whites earn 4x more than Black/African Americans in San Francisco.3

Homelessness
Black/African Americans are over-represented among the homeless in San Francisco.3

Heart Disease
Heart Disease impacts Black/African Americans at younger ages. Rates of heart disease related hospitalizations among Black/African Americans in their 40s and 50s are comparable to those seen in other races/ethnicities over 75 years of age.7

Juvenile Detentions
Black/African American youth make up over 57% of bookings at juvenile hall even though they make up only 6% of the population.9

Together Black/African American and Latinx youth comprise 86% of all juvenile bookings. Samoan youth are also over-represented and make up 3% of the bookings, but only account for less than 1% of the youth population.

The starkest inequities are seen between Black/African American residents and all other groups, and occur across the lifespan.
Healthy People 2020 defines access to health care as “the timely use of personal health services to achieve the best possible health outcomes.”

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.

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.

Many San Franciscans do not access health care
San Francisco’s population now numbers over 880,000 people.

Fewer Uninsured
Over 10,000 fewer San Franciscans were uninsured in 2017 compared to 2015. However, 2% of San Franciscans, 16,000, still lack insurance or health care access via Healthy San Francisco or Healthy Kids.

8% do not have a usual place to go for medical care.
24% of adults have not had a routine check-up in the past year.
51% of women ages 18–44 have not received counseling or information about birth control from a doctor or medical provider in the past year.
54% of women with public safety net insurance do not receive timely prenatal care.
15% of adults have not seen a dentist in the past year.
27% of Denti-Cal eligible infants aged 2 years or less do not access dental care.
82% of Denti-Cal eligible infants aged 2 years or less do not access dental care.

Language barriers and cultural competency of services are serious barriers to receiving quality care.

Increased cultural competence requires structural and systemic improvements, and can be linked to improvements in healthcare access, participation, and patient satisfaction.

From the community we heard...
“Cultural competency doesn’t happen with just a class or a one-day training.”
“Healthcare professionals need to be from the community and actually know the culture of the community.”
“Community-based organizations serve a critical role in small, data sparse cohorts, by informing public health efforts and bringing resources to multicultural communities.”

Young adults 18 to 34 years of age and people of color are less likely to be covered by insurance.

Different Levels of Prenatal Care
In 2013-15, ≥99% of mothers with private insurance received prenatal care in the first trimester.
Only 86% of those with Medi-Cal received early prenatal care.
Residents covered by public safety net insurance do not receive preventative care at the same rate as those with private insurance.

Preventable Hospitalizations and Emergency Room Visits
While preventable hospitalizations for most causes have decreased over time, preventable hospitalizations for hypertension and diabetes have respectively increased 45% and 50% between 2011 and 2016 — potentially indicating these conditions are not being well managed at the population level.

Preventable hospitalizations and ER visits are significantly higher among Black/African Americans and Pacific Islanders compared to all other ethnicities in San Francisco.
Many in San Francisco are food insecure

50% of low income residents surveyed in SF report food insecurity.6
20–30% of Black/African American and Latinx pregnant women are food insecure.5
50% of SFUSD students quality for free or reduced-price meals.3

Over 100,000 food insecure adults and seniors are eligible to receive meals, groceries or eating vouchers.

Services to ameliorate food insecurity are not meeting need

70% Percentage of eligible students not participating in the Summer Lunch Program.
-7% Decrease in the number of food vendors authorized to accept food stamps.14
1,969 The number of meals denied Seniors and persons with disabilities at congregate meal sites.6

21 days/187 days The number of days seniors/persons with disabilities must wait to start getting home delivered meals.6
616 The number of persons waiting for enrollment at a food pantry.33

The USDA has designated the Oceanview, Merced, Ingleside, Bayview Hunters Point, Visitation Valley and Treasure Island neighborhoods as areas of low food access.10

Facilities necessary to eat and drink healthily are not available for all

Barriers to drinking enough water include limited access to bathroom facilities to go to the bathroom.31,32 San Francisco operates 28 public restrooms that are open all day, which amounts to 3.3 restrooms per 100,000 residents.13

The Mission, Bayview Hunters Point and Treasure Island districts each have only one public access drinking water fountain.12

Not all have a kitchen to cook in. Over 21,000 occupied housing units in San Francisco do not have complete kitchen facilities.

Many in San Francisco do not eat and drink healthily

2 out of 3 pregnant women in the WIC Eat SF program and 2 out of 3 youth do not eat 5 or more servings of fruits or vegetables daily.5

Some San Franciscans do not drink enough water

614 people were hospitalized for “potentially preventable” dehydration in 2016.7

Many do drink sugary drinks. Two thirds of high school students and one third of young adults regularly consume soda.8

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.1

Leading medical and health associations recommend drinking water instead of sugary drinks.2 The institute of Medicine recommends 13 cups of liquids per for men and 9 cups for women who live in temperate climates.3

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.4

The San Francisco Health Improvement Partnership

Community Health Needs Assessment 2019 | 21
Regular exercise extends lives.

The World Health Organization (WHO) recommends that children and adolescents, age 5 to 17 years, should do at least one hour of moderate-to-vigorous physical activity daily, while adults, age 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.\(^\text{15}\)

Just 2.5 hours of moderate intensity aerobic physical activity each week is associated with a gain of approximately three years of life.\(^\text{16}\)

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.\(^\text{17}\)

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

1 out of 2
(56%) adults does not walk at least 150 min per week for transportation or leisure.\(^\text{18}\)

1 out of 2
(47%) children ages 3–5 years in child care centers are not physically active for 90 min per school day.\(^\text{19}\)

2 out of 3
(67%) middle schoolers do not spend 60 min per day each day of the week doing physical activity.\(^\text{20}\)

4 out of 5
(83%) high schoolers do not spend 60 min per day each day of the week doing physical activity.\(^\text{20}\)

Each day, 4.5 million transportation trips are made in San Francisco.

Of these, only about 37% are walking trips or public transit trips which include walking.\(^\text{21}\)

Many San Franciscans don’t meet activity standards

In San Francisco about 30% of 5th and 7th graders and 40% of high school students do not meet the Fitnessgram standard for aerobic capacity, which is ability to run one mile or pass a PACER test.

60 percent of Black/African American and Latinx 9th graders, do not meet the fitness standards, compared to 30% of White and Asian students.\(^\text{27}\)

Aerobic fitness is 10 percentage points lower for economically disadvantaged students\(^\text{27}\)

14% percent of adults ages 65-75 and 37% of adults over age 75 have difficulty walking or climbing stairs.\(^\text{28}\)
59% of adults do not feel safe walking alone in their neighborhood at night. 25

There are gaps in school and workplace supports for physical activity

2 out of 3 (67%) child care centers do not use physical activity curriculum. 29

All of our students, regardless of which neighborhood they live in or which school they attend, should be able to safely walk or bike to school. We are adding crossing guards across the City and I am pushing the SFMTA to expedite Vision Zero projects because we do not have time to waste. We need safer, more livable streets now.” — Mayor London Breed 23

Although each April, more than 10,000 people participate in Walk to Work Day, including San Francisco’s Mayor and Supervisors, over 200,000 workers drive to work on a daily basis. 30

35% of San Francisco playgrounds do not score an A or B for infrastructure quality, cleanliness and upkeep. 26

3 out of 4 (75%) parents report gaps in neighborhood resources for physical activity

Sidewalk networks support walkers to varying degrees. Downtown and in Chinatown, the blocks are short and provide many pedestrian connections. In other neighborhoods, pedestrians have to walk further to make less direct connections. 34

SF has 0.18 miles of bike lane for every 1 mile of streets. 24

Every day, on average 2 people walking are hit by cars

Cars violating a pedestrian’s right-of-way is the top risk factor for injuries to people walking. In 2018, there were 15 pedestrian deaths and 3 cyclist deaths. 22-23
Shelter is a basic human need

Housing is foundational to meeting people’s most basic needs. Quality housing provides a place to prepare and store food, access to water and sanitation facilities, protection from the elements, and a safe place to rest. Stable/permanent housing can also provide individuals with a sense of security. Unfortunately, California, and especially the Bay Area, suffers from an acute housing shortage which has been driving housing costs to unaffordable levels, leading an increasing number of residents to become homeless.1

Housing production has declined in the Bay Area

Between 2011 and 2015, the Bay Area added 501,000 new jobs — but only 65,000 new homes.2

<table>
<thead>
<tr>
<th>Housing Production Decline in the Bay Area, 1970–2015</th>
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<tbody>
<tr>
<td>500,000</td>
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<td>0</td>
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</tbody>
</table>


- Rest of Bay Area
- San Mateo & Santa Clara (except San Jose)
- San Jose
- Marin & Napa
- Outer East Bay, Solano, Sonoma
- Inner East Bay
- San Francisco city
- Bay Area 2020

Source: SF Planning Analysis of US Census and ACS Data

San Francisco usually exceeds requirements for development of above moderate-income housing (120% AMI), but builds less than a third of the units allocated for moderate and low-income residents.3

Homelessness

In 2017, about 7,500 homeless persons were counted in San Francisco.7 Despite making up only 6 percent of the general population, 35% of the homeless persons counted were Black/African American.

Among the many challenges homeless persons face, including those in temporary housing, are:

- Safely storing medications
- Eating healthfully
- Maintaining relationships
- Going to the doctor

Overcrowding

An estimated 24,000 people in San Francisco live in crowded conditions.4

Living in overcrowded conditions can increase risk for infectious disease.5
Evictions

There had been a steady increase in the number of all-cause eviction notices between 2011–2016; however, in 2017 there was a 27% decrease in the number of eviction notices filed. This rapid change may be attributable to the implementation of Eviction Protection 2.0 in November 2015, as well as economic shifts and other factors.

Moving can result in:
- Loss of employment
- Difficult school transitions
- Increased transportation costs
- Loss of health protective social networks

Housing Affordability

Between 2010 and 2018, the median market rate rent for a 2-bedroom unit increased 48% to $4,725.

4 full-time minimum wage jobs to afford a “fair market rate” ($3,121) 2-bedroom unit

6 full-time minimum wage jobs to afford a “median market rate” ($4,725) 2-bedroom unit

The median percent of income paid to gross rent in San Francisco was 30% in 2017. 17% of renter households spend 50% or more of their income on rent.

Nearly one-third of Chinatown residents live in overcrowded conditions.
Violent Crime is a Concern in San Francisco.

Violent crime rates in San Francisco are high (712/100,000) and exceed California rates (452/100,000).¹²

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.

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.⁵⁻⁸

Children are particularly vulnerable. Witnessing and experiencing violence disrupts early brain development and causes longer term behavioral, physical, and emotional problems.¹⁻⁴

Violence is rarely caused by a single risk factor but instead by the presence of multiple risk factors.⁹⁻¹¹

Young men, people of color, and residents of the Eastern neighborhoods are most likely to be victims of violence or to witness violence.

Violent Crime Rate

Violent crime rates and rates of emergency room visits due to assault are highest in the Eastern half of the City. Residents are also less likely to feel safe in these neighborhoods.¹³⁻¹⁵

122 males died violent deaths between 2015 and 2017.

Violence is the 5th leading cause of death among Black/African American men and the 8th cause among Latinx men.

Violence kills men in their prime years. 37 was the average age at death for men who died violently.¹⁶

89 of the 134 assault deaths (66%) resulted from use of a firearm.

Emergency room visit rates¹³

Black/African American 7.5 times higher

- Pacific Islanders 4 times higher

- Latinx 2 times higher than among other San Francisco residents.

Residents perceived safety during the day, 2017¹⁵

White 59%

Asian & Pacific Islander 47%

Black/African American 43%

Latinx 38%

Emergency Room Visit Rates for Assault, 2012–16¹³

Age-adjusted rate per 10,000 residents.

14.1 203.7

Crime rate (per 1,000)

0.00 91.82%

San Francisco Health Improvement Partnership

Community Health Needs Assessment 2019
Cases of child abuse have decreased in San Francisco since 2009. However, in 2017 there were 509 cases of substantiated child maltreatment in San Francisco. The majority of child abuse cases are due to neglect.  

In addition to a history of violence in family and community, maltreatment arises from the confluence of other preventable risk factors including:

- **High Unemployment and Poverty**  
  19% of Black/African American children in San Francisco live in poverty (<100% FPL); 7% of Latinx, 4% of Asian and 1% of White.  

- **Social and Social Economic Status Inequality**  
  San Francisco has the 6th highest income disparities in the US.

- **Low Levels of Education**  
  Only 24–26% of Black/African American, Pacific Islander and Asian residents have a bachelors degree or higher. 32% of Latinx, 43% of Asian and 74% of White residents.

- **Parenting Stress**  
  28% of Latinx births in San Francisco are unintended, 24% of Black/African American, 20% of Asian, and 12% of White. 27% of Latinx new mothers in San Francisco experience prenatal depression, 21% of Black/African American, 12% of Asian, and 10% of White.

- **High Residential Instability**  
  According to 2016 data, 2,512 or 4% of SFUSD students are homeless. Less than 25% of Black/African American, Latinx, and Native American residents own their homes.

- **Social Isolation and Lack of Social Support**  
  In San Francisco 18% of Households have minors compared to 36% in California.

- **Substance Abuse or Mental Health Issues**  
  27–30% of Latinx, Black/African American and White residents report needing help with mental health or Drug Use Problems. 11% of Asian reported needing help.
In San Francisco, steps have been taken to combat the school-to-prison pipeline. However, Black/African American, and Latinx students are still more likely to be suspended or expelled and, with Samoan youth, are more likely to be arrested.

During the 2016–17 school year nearly 40% of all SFUSD students who received at least one suspension were Black/African American, despite making up only 11% of the student population.

**Suspension rates for Black/African American and Pacific Islander students are 5x higher than those of Asian students.**

**Contributors to the school-to-prison pipeline include:**

- **Inadequate resources** (e.g. overcrowded classes, lack of counselors, special education services)
- **Police presence** at schools
- **Harsh punishments** that result in suspensions and out of class time.

An arrest, a court appearance, and even brief detention, especially for minor infractions, increase a minor’s risk of dropping out and getting into more serious crime.

Once a student enters the juvenile justice system they face barriers to re-entry into traditional schools and many never graduate from school.

**Unduplicated Count of Juvenile Hall Bookings/Criminal Offenses, by Ethnicity, 2017**

86% of Juvenile Hall Bookings are among Black/African American and Latinx youth.

Samoan youth make up 3% of the bookings, but only account for less than 1% of the youth population.
Black/African American and Latinx persons are disproportionately detained, searched and arrested by the police in San Francisco.\textsuperscript{25-28} Incarceration harms the mental and physical health of the incarcerated and that of non-incarcerated partners and children. Mass incarceration also compromises the community health and contributes to racial health inequities.\textsuperscript{29} At the population level, inequalities in incarceration impact employment and health which themselves further influence incarceration.\textsuperscript{30} Black/African American defendants experience delays in the criminal adjudication process, are convicted of more serious crimes and receive longer sentences than White defendants.\textsuperscript{32}

**Officer Initiated Detentions, 2017**

<table>
<thead>
<tr>
<th></th>
<th>Detentions (Stops)</th>
<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.0%</td>
<td>33.5</td>
<td>14.9</td>
<td>4.2</td>
<td>16.0</td>
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<tr>
<td>50.0%</td>
<td>41.1</td>
<td>21.8</td>
<td>4.8</td>
<td>18.6</td>
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<tr>
<td>40.0%</td>
<td>41.1</td>
<td>20.6</td>
<td>4.1</td>
<td>19.5</td>
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<tr>
<td>30.0%</td>
<td>42.5</td>
<td>15.3</td>
<td>0.2</td>
<td>5.2</td>
</tr>
<tr>
<td>20.0%</td>
<td>41.1</td>
<td>0.2</td>
<td>0.1</td>
<td>2.1</td>
</tr>
<tr>
<td>10.0%</td>
<td>42.5</td>
<td>0.1</td>
<td>0.2</td>
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<table>
<thead>
<tr>
<th>Asian &amp; Pacific Islander</th>
<th>Detentions (Stops)</th>
<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.0</td>
<td>4.7</td>
<td>5.2</td>
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<tr>
<td>Latinx</td>
<td>15.0</td>
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<td>0.1</td>
<td>15.2</td>
</tr>
<tr>
<td>Native American</td>
<td>17.7</td>
<td>16.4</td>
<td>15.2</td>
<td>15.8</td>
</tr>
<tr>
<td>White</td>
<td>17.7</td>
<td>16.4</td>
<td>15.2</td>
<td>15.8</td>
</tr>
<tr>
<td>Unknown</td>
<td>17.7</td>
<td>16.4</td>
<td>15.2</td>
<td>15.8</td>
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</table>

**Officer Initiated Traffic Stops, 2017**

<table>
<thead>
<tr>
<th></th>
<th>Detentions (Stops)</th>
<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
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</thead>
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<th>Detentions (Stops)</th>
<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.0</td>
<td>4.7</td>
<td>5.2</td>
<td>0.1</td>
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<tr>
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<td>15.2</td>
<td>15.8</td>
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</tbody>
</table>

**Criminal History has a “ripple effect”**

Differences in the severity of charges at booking and the number of times that people of color were previously arrested, convicted, and incarcerated explain almost all of the difference in conviction rates.

**Pretrial Custody** Black/African American defendants are held in pretrial custody \textbf{62\% longer} than whites.

**Adjudication Process Time** Cases involving Black/African American defendants take \textbf{90 days} for Black/African Americans, but only \textbf{77.5 days} for Whites.

**Conviction** Defendants of color are convicted of more serious crimes. Black/African American defendants are convicted of \textbf{60\% more} felonies and \textbf{10\% fewer} misdemeanors. Latinx defendants are convicted of similar number of felonies but \textbf{10\% more} misdemeanors.

**Length of Sentence** Black/African American defendants receive sentences which are \textbf{28\% longer} than for whites. Latinx defendants received probations which were \textbf{55\% longer}.

**Non-consensual Searches** Data from 2015 suggest that SFPD performs non-consensual searches among them with lower levels of evidence than for other racial and ethnic groups.\textsuperscript{31}

While Black/African Americans make up 5\% of the population in San Francisco, in 2017 they accounted for \textbf{33\% of officer initiated (non-dispatched) detentions} and \textbf{19\% of officer initiated traffic stops}. 

Detentions, searches, arrests and \% of population each sum to 100\%
Mental health and well-being are crucial to supporting, maintaining, and optimizing quality of life.\(^4\)

The presence of mental illness can adversely impact the ability to function at work, at home, and in social settings and impacts individuals as well as their respective families and communities.\(^1\)\(^-\)\(^3\)

**Mental disorders include:**
- Depression
- Schizophrenia
- Anxiety
- Injuries to the brain
- Dementias
- Intellectual disabilities
- Developmental disorders (e.g. autism)
- Substance abuse.\(^1\)

**Social isolation can be a precipitating factor for suicidal behavior.**

Individuals who experience isolation in their lives are more vulnerable to suicide than those who have strong social ties with others.\(^6\)
- Impaired quality of life
- Disability
- Hospitalization
- Institutionalization
- Incarceration
- Suicide, self-injury, and/or death.\(^1\)

---

**People with lower education, income, and/or social status, and those who experience discrimination on the basis of race, gender, social class, or other characteristics are at a particularly high risk of mental illness.**

- **23.3%** of adults reported needing help for mental health or substance use issues in 2011–2016.\(^6\)
- **7%** of adults experienced serious psychological distress in 2014–2016.\(^6\)
- **Lower income residents** are almost 3 times more likely to experience serious psychological distress than higher income residents (15.19% compared to 5.31%).\(^6\)

---

**Major Findings**

**Health Needs**

**Social, Emotional, and Behavioral Health**

**Depression is the most common mental illness.**\(^3\)

Depressive symptoms are common among San Francisco school-aged youth.\(^5\)

**High School depression** 26% of SFUSD high school students reported prolonged sad or hopeless feelings in 2017.

**Considering suicide** Almost 13% of SFUSD high school students and 20% of middle school students had considered attempting suicide in 2017.

**Sexual identification and depression** Bisexual and gay or lesbian high school students are more likely to report prolonged sadness or hopelessness (45%-62%) and suicidal thoughts (32-40%) than heterosexual students (22% and 10%, respectively).

**Between 2013 and 2015, 14.4% of pregnant women reported prenatal depressive symptoms in San Francisco.**\(^4\)

Prenatal depression greatly affects the quality of care given to the infant. **14.4% of pregnant women reported prenatal depressive symptoms** in 2013-2015.\(^11\)

**Women with less than high school education** are more than 3 times more likely to report prenatal depressive symptoms than women with a college degree (37.6% vs 9.0%).

**Women with Medi-Cal insurance** are more than 2.5 times more likely than women with private insurance to report prenatal depressive symptoms (24.1% vs 8.9%).

**Hispanic and Black/African American women are more likely to report prenatal depressive symptoms than White or Asian women.**
Major Findings
Health Needs

Hospitalizations in San Francisco to treat major depression among adults occurred 2,631 times during the three years between 2014 and 2016. The number of hospitalizations for depression exceeded that for hypertension (2296), asthma (1017).

Adults aged 18-24 years are the most likely to be hospitalized due to major depression followed by 45-54 years. Age-adjusted rate of hospitalizations due to major depression among Black/African Americans is almost 5 times higher than among Asian & Pacific Islanders who have the lowest rate (23.79 vs 4.93 per 10,000 residents).

Age-adjusted Mortality Rates due to Suicide by Race/Ethnicity in San Francisco, 2015–2017

Suicide is the 12th leading cause of death in San Francisco. 114 San Franciscans committed suicide between 2015-2017. 50.96 years is the average age of death for those who complete suicide. Suicide completion is 3 times more common among men than women (14.22 vs 4.95 per 100,000 population). The suicide rate is the highest in the Castro Neighborhood.
Major Findings
Health Needs

Social, Emotional, and Behavioral Health

Alcohol abuse is common in San Francisco

2 out of 5 (40%) adults reported binge drinking in 2014–2015.\(^{13}\)

Over half (53%) of men and 24% of women over 18 binge drink.

8.37% of SFUSD high school students reported binge drinking in 2013–2017.\(^{12}\)

1 out of 4 (25%) white students binge drink, which is 2–12 times higher than other race/ethnicities.

3 out of 5 (61%) young adults 18–24 years binge drink.\(^6\)

Binge drinking is defined as consuming 5 or more alcoholic drinks for men and 4 or more for women on at least one occasion.

Percentage of SFUSD HS Students Who Reported Binge Drinking in the Past 30 Days by Race/Ethnicity, 2013-2017\(^5\)

Youth in San Francisco are at risk of substance abuse\(^5\)

27% of SFUSD high school students and 6% of middle school students have smoked marijuana.

12% of SFUSD high school students and 3% of middle school students have abused prescription drugs.

8% of SFUSD high school students and 6% of middle school students have used methamphetamines, inhalants, ecstasy or cocaine.

Drug and alcohol abuse contribute to homelessness in San Francisco

15% of homeless persons reported drug and alcohol use as their primary cause of homelessness in 2017.\(^{13}\)

65% of chronically homeless persons reported alcohol or substance use.

Many factors determine whether someone will start to use or become dependent on drugs or alcohol

Risk factors for use among children and adolescents include:

- Unstable family relationships
- Exposure to physical, mental, and sexual abuse
- Mental illness
- Early aggressive behavior
- Poor social skills
- Poor academic performance
- Substance use among peers and family members
- Involvement with the juvenile justice system
- Poverty\(^{16,17}\)

The effects of drug and alcohol use are cumulative, and significantly contribute to costly social, physical, mental, and public health problems. These problems include:

- Poor academic performance
- Cognitive functioning deficits
- Unintended pregnancy
- HIV and other sexually transmitted diseases
- Hepatitis C
- Motor vehicle crashes
- Violence
- Child abuse
- Crime, homicide
- Chronic diseases including liver disease and certain cancers (e.g. colorectal, liver, breast, prostate)
- Mental and behavioral disorders (unipolar depressive disorders, epilepsy, suicide)\(^{11}\)
Between 2014 and 2016, 8,552 emergency room visits resulted from alcohol abuse and 8,245 from drugs.\(^7\)

### Rates of Emergency Room Visits by Ethnicity and Age, 2012-2016 \(^7\)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Asian</th>
<th>Black/African American</th>
<th>Latinx</th>
<th>Pacific Islander</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>Cannabis</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>Cocaine</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>Opioid</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>300</td>
<td>200</td>
</tr>
</tbody>
</table>

Data represent primary, contributing, and co-morbid causes of emergency room visits.

### Age-adjusted Rates of ER Visits due to Alcohol Abuse by Zip Code, 2012–2016, and off-site alcohol permits in San Francisco,\(^7,12\)

| Neighbouhoods with higher density of off-sale alcohol outlets coincide with those with higher rates of emergency room visits due to alcohol abuse. |

### Age-adjusted Mortality Rates due to Drug Use Disorders by Race/Ethnicity in San Francisco, 2015–2017 \(^8\)

<table>
<thead>
<tr>
<th>Rate per 10,000</th>
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<tbody>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
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<tr>
<td>50</td>
</tr>
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<td>30</td>
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<td>20</td>
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<td>10</td>
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</tbody>
</table>

San Francisco spends nearly $400 million a year on tobacco-related costs, including medical expenses, loss of productivity, and secondhand smoke exposure.14

Significant gains against smoking have been made, but not everybody has benefited from tobacco control policies and education campaigns.

In 2015-2016, 11% of adults in San Francisco reported they were current cigarette smokers. Young adults and low income earners residents are disproportionately affected by tobacco.13

17% vs 9% Residents who live under 200% federal poverty level are twice more likely to smoke than those live above 200% federal poverty level.

15% vs 5% Men are 3 times more likely to smoke than women.

16% vs 10% 18 to 24 years are more likely to smoke than those 25 and older.


- Asian
- Black/African American
- Latinx
- White
- All

Number of Cigarette Packs Sold by Zip Code, 2016

Since adoption of the Tobacco Permit Density Reduction Ordinance in 2014, the number of tobacco retailers has declined by 18%.

The reduction was 26% in the Tenderloin and SOMA districts which had the highest density of retailers.14

From 2015 to 2016, the number of packs of cigarettes sold in San Francisco fell by 10%.14

E-cigarette use

In 2017, while 4% of SFUSD high school students reported smoking cigarettes, 7% reported using e-cigarettes or other electronic smoking devices in the last 30 days.5

25% of SFUSD high school students reported ever using e-cigarettes or other electronic smoking devices.5

“Vaping” is on the rise, especially among young people, which caused the US Surgeon General to call for aggressive steps to curb the epidemic of teen nicotine use in 2018.15

To limit e-cigarette use among youth in San Francisco the following laws have been passed:

- 2014: prohibition of the use of electronic cigarettes wherever smoking of tobacco products is prohibited.
- 2016: raised the minimum age to purchase tobacco products from 18 to 21.
- 2018: banned flavored tobacco products sales including flavored electronic tobacco pods.

7% vs 1% of Black/African American women are 7x more likely to smoke before or during pregnancy.4
Executive Summary

1. “Housing And Health: An Overview Of The Literature,” Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/ hhp20180313.396577

Approach


San Francisco Snapshot


Poverty


7. We Defined “Middle Income” Jobs as between 80-120% AMI (per Brookings Institute). In 2014 the 80% AMI for 1 person was 54,350.


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


4. American Communities Survey. 2017


7. SFPDSFUSDF-SDFS Kindergarten Oral Health Screening Program. 2015.


Food Insecurity, Healthy Eating, and Active Living


11. USDA Economic Research Service

12. https://waterfill.me/


33. San Francisco Marin Food Bank.

34. Vision Zero SF. https://visionzerosf.org/

Housing Security and an end to Homelessness


Safety from Violence and Trauma


References


38. San Francisco Juvenile Probation Department. 2017 statistical report.


Social, Emotional, and Behavioral Health


SECTION 3

Chinese Hospital Supplemental Community Health Needs Assessment

Introduction

The San Francisco Health Improvement Partnership (SFHIP) is a collaborative body whose mission is to embrace collective impact and to improve community health and wellness in San Francisco. Members of SFHIP includes the San Francisco Department of Public Health, San Francisco’s non-profit hospitals, the Clinical and Translational Science Institute’s Community Engagement and Health Policy Program at UCSF, the San Francisco Unified School District, The Office of the Mayor, community representatives from the Asian and Pacific Islander Health Parity Coalition, Human Services Network, Chicano/Latino/Indigene Health Equity Coalition, and African American Community Health Council, Community Clinic Consortium, Faith-based and other philanthropic partners. SFHIP completes a CHNA once every three years.

The citywide CHNA conducted by the SFHIP is the foundation for each non-profit Hospital’s community health needs assessment in San Francisco. As Chinese Hospital is a part of the SFHIP, a city-wide assessment of the community health needs is conducted every three years. Since Chinese Hospital primarily serves the Chinese community, we have decided to conduct a supplemental community health needs assessment in addition to the citywide CHNA to specifically look at the subpopulation Chinese Hospital serves.

Community Profile

The Chinese Hospital Health System is an integrative health system, consists of Chinese Hospital and Clinics, Chinese Community Health Plan (CCHP), and Jade Health Care Medical Group. Each entity performs an important role in achieving the common goal of providing the community with quality, affordable care that is culturally competent and linguistically appropriate. The community Chinese Hospital serves has a majority of low-income, monolingual or linguistically isolated senior population. Of the inpatient population at Chinese Hospital, 98% are Chinese ancestry, 88% are over the age of 60, and 91% are Medicare/Medi-Cal beneficiaries.

Methodology

The Chinese Hospital Supplemental Community Health Needs Assessment was conducted through focus groups designed to assess the health status, concerns and access among the Chinese population that Chinese Hospital serves in the city and county of San Francisco. The recruitment of these focus groups was conducted through ethnic media press release, flyer distribution at local community organizations, as well as through popular Chinese social media App, WeChat. The focus group participants were recruited from over 15 different zip code neighborhoods. Please see community profiles of these zip code neighborhoods.

A series of four (4) focus groups were conducted to assess and identify the predominant health concerns of the Chinese-speaking population that Chinese Hospital.
The focus groups were conducted between September 7th-11th, 2019 at Chinese Hospital with an average of 10 participants per group. The facilitator of the focus group is a bilingual, trained Health Educator with more than 10 years of experience in conducting qualitative interview sessions. All four (4) focus groups were conducted in Cantonese-Chinese, the preferred Chinese dialect of the participants. All participants completed a demographic survey and the focus group sessions were audio recorded with participants’ consent. The facilitator utilized a question guide and the Sticky Note Technique (Peterson and Barron, 2007) to solicit feedback from participants. A bilingual, bicultural Patient Navigator/Health Information Specialist hand recorded the meeting notes. Participants were asked to rank their health needs from 1-5, with 1 being the most important, and their responses posted with sticky notes on a board for other participants to see. Sticky notes served as bases for further discussion to assess community needs.

Thematic analysis was utilized to examine themes or patterns of noted health status, concerns and barriers to health as identified by the focus group participants.

**Focus Group Demographics**

**Age, Gender, & Marital Status**

The average age of our participants was 63 years old, with the youngest participant being 22 years old and the oldest being 73. Less than one third of our focus group participants were male. Among all participants, 72% were married, 36% were single, and 7% were either windowed or separated.

**Birth Place**

As Chinese-speaking residents are the primary target population of this study, all of our focus group participants were foreign born. Participants born in mainland China comprised 92% of our total respondents, and 8% of participants were born in Hong Kong and Vietnam. The average number of years spent in the US among individuals was about 21 years.

**Languages**

Approximately 92% of participants identified Cantonese among their native languages, and similarly listed Cantonese as their preferred language. 10% of all participants considered their English-speaking ability sufficient, 64% of participants classified their English-speaking ability as “so-so”, and 26% spoke no English at all.

**Education Level**

Nearly half of all participants (46%) reported having a below high school-level education. Meanwhile, 38% of participants were high school graduates and only 10% held higher-level degrees. 59% of all participants have taken an English as a Second Language (ESL) course during their residency in the United States.
Income

Nearly half of all participants reported an annual individual income between $10,001 - $20,000. Less than 5% make.

---

**Income Level**

- No income
- $10,000 or less
- $10,001 - $20,000
- $20,001 - $35,000
- $35,001 - $50,000
- $50,001 or more
- Refused to answer

---

50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

---

8
Figure 1. San Francisco Neighborhoods Represented by Focus Group Participants
Community profiles of the top 5 zip code neighborhoods represented by the focus group participants

North Beach/Chinatown (94133)

Zip-code: 94133
Population: 26,942

Population by race:
- Asian: 50.2%
- Latino: 7.3%
- White: 42.9%
- African American: 1.7%
- Multi-ethnic: 3.2%
- Native American: 0%
- Other: 3.6%

Chinese Population: 11,771
Chinese population percentage: 43.7%
Per Capita Income: $58,461
Median household income: $66,422
Percentage of persons 65 years and over: 22.4%
Percentage of individuals below poverty level: 16.0%
<table>
<thead>
<tr>
<th>Zip-code</th>
<th>94134</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>43,074</td>
</tr>
<tr>
<td>Population by race</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>56.1%</td>
</tr>
<tr>
<td>Latino</td>
<td>24%</td>
</tr>
<tr>
<td>White</td>
<td>16.6%</td>
</tr>
<tr>
<td>African American</td>
<td>7.1%</td>
</tr>
<tr>
<td>Multi-ethnic</td>
<td>3.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
</tr>
<tr>
<td>Chinese Population</td>
<td>16,992</td>
</tr>
<tr>
<td>Chinese population percentage</td>
<td>39.4%</td>
</tr>
<tr>
<td>Per Capita Income</td>
<td>$28,790</td>
</tr>
<tr>
<td>Median household income</td>
<td>$71,352</td>
</tr>
<tr>
<td>Percentage of persons 65 years and over</td>
<td>15.4%</td>
</tr>
<tr>
<td>Percentage of individuals below poverty level</td>
<td>11.8%</td>
</tr>
</tbody>
</table>
Parkside/Forest Hill (94116)

Zip-code: 94116
Population: 47,708

Population by race:
- Asian: 53.0%
- Latino: 7.8%
- White: 36.9%
- African American: 2.1%
- Multi-ethnic: 4.7%
- Native American: 0.1%
- Other: 3.0%

Chinese Population: 19,782
Chinese population percentage: 41.5%
Per Capita Income: $50,165
Median household income: $101,746
Percentage of persons 65 years and over: 18.5%
Percentage of individuals below poverty level: 8.5%

Bayview/Hunters Point (94124)
Zip-code: 94124
Population: 35,492

Population by race:
- Asian: 34.8%
- Latino: 23.7%
- White: 13.4%
- African American: 28.8%
- Multi-ethnic: 5.2%
- Native American: 0.1%
- Other: 15.2%

Chinese Population: 8,787
Chinese population percentage: 24.8%

Per Capita Income: $26,061
Median household income: $55,823
Percentage of persons 65 years and over: 11.7%
Percentage of individuals below poverty level: 21.3%

Ingleside-Excelsior/Crocker-Amazon (94112)
Zip-code: 94112
Population: 85,373

Population by race:
- Asian: 50.7%
- Latino: 27.0%
- White: 24.4%
- African American: 3.6%
- Multi-ethnic: 4.5%
- Native American: 0.5%
- Other: 16.1%

Chinese Population: 26,971
Chinese population percentage: 31.6%
Per Capita Income: $31,905
Median household income: $82,692
Percentage of persons 65 years and over: 15.5%
Percentage of individuals below poverty level: 9.1%

Literature Review
A literature review of San Francisco community health status, including SFHIP “San Francisco Community Health Needs Assessment 2019” and Kaiser’s “San Francisco Community Health Needs Assessment 2019” have been conducted. Community demographics were extracted and analyzed from demographic survey data collected during focus group sessions. The literature review helps to set the direction and build the framework of our study.

**Key Findings**

A total of 39 focus group participants were asked to list their top five health concerns, which were then sorted into 3 main topics of interest (chronic diseases and health screenings, palliative care, and dementia and caregiver burden) and other health topics.

**Top 3 main topics of interest/concerns**

**Chronic diseases and health screenings**
Approximately seventy-four (74%) of the total focus group participants listed at least one chronic disease. The chronic diseases listed include cancer, heart disease, diabetes, oral disorders, and arthritis. Diseases of the eye and dental concerns were also mentioned. Twenty-one percent (21%) of the total focus group participants listed health screening as one of the top health concerns.

**Palliative care**
Forty-four percent (44%) of participants listed palliative care, comfort care, and end of life care among their top concerns. More specifically, twenty-eight percent (28%) expressed the need for more information and services in the area of advance health care directives.

**Dementia/Caregiver burden**
Forty-one percent (41%) of participants listed dementia as a top concern. Specifically, twenty-eight percent (28%) of all focus group participants expressed the need to provide education for caregivers of individuals living with dementia, as well as the need for resources to help alleviate caregiver burden.

**Other health topics of concerns**
Less than a quarter of the participants mentioned the following topics:
- Environmental and public safety (23%)
- Access and responsiveness to and of emergency health services (20%)
- Government supplement programs (18%)
- The use of technology (18%)
- Mental health (18%)
- Resources needed for medical devices, including blood pressure machines, blood glucose monitors (18%)
- Physical exercise (13%)
  - Smoking cessation (10%)
  - Exposure to and contact with marijuana smoke (10%)
  - Health insurance (5%)
The focus group participants **identified the following health needs and barriers:**

- Insufficient funds for local community health organizations to provide culturally competent programs and services
- Not able to access to existing resources provided by governments and or other national health care organizations
- Lack of language appropriate materials and services
- Lack of time due to heavy working schedule
- Physically exhausted from work and caregiving responsibilities

**To reduce the above barriers, participants recommended the following:**

- Using technology to deliver health information such as through culturally appropriate and credible websites and social media
- Using technology to address topics associated with stigma such as mental health
- To provide programs in stress management and counseling for mental health through Chinese social media platform such as WeChat if participants’ privacy is protected

The following **recommendations** were provided by the focus group participants in the areas of:

**Chronic diseases and health screenings**

- To offer bilingual health education programs and services on preventing and self-management of chronic diseases such as cardiovascular disease, hypertension, stroke, cancer, diabetes, oral disorders and etc.
- Increase access to preventive health screenings through community navigators who are from the Chinese immigrant community

**Palliative care**

- To provide educational programs on raising awareness of palliative care including advance health care directive form completion
- To offer palliative care programs and services that are tailored for the Chinese immigrant patients
- Increase access to palliative care programs and services through community navigators who are from the Chinese immigrant community

**Dementia/Caregiver burden**

- To offer educational programs on raising awareness of caregiver burden
- To provide practical information on how to provide care for individuals living with dementia including symptom recognition and management

**Section 4**
Implementation Strategy for the next 3 years

Implementation strategy to meet the community needs identified through the CHNA
Among all the community health needs identified by 2019 SFHIP CHNA and Chinese Hospital 2019 Supplemental CHNA, based on the resources available, Chinese Hospital selects the following 3 main areas as our priorities to address in the next three years. Additionally, Chinese Hospital will continue to address health concerns regarding mental health identified by the focus group participants under the category of other health concerns though they are not among the top 3 health concerns.

1. *Chronic diseases and low screening rates*
2. *Palliative care*
3. *Dementia/Caregiver burden*
4. *Mental health*

*See Table 1 for Summary of Implementation Strategy for the next 3 years.*

Table 1. Summary of Implementation Strategy for the next 3 years
<table>
<thead>
<tr>
<th>Health concerns</th>
<th>How will the need be addressed?</th>
<th>When</th>
<th>Who</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chronic diseases and low screening rates</td>
<td>a. Expand the existing chronic disease management programs to address chronic conditions that are concerning the Chinese population</td>
<td>Ongoing</td>
<td>G. Yam</td>
<td>• Ongoing free one on one diabetes self-management courses provided to diabetes patients</td>
</tr>
<tr>
<td></td>
<td>b. Promote patient usage of the technology-based patient dashboard system in Chinese Hospital patient rooms to increase patients’ access to educational videos on the prevention and management chronic diseases</td>
<td></td>
<td>G. Yam</td>
<td>• Free or low-cost diabetes prevention program for prediabetic patients</td>
</tr>
<tr>
<td></td>
<td>c. Work with our partner, Chinese Community Health Resource Center (CCHRC) to develop bilingual (Chinese &amp; English) health education materials on chronic diseases and health topics of community’s concern</td>
<td></td>
<td>A. Sun</td>
<td>• In August 2019, the technology-based patient dashboard system in Chinese Hospital patient rooms was implemented</td>
</tr>
<tr>
<td></td>
<td>d. Work with our partner, CCHRC to deliver health education materials and programs including through website and social media</td>
<td></td>
<td>A. Sun</td>
<td>• Develop bilingual educational information by CCHRC</td>
</tr>
<tr>
<td></td>
<td>e. Continue to work with NICOS, and the Chinatown Children’s Oral Health Taskforce to address the need for improved children’s dental health education and services.</td>
<td></td>
<td>J. Zhang</td>
<td>• Free educational classes offered by CCHRC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Chinese Hospital is working with NICOS and the Chinatown Children’s Oral Health Taskforce</td>
</tr>
<tr>
<td>2. Palliative care</td>
<td>a. Establish, implement, and evaluate an outpatient palliative care program at Chinese Hospital</td>
<td>Ongoing</td>
<td>G. Yam</td>
<td>• Case management</td>
</tr>
<tr>
<td></td>
<td>b. Expand bilingual (Chinese &amp; English) educational materials on palliative care</td>
<td></td>
<td>G. Yam A. Sun</td>
<td>• Provide bilingual health education information on medication management, advance health care directives, end of life and hospice care</td>
</tr>
<tr>
<td></td>
<td>c. Continue to collaborate with CCHRC to provide education programs and services on advance health care directives as well as provide assistance in form completion</td>
<td></td>
<td>A. Sun</td>
<td>• Educational seminars/counseling sessions on advance health care directive and assistance service with form completion provided by CCHRC</td>
</tr>
<tr>
<td>3. Dementia/ Caregiver burden</td>
<td>Provide education information and programs on dementia and practical information for providing care to individuals living with dementia</td>
<td>Ongoing</td>
<td>G. Yam A. Sun</td>
<td>Continues to provide bilingual health education information, programs and services to the community</td>
</tr>
</tbody>
</table>
1. Chronic diseases and low screening rates

Based on the findings from this qualitative health needs assessment, chronic disease and its screenings are among the top concerns. The need for accessible, culturally and linguistically appropriate chronic disease management programs in communities Chinese Hospital serves remained high. To meet these demands, we will continue to expand the Chinese Hospital’s programs and services as follow:

**a. Expand the existing chronic disease management programs to address chronic conditions that are concerning the Chinese population**

Chinese Hospital Patient-Centered Diabetes Programs continue to offer comprehensive diabetes care to the community with a multidisciplinary approach. Our multidisciplinary team consists of bilingual primary care doctors, an endocrinologist, nurse practitioners, certified diabetes educators, registered dietitians, care coordinators, medical assistants, a podiatrist and other providers and staff. We also provide American Diabetes Association certified Diabetes Self-Management Education (DSME) to diabetic patients and families. The courses are provided in Cantonese, Mandarin, and English, and education materials are bilingual in Chinese and English. The center is also expanding its program to serve the pre-diabetic population by adding the bilingual CDC recognized Diabetes Prevention Program.

Chinese Hospital Support Health Services also continues to provide chronic disease management for Chronic Obstructive Pulmonary Disease, Congestive Health Disease, Hepatitis B and other chronic diseases.

As low health screening rates was among the top concerns identified by the focus group, Chinese Hospital will continue the efforts in improving preventive health education and services. Chinese Hospital will continue to hold promotional events targeting the Chinese population, e.g. community health fairs will continue to be held on a regular basis. These fairs have and will continue to provide free health screenings and bilingual health education materials for those
who participate. Free or low-cost fitness classes will be provided to the community at a convenient location and time.

Using multimedia approach such as Chinese TV or radio channels, newspapers, health plan newsletters targeting the Chinese community, for outreaching and raising public awareness of preventive health is recommended. In addition, Chinese Hospital and CCHRC are developing and expanding its health education programs on preventive screenings, health behavior and healthy lifestyle to address the identified behavioral health concerns, e.g. smoking. Bilingual health education resources need to be made available to the public online, as well as by printed copies to certain population have little or no access to the internet.

b. Promote patient usage of the technology-based patient dashboard system in Chinese Hospital patient rooms to increase patients’ access to educational videos on the prevention and management chronic diseases.

Chinese Hospital implemented an interactive patient dashboard in all patient rooms in August 2019. This dashboard system enables patients to access health education materials, inpatient services, and entertainment during their stay at Chinese Hospital. We aims to increase patients’ usages of this dashboard to system access bilingual (Chinese & English) educational videos on the prevention and management of chronic diseases. To provide patient-centered care, each patient will receive a tailored list of educational videos specific to their needs, which will be selected by their health care team.

c. Continue to work with our partner, Chinese Community Health Resource Center (CCHRC) to expand the bilingual (Chinese & English) health education materials on chronic diseases and health topics of community’s concern.

Chinese Hospital together with Chinese Community Health Resource Center (CCHRC) will expand the free bilingual (Chinese & English) health education materials to include the health concerns identified by the focus group on chronic conditions such as oral disorders, eye health and chronic pain.

d. Work with our partner, CCHRC to deliver health education materials and programs including through website and social media.

Based on the recommendations of using technology to deliver health information, Chinese Hospital will work with CCHRC will continue to make bilingual (Chinese & English) educational websites (www.chinesehospital-sf.org and www.cchrhchealth.org). Additionally, Chinese Hospital and CCHRC will explore the use cultural appropriate social media to deliver health information. Specifically, we will explore the incorporation WeChat, a free mobile application, in the distribution of health education materials and programs. WeChat is one of the most widely used social media platform in China and Chinese individuals globally, including Chinese immigrants in the United States (Tencent, 2017). Given the feedback received from the conducted focus groups, WeChat is regularly used within the Chinese community of San Francisco. When able to, we will incorporate WeChat as a tool to inform and engage patients in programs offered by the hospital.
e. Continue to work with NICOS, and the Chinatown Children’s Oral Health Taskforce to address the need for improved children’s dental health education and services.

Chinese Hospital will continue working with NICOS, a coalition of community based organizations, and the Chinatown Children’s Oral Health Taskforce to address the need for improved children’s dental health education and services. Chinese Hospital plans to work with its community partner, the Chinese Community Health Resource Center, to produce further health education material on oral health.

2. Palliative care
Focus group participants identified the need for more palliative care educational materials and services as one of the top concerns.

a. Establish, implement and evaluate an outpatient palliative care program at Chinese Hospital.
Utilizing funds awarded to Chinese Hospital by the Stupski Foundation (2019-2022), the current inpatient palliative care services is being expanded to outpatient services as well. This outpatient palliative care project will include the recruitment and onboarding of a certified palliative care specialist/geriatrician, the development of policies and protocols, the implementation and monitoring of a data tracking system, and its evaluation and improvement.

b. Expand bilingual (Chinese & English) educational materials on palliative care.
Chinese Hospital will work with our partner CCHRC to develop bilingual (Chinese & English) educational materials on palliative care/comfort care and an educational video on pain management.

c. Continue to collaborate with CCHRC to provide education programs and services on advance health care directives as well as provide assistance in form completion.
Chinese Hospital will work with CCHRC will continue to provide education seminars, counseling sessions on the topic of advance health care directives as well as continue to provide service to assist with advance health care directive form completions.

3. Dementia/Caregiver burden
The focus group participants also identified as one of the top concerns was the awareness of dementia and the burden of caregivers providing care for individuals living with dementia.

Provide education information and programs on dementia and practical information for providing care to individuals living with dementia
Chinese Hospital will work with CCHRC to develop bilingual (Chinese & English) educational materials and training to raise the awareness of caregiver burden and to provide practical information on
symptom recognition and care management for caregiver of individuals living with
dementia.

4. Mental health

a. **Promote the system-wide mental/behavior health services.**
Chinese Hospital promotes the mental health services through the communications such as
system-wide announcement flyers, newsletters, websites, etc. to the community on a
regular basis.

b. **Continue to expand culturally and linguistically appropriate educational programs on
mental health including video conferencing for support.**
Chinese Hospital clinics outpatient mental health program provides outpatient psychiatric
and mental health therapy services will include video conferencing (WebEx). To increase the
access to mental health providers, video conferencing will connect patients with their care
team remotely.
Section 5

Evaluation of the 2016 CHNA Implementation Strategy

Based on findings from the 2016 Community Health Needs Assessment, Chinese Hospital adopted an Implementation Strategy to address the needs identified. Below is an evaluation of the work Chinese Hospital has accomplished and the outcomes achieved.

1. Expand patient-centered culturally and linguistically appropriate chronic disease management and education programs.

Chinese Hospital Diabetes Center is located in the heart of San Francisco Chinatown, California. Chinese Hospital is a unique healthcare provider with a long and rich history of serving the local community that dates back to the late 1800’s. It has a well-established Diabetes Self-Management Education (DSME) program recognized by American Diabetes Association (ADA) since 2009. It provides type 2 diabetic patients with extensive one on one diabetes self-management coaching, to help them manage the disease. Patients with diabetes whether on medication or not, will be offered to have a consultation with the endocrinologist first, and then start free nutrition counselling and diabetes self-management education with our registered dietitian or certified diabetes educator once a month for 6 months. Education session topics include physical activity, healthy eating, medication usage, monitoring blood sugar levels, and proper foot and eye care. Through the program, patients’ knowledge of diabetes and skills of self-management will be reinforced and improve. In addition to control diabetic outcomes, good self-management also improves patients’ quality of life significantly.

Serving a community with majority of Chinese immigrant population, Chinese Hospital Diabetes Center has a strong bilingual (Chinese & English) medical team made of endocrinologists, nurse practitioner, registered dietitians, and mental health therapists who provide quality medical management, frequent nutrition counselling, and psychosocial support to patients. Chinese Hospital Diabetes Center also provides numerous free bilingual health education resources on diabetes and other chronic conditions to the public through Chinese Community Health Resource Center (https://www.cchrchealth.org/).

To reach a broader prediabetic population and prevent or delay the progress of disease in our community, Chinese Hospital Diabetes Center joined the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC) in 2015, and enrolled in Medicare Diabetes Prevention Program in 2018. Through Chinese Hospital Diabetes Prevention Program, participants work in a group with a trained lifestyle coach to learn the skills needed to lose weight, become more physically active, and manage stress.

In addition, Chinese Hospital Diabetes Center launched a Gestational Diabetes Management program early this year, which is an affiliate of California Diabetes and Pregnancy Program (CDAPP) Sweet Success. The program aims to promote improved pregnancy outcomes for high-risk pregnant women with pre-existing diabetes and women who develop diabetes while pregnant, prevent the complications of diabetes through pregnancy, and promote healthy lifestyle changes in order to prevent recurrent gestational diabetes or development of diabetes after pregnancy.
Chinese Hospital Diabetes Center is striving to deliver quality diabetes care to our community in a cost effective way, be responsive to the community's ethnic and cultural uniqueness, and to provide access to health care and acceptability to all socioeconomic levels.

2. Increase culturally and linguistically appropriate mental health services.

In 2018, Chinese Hospital clinics launched an outpatient mental health program and started to provide outpatient psychiatry and mental health therapy services to our patients and the community in English, Cantonese, and Mandarin. Our physicians and providers are bilingual in Chinese and English, and are familiar with both eastern and western cultures.

3. Expand urgent care access in the area identified as lacking access to this services.

Chinese Hospital opened an in-hospital outpatient clinic in 2017 in Chinatown to provide primary care services and multi-specialty services, as well as walk in urgent care services Monday through Saturday. More than 5,000 visits were captured annually by 2018 and the volume keeps growing significantly in 2019.

Chinese Hospital Outpatient Center in Daly City, which opened in 2016, is now serving a broad community of patient population of San Mateo County as well as San Francisco City, over 16,000 clinic visits were captured annually by 2018. The Outpatient Center is also expanding its clinic hours to 7 days a week in 2020 to meet the increasing urgent care needs of the community.

4. Improve preventive health education and services.

Chinese Hospital clinics launches patient outreach project to reach out to patient to remind them for annual physical exam, eligible preventive screenings (cervical cancer screening, colorectal cancer screening, breast cancer screening, etc.) and immunizations plans. We make great effort to help our patient be on top of their preventive health schedules.

In addition, Chinese Hospital and the Chinese Community Health Resource Center (CCHRC) have continued to develop and expand its health education programs on preventive screenings, health behavior and healthy lifestyle to address the identified behavioral health concerns, e.g. smoking. Bilingual health education resources are available to the public online, as well as by printed copies, for individuals who may have little or no access to the internet. Community health promotion events targeting the Chinese population, e.g. free screening day have been held on a routine basis. Free or low-cost fitness classes can be provided to the community at a convenient location and time.

5. Enhance integrative health services.

Chinese Hospital East West Health Services opened a new acupuncture clinic in Daly City in 2016, the clinic has a total of over 3,000 annual visits now, a 40% volume increase has been observed compared to
2016. The Chinatown site has moved from Commercial Street to Grant Avenue, the clinic size is doubled and total annual visits has been increased by 10%.

6. Improve children’s dental health education and services

Chinese Hospital will continue working with and contributing as a partner member to NICOS and the Chinatown Children’s Oral Health Taskforce to address the need for improved children’s dental health education and services.

UPO and UCSF School of Dentistry provided pediatric dental screenings and the event drew 134 children attendees

*Please refer to Appendix A for the 2016 CHNA Implementation Strategy.
APPENDIX A: 2016 CHNA Implementation Strategy
Section 4

Implementation Strategy 2016

Chinese Hospital prioritizes the community health needs based on the inputs from surveyors and availability of resources. The sources of resources include Chinese Hospital and Chinese Community Health Plan operational and capital budget, federal and other grants, and community donations. Among all the community health needs identified, the following five areas are selected as our priorities to address in the next three years based on the importance rated by the surveyors and resources availability:

1. Expand patient-centered culturally and linguistically appropriate chronic disease management and education programs.
2. Increase culturally and linguistically appropriate mental health services.
3. Expand urgent care access in the areas identified as lacking access to this services.
4. Improve preventive health education and services.
5. Enhance integrative health services.
6. Improve Children’s Dental Health Education and Services
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>How will the need be addressed?</th>
<th>When</th>
<th>Who</th>
<th>Current Status</th>
</tr>
</thead>
</table>
| 1. Expand patient-centered culturally and linguistically appropriate chronic disease management and education programs |   Expand the existing chronic disease management programs to address more chronic conditions that are concerning the Chinese population.  
   Expand the services to all Chinese Hospital clinic sites in San Francisco and Daly City.  
   Expand educational classes on chronic diseases management to all clinic sites  
   Chinese Hospital and SF Hep B Free are working on developing a portal and navigational program, web based and direct hotline; to provide awareness and education about hepatitis B.                                                                                                               | Ongoing | J Zhang         |   Ongoing free one on one diabetes self-management courses provided to diabetes patients  
   Free or low-cost diabetes prevention program for pre-diabetic patients.  
   Free educational classes offered by CCHRC                                                                                                                                                                                                 |
| 2. Increase culturally and linguistically appropriate mental health services     |   Create system-wide mental/behavior health services  
   Build/expand educational programs on mental health that are culturally and linguistically appropriate for this population  
   Establishing mental health service at more clinic sites or establishing more partnerships that link mental health services to other social service agencies in the area  
   Incorporate culturally and linguistically appropriate programs and activities that help boost mental health into treatment                                                                                                                                                          | Ongoing | J Zhang, T Kravis, J Wu, A Sun | Chinese Hospital together with CCHRC are providing free or low cost mental health classes, stress management workshops, and group gentle fitness classes to communities in Chinatown, Sunset, Excelsior, and Daly City on a regular basis. |
| 3. Expand urgent care access in the areas identified as lacking access to this services. |   Expand clinic operation hours to weekends and after hours.  
   Contract with existing urgent care agencies in the identified areas.  
   Expand telemedicine services for those who can’t access our existing services.                                                                                                                                                                                                                                                                          | J Zhang |                | Short of urgent care services                                                                                                                                                              |
| 4. Improve preventive health education and services                              |   Use multimedia approaches for outreach to raise public awareness of preventive health  
   Provide education programs targeting the Chinese community on the topics of preventive screenings and disease prevention  
   Make bilingual health education resources available to the public online, as well as by printed copies                                                                                                                                                                                                                                         | Ongoing | J Zhang, A Sun   | Limited sites                                                                                                                                                                              |
to certain population have little or no access to the internet.

- Hold community health promotion events targeting the Chinese population, e.g. free screening day, nutrition counselling, onsite flu shot event, etc. on a routinely basis.
- Free or low-cost fitness classes can be provided to the community at a convenient location and time.

5. Provide integrative health services

- Expand traditional Chinese medicine service to more Chinese Hospital clinics and to other Chinese populated communities in San Francisco and San Mateo County if needed.
- Market the traditional Chinese medicine and integrative treatment to the Chinese population to promote and introduce the service to the community.

<table>
<thead>
<tr>
<th>5. Provide integrative health services</th>
<th>Ongoing</th>
<th>C Mao</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand traditional Chinese medicine service to more Chinese Hospital clinics and to other Chinese populated communities in San Francisco and San Mateo County if needed.</td>
<td>Ongoing</td>
<td>Chinese Hospital East West Health Services is providing traditional Chinese medicine health services at locations in downtown San Francisco and Daly City</td>
</tr>
<tr>
<td>Market the traditional Chinese medicine and integrative treatment to the Chinese population to promote and introduce the service to the community.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Improve children’s dental health education and services

- Provide and bring about awareness, and education about dental caries, screening, application of varnish and linkage to care (provide information regarding dental home) to the Chinese community
- Provide one-on-one training to community Pediatricians and primary care physicians with young pediatric patients, to perform oral screening for dental caries and cavities and application of fluoride varnish.

<table>
<thead>
<tr>
<th>6. Improve children’s dental health education and services</th>
<th>Ongoing</th>
<th>S Fong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide and bring about awareness, and education about dental caries, screening, application of varnish and linkage to care (provide information regarding dental home) to the Chinese community</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Provide one-on-one training to community Pediatricians and primary care physicians with young pediatric patients, to perform oral screening for dental caries and cavities and application of fluoride varnish.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Expanding patient-centered culturally and linguistically appropriate chronic disease management and education programs.**

Among the findings of this assessment, chronic diseases have been identified as the top health concern of the Chinese population in San Francisco. The demand for accessible, culturally and linguistically friendly chronic disease management programs in those communities has greatly increased. Education programs on chronic diseases management are also needed. Chinese Hospital together with has been putting great efforts in building its chronic disease management programs.

Chinese Hospital Patient-Centered Diabetes Programs offer comprehensive diabetes care to the community with a multidisciplinary approach. Our multidisciplinary team consists bilingual primary care doctors, an endocrinologist, nurse practitioners, certified diabetes educators, registered dietitians, care coordinators, medical assistants, a podiatrist and other providers and staff. We also provide American Diabetes Association certified Diabetes Self-Management Education (DSME) to diabetic patients and families. The courses are provided in Cantonese,
Mandarin, and English, and education materials are bilingual in Chinese and English. The center is also expanding its program to serve the pre-diabetic population by adding the bilingual CDC recognized Diabetes Prevention Program.

Chinese Hospital Support Health Services also provides chronic disease management for Chronic Obstructive Pulmonary Disease, Congestive Health Disease, Hepatitis B and other chronic diseases. We will expand to all clinic sites in San Francisco and Daly City.

Chinese Hospital together with Chinese Community Health Resource Center (CCHRC) have been providing free bilingual health education classes on chronic conditions like cardiovascular disease, diabetes, high blood pressure, hepatitis B, etc., to the community at various locations, and the education program has been expanding to meet growing needs of the population.

Chinese Hospital is also a partner and collaborative of the SFCAN (the San Francisco Cancer Initiative). SFCAN is a collaborative effort to reduce cancer in San Francisco by engaging health care systems, government, community leaders and residents. The goal is to decrease the incidence of liver cancer in San Francisco. The most common cause of liver cancer is Hepatitis B. Chinese Hospital, with its ongoing efforts to combat Hepatitis B, and established networks in the community; Chinese Hospital SF Hep B Free are working on developing a portal and navigational program, web based and direct hotline; to provide awareness and education about hepatitis B. The information will be provided in English, Cantonese, Mandarin and Vietnamese.

Increasing Mental Health Education and Services

From both this assessment and the NICOS Francisco Excelsior Health Needs Assessment for Chinese Community in 2015, we have learned that this population has both a high resistance and a high need for mental health services. Educational programs on mental health that are culturally and linguistically appropriate for this population is highly recommended. Establishing mental health service at more clinic sites or establishing more partnerships that link mental health services to other social service agencies in the area would help make services more accessible to this community. Incorporate culturally and linguistically appropriate programs and activities that help boost mental health into treatment are also encouraged, such as: free or low-cost stress relief workshops, gentle fitness classes like yoga and Tai Chi, etc.

Expanding urgent care access in the areas identified as lacking access to this services

Chinese Hospital health system has been working on expanding urgent care services to our serving areas, such efforts include but not limited to the following:

a) Expand clinic operation hours to weekends and after hours.
b) Contract with existing urgent care agencies in the identified areas.
c) Expand telemedicine services for those who can’t access our existing services.

Improving Preventive Health Education and Services

This needs assessment has identified that health education is greatly needed for the Chinese population in San Francisco to address the health disparities. Chinese Hospital has opened four community clinics in San Francisco and Daly City to provide preventive care services and
education since 1996. We will continue to assess the needs and expand to the area as needed when resources are available.

Using multimedia approach, for example, Chinese TV or radio channels, newspapers, health plan newsletters targeting the Chinese community, for outreaching and raising public awareness of preventive health is recommended. For example, on the importance of smoking cessation, raising awareness of the preventability of chronic illnesses and encouraging screening and preventive care utilization, as well as promoting healthy diet and exercise among this population.

In addition, Chinese Hospital and CCHRC are developing and expanding its health education programs on preventive screenings, health behavior and healthy lifestyle to address the identified behavioral health concerns, e.g. smoking. Bilingual health education resources need to be made available to the public online, as well as by printed copies to certain population have little or no access to the internet. Community health promotion events targeting the Chinese population, e.g. free screening day, nutrition counseling, onsite flu shot event, etc. can be held on a routine basis. Free or low-cost fitness classes can be provided to the community at a convenient location and time.

Providing Integrative Health Services

Identified from the assessment, there’s a high demand for traditional Chinese medicine and a safe, effective integration of complementary healing modalities among the Chinese population in San Francisco. Drawing from our cultural roots, Chinese Hospital is capable to offer and advance the practice of Chinese Medicine to serve the healthcare needs of people in this community.

Chinese Hospital East West Health Services is a community-based hospital clinic specializing in Chinese Medicine, a holistic system of health based on the philosophy that harmony and balance are the source of wellness. Our providers include licensed acupuncturists, herbalists and massage therapists. We partner with a range of allopathic and complementary health practitioners, researchers, and educators to support our patients in a holistic approach to health. As a supplement, traditional Chinese medicine approaches including acupuncture, cupping, herbs, and massage are being used to treat various health conditions, like diabetes, asthma, infertility, allergy, pain, and many other chronic conditions.

Expanding the service to more Chinese Hospital clinics, other than current locations in Downtown San Francisco and Daly City, and to other Chinese populated communities in San Francisco and San Mateo County, is on the plan. Marketing for traditional Chinese medicine and integrative treatment targeting Chinese population, is highly recommended to promote and introduce the service to the community.

Improving Children’s Dental Health Education and Services

It has been identified by the San Francisco Health Improvement Partnership has identified, that children in the Chinatown neighborhood have the highest incidence of dental caries and cavities, in San Francisco. Chinatown Children’s Oral Health Taskforce has been established with NICOS assuming the leadership role, Chinese Hospital is represented. The role of the taskforce is to help with community outreach and education. The taskforce meets monthly to discuss and plan
for events around Children’s oral health; i.e. health fairs; in addition, accessing day care centers and public schools in and around Chinatown. The taskforce provides and brings about awareness, and education about dental caries, screening, application of varnish and linkage to care (provide information regarding dental home), and provides one-on-one training to community Pediatricians and primary care physicians with young pediatric patients, to perform oral screening for dental caries and cavities and application of fluoride varnish. Chinese Hospital has implemented and continue to implement children’s oral health screening and varnish application to children, at our four neighborhood clinics in San Francisco and Daly City.
APPENDIX B: 2019 Community Health Needs Assessment

Focus Group Question Guide (English & Chinese)

I. Health Concerns

1. What are top 5 health concerns/needs you have? And for family/ friend?
   a. Please rank these concerns/needs in order of importance. Most important as #1, least important as #5.

2. What are top 5 health concerns/needs for the Chinese Immigrant/ American community?
   Prompt: Same prompts as above.
   a. Please rank these concerns/needs in order of importance. Most important as #1, least important as #5.

3. In your opinion, what areas of health needs to be addressed
   Prompt: raise awareness, educate general public, promote of available services, make service available, increase access to services
   Any suggestions or recommended strategies?

Definition: Define the definitions of health concerns being raised by participants

   a. Is/are (this/these health concern(s) –raised by participants) important to you and your family/friends?
      i. If yes, why?
      ii. If no, why not?

   b. Have you or your family/friend used these programs and or services related to the health concerns?
      i. If yes, how was your/their experience using these programs and or services?
         • If the experience was satisfactory, what went well?
         • If the experience was not satisfactory, what can be improved?
      ii. If no, why not?
2019年社區健康需求評估
小組指南

健康問題
1. 您、家人及朋友的五大健康問題的需求是什麼？
   a. 請按重要性排列這些問題與需求。最重要的是#1，最不重要的是#5。

2. 華人移民與美國社區的五大健康問題需求是什麼？
   提示：與上述提示相同。
   a. 請按重要性排列這些問題與需求。最重要的是#1，最不重要的是#5。

3. 在您看來，在這個領域需要做些什麼？
   提示：提高認識，教育公眾，推廣現有服務，提供服務，增加對服務的使用
   有什麼建議或推薦策略嗎？

定義：_____的定義是......

a. ____對您、您的家人及朋友很重要嗎？
   i. 如果是，為什麼？
   ii. 如果不是，為什麼不呢？

b. 您或您的家人及朋友是否使用過與_____相關的程序和/或服務？
   i. 如果是，您/他們使用這些程序和/或服務的經歷如何？
      • 如果經驗令人滿意，哪些做得好？
      • 如果經驗不令人滿意，哪些方面可以改進？
   ii. 如果不是，為什麼不呢？
References


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